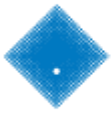

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Medical Care in Thailand: Motivating Factors for Australians

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Abstract

Australians travelling to Thailand for medical, surgical, and dental surgery are not unique. Medical tourism has become a global phenomenon, with citizens from the United Kingdom (UK), the European Union (EU) and the United States of America (USA) travelling to other countries for medical procedures or health care. Moreover, in some cases, private health insurers and organisations such as the UK's National Health Service (NHS) outsource health care to other countries. Medical tourism has been defined as "Cross border health care motivated by lower cost, avoidance of waitlists and services not available in one's country" (Lunt, 2015).

The primary aim of this study was to investigate and understand the factors that motivate Australians to seek medical, surgical, and dental procedures in Thailand. The secondary aim was to understand why Australians travel to other countries, specifically Thailand, for care.

This research used a multi-method, exploratory, sequential design which was undertaken in two phases:

1. Phase 1: Analysis of online blogs, hospital reviews and radio interviews
2. Phase 2: Online survey

For Phase 1 of the research, 27 independent narratives, 19 blogs, four hospital reviews and three radio interviews were selected and analysed. Most blogs and reviews were posted by medical travellers who sought cosmetic and dental procedures, while seven travelled for orthopaedic, optical, or other procedures. Via the Internet, Australian medical travellers have provided detailed narratives of their personal medical tourism experiences, offering advice, recommendations, or warnings to others. Overall, 80 per cent of medical travellers were very positive about their experiences; the remainder were negative.

Eighty-three respondents completed the survey for Phase 2 of this study. Responses indicated that the most common procedures were cosmetic and dental. Several conclusions were drawn from this phase of the research: Australian medical travellers are an empowered group of individuals; medical travellers take up to 12 months to decide to travel; medical travellers do significant research to understand surgical or dental procedures better, and they make contact with their Thai doctor or dentist before

travelling, and Australian travellers are resourceful and navigate a range of barriers to facilitate medical travel.

The pandemic was a major disrupter to businesses worldwide, including medical tourism, with international travel resuming after a three-year hiatus. Before the pandemic, approximately 15,000 Australians engaged in self-funded medical tourism annually. As a consequence, the demand for surgery continues to place a strain on the health system. Although accessibility and cost are initial considerations, these are traded off by other factors, such as the preferred surgeon or dentist. These considerations have three important motivators: ready access to services; health care tailored to the individual's needs; and pre-established relationships with Thai surgeons and dentists for ongoing care, which in some cases include other family members.

Finally, most Australian medical travellers report high levels of satisfaction with their medical tourism experiences, often describing the experience as high-quality personalised care. Medical tourism presents business opportunities for entities such as insurance firms and support care enterprises in Australia and Thailand.

Professional doctorate student declaration

Doctor of Business Administration Declaration

"I, Genevieve Juj, declare that the Doctor of Business Administration thesis titled Medical Care in Thailand: Motivating Factors for Australians is no more than 65,000 words in length including quotations and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

"I have conducted my research in alignment with the Australian Code for the Responsible Conduct of Research and Victoria University's Higher Degree by Research Policy and Procedures.

Ethics Declaration "All research procedures reported in the thesis were approved by the Human Research Ethics Committee HRE 18-218.

Signature  Date 25/11/22

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Lastly, this experience has been a revelation: I have learnt a lot about myself whilst undertaking my research, and in my self-development, I have discovered my attributes of resilience and determination.

> You cannot hope to build a better world without improving the individuals. To that end, each of us must work for our own improvement and, at the same time, share a general responsibility for all humanity, our particular duty being to aid those to whom we think we can be most useful. (Marie Curie 1867 - 1934)

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Abbreviations

ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
ACCC	Australian Competition & Consumer Commission
ACHS	Australian Council on Healthcare Standards
ADA	Australian Dental Association
AMA	Australian Medical Association
AIHW	Australian Institute of Health and Welfare
AHPRA	Australian Health Practitioner Regulation Agency
ASPS	Australian Society of Plastic Surgeons
AUD	Australian Dollar
B1	Blog 1
DHHS	Department of Health and Human Services
DIAC	Department of Immigration and Citizenship
DOHA	Department of Health and Ageing
ESCAP	Economic and Social Commission for Asia and the Pacific
EU	European Union
FEW	Fulltime workforce equivalent
GP	General Practitioner
HR	Hospital Review
IMTJ	International Medical Travel Journal
JCI	Joint Commission International Accreditation Standards for Hospitals

MSQH	Malaysian Society in Quality Health
NHS	National Health Service (UK)
RI	Radio Interview
SLA	Statistical Local Area
TRA	Tourism Research Australia
TGA	Therapeutic Goods Administration
UN	United Nations
UNESC	United Nations Educational, Scientific and Cultural Organisation
UK	United Kingdom
US	United States (of America)
USD	United States Dollars
WHO	World Health Organisation

Chapter 1. Introduction

Figure 1.1 Chapter 1 structure.

Chapter 1 describes medical tourism and provides a background to the study. This chapter introduces the research and identifies the scope and significance of the study. It also discusses the definitions and evolution of medical tourism and concludes by outlining the aims of the thesis and research questions.

1.1 Overview and definition of medical tourism

This chapter begins with a definition of medical tourism and then describes the evolution of medical travel in Australia over the last decade. Although an agreed medical tourism definition is still subject to debate, and there is no consensus regarding a definition, for the purposes of this research, the following is adopted:

> Medical tourism takes place when individuals opt to travel overseas with the primary intention of receiving medical treatments (Lunt, Smith, Exworthy, Green, Horsfall & Mannion 2011, p. 14).

The definition chosen covers associated activities and the principal reason for seeking treatment; therefore, in this study, the definition applies to medical, surgical, and dental procedures. The definition chosen has been used in other research studies and allows for comparing and contrasting Australian medical travellers with others (Medhekar & Wong 2020, Taheri, Chalmers, Wilson & Arshed 2021).

Many definitions are cited in the literature, and some debate exists on whether dental procedures should be included. The limitation of this definition is that it does not specify the actual procedures that medical travellers are seeking abroad.

There are two types of medical tourism, one based on a wellness model and the other based on medical surgical and dental care. This study researched only medical, surgical, and dental healthcare models.

This study investigated the phenomenon of Australian patients travelling to countries in Asia, specifically Thailand, for health care or medical procedures. Although these countries are recognised as 'developing' nations, Australians living outside major cities have a history of travelling long distances for health care. Many patients are accustomed to travelling from rural and remote regions to larger cities that facilitate their health needs.

1.2 Evolution of medical tourism

This research deals with an imperative aspect of health care - specifically medical, surgical, and dental that will be delivered globally in the next twenty years. People have travelled to different parts of the world for health reasons. The Roman Empire documented various health destinations, including Pompeii in Southern Italy and Bath in Somerset, England, known for their healing waters. Medical tourism is embedded in a historical context in Europe, with ancient Romans and Greeks travelling to specific sites for health requirements. Furthermore, Asian countries have offered alternative therapies, such as Ayurvedic medicine, a health and wellness model, and a delicate balance of mind, body and spirit (Chopra & Doiphode 2002). Ayurvedic treatments became popular in the West in the 1960s with yoga and other complementary health-related alternatives. The concept of travelling for health care is not new. In the 21st century, people with means have travelled to developed countries for health care unavailable in their own country of origin. Numerous affluent Middle Eastern patients have travelled to London for health care, which continues to this day.

Nowadays, medical tourism is facilitated by a number of enablers, two of which are affordable air travel and the wide utilisation of the Internet, which has encouraged Australians to search out information related to health and medical procedures. The Internet has changed how Australians access medical information; previously, patients relied on their medical professionals for advice on health care. The Internet enables individuals to access information and resources, thereby providing independence to explore alternatives rather than accept the status quo. There is a range of resources,

albeit both credible and unverifiable, on the Internet for travellers researching medical, surgical and dental procedures. (Connell 2016a; Golder, Ahmed, Norman & Booth 2017; Johnston, Crooks & Snyder 2012; Lunt, Hardey & Mannion 2010).

The difference between the past practices, where wealthy individuals sought care in Western countries and medical tourism today is that it is reversed. Patients from Western countries are now seeking care in developing countries, where a niche industry has been established to support the demand from Western countries.

For decades, Australians living in rural and remote environments outside significant cities have travelled long distances for health care. Also, the larger Australian states generally provided specialised health care to the smaller states and territories. Like others in Western countries, Australians live longer, requiring a range of procedures such as eye surgery and orthopaedic joint replacements to sustain their quality of life (Australian Institute of Health and Welfare 2020). However, the Australian health system can provide only a limited amount of health care, far short of the demand. Hence, medical tourism offers one way to manage the unrelenting demand for medical and surgical services.

1.3 Aim and scope

As aforementioned, the primary aim of this research is to investigate and understand the factors Australians consider when seeking medical, surgical, and dental procedures in Thailand. The research aims to understand why Australians seek medical, surgical, and dental care outside their country of residence.

Thailand has been a popular choice for Australians seeking medical and dental procedures. Thailand has established a reputation for high-quality medical, surgical and dental care. Besides, those Australians who travel to Thailand for tourism positively perceive Thailand and the Thai people. Australians seeking health care in Thailand demonstrate a resurgence with the destination. Over 563,000 Australians travel to Thailand for holidays annually (Australian Bureau of Statistics 2019a).

In some cases, family members may have travelled to Thailand for many years as tourists and have consequently established and maintained relationships with local Thais. Often medical travellers establish relationships with Thai clinicians and staff

working in health clinics. The relationships with Thai doctors, surgeons and dentists are critical to establishing trust between doctor and patient. This aspect of the care relationship has yet to be studied.

The Australian medical traveller continues to be underrepresented in studies; as such, understanding the motivation for travel and the procedures sought is the central objective of this study. There are identified gaps in what drives medical travel and the context and environment in which medical tourism operatives operate. The study's working assumption is that Australians who engage in medical travel are described as medical travellers, as their primary aim is to seek out medical, surgical, and dental care. In contrast, medical tourism is when both the medical procedure sought, and the destination are identified for tourism activities.

1.4 Research questions

The research questions formulated for this study are:

1. What are the behaviours and motivating factors of Australians who seek health care in Thailand?
2. How long does it take Australians to decide to travel for medical, surgical and dental health care?

1.5 Thesis outline

This thesis is comprised of six chapters summarised as follows.

Chapter 1. The introductory chapter states the aims and objectives of this study.

Chapter 2 reviews the literature on medical tourism, namely journal articles and multimedia resources published between 2007 and 2021. The aim of the literature review is to establish a comprehensive understanding and examination of medical tourism. The aim of the literature review establishes the context and aims to build knowledge in medical tourism.

Chapter 3 describes the research design used in the study and the methodology, including the framework used to analyse the datasets. A hybrid of Kotler's market segmentation theory and Dann's push-and-pull factors, provides a framework for

understanding the relationships between the factors driving medical tourism and the development of the industry (Dann 1981; Kotler 1999).

Chapter 4 presents the results obtained from the two phases of this research. The qualitative section reports the findings from the blogs, reviews and interviews. Subsequently, followed by the quantitative survey results that comprehensively describe Australian medical travellers. Both phases contributed new insights into the Australian medical traveller's demographic, geographic, psychographic, and behavioural aspects.

Chapter 5 discusses the findings obtained from both phases of the research and analyses these using the theoretical framework. The chapter provides an understanding of Australian medical travellers' motivations and behaviours. This chapter aims to answer the research questions.

Chapter 6 concludes the body of work of this doctoral thesis with a summary of the research findings. The contribution to knowledge is theoretical and practical; the study's distinctive aspects will be consolidated in this chapter. Future research directions are suggested, and the practical implications and business opportunities are discussed, particularly for health insurance companies. Specifically, there is the possibility of having an Australian outsourced model for elective procedures based in Thailand, similar to the partnership model that the UK has with India.

1.6 Summary

This chapter provided an overview of medical tourism. Specifically, the chapter focused on medical, surgical and dental procedures sought by Australian medical travellers in Thailand. A definition of medical tourism has been selected, and inclusion and exclusion criteria have been developed to guide the literature review. The research aims to investigate and understand what motivates Australians to travel to Thailand for medical care. The research questions and the thesis outline summarise the six chapters presented in this study.

Chapter 2 reviews the medical tourism literature to gain a comprehensive understanding of medical tourism specifically in Asian, Europe and North and South America. Factors such as supply and demand and their impact on the medical tourism industry will be examined within a theoretical framework of market segmentation and

push and pull factors. The literature review focuses on the Australian health system and how it influences and impacts medical tourism and travellers. The experiences of medical travellers are a key focus as are the risks associated with medical travel. The literature review concludes with the research questions that guide the study.

Chapter 2. Literature review

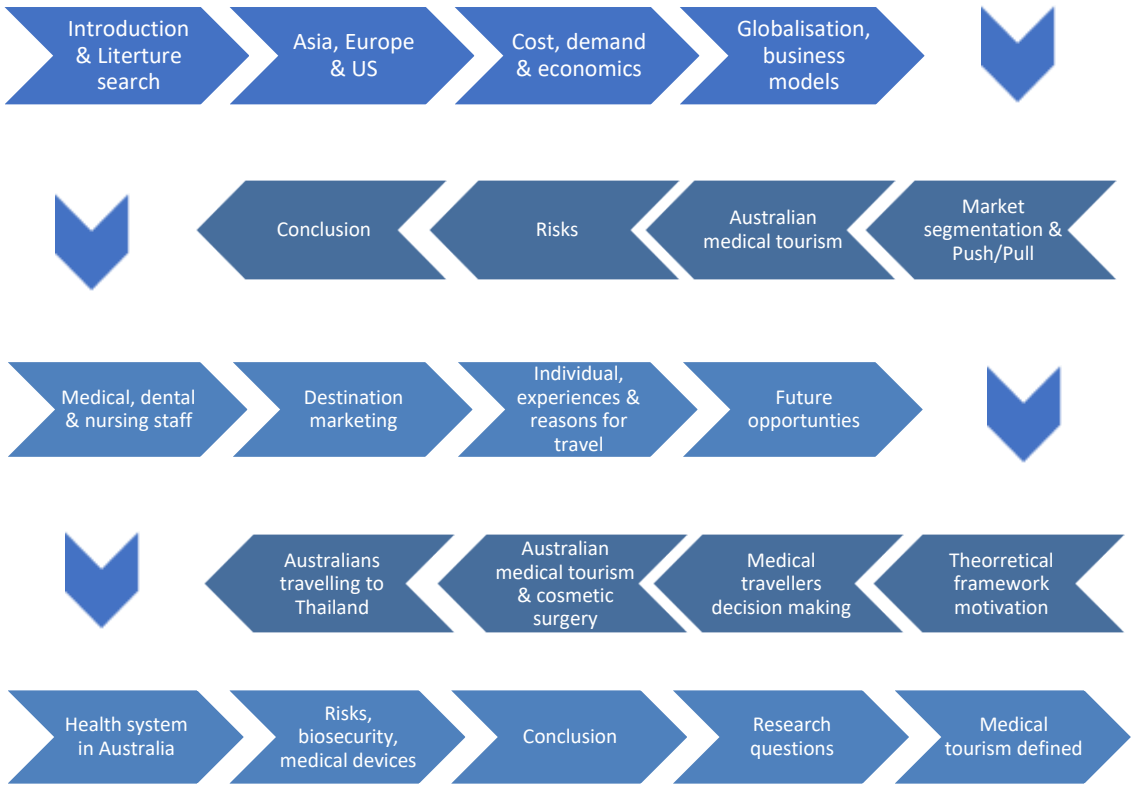

Figure 2.1 Chapter 2 structure.

Chapter 2 provides a thorough analysis of medical tourism literature. The review covers the definition and general overview of medical travel, with a focus on factors that influence Australians to seek medical, surgical, and dental procedures in Thailand. The literature review analyses the drivers behind medical travel, including both international and local factors, as well as individual motivations for medical care seeking.Additionally, the chapter delves into the analytical frameworks of market segmentation and push-pull factors to formulate a strategic approach.

2.1 Introduction

The medical tourism literature reviewed focused on the economic perspectives of supply and demand. Push-and-pull factors in medical tourism will be examined to understand the literature better. Critical to the study is the examination of the medical

tourism industry and the Australian medical travellers' motivations, experiences and level of satisfaction with their medical, surgical and dental procedures.

2.1.1 Literature search

For the literature review, the following databases were searched: Hospitality & Tourism Index, Academic Search Elite, Business Source Complete, Cumulative Index to Nursing and Allied Health Literature (CINAHL) with Medical Literature Analysis and Retrieval System Online, Full Text (MEDLINE) and Emerald Insight were examined. The search terms "Medical Tourism", "Medical Travel", "Australians Travelling Health Care", "Thailand Medical Tourism", and "Australians Medical Tourism in Thailand". Articles, conference papers and reports were accessed from the VU collection. These articles were from European countries, the United Kingdom, the United States of America and Canada, where medical tourism is well established. Articles selected for the literature review focused on South-East Asian countries such as Thailand, India, Malaysia and Singapore. However, articles from Japan, Korea and Taiwan were excluded as these countries specialise in facial cosmetic surgery, not the areas of medical, surgical, and dental procedures this study was investigating.

Any journal articles that were not published in English and studies related to inbound medical tourism were excluded from the analysis. Medical tourism can be both inbound and outbound, as is the case in Western countries such as the UK, US, and Australia. The study examined articles concerned with medical, surgical, and dental procedures and excluded those related to paediatrics, organ transplant, bariatric procedures, reproductive, and surrogacy procedures. Finally, duplicate articles were removed, resulting in a body of literature comprising full-text journal articles, conference presentations, multimedia publications, government reports and book chapters.

2.2 Medical tourism in Asian countries

South-East Asian countries such as Singapore, India, Thailand and Malaysia have a medical tourism industry. The level of development of the medical tourism industry in these countries varies from highly developed to new and emerging (Enderwick & Nagar 2011; Herberholz & Supakankunti 2015; Moghavvemi, Ormond, Musa, Isa, Thirumoorthi, Mustapha & Chandy 2017). Singapore's medical tourism industry is the

most developed in the region. It has adopted a differentiation strategy focusing on high-end surgeries with a focus on quality care and a reputation for excellence within the region (Ebrahim & Ganguli 2019a).

On the other hand, Thailand is a newer entrant to medical tourism, with 18 Joint Commission International (JCI) accredited hospitals. The US based JCI is the international accreditation body for hospitals. This body oversees international hospitals' quality, safety, and performance standards. The main challenge for Thailand has been the recent significant political unrest that has limited opportunities for short-term growth, with foreign investors less inclined to embark on joint ventures (Ormond 2013; Ormond & Sulianti 2017; Tangcharoensathien, Patcharanarumol, Ir, Aljunid, Mukti, Akkhavong, Banzon, Huong, Thabrany & Mills 2011; Turner 2007). Globally, the pandemic has challenged all countries, although Thailand, Singapore and Malaysia appear to have much lower mortality rates than India, which has experienced high mortality levels (Johns Hopkins University and Medicine 2020).

2.2.1 Medical tourism and competition

Beladi, Chao, Ee and Hollas (2017) argue that specialisation is required to sustain market position and competitive advantage and involves significant investment in technology and a highly skilled workforce.

The theory, whilst logical, fails to address medical tourism models operating in countries like India, Malaysia and Thailand. These market leaders in medical tourism offer a wide range of procedures and have developed expertise beyond various specialities. A According to Porter's (1980) generic competitive strategies model, there are four key factors that contribute to a company's success. This model has been used to analyse the success of various companies. Thailand is a leader in the medical tourism market, particularly in the field of cosmetic surgery, and meets the criteria for both the cost leadership strategy and the product differentiation strategy.

> “Factor 1 reasonably appears to represent a product differentiation strategy, factor 2 was the focus-cost leadership strategy, factor 3 was the cost leadership strategy, and factor 4 was the focus-product differentiation strategy” (Allen & Helms 2006).

Over time, various experts, including Kotler, have expanded upon Porter's initial work to create more models, theories, and frameworks. Kotler's (2012) marketing framework, for example, outlines three primary marketing strategies: product differentiation - where a business excels in providing superior value to customers; low-cost leadership - where companies focus on minimizing production and distribution costs; and narrow market segmentation. These strategies are relevant for medical tourism businesses in terms of how they distinguish their offerings and meet customer demands for value and service.

However, Porter (2000) argues that being good at all four is impossible as each position requires a different organisational culture and management system. The alternative concept of clusters is where companies or industries operate in one place, enabling a competitive advantage (Porter 2000). The example of local clusters is demonstrated in the Thai medical tourism industry, where there is a concentration of private providers engaged in medical tourism. Currently, 18 hospitals have received JCI accreditation (health-tourism.com, 2021). The Thai cluster represents interconnectivity between the hospitality, health and logistics industries and cooperation between the private sector, government and educational facilities (Porter 2000). Also, the Thai industry had its genesis in the niche area of gender realignment surgeries. Product differentiators continue to build and evolve expertise in cosmetic surgery. Similarly, this niche differentiates Thailand from the rest of Asia, enabling it to maintain its market position in terms of high quality and low cost within the region. Additionally, the specialisation of services is associated with the industry’s maturity level and needs to be considered within the context of the economic environment and public and private business models.

An exploratory study by Alsharif, Labonté and Lu (2010) suggested that respondents were consistent in their ranking of cost, and the reputation of both doctors’ and facilities’ as reasons for engaging in medical tourism. The findings reveal that hospital accreditation and facility reputation could be considered as interchangeable among medical travellers. It's noteworthy that affiliations with North American and European hospitals received higher scores than hospital accreditation, indicating a more favourable brand image attached to these affiliations.

Most articles and studies mention that the JCI-accredited hospitals these hospitals have met quality and safety standards set out under the accreditation framework. Currently, over 800 international medical facilities have JCI accreditation across the world. As accreditation is becoming commonplace, the majority of medical tourism hospitals are meeting the quality and safety standards of the accreditation process (Alleman, Luger, Reisinger, Martin, Horowitz & Cram 2011; Dehdashti, Zargham Brojeni, Nasehifar & Nakhaei Kamalabadi 2017; Enderwick & Nagar 2011; Mehta, Goldstein & Makary 2017; York 2008). While the literature mentions accreditation, medical travellers consider other criteria to support their decision-making. The concept of international accreditation has now become a given in the major medical tourism hubs identified by (Fetscherin & Stephano 2016b; John & Larke 2016b; John & Larke 2016a).

A limitation of this study is the lack of adequate evidence or data on demography and service utilisation behaviours of medical travellers. This limitation is generally due to issues of patient confidentiality.

2.3 Medical travellers and country of destination

Medical tourism branding is associated closely with the country of destination, also known as the Country-of-Origin effect (COO). In their study, Rosenbloom and Haefner (2009) found a relationship between risk and a global brand; therefore, the greater the risk, the more likely consumers will seek a 'surrogate for quality' and choose a global brand. Therefore, in the case of medical tourism, they will follow other consumers who have chosen the same hospital and doctors generally for the same reasons. The COO effect is a positive aspect of Thailand that extends to other services provided by Thai hospitals, doctors, and dentists who are closely aligned with medical tourism. An example of the COO effect is that the Thai people are friendly and offer superior customer service, and this view could extend to nurses and medical staff. The marketing of medical tourism is closely associated with the country of destination. The price point is an initial step to engaging in the market; prices are lower as costs in Asian countries are usually lower. Kotler (2012) suggests that people generally form a brand preference associated with customer value. Generally, low costs imply some form of unbundling. For example, budget flights are beverage only, have no choice of seats, and have no

check-in luggage. In this model, certain services are removed to curtail costs. However, medical tourism challenges this model as consumers are not asked to forgo anything. A major pull factor in medical tourism is the offering of more for less, including high levels of quality and the assurance of having well qualified staff, superior infrastructure and personalised health care. These inducements or pull factors allow medical travellers to experience "good value for money" in a resort-style environment typically associated with holidays.

A cross-sectional study by Noree, Hanefeld and Smith (2016) reviewed a large sample of medical travellers' records to determine the impact on the domestic economy in Thailand. This study estimated that 167,000 medical tourists visited Thailand in 2010. Specifically, 3360 were Australians who were travelling mainly for cosmetic surgery. The findings from the study suggest that medical travellers are not a homogenous group, as they present with conditions requiring treatments ranging from minor to serious. The study, which took an economic perspective, found that more revenue was generated by medical travellers from neighbouring regions than from long-haul regions. Also, male medical travellers spent more than female medical travellers, and older travellers spent more than younger medical travellers. The complex medical conditions of the older males were the reason for the expenditure. This study had the largest sample in the literature on medical travellers and involved five Thai hospitals with unprecedented access.

Consequently, the study provides empirical evidence of medical travellers travelling for surgery to Thailand, including Australians. The largest cohort of medical travellers comprised Eastern Mediterranean, South-East Asian, European, South Asian, North American, East Asian, African and Australasian travellers, the mass of whom had elective cosmetic procedures. Whilst this study confirmed the numbers of medical travellers, it exposed the over inflated estimates often used in the literature and provided by the medical tourism industry.

In a study by Wong, Velasamy, Arshad and Nuraina (2014), which included a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, Thailand was identified as the medical tourism market leader in Asia, supplanting Singapore, which had acquired a reputation for being politically stable, clean and safe. These attributes

enhanced Singapore's appeal as a destination. Singapore continues to have high-quality medical care and advanced diagnostic equipment, competitive advantage at one point. However, the prices for these services are higher than in other regional competitor countries. Moreover, in 2011, more than one in three doctors practising in Singapore was a foreigner, an inherent weakness for the sustainability of a specialised workforce.

2.3.1 Medical tourism and competition in Asian Countries

The SWOT exercise (Wong et al. 2014) identified Malaysia as the weakest amongst Asian countries, having developmental issues in all criteria areas. Furthermore, there has been political unrest and economic instability in Malaysia, which are core factors in developing and expanding the medical tourism industry. The SWOT analysis failed to show the growth trajectory that has resulted in Singapore's economic prosperity, despite Asia's highest medical service costs. On the other hand, Malaysia's competitive advantage is that it is centrally located geographically and has a market share of services provided to neighbouring countries and Muslim medical travellers, specifically those from Indonesia and Middle Eastern countries (Chee 2007, 2010; Kanchanachitra, Pachanee, Dayrit & Tangcharoensathien 2012). Additionally, Indonesia is home to the world's fourth largest population, and Indonesians engage in medical tourism as an outsourced model of care (Ormond 2013). Indonesians are generally outbound medical travellers, preferring to use neighbouring countries such as Malaysia and Singapore for medical services. Although other countries engage in medical tourism internationally and in Asia, data only from countries that are relevant to the research questions are included in this study.

2.4 Medical tourism: European and US experiences

In the last two decades, medical tourism has transformed. Previously, only wealthy individuals travelled to elite hospitals whereas, nowadays, medical travellers from Western countries are travelling for non-emergency procedures often referred to as 'elective surgery'. Hanefeld, Horsfall, Lunt and Smith (2013) found that in the UK, National Health Service (NHS) patients are travelling for medical, surgical and dental care to other countries in Europe and Asia. The NHS has established this model of outsourcing health services for patients in the UK (Lunt et al. 2011). The early adopters

who used this model were the diaspora populations living in the UK. Specifically, the British / Indian patients were willing to return to India for their health care. This group of early adopters was responsible for India's medical tourism industry (Connell 2016a). The outsourcing arrangement matured over time and resulted in the development of UK and Indian enterprises, encouraging a medical market with mutual benefits. An example of collaboration is sharing NHS expertise in technology and medical research. These initiatives benefit UK citizens using services in India (Department of Health and Social Care 2018). A national health system is well-established in the UK, Canada and Australia. The primary strategy used to manage demand in this type of health model is to use a queuing system for elective surgery and outpatient appointments. The ability of the NHS to use countries like India to manage medical and surgical demand provides a demand management business model for Australia. In 2020 the migrant populations made up 30 per cent of the overall Australian population; the largest migrant groups were from England, India, China and New Zealand; these groups could follow the diaspora patterns that are already well established in the UK and seek care in their COO (Australian Bureau Statistics, 2021). The diaspora medical travellers are a specific group. Therefore, they are targeted by their countries of origin examples of these are India, Middle Eastern countries Iran, Jordan, Lebanon and Turkey Mathijsen and Mathijsen (2020b).

Several studies confirm the high levels of satisfaction based on patients' experiences with the outsourcing model (Lunt, Horsfall & Hanefeld 2015, 2016; Lunt, Horsfall, Smith, Exworthy, Hanefeld & Mannion 2014a; Lunt, Mannion & Exworthy 2013; Lunt et al. 2011; Lunt, Smith, Mannion, Green, Exworthy, Hanefeld, Horsfall, Machin & King 2014b). Conversely, the patients' satisfaction level with the health system decreases on their return to the NHS, generally due to poor service. The demand pressure continues to drive service- and professional-centric models, resulting in patients experiencing long wait times and having limited options. Medical tourism in the US

There is no national health care system in the US (Cohen 2017), where health care is managed in three ways: employer-sponsored insurance, individuals purchasing health insurance, or coverage by Medicaid or Medicare. The Affordable Care Act of 2010 gave middle- and low-income people access to private health insurance coverage. The US

health system continues to be in flux but generally, health services are a hybrid system of private and public service delivery. The cost of health care in the US is the highest in the world (Centers for Disease Control and Prevention 2014). Consequently, US-based patients and, in some cases, insurance companies facilitate medical tourism to Mexico and Central and South American countries. A study by Bristow, Yang and Lu (2011) identified Brazil and Costa Rica as medical destinations and found that 14 per cent of all visitors to Costa Rica received some medical care, usually cosmetic surgery or dental procedures. More recently, Costa Rica has made significant economic investments in medical tourism (Cohen 2014b; Connell 2006). Individuals living in the US who are unable to afford health care locally seek it from other countries that are in the proximity. There continues to be demand for affordable health care from patients living in the US.

Medical tourism is occurring across the globe. This study examines Australian outbound medical travel as such it is grounded in the context of a health system that has more commonality with the UK and Canada than the US. However, the drivers of cost and accessibility continue to be the reasons for US and Canadian citizens seeking health care abroad.

2.5.1 Medical travellers' global flow

In the literature, the global flow of patients indicates the well-established routes used by medical travellers (Lunt et al. 2011; Piazolo & Zanca 2011). Medical tourism has historical and geographical influences determining the flow of travellers seeking care. There is some evidence that geographic proximity and well-serviced flight paths are two factors that promote medical tourism to a particular destination. For example, medical travellers from Western Europe access medical treatment in Hungary, and medical travellers from the US seek care in Mexico and Costa Rica. Studies argue that some nationalities travel for medical care to countries with an appropriate or familiar cultural context (Crooks, Kingsbury, Snyder & Johnston 2010; Crooks, Turner, Snyder, Johnston & Kingsbury 2011; Vasudevan 2015). For instance, medical travellers from Indonesia and the Gulf nations choose Malaysia for health care. There is consensus in the literature that most medical travellers seek health care from neighbouring countries where possible. The notion of medical travel being popular within regional boundaries

or localities is corroborated by studies discussing travel within the EU and Asia (Bell, Holliday, Jones, Probyn & Taylor 2011; Connell 2016b; Ormond 2013; Pocock & Phua 2011; Whittaker 2008).

A limited number of studies examine Australia's current economic, political, and geographic context of medical tourism and health care. When exploring the reasons for medical travel, the motivations of the Australian medical traveller can be understood by considering the push and pull factors determining their decision making. The definition of push and pull factors is described as:

> The push factors are defined as the factors that pushed the patients to choose overseas treatment destinations instead of having their treatment in the home country. On the other hand, "the pull factors" are the factors that attracted patients to treatment destination as they are perceived by the patients themselves (Alnakhi, Segal, Frick, Ahmed & Morlock 2019, p. 41).

Regarding the push factors, individuals who travel for medical procedures may be pushed by internal psychological factors such as sociodemographic characteristics, age, gender, and income (Fetscherin and Stephano (2016b). Individuals can also be pulled to a certain destination by external factors, which are generally destination attributes such as the reputation of doctors, the stable economy etc. (Dann 1981). John and Larke (2016b) analysed 407 peer-reviewed articles published between 2000 and 2016 to identify motivators for medical tourism. The study found that push factors are the primary motivators and are more frequently cited in the literature. The study was frequency-based and did not examine other specific factors and their importance. Hence, the study failed to show how important some pull factors were to medical tourism consumers. Some of the pull factors cited in the literature were: infrastructure, availability, the reputation of clinical staff providing the care, political and social stability, exchange rates, food and accommodation, regulatory environment (legal protection) and social and cultural familiarity (John & Larke 2016b, p. 82). Although the study was extensive, it took the perspective of health providers rather than the medical travellers themselves. Furthermore, most studies examined used an economic perspective, which was over-represented in the literature. These researchers

acknowledged that a better understanding of individuals' motives is required (Adams, Snyder, Crooks & Johnston 2015; John & Larke 2016b).

2.5 Cost as a factor

Costs of procedures continue to be predominated in the literature. Also, in the case of Australia, the cost of a procedure continues to be an important factor, although it is not always the only consideration. There continues to be inconsistency in the argument of lower medical cost as a significant driver. For example, in the literature, lower medical costs are often cited as the primary motivation for medical travel (Crooks et al. 2010; Hanefeld et al. 2013; Hanefeld, Smith, Horsfall & Lunt 2014; Hopkins, Labonte, Runnels & Packer 2010; Noree, Hanefeld & Smith 2016). However, regarding the pull factors within the same cohort of studies, infrastructure is cited as the strongest pull factor, closely followed by availability, the reputation of medical professionals and political and social stability. These are followed by several other common motivators: lower cost, service quality, language proficiency, accreditation of the medical facility, infrastructure, availability of specific treatments, and less waiting time. Access to timely care ranks seventh, which seems to be an anomaly given that lack of access to services in the home country continues to be a primary reason for travelling (Carrera & Bridges 2006; Crooks et al. 2010). A primary motivator for medical travellers is seeking services unavailable in their own country. According to Fetscherin and Stephano (2016b), service unavailability or inaccessibility is a push factor. Because motivators are inextricably linked, it is difficult to obtain a definitive or single motivation for medical travel and separate the majority of essential reasons for travel from the less important pull factors. However, what is clear is that decisions by medical travellers are multifactorial and non-linear.

2.6 Demand management

The push factors that affect the supply of health care and the expanding demand for elective surgery, specialist appointments and dental services will be the primary focus of this research. The demand for health care in Western countries continues unabated elective surgery in Australia has been delayed due to the pandemic. Hence, in the UK and the US the outsourcing of health care to developing countries is one strategy being

applied to manage demand prior to the pandemic and the restrictions on travel. These countries have formal agreements in place to facilitate the intercountry movement of patients. Although Australia has issues with the supply of health care, specifically, the demands for elective surgery are not being met. There are no formalised agreements with Asian countries for medical tourism (Australian Institute of Health and Welfare 2016; Chandra 2017; Lunt et al. 2014b; Ruggeri, Zalis, Meurice, Hilton, Ly, Zupan & Hinrichs 2015; Smith & Forgione 2007; Smith, Martinez Alvarez & Chanda 2011; Stolley & Watson 2014; Turner 2010; World Health Organization 2015; York 2008).

The global driver of medical tourism is the lack of access to services in the medical traveller's own country. The other key point from the literature is that cost and access are the primary considerations; individuals look for alternatives when these are not met. The medical traveller starts to seek out services, often within regional boundaries. As the global markets become more accessible, boundaries between countries become more fluid. Trade agreements, the World Trade Organization (WTO) and the General Agreement on Tariffs and Trade (GATT) have facilitated health service trade with cross-border industries (Beladi et al. 2017; Chandra 2017). In a study of factors driving medical tourism, Aydin and Karamehmet (2017) suggests that,

> Freedom in the movement of goods and services between countries has provided international mobility to medical equipment, health-care professionals and individuals looking for health-care services. This ease of movement has led to the emergence of health tourism as a significant economic phenomenon (Aydin & Karamehmet 2017, p. 19).

A clear advantage of developing countries is that they can manage the costs of prosthetics without the handling costs, which in the case of the US, makes these devices so expensive (Rosenthal 2013).

Medical travellers also prioritise cultural considerations when deciding to seek diaspora medical care. In these cases, medical travellers will follow pathways that reflect their individual needs (Lunt, Horsfall & Hanefeld 2016; Lunt et al. 2014a; Lunt et al. 2011). For example, cultural considerations see Middle Eastern and Indonesian patients travelling to Malaysia for health care. In contrast, health services would be more expensive in Thailand and not culturally aligned with the Muslim culture. Also,

the regional proximity of Indonesians going to Malaysia for care is a time- and cost-effective consideration (Ormond 2013; Ormond & Sulianti 2017).

2.7 Medical tourism and economics

Countries that engage in medical tourism as a form of international trade are looking for a return on investment (ROI). The economies of India and Thailand have become reliant on this industry (Chandra 2017). As the industry matures, these countries' economies need to move beyond providing a level of accreditation and consider sustainable regulatory environments where risks to the medical traveller are minimal. The industry's maturity could facilitate and support international health insurance, global accreditation of medical and dental clinicians, and a process that allows medical travellers to redress adverse surgical outcomes. Chandra (2017) suggests that medical tourism is an investment that would benefit the national economy and should therefore be a country's developmental goal. However, in the case of the Indian economy, this has not been realised. The economic growth and prosperity that India has enjoyed over the last decade have not "trickled-down" to the poor and marginalised sectors of the population. Health care continues to be inaccessible to the majority of the population, with conditions getting worse due to the spread of the pandemic. According to Chandra (2017), equity issues exist regardless of whether or not countries engage in medical tourism. Cuba is one example of the successful implementation of a health services trade (Connell 2006). The Cuban government provides inbound medical tourism and sponsors doctors to different countries, mainly Africa and Central America, in exchange for foreign currency. Cuba is a unique economy with few trade options given the US embargo, which continued under the US administration. Therefore, providing a skilled health workforce to other parts of the globe is pragmatic.

Connell's (2006) argument focused on the economic perspective of medical tourism, specifically how individuals from wealthier countries seek healthcare in Asia. However, the argument does not address the issue of governments failing to meet their responsibilities in providing healthcare for their own citizens. In 2010, Obamacare was introduced in the US and has had a substantial impact on health care in the country (Cohen, 2014).

2.8 The globalisation of health services

The commoditisation of health care has led to the unintended consequence of an efficiency-based model being pursued. This model has resulted in depersonalised, bureaucratic and commodified services in most Western countries. Under the current model, medical, surgical and dental care continues to be dominated by technology, where almost every condition in health care is subjected to a technological process. Subsequently, one of the core relationships linking doctor and patient has changed, with some arguing that this has resulted in the breakdown of the relationship between physician and patient (Cohen 2008b; Connell 2016b; Imison & Schweinsberg 2013; Lunt, Mannion & Exworthy 2013). In the past, the expert physician would make a diagnosis using their clinical experience. The physician's role is established during the examination process, and the relationship between doctor and patient is built through assessment and diagnosis (Scaioli, Schäfer, Boerma, Spreeuwenberg, Schellevis & Groenewegen 2020). The investment in time required to take a patient's history and understand the patient's issues and perspective creates a bond and rapport between patient and doctor (Chandra, Mohammadnezhad & Ward 2018). The traditional consultation has now been replaced with pathology, radiology and other technocratic processes, which have changed the doctor's role and become a facilitator of other professionals' findings.

Health care, like other industries, is subject to market forces of supply and demand. As the provision of health care has evolved, the model of care resembles a business model. (Petrocchi, Iannello, Lecciso, Levante, Antonietti & Schulz 2019). Consequently, the roles of doctors, surgeons and dentists have changed, as they now operate as businesses. In some models in Western countries, health care is often delivered by teams emphasising multiple clinicians working together to treat a patient. Therefore, independent practice is now group practice. The drive for greater throughputs to meet the demand and maximise resources continues to pressure doctors to see more patients. The patient's consultation turns into a business item, transforming a more personal relationship into a transactional one with several stakeholders involved in the patient's care. Finally, it is much harder to have a relationship with multiple people who oversee specific aspects of the patient's care. Smits, Bowden and Wells

(2016) clearly describe how medical care is delivered in a Western context. Also, aspects of health care in the West have already been outsourced to the global marketplace. For example, several US hospitals send radiology results to India for interpretation, further fragmenting patient care (Cohen 2008b; Johnston, Crooks & Snyder 2012; Lunt, Mannion & Exworthy 2013; Lunt et al. 2011; Ormond 2013; Ormond & Sulianti 2017).

Health care continues to evolve as new technologies and surgical procedures are introduced. This evolution of the health care industry is constant and like other goods and services the industry is changing in response to technological advances. This shift has changed the economic and political context of how health care is supplied to citizens, raising the issue of who has responsibility for health care - individuals or the government? In practice, health care is delivered by medical practitioners. Doctors in the West are often described as time-poor and overworked. These conditions have flow-on effects on the patients they are managing and the profession, which experiences high turnover rates (Byrne, Conway, McDermott, Costello, Prihodova, Matthews & Humphries 2020). Although medical consultation time per se does not increase a patient's satisfaction, better satisfaction is achieved when the patient's psychosocial factors or needs are explored (Baumgardner 2021).

2.9 Medical tourism: business models

In a study of US and European medical travellers, Connell (2013) argues that medical tourism becomes a form of liberation in that patients are perusing self-determination, which inherently provides personal satisfaction. In the majority of studies on medical tourism, patients globally continue to report high levels of satisfaction with their care. The reasons are not explored in the literature other than to mention that medical travellers have perceived satisfaction levels. Some of the reasons could be that the level of control over their procedure and the positive relationship with medical, surgical or dental professionals drive high patient satisfaction levels. Medical travellers own the decisions being made as they are partners in the decision-making process. Moreover, medical travellers have established trust with their medical tourism physicians and have chosen these individuals to care for them.

The medical tourism sector is highly competitive, but one core aspect that creates a competitive advantage is that medical tourism is a consumer-oriented approach. The industry is consumer-sensitive, providing tailored services to consumers and, in the main, appears to be successful in gaining consumers' trust. Medical travellers rely on others for word-of-mouth and online recommendations to assist them in making decisions (Connell 2013; Horowitz, Rosensweig & Jones 2007; Ngamvichaikit & Beise-Zee 2014). Studies from Western countries take the perspective that the patient's choice is paramount, specifically with people with chronic illnesses and ongoing health management needs (Guiry, Scott & Vequist 2013; Prajitmutita, Perényi & Prentice 2016; Van de Walle & Marien 2017). Compared to other Western countries, the US market is expensive in terms of health care (Bies & Zacharia 2007; Foley, Haglin, Tanzer & Eltorai 2019; Smith & Forgione 2007). The US insurance companies are dominant stakeholders in the marketplace, where health insurers are health care providers and facilitators. In the US, large insurance companies enable and facilitate procedures offshore, often providing incentives for patients to choose outsourced care. Such incentives may be the payment for the travel expenses of family members and the waiving of out-of-pocket expenses. The substantial savings from medical tourism make this model feasible (Horowitz, Rosensweig & Jones 2007). Many North Americans cannot afford health care for various reasons. These individuals are either uninsured or underinsured due to having pre-existing conditions, being ineligible for public medical schemes, or their insurance not covering a particular elective surgery (Cohen 2008b; Connell 2016b).

Consequently, US patients take their business offshore, seeking alternative markets that maximise quality and provide affordable care. These developing markets are located in Asia and Central America. These countries have many competitive advantages. In particular, the price difference is a significant factor as these countries have lower wages and insurance costs.

2.10 Analytical framework: market segmentation model

This study's framework is based on the Kotler and Keller (2001) market segmentation model consisting of four categories, enabling a better understanding of the Australian medical traveller and the medical tourism industry. The market

segments help to break down and categorise the information and incorporate the characteristics of the Australian medical traveller. Kotler and Keller (2001) provided a comprehensive framework against which the study could appraise the Australian medical traveller's identity and understand who is using medical tourism in Australia.

The market segmentation model comprises geographic, demographic, psychographic and behavioural segments (Kotler & Keller 2001). The geographic segment will assist with understanding where people live and their environmental context. Geographic segmentation is defined as

> ... a market divided by location. The geographic segmentation is based on the belief that consumers who live in the same region share some related wants and needs, which could be very different from those living in other regions of the world (Martin 2011, p. 17).

Does this definition suggest that the medical tourism industry has a community of buyers and sellers? The majority of the Australian population live in the south eastern part of the country. Sixty-seven per cent of Australians live in capital cities near the coastline (Australian Bureau of Statistics 2021).

Australia is a country with a rich diversity of people and environments. Therefore, the geographic segmentation should consider various aspects of communities beyond just their physical locations. As such medical travellers gathering to share experiences are a community with a common purpose. Medical travellers rely on cyber communities to gather online, sharing experiences on websites such as Facebook, where pages are dedicated to medical tourism with individuals discussing their procedures pre-and post-travel.

Medical travellers rely on cyber communities to gather online, sharing experiences on websites such as Facebook, where pages are dedicated to medical tourism with individuals discussing their procedures pre-and post-travel. Some websites, such as Real Self, have a dual purpose: to exchange information about professionals specialising in cosmetic surgery procedures and meet like-minded individuals. The development of these sub-communities stems from an interest in cosmetic surgery. These websites are moderated by individuals who believe that others would benefit from the shared

capacity of the community. Websites are sometimes commercially based and often used for advertising various services.

2.11 Medical tourism enablers

The Internet is critical in enabling medical tourism, as this is the main communication platform where information is exchanged. This medium also facilitates access to doctors and dentists through recommendations made by other medical travellers.

Studies have established that travellers seeking medical tourism do so because they cannot access particular procedures and medical services at affordable prices in their own country (Aydin & Karamehmet 2017; Connell 2016b; Fetscherin & Stephano 2016a; Heung, Kucukusta & Song 2011; Lunt, Horsfall & Hanefeld 2015). Depending on the medical traveller's geographic location, several studies suggest that medical travellers seek medical care from countries within regional boundaries. Europeans travel to other European countries, from North America to Central America. Similarly, Australian medical travellers travel to Asia, specifically Thailand and Malaysia, for medical tourism (Chandra 2017; Connell 2011c; Ormond & Sulianti 2017; Turner 2007). Furthermore, regarding the geographic marketing segment, there is strong evidence that medical travellers prefer to stay within prescribed boundaries. This behaviour or preference depends on several factors, one of which is that the services sought are available within the regional boundary. If services or treatments are unavailable, medical travellers will travel longer distances in those circumstances. For example, Fisher, Petersen and Burstein (2017) suggest that many Australians seek services in China for stem cell treatment. The relationship between not being able to access health services in Australia for various reasons and seeking services in Asia is a key aspect of this study.

2.12 Market segment: psychographics

This market segment uses psychology and demographics to understand the consumer. Kotler and Keller (2006) maintain that consumers are inspired by three primary motivations: ideals, achievements, and self-expression. Consumers are motivated by ideals that are guided by their knowledge and principles. Similarly, those

interested in achievement look for products that demonstrate success to their peers. The Australian medical traveller could be associated with all three primary motivations. However, the closest identified behaviours would be with the two primary motivators: achievement and self-expression. These two primary motivators are identifiable in Australian medical travellers' awareness of peers who engage in cosmetic surgery. Also, the cohort of medical travellers seeking cosmetic surgery comprises mainly women driven by addressing issues with their body image and sometimes trying to re-invent their physical selves. Self-expression and self-improvement behaviours can also describe Australian medical travellers as early adopters of a relatively new industry and willing to take calculated risks to improve their image. Finally, medical tourism is action-orientated: patients identify and locate dentists or doctors, research their respective procedures, take responsibility for themselves, and own their decisions whilst driving their agendas (Connell 2006; Connell 2008, 2011a, 2011b). Medical travellers who engage in medical tourism appear to be satisfied with the services they receive. They exercise their autonomy by choosing to seek care outside of Australia, indicating a departure from the norms of society. Their attitudes, values, and beliefs align with the decision to pursue medical procedures abroad.

Cosmetic surgery and dental procedures are over-represented in outbound medical tourism in Australia. These procedures are currently limited and could be broadened to other elective procedures to manage the demand for surgery in this country. The Australian insurance industry is in flux, with reforms well overdue as the industry continues to look for new markets. There are fewer Australians with private health insurance now than when it was introduced in 1999 (Australian Competition and Consumer Commission, 2018). The dropout rate continues to escalate with younger people leaving the scheme and older Australians using hospital services to meet growing health demands (Duckett, Moran & Danks 2017; Lewis, Collyer, Willis, Harley, Marcus, Calnan & Gabe 2017). As private health insurance membership diminishes, consumers are offered limited options domestically. Medical tourism provides a range of options that appear limitless to consumers. Sometimes, Australians living in Perth have a four-hour journey to Asia to access health care. Adams et al. (2015) study of Canadian medical travellers found that further research is needed to understand the decision making of medical travellers. The greater number of narratives

obtained from research respondents were focused on quality-of-life issues, such as pain reduction, management of chronic disease, and individual control of health needs. Many of these travellers had exhausted the options the Canadian health system offered. These medical travellers were not content to remain passive recipients of domestic health services. They actively sought alternatives to meet their health needs and wants, demonstrating a preference for exercising autonomy.

2.13 Market segment: behavioural

According to Kotler and Keller (2006), the behavioural segment is consumers' knowledge of, attitudes toward, use of, or response to a product. Social, economic and political environments have pushed Australian medical travellers at home to explore medical tourism. Medical travellers cannot rely on formal structures, often researching their procedures and exhibiting a level of self-determination. Often travelling alone, with a companion or in a tour group, they are loyal to their belief system and determined to achieve their goal (Crooks et al. 2010).

In the behavioural segment, the user's status is determined by non-users, ex-users, first-time users and regular users; this is the case with users of medical tourism, according to Kotler and Keller (2006). Some Australian medical travellers begin as first-time users and then become regular users as they engage in medical tourism on multiple occasions for various procedures. In the narratives, Australian medical travellers describe their cosmetic surgery experiences which offer insights into how cosmetic tourism is constructed and consumed. These types of procedures appear to be dominating the Australian medical tourism industry (Bell et al. 2011; Connell 2016a; Holliday, Bell, Cheung, Jones & Probyn 2015; Holliday, Bell, Jones, Hardy, Hunter, Probyn & Taylor 2013a; Holliday, Bell, Jones, Probyn & Sanchez 2014; Noree 2015). The literature also suggests that medical travellers are patients of modest means. However, there is scant empirical evidence regarding numbers, and the industry often overestimates the number of medical travellers. Independent verification of the numbers continues to be problematic due to commercial, in-confidence, and privacy issues (Bell et al. 2011; Connell 2016a; Holliday et al. 2015; Holliday et al. 2013a; Holliday et al. 2014; Noree 2015).

Consequently, given these demands, Australians have begun to self-manage their surgical and dental needs by making private arrangements, including organising medical tourism. Additionally, in some parts of the country, patients are expected to travel great distances for care and have to wait. In some cases, these push factors are related to Australia's demand or availability of health services. Pull factors relate to supply or the reasons Australian medical travellers seek health care in Thailand. Hanefeld et al. (2014) suggest that patients' unwillingness to wait for services is a major reason medical travellers seek care in other countries depending on the procedure. The inability to access timely public health services in Australia, when combined with the knowledge gained through internet sources of services in other counties. The services offered in countries such as Thailand can be organised and tailored to the requirements of the medical traveller making medical tourism an attractive alternative for the potential medical traveller. The pull factors are the external motivators such as choice of destination, relationship with the physician, the types of procedures, and the availability of high-quality care. All these factors draw patients to other countries, hospitals, and doctors. The pull factors are overrepresented in the literature, mainly because the bulk of the research on medical tourism has focused on the economies and destination countries rather than the medical traveller who is a medical tourism consumer.

2.14 Demand: push factors

In the literature, there is limited information about medical travellers and why some patients travel for medical procedures and others do not. Exact figures for the number of medical travellers are unavailable, thereby limiting the types of research. There continue to be no formal structures for ascertaining the number of medical travellers (Crooks, Whitmore, Snyder & Turner 2017; Khan, Chelliah & Haron 2016; lajevardi 2016a; Lajevardi 2016b; Moghavvemi et al. 2017; Noree, Hanefeld & Smith 2016; Ormond & Sulianti 2017).

In Western economies, rationing or queuing is used to manage increasing demand. It is common to have to wait or queue for appointments and procedures within the public and private health systems. (Johnston, Crooks, Snyder & Kingsbury 2010; Lunt, Horsfall & Hanefeld 2015; Whittaker 2008). Patients often wait for long periods when demand is high. The economic situation of high demand levels leads to the rationing of

care. Patients are told the estimated time for specialist appointments and elective surgery. These wait periods have doubled since the pandemic. The number of patients waiting in 2020-21 for more than 365 days increased from three per cent to eight per cent (Australian Institute of Health and Welfare 2020).

There are consequences for patients when access is limited. These can have a psychological effect of making patients feel that they will never be able to receive the medical attention they need (Gan & Frederick 2011a; Guiry & Vega 2015; Hanefeld et al. 2014; Lunt et al. 2011; Vasudevan 2015).

2.15.1 Medical tourism driven by demand

The demand or push factors are the limited access to health services in Australia, the long waiting times for elective surgery, and the lack of availability of some procedures (Carrera & Bridges 2006; Heung, Kucukusta & Song 2010; Hunter 2015; Vijaya 2010; World Health Organization 2015). Moreover, Hopkins et al. (2010) suggest that the ongoing pressure on demand for health care is universal. A significant factor is the ageing populations in Western countries. Often older people require expensive and specialised interventions for extended periods (Connell 2006). Technological advances in medical procedures for replacing joints, repairing heart valves, and other procedures, give baby boomers and others access to a range of options in health care. Innovation in the areas of medical development and a generation with the means to support alternatives to domestic health care are driving medical tourism.

Sometimes, medical travellers seek out the available technology and or procedures to improve their lives. Medical tourism offers an affordable path to health care for people who can afford to travel to other countries for care, generally have no or limited insurance, need procedures not covered by insurance, or are on a public list waiting for care. The demand drivers are compelling, with the US literature suggesting that at least half of US bankruptcies are caused by medical bills (Himmelstein, Woolhandler & Warren 2018). Medical costs in the US continue to rise simultaneously with the numbers of underinsured and uninsured US patients (Carrera & Lunt 2010; Cohen 2014). As more Australians utilise medical tourism and travel to another country this builds confidence and increases familiarity with health care in other countries. The possibility of formalised pathways to assist with medical travel is more likely for

Australian medical travellers. Pressure on Australia's medical and dental industries could drive a reform that sees aftercare being provided for returning medical travellers.

The medical tourism industry is a major disrupter in Australia: the early adopters are already engaging in it. Medical tourism has “the potential of doing to the US health care system what the Japanese auto industry did to American carmakers” (Horowitz, Rosensweig & Jones 2007, p. 33). Horowitz, Rosensweig and Jones (2007) made this observation fifteen years ago, indicating that medical tourism is at least two decades old and has been described as an industry disrupter by several studies (Bies & Zacharia 2007; Cohen 2008b; Connell 2011c). Paradoxically, as an industry, it is also very fragile and susceptible to external environmental conditions. Medical tourism relies heavily on other external factors such as political stability, affordable air travel, availability of a specialised workforce, government support and stable biosecurity conditions. The wide range of procedures and the extent of health care options available continue to drive the demand. The Internet enables health care options to be searched and researched. Numerous websites provide access to information, speciality surgeons, and hospitals which are often ‘one-stop-shops’, with some hospitals in Thailand assisting with visa entry and travel arrangements (Moghavvemi et al. 2017).

Furthermore, Australian medical travellers have access to cheap international flights by budget carriers such as Jetstar and Air Asia and a range of accommodation which facilitates access and promotes the growth of medical tourism. The medical tourism industry has seen the rise of secondary businesses that specialise in arranging particular surgeries, mainly cosmetics. These businesses can negotiate the logistics for medical travellers. Other businesses such as hotels and transport companies specialise in providing support services to the medical tourism industry and are referred to in the literature as ‘third party intermediaries' (Lunt, Mannion & Exworthy 2013)

Consistently emerging in the literature is the theme of positive patient experiences of medical tourism. Specifically, studies refer to NHS patients who report having a positive medical tourism experience. The UK has the most mature medical tourism industry with established pathways. As such, the UK patients comment on the differing standards of health care provision across Western European countries. For example, some observe that the NHS is slower than Germany's health services in providing care

access. Patients interviewed by Lunt et al. (2014a) were distrustful of or dissatisfied with previous treatments provided by the NHS. Subsequently, these patients chose medical tourism for their health care. Travellers returning to the UK after a medical procedure abroad are entitled to post-operative care provided by the NHS. The outsourced model of care provides a pathway for UK patients on their return to continue to receive post-surgery care, often referred to as after-care. Interviewees in the Lunt et al. (2014a) study stated that their expectations on their return were not realised, as the medical travellers experienced dissatisfaction with the NHS services.

Additionally, diaspora patients had very positive views on medical tourism (Mathijsen & Mathijsen 2020). Some of the reasons may be that they were well sustained by local family members, cultural familiarity, religious practices, food preferences and communication in their first language. Some medical travellers perceive that their care is better overseas than at home (Heung, Kucukusta & Song 2010; Holliday et al. 2015; Noree, Hanefeld & Smith 2014; World Health Organization 2015a).

In another study of medical travellers, Gan and Frederick (2011a) suggest that the quality of care for US-based medical travellers was determined by four factors: the credentials of doctors, high ratio of nursing staff, state-of-art medical equipment and, in some cases, the confidentiality of treatment, all of which were driving medical tourism. These drivers are similar to those mentioned by Australian medical travellers a decade later, although they travel for a limited number of elective procedures. More research is necessary to understand Australian medical travellers, mainly since most rely on their GP on their return. There is limited data on managing this aspect of the medical tourism journey for the returning Australian medical traveller (Brightman, Ng, Ahern, Cooter & Hopper 2018; Leggat 2015a).

2.16 Supply: pull factors

In the literature, the pull factors related to medical tourism are (albeit not in order of importance): recognised hospitals and high standard of medical facilities, medical accreditation, recognised positive reputations of medical staff, ability to choose surgeon or dentist, competitive costs of procedures, and hospitals that are perceived as resembling five-star hotels (Al-Amin, Makarem & Pradhan 2011; Rodrigues, Brochado,

Troilo & Mohsin 2017). Several studies support the medical travellers' reasons for engaging in medical tourism (Crooks et al. 2010; Taheri, Chalmers, Wilson & Arshed 2021). In the study conducted by (Taheri et al. 2021),

> "five quality dimensions were identified: "the physical facilities offered by service providers, the reliability and dependability of the service, the responsiveness of the service providers these include employee knowledge and courtesy, empathy in terms of care and provision, and finally individualised attention" (Taheri et al. 2021, p. 5).

Pull factors are destination-driven and are formed by the medical traveller's subjective perception and knowledge of the destination (discussed in 2.23, Australian medical travellers: Thailand). Pull factors attract medical travellers to specific countries; these characteristics guide destination choice in conjunction with the destination's perceived image (Horowitz, Rosensweig & Jones 2007). In the literature, the factors influencing the perceived quality of medical tourists' experiences are cost, insurance status, and quality of care received (Gan & Frederick 2013; Mathijsen & Mathijsen 2020a). Also, clarity and access to information (concerning the treatment as well as travel and administrative procedures), ease of logistics (regarding both travel and medical processes), and ease of visa procurement (Taheri et al. 2021). Therefore, push factors to catalyse the desire to travel, whereas pull factors guide the destination (Drinkert 2015).

2.17 Medical tourism: medical, dental and nursing staff

The medical tourism workforce is highly specialised and critical to providing quality health care (Tangcharoensathien, Limwattananon, Suphanchaimat, Patcharanarumol, Sawaengdee & Putthasri 2013). Many Thai surgeons, doctors and dentists are trained in the UK, US and Australia (Ormond 2016). The specialised workforce is a driver of the medical tourism industry, both in determining the reputations of specific hospitals and building market share for a country and the region. Moreover, the medical workforce has high levels of English literacy, which gives some Asian countries a competitive advantage in medical tourism.

In some cases, there are other areas of specialisation. Jones (2011) states that cosmetic surgery is an area of specialisation in Thailand, with Australian medical

travellers' frequent visitors to Thailand for dental and cosmetic surgery procedures (Bell et al. 2011; Connell 2011a; Holliday et al. 2014a; Jones 2011). There are perceptions amongst Australian medical travellers that Thai surgeons are better trained than their domestic counterparts and that the health care experiences in Thailand are vastly superior (Ebrahim & Ganguli 2019b; Holliday et al. 2013a). In a study by Guiry and Vega (2015), the SERVQUAL scale was applied to measure service quality from a consumer's perspective. Medical travellers scored their experiences in Thailand on five aspects of service quality: tangibility, reliability, responsiveness, assurance, and empathy.

Testimonials from 118 patients of a sample size of 133 participants were favourable, and recommendations to friends were common. The medical travellers were from Australia, New Zealand, Europe, Canada, and the US.

The study found that assurance (knowledge and courtesy of employees) was the strongest, followed by reliability (the ability to perform the promised service dependably and accurately). Hence, for marketing purposes, medical tourism providers should focus efforts on these two factors when promoting their services to medical travellers as they reduce perceived risk and strengthen behavioural intentions. The consistent theme in the literature is that medical travellers are highly satisfied with their surgical or dental procedures. The reputation of the medical tourism industry for providing high-quality care is unsurprising; consequently, Australians have positive perceptions of the services. Regarding destination image, "the images that people possess of anything in their world are essentially taken as reality. "*Images help us organise how we perceive and feel about something, someone or someplace*" (Gartner 2014, p. 109). Furthermore, it is a brand perception: the way that Thailand is seen as a holiday destination. (Noree, Hanefeld & Smith 2016; Wong et al. 2014; Wongkit & McKercher 2015). These studies could have had a broader application if they had examined the benefits of medical tourism and how destinations have a strong positive association with medical travellers.

2.17.1 Thai government investment

The Thai government and private hospital providers have invested in systems that give medical travellers special visas, and partnerships between the government and the

private sector have enabled hospitals to be built. These private hospitals have aligned their marketing to maximise the perception that Thailand has a sophisticated medical tourism industry. Also, with most medical tourism occurring along the coastline in resort towns and Thailand's capital city of Bangkok, there are perceptions that Thailand can cater to a wide range of tourism requirements.

The study by Noree (2015) has provided some unique insights, although it infers that medical travellers are a homogenous group who will focus on assurance and reliability. However, even in a small sample, medical travellers are very diverse, and medical tourism is generally tailored to the individual's needs. Another advantage of medical tourism is that it can offer patients procedures unavailable in Western countries. For example, currently, stem cell therapy is not available in Australia. However, in 2021 the Australian government announced that it would fund a nine-year research project to develop stem cell therapies; these treatments are available in several countries (Department of Aged Care 2011).

A recent Australian study (Fisher, Petersen & Burstein 2017et al.) explored the experiences of 27 medical travellers and carers with chronic neurological conditions such as multiple sclerosis and Parkinson's disease who were seeking stem cell therapy. The study found that the participants spent an average of 55,000 AUD on stem cell treatment. Thirty per cent had no improvement, while 70 per cent had moderate to excellent improvement. While focusing on the risks to travellers, the study appeared to neglect the psychological needs of patients with debilitating conditions and underestimated the patients' desire to try to manage their disease, ignoring the information given to them by their medical practitioner. The results of the study group of medical travellers into the same results cluster regardless of whether they had no improvement, slight improvement or modest improvement. However, 70 per cent of medical travellers benefited from the treatment. The research focused on the patients' decision to act against their doctor's medical advice rather than the medical traveller's reported benefits.

Like others in the literature, Fisher et al.'s (2017) study takes an economic perspective, not that of the consumer. Individuals with chronic and debilitating diseases are strongly motivated to maintain quality of life, with most participants in the study

travelling to China to seek treatment currently unavailable in Australia. A further limitation was the researchers' focus on the risk to patients and the medical travellers' non-acceptance of "reliable information sources" (Fisher, Petersen & Burstein 2017), that is, the currently-available medical evidence. Establishing a reliable evidence base for a procedure is a longitudinal process that takes several years. However, medical travellers are driven by hope and a belief that stem cell therapies can maximise their quality of life (Fisher, Petersen & Burstein 2017).

2.18 Medical tourism: destination marketing

There are a number of published studies on destination marketing and core to the marketing is the infrastructure of Asian hospitals that engage in medical tourism (Connell 2011a; Moghavvemi et al. 2017; Othuman Mydin et al. 2014; Turner 2007). These articles describe detailed information on Thai hospitals when compared with hospitals in Western countries. Most medical travellers were travelling from the Western countries and the Thai hospital offered superior facilities, such as private rooms and resort like infrastructure. The physical environment in some of these hospitals was conducive to recovery, with some facilities resembling five-star hotels located in central destinations. The Bumrungrad International Hospital (BIH) in Bangkok is often cited in the literature as an exemplary five-star hospital. This facility has all the infrastructure expected of modern Western hospitals, although, like many other Thai medical tourism hospitals, it resembles an expensive hotel. Moreover, BIH has restaurants, shops, accommodation for family members, and services that assist with insurance, visas, languages and religious needs. Sometimes referred to as "hotel-spitals", these facilities appear to be a hybrid of a hotel and hospital (Cohen 2008; Whittaker & Chee 2015).

The marketing of these hospitals focuses on the destination's attributes. The beautiful beaches, clear waters and exotic weather are the focus of the marketing, rather than the medical, surgical or dental procedures that are the primary reason for travel. The information on the websites about medical tourism appears to be about logistics, accommodation and not on the primary reason for travel. The medical, surgical and dental procedures appear to be secondary considerations and not a focus of the initial marketing used in medical tourism (Cormany & Baloglu 2011).

A book chapter by Connell (2008) titled ‘Tummy Tucks and the Taj Mahal?’ suggests that the marketing of the destinations is dominated by tourist sites, typical of how medical tourism is marketed. The literature also refers to this type of marketing as a destination image where stereotypes influence medical travellers’ perceptions (Cormany & Baloglu 2011; World Health Organization 2015b). The emphasis was on the destination which might distract the medical traveller from dwelling on other more serious aspects of their impending care. Alternatively, the model could build from generic information about the country, then move on to the hospital and next individualise to the procedure for the medical traveller.

Furthermore, in studies of medical travellers in Thailand, patients' perceived value had the strongest effect, followed by patient satisfaction (Cormany & Baloglu 2011; Tat Huei, Boon Liat, Mei Peng & Jason Boon Chuan 2020). The findings from these studies suggest that medical travellers are value-orientated and identify value in other aspects of care. Some factors associated with value acknowledged by medical travellers are hospital reputation, medical attention, the convenience of access to the premises, and the patient's emotional experience during care. The perception of value varies with each individual and is based on the psychological aspect of what drives individuals to medical tourism. In the case of neurological patients, Fisher, Petersen and Burstein (2017) found that any improvement would have been beneficial as the treatment could have halted the progression of the disease.

2.19 The current state of health

In Australia, there are several demand factors, including limited access to health services, long waiting times for elective surgery, and the lack of availability of some procedures. This situation has worsened since the COVID-19 pandemic as hospitals have been treating COVID patients and have redirected resources. Surgery has been delayed or deferred unless not attending to the surgical cases unless they are emergencies (Babidge, Tivey, Kovoor, Weidenbach, Collinson, Hewett, Hugh, Padbury, Hill & Maddern 2020; Carrera & Bridges 2006; Heung, Kucukusta & Song 2010; Hunter 2015; Vijaya 2010; World Health Organization 2015).

Moreover, Hopkins et al. (2010) suggest that the ongoing pressure on demand for health care is universal. Ageing Western countries’ populations often require specialised

intensive treatments for extended periods (Connell 2006). Technological advances in medical procedures for replacing joints, repairing heart valves, and other procedures, give baby boomers and others access to a range of options in health care. The study occurs in a unique time where Australians have the means and, in some cases, the mobility to seek out the available technology to improve their lives. Medical tourism offers an affordable path to health care for people with no insurance, limited insurance or those who need procedures that they cannot access or are waiting for surgery on hospital waiting lists. Medical costs in the US continue to rise simultaneously with the numbers of underinsured and uninsured US patients (Carrera & Lunt 2010; Cohen 2014).

2.19.1 Medical tourism as a disrupter

The medical tourism industry is a major disrupter in Australia since the early adopters are already engaging in it. Medical tourism has "the potential of doing to the US health care system what the Japanese auto industry did to American carmakers" (Horowitz, Rosensweig & Jones 2007, p. 33). Horowitz, Rosensweig and Jones (2007) made this observation sixteen years ago. Medical tourism continues to be an industry disrupter noted in several studies (Bies & Zacharia 2007; Cohen 2008b; Connell 2011c). Paradoxically, as an industry, it is also very fragile and susceptible to external environmental conditions. Medical tourism relies heavily on external factors such as political stability, affordable air travel, availability of a specialised workforce, government support and stable biosecurity conditions that can adversely impact the sector.

Furthermore, the availability of cheap flights and accommodation facilitates access and promotes medical tourism growth. The wide range of procedures and the extent of health care options available continue to drive the demand. The Internet enables these health care options to be investigated, and medical travellers can find doctors, surgeons and dentists that will provide procedures. Moreover, numerous websites provide access to information, speciality surgeons, and hospitals which are often 'one-stop-shops', with some hospitals in Thailand assisting with visa entry and travel arrangements (Moghavvemi et al. 2017).

2.19.2 Medical travellers' satisfaction

Positive patient experiences are documented in the literature. However, this is an under-researched area of medical tourism(Hanefeld et al. 2013). Specifically, studies refer to NHS patients who report a positive medical tourism experience. These patients comment on the differing standards of health care provision across Western European countries. Patients interviewed by Lunt et al. (2014a) were distrustful of or dissatisfied with previous treatments provided by the NHS. Subsequently, these patients chose medical tourism for their health care. Travellers returning to the UK after a medical procedure abroad are entitled to post-operative care provided by the NHS. The outsourced model of care provides a pathway for UK patients on their return to continue to receive post-surgery care, often referred to as after-care. Interviewees in the Lunt et

al. (2014a) study stated that their expectations were not realised, as the medical travellers experienced dissatisfaction with the NHS services on their return.

Additionally, diaspora patients had very positive views of medical tourism. Some of the reasons may be that they were well sustained by local family members, cultural familiarity, religious practices, food preferences and communication in their first language. Some medical travellers perceived that they received better care overseas than at home (Heung, Kucukusta & Song 2010; Holliday et al. 2015; Noree, Hanefeld & Smith 2014; World Health Organization 2015a).

In another study of medical travellers, Gan and Frederick (2011a) suggest that the quality of care for US-based medical travellers was determined by four factors: the credentials of doctors, high ratio of nursing staff, state-of-art medical equipment and, in some cases, the confidentiality of treatment, all of which were driving medical tourism. These drivers are similar to those mentioned by Australian medical travellers a decade later, although they travel for a limited number of elective procedures. More research is necessary to understand Australian medical travellers, mainly since most travellers rely on their GP on their return (Brightman et al. 2018; Leggat 2015a).

2.20 Medical tourism: individual experiences

Medical tourism is about the movement of people seeking health care outside their country of origin. There is a case history of Howard Stabb, a US citizen, who went to India to have cardiac surgery for a leaking mitral valve that needed to be replaced (Grace 2007). The estimated cost for his medical care and his surgery in the US was 200,000 USD, half of which the patient had to pay before surgery. Howard's surgery was performed in 2004 in India at the cost of 10,000 USD, which included his partner's travel expenses. Subsequently, his partner wrote a book detailing Howard's journey from the time of diagnosis to post-surgery. Howard returned to work in the US as a construction contractor and strongly advocates medical tourism (Grace 2007).

Similarly, another US citizen, Eileen Clemenzi (York 2008) required a hip replacement. Eileen had no insurance, and the estimated fee for her surgery was 48,000 USD. She had three years of extreme pain, and her hip had deteriorated to the point where she had bone-on-bone friction. Eileen had her surgery in Malaysia, where she

spent one week in the hospital and two weeks in a hotel undergoing physical therapy. The total cost, including travel, was 11,000 USD (Alleman et al. 2011; York 2008). The immediate beneficiaries of medical tourism are the medical travellers who have undergone successful surgeries and the medical and dental personnel who provide the services. Although the number of medical travellers is uncertain, Bennie (2014) estimates that 23 million people are uninsured in the US, and approximately 1.6 million US citizens travel abroad for medical procedures. Some US citizens have a mix of care, receiving primary care in the US and then travelling to other countries for specialist procedures and prescription drugs. The cost of care in the US is the highest globally and will continue to drive demand for medical tourism. However, the possibility of medical tourism reshaping health care in the US is unlikely, as demand for inbound US medical tourism continues to grow (Chambers 2018; Dalen & Alpert 2019). The current US situation, where citizens cannot afford care, indicates a market economy. An alternative perspective is that failure to care for your citizens is a health policy failure. The government has been unable to moderate the market to consider the needs of citizens and make adjustments to meet its responsibilities (Al-Amin, Makarem & Pradhan 2011; Cohen 2008b; Connell 2016b).

Several studies (Cohen 2008b; Cohen 2014b; Connell 2006; Turner 2007) found that medical travellers perceive the quality of care they receive when engaging in medical tourism is better than what they receive in their home country. As this perception is difficult to measure, the studies and articles reiterate this point with limited empirical evidence to substantiate this claim.

Lunt et al. (2011) studies suggested that “the profile of the medical traveller is opaque, little is known about the social demographic such as age, gender, health status and that this is a significant gap in the literature on medical tourism” (Lunt et al. 2011, p. 16). Quantitative studies have been conducted to profile inbound medical travellers to India, Malaysia, and the US. These studies provide a range of demographic data and information on procedures that are commonly sought by medical travellers within the scope of the study. Examples of such studies include those conducted by Cham, Lim, Aik & Tay in 2016, Guiry, Scott & Vequist in 2013, Medhekar & Wong in 2020, and Yet Mee, Cham & Chuan in 2018.

Little is known about how medical travellers make decisions and their ability and willingness to travel longer distances when faced with trade-offs. An example of trade-offs could entail procedures such as cosmetic surgery, where several countries, including Thailand, have developed niche markets of speciality procedures. An example of a trade-off would be medical travellers choosing to travel long distances to access specialists in cosmetic surgery (Guntawongwan 2018). Medical tourism in Australia is a niche area that is still developing. Medical travellers' findings relate more specifically to one group of travellers or those seeking a range of medical services. As a result, it is difficult to relate findings to all medical travellers.

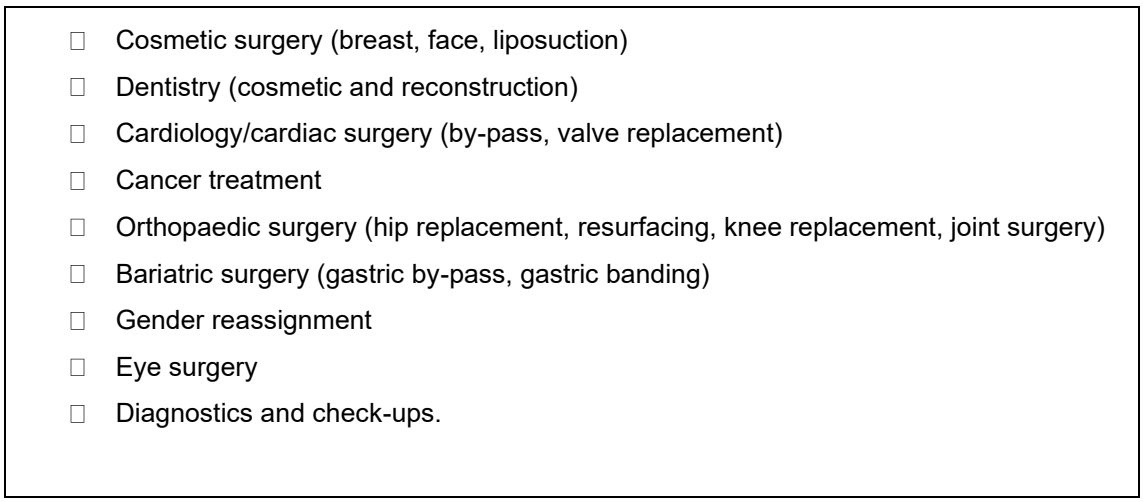

Figure 2.2 Types of procedures (Adapted from Lunt et al. 2011).

Medical tourism in Australia is a niche area that is still developing. Findings in relation to medical travellers relate more specifically to a particular group of travellers, or to those seeking a range of medical services. As a result, it is difficult to relate findings to all medical travellers. Figure 2.2 lists a range of medical, surgical, and dental procedures offered to medical travellers. The figure has been adapted to include dentistry and shows the procedures identified in the literature review that medical travellers seek.

2.21 Medical tourism and medical travellers

There are several examples of patient experiences of medical tourism, despite the exact numbers of medical travellers not being well established. In a qualitative study that explored the leisure behaviours of medical travellers, Lovelock and Lovelock (2018) found that of 18 participants from New Zealand, three went to Thailand, two for cosmetic procedures and one for screening. Some patients in the study were too unwell to participate in tourist activities, while others managed to engage in travel post-surgery. The study's findings suggest that many medical tourists are ‘accidental tourists' or ‘disappointed tourists' as the ability to participate in leisure activities depends on the individual's post-operative condition. Combining a holiday with medical tourism depends on the type of procedure and the medical traveller’s health literacy. Medical tourism hubs are often located in resort-style towns or capital cities where travellers can engage in general tourism. However, individuals’ recovery from surgical procedures is variable and often takes longer than is initially proposed. Lovelock and Lovelock (2018) suggest two types of medical travellers: those who primarily travel for leisure and have medical and dental procedures and those who travel specifically for medical tourism.

> An Australian couple, who had made four visits to Malaysia for cosmetic surgery were said to return as much as anything for “shopping and trying traditional Malaysian food” while another Australian medical tourist noted “I felt a bit groggy after surgery but as soon as I got back to the hotel – the day after surgery – I was out shopping” (Lovelock & Lovelock 2018, p. 147).

These medical traveller behaviours largely depend on the medical procedure, the destination, finances, and personal factors. Considerations such as the environment, specifically the humidity levels, the availability of suitable accommodation, and adherence to post-operative recommendations are other factors determining the behaviour of the medical traveller. In some circumstances, there is a forced holiday as some medical travellers must stay to remove stitches or undergo post-operative diagnostic procedures. Several medical travellers remain to see the specialist after a period of convalescence. Guidelines on Australian industry websites inform medical travellers about the necessary post-operative behaviours. The conclusion drawn by Lovelock and Lovelock (2018) is that any leisure tourism undertaken is generally

incidental and not the main concern of medical travellers. Although the participants constitute a relatively small sample, the behaviours of the medical travellers appear to be more opportunistic rather than planned or purposeful. Researchers have previously not separated the medical travel component from the leisure activities available at the destination.

2.22 Reasons for medical travel

This literature review focused on the aims of the study; to increase understanding of medical tourism and the reasons for travel by Australian medical travellers.The medical tourism industry has been well-established for several decades in the EU, and a range of countries including the UK, the US and Canada. Primarily driven by the reforms of the NHS, medical tourism was first explored by large diaspora populations living in the UK. The British/Indian migrants would return to India for care as the British/Somali migrants return to Somalia, where support systems and care are provided in the patient's language.

In contrast, medical tourism in Australia is at a developmental stage, driven by individuals seeking care for themselves. In more recent years, several travel companies have developed this niche market, taking groups of Australians to Thailand for a range of procedures that tend to be cosmetic or dental (Hwang, Lee & Kang 2018; Jaapar, Musa, Moghavvemi & Saub 2017). These procedures are self-funded by individuals as they are not generally covered by Medicare or private insurance.

The motivations identified for medical travel suggest that medical travellers are accessing services and advanced technologies such as experimental procedures, cancer treatments and stem cell treatment which are unavailable in their home country (Alleman et al. 2011; Crooks et al. 2010; Johnston et al. 2010; Jones 2011; Lunt et al. 2011; Turner 2010). Among the motivating factors are the success stories and positive outcomes of others sharing their experience through word of mouth. The literature on medical tourism acknowledges that the industry would not exist at the level it does without major enablers such as the Internet, affordable airline fares and accommodation - resources that provide individuals with options (Golder et al. 2017).

2.23 Medical tourism and future opportunities

Several studies from the UK, Canada and the US provide the greatest part of the information on medical tourism from a global perspective (Cohen 2008b; Cohen 2017; Connell 2011c, 2013, 2016a, 2016b; Lunt 2017; Lunt, Horsfall & Hanefeld 2016; Lunt, Mannion & Exworthy 2013; Lunt et al. 2011; Lunt et al. 2014b). The NHS has progressed with an outsourcing model for elective surgeries that provides a pathway for UK citizens. These NHS patients travel to places like India, where there are established medical tourism hospitals, some of which are part of groups or chains located within major cities that cater to foreigners' needs (Lunt et al. 2011; Medhekar 2014; Medhekar & Wong 2020). The outsourcing of health care provides accessibility to patients waiting for elective surgery. Globally, the specialised workforce is well developed, with qualified professionals returning to India and Thailand after overseas training. An example of this workforce is that in one hospital in India, there are 200 US-trained board-certified surgeons (Dalen & Alpert 2019). Also, the medical workforce in Thailand is highly qualified and continues to be trained in the UK and the US. The strength of the outsourcing model is that it minimises the need for patients to wait for procedures. Surgical or dental care can be provided at patients' discretion and availability. The elective procedures can be managed and planned by both the provider and the medical traveller.

There are large migrant populations in Australia who would benefit from this pathway. Systems for managing an outsourced model's safety, costs and quality controls would need to be negotiated and supervised. Currently, in Australia, there is no process for managing a medical traveller’s information about a surgical procedure in Thailand. Hence, creating a pathway and formalising the process would benefit Australian medical travellers returning after surgery so that Australian professionals can support them on their return. Additionally, health funds are in an excellent position to develop an outsourcing model similar to the UK and the US (Lunt, Horsfall & Hanefeld 2016). The common shortcoming of the UK and US models is that they have a limited understanding of the medical traveller, making it challenging to build service models that consider the motivations and drivers that facilitate overseas travel. The absence of information about the medical travellers’ social, economic and demographic

backgrounds is a significant gap in understanding the medical tourism market and needs to be addressed (Lunt, Horsfall & Hanefeld 2016).

2.24 Theoretical framework: motivation

The theory of motivation has its origins in the study of human behaviour. Well-known theorists - Freud, Herzberg, McClelland and Maslow - conducted studies and established theories to explain human motivation. In understanding the science of marketing, Maslow's hierarchy of needs developed in the 1950s is a model that specifies the needs and wants of individuals (Yet Mee, Cham & Chuan 2018). The model's five levels of need are commonly presented as a pyramid, arranged from the lowest level to the highest-level of need: physiological, safety, social, esteem and self-actualisation.

Herzberg, Mausner and Bloch Snyderman (2017) proposed two divergent sets of factors: hygiene factors (extrinsic), sometimes referred to as maintenance, and motivator factors (intrinsic), used widely in the social sciences but more often to explain workplace motivation. This theory is applied in the context of employment behaviours but has some transferability to tourism.

> The motivation-hygiene theory explains human nature as a paradox of two dynamics (not two factors) moving in opposite directions, pain-avoiding and growth-seeking; mankind is determined to be a determiner. Motivation-hygiene theory furnishes a map for "What people want?" That connects the strategic with the tactical, with the DNA of human motivation (Herzberg, Mausner and Bloch Snyderman (2017, p. xvii).

The theory suggests that individuals satisfy and prioritise their most important needs first, then move to the next most pressing need. This theory is commonly used to understand consumer behaviour in marketing. Similarly, Juvan, Omerzel and Maravic (2017) describe a range of models on consumer behaviours. One model is the 5-phase model of consumer behaviour of tourists. First, the individual recognises the need or wish to travel. Second, the consumer collects all the information and evaluates the options, third they decide between the different alternatives. Fourth, consumers prepare to travel and finally they assess their satisfaction. The limitations of 5 - phase model lies in the assumption that consumers have the necessary information to make decisions

and that they will act rationally. Also, individual variables such as motivation, mood and past experience impact on consumer behaviour.

Tourism consumers are unique because they want satisfaction from their choices compared to a return on investment (ROI). Often, a consumer experience that exceeds expectations remains in the memory as a positive experience. Also, consumer expectations are often based on several sources, such as personal experience and recommendations from others, and these factors reinforce memories. Therefore, comprehending the needs and wants of people engaging in tourism requires an understanding of other personal factors such as consumers' values, social status and culture, all of which guide the actions and decisions of consumers, contributing to the behaviour. McClelland's achievement motivation theory suggests individual's specific needs are developed over time and are linked to life experiences. Australians engaging in medical tourism are challenged by the situation of seeking care overseas. McClelland describes three types of motivations factors, Achievement – a desire to do better than others, solve problems and master difficult tasks. Power – a desire to control other people, influence behaviour or to be responsible for other people and their work. Affiliation – a desire to establish and maintain friendly and close relationships with other people (Andersen 2018, p. 2).

Australians engaging in medical tourism would find the processes for learning about their condition or procedure, as well as navigating a health system in other country as a difficult problems or situations which in turn should be extremely motivating to some individuals. Achievement goals are a cognitive process directing individuals to a specific purpose (Rabideau 2005). Accordingly, deciding to go overseas for a medical procedure is difficult, and those who make the decision would experience control over their situation and high levels of satisfaction from their efforts. Australian medical travellers have few support systems and are pioneers in an industry that is very fluid and unstructured.

2.25 Motivations of medical travellers

Motivation is a key concept in this research on medical tourism. Motivation is defined as the "psychological/biological needs and wants, including integral forces that arouse, direct and integrate a person's behaviour and activity" (Cohen, Prayag & Moital

2014, p. 881). The study's main aim is to understand the forces driving medical travellers to pursue travel at a time when they are most vulnerable. Understanding the motivations that prompt Australian medical travellers to travel overseas for medical, surgical and dental care is required. Although this may take them outside of their comfort zone, they continue to seek care by understanding their conditions and seeking out Thai surgeons and dentists to manage their health needs.

In a review of consumer travel behaviours, Cohen, Prayag and Moital (2014) identified and categorised the literature into key themes. A total of 191 studies were reviewed, comprising nine key concepts: decision making, values, satisfaction, trust, loyalty and motivations of tourists engaged in the tourism industry. The motivation of individuals continues to be debated, with some researchers arguing that it is neither a behaviourist nor cognitive approach but a hybrid of the two.

Furthermore, the literature search modelled Iso-Ahola's motivation theory in a tourism context. The findings suggest that motivations may be useful for segmenting tourists and positioning tourism and recreation experiences (Snepenger, King, Marshall & Uysal 2006, p. 148). Also, Snepenger et al. (2006) study on general tourism is useful for segmenting tourists and positioning tourism using the four dimensions of the Iso-Ahola theory. These dimensions are generally described as personal and interpersonal escaping and personal and interpersonal seeking, push factors that drive tourism behaviour, often underlying the actions of individuals who participate in recreational activities. However, the study respondents were all undergraduate students, which narrowed the perspective to a specific demographic. In addition to this limitation, the undergraduate students were incentivised to participate, they received credit points for completing the survey. The research method was a scenario-based repeated-measure research design using different cohorts of undergraduate students at different time intervals. As with some of the other articles, generalizability was limited by a number of variables.

Several studies use the Iso-Ahola theory, and a search of relevant works yielded over 2000 articles. For example, Dreisbach, Vij and Dreisbach (2020) investigated women's travelling behaviours. These medical travellers had breast cancer, and their travel motivations were examined by applying the Iso-Ahola motivation theory. Four

categories: personal escaping, interpersonal escaping, personal seeking, and interpersonal seeking, were examined through descriptive analysis. The results suggest that travelling itself is part of the patient's treatment and that travel creates shared experiences with family and friends, offering a sense of hope.

It would appear that motivation and the push-pull approach are synonymous (Dann 1977). The push-pull approach is widely used to explain behaviours such as the movement of people to a new location since the theory purports to explain why people are driven away from a place (Cohen, Prayag & Moital 2014). The approach was developed as an explanation for travel motivation in the 1970s. The theory conceptualised that people travel because they are (1) pushed and (2) pulled. Both internal and external factors can motivate people's behaviour (Dann 1977). Push factors are further defined as internal motives or forces that cause tourists to seek activities that reduce their needs.

In contrast, pull factors are defined as destination-generated forces and knowledge the tourist has about a certain destination. Push factors are intrinsic motivators associated with the desire for escape and relaxation, prestige, health and fitness, adventure, and social interaction (Yet Mee, Cham & Chuan 2018). The push-and-pull model is popular in the literature as it provides a conceptual framework for understanding the motivators of medical travellers: factors that are drawing medical travellers to the destination for medical tourism and the factors that are pushing them to consider the option of medical tourism.

Most studies suggest that further research is required to understand factors beyond cost, availability, and distance. Investigations between cost and quality need to be examined with further research.

The research focuses on the academic hypothesis that medical travellers are risk-takers and health care bargain hunters, except for diaspora populations. However, fewer studies have considered the lived experience of the medical traveller, and the Australian medical traveller continues to be an enigma in the literature. Furthermore, the perception of high-quality services and affordable costs is a strong theme in the literature (Guiry, Scott & Vequist 2013).

As noted in other parts of this chapter, the EU and UK markets have a highly developed and mature medical tourism market due to the EU directive on cross border health. There are a number of recent changes to the European context, specifically in terms of countries being added to the EU and the exit of the UK as a significant partner.

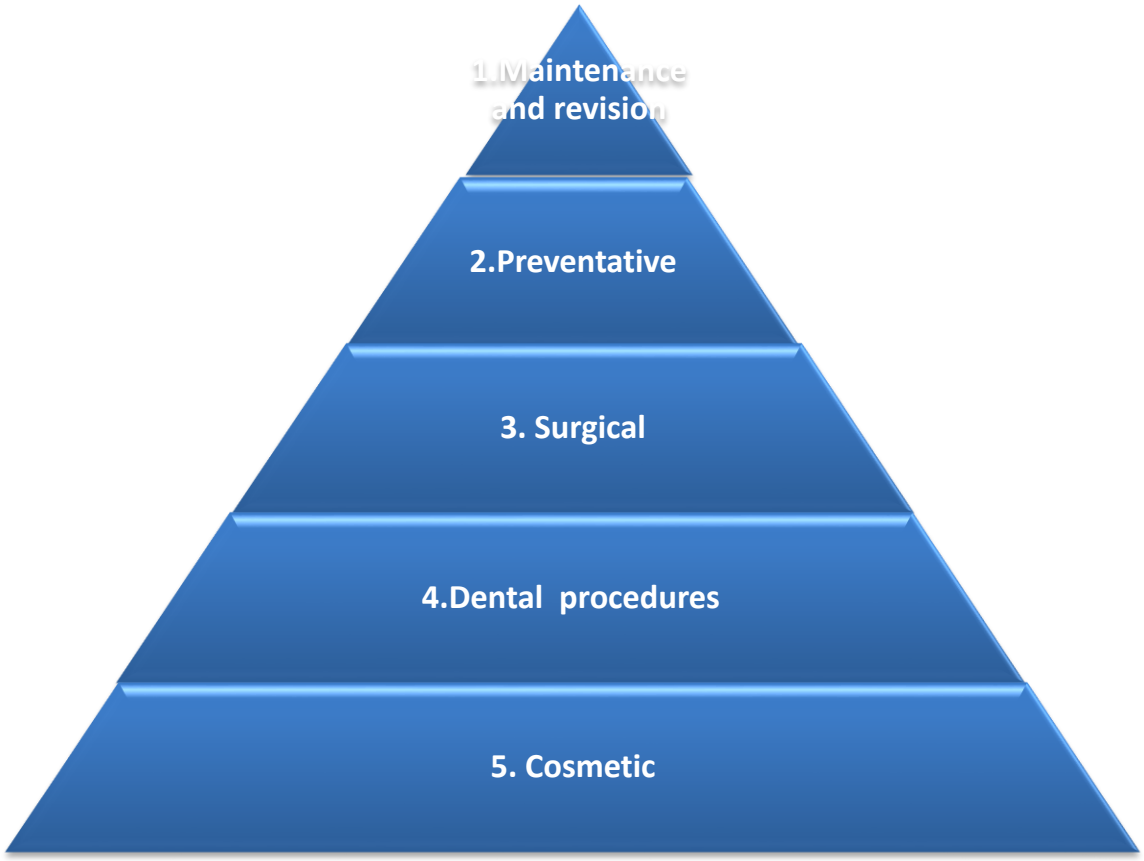

Figure 2.3 Pyramid of medical tourism procedures.

The pyramid of procedures in Figure 2.3 depicts the pyramid of procedures that medical travellers seek, which mainly includes cosmetic, surgical, and dental procedures. The top section of the pyramid covers maintenance procedures, including minor dental and cosmetic procedures.

Preventative screening procedures, such as mammograms, diagnostic procedures, screening for common cancers, skin checks, and tests identifying cardiovascular and diabetes risks, are also quite popular among US medical travellers.

The pyramid that represents medical tourism procedures illustrates the different surgeries and treatments that patients undergo when seeking healthcare abroad. This pyramid is based on the five categories identified in Chapter 2's literature review. Medical travellers may choose routine dental care or advanced dental procedures, among other treatments. These categories are flexible and can be customized to cater to the needs of individual medical travellers.

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1. Maintenance and revision include general health care, such as dental visits and minor cosmetic surgery. Cosmetic surgery revisions include removing implants and surgical revisions of hip and knee joint procedures. As people live longer and manage chronic diseases, the need for dental and surgical care maintenance increases. Surgical revisions like removing and replacing implants may also be necessary in some cases (Eissler & Casken 2013; Turner 2007). Medical travellers from the US generally use these services as costs are prohibitive in the US (Turner 2010, 2012a).

2. Preventative medical procedures are identified and sought by medical travellers; these include medical screening and check-ups. Preventative procedures were more frequently mentioned in the literature than were maintenance and revision procedures. These procedures include genetic screening and Positron Emission Tomography (PET) scans to determine disease profiles and cancer status (Lunt, 2013). Included are specialist medical appointments to manage medical and chronic conditions (Alleman et al. 2011; Connell 2016a; Hanefeld et al. 2013). There is no evidence in the literature that Australian medical travellers seek these

types of procedures.There is no evidence in the literature that Australian medical travellers seek these types of procedures.

3. Surgical procedures identified in studies include bariatric, cardiac, joint, and spinal surgeries (Fetscherin & Stephano 2016b; Piazolo & Zanca 2011). Eight medical tourism studies identified a range of procedures that medical travellers are accessing. The numbers of medical travellers are variable depending on the study; however, they appear to come from Europe, US and Canada (Cohen 2017; Johnston, Crooks & Snyder 2012; Lunt, 2016).

4. Dental surgery procedures such as gum surgery, implants and jaw surgery are gaining popularity with medical travellers. These procedures have not traditionally been included in medical tourism; however, the review identified sixteen studies where dentistry was included. These procedures include fillings, cleaning, braces and a range of teeth straightening procedures, in addition to bridges, implants, crowns and caps. There is evidence in the literature that Australians are travelling to access dental services (Hall 2011; Lunt, Horsfall & Hanefeld 2016; Lunt et al. 2011; Österle, Balazs & Delgado 2009)..

5. Cosmetic procedures are the most common reason for medical tourism in the literature. Twenty-six studies focused on cosmetic surgery, including studies that identified Australian medical travellers. These procedures include breast surgery, liposuction, facelifts and rhinoplasties, or any procedures related to the external parts of the body. Cosmetic surgery is a major reason that Australian medical travellers seek medical tourism (Aizura 2010; Holliday et al. 2015; Holliday et al. 2013a; Jones 2011; Rodrigues et al. 2017).

Existing research in the field of medical tourism mainly focuses on cosmetic, surgical, and dental procedures. However, there is a lack of evidence on Australians travelling for preventative procedures. This literature review highlights the need for further exploration to understand the motivations behind Australians' medical travel and the specific types of procedures they seek, as currently, cosmetic, dental, and surgical procedures appear to be the primary drivers of demand.

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2.26 Medical tourism: decision making

In a study by Laing and Crouch (2009), the primary finding was the strong association between past travel and future intent. In addition to demographic traits, overall travel motivations may affect the relationship between past vacation activities and intended future activities. Tourists repeating their previous vacation in terms of the actual destination, or the vacation activity are viewed as loyal to the destination or brand. These findings could translate to Australians who travel to Thailand in large numbers each year. There is a possibility that when Australians seek out medical tourism, they do so in a familiar country. According to the Australian Bureau of Statistics (ABS), approximately 563,000 Australians travel annually to Thailand, the fifth most frequently visited country by Australians, generally for short-term leisure activities (Australian Bureau of Statistics 2019a).

2.26.1 Medical travellers perceived interest and motivation

Adams et al. (2015) study of medical travellers from Canada, which has similar economic and health systems to Australia, found that participants were looking to improve their quality of life and take control of their health management. Nearly all participants in this study wanted to feel good about themselves. The paper focuses on

what motivates medical travellers, finding that hope plays an important part in medical travellers' decision-making. Additionally, “doing something” to change the status quo, rather than doing nothing, suggests that medical travellers are action orientated. The 32 medical travellers participating in this study had various health issues. The majority were having orthopaedic or other surgeries, whilst some were seeking treatment for chronic diseases. Most medical travellers spend time researching the travel destination, the surgeon's abilities and the hospital's reputation. Some of the participants in this study discussed “personally escaping” as they sought a change of environments, lifestyle and stress associated with their respective conditions. Also, there are examples (Holliday et al. 2015; Holliday et al. 2013a; Holliday et al. 2014) of some Australian medical travellers discussing and researching infection rates of specific facilities where they were planning to have surgery. The strength of this paper is its strong consumer focus.

Generally, motivations to travel are informed by perceived interests, wants and needs, which are associated with personal values and situational influences. Several studies suggest (Connell 2013; Johnston, Crooks & Snyder 2012) that promotional information and word-of-mouth, specifical recommendations from doctors, family and friends, carry much weight in decision making. An article on medical tourism motivators by (John & Larke 2016b) suggests that word-of-mouth or recommendations are primary factors and cites a study where 80 per cent of US medical travellers seek the opinion of their primary physician regarding a destination for medical care. Generally, this pertains to the US context and not the current referral pathway in Australia. Australian medical staff and associated bodies such as the government and health facilities actively discourage medical tourism (Australian Society of Plastic Surgeons 2019). In Australia, cosmetic surgery is not a deregulated speciality and can be performed by several professions. Australian doctors are uncomfortable undertaking revision surgery on medical travellers as the liability shifts to the treating physician. Doctors and dentists also lose market share with Australians travelling for health care. In some instances, Australian professionals believe that Thai surgeons and dentists are poorly trained and that patients risk their lives by engaging in medical tourism (Leggat 2015b).

2.26.2 Medical travellers' reasons for travel

In a study of Asian medical travellers, specifically Indonesians, the researchers examined the motivations, preparations and practices involved in medical travellers' decision-making, including their reasoning and the considerations that encouraged them to make particular decisions regarding travel to another country. (Ormond & Sulianti 2017) The push factors in this study were distrust of the medical profession in Indonesia and the model of care provided by Indonesian medical staff, which was described as autocratic. A lack of diagnostic resources was a push factor encouraging Indonesians to travel to Malaysia for treatment (Ormond & Sulianti 2017). This study describes the Indonesian medical workforce as conservative, poorly equipped and not meeting the expectations and needs of the middle-class demographic. This study describes medical tourism between Indonesia and Malaysia, which are culturally similar countries. The limitation of this study is that it is mainly concerned with the impacts on the medical travellers' country of origin. Indonesia is losing much-needed revenue to Malaysia. It could be argued that the health investment and reform within Indonesia will be slower whilst the cross-border model continues to push medical travellers to neighbouring countries.

In their review of international research, John and Larke (2016b) analysed the contents of 400 medical tourism articles published between 2000 and 2016 to determine what motivates medical travellers. The analysis found that cost was the most-discussed motivator in 80 per cent of the articles, followed by perceived service quality—the medical staff's proficiency with the patient's spoken language. Finally, accreditation was identified as a motivating factor (John & Larke 2016b). Regarding the accreditation of foreign hospitals, the Joint Commission has been operating since 1998. By 2017, 800 foreign hospitals had been accredited for patient safety and quality of care (Dalen & Alpert 2019). Hospital accreditation is routine among Thai hospitals engaged in medical tourism. The evidence suggests that accreditation is important, although it is now an accepted norm that hospitals have international accreditation (John & Larke 2016b).

2.26.3 Decision making and cost

One of the major push factors driving medical tourism in Australia is that many procedures, mainly cosmetic and dental, are not covered by universal or private insurance. Therefore, the cost is borne by the patient. The patient's medical insurance status is a push factor associated with cost; being underinsured or uninsured are key indicator of patients engaging in medical tourism. John and Larke (2016b) did raise a push factor: that recommendations from doctors, family and friends were important to medical travellers in the more mature markets of the UK and US. However, although the researchers focus on salient issues in the literature, they limit their study to push and pull factors in countries other than Australia. There are references to Australian author Connell, who researches the subject of medical tourism.

As previously discussed, push factors to motivate medical travellers and pull factors influence the choices made by medical travellers. Also considered are the geographic and demographic issues such as location and ageing. For the first time in history, the population on the planet is the oldest. Nowadays, far more people reach the nineties, their longevity sustained by better living standards and access to medical care and other resources. In 2020, Japan had the largest number of people aged over 65 years, some 27 per cent of the population, followed by European countries such as Italy and Greece (World Bank, 2019).

Studies have examined the destinations chosen by medical travellers, finding that they tend to seek services within regional boundaries (Alberti, Giusti, Papa & Pizzurno 2014; Chandra 2017; Connell 2011c, 2016a, 2016b; Population Reference Bureau 2019).

The literature review has demonstrated that medical travellers start by thinking about affordability but then trade this consideration for other factors as more personal variables come into the decision-making process. Examples of these trade-offs included taking family members with them for support. Some medical travellers also travel alone due to cost and privacy considerations, and there are different types of medical tourism as there are different types of travel. The Bumrungrad International Hospital is at the high end of Thai medical tourism, while other hospitals are less expensive.

The process in the Australian health system for surgical and specialist medical care requires a GP's referral. A referral is required to access a specialist or surgeon GPs are "gatekeepers" of specialist and surgical services. Some patients might know a particular surgeon and need to ask their GP to provide a referral.

In a national health system where public and private health entities deliver care, demand is managed by waiting for or paying for services. There are some cases where even if you pay for services in the private system, patients are required to wait for care.

The push-and-pull factors relate to two separate decisions made at two separate points in time. The first is whether or not to go; the second concerns where to go. However, some researchers believe that push-and-pull factors should not be viewed as independent but as related. Internal forces push people to travel away from home, and external forces associated with the destination pull them to choose a particular place (Heung, Kucukusta & Song 2010).

2.26.4 Medical traveller loyalty

Studies found that the behaviour intentions of travellers to engage in a particular action such as travel is associated with customer loyalty. Behaviour intention is the perceived likelihood of an individual to engage in a particular behaviour that will give them the expected outcome(Yet Mee, Cham & Chuan 2018{Tat Huei, 2020 #900)} This seems logical given that human behaviour depends on a person's knowledge base. An example would be the favourable perception of well-known brands. For example, international hospitals such as the US Mayo Clinic, Johns Hopkins, Cleveland Clinic and Kings College in the UK rank among the top 10 institutions globally, making these hospitals market leaders and global brands. It would suggest that if you were a patient in one of these hospitals, your expected outcomes would most likely meet your expectations (Dalen & Alpert 2019).

Kotler and Keller (2001) maintain that the psychographic market segment is concerned with how customers make lifestyle choices. The psychographic segment can assist in understanding the alignment with medical travellers who seek cosmetic and dental procedures. Dental and surgical cosmetic procedures are linked to lifestyle choices specific to individuals' personalities, attitudes and values. The literature on

cosmetic surgery and medical tourism suggests that the ‘mummy makeover’ is very common for those medical travellers returning to the same surgeon for multiple procedures. Also closely associated with the demographic segment is the recognition that female medical travellers experience life changes, particularly after having children and breastfeeding. Australian medical travellers discussed their experiences of medical travel in terms of issues such as leaving young children in the care of family members, including partners, and experiencing time constraints. Their need to return is balanced with the cost of remaining in Thailand to adhere to post-surgery guidelines. The value placed on being a ‘yummy mummy’ is an important consideration for women (Holliday, Hardy, Bell, Hunter, Jones, Probyn & Taylor 2013b). These societal pressures now extend to other ages and are in response to some industries adhering to ageist work practices. Women extending their time in the workplace drives some surgery. (Aizura 2010; Bell et al. 2011; Brightman et al. 2018; Browne 2017; Carey 2018; Connell 2011b; Holliday et al. 2015; Holliday et al. 2013a; Holliday et al. 2014; Holliday, Cheung, Cho & Bell 2017; Holliday et al. 2013b; Jones 2008, 2011; Lunt, Horsfall & Hanefeld 2016; Lunt, Mannion & Exworthy 2013; Lunt et al. 2011).

2.26.5 Medical travellers’ behaviours

Kotler’s behavioural market segment examines customers' behaviours towards products and services (Kotler & Keller 2001). They are described as benefits sought, loyalty, usage rates, readiness to buy, and user status. In medical tourism, the literature identifies that medical travellers have loyalty toward the surgeon and dentists if they are satisfied with the service they receive from these professionals (Debata, Patnaik, Mahapatra & Sree 2015; Lertwannawit & Gulid 2011). These studies establish a correlating relationship between medical travellers and the surgeon and treating dentist and the trust that develops from seeking medical or dental care. Therefore, service quality and satisfaction significant impact medical travellers’ loyalty. In this respect, the medical travellers’ behaviour is driven by their psychographic position. For example, whilst Australian medical travellers are cost-aware, they also appear to value the quality of care, which can be more important (Holliday et al. 2013b, p. 84). There are various stages in the decision-making process. Firstly, potential medical travellers begin by looking at prices for procedures. A major decision is made regarding affordability. They

begin to look for quality within the cost bracket or parameter that has been determined. In some cases, leading to other key decisions and choices, with some choices being prioritised over others. One example could be deciding to travel alone and using the services of a more expensive hospital.

2.26.6 Medical tourism and complications

Brightman et al. (2018) conducted a systematic review of international literature on breast augmentation procedures. This procedure is popular with Australian medical travellers in Thailand. The study suggests that demographic features and motivating factors driving patients are not well understood and aims to understand the risk profile of medical travellers. The Foundation of Plastic Surgery funded the study. It consisted of a systematic review of 17 articles and a cost analysis of records which identified 12 medical travellers who, on returning to Australia, presented to an Australian public hospital from 2012 to 2013. Four patients had infected implants, while other medical travellers presented with a range of pain and infection. Other conditions included deep vein thrombosis and pulmonary emboli. Though common after surgical procedures, these post-operative complications can be exacerbated by air travel, one of the points made in the study. Medical travellers can mitigate these risks by following the post-surgery guidelines. The study focuses on the cost of treating the complications experienced by these returning patients, which on average was 12,000 AUD. A weakness of the study is that it did not include comparable data for women who have had locally performed breast augmentations or the overall number of patients travelling for breast surgery. The cost of treating these patients in the public system suggests the wastage of an expensive resource, but the lack of comparable data is a significant shortcoming of the analysis. Another Australian study referenced in the article notes that post-operative infections and a range of complications from breast augmentation surgery conducted in Australia have also cost the public health system approximately 10 million AUD over two decades. This type of elective surgery appears to be problematic regardless of where it is performed due to several independent variables such as the surgeon's skill, the patient's condition pre-surgery, and the aftercare pathway. The strength of this study is that it raises awareness of the surgical guidelines for Australian health professionals and medical travellers seeking breast surgery.

2.27 Australian medical tourism

Cosmetic and dental procedures dominate Australian outbound medical tourism. Both these procedures generally require a fee for service and are self-funded in Australia. Based on cost alone, these procedures are more affordable in developing countries. Australians have several reasons for considering medical tourism, although the four drivers consistently cited in the literature are cost, access, quality and service (Bell et al. 2011; Connell 2011a; Holliday et al. 2015; Holliday et al. 2013).

Australians living in regional and remote parts of the country travel to medical hubs for medical, surgical and dental health care. These Australians are accustomed to travelling long distances and interstate in some cases to access health services. An example is Tasmania, where there are a limited number of specialist services, and some residents must travel to Victoria and other states for health and specialist surgical care.

2.27.1 Medical tourism and the context of cosmetic surgery

Several studies are relevant to Australian outbound medical tourism. Jones (2011) examines Australians seeking cosmetic surgery in Thailand, discussing changes in how cosmetic surgery was initially viewed as a medical /surgical procedure and how it has evolved into a consumable item. According to Jones (2008), the makeover is about the journey, not the renewed self at the end. The idea of cosmetic surgery becoming an extension of fashion trends is already evident; enhanced lips and liposuction are now common, as are the procedures that reshape the body to the fashion requirements of the day. Lunt, Mannion & Exworthy (2013). This concept extends the argument regarding health care's commercialisation, commodification and internationalisation. Health care in Western countries has moved beyond delivering relief from disease in some specialities of medicine; it now has a role in driving the demand for aesthetic procedures, specifically cosmetic and dental procedures and major cosmetic surgery.

The literature review identified several studies addressing the Australian context. These include those of Connell who has published books and multiple articles (Connell 2019); Connell 2006; Connell 2008; Connell 2011a, 2011b, 2011c, 2013, 2016a, 2016b. A study by(Fisher, Petersen & Burstein 2017) on travelling for stem cell treatment focused on Australian travellers. Articles by Hall & James (2011) and Turner (2012a)

discussed biosecurity, ethics and regulation in medical tourism. Furthermore, Greenfield & Pawsey (2014) identify the ethics of consumers from developed countries seeking care in developing countries and identify the knowledge gap in the literture of how decisions are made by consumer to seek care overseas.

On the other hand, Barrowman, Grubor & Chandu (2010) published an article on oral health, acknowledging that access and affordability are issues that limit the services available to Australians. The article focuses on five case studies where patients have experienced adverse outcomes. In contrast, Leggat (2015) writes on medical tourism from a general practitioner's perspective and argues for a pragmatic approach to treating medical travellers pre-and post-operatively. The Australian Society of Plastic Surgeons warns that Australians should beware of having procedures done overseas and must understand the risks associated with medical tourism (Australian Society of Plastic Surgeons 2019). This position is not uncommon among medical specialities as plastic surgeons are protecting their market and believe that the health services in Asia are not at the Australian standard (Royal Australian College of Surgeons 2020). Doctors cite examples where they have had to redo procedures for patients who have engaged in medical tourism and had adverse outcomes (Brightman et al. 2018).

2.28 Cosmetic surgery

Cosmetic surgery is popular with Australian medical travellers. Holliday et al. (2015) discuss cosmetic surgery, as does Jones (2011), who investigates cosmetic surgery tourism with a focus on ethnoscapes or flows of people, specifically medical travellers. Ethnoscapes refer to the global flows of people (Whittaker 2018). An example of this type of flow could be Australian holidaymakers going to Thailand, and a further example would be the movement of Syrian refugees travelling across Europe. Holliday et al. (2015) define ethnoscapes as the flow of people, both temporary and permanent. These flows have established routes; in other cases, they are carving out new routes where medical tourism can be established.

Moreover, assemblage combines elements that facilitate cosmetic surgery, such as surgeons, intermediaries and medical travellers in a particular country. The example provided was that surgeons flew in and out of Tunisia, where cross-border conflict was occurring, performed surgery on Europeans, and left with their payments in cash. This

model gathers all the actors for surgery when completed. They disassemble as a surgical team and move to another country.

2.29 Health system in Australia

Australians have access to a national health system, with Medicare funding medical and surgical care in public hospitals. However, access to non-emergency treatments is limited, and patients are required to wait for long periods for specialist appointments and elective surgery (Australian Institute of Health and Welfare 2016). Australian patients waiting for care can suffer from multiple conditions. For example, approximately 1 in 11 people have osteoarthritis, a total of 2.2 million Australians in 2017-18. Chronic and progressive condition often requires knee and hip replacement surgery (Australian Institute of Health and Welfare 2016). The muscular-skeletal condition is also associated with chronic pain and decreased mobility, where time-critical care is the best practice. Patients with osteoarthritis and associated pain have reduced mobility, and in some cases, weight gain leads to further complications such as diabetes and depression (Hudson & Li 2012; Lee & Spisto 2007; Tullao & Hin 2012).

The private hospital system in Australia is somewhat similar to the US system as it depends on patients who are self-funded or have private health insurance. In Australia, private health insurance companies determine patients' coverage, which determines the gap or out-of-pocket expenses that the patients bear for medical procedures. However, the Australian health system generally has more in common with the UK and Canada than the US.

The Australian Government continues to subsidise private health insurance through tax incentives. However, recent reports by The Australian Prudential Regulation Authority (2019) advise that only 44 per cent of Australians have private health insurance. Australians continue to leave the private health insurance industry, especially young people who find health insurance expensive and poor value for money. The federal government’s policy of rebates through taxation promotes the use of parallel private insurance to supplement public coverage for health services. It has been suggested that the private system is generally “engaged in low-value services resulting in wasteful spending that could be controlled in a public system” (Landon, Larkin & Elshaug 2021, p. 421). Therefore, as costs continue to rise, more Australians will move

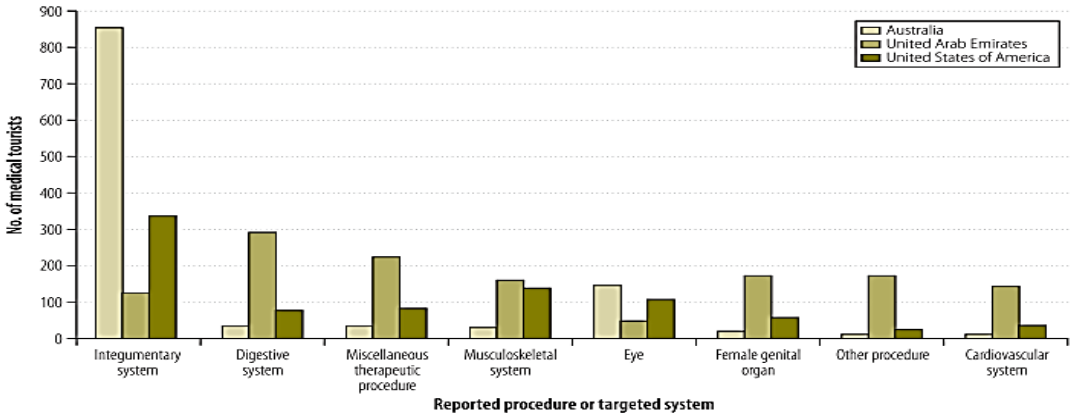
away from private health insurance. Subsequently, a more significant percentage of Australians will be uninsured and reliant on public hospital services. It is creating an opportunity for health insurance companies operating in Australia to diversify and adopt alternative models that are similar to the Brazilian international health insurance company Amil Health Insurance. This company covers members who have operations in other countries and provides other competitive services (Kotler 2012, p. 153).

2.30 Australian medical travellers: Thailand

There are a number of studies that focus on Thailand. Bhaidkar (2014) and Chomvilailuk and Srisomyong (2015) compare Thailand and India as medical tourism destinations. Both these countries have different market shares in the industry. India has a formal arrangement with the NHS for UK patients having surgery for various medical issues. It is argued that India has a push strategy where UK patients are sent to India as part of the outsourced medical care model. In comparison, Thailand has a pull strategy with the high-end Bumrungrad International Hospital in Bangkok marketed as a five-star medical facility. There are 18 accredited hospitals in Thailand specifically for medical tourism. These Thai hospitals are located in popular tourist destinations like Phuket.

Noree (2015) study examined the impact of medical tourism on the economy in Thailand, reiterating that the number of medical travellers continues to be inaccurately reported. The number of medical travellers is lower than that suggested by the Thai government and the medical tourism industry. The popular procedures from long-haul regions such as Europe, the US and Australia are cosmetic, although heart-related procedures are also being performed in large numbers. The heart-related procedures are generally performed on Asian patients, while most cosmetic surgery is for Western medical travellers. The benefits to the Thai economy are yet to be determined as there is little empirical evidence to suggest that medical tourism provides additional revenue that could also be generated by tourism.

Fig. 1. **Most commonly-recorded procedures or targeted systems among medical tourists from three countries attending five hospitals, Thailand, 2010**



Notes: The procedures targeted at the integumentary system were mostly cosmetic. Cardiac catheterizations accounted for most of the "miscellaneous therapeutic procedures" and angiocardiograms accounted for most of the "other procedures".

Figure 2.4 Types of procedures sought by medical travellers (Noree, Hanefeld & Smith 2016, p. 33).

On average, medical travellers and their companions spend 4,000AUD each, more than tourists and Thais. However, there are fewer medical travellers. These high-end Thai hospitals are not at capacity, often reporting averages of 70 per cent occupancy, generally a mix of affluent Thais and foreign patients. The limitation of Noree's (2015) research is the externality of costs: all costs, not just the costs related to individual travellers, but costs associated with reducing care in the regional and rural areas of Thailand, and the cost of training doctors which is publicly funded.

2.30.1 Medical travellers in Thailand

Medical tourism is a cornerstone policy of the Thai government's intention to create a medical hub for foreign medical travellers. One of the consequences of the pro-medical tourism policy is that the private sector takes experienced doctors and nurses from government hospitals to work in private hospitals that treat wealthy Thais and foreign medical travellers (Noree 2015). It is argued that medical tourism depletes the Thai public health services of the most experienced specialists and nurses trained through government-funded programs and migrates to the private sector. Consequently,

due to the health-related trade, there appears to be an adverse impact on and cost to the delivery of domestic health services (Lunt et al. 2011; Noree, Hanefeld & Smith 2016).

An alternative policy direction for Thailand could be sponsored places for Thai patients in these unique hospitals to utilise the bed capacity and the expensive investments in technology. Also, business investment in medical tourism is often at the expense of the domestic market. For example, medical tourism is operated by the private sector and sometimes owned by foreign companies with no consideration for the domestic consequences depending on the business model (Kruse & Jeurissen 2020). A change in the policy direction as part of the pandemic response sees the Victorian government moving non-urgent elective surgery to private hospitals so that public hospitals can continue to concentrate on caring for COVID patients (Stobart & Duckett 2021).

Guiry and Vega (2015) investigated the perceptions of Thailand's medical tourism by analysing testimonials from ThailandMedTourism.com. The overall results indicated that medical travellers were very positive about their experiences. Procedures such as cosmetic surgery, dental and LASIK (eye surgery) were popular amongst medical travellers. The study found that medical travellers desire to reduce risk before, during and after treatment in Thailand. The literature is mainly positive about the high levels of satisfaction of medical travellers.

Nevertheless, several deaths, including those of Australians, have been associated with medical tourism across the globe. Furthermore, biosecurity issues exist with patients presenting with antibiotic-resistant infections after overseas surgery. However, it must be noted that negative commentary about medical tourism comes from professional bodies, specifically Australian plastic surgeons and dentists. These professionals are directly impacted and stand to lose a significant market share if medical travel becomes more widespread in Australia (Crooks, Turner, Cohen, Bristeir, Snyder, Casey & Whitmore 2013; Hill 2011; Turner 2012b).

2.31 Medical tourism risks to medical travellers

In a comprehensive review of patients' experiences, Crooks et al. (2010) argue that patients' experiences are mainly derived from reports and media sources, identifying

this as a significant gap in the literature. Subsequently, a review of 216 sources found that patients make decisions based on push-and-pull factors. Finally, the review found that patients' motivations are based on the procedure, travel and cost. Plastic surgeons have over 12 years of medical and surgical training and consequently are well qualified to perform cosmetic surgery. However, in Australia, qualified medical practitioners saw a gap in the market. Many cosmetic surgery clinics have developed offering services from Botox fillers, liposuction and breast surgery. The Australian cosmetic surgery industry continues to operate in the area of ambiguity described by the media as the Wild West {Ferguson, 2021 #1096. Cosmetic surgery delivered in Australia is often perceived as safer than travelling for care in Thailand. In the current situation, that perception is challenged.

Other risks are associated with medical tourism, travel, and pre-and post-operative risks (Turner 2012a). The common risks are related to air travel. Conditions such as deep vein thrombosis (DVT) and pulmonary embolism, where blood clots travel to the patient's lungs, are associated with long-haul flights post-surgery. The risks can increase depending on the procedure. However, these medical conditions pertain to all air travellers and are not specific to medical travellers. The advice to mitigate these risks from Turner (2012a) is that “medical travellers need to arrive well before surgery and not return home quickly after invasive procedures as the long haul flights have a risk associated with them” (Turner 2012a, p. 260).

The transfer of care is the communication between professionals doing the procedure and those who provide the follow-up care. The risk to medical travellers also pertains to how information regarding the treatment or procedure is transferred to other professionals when the medical traveller returns home, mainly since there are no formal pathways to communicate this information. Typically, a letter or form explaining an operation would be the source of information. In the case of medical tourism, medical travellers are the holders of such information. This responsibility is challenging and requires a level of health literacy. The risks and challenges raised by Turner (2012a) can also be applied to the care provided in the domestic setting. Australian health services struggle with continuity of care issues if care is provided in another state or another hospital in the same city. However, Turner (2012a) fails to compare the risks and challenges faced by domestic patients with those faced by medical travellers. Therefore,

a comparative study of these two cohorts would have been valuable in assessing medical travellers' risk when choosing to undergo medical procedures abroad.

2.32 Biosecurity

Global travel is an intrinsic part of medical tourism. As such, biosecurity both at an individual level, in the case of patients with antibiotic resistance and the environment such as high levels of COVID infection in Thailand, has the potential to have an immediate effect on medical travel. The biosecurity issues impact medical travel and are a consideration for medical travellers. Medical tourism is a fragile industry disrupted by unstable economics, pandemics and other factors that limit travel. Australians travelling to Thailand would consider infection rates and other potential risks, along with access to flights, before travelling for care. There are many articles on biosecurity and tourism or medical tourism (Chen, Law & Zhang 2021; Cohen 2017; Crooks et al. 2013; Hall 2011; Hall & James 2011; Hill 2011). Fundamentally, disease transfer is an ever-present possibility that needs to be minimised if not eliminated. Before the COVID-19 pandemic, the availability of cheap flights saw more than a million people in the air at any time. In the case of medical tourism, the literature reports antibiotic-resistant strains of bacteria being found in returning medical travellers (Pavli & Maltezou 2020). There are also unknown risks that are difficult to manage and consequently mitigate. The movement of large cohorts of people facilitates the cross-pollination of disease and respiratory conditions such as severe acute respiratory syndrome (SARS), which emerged in Asia in 2003 and spread rapidly across the world.

In 2019, the Coronavirus, which originated in Wuhan, China, rapidly became a pandemic that has had global effects on countries' economic, political and social structures. This respiratory disease attacks the most vulnerable, particularly the elderly, and medical travellers have the potential to be carriers of these types of infection. The total costs of this pandemic are yet to be assessed. Still, as of February 2022, over 5,811,065 people had died from the virus, with Peru being the most affected country for COVID-related deaths (Johns Hopkins University and Medicine 2022)

The transmission of diseases is not unique or limited to medical travellers, although medical travellers are more susceptible to health threats post-surgery. As for the issue of antibiotic-resistant bacteria, this is a worldwide problem that is present in Australian hospitals. The WHO has released a communiqué concerning the issue (World Health Organization 2018). Australia has the advantage of being geographically further away from other countries with good quarantine enforcement, although it continues to be challenged by global issues Thailand reopened in June 2022, although it has had 30,386 deaths and over 4,490,760 confirmed cases of infections. (World Health Organization 2020). The biosecurity issues impact on medical travel and as such are part of the reasons individuals don't travel during a pandemic. Medical tourism is a fragile industry and is disrupted by unstable economics, pandemics and other factors that limit travel. Australians travelling to Thailand would consider the rates of infection, access to flights and other consideration prior to travelling for care.

Different medical devices are used in medical tourism procedures, ranging from breast implants to prosthetic joints for knee and hip replacements. According to Turner 2007, 2010, 2012a, the risks include the likelihood of outdated prostheses being implanted. Australian travel for medical, surgical and dental care. Medical devices are used in several procedures, such as breast enhancement or joint replacements. Dental surgery uses devices such as implants. Potentially, with these devices comes the risk of replacement and in some cases the recall of implants. These are an area of risk that medical travellers do not clearly understand. Medical travellers often do not consider medical devices an area of risk.In some instances, there are risks associated with purchasing the least expensive treatments available. The knowledge required to understand the pros and cons of prosthetic devices and the various combinations of components is substantial. The literature on medical tourism has been mostly restricted to the risks involved in seeking care rather than the comparable risks of not acting or the surgical risks associated with the condition.

The medical traveller assumes that the medical device will be inserted following the manufacturer's guidelines. Some companies track their devices in registries. In Australia, the Therapeutic Goods Administration (TGA) oversees devices registered to specific patients and tracked by serial numbers. As an example of the risk associated with prosthetics, in July 2019, the Australian government warned consumers about

textured breast implants as they were linked to rare cancers (Department of Health 2019). Unlike other industries where recalls are inconvenient, removing prosthetics is expensive and carries surgical risks. In the case of surgical prosthetics, the removal of surgical devices often leaves patients with ongoing health issues for years.

2.34 Medical travellers the knowledge gap

Based on the literature review, it has been determined that there is a lack of knowledge about Australian medical travellers. This knowledge gap highlights the necessity for further research in this field. Previous studies have shown that medical travellers have not been thoroughly examined, emphasizing the need for additional research.

The unique geography of Australia generally predisposes some medical travellers to commute long distances for health care. Australians are not homogenous: they differ in terms of geographic, demographic and economic characteristics. A study of 27 patients travelling to Thailand identified reasons for travel as “high costs and the deteriorating conditions of health care in developed countries, and pull factors such as innovation, efficiency, service quality and patient-doctor relationships” (Lunt, Horsfall & Hanefeld 2016, p. 40). The literature continues to report the experiences of medical travellers in the US, UK, EU and Asia. Medical travellers across the globe perceive that care sought through medical tourism is high quality and better than the care received at home (Bennie, 2014, Turner, 2010).

The existing research on medical tourism was found to provide a limited focus on the medical travellers' experiences and motivations. In particular the gap identified in the literature that had not been previously explore in depth (Lunt, Horsfall & Hanefeld 2015, 2016). Some studies discuss the UK traveller from an economic and service perspective the studies do not examine the medical traveller’s motivation and experiences. As such a further understanding of medical travellers can provide valuable insights that can be used to address their needs effectively (Lunt, Horsfall & Hanefeld 2016; Lunt et al. 2011) (Cohen 2008a; Cohen 2014a, 2017; Cohen, Prayag & Moital 2014)..

In Cohen (2014a), several US cases illustrate the medical traveller's perspective on seeking out medical tourism. However, this was in the context of the law and ethics. Finally, (Connell 2006; Connell 2008, 2011a, 2011b, 2011c, 2013, 2016a, 2016b) focused on a regional perspective of the medical tourism industry in Thailand and Asia. The finding is dissimilar to the research being undertaken, Connell (2008) perspective is that medical tourism and general tourism activities are closely affiliated. Australian travel for surgical and dental procedures is a primary consideration, and leisure activities are secondary or incidental. The engagement in leisure activities was often dependent on medical procedures. Medical travellers who underwent cosmetic and dental procedures that are less invasive were more likely to engage in leisure tourism options (Jones 2011).

The gap identified in the literature continues to be the experiences of Australian travellers engaging in medical tourism, including the types of medical, surgical and dental procedures sought.

2.35 Conclusion

The literature is inconsistent concerning the number of Australians using medical tourism. However, there continues to be variable information on the number of Australian medical travellers or the specific destinations they visit for health care. There were a lack of systems and processes that capture data to identify medical travellers. There are gaps in the literature, particularly in understanding the motivations of Australian medical travellers and their respective choices concerning their health care. Although several authors write from an Australian perspective, most articles focus on the EU, UK and US patients, where medical tourism has been established for two decades. Australian medical travellers remain an enigma since little is known about their motivations for travel and whether the outcomes they seek have been achieved. Although there are studies on the experiences of EU, US and UK patients, the findings are not always transferable to Australian medical travellers. The health systems in these countries vary, as does the destination where medical tourism is established as an industry. There is a clear need for further research to understand the Australian outbound medical tourism industry, which is in a developmental stage. The sector will take years to recover from the COVID pandemic (Tatum 2020). Medical travellers act

independently or with a medical tourism operator seeking care in Asian countries, specifically Thailand. There is evidence that the procedures Australians seek are mainly dental and cosmetic. These elective procedures are not necessarily time-critical and can be planned months ahead. The Australian medical tourism industry has many medical tour businesses that provide coordination and logistics support to Australian medical travellers. These businesses are a relatively recent addition to tourism and organise tours for Australians having cosmetic surgery. They assist travellers who are sometimes making the medical tourism journey alone, thereby providing a certain level of emotional and logistical support.

As the economic and political landscape post-pandemic continues to evolve and the government's plan on providing health care will be constrained by budget considerations, the demand for health care will continue to exceed the domestic supply. The Australian Competition Consumer Commission suggests that other options should be considered (Australian Competition and Consumer Commission 2018). Moreover, services that support rural and regional Australians, new models and information and communication-rich technologies will continue to drive models of health care in Australia. For example, the Victorian government continues to look at gaining efficiencies in health. Examples of models, such as using telehealth for medical appointments, provide patients with access to health care without travelling to hospitals (Department Health and Human Services 2021).

2.35.1 Research questions

The research questions for this study are:

1. What motivates Australians to travel to Thailand, for health care?
2. What are the experiences of Australians who have travelled to Thailand for medical care or procedures?

2.36 Medical tourism defined

Australians living in Australia and travelling to Asia for medical tourism are the scope of this study. As previously discussed, medical tourism is embedded in a

historical context in Europe, travelling to specific sites for health requirements. There are multiple definitions of medical tourism in the literature,

> "medical tourism as the sum of all the relationships and phenomena resulting from a journey by people whose primary motive is to treat or cure a medical condition by taking advantage of medical intervention services away from their usual place of residence while typically combining this journey with a vacation or touristic elements in the conventional sense"(Voigt 2010, p. 28).

Although there are numerous definitions of medical tourism, all include the movement of patients across borders to other countries for health care needs (Carrera & Bridges 2006; Chee, Whittaker & Yeoh 2017; Connell 2006; Lunt et al. 2011).

However, the following definition was chosen for this study.

> Medical tourism takes place when individuals opt to travel overseas with the primary intention of receiving medical treatments (Lunt et al. 2011, p. 14).

Connell (2013) suggests that dental surgery is often omitted from these definitions. In this study, dental procedures are included in the definition of medical tourism despite the ongoing debate on this issue (Lunt et al. 2011). For Australians, dental procedures are a popular reason for their medical travel and are seen as a low-risk, entry-level introduction to medical tourism. Dental tourism can be divided into two categories: dental procedures and cosmetic dental procedures. The latter is more invasive, requiring similar recovery times as elective surgical procedures. Jaw reconstruction is one example of such a procedure. However, unlike other procedures involved in medical tourism, dental procedures are often combined with tourism activities (Hall 2011; Lunt et al. 2011; Panteli, Augustin, Rottger, Struckmann, Verheyen, Wagner & Busse 2015; Rodrigues et al. 2017).

Finally, as a worldwide phenomenon, medical tourism has developed in response to the globalisation of health care (Connell 2011a). Traditionally, the provision of health care has been a societal responsibility with the nation-state taking care of its citizens and providing health care as its core responsibilities. In a democratic framework, the right to health care is intrinsically linked to public policy and the responsibility of government

(Ruger 2005). However, in some countries, the state has failed numerous individuals by not providing access to health care.

2.37 Summary

The review of the literature established the knowledge base for the research. The study was established within a global and local context using hybrid of market segmentation and push and pull factors. The literature review presented in the above chapter discussed medical tourism decision making, types of surgery, and described the Australian medical traveller.

The ambiguity concerning the number of Australians travelling for medical tourism, types of procedures and what motivates Australians to travel are gaps in the literature and yet to be examined.

The literature review identified cost as a significant factor in seeking medical tourism. The supply issues and the demand for health care continue to impact on Australians. The context of how push and pull factors influence medical travellers' decision-making were examined. The primary focus of the literature review was the reasons behind what motivates Australian medical travellers. Medical tourism is a complex industry; environmental factors such as access, cost, stability of the destination country and biosecurity have a significant impact on the sector.

In Chapter 3, the research design paradigm is identified. The rationale for the research and the study design is established and articulated. An explanatory multi-method study design with two sequential phases is used to answer the research questions: an inductive approach, data analysis, and the strengths and limitations of the study design will be explored.

Chapter 3. Research design

Figure 3.1 Chapter 3 structure.

3.1 Introduction

The literature review in Chapter 2 identified published studies exploring the experience of medical tourism, particularly from an Australian perspective. The research questions aim to explore and describe the experiences of Australians who travel to Thailand for the purposes of medical tourism. This chapter describes the analytical framework, methodology and data collection methods used in the study. A description of data analysis and a section on the strengths and limitations closes the chapter.

Chapter 3 describes the data collection methods and analysis. The study design is informed by the hybrid market segmentation, push and pull factors model which is applied to medical tourism. The chapter discusses the research paradigm, research aims, rationale and research questions.

3.2 Analytical framework

The analytical framework used in this study is a hybrid of Kotler's market segmentation model (Kotler 1999) and push-and-pull factors (Dann 1977, 1981). The market segmentation model characterises and examines demographic, geographic, psychographic and behavioural factors to understand consumer choice. The push-pull approach identifies the internal and external drivers of travel and is applied to understand the behaviours of medical travellers in their environmental context. Traditionally, the marketplace was where buyers and sellers exchanged goods and services. In contemporary times, this has evolved to industries described as sellers and markets identified as buyers. In medical tourism, medical travellers are the market, and

the suppliers of health services are the sellers (Kotler 2012). The push-pull approach explains the internal and external factors that drive tourism and is applied to understand the behaviours of medical travellers and economic and political environments (Dann 1977, 1981); Heung, Kucukusta and Song (2010). According to (Dann 1977, 1981), tourism is an opportunity to leave the mundane lives we lead behind, albeit for a short time.

> The greatest reason for travel can be summed up in one word, "Escape": escape from the dull, daily routine; escape from the familiar, the commonplace, the ordinary; escape from the job, the boss, the customer, the commuting, the house, the lawn, the leaky faucets (Dann 1977, p. 184).

In some cases, the factors that motivate tourists can also be applied to medical travellers who travel for the medical, surgical and dental health care offered in a location away from home. Australian medical travellers can navigate access to health care in a foreign country. They are geographically isolated from other countries in Asia. Australian medical travellers are committing time and effort to understand their medical, surgical, or dental procedures. (Chomvilailuk & Srisomyong 2015; Connell 2011b, 2011c, 2013, 2016a).

This study uses a hybrid of two theories as an analytical framework to identify Australian medical travellers' characteristics and the reasons for travel. The first part of the hybrid framework comprises Kotler's (Dann 1981; Kotler 2012) four market segments: demographic, geographic, psychographic and behavioural, which are used to describe, understand and examine behaviours of Australian medical travellers. In this framework, marketing segmentation helps to categorise and explain medical travellers' motivations and experiences from four perspectives. The second approach, (Dann 1981) push-and-pull factors, describes the political, economic and environmental context of medical tourism in Australia and Thailand.

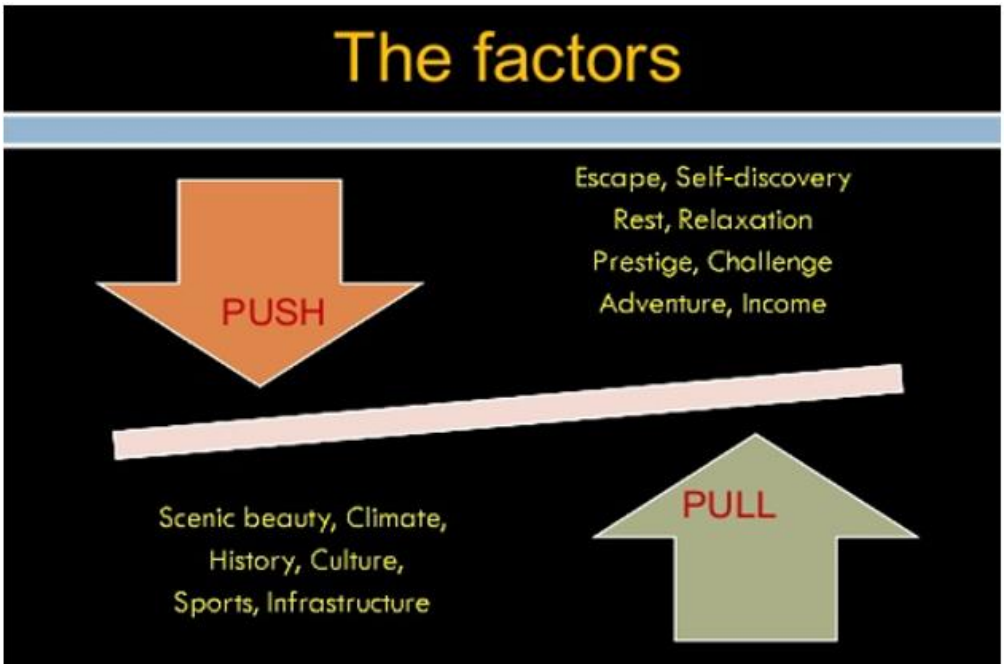


Figure 3.2 Push and Pull Factors (Dann 1977; Leiper 1990).

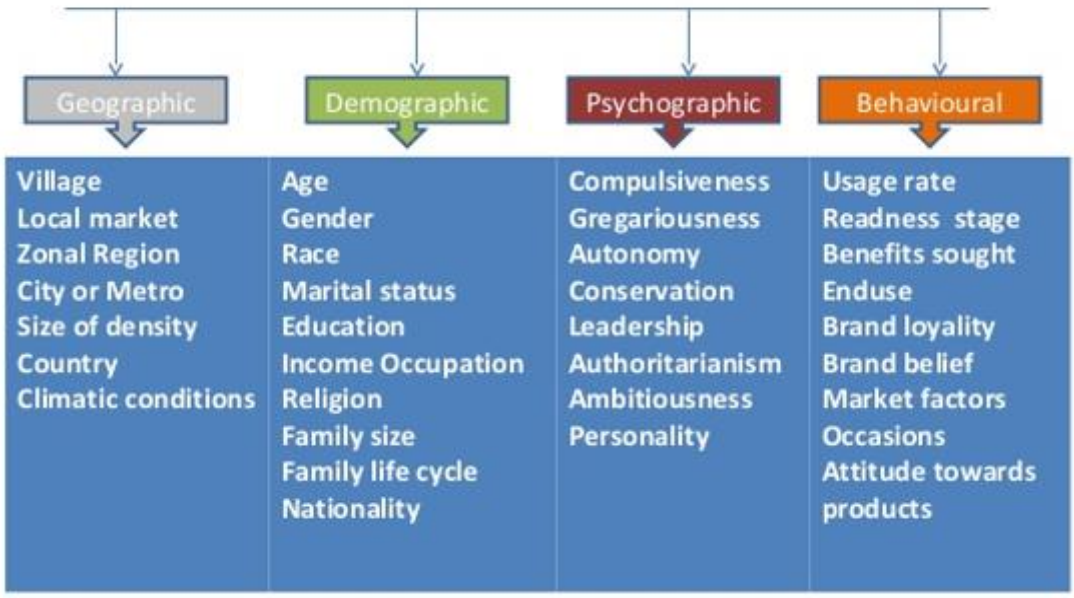


Figure 3.3 Market segmentation Kotler 2015: p117 – 122.

The analytical framework used in this study is based on Dann's push and pull factors, and Kotler's market segmentation model which identifies the profile of the Australian medical traveller (Dann 1981; Kotler 2012). For example, in Figure 3.3, the geographic

and demographic segments are self-explanatory. The behavioural segment identified medical travellers' loyalty to Thai surgeons and dentists and, in some cases, Thai hospitals, with patients often returning for multiple surgeries and recommending them to family and friends. The psychographic segment describes medical travellers' values, lifestyle, autonomy, personality and attitudes. Medical travellers' choices as they relate to lifestyle decisions and attitudes. Medical travellers highly value their relationship with their Thai surgeons and dentists. Additionally, lifestyle and employment pressures on Australian female medical travellers continue to drive the demand for cosmetic procedures (Holliday et al. 2015; Jones 2011; Rodrigues et al. 2017).

3.2.1 Research paradigm

Research paradigms are made up of four components; these are ontology, epistemology, methodology, and methods. First, according to Crotty (2020), ontology is the study of being. The researcher decides on their stance early in the study, addressing the objective or subjective position. An example is that medical tourism is subjective regarding medical travellers' experiences. The ontological beliefs suggest multiple realities exist for Australian medical travellers. Their experiences are constructed through their interactions with others.

> Ontology is an attempt to recognize the world of things and facts in an all-encompassing way and to categorize and name everything (Busse, Humm, Lübbert, Moelter, Reibold, Rewald, Schlüter, Seiler, Tegtmeier & Zeh 2015, p. 35).

The assumptions made in this study are that Australian medical travellers have different experiences from UK or US medical travellers. Individually their experiences would also vary depending on the procedures they seek from medical travel.

Epistemology is the study of beliefs and the origin and acquisition of knowledge. The assumption proposes that different individuals hold different views (Bromme, Kienhues & Stahl 2008). Epistemological assumptions describe knowledge creation, acquisition and communication (Guba & Lincoln 1994). In the data collection phase, some initial assumptions of medical travellers challenged the researcher.

According to Carter and Little (2007), epistemology shapes the methods used in a study. Methodology justifies the method which produces data and analyses.

Epistemology is the knowledge created by the method; as such, it would be evaluated and justified by the assumptions driving the study. Therefore, epistemology is surrounded by axiology. Knowledge generated will be compared by the values held by the researcher and the research participants (Carter & Little 2007, pp. 1316-28).

> The axiological belief pertains to the nature of ethics and what we value, "the axiological standards of honouring the life experience of research participants, maintaining awareness of power differentials, and enhancing social justice" (Biddle & Schafft 2014, p. 321).

The methodology provides a road map or plan for the study. It informs the methods used in research. Generally, it addresses "the why, what, when and how data is collected and analysed" (Guba & Lincoln 1994, p. 108). There are different methods used in quantitative research. These are experimental, descriptive, correlational and survey methods. Interviews and focus groups are methods used in qualitative research, and observational methods can be used in both qualitative and quantitative research (Creswell & Creswell 2017).

The interpretivist paradigm guides the research working on the assumption of understanding knowledge in the social sciences Table 3.1. Research using this paradigm is described as adopting a relativist ontology in which a "single phenomenon may have multiple interpretations rather than a truth that can be determined by a measurement process" (Pham 2018, p. 3). This approach provides an expanding view of identifying and examining a phenomenon. The medical tourism industry is not well understood and as such the interpretivist paradigm will enable the understand of the Australian industry from two perspectives in this multi method study. This study is subjective and is grounded in the context of the Australian health system.

Interpretivist researchers examine and describe objects, humans and their interactions or events but also enable a deep understanding of them in the social context (Schwandt 1994). Researchers can also conduct this research in a natural setting using key methodologies associated with grounded theory (McChesney & Aldridge 2019). The interpretivists seek a deeper understanding of the phenomenon's complexities and

context instead of generalising the data and applying it to the whole population (Creswell & Clark 2017).

The table below provides four paradigms commonly used in the social sciences.

Table 3.1 Four paradigms used in social sciences adapted (Sheppard 2020).

Paradigms	Descriptors	Assumptions
Positivism	Objective, Knowability and uses deductive logic	Society can be studied empirically and scientifically
Interpretivist	Subjective, interpret social roles in relationships and inductive	Social interactions and the differences between humans are explored and examined
Social Constructivism	Reality is framed by social context and created collectively	Truth is socially constructed and evolving. Participants' view is central
Critical Paradigm	Subjective, focused on social change, biases exist and should be acknowledged	Focuses on power, equity and social change

This study uses an interpretive framework with multiple realities core to the research design. The interpretive worldview assumes that knowledge needs to be interpreted. The assumptions identify participants' historical, social and cultural perspectives. A further assumption is that human beings construct meanings as they engage with the world; they are participants in interpreting meaning by making sense of information and giving it their interpretation.

> Although the interpretive paradigm is not a dominant model of research, it is gaining considerable influence, because it can accommodate multiple perspectives and versions of truths (Thanh & Thanh 2015, p. 25).

The interpretivism paradigm is subjective, collaborative and participatory (Antwi & Hamza 2015). In this study, research participants shared their views via several media platforms, specifically blogs, reviews and radio interviews. (Barry 1996, p. 3; Mills, Bonner & Francis 2006). Accordingly, qualitative researchers who adopt this approach strive to understand the context or setting of the research participants. Researchers also

contribute by interpreting what they discover. The researcher participates in this process by interacting with the research participants and interpreting the data, shaped by the researcher's own experience, perspective and background. Therefore, the creation of knowledge comes from the generating of meaning. This suggests that

> the basic generation of meaning is always social, arising in and out of interaction with a human community", and "the process of qualitative research is largely inductive; the inquirer generates meaning from the data collected in the field (Creswell & Creswell 2017, p. 9).

3.3 Aims and research questions

This study aims to understand the factors motivating Australians to seek health care in Thailand. The literature review described in the previous chapter identified a gap about Australian medical travellers, this study aims to contribute to the body of knowledge from an Australian medical traveller's perspective. Thailand was chosen as the medical tourism destination as it is popular with Australian travellers and geographically accessible.

This chapter expands on the methodology and methods used to answer the following research questions. The overarching analytical framework and the questions that guided this research are below.

1. What motivates Australians to travel to Asia, specifically Thailand, for health care?
2. What are the experiences of Australians who have travelled to Thailand for medical care procedures?

3.4 Study design

The study design primarily aims to answer the research questions. The study has both qualitative and quantitative phases and is described as a multi-method research design. Both mixed and multi-methods are used in social science research this study had two phases which were sequential and exploratory. Mixed methods have an integration phase where the data is mixed, merged or embedded, whilst there is no integration phase in the multi-method approach (Anguera, Blanco-Villaseñor, Losada, Sánchez-Algarra & Onwuegbuzie 2018). As such the study design chosen for this study was the

multi-methods approach. A number of designs were reviewed these were exploratory sequential, explanatory sequential and convergent designs (Fetters, Curry & Creswell 2013). The multi-method sequential two-phase study design, where the qualitative phase is examined first to understand the problem under study. Subsequentially the quantitative study in the second phase is then completed. The design intends to build a comprehensive approach to answer the research questions. The exploratory approach was chosen as the logical alternative, given that medical tourism in Australia is still in the developmental stage. Exploratory research has several advantages and is often used to understand a phenomenon.

The multi-methods approach enabled the study to focus on both the experiences and gain a comprehensive understanding the Australian medical traveller. The survey in Phase 2 provided a more focused exploration of the phenomenon of interest (Mason, Augustyn & Seakhoa-King 2010).

As there are many unknowns in the medical tourism industry, the exploratory design was selected to discover the variables. The gaps identified in Phase 1 of the study suggested that limited information was known about Australians seeking to travel for care. The reasons for travel and the processes undertaken before travelling were all areas for exploration. The following briefly explains what constitutes the research design.

> Exploratory research is characterised by process of reformulating and adapting explanations, theories and hypothesises inductively. It seeks to refine adapt or change the initial explanation in an itinerary process of applying other explanations (Harrison & Reilly 2011, p. 144).

Phase 1 examined the narrative data using a qualitative method, and Phase 2 consisted of designing a survey using a quantitative method. A single method was deemed inadequate to understand the problem; therefore, a multi-method approach was employed, described in Figure 3.4.

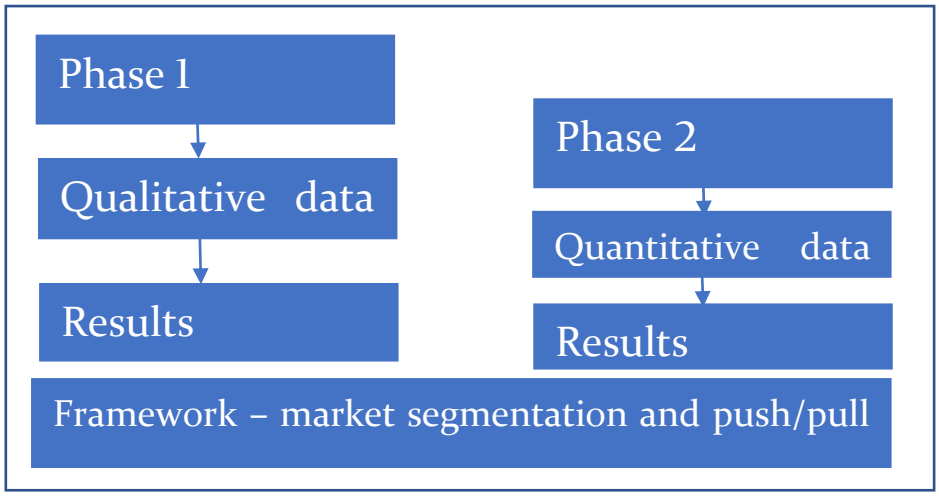


Figure 3.4 Exploratory multi-methods sequential approach applied to this study.

3.5 The rationale for the research method

The rationale for using the multi-methods approach in this two-phase sequential study was to ensure that an inclusive design examines the experiences of medical travellers and the environment in Australia and Thailand, where the sector operates. The research design emphasised the qualitative method to understand travellers' experiences and reasons for travelling outside Australia for health care. Multiple methods research is used in social science research. Multi-methods studies can employ two or more qualitative methods, two or more quantitative methods, or a combination of qualitative and quantitative methods (Davis, Golicic & Boerstler 2011). Multiple methods research is described as the type of research in which researchers draw on data from more than one source and employ more than one type of analysis (Creswell and Plano Clark 2007; Johnson and Onwuegbuzie 2004).

The multi-method approach uses multiple methods the qualitative and quantitative research methods in a practical approach. Each approach has its strengths and shortcomings, with the latter being mitigated by using two methods (Johnson, Onwuegbuzie & Turner 2007). A multi-method could also include quantitative methods or the practice of "two or more different methods within the same study" (Hunter & Brewer 2015, p187). It provides a study with the advantages of both quantitative and

qualitative data. In addition, by using the two different methods in this fashion, a researcher can gain perspectives from the different types of data or from different levels within the study (Creswell, Plano Clark, Gutmann & Hanson 2003, p. 185).

3.6 Research method

The study focuses on exploring medical tourism in Thailand and understanding the perspective of the Australian medical traveller. Australians are travelling to Thailand for medical, surgical and or dental procedures.

Therefore, a multi-method sequential study was used to answer these research questions. The designs use two approaches, qualitative and quantitative research methods, providing a comprehensive study design. The study's primary and secondary questions were formulated in Chapter 2.

Mixed methods and multi-methods are often described as inter-related with the main difference being that integration is not required in a multi-method study design (Anguera, Blanco-Villaseñor, Losada et al. 2018). Consequently, a multi-methods sequential study design was adopted, consisting of two phases the first phase was qualitative exploring the blog dataset. A quantitative approach was used in the second phase with a survey developed and implemented online.

Qualitative data was collected during Phase 1, providing a baseline of experiences and motivations. This data was available on public websites and provided a base for understanding medical tourism in Australia. Also, the qualitative data supplemented the gaps identified in the literature review. In Phase 2 of the study, the intent was to understand the Australian medical travellers further, as Phase 1 focused on their experiences. Phase 2 aimed to understand where they lived and a range of demography and geography information that was an identified gap in Phase 1. It was anticipated that the data obtained via the survey questions would consolidate the information derived from Phase 1 and provide a more comprehensive response to the research questions.

The literature on study design methods suggests that mixed and multi-methods across social science research continues to grow in popularity, however multi-methods is described as when both types of methods are used in a single study in a number of combinations (Anguera et al. 2018). The use of both qualitative and quantitative

methods within a study provides a solid research design. In this study the multi-methods approach enables triangulation because when the topic is investigated using two different approaches the findings of both independent approaches provide a more comprehensive understanding of the matter under investigation.

> Multi-method research may be broadly defined as the practice of employing two or more different methods or styles of research within the same study or research program rather than confining the research to the use of a single method. Unlike mixed method research, it is not restricted to combining qualitative and quantitative methods but rather is open to the full variety of possible methodological combinations (Hunter & Brewer 2015).

3.7 Phase 1: qualitative data

Australians requiring specialist medical and surgical care have four choices within the Australian health system: waiting for medical and surgical services to become available, using health insurance and paying out-of-pocket fees if uninsured, paying total fees domestically, or engaging in medical tourism (Willis, Reynolds & Rudge 2019). If the option selected is medical tourism, then Australian patients use the Internet to search for websites or get recommendations from friends and family. At this point in the process, what is not known are the motivating factors and decision points? In the literature review, many international articles suggest that the cost of procedures, access, and lack of insurance are the key push factors for medical tourism depending on the nationality of the medical traveller. The study includes dental procedures as dental care for adults in Australia is a full-fee-paying procedure; for some Australians, health insurance covers some of the cost, or individuals pay for the treatment. Some vulnerable groups, such as the socially or economically disadvantaged, are serviced by state-run dental hospitals with long waiting times. Therefore, seeking dental procedures overseas continues to be popular with Australians mainly due to the expenses related to dental procedures in Australia (Barrowman, Grubor & Chandu 2010; Bell et al. 2011; Whittaker 2015).

In Phase 1 of this multi-methods qualitative study, data was collected from several sources and medical tourism websites. Several studies used secondary data to gather information about participants' motivations, experiences, perceptions and feelings

(Banyai & Glover 2012; Eastham 2011; Hookway 2008; Kurtz et al. 2017; Wilson, Kenny & Dickson-Swift 2015). Also, Kurtz, Trainer, Beresford, Wutich and Brewis (2017) argue that online blogs and forums are a rich data resource that has not been well-utilised by researchers due to the absence of clear methodological protocols. However, one disadvantage of using this source is that, often, the researcher can be overwhelmed by the sheer volume of available data. Another issue is that some professional writers make a living out of posting blogs. Their income is derived from having a following of supporters, allowing them to endorse services and products. These individuals are referred to as Influencers and provide experiential advertising for services and products they use. Some blogs and editorials are also a form of advertising; these postings were vetted, which is time consuming but required to validate the data set. Therefore, for this study, only privately authored blogs, reviews and interviews were considered.

Hookway (2008) defines the blogosphere as where an online diary is shared with peers, and private and intimate content is posted daily, monthly and yearly. Blogs can be about specific subjects such as surfing, cosmetic surgery or travel in certain regions. One advantage of using blog data is that it is easily accessible. For Phase 1, blogs, reviews and interviews were selected from independent websites relevant to Australian medical travellers' experiences.

The individuals had travelled for medical, surgical and dental surgery, posting blogs and reviews and engaging in interviews. The data was sourced from RealSelf, Facebook, TripAdvisor, Reviews Treatment Abroad, Forum Whirlpool and ABC radio. Inclusion and exclusion criteria were established to facilitate sampling the data for Phase 1. The websites provided large amounts of personal data, including information about health history, photos, radiology results, procedures videos, pathology results and quotes for procedures. All this information can be viewed by individuals who sign up for websites. There is an established cyber community where information is shared and, in some forums, specific details like doctors’ names, quotes for procedures, and surgical experiences are shared by participants. The researcher joined these websites to access the information and said she was undertaking a doctoral study on medical tourism.

A flexible approach was adopted when collecting data from blogs, reviews and interviews posted on multiple websites. For example, when searching TripAdvisor, many posts recommended that medical travellers go to RealSelf for more specific information. RealSelf is a website that specialises in cosmetic surgery. A significant advantage of using this type of data is the level of information individuals provide. Likewise, blogs and reviews may encourage authors to share feelings and experiences more openly than in a face-to-face interview. An assumption of this behaviour could be due to the anonymity afforded by the pseudonym and the absence of face-to-face encounters (Eastham 2011, p. 354).

It is "helpful to conceptualise research conducted in online environments into three separate categories: (1) the "big data approach," (2) the "quantitative approach," and (3) the "qualitative approach" (Kurtz et al. 2017, p. 2). This study used data from medical travellers describing their experiences in the qualitative approach. The data collection process for this research involved scanning websites for Australian medical travellers' blogs, reviews and radio interviews. The exclusion and inclusion criteria determined the data that would be collected and included for analysis. As an understanding of the topic progressed, the inclusion and exclusion criteria were expanded. For example, many blogs mentioned dental procedures; therefore, dental procedures were incorporated into the inclusion criteria.

Initially, the researcher planned to limit the search to blogs and reviews on orthopaedic surgery. However, the feedback from the candidature review suggested that the study include all surgeries, which appeared to be a departure from the study's original purpose. However, on reflection, all medical procedures, specifically cosmetic surgeries, provided a larger sample. Moreover, there were not as many blogs for orthopaedic surgery, and blogs are generally posted by a younger demographic. Consequently, the group would not require orthopaedic and joint replacement surgeries, which are more common in an older demographic.

The inclusion criteria for the data collected for Phase 1 were: blogs and reviews by Australians who were medical travellers as defined in chapter 2 (bloggers, reviewers and interviewees were identified as Australian by the text in the blog or the blog name); participants were 18 years and over, which enabled them to consent to surgery;

bloggers' and reviewers' destinations had to be an Asian country with a preference for Thailand; data pertained to all medical, surgical and dental procedures; the blogs and reviews were in English, and posts from 2010 to 2018 were identified and data collection was completed in 2018.

The exclusion criteria included: Australians residing in Asian countries, including Thailand (expatriates did not meet the definition of medical traveller); the medical tourism destinations were outside South-East Asia; procedures were other than medical, surgical or dental (i.e., bariatric surgery, surrogacy, organ donation and euthanasia); and blogs were advertising testimonials and or business promotions.

The datasets derived from blogs, reviews and interviews were collated, usually organised in reverse chronological order with links to other sites. Blogs divulge information about the individuals posting the narrative; for example, 'Tina from Timboon' indicates her location – the town of Timboon. All secondary data in the inclusion criteria were given a number that identified each narrative in the study; other personal identifiers were removed.

The data comprised 27 items blogs, hospital reviews and radio interviews. The data were manually coded for themes and categories; this is described as becoming familiar with and delving into the data (Charmaz 2012). The NVivo software package was used to code the blogs using four market segmentation categories demographic, geographic, psychographic and behavioural. (Kotler & Keller 2006). Phase 1 data were categorised into all or some categories, as coding was an emergent process. Line-by-line coding identified the initial themes and categories of the blogs and reviews. This secondary process also enables validation where the adequacy of the initial coding is determined (Charmaz 2014, p. 57). The data derived from Phase 1 was then loaded into NVivo software for further analysis.

3.8 multi-methods sampling

For this study, Phase 1 of the qualitative study used purposive sampling dimensions, a multi-methods sampling technique described by Teddlie and Yu (2007) as a technique that focuses on the research questions and is appropriate for a smaller sample size. The advantages of purposive sampling are that it gives the researcher the flexibility to select

the participants and focus on the quality and depth of the narrative data. Also, "particular settings, persons, or events are deliberately selected for the important information they can provide that cannot be gotten as well from other choices" (Teddlie & Yu 2007, p. 77). There are two types of sampling: random and non-random. The definition of these two techniques is random sampling, where there is an equal probability of being selected, and non-random sampling, which is based on specific factors deemed appropriate for the study design (Hookway 2008; Onwuegbuzie & Collins 2007; Wright 2005). Purposive sampling was selected for this study; it is non-random sampling commonly used in qualitative studies, but for the most part, it is applied to achieve a depth of understanding of the data. A purposive sampling approach was used to identify 27 blogs, reviews and interviews covering a variety of procedures and a mix of genders. With purposive sampling, the researcher decides the data inclusion and exclusion criteria. This method is often used to select participants for health research, as it is inexpensive and pragmatic. When determining sample size using the purposive sampling method, four rationales need to be considered: the study design should be multi-methods; participant enrichment should be the aim (the sample should be optimised by recruiting participants); each participant must be appropriate for inclusion; and finally the selection of participants should facilitate the "thickness and richness" of data (Johnson, Onwuegbuzie & Turner 2007, p. 116). This method was selected to maximise the understanding of a phenomenon. The minimum sample size suggested is 15-20 participants (Onwuegbuzie and Collins (2007, p. 289). Also, Young and Casey (2018, p. 54) suggest that “rich qualitative findings can be discovered in relatively small sample sizes”; the paper identified three studies of cohorts ranging from 15 to 27 participants using interviews and focus groups. (Barratt, Ferris & Lenton 2014, p. 5) suggest that purposive sampling is a method that can be used to understand hidden populations; this method relies on the researchers' knowledge and field connections and networks. Moreover, the method also works well with Internet recruitment and survey methods, providing access to a broader range of potential participants.

In this study, the researcher identified medical travellers through their online blogs, reviews, and interviews. The advantage of this technique was that those subjective elements were driving the data selection. The researcher uses her judgement in deciding the sample elements. As such, inclusion and exclusion criteria were developed to guide

the selection decisions. The data in Phase 1 consisted of 'thick and rich' descriptions, which increases both the descriptive weight and the interpretive validity of the data (Denzin & Lincoln 2001, 2011). The issue of data saturation was a primary consideration. It is often described as the same themes keep recurring, adding no new information to the body of the dataset. This occurrence was also referred to as theoretical saturation or informational redundancy. This method supposes the sample size is not determined by statistical power analysis but by data saturation (Onwuegbuzie & Collins 2007; Young & Casey 2018).

3.9 Phase 2: survey

In Phase 2 of this research study, a quantitative survey targeting Australian medical travellers was designed and implemented in 2019. The very nature of a phenomenon lends itself to a multi-methods sequential design as the topic of medical tourism in Australia is under-explored and requires a matrix approach. First, qualitative data is collected, which subsequently is analysed, and the results establish gaps in knowledge which in turn directs the development of the second phase of the study. In this research, that took the form of a survey to gather a broader range of data for analysis. These two phases are independent of each other and are discussed in detail in Chapter 4.

On the other hand, explanatory research design identifies causal relationships among variables (Malhotra & Grover 1998, p. 409). Also, the positivist approach was used in Phase 2 of this study. The positivist approach is objective by treating people as objects, emphasising measuring variables and testing hypotheses. The approach is independent of the participants, has a scientific nature, is highly structured and follows a strict set of guidelines. It is frequently associated with survey methods and quantitative designs. This approach has high levels of reliability (Wilson 2014).

The quantitative phase of the study involved an online survey (Appendix 4) conducted via SurveyMonkey in 2019. The survey design was based on the knowledge gap from dataset derived from Phase 1, where posts were collected and themed. Phase 1 yielded valuable demographic and geographic information, subsequently informing the survey design in Phase 2. The online survey provided a larger sample size which helped consolidate the narrative data obtained in Phase 1, thereby strengthening the validity of the results. The demographic and geographic information on Australian medical

travellers complements the narrative approach taken for Phase 1. Also, asking Australian medical travellers to identify their reasons for travel was critical to answering the primary research question: What are the motivating factors for Australian medical travellers seeking health care in Thailand? The aim of Phase 2 was to acquire a broader understanding of medical tourism in Australia by utilising a questionnaire distributed to a larger sample.

The survey was designed to test some assumptions, such as the time that medical travellers take to decide to travel, and the process undertaken before major decision points.

Phase 2 of the study sought additional participant information, particularly demographic, geographic, psychographic and behavioural attributes, which were not consistently available in the Phase1 data. Also, survey participants were asked to rate their satisfaction with their medical, surgical and or dental procedures.

For the online data collection, an online survey link was posted on multiple Facebook pages and the Messenger platform. The researcher also sent the link to a personal social network to forward to others who might have had an experience with medical tourism. The link was also sent to individuals posting on Facebook's Medical Tourism in Thailand sites. The messages were personalised for the potential participants. The researcher's post introduced the study and invited individuals to participate in the survey via a link. Before this, the researcher checked individuals' profiles on Facebook to ensure that potential participants resided in Australia. Also, some participants responded via Facebook Messenger, advising that they had completed the survey. The online survey was open for 4 months during which 118 respondents completed the survey.

The next stage was data preparation and presenting the survey data. The incomplete returned surveys were excluded, and the remaining responses' data were coded and graphed. Some participants did not answer all the survey questions, resulting in 35 incomplete questionnaires. The survey yielded 83 completed questionnaires that were used in the analysis. Reports were generated from SurveyMonkey that collated descriptive information on each question and a summary of the completed surveys. Finally, the survey data from Phase 2 was reviewed, collated and graphed for analysis.

3.10 Data analysis

The study design enabled the researcher to generate a theory from the data analysis in Phase 1. Veal (2017) describes the approach as a comparative method. Constant comparative analysis in qualitative data gathers information coded into emergent themes. The process was undertaken twice, as described previously.

> In this type of analysis, the researcher's task is to configure the data elements into a story that unites and gives meaning to the data as contributors to a goal or purpose. (Polkinghorne 1995, p. 15).

The theory is driven by an inductive approach and involves an iterative, cyclical process. The development of theory from data requires repeated rounds of analysis, described as an iterative process where each repetition brings the researcher closer to answering the question. The purpose of the inductive approach is to:

> Condense extensive and varied raw text data into a brief, summary format; Establish clear links between the research objectives and the summary findings derived from the raw data and to ensure these links are both transparent (able to be demonstrated to others) and defensible (justifiable given the objectives of the research); and develop of model or theory about the underlying structure of experiences or processes which are evident in the text (raw data) Thomas (2003, p. 2).

In Phase 2, the data collected via SurveyMonkey was analysed using descriptive and frequency analysis. The framework aims to examine and understand the characteristics of the medical traveller and medical tourism in Australia. Kotler (2012). The data from Phase 1 and Phase 2 were reported, with both phases being analysed and discussed independently in Chapter 4 and the findings discussed in Chapter 5.

> Integration can also occur when findings from the first phase are used to inform the development of the second phase, termed integration. In an exploratory study, findings from interviews may be used to develop an instrument that is then tested quantitatively in phase two (Doyle, Brady & Byrne 2016, p. 631).

3.11 Strengths and limitations

The multi-method approach was a strength of the study design, although it was more work and time consuming to manage. The approach enabled a richness of the data, providing depth and complexity to answer the research questions comprehensively. It is argued that a multi-methods research design is more comprehensive as it uses two different methods to answer the research questions. The strength of this approach is that it can answer complex questions that might not easily be explained by the data obtained from a single method. It is also possible that the strengths of one method can assist in overcoming the limitations of the other approach. For example, a survey with questions might not provide data on the experiences of the respondent or the reasons that they answered in a particular manner. In this study, if the qualitative method alone were used in Phase 1, the study would have only had the individual medical traveller's perspectives. The design focuses on the two different methods with two data sets which enhance the study design, the qualitative dataset focuses on the medical travellers' experiences and the survey data provides context and a broader perspective potentially guiding the study to realise the aims and objectives (Creswell & Clark 2017; Tashakkori, Teddlie & Teddlie 1998). The strengths of the sequential exploratory design are that both data sets are interpreted separately (Hughes 2016). There were also some inherent disadvantages in the study design, including the time required to collect qualitative data before proceeding to the quantitative phase. The issues associated with multi-methods research are described as requiring more work. It is time-consuming and requires financial resources, often taking longer to complete.

Triangulations combine theories and methods to explore and explain complex human behaviour. Methodological triangulation was applied in this study, which enabled the credibility and validity of the findings. This type of triangulation promotes the use of several methods, such as the research design in this study, where survey questions were informed by the findings of data collected in Phase 1 (Noble & Heale 2019).

The process of managing both methods in this approach was made more efficient by compartmentalising into sections the tasks required and limiting the time spent on them. For example, the search ended once 27 blogs, reviews and radio interviews from Australian medical travellers had been collected. The radio interview transcripts and

hospital reviews were long and provided a similar depth of data. Although the hospital reviews and radio interviews were longer and more comprehensive, they were not interactive. In this respect, they differed from the blogs where individuals interacted with others in online conversation threads. Although data derived from blogs and reviews were used in research studies, they have limitations, one of which is that medical travellers provide a subjective perspective. (Banyai & Glover 2012; Chenail 2011; Eastham 2011; Hookway 2008; Kurtz et al. 2017; Lövheim 2011; Wilson, Kenny & Dickson-Swift 2015).

3.12 Summary

Chapter 3 described the study design using a hybrid market segmentation and the push and pull approach. The market segmentation model characterised the four segments: demographic, geographic, psychographic and behavioural, to understand consumer choice. The push and pull approach identified the internal and external drivers of medical travel. The approach was applied to understand the motivation and behaviours of Australian medical travellers.

The multi- method study design provided a comprehensive approach to answering the two research questions. The exploratory approach was chosen as the logical alternative, as medical tourism in Australia is still in a developmental stage. The design justifies how the data will be analysed and the strengths and limitations of the approach.

In Chapter 4 the results of the study are reported separately first, the 27 blogs are themed and presented into eight categories. Second, 83 respondents completed a nine-question survey; the results are graphed and described below. Chapter 4 depicts tables and graphs which describe the data in various categories such as demographic, and geographic results of Australian medical travellers.

Chapter 4. Results

Figure 4.1 Chapter 4 structure.

Chapter 4 reports the results from Phases 1 and 2 of this medical tourism study. The results are reported separately. First the qualitative data are provided under eight identified themes. In Phase two the survey results from 83 respondents are reported. The results are then followed by discussion of the contribution to the body of knowledge, which is followed by suggestion for future research.

4.1 Introduction

In Phase 1 of this study on medical tourism, a total of 27 blogs, hospital reviews and radio interviews were selected from six websites: Realself, Forum Whirlpool (Health), TripAdvisor Forums Medical Tourism, Facebook Thailand Plastic Surgery Group, Reviews Treatment Aboard, WordPress and interviews from programs on ABC radio. These websites and the identified blogs, reviews and interviews are listed in Appendix 1.

The method was used to identify websites and individual posts comprised a labelling system of the source and the allocation of a number for unique identifier RS (Realself) and a number (1), with a number indicating a specific entry. The respondents' posts to the initial blog were numbered in chronological order. For instance, the first respondent's post in Realself is shown as: (RS1R1). Other sources of data are coded as follows: Hospital Reviews (HR), Radio Interviews (ABC), Forum Whirlpool (FW) and WordPress (WP). The identified narratives from blogs, reviews and interviews presented below are verbatim and themed according to the frequency of presentation.

The second section of this chapter reports the results of Phase 2, the online survey that gathered demographic, geographic, educational and professional details of

Australian medical travellers and their reasons for engaging in medical tourism. The final section in this chapter presents a summary of all the research results.

4.2 Phase 1: results

The data set consisted of 22 blogs and comments, three hospital reviews and two radio interviews. A total of 27 reports on the personal experiences of Australian medical travellers. The themes and sub-themes developed following a thematic analysis of the blogs, reviews and radio interviews are identified in the chapter and summarised in Appendix 4. These themes were developed by determining the frequency with which medical travellers repeated them. The collected data were reviewed and coded according to frequently occurring themes. Phase 1 data were subsequently loaded into NVivo software to determine commonly occurring words and statements that identified major and minor themes. In Figure 5.2 NVivo software was used to create a Word cloud from a word frequency query of commonly used procedures by Australian medical travellers. NVivo was used to code Phase 1 data, and this process yielded nine significant themes, described next.

4.2.1 Theme 1: care and attention

Care and attention were consistent themes that emerged from Phase 1 data, evident in 80 per cent of medical travellers' blogs and comments. Medical travellers described care and attention as the time, effort, and attentiveness of Thai medical staff. Also identified were the pre-surgery emails and video conferencing meetings with the surgeon or dentist. Medical travellers valued the physical and post-operative attention paid by medical staff and the high numbers of nursing staff available to care for them. Other positive attributes identified were professional behaviours, nurses' uniforms, and the friendly and caring attitudes of treating staff. One blog was written by an Australian nurse who had undergone surgery and appreciated the level of care delivered in Thailand. Finally, the timely attention to the medical travellers' needs was another recurrent theme in the Phase 1 data.

Medical travellers posted comments about the level of information that they were given by the surgeons, which was described as comprehensive and personalised. Surgeons were not hurried or rushed in delivering information: they were considerate

and took time with the medical travellers. The information provided was detailed, often delivered by the surgeon, and the medical travellers were encouraged to ask questions about their procedures. The travellers partnered with the professionals to achieve their goals; in some cases, the medical travellers' expectations were not realised and needed to be readjusted.

Communication was considered an essential aspect of the care received and was highly valued by medical travellers. The other aspects of care were that surgeons, dentists and nurses spoke English, which gave patients confidence and reassurance. Medical, surgical, and dental procedures are complex and often difficult to understand. Because translations would add to the complexity, the majority of Australians were appreciative that Thai doctors and nurses were fluent in English. In some cases, 20 per cent, of patients reported that post-operative pain relief was a concerning issue. However, most medical travellers advised that good pain relief was provided, with some opting for enhanced drug therapy.

In the medical tourism model, post-surgery medical travellers could convalesce at their hotels, with Thai doctors and nurses readily available and easy to contact. Another positive aspect of medical travel is the relationship between Australian medical travellers and the Thai doctors and dentists who treat them. There are suggestions from medical travellers that a partnership exists between the surgeon and the patients described in detail in the dataset. An example was RS13, who was on a return trip to the same surgeon and stated: "so Dr XX and I decided on …". Medical traveller TA20 compared their experience with the suboptimal experiences of friends having similar procedures in Australia. The following quotations indicate the perceptions of Australian medical travellers regarding the efficiency of services in Thailand; the comments relate to the actions of medical and nursing staff. These extracts from the Phase 1 data are exemplars of the themes of care and attention.

"My surgery was booked for the Ist week in May and we arrived on the Sunday. Monday 8am, I had an appointment with the surgeon and he went over everything in detail and only when I was satisfied, we proceeded to filling in and signing lots of consent" (B19)

"When I arrived at the hospital the staff were extremely helpful, I was approached and directed to where I needed to be before I even had an opportunity to think to ask for help. My blood pressure and details were taken and I was escorted into the health education room"(WP17)[1]

"My breast surgery consultation with Dr. X was so easy and incredibly informative, he set my nerves at ease by explaining thoroughly the great jobs and the possible conplications of surgery My heart was beating out of my chest, but the nurses were so professional and caring that I forgot my nerves. When it was all over,i awoke in the recovery room and received the absolute best care from the nurses and Dr X until discharge the next night" (HR2)

"I have had friends get the surgery in Australia and have left feeling un-informed about aftercare and the surgery implications" (TA20)

Thai medical and dental professionals provided frequent levels of attention translated to high customer satisfaction. Communication was viewed as positive as most hospital staff spoke English. TA20 had an unsatisfactory consultation with an Australian surgeon before going to Thailand.

"My doctor [in Thailand] was more experienced, more reliable and had fantastic customer service and after care" (TA20)

"The staff speak very good English and they are all kind and caring. Everything is all about your needs and total comfort. They even dress you in your gowns for surgery. My appointment with Dr XX was not rushed. Everything was explained in detail and all my questions were answered" (RS11)

''The staff speak very good English and they are all kind and caring" (RS13)

Medical tourism in Thailand exceeded the expectations of Australian medical travellers. The nurses were plentiful, and several different levels of nursing were identified. The nursing model enabled medical travellers to access appropriate professional skills and qualifications, thus enabling nurses to focus on the patients'

[1]'All quotes are verbatim. As is common with quickly entered items such as blogs, typographical, grammatical and expression errors occur. These have not been amended'

needs. This professionalism was experienced from the beginning, as was the efficiency of staff and other aspects of the medical travellers' journey:

> *"They have different levels of nurses, RNs who do the medications Dr rounds etc, trainee nurses at different stages of training and practical nurses. I have no complaints about the care I received, as soon as I buzzed someone answered the intercom and came to my room immediately. I was sponged bathed twice a day and checked on regularly" (TA19)*

> *"This level of professionalism was evident from the beginning through the experiences with travel and accommodation, and at the arrival of the surgical facilities. I went through XXXX and they arranged everything for me. I went on my own and was and looked after from the time I decided to go, to the time they dropped me off at the airport to fly home. It was totally stress free. The International Hospital in XXXXX is absolutely wonderful and more professional than any I have been to in Australia" (RS13)*

> *"The surgery was very successful. They were very professional and thorough...and where else during your 2 hour preparation for the surgery, laying back in a recliner, does someone come around and give you a foot massage.all part of the service!" (TA18)*

4.2.2 Theme 2: rapid accessibility

Accessibility, in this study, is defined as having access to medical, surgical, and dental procedures within time frames that suit the medical traveller. Medical tourism prioritises the needs of medical travellers. Hence, services organise medical, surgical and dental procedures according to the needs of the individual – one aspect of medical tourism that Australian medical travellers highly value and generally outside their usual experience. Medical travellers could access tests such as radiology and pathology and have results available the same day they visited the treating doctor. Medical travellers to Thailand could have their surgery on the day they arrived or the next day. The services are accessible, and access to high-level technology was also viewed positively.

Medical travellers chose personal options for care overseas rather than in Australia and were travelling to access medical, surgical and dental procedures. The prospect of waiting for health care for years and being able to access it was explored financially. Once Australian medical travellers have decided to have surgery abroad, most individuals prefer to have procedures done as soon as possible.

Medical travellers value the accessibility and timeliness of services provided and understand the adverse impact of waiting, as indicated by TA1, ABC1, and ABC2:

"My surgery saved my life. I would have had to wait years to have it done in Aus and would likely have died waiting" (TA1)

"I've had the dental in Thailand, (a) I'm going there because I'm sick of my teeth falling out so I need them fixed. And (b) because I'm $20,000 richer if I get it done overseas. And I get it done straight away" (ABC2)

"We had an 86 year old man travel to Thailand for a hip replacement because he didn't want to wait any longer" (ABC2)

Australian medical travellers who reside in regional or remote areas of Australia appreciated that they could readily access appropriate and timely care in an overseas hospital, as shown by the following comments:

"I was under the impression I was going on a waiting list, but the specialist later said I was on a list to go on a list, I'm 67 and I can't wait three or four years or I'll be a cripple" (ABC1)

"We now live in Townsville, and my wife was referred to a Rheumatologist here. Six months later, we were still not able to get an appointment through the public system, and we were told that even if we paid, it would be another 3 months. Rather than fly to one of the capital cities, she flew back to Thailand, saw a specialist immediately, received treatment, and came home" (ABC2R1)

"We live out of Melbourne and would have had to travel into town for each eye and take extra time off work, and get very little back on our health insurance" (TA18)

"Unless you need emergency work done I thoroughly recommend going to Bangkok. Flight specials start at $139 direct using Jetstar and accommodation is endless" (FW14)

Health care provided by medical tourism was designed around the medical traveller and not based on the availability of services or professionals.

"The best thing about getting it done overseas is if ur going on a long trip like 4weeks annual leave depending on the travel period whether its peak/off season.

. ...get it all done within 2 weeks, then final 2 weeks u can always come back for the after service see if there is still anything wrong to fix it then return home...they usually come with product service warranty for the crowns" (FW14)

"And if it's in your power or you can afford to get this surgery done then I see it as something you can do" (ABC2)

Health care provided by medical tourism was designed around the medical traveller rather than the availability of services or professionals. Medical travellers value their autonomy and ability to take control of their health-related situations. The Australian system of having a waiting list for care was frustrating, as shown by ABC1's comment. Medical tourism provides an alternative and allows patients to take control of their care. Therefore, taking charge of and having power over health decisions gives medical travellers some measure of control and relief.

4.2.3 Theme 3: low costs

The cost was defined as the price of the medical appointment, surgical procedure, or dental procedure. The cost of procedures in Thailand was often compared with the costs quoted in Australia and was an important criterion for Australian medical travellers. In Thailand and other parts of Asia, prices are significantly lower. Medical travellers note that in the case of cosmetic surgery, the price for medical, surgical, and dental procedures was approximately 25 per cent less than the cost of similar procedures in Australia.

"The cost of seeing a specialist is (generally) 25-30% of the cost of seeing a specialist in Australia, AND you can get to see them immediately. If we had waited here in Australia, we may have seen a specialist in another 6 months, but the $2,000 (which includes the airfare) was well worth it" (FB3)

The following statements from the transcripts relate to the theme of costs, with medical travellers viewing prices as being affordable in Thailand which influence their decision to engage in medical tourism. As procedures become affordable, further options were available, and some medical travellers choose the more expensive procedures or options. The costs of the procedures were reasonable, and the superior level of care provided good value for medical travellers. The exemplar statements from

blogs below indicated that cost was an initial deciding factor. The costs extend to include other associated costs such as accommodation and airfare.

These quotations indicate that medical travellers have planned and considered a range of costs associated with medical travel:

> *"I am traveling to Thailand for the surgery simply because I can not afford the surgery in Australia. The surgery costs $10,000 – $12,000 Australian dollars if I were to have the procedure in Australia. The surgery is costing me 95,000 Thai Baht in Thailand, this is $3,000 Australian dollars"(WP17)*

The Australian medical traveller above considered the costs of surgery and even with the added costs of travel believed that the cost would be cheaper than in Australia.

> *"The operation would cost about $17,000 … and up to $24,000 fully private, depending on the number of days of his hospital stay and the implant type" (ABC1)*

Medical travellers were actively researching their care requirements to fulfil their needs. The comment below suggests that some medical travellers had consolidated their research and maintained long-term relationships with their dentist, which extended to other family members and friends using the same dentist.

> *"Have been using dentists in Bangkok for over 10 years now. Myself, husband, mother, friends and strangers. So long as you do your homework and make sure the dental clinic you use is good you can get procedures done over there for less than a third of the price you can here" (RS11)*

The comments below indicate the other costs associated with medical tourism services, such as hotels and airfares. These were researched by medical travellers and factored into their decision-making. The five Australian medical travellers below sought procedures in Thailand and found the costs attractive. Specifically, (FW16) wrote this blog in 2011 and appears to have found the cost attractive.

> *"So flights and accommodation were $4478 for 2 trips totalling 4 weeks and with the dental work it was $15,432. Of course this doesn't include food or transport while there but food is very cheap and transport too" (FW16)*

> *"The whole holiday- including surgery, flights, accommodation and spending money cost a total of $5350 HALF OF THAT IN AUSTRALIA" (TA20)*

"In Australia, All-on-6s cost AUD $36,000. Because the prices are INSANELY cheaper and depending on the country" (FW15R1)

Medical travellers mention the theme of value for money without compromising quality. Negative experiences by some medical travellers are usually the result of poor decision choices by individuals, which could have been avoided. At least two medical travellers - RS2 and TA18 - believed that the prices were comparable and reasonable.

"Everything was perfect including the price which was very reasonable" (RS2)

"The cost was the same as Aust.....$2000 per eye I think, but in the end we decided to have it done there" (TA18)

The Australian medical traveller (TA18) was having extensive dental work in Thailand and used the stay opportunistically to have eye surgery, although the cost of the surgery was the same as in Australia. The rationale was that she lives outside of a major city in Australia, and this would require extra travel and time off work with nominal return from her health insurance.

4.2.4 Theme 4: the quality of services offered by medical tourism

The quality of services is defined as that which meets the medical travellers' expectations. Many medical travellers described the level of service as superior. The hospitals were described as resembling five-star hotels: new and clean. Australian travellers considered Thai hospitals superior to Australian hospitals, with better administrative processes. Analysis of the blogs, reviews and interviews revealed that medical travellers viewed Thai hospitals as a 'one-stop-shop' where diagnostics were conducted on the same day as the appointment with the surgeon, who could refer to the results during the consultation. Typically, medical travellers did not have to wait for test results or specialised radiology.

The successful outcome of procedures and the level of care are identified as quality services. Phase 1 data indicated that 84 per cent of travellers had successful surgery and dental work outcomes. Medical travellers had high levels of satisfaction indicative of quality services. They experience sometimes resulted in recommendations to friends and families. The following are extracts that demonstrate the quality of service. A theme

of trustworthiness emerged from the comment made by FW16, who advised that he did not require the level of dental work initially quoted before the examination. However, RS10 was impatient with her results and therefore made an appointment with a local surgeon. RS10 regretted that she did not trust her Thai surgeon's advice and that it took time for the required results to emerge.

"He also warned me it will take a year to recover completely.(RS10)

"I didn't end up needing root canal work on my lower right tooth after he did the consultation in person so saved 9000 baht there, it was great that he was not out to get me for all I had :) I went with the top implants he had on offer" (FW16)

"I think XXXXX is the best surgeon if your nose neefs augmentation. Because he is good at manipulating tissue and using donor material" (RS9)

The quality of the care received was closely associated with the skills of the Thai surgeons. Some surgeons were certified to work in Western countries, and in the case of ABC1, the knee joint was a brand prosthetic which suggested that there was no cost-cutting by the use of cheaper generic brands. Therefore, in this case, the quality of the service was not compromised by cost.

"Oh yes, it's called a PFC Sigma, manufactured by Johnson and Johnson.: So you got a brand named knee" (ABC1)

Medical and surgical expertise, combined with a suitable 'bedside manner', led to several medical travellers commenting on the quality of services and how they were delivered.

"Dr XXX is the top of his field in plastic surgery and I recommend him very highly (I have since returned to him for a small procedure with much confidence) Everything is so quick, smoothly run with no fuss" (FB4).

"World class quality. Could not recommend highly enough" (FW14)

"Be patient and most importantly trust your surgeon. I owe dr. XXXX an apology for, at one stage, doubting him and by writing this review I am hoping to redeem myself" (RS10)

"Thai surgeons are known for trying to make their patients as happy as possible" (WP17)

"This was my second time back to Dr XXX. A year and a half ago he did a breast lift with 250cc implants. He did a fantastic job. I was very happy with them" (RS13).

The quality of care was considered preferable to the care provided in Australia, combined with reasonable cost, making travel a good choice for many Australians.

"And basically it just came down to getting a plastic reconstructive surgeon who had board certified excellent credentials, had worked in either Australia, or America or the UK - and half the price, a quarter of the price" (ABC2)

"Do preventative work and it is all cheap but world class quality" (FW14)

"I saw my GP to ensure all was well, and they were amazed at the good work Dr XXXX did" (FB4)

"I cannot recommend xxx hospital or Dr. xxx highly enough. They will receive the utmost positive recommendations from me to anyone who asks about medical holidays. Â I will be using their services again in future for dental treatment" (RS6)

4.2.5 Theme 5: Thais are experts in surgical and dental procedures

Here, the 'experts' are the Thai surgeons and dentists who specialise in cosmetic and dental procedures. About 30 per cent of medical travellers maintain that dental procedures are high-quality and have good value for money. Most medical travellers believe that Thai surgeons are superior and have greater levels of expertise than their Australian counterparts. There was a perception that medical tourism in Thailand is technologically superior.

Australian medical travellers considered plastic surgeons in Thailand to be experts in plastic surgery. Almost 50 per cent of medical travellers had plastic surgery, including breast surgeries, rhinoplasty and labiaplasty.

"The procedure started with tear-jerking anesthetic needles and within thirty minutes, the surgeon was finishing with the last of my stitches. He showed me what he had done with a mirror and I was already amazed with the difference it had made in evening up the gum line and was very relieved to know that it was only going to get better once the new veneers are put on in a few months time". (TA27)

"There are life saving cancer treatments unavailable in ones own country. Knee and hip replacement surgery is huge in Bangkok - They are light years ahead of Aus in technology and methods" (TA1)

"He is not only a plastic surgeon, he is a magician. Mine took about 5 months but the results were absolutely magnificent. Dr. XXXX did tell me it takes a year to see the results but I can see it now" (RS10)

Furthermore, satisfied patients provided examples that support the theme of Thai medical practitioners being highly skilled in medical, surgical, and dental procedures.

"So my desire led me to the very famous XXXX Hospital for another correction procedure with Dr XXX. I could not be any happier with the amazing outcome and I now feel I have the beautiful vagina that I always knew was possible" (RS19)

"I tell anyone who will listen to go to XXXXX for any surgery they may need. My sister needs a hip replacement and will not go to Thailand which drives me crazy, If she was to see the hospital & speak to the doctors I'm sure she would change her mind" (FB4)

4.2.6 Theme 6: enablers of medical tourism

Enablers are the technologies, processes or services that make medical tourism possible. The enablers of medical tourism are affordable flights, affordable accommodation, advantages of currency conversion, and the Internet, social media, and community platforms that assist medical travellers in connecting with dentists' surgeons and hospitals. Several providers market the package of flights, accommodation and medical, surgical and or dental care in an advertised bundle good.

Medical travellers rely on family and friends to support their decision to travel for medical care. This support is an enabler; in some instances, family members and friends accompany the medical travellers. In other instances, family members look after the young children of medical travellers. The positive experiences of medical travellers providing recommendations and posting first-hand accounts were enablers that drive the demand for medical tourism. Finally, timely access to surgeons and dentists who can provide surgical and dental services is an enabler for Australian medical travellers.

One medical traveller, RS10, could not manage the technology and spent many months trying to access the Thai service. She was able to get a level of support from the

cyber community. A lack of expertise in using technology, explicitly taking photos post-operatively, presented a problem when dealing with the Thai surgeon, which meant that RS10 could not have the necessary consultation with the surgeon. However, RS10 was "very satisfied" with her results.

The extracts below describe a range of services that supports the medical tourism industry in Thailand. Medical travellers require all or some of these services to participate in medical tourism. In addition, processes such as free detailed quotes for proposed services and upfront, free assist medical travellers to control variables and budget for expenses.

Several Australian based medical tourism companies take care of the logistics for medical travellers, including all the bookings and introductions to surgeons and dentists. The logistics include arranging appointments. These services are often taken up by solo travellers such as FB4. Some medical tourism companies provide Australian medical travellers access services, particularly in Thailand.

> *"I travelled alone to Bangkok with an Australian Company who facilitated medical procedures at the XXXX Hospital" (FB4)*

> *I was greeted by a XXXX representative, she was amazing. She sat and talked to my partner and I about any concerns I may have, the pain I may expect and just general chit chat. Oh I forgot to mention, they all speak perfect English You are then provided with a quote (the cost of surgery is paid on the day of your breast augmentation) and an estimate of the size that you may receive, you are also provided with the opportunity to choose your surgeon."(WB17)*

As previously discussed, costs are provided in written quotes, so there are no surprises. There are also affordable airfares, hospital and hotel accommodation packages. These are described in detail online and discussed with others for the purpose of comparison, similar to planning a holiday.

> *"My flights from Launceston to Bangkok via Melbourne the first time flying Jetstar with checked baggage allowance, credit card surcharge, in-flight entertainment and meal cost me $1308 return. The second trip cost with the same options cost $1107 return, so flights were $2,415 total" (FW16)*

"Flight specials start at $139 direct using Jetstar and accommodation is endless" (FW14)

"ROOM: Was booked into a single room as part of a 3 night package and had a room on the 6th floor which had the view of a tropical garden right outside the window.It was quite a big room with a very modern bathroom,a kitchenette with full fridge and microwave and couch and a big plasma TV which made Hubby happy! Hubby was able to stay with me for the 3nights even though we had a room booked in the hotel across from the hospital.I was very happy with that." (TA19)

The Internet was the most critical enabler, providing access to these overseas-based professionals. Medical travellers from their home country could engage with a prospective surgeon or dentist. The Internet enabled access to a vast range of services that assists medical travellers in making an informed decision and to the comments offered by other travellers who have undertaken similar procedures.

"We skyped, emailed back and forth (for about a month) and he did my consultations from the comfort of my bedroom, all with the UTMOST respect and professionalism" (TA20)

4.2.7 Theme 7: research by Australian medical travellers

Australian medical travellers use the Internet to research medical procedures offered by medical tourism countries. The research is often carried out over several months or years and can involve online discussions and reading recommendations posted by other medical travellers who have had similar procedures. This knowledge gathering includes visiting local surgeons and dentists to understand the required procedures and finding professionals who can perform the procedure.

Some Phase 1 data contained detailed information by medical travellers, which was shared on websites. Several medical travellers shared pictures and opinions, radiology results, and other specialist data often used for diagnostic purposes. The medical travellers had researched their surgery or dental procedure and shared the information from Australian dentists about their condition.

Below, the extracts from Phase 1 data indicate how Australian medical travellers research medical tourism. The research undertaken by TA20 was extensive. Her step was to visit an Australian surgeon in her hometown. The latter consultation provided

some baseline information about the procedure in the Australian system. TA20 was a university student and used her research skills to understand the procedure and the available services before deciding to go to Thailand.

Furthermore, TA20 was one of the few medical travellers who understood that Thailand's surgeons and hospitals were different entities and operated separately. Medical travellers often mention that choosing a doctor is essential to medical travellers. In Australia, GPs often choose surgeons through their professional networks if the patient does not know a professional. In contrast, medical travellers engage directly with surgeons and make decisions for themselves.

The differences in medical tourism between countries such as Thailand and India can be extreme. ABC1, who had knee surgery in India, underestimated the crowds of people, traffic and weather, adversely affecting his recovery. Also, the lack of complex infrastructure outside the hospital and hotel made these facilities challenging to access for several reasons. Moreover, English was not widely spoken, and access to services such as travel agents and flights was difficult.

In their research, the quotes below from medical travellers focus on the Thai surgeon:

> *"I researched for countless hours the different options I had- including surgery overseas. I decided to book an appointment with a Perth-based consultant that dealt with overseas surgery travel. After meeting with them, I decided that this was my best option and made the move to look into it myself rather than through a company, as I felt more comfortable speaking to the doctors and hospital one on one. After reading reviews, seeing before and after images and speaking to friends who had been through the same, I decided to move forward in booking my surgery through XXXX" (TA20)*

> *"I then narrowed it down to a particular surgeon via searches on the net and was thankfully able to contact a few people who have had the same type of surgery performed by him.We corresponded via email and he answered all my questions promptly and to my satisfaction" (TA19)*

Australian medical travellers rely on others posting blogs and reviews of their experiences as this is their primary source of information.

“The reason I am writing this blog is to provide other woman with answers to the questions they seek and also provide an insight into the journey of surgery abroad” (WP17)

“I will attach some photos of day 4 I never took any photos of day 1 to 3 as I didn't think I would write a blog or have anything interesting to say. But I just want to show people like me who read this forum but never say anything because they are too shy” (RS11)

“After doing some research, I requested a quote from Dr. XXX and after sending pictures was quickly sent a price that I found to be fair” (RS5)

“Surethere are shills. As there are in every travel based industry from Taxis to tour guides to hotels. So what. The average human is fully capable of researching (ok minus those folk that keep using dodgy online airfare companies - but those folks never learn !). All a forum does is consolidate a place for some of that research and allow people to point folks in some direction” (TA1)

“After quite a thorough research, I finally decided to have my surgery (TT and BR) at XXXX hospital. I then narrowed it down to a particular surgeon via searches on the net and was thankfully able to contact a few people who have had the same type of surgery performed by him. As a former plastic surgery patient of Thailand’s plastic surgery hospital, I would suggest anyone who is looking to have a surgery done in Thailand to check carefully and do an in-depth research on your surgeon” (FW12)

“I don't really know what to say, I have been reading this site for months and I just want to thank everybody for sharing there experiences. I couldn't afford to have the surgery done in Australia so I sneaked away to Thailand to do it. I haven't told anyone except my husband and we knew we were taking a risk and you get what you pay for so I just wanted to share my experience” (RS11)

“Understanding the procedures and doing research takes time often up to 12 months or more

I got my Facelift done with Dr XXXX at XXXX after over a year research and communication” (FW12)

“Yes, and I made two mistakes. First of all I should have researched the weather a bit better. The second point is if anybody goes, go on an open ticket, even if you come out really, really quickly you're still stuck with a bloody knee that's up all over the place, you're not going to be comfortable. India is not made for disabled people let me tell you” (RSI1)

4.2.8 Theme 8: risks associated with medical tourism

According to Australian medical travellers, the risk is associated with not obtaining the desired outcome or the satisfaction they expected from their medical tourism experience. Medical travellers caution others to check the credentials of the surgeon or dentist. Medical travellers' due diligence was undertaken when considering medical or dental procedures in Asian countries. Medical travellers concur that research is crucial to mitigating the risks.

A standard research method employed by medical travellers was to identify people who had had similar procedures and ask them questions and seek advice through social media or medical tourism websites. Medical travellers maintain control and look at pre- and post-operation photos to understand the procedures. Medical travellers posted radiology results, quotes, and information from doctors and dentists on the Realself website. The data from Phases 1 and 2 indicated that before they left Australia, all medical travellers contacted and spoke to the surgeons and dentists who performed the procedure.

Twenty per cent of Phase 1 data (FW12. HR1. RS9, RS7and FW15) contained negative comments indicating that the medical travellers had not obtained the expected outcome. Based on lessons learnt, these medical travellers advised others contemplating medical tourism to clarify the specifics of the procedure with the surgeon or dentist before surgery. The research completed by medical travellers and the process of sharing their knowledge on websites highlights the importance of sharing the learnings with others.

The medical traveller identified as HR1 provided a detailed summary of how her pain was not managed post-operatively, and she warned others not to use the specific hospital. In this example, the advice offered pertained mainly to the surgeon; however, this traveller’s experience suggests to subsequent travellers that the surgeon and the choice of the hospital are equally important. These examples provide a valuable resource for decision-making. Additionally, HR1, FW12 and RS7 had issues with the hospitals. Two medical travellers did not realise that hospitals are separate entities from the surgeon. The Thai hospitals were separate service entities, although some medical

travellers have associated the hospital and surgeon. The following are extracts that demonstrate some of the risks of medical tourism.

"My experience at XXX has been really weird, terrifying, and upsetting. I chose them because of several people who recommended a particular surgeon. I did not choose the hospital itself and did not know what the costs would be like before I went there. I was told by doctors that I should pick a surgeon rather than a hospital" (HR1)

"Only recommendation for anyone getting a nose job whether it be at your home place or anywhere else, make sure you and your doctor understand what you want out of your surgery before you get it done, it will avoid disappointment" (HR2)

"For 4 days I went to the surgery and had one of the most harshest dental experiences ever of hours or being treated like a piece of meat to butcher my mouth Dr XXX operation is a slick get you in, get your money operation" (RS7)

"I have since returned to Sydney without any surgery to fix the problem. Please take this warning to anyone looking at surgery at XXXXX hospital if you have any problems they will not help, money is more important then customer service. I wish I had paid the extra and got it done in Sydney" (FW12)

"They pulled all teeth and straight away inserted the implants, they where more or less put straight into the place My thee that where extracted from. I trust no one it is all about money and not lives" (FW15)

Advanced dentistry procedures are complex and require medical travellers to have a certain level of health literacy both to understand and compare and contrast procedures.

"Hi, I am really stuck trying to find other people that have had a bad experience getting major dental work done. I have had all my teeth removed top and bottom,implants placed straight away all-on-6, 12 months later ready for return visit, I popped into a local dentist,to my shock he told me that , the top implants have failed and have to be removed asap" (FW15)

"Well unfortunately I had a reaction to something called Tramidol hydrochloride. I was whacked out my tree quite frankly. In the morning I'd wake up and really feel good, and I've got to lift my leg blah blah and do some exercises. They'd give me this damned pill and ten minutes later I'm hello" (ABC1)

"I said look if something goes wrong and I kark it, if I can get a Parsi burial it would suit me, you know, I mean there's some Promethean about being picked apart by buzzards.:

So you'd been quite happy up on sticks there exposed to the elements.: Not a problem, I said failing that, just get me cremated" (ABC1)

4.2.9 Theme 9: infrastructure in Thailand

Australian medical travellers were impressed with the Thai hospitals' infrastructure the buildings and how efficient the processes for organising surgery. The cleanliness, the attention to detail and the available services made them feel special, as did the number of staff available to care for them. TA19 identified the different levels of nursing staff as she was a nurse herself. There were also comments about the doctors visiting every day:

"I also went to XXXX hospital for my OPG x-ray (that place is incredible, looks like a 5-star hotel!)" (WP16)

"For the few minutes I was conscious I saw that the OR was very clean, equipment looked new and my photos were displayed on a LCD TV" (HR2)

"Cleaning staff: the room was swept, mopped and dusted every day and a single rose was replaced every day!" (TA19)

"I have never seen such first-class facilities or such a beautiful hospital. Hospitals make me extremely nervous and depressed, but the XXX Hospital felt more like a 5-star hotel rather than a medical facility; Private rooms with flat-screen TVs, four super attentive nurses to one patient and free wi-fi to contact loved ones. From consultation to discharge, they were an absolute pleasure to stay with... And to be honest, I would have liked to stay longer than what was required of me - I was so comfortable" (HR2)

"We got to this block for foreigners and it was a beautiful room, air conditioning, television, internet, you name it and immediate care. I mean as soon as you settled in there's at least four nurses taking your temperature, your blood pressure, you know making sure oh my God it's unbelievable" (ABC1)

"My bloods x-rays and all other per work were done immediately and the doctor had the results on his computer the same day" (TA1)

4.3 Phase 2: results

In Phase 2, descriptive statistics were used to present the online survey results displayed below. One hundred and eighteen travellers responded to the survey, and 83 respondents completed the survey, 70 per cent of the sample. The 35 incomplete surveys were not included in the data analysis. The survey was developed with the ANZSCO classification used in the ABS data set https://www.abs.gov.au/statistics/classifications/anzsco-australian-and-new-zealand-standard-classification-occupations/2022

Table 4.1 shows the respondents' demographic data: gender, age, income, occupation and education. The table also details responses and provides the number of respondents who answered each item in the survey questionnaire.

Table 4.1 Respondents' age, gender, annual income, occupation and education.

Characteristic	N	% of sample
Female	63	76
Male	17	21
Transgender	1	1
Not identified	2	2
Total	**83**	**100**
Age group		
18-29 years old	7	8
30-39	16	19
40-49	18	22
50-59	23	28
60-69	17	21
70 and older	2	2
Total	**83**	**100**

Characteristic	N	% of sample
Annual income pre-tax income (AUD)		
$15,600-$20,799	1	1.2
$20,800-$31,199	1	1.2
$31,200-$41,599	1	1.2
$41,600-$51,999	5	6.0
$52,000-$64,999	13	15.7
$65,000-$77,999	14	16.9
$78,000-$103,999	23	27.7
$104,000-$155,999	16	19.3
$156,000 or more	7	8.4
Nil income	1	1.2
Not identified	1	1.2
Total	**83**	**100**

Occupation		
Executive or manager	6	7
Professional or associate professional	33	40
Tradesperson	7	8.5
Clerical, sales or service worker	29	35
Self-employed	7	8.5
Not identified	1	1
Total	**83**	**100**

Education completed		
Year 12 high school	10	12
TAFE certificate or diploma	24	29
Undergraduate degree	32	38
Postgraduate degree	13	16
Doctoral qualification	3	4
Not identified	1	1
Total	**83**	**100**

The survey respondents were 76 per cent female, 21 per cent male and three per cent unspecified. The respondents were aged between 18 and 70+ years. However, the most significant cohort comprised respondents between 50 and 59 years, accounting for 28 per cent of all respondents. A further 22 per cent were aged 40-49 years, followed by 21 per cent aged 60-69 years, and 19 per cent aged 30-39 years. In the youngest age group, eight per cent were 18-29 years. Data were collected from an online survey disseminated on Facebook, acquiring respondents with a diverse age range.

In terms of income, there was a single respondent with Nil income, and 8 per cent of respondents earned 156,000 AUD or more. The highest number of respondents being 27 per cent reported an annual income between 78,000-103,999 AUD. Nineteen per cent of respondents had an income between 104,000 – 155,000AUD. Finally, 17 per cent of respondents had an income of 65,000 – 78,000 AUD. Most respondents were middle-income earners whose incomes were between 65,000 and 155,000AUD.

Respondents' occupations were categorised into five groups with the largest being the professional / associate professionals' group (40 per cent). Clerical, sales, and service workers accounted for 35 per cent of the sample, tradespersons for eight per cent, and self-employed for eight per cent. Regarding education, 38 per cent held bachelor's degrees, 29 per cent had TAFE certificates or diplomas, and 16 per cent had post-graduate degrees. A further 12 per cent had a Year 12 high school certificate, and four per cent had doctoral qualifications.

Table 4.2 Geographic location of respondents.

Place of origin	N	% of sample
Adelaide	1	1
Brisbane	12	14
Melbourne	33	40
Sydney	7	8
Perth	17	20
Other e.g., regional, rural	13	17
Total	**83**	**100**

The majority of respondents were from Melbourne being 40 per cent, 20 per cent were from Perth, and 14 per cent were from Brisbane. Seventeen per cent of medical travellers were from regional centres in Queensland and Victoria. However, most respondents were urban dwellers and less likely to be from Sydney or Adelaide.

Table 4.1 Year procedure was undertaken.

Year of procedure	N	% of sample
Other	33	40
2015 - 2018	31	38
2010 - 2015	12	15
Before 2010	6	7
Not identified	1	
Total	**83**	**100**

The gathered data captures the recent experiences of medical travellers. Forty per cent of respondents stated that they had surgery in 2019. Thirty-eight per cent of

respondents had surgery or procedures between 2015 and 2018. A further 15 per cent had procedures between 2010 -2015. Finally, seven per cent of respondents had their procedures before 2010. Between 2010 and 2018 fifty-three per cent of Australian medical travellers had procedures, indicating an increase in the number of Australians seeking medical and dental care.

Table 4.4 Types of surgery.

Procedure type	N	% of sample
Cardiac	3	4
Cosmetic	44	54
Dental	38	47
Orthopaedic	6	7
Other	13	16

Note: of the 83 participants, some had multiple surgeries.

The most common procedures were cosmetic surgery 54 per cent and dental 47 per cent. Many respondents had multiple surgeries. When multiple procedures were reported, these included cosmetic (breast, abdomen, and thigh) surgeries and dental surgeries. Additionally, 49 respondents offered comments in the free text section; these indicated that most surgeries were cosmetic and dental. In some cases, multiple procedures for individual travellers.

Table 4.5 Confidence in decision.

Confidence in decision	N	% of sample
Not confident at all	19	23
Slightly confident	43	52
Somewhat confident	15	18
Quite confident	4	5
Extremely confident	2	2
Total	**83**	

The confidence levels of respondents were specified in their responses: 52 per cent were slightly confident, and 18 per cent were somewhat confident. Also, 23 per cent were not confident, five per cent were quite confident, and two per cent were highly confident. Most medical travellers in this sample were female, and potentially early adopters in this growing industry, which could explain the range of confidence levels most of which were not high. Medical travellers doubt their ability to make good decisions. The survey question challenged the participant's memory as they had to remember whether or not they had confidence in their decision. However, even though their reported confidence levels were not high, respondents nonetheless pursued the medical tourism experience.

Table 4.2 Length of time taken to make the decision.

Length of time to make your decision	N	% of sample
Under 12 months	46	56
12 months to 18 months	23	28
18 months to 3 years	9	11
3 years to 5 years	3	4
Other	1	1
Not identified	1	1

Just over half the respondents at 56 per cent took under 12 months to make their choice. The next largest group of respondents 28 per cent, took between 12 to 18 months, while 11 per cent of respondents took between 18 months to three years. Based on the data, it appears that medical travellers take a considerable amount of time to make their decisions. However, the data does not necessarily indicate that they are always cautious in their decision-making process. As noted in the section reporting the research undertaken prior to making decisions, the travellers likely took time to confirm their choice of procedures, hospital, accommodation, and practitioners.

Table 4.3 Research undertaken before the procedure.

What research did you undertake prior?	N	% of sample
Contacted the doctor / dentist	70	84
Forums on the Internet	41	49
Searched for the doctor	34	41
Blogs on surgical procedures	31	37
Recommendations friends	30	36
Word of mouth	32	39

Note: of the 83 participants, many had combined research methods

The research undertaken by respondents prior to surgery included a range of strategies, with 84 per cent of the respondents contacting their Thai doctor or dentist before leaving Australia. Also, 49 per cent of respondents used forums on the Internet to discuss their procedures. Before having surgery, 41 per cent of respondents indicated that they had searched for information on doctors to assist them with choosing a surgeon before undertaking the procedure. A further 37 per cent used blogs to find the surgical procedures available. Other research suggests that word-of-mouth (WOM) is influential when seeking information on medical tourism. Finally, recommendations from friends formed an essential part of the research process. Thirty-six per cent indicated that recommendations from friends had informed their decision-making.

Table 4.4 Motivations for choosing to have a medical procedure in Thailand.

Motivations	N	% of sample
Availability (no waiting for the procedure)	32	39
Cost	20	24
Unable to access the service in time with your expectations	10	12
No health insurance	4	5
Combining it with a holiday	1	1
Previous personal experience	3	4

Experiences of others	9	11
Procedure is not available in Australia	3	4
Not identified	1	1
Total	**83**	

A large cohort of the respondents 39 per cent reported that the availability of a procedure was their motivation for travelling to Thailand to have it done. The cost was the second-highest motivation, according to 24 per cent of respondents. A further 12 per cent had been unable to access the service in Australia within the expected time. Eleven per cent commented that the reported experiences of others motivated them to engage in medical tourism. Five per cent of respondents were motivated by insurance issues, while four per cent had had previous personal experiences.

Similarly, four per cent identified the experiences of others as an influencer. The least commonly reported motivation was the intention to combine the medical procedure with a holiday. The result is at odds with some of the literature suggesting holidays are motivating factors for medical travellers.

Table 4.5 Satisfaction levels with the procedure.

Satisfaction levels	N	% of sample
Very satisfied	60	73
Somewhat satisfied	21	25
Neither satisfied nor dissatisfied	1	1
Not identified	1	1
Total	**83**	

Most respondents (73 per cent) were very satisfied, and 25 per cent were somewhat satisfied with their procedure. The literature reports that Australian medical travellers are consistently satisfied with medical tourism. The result is supported by this study which indicated respondents' high satisfaction levels with medical tourism.

4.4 Summary

Chapter 4 presented the separate finding of the analysis of the data of Phase 1 and Phase 2. The analysis of the data is presented separately. In Phase 1, Australian medical

travellers provided narrative data on eight identified themes: one theme was the care and attention received from Thai medical and nursing staff. Other themes were the positive experiences with accessing services in Thailand. The affordable cost of procedures was also a significant theme for Australian medical travellers.

In Phase 2, 83 respondents completed an online survey which described the Australian medical travellers through a demographic, geographic, behavioural, and psychographic perspective. These descriptive characteristics were a key component of identifying information of Australian medical travellers and addressing a gap in the literature. The finding identified the Australian medical traveller providing a better understanding of who is using medical tourism and what motivates the decision to travel overseas. Integration of the finding of the two phases of data analysis is discussed next in Chapter 5 which presents the 10 key findings of the study.

Chapter 5. Discussion and analysis

Figure 5.1 Chapter 5 structure.

In the previous chapters, the study identified the literature and reported the results of the study. This discussion chapter interprets the findings in the context of the broader literature on the topic and focuses on the research questions which were designed to gather information that would provide understanding of (1) the motivation of Australians to travel for health care and (2) the experiences of Australians who have travelled to Thailand for medical care or procedures.

5.1 Overview

This chapter discusses the findings as an outcome of the analysis of this study and compares and contrasts the literature on medical tourism. In addition, strengths and limitations of the findings will be discussed, and recommendations for further research on medical tourism will be formulated. The primary aim of this thesis was to explore why Australians seek medical, surgical and dental procedures overseas, specifically in Thailand. The study used two-phase multi-methods approach and market segmentation to articulate the analysis and discussion.

5.2 Key findings

A key finding was that surgical and dental services tailored around the medical traveller were a preferred service model. Australian medical travellers value Thai service providers' personalised care and attention, especially the medical and dental professionals.

Australian medical travellers' primary considerations are accessibility and the costs of surgical and dental procedures. These attentions are critical drivers of medical tourism. Timely access to care continues to be a reason for travelling.

The research differs from other studies in that it focused on the medical travellers' experiences and motivations rather than on the economics of medical tourism. Although there are several studies that discuss UK travellers from an economic and service perspective (Cohen 2008a; Cohen, Prayag & Moital 2014; Lunt, Horsfall & Hanefeld 2016; Lunt et al. 2011, 2014, 2017).

Cohen (2014) uses several US cases to illustrate the medical traveller's perspective on seeking out medical tourism. However, this was in the context of the law and ethical issues Finally, Connell (2006, 2008, 2011a, 2011b, 2011c, 2013, 2016a, 2016b) has focused on a regional perspective on the medical tourism industry in Thailand and Asia. However, the findings of the present study differ from those of Connell, who reports that medical tourism and general tourism activities are closely affiliated (Connell 2008). Australian travel for surgical and dental procedures is a primary consideration, and leisure activities are secondary or incidental. The engagement in leisure activities was often dependent on medical procedures. Medical travellers who underwent cosmetic and dental procedures that were less invasive were more likely to engage in leisure tourism options (Jones 2011).

5.3 Medical tourism: key themes from Phase 1 and Phase 2

In Phase 1 of the results, eight categories were identified and grouped into three major themes for analysis and discussion: 1. Care, attention, access, cost and quality of services in Thailand, 2. Medical-Surgical and Dental experts, 3. Enablers, research was undertaken by medical travellers and risks associated with medical tourism.

5.3.1 Key finding 1

5.3.1.1 Care and attention, accessibility, cost and quality of service

Phase 1 of the data set identified Care and Attention, defined as time spent with the medical traveller by surgeons and dentists and the responsiveness in communication by

surgeons, dentists and nursing professionals. Care and attention were frequently occurring theme identified by eighty per cent of medical travellers.

Accessibility was defined as timely access to medical, surgical and dental procedures. Surgeries and procedures are routinely done on the same or the next day and viewed as positive and responsive. Australian medical travellers are reacting to waiting for services. Although the procedures are described as elective surgery and dental, they significantly impact individuals. The cost of surgical and dental procedures was a significant barrier to accessing services in Australia, with bloggers noting that the costs of surgical and dental procedures are significantly lower in Thailand and other Asian countries. In thirty-five per cent of cases, medical travellers identify costs, specifically being affordable in some cases twenty-five to fifty per cent cheaper when compared to Australian prices of the same procedures. The quality of procedures was another motivator for medical tourism. Medical travellers view quality as getting the expected outcome and satisfaction from services rendered. In eighty per cent of medical travellers' experiences, there were high levels of satisfaction and recommendations of the surgeon or dentist, often associated with high praise for the Thai surgeons and dentists. An additional novel finding was that twenty per cent of satisfied medical travellers returned to Thailand for surgical and dental procedures. Repeat business with the same professionals suggests confidence and satisfaction with their initial procedures and experiences.

Crooks et al. (2017) found that uniformed medical travellers generally experienced adverse outcomes. Furthermore, some medical travellers lacked the skills to understand information. Factors such as unscrupulous service providers or unsafe local conditions were threats and safety risks. lajevardi (2016a) study had similar results with low levels of dissatisfaction, suggesting that the medical tourism sector was highly competitive; therefore, satisfaction levels had to be high. (Fetscherin & Stephano 2016b; Lunt, Horsfall & Hanefeld 2016) medical traveller satisfaction is complex and requires further research. Though Rosechongporn and Sarika (2016) study identified Thailand's positive reputation with Middle Eastern medical travellers for service quality and affordability, both aspects need to be strengthened and maintained.

5.3.2 Key finding 2

5.3.2.1 Medical tourism: experts in medical-surgical and dental care

This study's identified quality of medical and dental services in Thailand was a key finding. Australian medical travellers describe the quality of services received as good outcomes from their procedures and positive medical tourism experiences. Medical travellers highly value the medical, dental and nursing professional's proficiency in English. Another essential factor raised was the cleanliness of the Thai hospitals providing medical tourism with modern infrastructure resembling expensive hotels. The study is further supported by (Crooks et al. 2010; Jotikasthira 2010), who identified three motivators in analysing 216 academic and media sources. These motivators were described as procedure-based, cost-based and travel-based factors that drove medical tourism. The study was similar to the factors identified in this program of research. However, there were from an industry perspective and had limitations in understanding the patients' experience. The authors called for empirical research of medical travellers' experiences and identified that the area was under-researched.

The relationship between the Australian medical traveller and their Thai doctors, surgeons and dentists is a strong theme in Phase 1 of the study. The medical tourism literature does not identify the relationship factor often. However, the literature does identify high levels of satisfaction with medical tourism. Identifying the relationship between medical travellers and their surgeons or dentists was not evident in the studies of medical tourism. Chomvilailuk and Srisomyong (2015) were unique in identifying the relationship as a positive brand image which included the country, doctors and hospitals.

The study in Phase 1 identified an important and new finding: the trust and high regard Australian medical travellers have for their Thai health doctors and dentists. Khan, Chelliah and Haron (2016) suggest that patients have lost faith in medical care in their home country. The study is supported by other studies on the globalisation of health care in Western countries (Smith, Martinez Alvarez & Chanda 2011). In Phase 1, fifty-five per cent of Australian medical travellers identified that care and attention were crucial aspects of the services they were seeking through medical travel. The majority of Australian medical travellers' experiences were positive, with eighty per cent identifying

that the care they received was personalised and met their expectations. Also, the Thai surgeons and dentists' responsiveness in emailing them and video chatting before the surgery were actions that were viewed as positive and caring behaviours. Post-surgery medical travellers described the surgeons visiting them in the hospital frequently, and the daily visits were identified as positive behaviours.

In Phase 1 and 2 of the study, Australian medical travellers identified the length of time spent with the Thai surgeon or dentist as a positive attribute and communication responsiveness as a highly valued behaviour. Additionally, twenty per cent of Australian medical travellers returned to the same Thai surgeons or dentists for dental and surgical procedures. Medical travellers made recommendations to other family members and or friends. Other positive aspects of care that medical travellers identified were that the Thai hospitals had all the medical traveller's results available for medical consultation. Thailand's investment in the patient electronic medical record has enabled a level of efficiency which links all the components of the patient's care. Some Australian hospitals invested in this technology in 2020 (Hydari, Telang & Marella 2019).

Whittaker and Chee (2015) study identifies several international papers on how cross-cultural aspects of space within international hospitals intersect with international patients' expectations and relationships in a transnational space. This study was distinctive in acknowledging the relationships between the medical care providers, the infrastructure and the medical travellers. Medical travellers in Phase 1 also describe the space in favourable terms, specifically when contrasting it with their experiences in Australian hospitals. Some international patients from the US and Australia described the Thai female nursing staff as friendly, smiling, and passive. Most importantly, the Thai doctors were described as having a friendly manner and good English skills. This view was similar to the research with Australian medical travellers. Medical travellers held the medical staff in high regard, and comments that referred to Thai nurses were also described positively with the higher ratios of nurses to patients in medical tourism.

In both data sets, eighty per cent of Australian medical travellers commented on the positive aspects of the routine care, responsiveness and attention of Thai service providers.

5.3.3 Key finding 3

5.3.3.1 Medical tourism: enablers, research, and risks

The Internet enabled Australians' medical travel, providing access to overseas-based professionals. Also, access to affordable airfares, hotels and companies that provide logistic services can be sourced and processed on the Internet. The Internet was critical for Australian medical travellers engaging with Thai surgeons and dentists before leaving Australia. Medical travellers connected with other medical travellers on webchat rooms via the Internet and other platforms and provided medical travellers with real-time information to assist with decision making. Phases 1 and 2 identified that Australian medical traveller's take up to 12 months to decide on travel for care. These decisions were not made lightly, and medical travellers educated and empowered themselves to understand the procedures and do their due diligence before travelling. A study of Australian tourist's states that,

> "the finding is the demonstrated specific context - conditions where social media are most likely to influence tourists' destination choices" (Tham, Mair & Croy 2020, p. 173).

Although, this study was not specific to medical tourism. Social media is central to medical tourism and greatly influences Australian medical travellers' decision-making. Australian travellers rely on reviews, blogs and other medical travel media to provide independent information about doctors, dentists, hospitals and other associated intelligence on medical tourism services in Asia.

Medical tourism risks are often discussed in the media, focusing on poor outcomes and followed by subsequent warnings not to engage in medical tourism. A study that reviewed 131 television and newspaper items about medical care overseas found that Australian coverage was dominated by cosmetic surgery in Asia. The reasons for travel were access and low costs (Imison & Schweinsberg 2013). The study found that the media coverage was narrow in its subject representation.

Regarding general risks associated with air travel and post-surgery medical travellers could be more susceptible to these adverse conditions. The literature on risks associated with medical tourism was based on travelling too soon after procedures and biosecurity

(Brightman et al. 2018; Lunt et al. 2011; Lunt et al. 2014b; Penney, Snyder, Crooks & Johnston 2011; Ross, Moscoso, Bayer, Rosselli-Risal & Orgill 2018). The main issues identified were not following post-operative instructions, travelling soon after the procedure, and suture lines not healing due to infections. In this study, twenty per cent of travellers had negative experiences. The Australian medical travellers' expectations were unmet due to communication difficulties with Thai hospital staff not fluent in English. In one example, the Thai dentist was identified as too rough and was keen to upsell more expensive procedures. Also, one traveller had a bad drug reaction to pain medication which made the experience difficult in the short term.

Australians travel for many reasons; however, their motivation continues to be portrayed as self-indulgent and, in some cases, thoughtless. In this study, motivation theory was vital to understanding how and why Australian medical travellers seek out medical tourism.

5.3.4 Key finding 4

5.3.4.1 Motivation and medical travellers

A study by (Deci & Ryan 2000) suggests that psychological need is the more critical defining characteristic of intrinsic motivation. People are actively engaged with tasks that they find interesting, and subsequently, this activity promotes growth. Australian medical travellers exhibit high levels of competence and autonomy and are actively engaged in their care. Medical travellers' characteristics can be aligned with all of the above factors; their self-determination is the unique characteristic that drives them to goal attainment over the long term. Understanding Australian medical travellers are influenced by the push and pull factors. Accessibility, affordability, tailored care, and geographic proximity to Thailand, are pull factors making this attractive to Australians. The literature is supported by various studies (Snepenger et al. 2006; Yet Mee, Cham & Chuan 2018). The identification of these behaviour suggests a level of self-determination, a significant finding not widely present in the medical tourism literature. Medical tourism literature is generally based on the economic context. Some studies have the medical travellers' perspective as case studies, often to illustrate examples of procedures or to discuss the demand for services (Crooks et al. 2017; Guiry, Scott & Vequist 2013; Noree, Hanefeld & Smith 2014; Prajitmutita, Perényi & Prentice 2016).

Many studies use an economic perspective, often citing health service constraints in the home country as a factor that forces patients to look for services in other countries. The confines of the economic perspective are that it limits the analysis to cost and affordability (Fetscherin & Stephano 2016b; Hopkins et al. 2010; Ruggeri et al. 2015; Turner 2010; York 2008).

In contrast, Australian medical travellers are motivated by the convenience of timely access to health care, affordable cost and other factors specific to their circumstances. Australians residing in Western and Northern Australia are well placed geographically to seek medical care from Asian countries. In both phases of the study, Western Australians were twenty per cent of survey respondents, and a further seventeen per cent were residents of regional and rural areas. Both phases of data identified that medical travellers from Melbourne and Victoria were twenty per cent and forty per cent, respectively. Sydney was under-represented in this study; this could be for several reasons. First, Sydney is closer to Queensland, where cosmetic surgery is available. Medical travel and cosmetic surgery might be prevalent in a younger cohort in Sydney using other platforms such as Instagram.

5.3.5 Key finding 5

5.3.5.1 Demographics

Demographic segmentation was described as a critical macro-environmental force in marketing. Specifically, data about the population with information relating to age, gender, professions, location and marital status are categories within the segment (Kotler & Keller 2001). Australian medical travellers' demographic profile ranged from 20–30 year-olds to older Australians in their late 60s having joint replacement procedures and eye surgery. In Phase 2 of this study, respondents were between 18 years and 70 and older, with the largest group, twenty-three per cent being between 50-59 years old. Also, twenty-two per cent were between 40-49 years old, and twenty-one per cent were between 60-69 years old. A further nineteen per cent were between 30-39 years; lastly, eight per cent were between 18-29 years old. Australians of a diverse range of ages were actively engaged in medical tourism. The over-70 age group was underrepresented in both study phases. In Phase 2, respondents were ten years older

than in Phase 1. The survey was implemented through Facebook groups; therefore, there was a broad demographic of respondents.

Conversely, Noree (2015) study found that the age demographic of medical travellers to Thailand was between 35 and 54. The Australian medical traveller was an older age group. There are few studies with this level of data in the literature. Campbell, Restrepo, Navas, Vergara and Peluffo (2019) cosmetic surgery study based in the US identified that 90 per cent of medical travellers were between 20-54 years old. Australian travellers were older than the group in the US study, which suggests a link between the procedure, the age and the gender of the medical travellers.

5.3.5.2 Medical travellers and gender

Furthermore, in the case of gender, there were significantly more women than men in both phases; the Australian medical travellers were female. In Phase 2, seventy-eight per cent were female, and twenty-two per cent were male. Most were female, travelling for cosmetic procedures; the males had dental and joint procedures. This study was dissimilar to other studies (Guiry & Vega 2015; Lovelock & Lovelock 2018; Noree 2015). Noree (2015) study compares medical tourists in Thailand with Thai private patients. In a sample of 104,810 medical tourists, sixteen per cent more males than females were present. Also, Alsharif, Labonté and Lu (2010) study identified males outnumbered females travelling to India and China for medical and surgical care. This study's phase 1 and Phase 2 were dominated by female medical travellers. There were strong links between cosmetic surgery procedures and female medical travellers. Female participants in several studies dominated the findings, specifically in cosmetic surgery (Campbell et al. 2019; Holliday et al. 2014; Johnston, Crooks & Snyder 2012; Rodrigues et al. 2017).

5.3.5.3 Medical travellers and income

Regarding the income of medical travellers, the income range was between nil income to 156,000 AUD and more. The highest group, twenty-eight per cent, reported an annual income of 78,000- 103,000 AUD. A further nineteen per cent had an income range from 104,000 -155AUD. In the next group, sixteen per cent of respondents were in the income range of 52,000- 64,000AUD. A smaller group of eight per cent had an

income of 156,000AUD or more. These results suggest that Australian medical travellers are middle-income earners, as in the cosmetic surgery study (Holliday et al. 2015). Medical travellers are not wealthy Westerners but patients on modest incomes.

The income finding is supported by the data in Phases 1 and 2. Access to cosmetic surgery is limited by the availability and cost of procedures in Australia. Therefore, many female medical travellers access this procedure through medical tourism, which they self-fund. In comparison, (Gan & Frederick 2011b) identified the US medical traveller as 18 – 65. The study found that younger medical travellers between 51- 64 years and medical travellers older than this group (although in smaller numbers) were more likely to travel as they were motivated by economic factors. These medical travellers had an income of under 50,000USD, which was lower than the Australian medical travellers. In Phase 2 of this study, forty-seven per cent had an income range of between 78,000-156,000AUD.

The income bracket suggests that this group had disposable income that funded some health care choices. The media reports that Australians are accessing their Superannuation for medical and dental procedures. Supercare, an Australian company, provides a service to assist Australians in accessing their super funds. Australian medical travellers are action-orientated; they are active in organising care. Some Australian travellers are using their Superannuation to fund medical tourism; super funds allow 10,000AUD per year for dental, orthopaedics, eye surgery, cosmetic and plastic surgery. There is a gap in the literature with this level of data on medical travellers. Generally, this is due to patient confidentiality. Noree (2015) study identified that medical travellers' income ranged from Less than 20,000USD to 39,999USD for 76 per cent of the participants. Therefore, most medical travellers had a lower income range than the Australian medical traveller.

5.3.5.4 Medical travellers and occupation

The study identified (N=83) respondents in six main occupations: First, forty per cent were professionals, and associate professionals, thirty-five per cent identified as sales and clerical professionals and accounted for seventy-two per cent of respondents. Tradesperson and self-employed were eight per cent respectively. Finally, the executive or managers were seven per cent. These occupations gave Australian medical travellers

the skills and confidence to navigate health care in Thailand and other Asian countries. The occupation criteria compared to Noree (2015), where the largest occupational group were professionals, administrative and managerial, agricultural workers, and government and military. Australian medical travellers were also professionals in administrative and clerical positions, suggesting that these occupations have disposable income to fund their care requirements.

5.3.5.5 Medical travellers and education

The largest group of respondents were undergraduates (forty per cent) followed by respondents with a TAFE Diploma qualification (twenty-nine per cent). A further eighteen per cent of respondents had a post-graduate qualification. Most Australian medical travellers are professionals, advanced clerical, sales and service workers, often described as white-collar workers, office-based and customer-focused. Similarly, a US study (Gan & Frederick 2013) found that forty-five per cent of medical travellers had a higher bachelor degree or above and prior experience with medical tourism, making them more likely to travel for health care. The levels of education and the types of professions that Australian medical travellers occupy assist them in undertaking research required to facilitate and navigate aspects of medical tourism. Australian medical travellers that have completed post-secondary education and work in roles that require them to research and make decisions based on that research they are better equipped to carry out the necessary research related to medical tourism and subsequently decisions to travel for care.

5.3.6 Key finding 6

5.3.6.1 Geographic

The geographic segment identifies the customer, location, region and urban or rural settings Kotler (2012). In Phase 1 of the study, twenty per cent of medical travellers were from Victoria. Similarly, there was sixteen per cent from Perth and Western Australia. A further thirty-three per cent were not identified. In Phase 2, forty per cent of respondents were from Melbourne, twenty per cent were from Perth, and fourteen per cent were from Brisbane and Queensland. Though, Sydney was underrepresented with eight per cent. Finally, seventeen per cent of respondents were from Other and rural and

regional areas; this is explainable. Medical tourism is a good option for regional and rural Australians. These individuals have to travel for health care to regional centres and sometimes to the eastern states in Australia. In these circumstances where travel is necessary, Thailand would compare favourably from a value perspective with travelling to Australian cities and regional hubs.

The geographic segment provides a sample of Australians travelling to Asia. The literature suggests that 15,000 Australians travel for medical tourism(Australian Department of Foreign Affairs and Trade 2021). Many Australian medical travellers go to Thailand, which is geographically accessible and a popular hub for travellers. Australians are familiar with Thailand as a holiday destination, with over 563,000 Australians travelling there yearly (Australian Bureau of Statistics 2019b). There is evidence in the literature that Asian countries have established a competitive advantage. Thailand is a leader in medical tourism within the Asian region. Most Thai hospitals and medical services offer a one-stop-shop where diagnostic procedures are completed in the same visit, and care is organised around the medical traveller (Connell 2016a; Moghavvemi et al. 2017; Othuman Mydin, Wong, Velasamy, Tengku Arshad & Marzuki 2014; Srivoravilai, Melewar, Liu & Yannopoulou 2011). Compared with Australian practices, specialist services often mean multiple visits, with the care organised around the availability of services and service providers. For example, in some parts of Melbourne, Australia, the wait time for magnetic resonance imaging (MRI) is 60 days (Commonwealth of Australia 2018).

5.3.7 Key finding 7

5.3.7.1 Psychographics

The psychographics segment is characterised by personality, values, activities, interests and opinions (Kotler 2012). Australian medical travellers have discovered medical tourism, with most travelling to Asian countries (Lunt, Mannion & Exworthy 2013; Ormond & Sulianti 2017). Australian medical travellers are making lifestyle decisions (Kotler & Keller 2001) to engage in medical travel. Their actions demonstrate they value the benefits that a range of procedures provide. They enjoy the autonomy that the ease of access and affordability enables them to obtain promptly. As such, they seek procedures for various reasons; to enhance, correct or change their appearances or

maintain good oral health. Australian's value surgical, medical and dental care in Thailand and other Asian countries. The Phase 1 data demonstrated that Australian medical travellers' interests and opinions favour medical travel. In addition, the rapid accessibility, low costs and quality of services are pulling Australians toward medical travel. Australian medical travellers have a risk appetite for medical tourism. They value the services provided in Thailand and pursue medical, surgical and dental procedures.

Thailand is a popular destination for Australian travellers, with over 563,000 Australian visitors in 2019 (Australian Bureau of Statistics 2019b); this provides familiarity to Australians seeking medical tourism. Australians hold favourable views of the Thais, which extends to surgeons, dentists and nurses. Australians perceive Thais as excelling in customer service and are highly skilled in cosmetic surgery. The study identified that Thai surgeons, dentists, and nurses provided better care and attention from the medical travellers' perspective than their counterparts in Australia.

In contrast, medical travellers with negative experiences cited the breakdown in communication and low levels of care and attention as the primary reasons for these poor experiences. In Phase 1, twenty per cent of medical travellers had negative experiences, some were where Thai hospital staff were not proficient in English and staff in some hospitals could not understand the requirements of Australian medical travellers. Lunt et al. (2011) identify a gap in research specifically understanding medical travellers, noting that there is little understanding of the groups that travel an area of further research. The experiences, satisfaction and outcomes of medical travel are areas of further investigation.

> Nevertheless, while most patients "obtained comparable functional results, they were often dissatisfied with the overall experience" (Lunt et al. 2011, p. 24).

In contrast, most Australian medical travellers in both phases of the study were very satisfied or satisfied with their medical tourism experience. In Phase 2, respondents made eighteen comments which were all very positive.

Further to this point, medical travellers' psychographics is limited to several articles on patient autonomy. However, the Ngamvichaikit and Beise-Zee (2014) study provides a link between decision autonomy and confidence in decision making. Medical travellers show a high degree of control and decision autonomy, and similarly,

Australian medical travellers build this capacity and confidence while researching their procedures and informing themselves.

5.3.8 Key finding 8

5.3.8.1 Relationships with professionals

Traditionally in Australia and other Western countries, the doctor-patient role can be paternalistic, with the power often being with the expert. Other models include the service-consumer model and the partnership model (Fritzsche, Diaz-Monsalve, Abbo, Goli & Dobos 2020). Australian medical travellers describe the service or consumer-driven model operating with the Thai surgeon or dentist as patient-centric. In this model, the doctor or dentist facilitates medical travellers' decisions. The medical traveller is a consumer and a partner in this role and works with the doctor, surgeon or dentist to articulate their needs for a satisfactory outcome (Fritzsche et al. 2020, p. 39).

The Australian respondents' behaviours and the data from Phase 1 demonstrate high levels of autonomy in both phases of this study. The Australian medical traveller has no formalised pathway except for several companies that facilitate medical tourism. In this study, there was a mix of medical travellers, some of whom engaged in medical tourism using medical tourism companies. Australian medical travellers are invested in their abilities, which is supported by the time participants spend researching before travelling. In Phase 2, fifty-six per cent of respondents spent up to twelve months researching before travelling. A further twenty-eight per cent took between twelve to eighteen months to decide to travel.

Medical travellers take time to research, and medical travel is considered. It is not driven by impulse. In cosmetic surgery cases, over fifty per cent of procedures were cosmetic in both data sets. These procedures are standard among Australian women; there is evidence that this is a considered decision planned and deliberated by Australian medical travellers. Some studies support these findings and observe that medical tourism is a consideration and contemplated by medical travellers with some evidence that the decision is not lightly taken and activities of planning before surgery by travellers for many months and sometimes years before making decisions to travel (Holliday et al. 2015; Holliday et al. 2013a; Holliday et al. 2014).

In the case of Phase 1 and Phase 2, the decision-making process included time spent understanding the surgical and dental procedure, researching and gathering information from other medical travellers, and online preliminary meetings with Thai surgeons and dentists regarding their procedure. Australian dental travellers request quotes from Australian dentists and use these documents to understand the procedures required and then establish a price for the procedures with Thai dentists.

Australian medical travellers' high satisfaction levels could be derived from personal investment in arranging the procedures. Phase 1 identified frequent interaction with the surgeons and dentists and lengthy consultations. Subsequently, medical travellers interpret these behaviours as a positive sign of care, attention and quality interactions. Several travellers discuss their needs with the surgeon.

> However, they needed a different allocation of a physician's time. Overseas patients needed more time for consultation and communication than Thai patients. However, there is no evidence that spending a longer time with patients had any effect on the quality of care or health outcomes compared to Thais (Noree 2015, p. 190)

Sometimes, the surgeon or dentist dissuades them from their initial choice. The findings identified that eighty per cent of medical travellers saw personalised medical services as critical to positive experiences and levels of satisfaction. Also, eighty per cent of medical travellers were impressed by the English-speaking medical and nursing staff in medical tourism hospitals.

5.3.9 Key finding 9

5.3.9.1 Behavioural

The behaviour segment is defined as occasion, benefits sought, degree of loyalty, usage and readiness to buy (Kotler 2012). Australians are loyal to their Thai doctors, surgeons, and dentists, demonstrating brand loyalty to Thailand's hospitals, surgeons, and dentists (Noree, Hanefeld & Smith 2016). Twenty per cent were returning to Thailand for procedures; furthermore, several articles identified medical travellers returning to the surgeon, dentist and hospital. There are suggestions that the perception of service quality is associated with favourable imagery, which translates to brand loyalty (Yet Mee, Cham & Chuan 2018). The Australian study supports the behaviour

segment of loyalty. There were high levels of satisfaction; seventy-three per cent were very satisfied, and twenty-six per cent were somewhat satisfied. Australian travellers held favourable views on the quality, care and affordability of the services received by Thai hospitals and medical and nursing staff. Several articles report the satisfaction levels of medical travellers, and some medical tour companies collect satisfaction data (Alleman et al. 2011; Alsharif, Labonté & Lu 2010; Debata et al. 2015). Similarly, most respondents had favourable opinions of Thai surgeons, dentists and hospitals, stating they were better than in their own country. These high satisfaction levels translate to loyalty and result in medical travellers' recommendations.

Studies of medical travellers suggest that satisfaction and quality are intrinsically linked and are articulated as benefits (Guiry, Scott & Vequist 2013; Prajitmutita, Perényi & Prentice 2016). A sample of 330 respondents who completed a discharge survey in two Thai hospitals found that medical travellers' value perception is based on how satisfied they are with the services. Moreover, perceived value has a non-monetary perspective described as satisfaction with the service provider; this could be the surgeon, dentist or hospital service. The study also found that patient, service quality, perceived value, and satisfaction influence medical travellers' behaviour. Furthermore, the perceived value key in achieving loyalty of the medical traveller and behavioural intentions are described as customer loyalty (Prajitmutita, Perényi & Prentice 2016).

5.3.10 Key finding 10

5.3.10.1 Types of procedures

Australian medical travellers appear to have multiple surgeries, often dental and cosmetic surgeries, or multiple surgeries during the same trip due to travel expenses, including fees for surgeons, hospitals, airfares, hotel accommodation, and absences from work and family commitments. The study by Gaines and Lee (2019) identified the most common categories of procedures are cosmetic surgery, dentistry, cardiac surgery, and orthopaedic surgery. These findings are similar to the types of procedures that Australian travellers seek. Other findings are that Australian medical travellers travel alone or with at least one other person, often a partner or close friend, for support (Abd Mutalib, Soh, Wong, Yee, Yang, Murugiah & Ming 2016). Some Thai hospitals provide

facilities such as a second bed and private shower; in some cases, the companion can share the same room.

Phase 1 of the study suggests that more women than men write about their medical tourism experiences. Most services were surgical, described as cosmetic procedures, specifically breast augmentation and other breast surgeries. Breast surgery, both implants and explants, are specialities of Thai surgeons. Consequently, Australian females were over-represented in both Phase 1and 2 groups, given the popularity of these procedures. In Phase 1, medical travellers engaged in cosmetic surgery "wanted to look my best". In several studies, women said they wanted to return to pre-baby bodies, often called "mummy makeovers". There are also nanna makeovers as women in their 50s and 60s discovered cosmetic surgery (Holliday et al. 2013a; Jones 2011; Littler 2013). The study identified cosmetic surgery as the main reason those Australian medical travellers travel for medical tourism. NVivo software was used to create a Word Cloud from a word frequency query of commonly used procedures by Australian medical travellers. In Figure 5.2 A word frequency query of the common procedures identified by Australians were breast, specifically implants and dental surgery. Other words such as Thailand, hospital and cost also feature in the word cloud.NVivo was used to code Phase 1 data, and this process yielded nine significant themes, described next.

As the population ages, women continue to stay employed longer in the workforce. In some cases, cosmetic surgery enables employment prospects in customer-focused industries. Moreover, Connell (2016a) identified the dominance of cosmetic surgery in the corporatised chain hospitals as part of a global medical tourism market.

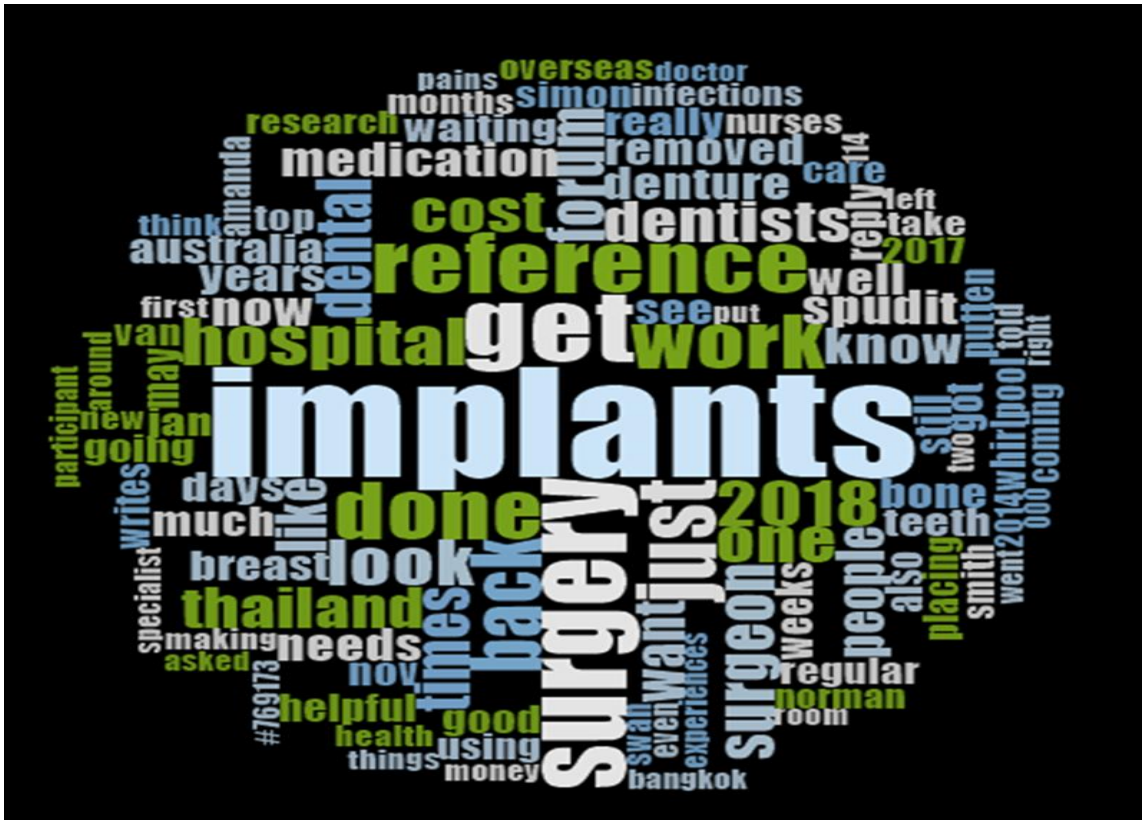


Figure 5.2 Types of Procedures (Phase 1).

Australia's universal health care system functions to meet the demand by restricting the supply of services. When demand cannot be met, rationing services often result in Australians waiting for services. The Australian government has provided rebates in tax relief to some Australians. However, the number of Australians with private health insurance continues to diminish. Health policy is affected by various competing interests, including the economy and demographics, specifically an aging population, chronic disease prevalence, and limitations on increasing the professional medical workforce. Besides, there are many powerful entities involved in medicine. These lobby groups and health care entities have the market share to lose and are directly affected by patients engaging in medical tourism.

Dentistry in Australia is self-funded. In the context of medical tourism, Australian travellers often see dentistry as a lower-risk procedure. Therefore, it is a starting point where medical travellers gain confidence in navigating medical tourism (Österle, Balazs & Delgado 2009). In this study, dental procedures are considered medical tourism in

some studies, and dental care is excluded. Conversely, a range of authors included dental in the definition of medical travel. (Fetscherin & Stephano 2016b; Lunt et al. 2011; Noree 2015; Pocock & Phua 2011; Voigt 2010). The study adopted the inclusion of dental in the definition of medical tourism as Australians are frequent medical travellers to Thailand for dental procedures, including major dental surgery.

5.4 Contribution to the body of knowledge

The medical tourism industry in Australia continues to be in a developmental stage. The Australian medical travellers' study was a different body of research. The study has identified new and vital information about the characteristic of the Australian medical traveller and a range of descriptors that are useful for future business ventures with outbound medical tourism. In addition to the focal participants' motivations and actions, the research findings presented in this thesis can be examined against a broader range of stakeholders.

The study found that medical travellers seeking out information on health care in Thailand have a broad range of resources. Friends and families, blog sites and both users and providers of services are accessed through the Internet. Also, medical tourism facilitators who provide services currently would benefit by broadening their client base; a strategy could be a bundle of cosmetic and dental procedures for the Australian market.

Marketing to Australians using the finding of this research. The private health sector could explore outsourced care if the Australian government approved the credentialing of Thai professionals and agreed on accreditation standards of overseas hospitals. Opportunities exist for private health insurance to extend coverage to services delivered overseas through health policy reform. Federal and state governments are responsible for health care outsourcing the demand and could manage the wait times for surgery and specialist appointments. There continues to be potential for the medical tourism market to grow, which could alleviate the demand pressures for health resources

The contribution to the body of knowledge is fourfold; first, there are new business enterprises that could be developed in the medical tourism industry. Second, the study's research design used medical traveller data sources, demonstrating that data from these

secondary sources can be used in researching a sensitive topic. Third, the study has examined Australian medical tourism industry users. The study has identified and described the Australian medical traveller through demographic, geographic, psychographic and behavioural data. Fourth, governments are responsible for the universal health model in Australia. As costs escalate and alternatives are sought to manage the demand for health, innovative models will need to be considered. One of these models could be that Australians might be given further autonomy over their health, like the models operating within aged care services in Australia where identified eligible individuals get a block of funds to spend on personalised health care.

5.4.1 Future research

There are opportunities for further research on the findings. The experiences of Australian medical travellers and clinical outcomes from medical tourism procedures in Thailand are some areas that would benefit from further research. The medical travellers sharing information through hospital reviews, online blogs and radio interviews of their experiences provided data that could be used in other studies. Many studies and papers have suggested that further research is required in medical tourism. The numbers of medical travellers are variable with specific information on the numbers has been difficult to establish (Brightman et al. 2018; Fisher, Petersen & Burstein 2017; LaingBuisson Health Intelligence 2018; Ormond & Sulianti 2017; The Organisation for Economic Co-operation and Development 2019; Yet Mee, Cham & Chuan 2018).

The area of medical tourism in Australia is under-researched; therefore, further research is required to understand the benefits to medical travellers. This study identified that Australians travel for practical reasons such as access to procedures, timely care and affordability. These studies indicate that more research in medical tourism is required (Beladi et al. 2017; Crooks et al. 2017; Lunt 2017). The sizeable professional service firms Deloitte and McKinsey have completed papers on the medical tourism industry. Horowitz, Rosensweig and Jones (2007) compare the automotive industry, suggesting that medical tourism is a significant disruptor in the health care sector. They were proposing that the changes in the sector could well be likened to the Japanese auto motor industry and the subsequent effects of that change which resulted in the demise of American carmakers.

India lost medical travellers from Syria and Iraqi due to the political crisis that continues in the region. This study is being documented in a time of a global pandemic that is unmatched in modern times. Australian medical travellers continue to post online supporting each other, hoping to continue with their surgeries. Correspondingly, (Connell 2016a) argues that medical tourism is sensitive to political unrest, citing Thailand in 2013, where the country experienced political turmoil, which resulted in a drop in the number of foreign patients. After the global pandemic, Australia is starting to experience inflationary pressure; consequently, disposable income will begin to retract. Flow-on effects on travel and medical tourism, where both industries are susceptible to economic conditions.

5.5 Summary

Chapter 5 covered the discussion and analysis section of this study. Ten key findings were identified and are contrasted with the studies in the literature. The study found that Australians seeking care have a broad range of resources and are self-sufficient in enabling medical travel to meet their needs. Other identified finding were the care and attention that Australian medical travellers received by Thai doctors and nurses, the quality of services provided, and the high satisfaction rates by Australian medical travellers. Also, cosmetic surgery is the most common procedure sought by Australian medical travellers. Australians identified that they travel for medical, surgical and dental care primarily and any further tourism is often incidental.

The contribution to the body of knowledge is the provision of opportunities for businesses specifically health insurance companies and the travel industry, to use this research to provide products for Australian medical travellers. The study findings identified demographic, geographic, behavioural and psychographic characteristics which identify the Australian medical traveller's motivation and health needs.

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Appendices

Appendix 1. Website source, URL and study identification code

Source Website	URL	Identifier
RealSelf	https://www.realself.com/review/thailand-mtf-vaginoplasty-labia-reconstruction-clitoral-hood-correction-urethraplasty?offset=20&sle=0	RS2
	https://www.realself.com/review/labiaplasty-cosmetic-procedure https://www.realself.com/review/piac-phuket-thailand-breast-augmentation-46-year-children-requiring-top	RS5
	https://www.realself.com/review/drsunil-dental-clinic-bangkok-dental-crown-disaster-thailand-drsunil-dental?offset=31&sle=0	RS6
	https://www.realself.com/review/unknown-revision-rhinoplasty-fourth-time-nose-job-and-sick	RS7
	https://www.realself.com/user/1543413	RS9
	https://www.realself.com/user/310870	RS10
	https://www.realself.com/user/593998	RS11
		RS13
Whirlpool Forum	https://forums.whirlpool.net.au/user/68718585	FW12
	http://whrl.pl/RfbX4C	FW14
	https://forums.whirlpool.net.au/archive/2680303#r54998306	FW15
	https://forums.whirlpool.net.au/archive/1657596#r28474780	FW16
Trip Advisor	https://www.tripadvisor.com.au/ShowTopic-g1-i12104-k11356207-o10-Medical_Tourism-Help_us_make_Tripadvisor_better.html (PP)	TA1
	https://www.tripadvisor.com.au/members-forums/chooklady	TA18
	https://www.tripadvisor.com.au/ShowTopic-g293916-i3687-k3678148-My_experience_at_Bumrungrad_Hospital-Bangkok.html	TA19
	https://www.tripadvisor.com.au/ShowTopic-g293916-i3687-k4473586-o200-Cosmetic_Dentistry_in_Thailand-Bangkok.html#66852019. (ML)	TA20
	https://www.tripadvisor.com.au/ShowTopic-g293915-i3686-k5070331-Thailand.html (AC) Appendix 7	TA8
		TA27

Facebook Group Surgery Thailand	https://www.facebook.com/groups/290626847982016 (Thailand Plastic and Cosmetic Surgery Group – Facebook women only) https://www.facebook.com/groups/290626847982016	FB3 FB4
ABC Radio	http://www.abc.net.au/radionational/programs/healthreport/the-return-of-the-medical-tourist/3438506#transcript http://www.abc.net.au/radionational/programs/archived/bodysphere/perfect-worlds3a-medical-tourism/4265878#transcript http://www.abc.net.au/radionational/programs/archived/bodysphere/perfect-worlds3a-medical-tourism/4265878 (Responded to RN program with his experience)	ABC1 ABC2 ABC2R1
Hospital Review	https://reviews.treatmentabroad.com/private_hospital/thailand/bnh_hospital https://reviews.treatmentabroad.com/private_hospital/thailand/bumrungrad_international_hospital?p=2&order=desc&fld=sd https://reviews.treatmentabroad.com/private_hospital/thailand/bumrungrad_international_hospital	HR1 HR2 HR3
Other	https://emilyjanering.wordpress.com/	B17

Appendix 2. Summary of phase 1 data

Theme	N	Comments
Thai Hospitals	27	16 of the 27 commented on the hygienic physical environment in Thai hospitals – for example, it was comparable to a hotel rather than a hospital. The level of hygiene: patients' rooms were cleaned twice daily.
Procedures sought by medical travellers	27	10 of the 27 had cosmetic surgery: rhinoplasty, labiaplasty, and breast surgery. 6 of the 27 had dental surgery, eye surgery, spinal surgery and total knee replacement and specialist medical consult.
High levels of satisfaction with the outcome	27	18 of the 27 were highly satisfied with the care they received and the outcome of their surgeries. Three of the 24 recommended the experience to family and friends and followed up with their family and friends after their surgeries.
Communications	27	18 of the 27 thought the communication with the surgeon, nursing staff and hospital was excellent.
English was spoken by staff	27	This was important to 20 of the 27, and hospital reviewers.
Nursing staff	27	18 of the 27 agreed hospital and surgical staff were well trained and caring.
Thais are experts' surgeons and dentists'	27	21 out of 27 were satisfied with their procedure, had high regard for their surgeon/ dentist - three have ongoing personal relationships.
Dissatisfaction with the MT experience	27	4 of the 27 were dissatisfied: 2 dental and 2 surgical.

Theme	N	Comments
MT investigations before surgery	27	All 27 blogs identified that they did "research". Quotes for dental procedures were obtained, as were before and after photos from other medical travellers. Recommendations from others on the Internet. Four returned for repeat surgeries with the same dentist or surgeon.
Accessibility	27	18 of the 27 blogs identified that procedures were almost immediate and organised on arrival or the next day.
Holidays	20	4 of the 27 identified a holiday was a possibility and brought some family members with them (mainly dental).
Cyber Community	27	Phase 1 data identified the online community to find out information and obtain support from others.
Demographics Phase 1 1	27	Ages N % 18-29 years old 5 20 30-39 2 8 40-49 6 25 50-59 2 8 60-69 2 8 Not identified 8 29 Total 27 100
Locations	27	Place of origin N % Brisbane & Queensland 3 12 Melbourne & Victoria 5 20 Sydney & NSW 4 14

Theme	N	Comments
		Tasmania 1 5 Perth & Western Australia 4 16 Not identified 10 33 Total 27 100
NVivo text Search		Results
Cost	13	13 out of 24 in the Phase 1 sample mentioned costs.
Quality	9	9 of the 24, predominantly dental and cosmetic surgery, mentioned the word ‘quality’ (with stemmed words).
Internet search terms	19	19 of the 24 used these terms (or synonyms) in their blogs: Internet, search, research.
	24	22 had their surgical or dental procedures performed in Thailand; the other two were in India and Vietnam.

Appendix 3. Summary of themes emerging from phase 1

Cost	**Primary** Affordable Value for money Dental procedures very reasonable	**Secondary** Cost of procedures Cost of fares Cost of accommodation Some procedures are the same cost as at home
Quality of services	High nurse to patient ratio Doctors are specialists and care English is spoken by staff Hospitals are large with private rooms Rooms are cleaned often Aftercare is well delivered and supported Good pain relief postoperatively	Relatives travelling with MTs
Experts in procedures	Experts in care Cosmetic surgery, breast procedures, rhinoplasty, labiaplasty, dental surgery Dental procedures	Eye surgery Specialist medical appointment
Enablers	Internet Cyber community Affordable fares and accommodation High levels of support from the community	Insurance Medical tourism Companies
Research by medical travellers	Recommendations from other medical travellers on independent websites Word of Mouth (WOM) Engagement with Thai medical staff before surgery	Advertising Testimonials Accreditation Weather
Risk	Not getting what you wanted or expected. Understanding what you want from the procedure Having to pay more for the surgery than was quoted.	Having to return to get the procedure fixed

Appendix 4. Survey sample

This survey has been developed to gain information and an understanding of the Australian medical traveller. The study will contribute to my Phd at Victoria University in Melbourne, Australia

The aim of this survey is to investigate and understand the factors that motivate Australians when deciding to undertake medical procedures in Thailand.

There are 16 questions in this survey and it should take 7 minutes to complete. I would be grateful if you could complete this survey so that we can understand why Australians travel for health care.

* 1. What is your age?

* 2. What is your Gender?

* 3. What is your current annual income?

* 4. Which of the following best describes your current occupation?

- ◯ MANAGER OR ADMINISTRATOR
- ◯ EXECUTIVE
- ◯ PROFESSIONAL
- ◯ ASSOCIATE PROFESSIONAL
- ◯ TRADES PERSON OR LABOURER
- ◯ ADVANCED CLERICAL AND SERVICE WORKER
- ◯ INTERMEDIATE CLERICAL, SALES AND SERVICE WORKER
- ◯ INTERMEDIATE PRODUCTION AND TRANSPORT WORKER
- ◯ ELEMENTARY CLERICAL, SALES AND SERVICE WORKER
- ◯ SELF EMPLOYED

Other, please specify

* 5. What is the highest level of education you have completed?

Other (please specify)

* 6. What city do you currently live in?

* 7. What is your Postcode?

* 8. Have you had a surgical procedure overseas?

- ◯ Yes
- ◯ No. Thank you for participating.

* 9. What was the year that you had your surgical procedure overseas?

- ◯ Before 2000
- ◯ 2000 - 2005
- ◯ 2005 - 2010
- ◯ 2010 -2015
- ◯ 2015 - 2018
- ◯ Other (please specify)

* 10. Can you please describe the surgical procedure that you had overseas?

- ☐ Cardiac Surgery
- ☐ Cosmetic Surgery- please specify below, e.g. breast augmentation
- ☐ Dental Surgery
- ☐ Neurosurgery
- ☐ Orthopaedic Surgery
- ☐ Other procedures or interventions- please specify below

Please specify

* 11. How confident were you in how you made the decision to have a surgical procedure/ intervention in Thailand?

- ◯ Not confident at all
- ◯ Slightly confident
- ◯ Somewhat confident
- ◯ Quite confident
- ◯ Extremely confident

* 12. How long did you take to make your decision?

* 13. What research did you undertake prior to your decision to have a surgical procedure in Thailand?

Word of Mouth	◯	◯	◯	◯
Recommendations from a collegue or friend	◯	◯	◯	◯
Internet search of the doctor preforming the procedure in Thailand	◯	◯	◯	◯
Blogs on surgical procedures	◯	◯	◯	◯
Forums on the internet that discuss the procedure in Thailand	◯	◯	◯	◯
Contacted the doctor or dentist	◯	◯	◯	◯

Other (please specify)

* 14. What are your motivations for choosing to have a medical procedure in Thailand?

- [ ] Avaliability (no waiting for the procedure)
- [ ] Cost
- [ ] Unable to access the service in time with your expectations
- [ ] No health insurance
- [ ] Combining it with a holiday
- [ ] Previous personal experience
- [ ] Experiences of others
- [ ] Procedure is not available in Australia

* 15. How satisfied were you with your procedure ?

- ◯ Very satisfied
- ◯ Somewhat satisfied
- ◯ Neither satisfied nor dissatisfied
- ◯ Somewhat dissatisfied
- ◯ Very dissatisfied

Other (please specify)

16. I would welcome any further information you would like to share about your experience.

Finished

thank you very much for participating I appreciate your efforts in taking the time to complete this survey.

Appendix 5. Ethics approval

ResearchMaster
Human Ethics Application

Application ID :	HRE18-218
Application Title :	'Medical Care in Thailand: Motivating Factors for Australians;. This research is for my thesis in the Doctorate of Business Administration. My study aims to investigate the reasons why Australian participate in medical tourism by travelling overseas. In particular, this research will attempt to reveal why Australians choose Thailand for medical, surgical and/or dental procedures.
Date of Submission :	07/11/2018
Primary Investigator :	DR BEVERLEY LLOYD WALKER (Chief Investigator)
Other Personnel :	DR LEANNE WHITE (Associate Investigator) MS Genevieve Juj (Student)

Summary Comments

None

SECTION 4 - PROJECT DESCRIPTION

General Information

Action Comment: (closed)
ASPR DEBORAH ZION; 26/11/2018 00:00:00
4.2 Re-phrase the last 2 sentences - it is not clear.

MS Genevieve Juj; 21/12/2018 00:00:00
Re phrased as per your suggestions.

Data Collection

Action Comment: (closed)
ASPR DEBORAH ZION; 26/11/2018 00:00:00
Will you be only using blogs? Or will you be using reviews and comments to these blogs and reviews? There is a difference between blogs and reviews.

Action Comment: (closed)
ASPR DEBORAH ZION; 26/11/2018 00:00:00
Are these the only websites you will use? What about other social media like youtube?

MS Genevieve Juj; 21/12/2018 00:00:00
I will be using both blog and review data. I have amended the section to reflect this change.

MS Genevieve Juj; 21/12/2018 00:00:00
These are the only websites after an extensive search I found that youtube information was focused on marketing medical tourism as opposed to user review experiences.

SECTION 6 - RECRUITMENT OF PARTICIPANTS

Recruitment and Informed Consent

Action Comment: (closed)
ASPR DEBORAH ZION; 26/11/2018 00:00:00
You should be using the VU paid for survey software called Qualtrics. https://www.vu.edu.au/researchers/contacts-support/research-systems-networks-software/qualtrics-online-surveys

MS Genevieve Juj; 21/12/2018 00:00:00
Thank you for your suggestion. Survey monkey was discussed as the preferred platform with my thesis supervisors. This was due to my familiarity and confidence in using Survey Monkey

Appendix 6. Blog example

Trip advisor blog also provided themostalive.com

As the title suggests, this is the continuation of a piece I posted a few weeks ago outlining my experiences using the Thai Dental tourism industry, so follow the link if you want the background story of what led me down this path.

If you have read Part 1 of this series, you would know that I have nothing but praise so far for the customer service and standards shown by Bangkok International Dental Centre (BIDC) during my previous visit, but at the end of the day, it was a consultation with some minor dental work, nothing more.

It was time to (taking my denture out first of course) bight the bullet and start organizing the first stage of my dental implant surgery. This stage was to involve the gum augmentation surgery on the front partner tooth, making my receded gum line of the missing tooth symmetrical with the gum line of the teeth either side of it, as well as the bone graft required to support the titanium screw that would become the 'root' for the new artificial tooth, that was also to be inserted in this sitting.

Mentally and emotionally, not the easiest scenario to come to grips with, especially as it happens while you're still awake in the chair.

On the advice of a friend, who had recently had the whole procedure finished on both front teeth, which was: "the sooner you get it done the better, as the rewards (no longer having a denture) are definitely worth the procedure and healing time involved", I contacted BIDC and asked what was the earliest I could get an appointment to have the required work done.

I received a now trademark immediate response from BIDC saying that my request to begin the surgery had been past to the Doctor 'managing' my case (that's right, I have a dental 'project manager'), and a specific date and time for the required treatment would be given to me for confirmation in the days to follow.

A few days past and I received an e-mail from BIDC outlining the exact procedures to be performed on my next visit, as well as a date and specific times for the two required (gum augmentation and implant placement). The date I was given was dictated by the need for the periodontist (gum specialist) and the implant specialist to be at the centre at the same time as to be able to perform each of their respective operations immediately after the other to achieve the best results.

This time frame (within the coming two weeks) worked well with so I confirmed the dates and timings, and booked my flights and accommodation immediately after.

Accommodation wise, I opted to return to Mini R hotel, which I stayed at on my previous visit, as its facilities, service and close proximity to BIDC are extremely good value.

The time passed and I returned to Bangkok from my current location in the Philippines. BIDC and Mini R are located on a significantly major road in the Din Daeng area of Bangkok, so getting to BIDC/Mini R isn't difficult at all.

The day for the surgery soon arrived and I made the nervous stroll over to BIDC where I was met with the same professional service as I was on my first visit. After a minor wait in the reception area I was directed to the first surgery room where the Periodontist (Gum Specialist) was waiting for me. He quickly re-explained what he was about to do, how he was going to do it and then answered any last questions I had.

Pre-Op photo 1. Denture is the longer of the two front teeth where the gum line receded.

Pre-Op photo 2. Without my denture in. Obviously...

The procedure started with tear-jerking anesthetics needles and within thirty minutes, the surgeon was finishing with the last of my stitches. He showed me what he had done with a mirror and I was already amazed with the difference it had made in evening up the gum line and was very relieved to know that it was only going to get better once the new veneers are put on in a few months time.

I was guided back to the waiting area and a few minutes later I was back in the chair but this time for the implant. After seeing the footage of what's involved and from previous dental experiences i.e. getting wisdom teeth removed, this was definitely the part I was dreading the most.

If there's any advice I can give to anybody who may need to get this done in the future, it would be that you have nothing to worry about. You are well and truly numb to any feeling in your mouth by this stage, and the fact that the specialist is working with gum/flesh means you aren't enduring the nauseating sounds, feelings or vibrations that come with any work associated with most dental work on actual teeth such as fillings, root canal etc. The initial needle was the worst part.

Another thirty minutes later and I was all done.

Post-Op Photo 1 (next day). Implant has been put in and gum line has been corrected to be in line with other teeth. (yes, braces for the bottom teeth are definately now on the cards!)

Post-Op Photo 2. Already noticed the difference. Cant wait to get the crown on the implant and the new veneers!

I was given antibiotics, mouthwash and pain killers. I then paid for the work that was done that day and then sent on my way. Both procedures combined were done in less than an hour!

The itemization of what was charged that day was as follows:

- Crown lengthening (gum augmentation) – 5,000 THB
- Surgical Placement of implant – 55,000 THB
- Amoxi anti-biotics – 126 THB
- Ponstan pain killers – 50 THB
- C-20 antiseptic mouth wash – 60 THB
- BIO-OSS implant – 5,500 THB
- Total – 65, 736.00 THB ($AUD 1,994.70)

The afternoon following the surgery I was starting to feel sorry for myself pain wise once the anesthetic began to wear off, but it was nothing the pain killers didn't immediately hit on the head. I wasn't affected with my eating or anything like that as a result of the surgery and any bleeding I had was well and truly stopped by the next day.

I returned five days later for a checkup so the surgeon could inspect the work. He was more than happy with the healing and informed me that I would be ready to have the next stage (placement of the crown onto the implant root and new crowns on adjoining teeth either side) in two months time.

One negative of this visit was that they informed me I needed to be around Bangkok for ten days to have the checkup after the surgery. I was able to get them down to seven days as I was restricted by work commitments. As I already said, the doctor ended up seeing me only five days after and as I had already pre-booked flights, I had to hang around in Bangkok three days longer than I needed to.

Overall another great experiences and I am more than relieved to have the 'hard part' behind me. One more sitting and I'm done!

This is just one experience and it is clearly positive but at the end of the day, its just one experience. If you are seriously considering this sort of work using the Thai system I highly recommend doing your home work and researching it extensively for yourself. The most credible source I came across and used was the "Thailand Dental holidays Travel Guide" which meant dropping a few dollars, but considering the amount of money I have saved so far, not to mention the quality of service I have also received, I consider it an investment. It's also worth the stress relief it provides by giving sound advice and information on a pending major dental operation such as mine.

If this article has been a help, be sure to keep an eye on this blog over the next few months as I will definitely write up on my experiences surrounding the final phase of my treatment

Appendix 7. Medical travellers pre- and post-procedure

Appendix 8. Permissions

Thesis Page no.	Copyright Item	Nature of Item (table, list, chart)	Permission required and requested (Yes/No)	Permission obtained (Yes/No)	Date obtained
P. 35	Figure 2.2 Types of procedures (Adapted from Lunt et al. 2011)	List	Not required	N/A	N/A
P. 56	Figure 2.4 Types of procedures sought by medical travellers (Noree, Hanefeld & Smith 2016, p. 33)	Graph	Yes	Yes	23/11/2022
P. 67	Figure 3.2 Push and Pull Factors (Dann 1977; Leiper 1990).	Diagram	Yes	Yes	23/11/2022
P. 67	Figure 3.3 Market segmentation Kotler 2015: p117 – 122.	Table	Yes	Yes	26/11/2023