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With an Austrian Perspective“

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Foreword

My personal interest for the subject medical tourism in Southeast Asia emerged during my studies as my focus was set on the region Asia and furthermore demographic issues are a main part of the studies of human geography. Therefore the challenges our society is facing especially concerning health systems were crucial for my decision to work on this topic. As an aging population and reduced reproduction on a global scale are starting to stress existing social and health systems in particularly developed nations, like Austria, I focused on possible alternative sources for health services abroad. These alternatives can not only be found in neighboring countries such as Hungary, but also in overseas destinations like Southeast Asia. Because this opportunity is already attractive for certain people in the world, e.g. US-citizens, my interest was set on the Austrian attitude for seeking medical treatment in this overseas region.

At this point I would like to thank all the people who encouraged me during my studies. First I want to thank my friends who constantly motivated me and of course I want to thank my family who always supported my decision to study. A special thank is addressed to my mother who accompanied me through all ups and downs during my studies and always encouraged me to continue. Without these people I could not have finished this thesis.

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1 Introduction

1.1 Lead-In

Medical tourism is a fast growing industry for patients who travel across national borders to receive almost every kind of medical treatment and is starting to reach international attention on the healthcare landscape.

There are various treatments such as elective procedures, usually focused on aesthetic values like cosmetic surgeries and there are specialist procedures, such as major and minor surgeries, or dental treatments. The integration of leisure activities into a package for patients who receive medical treatment overseas is known as medical tourism (cf. YAP/ CHEN/ NONES 2008, 1). Moreover it is a burgeoning commercial industry consisting of people willing to organize and finance their own treatment overseas (cf. LUNT et al 2011, 133).

The growing demand for health services is a new occurrence on a global scale and linked to economic development, incomes and education. The demographic change, particularly the ageing population leads to more and specialized medical services as a consequence of older people's requirements, thus it is an enormous challenge for health systems and supply. This changing circumstances result in waiting times and increasing costs of health services in certain countries, hence people start to seek for treatment overseas.

South East Asia has a rapidly expanding health sector. Medical tourism emerged as a lucrative business opportunity when countries combine high quality medical services for low cost with tourist packages to position themselves in the global competitive (tourism) market (cf. POCOCK/ PHUA 2011, 1). Especially in Southeast Asia the number of medical tourists is expected to grow constantly (cf. YAP/ CHEN/ NONES 2008, 1).

In the framework of this thesis the importance of an increasing demand of health related services and facilities will be illuminated. As changing conditions such as demographic components, economic competition as well as political implications led to a transformation of the perception of health, the phenomenon medical tourism starts to become a global issue. Especially considering both perspectives, supply and demand of healthcare, there is a changing operation of health relevant subjects and procedures noticeable.

Thus, the content of this thesis also focuses on the emergence of these transforming health issues as a result of globalizing processes. Furthermore it shows the in- and exclusion of

people to healthcare because of determining criteria formulated by the economy, moreover the competitive market, and political regulations.

The individual perspective of the medical tourists has to be particularly highlighted as seeking for treatment overseas is often accompanied by certain issues which are rather serious than touristic. Hence, medical treatment and healthcare in a foreign country can be challenging for both, patient and provider.

This thesis works on different aspects of medical tourism in Southeast Asia whereby also the Austrian perspective is taken into account, specifically concerning the individual attitude and awareness for this tourism niche overseas.

Therefore the following research question will be focused for further studies in the frame of this paper:

What makes Southeast Asia attractive as a medical tourism destination and which factors influence the willingness for medical travel in this region?

Furthermore the research deals with some subordinate questions and formulated hypotheses which serve as a starting point:

What challenges are related to medical tourism and to what extent does it influence the local providers in the health sector?

- As a consequence of the trade & buying of services as well as the global commodification of health issues, medical tourism tends to be health-off the shelf for a select number of people.
- The foreigner-oriented medical business causes brain drain and “quality tourism” which provokes an expanding gap between foreigner and local clientele.
- Medical tourism causes internal brain drain but at the same time it provokes an increasing return of highly skilled people in their home countries which further leads to an uplift of a country’s general medicine level.

Which country-conditions are crucial to attract medical tourists?

- Westernized environment is a crucial condition to attract people from developed countries to seek for medical treatment in a certain destination.

How and to what extent does the country's reputation influence the patient's choice as a medical tourism destination?

- A country's reputation influences the decision-making process for medical travel more than the (affordable) price for the treatment.
- The people's unawareness of the range, quality and affordable costs of medical services in Southeast Asia affects their judgments and estimations for medical travels.

1.2 Structure

The thesis starts with an introduction to the topic of healthcare globalization. In this process the focus is set on the development of globalization, especially regarding to economic growth, and furthermore its impacts on the healthcare sector. Moreover the commodification of health issues as well as international organizations and agreements, which built the frame for a health related tourism industry in the region of Southeast Asia, will be illuminated.

An approach to wellness and health tourism leads to the definition and emergence of today's medical tourism whereby terminological issues are discussed. Further the role of cost and quality are going to be highlighted which brings up possible risks by treatments overseas as well as ethical questions.

Medical tourism especially in Southeast Asia including the implications on local health systems are described which also emphasizes the impacts on health care equity.

A typology of medical tourists and their motivations serves as a basis for the interpretation of the survey results concerning the willingness for medical travel to Southeast Asia. Finally the conclusion sums up the research results by giving answers to the research questions and gives an impression about the challenges related to medical tourism.

1.3 Methodology

The thesis is based on a literature analysis about healthcare globalization and the interplay of health and tourism to set the necessary frame for medical tourism today. The research started in university libraries as well as in the internet.

The first part of the thesis which focuses on globalizing processes led to the search for following subjects: globalization, history of globalization and globalizing processes.

To specify on the topic of healthcare the search terms went into the direction of healthcare globalization, globalization and health, globalization of health systems, healthcare card systems, and due to the knowledge of the importance of trade in a globalizing world also trade of healthcare, trade in health services, commodification of health and/or healthcare, and impacts of globalization on healthcare and/or health. By studying the available literature and internet sources the relevance for an introduction of a variety of international organizations and also agreements emerged. Thus, the official homepages of these organizations were analyzed and existing documents as well as further links were considered.

Up-to-date literature of the emerging phenomenon of medical tourism in Southeast Asia gives an impression of the growing implications of the medical tourism industry on an international and particularly on a regional and local level. Hence, search terms such as healthcare, Southeast Asia, medical tourism, Medizintourismus, tourism, health, health tourism and, wellness tourism were emphasized. As most of the existing papers about medical tourism focus on specific countries of Southeast Asia a more detailed search which implied to highlight single countries was necessary. Noticeable was the availability of papers and studies of especially Thailand, Singapore and Malaysia which are handled as the main hubs for medical tourism. Further research about other Southeast Asian countries led into the search direction of health workforce, health distribution and, health inequalities with a focus on the region's main hubs as well as neighboring countries such as Philippines, Vietnam, Cambodia and, Laos. There were no results about Brunei and East Timor concerning medical tourism and very little scientific articles about Laos, thus the main focus was set on the remaining Southeast Asian countries but especially Thailand, Singapore and Malaysia.

To analyze the tourists of the medical tourism industry a detailed research about tourists and medical tourists started. This further led to focus also on medical treatments and treatment options, the range of treatments in Southeast Asia as well as comparing costs of treatments in industrialized nations with Southeast Asian countries.

Furthermore privatization in health-related fields and accessibility of health facilities got emphasized as these topics are linked with the subject of supply and demand within the medical tourism industry.

To find out more about the willingness to travel for medical reasons to Southeast Asia a survey in Austria was started. Out of 100 questionnaires 71 were returned. The inclusion criteria consisted of: an age of 50 and above, Austrian citizen or at least center of life is Austria, the German language should be spoken as the questionnaires are written in German and the main focus of the survey is to find out more about the Austrian perspective concerning medical tourism in Southeast Asia. Additionally either they already have been to Southeast Asia or at least they are planning to go there in the near future.

Consequently exclusion criteria implied the age younger than 50, people living only temporary in Austria, people not speaking German and people without any knowledge or interest in the region Southeast Asia.

The questionnaires contain their attitudes and knowledge about Southeast Asia in combination with medical tourism.

2 Healthcare Globalization

2.1 An Introduction

Globalization is a much used term nowadays, not only on the scientific level but also in the media and in broad public discourses. “‘Globalization’ is on everyone’s lips; a fad word fast turning into a shibboleth, a magic incantation, a pass-key meant to unlock the gates to all present and future mysteries” (BAUMAN 1998, 1).

Especially in the context with healthcare it is necessary to give a short overview about globalization in general. Therefore a small part of the history of the development of globalization processes should give an impression about the dimension of this phenomenon. Nederveen Pieterse (2012) explained the formation of globalization by dividing it in four major perspectives, as seen in the table below (Table 1).

<i>Time frame</i>	<i>Dynamics of globalization</i>
1970	Production and transport technologies, form of enterprises, value chains, marketing; cultural flows
1800	Modernity
1500	World market, modern capitalism
3000 BCE	Growing connectivity; forms of social cooperation

Table 1: Major Perspectives on Start of Globalization;
Source: NEDERVEEN PIETERSE 2012, 4; edited by author

The dynamics according to the time frame show that “several features that are associated with contemporary globalization existed also in earlier eras, which gives us a finer understanding of what is distinctive for contemporary times“ (NEDERVEEN PIETERSE 2012, 4).

Therefore it is recognizable that globalization has its origins in the interconnections of humans which have slowly developed. There are three common strategies human societies followed in the globalization process:

1. Migration can be seen as a response to a growing population and has formed human societies on a global scale ever since.
2. The human strategy of conquest stimulated trade, agricultural technology and therefore economic growth of an empire.
3. Commerce involves the desires of people for luxuries. This further led to specialization of destinations to meet certain needs and additionally to an increase in

trade. Hence, politics emerged as rules and norms had to be set up to regulate the new business (cf. ROBERTSON 2003, 3, 54, 60ff).

Especially the improving technology developed into a valuable factor as it offered extending trading as well as fighting capacities and was therefore a very supportive strategy.

The 18th century was a time when technology transformed into an instrument for political and social dynamics as it offered more benefits than the conquest or trade strategies before (cf. *ibid*, 65).

Europe's population doubled between 1800 and 1914 and led to a massive imperial expansion to maximize national power. So called symbols of greatness, like the image of a world power, became necessary and important to maintain the existing social order. But as the European conquerors were not able to built alliances they brought rather anarchy than security and order. This was the beginning of the First World War.

The industrialization in the 19th century led to an increase of the middle class of developed nations as they were able to follow the modern productivity strategies. But not all countries, particularly African, Asian or Latin American colonies, were at the same level because of the failing independency, some were just left behind which maneuvered them into an inequality gap.

At the end of the First World War the major industrialized countries in Europe started to prepare for a new wave of competition. The first challenge was the missing acknowledgement of a necessary independency as well as new economic deals for their colonies. This undermined economic recovery for many colonized nations.

Especially after the decolonization in the 20th century former colonies struggled with the integration in the world economy. Infrastructure and human capital were only suitable in colonialism and there was a massive lack of sustainable democratic practices. The concept of a global duality emerged which excluded traditional economic sectors. Moreover they were denied of integration into national economies as they are supposed to be static and therefore beyond the industrial modernity. Hence, former colonies were forced to follow the example of the developed First World and were subject to the West's civilizing mission (cf. *ibid*, 105, 152-157, 179-183).

After the Second World War trade liberalization got implemented by the United States, as they emerged as a worldwide hegemony in political, military and economic spheres. Thus, they could establish a trade system that primarily represented their interests (cf. WATERS

1996, 66ff). The emerging political and economical activities at this point started to emphasize the asymmetries between developed and less developed countries especially in regard to the existing dependencies which had a crucial influence on the development of particularly former colonies (cf. WALLERSTEIN 2008, 169f).

Accordingly globalization created and still creates a variety of dependencies and interactions between countries and regions. This includes not only economical or political aspects but also social challenges due to demographic changes. The globalizing processes start to connect people, nations and diverse sectors with each other and therefore emphasize its complexity in all fields. (cf. KOLLAND 2010, 15f).

2.2 Today's Globalization and Healthcare

Contemporary globalization has become a cliché even though there is no standardized definition. The focus, as mentioned before, is primarily set on aspects like economics, politics and technology and only started to consider also other sectors like health (cf. COLLINS 2003, 98).

Particularly trade can be seen as fundamental for globalization as it can link together producers and consumers all over the world. Moreover since industrialization the trade of commodities and services increased rapidly (cf. WATERS 1996, 66f).

Especially contemporary globalization is characterized by trade liberalization which implies the lowering of certain tariffs and barriers to imports (cf. LABONTÉ/ SCHRECKER 2007, 2). Due to the increasing interconnections in economic and cultural fields also a political globalization has taken place. Notably concerning the control of the flow of ideas national borders became too narrow and internal policies ineffective (cf. WATERS 1996, 97).

The difficulties in particular of who owns intellectual property and how to protect it in a globalized world without borders (cf. FRIEDMAN 2006, 311) emphasize also the movement of people and knowledge as a major factor of globalization (cf. NEDERVEEN PIETERSE 2012, 4) especially concerning health issues. Here, the availability of transport and communication technology is significant for the trade of goods as well as services. Through the permanent improvement in this fields the traditional idea of trade changed dramatically as much information is digitized nowadays and therefore easier to trade (cf. FRIEDMAN 2006, 341).

In addition is “[o]ur society a consumer society” (BAUMAN 1998, 79). This implies those people who need to consume to exist and others who exist for people to consume. The consumers of this society are steadily on the move and looking for the satisfaction of their needs (cf. *ibid*, 80ff).

Further “[i]t is often said that the consumer market seduces its customers” (*ibid*, 83), but not everybody is capable to be a consumer. Thus, there is a distinction between those who can afford their move and those who cannot (cf. *ibid*, 85f).

To understand the processes and effects of globalization on the mobility of bodies, the macro and micro level have to be taken into account. Hence, the various scales of globalization which are global, regional, national, local, and of course individual have to be considered. The reasons for people’s movement differentiate in their motivations but also because of regulations and opportunities for mobility (cf. MACKIE/ STEVENS 2009, 258f). “Mobility is a literal reality for individuals around the globe, but it has also become a potent symbol of personal power” (*ibid*, 259).

However, not all individuals who move really want to move. Most of the times those people get pushed due to certain forces and circumstances (cf. BAUMAN 1998, 92). Because of rapid economic as well as political changes some people are unable to follow, furthermore to assess the implications of these changes (cf. BADAWI 2004, 73).

Figure 1 shows the different but interconnected types of movements by Giddens (1990), whereby healthcare movements are added by the author as it starts to represent an important and dominant motivation to move when talking about modernity, forces and future based scenarios. Due to the interdependences between the different types of movement also healthcare movements are not limited to only receive healthcare rather they involve education, research and employment within this field.

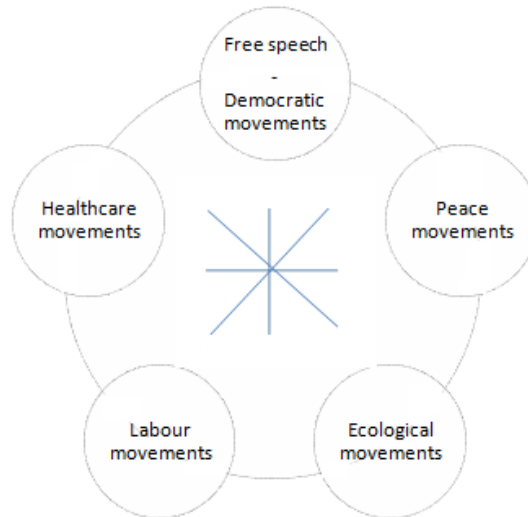


Figure 1: Types of social movements, Source: GIDDENS 1990, 159; edited by author

Giddens (1990) mentioned that “social movements provide significant guidelines to potential future transformation” (GIDDENS 1990, 158). Hence, movements of people have a multidimensional character and are significant parts of globalizing processes (ibid, 159).

As seen in Figure 2, the social dimension of globalization includes different social aspects like education, employment, social security, equity and of course health. Thus, especially countries with weak governmental structures are affected of negative impacts of globalization, like for example the loss of labour market or the neglect of labour standards (cf. BADAWI 2004, 73, 75), therefore “the labour movement is the social movement par excellence” (GIDDENS 1990, 158). But also limited coverage of social insurances and unavailability of health services force people to accept certain conditions (cf. BADAWI 2004, 75), respectively to seek for alternatives elsewhere.

“Globalization has a complex influence on health” (CORNIA 2001, 834). This influence appears in several fields, such as on the health staff and facilities, on the accessibility and trade of drugs, on health insurances as well as on the necessary environment needed in the health service sector (cf. BADAWI 2004, 76-82). Thus, globalization has implications on the functions of whole health systems of countries (cf. COLLINS 2003, 97).

Especially in case of searching for alternative healthcare abroad the internet constitutes a major occasion to appropriate intellectual capital by individuals and can be seen as an essential element of the globalizing process today (cf. SCHROTH/ KHAWAJA 2007, 20).

Besides that, these new educated consumers are part of the emerging wealthy middle-class which is able and willing to purchase healthcare nearly everywhere. Additionally the

demographic change is stressing the social and health systems of almost all nations in the world. As a result, the demand for globalizing healthcare is increasing.

That is why international partnerships and collaborations between institutions, implying state-actors as well as a variety of non-state actors, all over the world, particularly between developed and developing regions, start to become more attractive and lucrative for both, sending and receiving countries (cf. *ibid*, 22, 26-29).

These collaborations are further called ‘global health diplomacy’ and refer to the negotiation processes concerning global health actions (cf. GAGNON/LABONTÉ 2013, 2).

In detail these are “policy-shaping processes through which state, non-state and other institutional actors negotiate responses to health challenges, or utilise health concepts or mechanisms in policy-shaping and negotiation strategies, to achieve other political, economic or social objectives” (LEE/SMITH 2011, 10).

However, reality shows the framework regarding to this concept gets constantly adjusted by the individual actors, rather personal advantages are in the foreground, and is only poorly understood (cf. GAGNON/LABONTÉ 2013, 2). The positive or negative impacts of globalization on nations all over the world have made it to “an issue of global concern” (COLLINS 2003, 99).

Especially due to economic liberalization also access to healthcare seems to be a barometer to determine success or failing of globalization. It shows if social infrastructure and social welfare exists and therefore can be seen as an important marker to identify advantages and disadvantages of globalizing processes (cf. MARTIN 2005, 2). Further barometers of contemporary globalization are the increasing liberalization of finance capital as well as trade in goods and services (cf. LABONTÉ 2004, 48, 53).

Due to the globalization processes many governments emphasize the economy as it is still seen as the driver for development and growth. This often leads to budget cuts in many other areas like education, social welfare or health. Especially the poorer people in developing countries get harmed, as due to the so called structural adjustment programs, promoted by the World Bank and the International Monetary Fund in the 1980s, the public funds in these fields were shrinking anyway. Until today many countries, particularly in Asia, adopt similar policies under the name of ‘reform’ and also implement the new structures in their health systems which result in reducing services and facilities (cf. MATSUDA 2008, 429).

According to the historical context of countries, globalization affects health, specifically due to political, social and economic traditions. Depending on the level of economic development or resources of a country, macro-economic policies have different implications on health as it has effects on the micro-level and therefore on the ability of governments to regulate health issues (cf. LABONTÉ 2004, 53f).

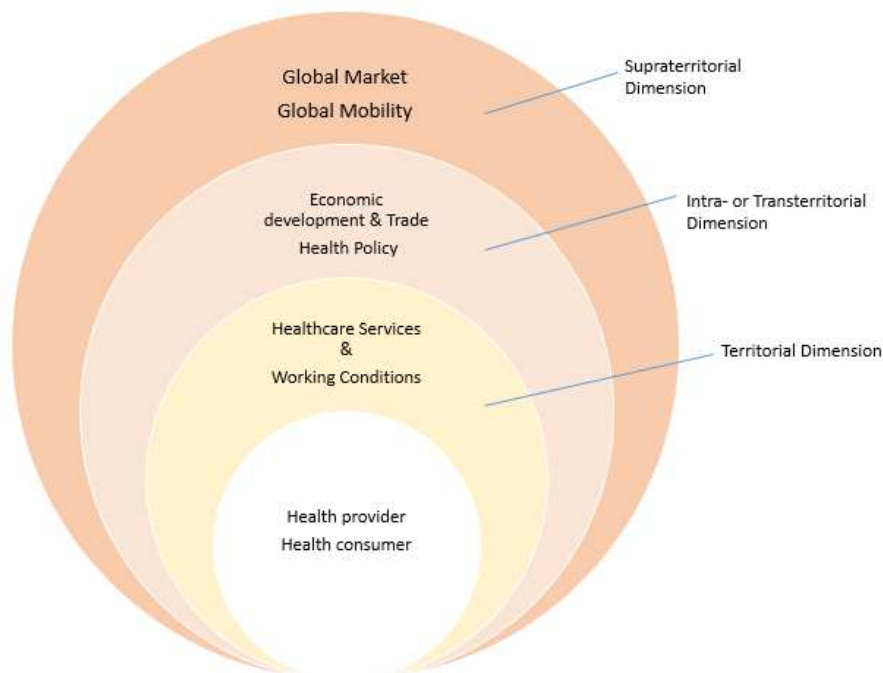


Figure 2: Interdependences between dimensions of globalization and health;
Source: BOZORGMEHR et al 2011, 4, edited by author

Figure 2 shows the different dimensions and interdependences of globalization and health whereby political, economical, social as well as cultural forces have to be considered. The supraterritorial dimension is related to globalization processes with global implications on health issues, like mobility or market forces, on a global scale. This further leads to the intra- or transterritorial dimension which goes beyond national borders and is connected with development and policies of especially economic relations like for example trade of health services. Consequently, this affects access and availability to health facilities and services and can result in inequalities. The territorial dimension focuses on the social determinants of health on a local, state or national level and depends on the trickle down impacts of the other dimensions (cf. BOZORGMEHR et al 2011, 3ff).

Thus, “[g]lobalization describes a process by which nations, business and people are becoming more connected and interdependent across the globe through increased economic integration and communication exchange, cultural diffusion [...] and travel” (LABONTÉ 2004, 47f).

2.2.1 Globalization of Health Systems

The relationship between globalization and health is very complex especially considering the interdisciplinary field of determinants. Hence, the field contains social, political, cultural as well as economical perspectives on health and health related issues (cf. MURRAY et al 2012, 1f). This includes also the global flow of professional skills, know-how and innovations. For example, vaccination developed by adopting innovative ideas from Asia and Africa, the same holds for anti-malaria medication based on Chinese knowledge. Thus it can be said, health systems of today are results of centuries of innovation flows on a global scale (cf. SYED/DADWAL/ MARTIN 2013, 1).

“A good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality medicines and technologies” (WHO 2015d).

Even though globalization is characterized by the movement of goods and services, the circulation of health professionals and particularly patients emerged as a recent phenomenon which further starts to challenge national health systems (cf. SEGOUIN/ HODGES/ BRECHAT 2005, 277). Since 1980 the number of international travelers tripled, this emphasizes the rising global interconnections. Changes for health in the form of transfer of risks, such as microbes, bacteria or even lifestyles, due to travelling from one country to another are possible consequences. The interdependences brought a rising awareness of certain risk factors and led furthermore to the implementation of national policy regulations. These regulations have to be adjusted to global actions as the policy effects should not be limited by national borders. Especially concerning the competitive market where companies

just look for areas with fewer regulations or restrictions for certain products or procedures (cf. FRENK/ GOMEZ-DANTES 2002a, 95f).

In regard to healthcare, international standards and regulations can help to improve quality and availability to health facilities and services. But there should be always considered that very different cultural, social, political as well as economical contexts are prevailing in particularly less developed nations. Thus, the adoption of international standards defined by only a few countries does not necessarily lead to improvements of access to healthcare for everybody. Additionally a certain standard implies rising costs for treatments which exclude diverse population groups from benefiting of healthcare provided in their own country (cf. SEGOUIN/ HODGES/ BRECHAT 2005, 278). Hence, the challenge is to create a global health system in the form of international collaboration (cf. FRENK/ GOMEZ-DANTES 2002b, 164) by cross-border transfers of expertise, knowledge and efficiency of healthcare. This also includes patient mobility and willingness to travel for treatment which is often accompanied by dissatisfaction of the health care providers as well as negative experiences with existing health systems in the home country. Consequently some health insurances and also competent authorities start to cooperate with health providers abroad. To guarantee a certain standard of quality the cooperating partners have to find a consensus especially considering the diversity of health systems. Additionally it is necessary to implement the patient's rights across borders as it is an important factor concerning trust and confidence, particularly for the decision making process for a treatment abroad. For example, patients from European countries like Austria or Germany expect a number of key rights in regard to cross-border healthcare, such as obtaining sufficient information about their treatment, privacy protections, access to their health data, and mechanism to reimburse harm or to complain (cf. WISMAR et al 2011, iX, 1, 10, 13). “[T]he way in which patients’ rights are defined and implemented is still largely determined by national law and differs widely from country to country “ (ibid, 13).

Collaborations are not only taken place between countries but also between systems. Differences between political and social administrative structures additionally challenge cross-border healthcare transfers (cf. GLINOS 2011, 241). “Lack of clarity can severely hinder collaboration, for example if there is uncertainty regarding whether responsibility to make agreements lies at the federal, regional or local level” (ibid). Organizational mismatches because of operational differences of foreign systems are time and resource consuming to achieve agreements.

Also the geographical position of a country or region can be seen as a crucial factor for international cross-border transfers of health related services. Borders separate national healthcare systems, thus patients, professionals, knowledge, and more not only cross frontiers but also systems. Hence, cross-border arrangements start to develop into a bridge between diverse systems, for example with portable healthcare cards for patients (cf. *ibid*, 238f, 241).

2.2.2 Healthcare Card Systems

Certain healthcare systems already started to emphasize computer-readable cards systems; particularly in some European countries this is a common way to transport information and data of patients more easily (cf. PERNICE/ DOARE/ RIENHOFF 1995, 77) Additionally “these cards are used to meet the requirements of healthcare insurers” (*ibid*), such as the e-card in Austria.

The cards can be used to save patient identity, administrative information as well as data in case of emergency. Some healthcare applications use these cards to collect more detailed information about the patient especially if there is a specific need for treatment by healthcare specialists. In these cases an appropriate and timely treatment can be organized more easily as the quick access to necessary information is given.

The increasing mobility of people starts to challenge certain health systems, especially in regard to healthcare card systems as there is an existing lack of healthcare card standards. That means, the cards of one system cannot be used by a different card system and is therefore barely beneficial for patients who cross borders for treatment (cf. *ibid*). “[T]he flow of relevant healthcare information should not be constrained by national or organisational boundaries” (*ibid*). Furthermore, necessary information about the patient should be available for professionals no matter when and where they are. Therefore the healthcare card systems have to be interoperable (cf. *ibid*). The authors define interoperability of healthcare cards as follows:

“Interoperability of Healthcare Card Systems is the ability of one Health Card System to read, use and /or update the data on cards issued by another Healthcare Card System” (*ibid*).

Moreover the interoperability can be distinguished between technical and functional interoperability, whereby both are responsible for the legibility of different card systems.

There are minimum requirements which have to be met to guarantee interoperability between two card systems such as:

- Same content of visible data
- Card access devices as well as cards of the two systems have to be interchangeable between these two systems
- Application software has to be readable for all users regarding to the relevant data they need
- Application Software has to offer the opportunity to update the relevant card data (cf. *ibid*, 77, 83)

Compared to other industries such as finance or airlines, the information technology for health services is developing slowly. Especially due to the rising mobility of patients this lack of progress starts to get highlighted by diverse health management systems (cf. CHAN 2000, 127f). A healthcare card in form of a “credit-card size device [...] provides a true mobility of database in the pocket” (*ibid*, 131). This is also an advantage for the patient who is moving as the card serves comprehensive medical data which further guarantees an immediate availability of crucial medical information as well as identification in case of an emergency or accident.

The World Wide Web offers the necessary infrastructure to support the development of healthcare card systems as it is an ideal platform for the implementation of such systems (cf. *ibid*, 131, 133). “[A]n open and platform-independent medical record structure across heterogeneous health information systems ensures that patient’s records are portable and readable across multiple operating systems” (*ibid*). Furthermore the exchange of health information between related health institutions could lead to better healthcare quality (cf. *ibid*). Hence, the care provider’s benefits are: more efficiency, a reduced redundancy of procedures, and more accurate patient data. The patient’s benefits are: an easier access to certain healthcare systems as well as faster services, a more accurate medical recording, and a simplified application of healthcare services (cf. ALKHATEEB et al. 1999, 83, 85).

The increasing mobility of people due to globalizing processes in diverse fields and industries often leads to blurred lines, especially considering health issues (cf. FRENK/ GOMEZ-DANTES 2002b, 161). “In addition to their own domestic problems, all countries must now deal with the international transfer of risks” (*ibid*), whereby these risks result in diseases as well as the challenges of international trade of goods and services (cf. *ibid*).

2.3 Trade in Health Services

The last decades the importance of services increased enormous and it turned out to be the fastest growing sector worldwide. This expansion of the service sector leads to economic growth as it is closely linked to other industries which boost the growth process.

The development of financial services with the options for saving as well as borrowing money, led to increasing investments. Telecommunication improved the distribution and access of information; the transportation services support the movement of diverse goods and services all over the world. Due to education as well as health services the stock of human capital increased which is relevant for economic growth as it is crucial for a health-related tourism industry (cf. BOOKMAN/ BOOKMAN 2007, 24f).

Trade in health services implies international movement of patients as well as health workers. These movements can be limited by certain barriers such as the lack of language knowledge or the non-recognition of qualifications outside a country.

There is a significant circulation of patients to facilities and treatments abroad. Especially wealthier individuals travel abroad as services are either unavailable, too expensive or of better quality than in their home countries.

There are different kinds of trade in health services identified by the General Agreement on Trade in Services, GATS, (Table 2) such as cross- border trade which includes for example telemedicine but also the movement of patients from different countries to consume health and/or health related products and services. Further foreign direct investment can be also seen as trade in health services as it stimulates the economy and therefore the healthcare landscape. And of course the movement of health workers is an important type as it is a crucial factor in the trade of health services with a determining character especially in regard to the emerging competition in this field.

Hand in hand with trade in health services goes the trade of relevant goods associated with these services. This implies necessary equipment for medical treatments or other health procedures and drugs but also the produced medical waste of health services. (cf. KANCHANACHITRA et al 2011, 775)

Cross-border Supply (Mode 1)	Consumption abroad (Mode 2)	Commercial presence (Mode 3)	Presence of natural persons (Mode 4)
<ul style="list-style-type: none"> •Tele-medicine, including diagnostic, radiology 	<ul style="list-style-type: none"> •Medical Tourism: Voluntary trip to receive medical treatment abroad •Medically-assisted residence for retirees •Expatriates seeking care in country of residence •Emergency cases (e.g. accident abroad) 	<ul style="list-style-type: none"> •Foreign participation of ownership of hospital/clinic or medical facilities (e.g. capital investment, technology) 	<ul style="list-style-type: none"> •Movement of doctors and health personnel for the purpose of commercial medical practice
Trade in goods associated with health services			
<ul style="list-style-type: none"> •Health care equipment •Drugs •Medical waste •Prosthesis 			

Table 2: Trade in Health Services identified by the GATS; Source: CATTANEO 2009, 3; edited by author

Hence, trade in health services implies as well imports, for example importing professionals, services for constructions, services for certain facilities but as well local citizen going abroad to buy health care can be seen as imports (cf. BOOKMAN/ BOOKMAN 2007, 29).

Additionally the media plays a crucial role in these trade processes as it makes health trade public and moreover gives access to information through reports about the movement of patients, doctors and goods, both from North to South as from South to North. It is not only the two directions but also South-South movements which are strongly represented in this field (cf. CATTANEO 2009, 4).

2.3.1 Commodification of Health

When talking about commodification of health the question arises if healthcare is a commodity at all. An economic as well as an ethic perspective should be taken up, which means whether health issues are part of a competitive market and consequently to what extent does this affect quality and accessibility of healthcare (cf. PELLEGRINO 1999, 244ff).

Within the health sector, particularly the private, the term “consumer” has become very common. Rather health and healthcare can be seen as a consumable product. This leads to the assumption that people can purchase and use healthcare according to their needs like they

would do it with any other goods and services (cf. RUBIO 2004, 245f). The difficulty is that “[i]nadequate and unsatisfactory health care cannot be returned for a refund” (ibid, 246).

Further, money and market have a significant influence on the health sector, especially concerning medical treatments as it comes to a dehumanization of patients and practitioners. Here, the human body is undergoing an objectification which leads to a market in human goods which offers bodily products to physicians as well as patients (cf. TIMMERMANS/ ALMELING 2009, 24).

Moreover the delivery of healthcare is concentrated on cost control and strategies to reduce these costs. The management of healthcare resources can be seen as an allocation of priorities in a world of limited resources. Thus, the creation of a market economy in healthcare where market forces develop, distribute and manage resources, health and healthcare can be equated with a commodity (cf. WILDES 1999, 307f). Healthcare benefits are then also part of a commodity, a cost that should be calculated within this constellation. This results primarily in the exclusion of expensive treatments from insurance coverage (cf. BANJA 1995, 34).

That is why some authors argue that commodification of human bodies and healthcare tends to result in disproportions of quality and availability, further to corruption and pro-profit oriented actions. On the other hand commodification of health and healthcare brings benefits through new products on the market or the rising consciousness of the variety of treatment options (cf. TIMMERMANS/ ALMELING 2009, 24f).

Commodification of healthcare effects both consumer and professionals. Especially the marketization and consumer-orientation of healthcare result in a change in dealing with health. There are several ways of responding to the commodification from the professional point of view. Tonkens et al (2013) found five ways of professionalism within the commodifying healthcare area:

1. *The entrepreneurial way*: This way is profit oriented and connects market with professional structures.
2. *The way of activism*: Activism is strongly linked to traditional methods and defends the professional’s autonomy.
3. *The pretending style*: This means to work by the rules which have to be distinguished between the professional’s own rules and the rules of external controllers, like, for example, insurance companies.

4. *Bureaucratization*: It is a way to reduce risks through bureaucratic procedures in order to protect the professional's position and actions in case of patient complaints or lawsuits.
5. *Performance*: A way of professional performance means the creation of the impression of professionalism in the eyes of patients or controllers (cf. TONKENS et al 2013, 369f, 375-383).

Most of the professionals take up more than one of these ways, which further leads to price-rivalry between professionals as well as organizations and in the next step turns care again “into a measurable product, enabling comparison and competition” (ibid, 372) which results in increasing pressure on professional standards (cf. ibid, 370, 372f).

Moreover standards often require adaptation of certain structures no matter about the existing or missing economical or cultural basics. Nevertheless, standards do not necessarily result in standardization because for every aspect of life a diversity of standards exists, especially regarding to health. One person's standard can be another one's confusion or, in the case of healthcare, even lead to exclusion of certain health issues (cf. TIMMERMANS/ ALMELING 2009, 25). Thus, “commodification is a social process that will be shaped by social values” (ibid, 24). Consequently health and healthcare are social constructions and therefore reflect moral visions as well as visions of a so called good life of a society (cf. WILDES 1999, 310). Still, organizational and entrepreneurial structures became dominant elements of professional identities and further, as mentioned above, led to new forms of professionalism which combine management with medical functions. This change results in competitive behavior of professionals and can be seen as a global response to national restrictions and commitments. Moreover professionals as well as patients make use of the emerging commodification of health by treating health as a commodity, hence patients consume and professionals provide health. Of course, these strategies rather than counter the process of commodification of health and healthcare (cf. TONKENS et al 2013, 369f).

2.3.2 International Organizations and Trade Agreements

International organizations play a major role in today's globalized world system, thus they are significant for countries to build or deepen cross-border relationships as well as to be part of political, economical and social processes.

A short overview about some international organizations and agreements should be given to delimit the frame of certain conditions and rules states have to follow as they coordinate public and private sectors in several developing countries. It can be seen as a behavioral framework for governments to operate (cf. BOOKMAN/ BOOKMAN 2007, 89).

First the general definition of an organization shows the basis for further explanations. Therefor an organization is:

“A social unit of people that is structured and managed to meet a need or to pursue collective goals. All organizations have a management structure that determines relationships between the different activities and the members, and subdivides and assigns roles, responsibilities, and authority to carry out different tasks. Organizations are open systems--they affect and are affected by their environment” (BUSINESSDICTIONARY 2015a).

As agreements are results of these organizational systems another definition is needed for a more accurate understanding of agreement. An agreement is per definition:

“A negotiated and usually legally enforceable understanding between two or more legally competent parties. Although a binding contract can (and often does) result from an agreement, an agreement typically documents the give-and-take of a negotiated settlement and a contract specifies the minimum acceptable standard of performance.” (BUSINESSDICTIONARY 2015b).

The following international organizations and agreements will be described briefly as they are of relevance for further understanding of the development frame of global healthcare issues. Additionally the ASEAN, an organization implemented by Southeast Asian countries only, will be mentioned as it focuses especially on intraregional trade movements.

– UNWTO- United Nations Tourism Organization

The UNWTO is “responsible for the promotion of responsible, sustainable and universally accessible tourism” (UNWTO 2015a). It promotes tourism as significant for economic growth and development and offers therefore tourism policies and exchange of know how worldwide. The Global Code of Ethics for Tourism serves as a frame of reference as it should help to

maximize the benefits and at the same time minimize the negative impacts of the tourism industry. The code is not binding; it consists of ten principles covering economic, social, cultural as well as environmental elements of tourism and travel.

Further tourism is seen as a driver for fulfillment both collective and individual as well as for sustainable development. Moreover tourism can be seen as very beneficial for the host countries therefore everyone has the right and liberty to tourism and necessary tourism movements. Another important principle implies the rights of workers and entrepreneurs of the tourism industry (cf. Ibid, UNWTO 2015b). That means the UNWTO supports a business friendly environment that offers public/private partnerships as well as options for private investments into tourism projects (cf. BOOKMAN/ BOOKMAN 2007, 90).

– WHO- World Health Organization

The WHO was established in 1948, three years after the United Nations were formed and has 194 Member States. The organization addresses the challenges of the health of the population, including both, existing and emerging problems especially in the public health sector (cf. WHO 2015a). Therefore the WHO created a reform with three aims:

1. To improve people's health;
2. To increase coherence in global health;
3. The pursuance of organizational excellence; (WHO 2015b)

Today the organization has many important functions which include also the International Health Regulations (cf. BLOOM 2011, 143). "These regulate travel and transport, and as stated in its constitution, give the WHO unique supranational authority" (ibid) whereby the field of action is a complex and diverse world of global health. (cf. ibid)

"Global health refers to widespread health impacts that affect large numbers of people across boundaries of geography, time and culture. [It] [...] implies a context that includes the whole world and produces its own institutional complexities" (WHO 2015c).

Especially compared to the beginning of the WHO the number of international players increased enormous. This is particularly noticeable in the bureaucratic way of dealing with requests of this growing number of member countries. There are several organizational levels

from which countries requests must obtain approval, this can take between six month and years.

The board of the WHO is highly politicized especially regarding to major decisions as elections within the organization but also concerning votes which are held in secret and as Bloom (2011) claims there exists political and financial pressure on members of the committee to fulfill certain demands (cf. BLOOM 2011, 143f).

– WTO- World Trade Organization

The WTO was established in 1995 as a result of the Uruguay- Round (cf. BENEDEK 1998, 1). It was formed by members of the GATT-System which was founded back in 1947 as a General Agreement on Tariffs and Trade (cf. KRENZLER 2003, 2f). The GATT- Agreement should “encourage member states to restrict protection only to tariff duties [...] and then to seek consensus on tariff reduction” (WATERS 1996, 68f). The trading effectiveness increased during the 1950s and the general level of economic interdependence on a global scale rose (cf. *ibid*, 69).

Due to the oil price shock in the 1980s the member states started to follow a protectionist approach which led individual export self-restraint agreements start to become popular. Through this measure the competition pressure for local producers should be alleviated. Though, moreover the foreign trade became power-oriented which favored especially the big trading powers (cf. KRENZLER 2003, 2f, 5). Due to the lack of universal applicable regulations the need for a new frame organization to monitor the actions emerged, the WTO was founded and the GATT was modified.

The membership of the WTO includes the affiliation to all agreements and accordance to the before mentioned Uruguay Round. With these conditions a fragmentation of the international trading system into small independent trading instruments was prevented. Thus a so called ‘free rider position’ for many developing countries was eliminated as they were no member states (cf. BENEDEK 1998, 5, 15). Therefore a revised version of the GATT was implemented which includes special provisions for the treatment of developing countries (cf. KRENZLER 2003, 5).

Today the WTO is dealing with rules and functions of trade between nations whereby it focuses on the predictability, which means binding and transparency to encourage

investments and competition, and the smoothness of trade flows. The core of this organization consists of several agreements which follow principles for trading systems, developed and formulated by the member states. The principles are against discrimination between trading partners, they are highly pro-liberalization and therefore for freer trade barriers.

The main trade agreements cover goods, services and intellectual property whereby the agreements can be renegotiated from time to time as well as new agreements can be added. Moreover, individual country commitments on specific types of goods and services exist which include bindings and schedules (cf. WTO 2015a).

– GATS- General Agreement on Trade and Services

The GATS resulted 1995, under the direction of the WTO, as a response to the massive growth in the trade of services because of the emergence and spread of communication technologies and was negotiated in the Uruguay Round to create a multilateral trading system in the service sector. The agreement involves internationally-traded services like for example tourism or professional services, e.g. nurses and doctors.

The coverage of the GATS consists of four modes (as seen in table 2). As mentioned in chapter 2 they consider:

1. Cross-border supply that means a country supplies a service to another.
2. Consumption abroad where consumers use a service in another country.
3. Commercial presence is also part of the agreement and implies foreign companies providing services within a country.
4. The travel of individuals to supply services abroad (cf. WTO 2015b).

– TRIPS- Trade-Related Aspects of Intellectual Property Rights

The agreement focuses on the protection and implementation of intellectual property rights under consideration of the varying standards and the missing multilateral framework of necessary rules concerning international trade of intellectual property. The agreement addresses the basic GATS principles as well as several international intellectual property agreements (cf. WTO 2015c). The latter focuses on global minimum standards to protect all

forms of intellectual property rights like for example those for pharmaceuticals (cf. MARTIN et al 2007, 2).

The WTO divides the international property rights into two main areas, first the copyrights as well as rights related to copyrights. This implies the protection of author's works by copyright for a minimum of 50 years after the death of concerned authors.

The second area is industrial property which involves on the one hand the protection trademarks as well as geographical indications. On the other hand there are inventions, new technologies and industrial designs. If patents occur this protection is typically 20 years (cf. WTO 2015c). "The TRIPS agreement indicates that patent rights need to be balanced against other important interests, such as public health" (MARTIN et al 2007, 3).

The implementation of the TRIPS agreement can be challenging as it is a complex process and requires an existing efficient administrative infrastructure which is combined with high expenditures and therefore often not feasible for many developing countries (cf. *ibid*).

– ASEAN- Association of Southeast Asian Nations

ASEAN exists since August 1967 due to the signing of the ASEAN declaration in Bangkok, Thailand, by Indonesia, Malaysia, Philippines, Singapore and Thailand itself. In 1984 Brunei Darussalam joined followed by Vietnam 1995, Lao and Myanmar 1997 and Cambodia 1999. Until today these are the ten Member States of ASEAN following certain aims and purposes as set out in the declaration. Four of these aims are mentioned as they seem to be relevant according to global healthcare issues:

1. Active collaboration as well as mutual assistance on common affairs in economic, social, cultural, technical, scientific and administrative fields should be promoted;
2. Exchange and support in form of diverse training and research facilities in educational, professional, technical and administrative spheres within the ASEAN Member States has to be provided.
3. The expansion of trade involving the emerging issues of international commodity trade as well as the demographic change of the population has to be considered.
4. Beneficial cooperation with international as well as regional organizations should be preserved and strengthened (cf. ASEAN 2014).

Further the idea of a Free Trade Area within the ASEAN Member States developed, called AFTA (ASEAN Free Trade Area). The AFTA should improve the regional competitiveness through the liberalization of diverse production sectors and can be seen as a response to the North American Free Trade Area, NAFTA. The trend of economical regionalization led to intraregional trade liberalization which implies the reduction or elimination of intern trade barriers and attracts therefore also foreign investors (cf. DOSCH 1997, 236f).

2.3.3 Impact on the Health Care Industry

The impact of globalization on health and health care is very complex as it is not only people and infectious diseases travelling around but also unhealthy lifestyles like smoking or obesity (cf. FRENK 2009). This shows that globalization is not only an economic process; moreover it developed into a comprehensive phenomenon influenced by a variety of factors that are shaping today's society permanently. The internationalization especially the movement of people influences the health landscape as more people travel more frequently and therefore also come in contact with more other people as well as goods. Thus, the increased movement leads to increased opportunities for the spread of diseases as well as for goods and services (cf. UCHE n.d., 33). This implies that domestic health policies are challenged by the international integration in the world market whereby not only global pharmaceutical industries are increasingly globalized but also health care. International health policies need to coordinate health education as well as policies between nations and states. Further the states have to work together to influence the impacts of cross-border movements of patients but also to protect the collective welfare within a state (cf. JARMAN 2014, 2f).

Martens et al (2010) gives an impression about possible health impacts of globalization as seen in table 3 below. The table shows impacts embedded in a global context with multi-factorial causalities which influence the world population's health (cf. MARTENS et al 2010, 2).

Positive health impacts	Negative health impacts
<ul style="list-style-type: none"> -Diffusion of knowledge and technologies, improving health services, improving food and water availability -Improvements in healthcare or sanitation due to economic development -Global governance efforts (such as WHO, WTO, ASEAN,...) -Increased access to affordable food supplies due to free trade 	<ul style="list-style-type: none"> -Spread of infectious diseases due to increased movement of goods and people -Spread of unhealthy lifestyle due to, for example, cultural globalization, global trade marketing -Brain drain in the health sector -Decreased government spending on public health services -Inequitable access to food supplies and health services due to asymmetries in the global market -Health risks due to global environmental change

Table 3: Positive and negative Health Impacts of Globalization; Source: MARTENS et al 2010, 3; edited by author

Further impacts of contemporary globalization are the scale and speed of movements of finance capital and trade of goods and services which reduce the ability of governments to stabilize their economies and preserve fiscal autonomy. Trade agreements imply obligations on states which reinforce asymmetries because of unequal preconditions, notably next to existing commitments of global economic integration through market liberalization. Without governmental support rapid liberalization may damage the health of populations because of the loss of influence in policies to provide public health (cf. LABONTÉ 2004, 48f, 51, 53). Thus, “the negative impact of globalization on access to healthcare is particularly well demonstrated in countries of transitional economies“ (COLLINS 2003, 97). Globalization and economic growth are in a close relationship as higher incomes result in better health outcomes due to an improved access to healthcare facilities and services (cf. *ibid*, 99).

Also legal issues like to obtain western health services to attract foreign patients and to improve the existing services through intellectual property transfers, are challenging especially countries with weak economies (cf. SCHROTH/ KHAWAJA 2007, 24). Particularly in the healthcare sector states are responsible to regulate goods and services such as medical devices, medicines and medical workforce and are therefore especially susceptible for changes due to globalization processes. Thus, states do not only regulate goods and services but also shape and determine the people’s lifestyle by public health policies. Further

due to the emerging competition caused by the increasing liberalization, states run the risk to prioritize economic growth over health policy goals (cf. JARMAN 2014, 3f).

The reforms of the healthcare sector were defined in the 1970s and advanced in the following decades. Especially due to an expanding flow of financial capital into the health sector new actors, rules and insurance models emerged, which had direct impacts on healthcare services. The deregulation of the financial markets in the 1990s brought huge changes into the health sector, particularly in the way businesses were transacted. This further led to profit-oriented actions by companies through cutting free access to diverse services and treatment options.

Especially the structural adjustment policies and the neoliberal ideology created new health reforms which entailed entrance of multinational financial companies and their capital into the management of public healthcare services. This resulted in a change of health reforms particularly concerning access, availability and affordability of care (cf. IRIART et al 2011, 1f).

“Many developing countries are “selling” their public institutions to the private sector” (BADAWI 2004, 77). Specifically the health sector is highly affected by privatization. On the one hand this change increases the investment in state-of-the-art technology which benefits the local health sector. On the other hand equity and access to certain services for the neediest members of a population cannot be guaranteed as the public health sector is shrinking. Moreover particularly health institutions from developed countries enter the markets of less developed countries to offer a variety of health services for foreign as well as local paying customers. This kind of foreign presence can worsen the existing level of health services provided and further create a monopoly position by combining health facilities with health insurances (cf. *ibid*, 77f).

The influence of globalization on the health staff can be seen in disparities of curricula in their education and is especially perceptible through diplomas and licenses between developed countries and developing countries. This results in inequity even though “[m]edical education in many developing countries is quite reputable” (*ibid*, 80). Badawi (2004) recommends better marketing of medical education in less developed countries to minimize unequal treatment and therefore to reduce the brain drains of health professionals from developing countries (cf. BADWAI 2004, 77f, 80).

2.3.3.1 Brain Drain

The movement and migration of people across national borders is an essential part of the globalizing process (cf. OECD 2002, 1). In the 1950s the British Royal Society has created the phrase 'brain drain' to describe the flow of scientists from Europe to North America (cf. LOWELL 2004, 3). An important relationship between migration of highly skilled people and regenerative capacity evolved. The volume and quality of employment opportunities were essential for the movement of skilled workers. These opportunities comprised the underlying conditions in the home country, like the personal income to sustain themselves and their families at an acceptable level (cf. ACKERS/ GILL 2008, 195-199).

During the 1960s the belief that state capacity could increase economic growth in developing countries predominated. This was supposed to result from financial remittances from migrants abroad.

Developed countries of the North opened their borders which attracted many migrants from the global South. The public policies from the more developed nations thought that the labor surplus which created capital inflow could also have an effect on development in the sending countries. But a decade later the term development was replaced by the term dependency as nations and states started to realize that it is not the migration that effects development rather it is the other way around, underdevelopment causes migration.

Consequently the developed nations closed their borders and recruited only skilled migrants. Thus, the brain drain emerged as highly skilled workers especially from less developed countries moved to the industrialized world as well as from the periphery to urban areas (cf. FAIST 2007, 186- 188).

To control the migration flow most nations are protected by numerical visa limits (cf. LOWELL 2004, 14). There are several positive effects of the migration of highly skilled people, for example it stimulates innovation capacity, leads to increases in the stock of human capital and of course to an exchange of scientific knowledge.

There are as well negative impacts of the brain drain as for example the loss of skilled workers in certain areas such as health and education, especially in rural regions in developing countries, which effects particularly the vulnerable poorer population (cf. OECD 2002, 4f). Further high levels of skilled migration can slow economic growth in the countries of origin and may cause increasing poverty and inequality (cf. LOWELL/ FINDLAY 2001, 6).

Migration as well as migration policy have an impact on a country and on development (cf. IOM 2006, 3-9).

Although there are little evidences of a 'beneficial brain drain effect' migration offers an opportunity for sending countries to benefit eventually from the investment they made in their skilled workers abroad. The opportunities associated with international mobility could attract young people to return or even retain in science research in the sending country and as a result stimulate the competitiveness of a country (cf. ACKERS/GILL 2008, 223- 227).

3 Wellness, Health and Tourism

3.1 An Introduction

“A *visitor* is a *traveller* taking a trip to a main destination outside his/her *usual environment*, for less than a year, for any main purpose (business, leisure or other personal purpose) other than to be employed by a resident entity in the country or place visited” (UNWTO 2015) whereby “[t]ourism refers to the activity of visitors” (ibid).

Tourism is a fast growing economic sector and closely linked to development, which turns tourism into a key driver to position a country in the competitive market (cf. ibid).

Health, cited by the World Health Organization, is defined as,

“[...] a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living, and is a positive concept emphasizing social and personal resources as well as physical capabilities. Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948). It is also an essential component of development, vital to a nation's economic growth and internal stability” (WHO 2014).

Furthermore “health is as much an ideal as an actual state of existence, and [...] this opens up the possibility of seeking a desired future state of health” (ERFURT-COOPER/ COOPER 2009, 5). Consequently the quality of life depends on the personal health state and can be influenced by tourism as it can result in significant health benefits. Especially the social and physical environment is determining primary health risks and can be directed by tourism related products and services, for example wellness tourism (cf. BUSHELL 2009, 30ff).

This further leads to the explanation of health tourism which can be defined as,

“ [...] a commercial phenomena of industrial society which involves a person travelling overnight away from the normal home environment for the express benefit of maintaining or improving health, and the supply and promotion of facilities and destinations which seek to provide such benefits “ (HALL 2003, 274 cited by HALL 2011, 6).

Halbert Dunn was the first who published 1959 his ideas about the term ‘wellness’ as a condition of “great personal contentment” (DUNN 1961, 3 cited by SHELDON/ BUSHELL 2009, 6). Wellness is a choice “for one’s own quality of life” (SHELDON/ BUSHELL 2009, 6), especially in the tourism context (ibid.). Further wellness tourism is “the sum of all relationships and phenomena resulting from a journey...by people whose main motive is to preserve or promote their health. They stay in a specialized hotel that provides the appropriate know-how and individual care“ (MUELLER/ KAUFMANN 2001, 7). There are a number of attributes and factors which lead to different types of wellness tourism. These attributes include:

- Motivation and purpose of travel or activity; e.g. physical, beauty, relaxation, lifestyle, etc.
- Type of facility; e.g. hotel, clinic, hospital, etc.
- Destination
- Style of the product for consumption; e.g. traditional, alternative, spiritual, etc.
- Focus of the activity; e.g. health oriented, medical, psychological, etc.

Concerning these factors there are some subcategories of wellness tourism. These categories develop their own attributes under the umbrella of wellness (cf. SHELDON/ BUSHELL 2009, 9). “[W]ellness is an approach to health care and life style choice that is based on active prevention of illness and active promotion of a state well-being” (ERFURT-COOPER/ COOPER 2009, 5).

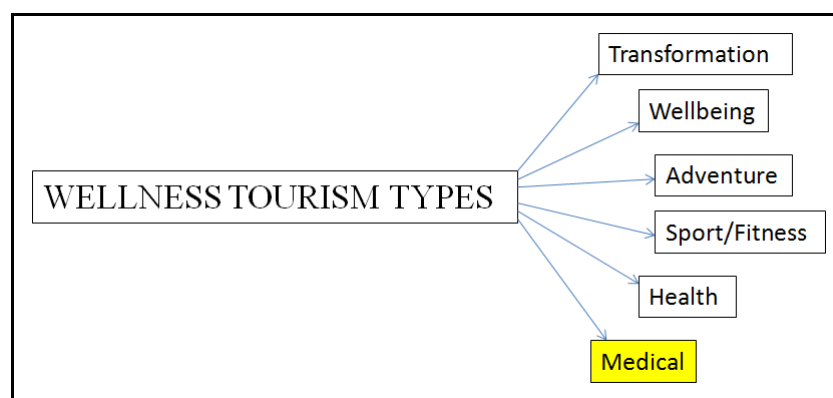


Figure 3: Wellness Tourism Types; Source: BUSHELL/ SHELDON 2009, 9; edited by author

This typology is within a frame of typical tourism as well as leisure constructs (Figure 3). This means products and providers have to serve both touristic elements and local market products.

Holistic wellness experiences like yoga, rebirthing, breathing, vision quests, etc. are meant by the category ‘Transformation’ whereas ‘Wellbeing’ includes all wellness promoting experiences like massage, spas, saunas, etc. The type ‘Adventure’ implies physical and personal challenges close to the category ‘Sport/Fitness’ which includes sport participation of all types and is either to start to become fit or to improve the existing fitness level. With a focus on the topic of this thesis the types ‘Health’ and especially ‘Medical’ are emphasized. While the type ‘Health’ is more focused on preventative treatment with qualified practitioners the category ‘Medical’ means curative treatment with qualified medical or health practitioners including surgeries and all medical procedures like dental orthopedic, chiropractic, etc. procedures (cf. SHELDON/ BUSHELL 2009, 9f).

Health, wellness and tourism started to become a form of preventative medicine especially in industrialized nations where the awareness approached that higher incomes and increased life expectancies do not necessarily lead to a happier life. Consequently physical and mental health benefits of vacation and tourism, especially regarding to chronic diseases emerging in industrialized nations, such as for example burn-out syndromes. It is evidence based that vacation reduces stress by removing stress triggers (cf. SÖNMEZ/ APOSTOLOPOULOS 2009, 37f).

Further Breitrück/ Nunn (2011) argue that “health tourism can be seen as a general term for cure tourism and spa or wellness tourism” (BREITRÜCK/ NUNN 2011, 58) as both forms attract people for the same reasons, the regeneration and treating of physical and psychological well-being and diseases (cf. *ibid*, 58f).

With a more focused look on the characteristics of these health-related tourism branches there are some overlaps recognizable, especially in relation to their tasks and offers (Figure 4) (cf. KUSEN 2011, 97).

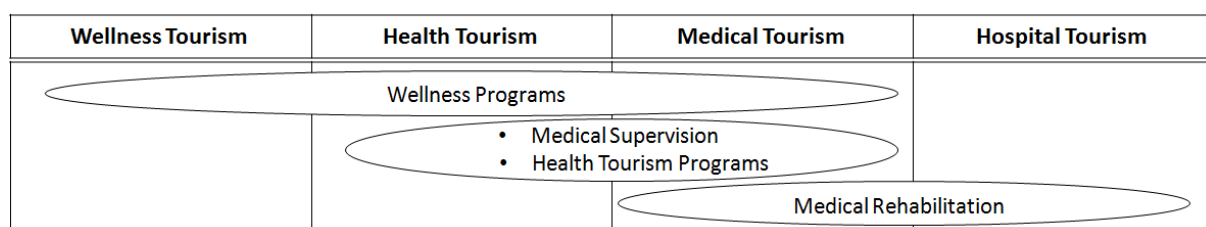


Figure 4: Overlaps of characteristics in health-related tourism branches; Source: KUSEN 2011, 97; edited by author

Therefore wellness programs can fall into other areas dealing with preventative services while medical rehabilitation is a concern of medical or hospital tourism where patients need to recover in a specific environment (cf. *ibid*).

3.2 Medical Tourism/ Medical Travel

Medical tourism means travelling to a foreign destination, another country or even another continent to obtain medical or surgical treatment. Additionally people can experience the attractions and sight-seeing points of the countries they visit (cf. KUMAR 2009, 11).

“The term Medical Tourism has emerged from the practice of citizens of highly industrialized nations [...] travelling to other countries [...] to receive a variety of medical and healthcare services” (ibid) often because of rising costs of the similar services in their countries of origin. In the process of medical travel are both private and public sector involved (cf. ibid).

Medical travel has a long history; the first foundations of health tourism can be found in ancient Greece. Back then doctors believed in the balance of the four elements: water, fire, earth and air. Thus, doctors prescribed diets and massages as well as baths in natural springs. Also the Romans adopted this kind of medicine and until the 18th century these baths even turned into social events by tea parties or gaming nights (cf. BREITRÜCK/ NUNN 2011, 57f).

The Second World War changed these cure destinations into addresses for injured soldiers. Only slowly the first social insurance companies emerged and made it possible that also the middle class could join such spas and resorts.

Since the 1990s the health tourism developed into a lucrative business with modern offers often strongly deviating from the traditional cure tourism. Moreover diverse changes in political, social, technological as well as health related fields like demographic aging and therefore changing health policies or improving transportation or communication caused a transformation of the traditional cure character into a new branch called medical tourism (cf. BREITRÜCK/ NUNN 2011, 57f). Nowadays “[m]edical tourism can be broadly defined as provision of “cost effective” private medical care in collaboration with the tourism industry for patients needing surgical and other forms of specialized treatment” (KUMAR 2009, 11).

Figure 5 illustrates an overview about the evolution process of medical tourism:

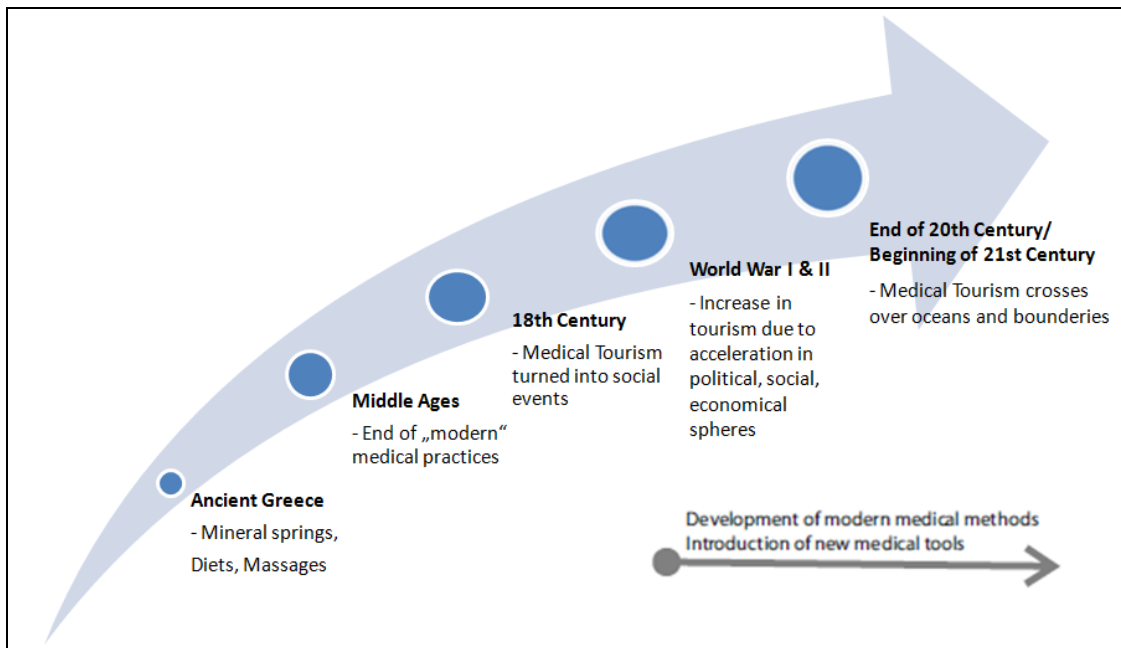


Figure 5: Evolution process of medical tourism, Source: MENVIELLE & MENVIELLE 2010 In: MENVIELLE/ MENVIELLE/ TOURNOIS 2011, 49; edited by author

Accordingly medical tourism is characterized by its disposal of health oriented services and treatments in specifically chosen destinations. These destinations in turn are characterized by prestigious hotels and accommodations and medical institutions. Moreover this implies an enlargement of infrastructure and capacities and therefore results rather in the development of a tourism destination than just a medical oriented destination (cf. BREITRÜCK/ NUNN 2011, 60). Hence, “medical tourism is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism” (BOOKMAN/ BOOKMAN 2007, 1).

3.2.1 Terminology Issues

The term and the concept of “tourism” complicate the analysis of medical tourism. Sometimes the conditions of people traveling abroad for medical treatment are so weak or incapacitated afterwards that any kind of tourism is impossible.

Health and wellness tourism are sometimes meant to be too “soft” to be medical tourism, because the word medical includes illness or injuries (cf. CONNELL 2013, 3). “[B]road notions of tourism fit poorly, and are widely rejected, in procedures associated with desperation, last resort and heavy financial liability” (ibid). Even though people travel for serious reasons the term ‘medical tourism’ often carries the connotation of pleasure.

But there is only little touristic intent in the desperation and enforcement of international travel in order to seek medical care people need or desire. It is hard to distinguish between those who look for treatment overseas because they cannot afford it in their home countries and others who “just” seek for low-cost aesthetic procedures (cf. *ibid.*).

There exist a variety of medical tourism such as the so-called “maternity tourism” or “citizenship-tourism” where expectant mothers cross borders to give births to their babies in more developed countries. As well the “reproductive tourism” where people desperately seek for a treatment to become pregnant cannot be seen as a typical tourism characteristic (cf. CONNELL 2013, 3). “Abortion tourism” is another dimension of medical tourism, whereby women cross borders due to abortion procedures which may be prohibited in their own country. Also highly experimental procedures like stem-cell medicine are reasons to travel international as they are often regulated by states due to ethical regulations and therefore not available (cf. HALL 2011, 7).

Consequently medical travel, medical care abroad or treatment abroad would be more suitable. In many cases the focus should be set on the medical treatment or surgery and not on the vacation options of the destination (cf. CONNELL 2013, 3).

Figure 6 shows the interrelated fields of the terms health, medical and wellness tourism. Thus, health tourism can be seen as the basis for the other dimensions as the primarily concern is the patients improvement of health (cf. HALL 2011, 6).

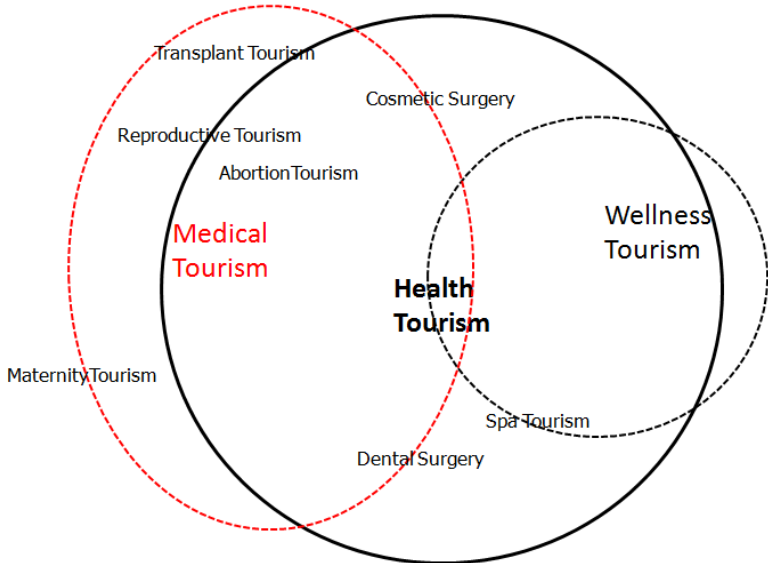


Figure 6: Interrelatedness of health and medical tourism; Source: HALL 2011, 8; edited by author

While wellness tourism is a preventive measure, medical tourism often involves very delicate issues and therefore gains distance to the other dimension.

Some experts see that the tourism industry is working to get medical tourism counted as a new niche in the tourism sector. But there are some problems emerging, like the creation of stereotypes about race and class, e.g. a wealthy white Westerner or East Asian Tourist who travels for cosmetic surgery in combination with a relaxing beach holiday to less developed countries. This of course is a market strategy and perfect promotional material (cf. CONNELL 2013, 3f).

The term medical tourism implies subcategories of tourists:

- “Medical tourists’ proper” and “mere tourists”, these people visit a country especially and solely for some medical treatment (cf. *ibid.*). They may travel long distances to receive medical treatment or they are just residents of border areas (cf. HELBLE 2010).
- The “vacationing patient” whose main purpose of travelling is indeed medical treatment but incidental makes typical holiday activities (cf. CONNELL 2013, 3f).
- “Medicated tourists”, they receive treatment because of health problems which occur during their stay (cf. CONNELL 2013, 3f). This category includes all people who are already abroad, may fall sick and therefore need healthcare during their stay. Except tourists this could also be temporary or migrant workers or retirees abroad (cf. HELBLE 2010).

The first two categories are more seen as medical travel than medical tourism because the medical component dominates (cf. CONNELL 2013, 3f).

Patients belonging to these groups are relatively easy to identify while the other group includes as well foreigners who live on a permanent basis abroad and therefore pay taxes and contribute to the medical health system of the country (HELBLE 2010).

Medical Tourism is varying in intent, procedure and duration. There are elite patients who travel from different regions in the world to expensive high standard places in industrialized developed countries “for exclusive and costly medical treatment, continuing a century long tradition” (CONNELL 2013, 4). Most of the global affluent middle class population travel for cosmetic reasons particularly to Asia or Latin America. Others go for cheaper services abroad or because their insurance doesn’t cover necessary treatments. But they are not only

westerners, also diasporic patients who return to their home countries for political, economical, cultural, and health reasons. Actually their number is much higher than expected but most of the time not particularly emphasized when speaking about medical tourists (cf. *ibid*, 4f). “Diaspora tourists are loosely familiar with what is available at ‘home’ and many rely almost entirely on word of mouth or good luck, depending on the gravity of the procedure” (*ibid*, 6). The internet has been taken over all medical tourism guides and information and has become crucial to the marketing. All people without internet access especially poor people from rural areas in less developed areas depend on advices and referrals from friends or families.

But furthermore surveys showed that especially in Asia (at least Japan, China and Korea), recommendations from friends are more preferred rather than the internet. The word of mouth seems to become more important concerning medical tourism; the internet plays the role of checking afterwards as well as booking (cf. *ibid*).

3.2.2 Medical Tourism Today- More than a Wellness Adventure

Medical Tourism has developed into a big business as a steadily increasing number of patients seeking medical treatment abroad (cf. KUMAR 2009, 11). Thus, it can be seen as a global phenomenon as people travel from almost everywhere to seek for medical treatment abroad (cf. EHRBECK/ GUEVARA/ MANGO 2008, 5).

The factors for the growth of medical tourism are wide spread but especially overall economic growth has brought technology advancement in communications, better access to health care information as well as an improved logistic. Other contributing factors are the health care standard convergence, increased cost efficiency and of course the increasing adoption of sophisticated medical technology.

Also the middle class has become wealthier the last decades and plays an important role, because more patients are able to afford higher quality medical care and therefore are willing to cross borders. Additionally access to certain treatments in their home countries is combined with especially long waiting times for procedures.

These people are part of an overall aging population who look for specialized treatment and get supported by the expansion of the travel industry. This includes the expansion of budget airlines which is responsible for easy and cheap travelling to and within a region (cf. YAP/

CHEN/ NONES 2008, 2). That is why “[t]he pool of patients seeking treatment overseas, therefore, expands naturally and drives the growth of the medical tourism market” (ibid).

Additionally new service delivery models emerged which attract and help patients from different destinations to get familiar with the operating environment of the focused country by introducing the medical legislation as well as procedures.

This outreach supports also hospitals to establish a certain framework beyond their national borders and therefore to adopt and adjust necessary health products to provide (ibid, 4).

People travel to receive treatment from almost all nations to every continent. Figure 7 shows the patients flow whereby patients from North America, Europe, Asia, Middle East, Africa, Oceania, and Latin America are involved. Further it is noticeable that some regions seek for treatment in at least three continents (cf. EHRBECK/ GUEVARA/ MANGO 2008, 5).



Figure 7: International Medical Travel; Source: EHRBECK/ GUEVARA/ MANGO 2008, 5

General reasons to choose medical treatment in a foreign country are:

- To avoid waiting lists in the home country
- Affordable cost
- Healthcare standards at least at the same level as in the home country

- Touring the visiting place
- Western medical treatment

(cf. KUMAR 2009, 12)

As seeking medical treatment abroad includes risks it is in the patient's hands to find out the necessary information concerning travel, healthcare and diseases of the chosen destination.

The change of medical services from the public to the private sector led to a two tier health system as the middle and lower class in many countries is not able to afford certain treatments due to missing insurances. Because of the open market politics the deregulation of transportation emerged and allowed people to travel elsewhere which further made foreign countries more attractive especially concerning affordable treatment costs (cf. MENVIELLE/ MENVIELLE/ TOURNOIS 2011, 48f).

“Medical tourism constitutes an individual solution to what is traditionally considered a public (government) concern, health for its citizens, who at the micro level are responding to market incentives by seeking lower cost and/or high quality care overseas that cannot be found at home” (POCOCK/ PHUA 2011, 2).

Cohen (2010) distinguishes three types of medical tourism:

1. “Medical tourism for services those are illegal in both the patient's home and destination countries” (COHEN 2010, 11).

The best example is probably organ sale as it is prohibited in almost every country in the world. Hence, medical tourism brings up new challenges concerning domestic and international laws and rules. For example if a country tolerates a gray market dealing with organs is it the patient country's task to punish its citizen purchasing these organs (cf. *ibid*)?

2. “Medical tourism for services those are illegal in the patient's home country but legal in the destination country” (*ibid*).

Assisted suicide, surrogacy but also certain drugs and more, are illegal in many countries while in others they are legally available (cf. *ibid* 11f).

3. “Medical tourism for services legal in both the home and destination countries” (COHEN 2010, 12).

This often depends on the existing healthcare in the origin country compared with the destination's healthcare costs as well as quality and/ or accessibility (cf. *ibid.*).

Particularly the aging population is stimulating the development of medical tourism as there is an increasing demand for various treatments especially cosmetic procedures due to certain lifestyles. As mentioned before even if it concerns urgent surgical procedures long waiting lists, non availability or exploding costs in industrialized nations have to be considered and play therefore a major role in this branch (cf. MENVIELLE/ MENVIELLE/ TOURNOIS 2011, 51).

3.2.2.1. The Role of Cost and Quality

Especially the permanent increasing costs of healthcare in industrialized nations force people to travel for medical needs. Affordable and easy international travel options, favorable exchange rates and of course the fast improving technology which leads to high standards of care in a lot of countries all over the world, support people by choosing medical treatment abroad. The most important fact is that the proven safety of healthcare in some nations abroad led to a rise of medical tourism and because of that more and more people travel in foreign countries (cf. KUMAR 2009, 11f) “as an affordable, enjoyable, and safe alternative to having treatment in their home countries” (*ibid.*, 12).

The patient safety and the quality of healthcare are the main issues within the medical tourism branch. These are issues of high concern as the “[q]uality of healthcare and standard by which it is measured varies to a great extent around the world” (NAFISA/ SAMIR 2011, 216).

The portability of health insurances can be seen as a major incentive for the medical tourism industry as it encourages more people to seek for medical treatment abroad. Sometimes patients even receive governmental support for certain treatments abroad when they are not available in their own country. In some countries patients can submit a variety of treatment costs from abroad to their health insurances at home. Therefore hospitals need a measurable quality standard to make them suitable for health insurances; hence international accreditations are required (cf. WHITTAKER 2008, 276).

These International Health Accreditations recommend travelers who seek for medical treatments abroad, hospitals and medical facilities. As there are several accreditation groups also within these accreditation schemes the variety between quality, size, cost or skills

differentiates. Four of these accreditation types established to be internationally on top of the list. These are Accreditation Canada, QHA Trent Accreditation, United Kingdom Accreditation (UKAF) and, Joint Commission International (JCI).

All of these accreditation groups work independent whereby the last one can be seen as one of the best known on an international scale (cf. *ibid*).

The remits of these accreditation types include diverse subjects such as for example:

- Operational policies and procedures
- Patient care
- Facilities and equipment
- Staff development, education and training
- Cosmetic and aesthetic surgery and medicine
- Transplant surgery
- Health screening centres
- Home Care Standards
- Long Term Care Standards
- Etc.

(QHA 2013, JCI 2015)

Furthermore the accreditation criteria are developed under consideration of standards of the European Union, United Kingdom, Canada, USA as well as international organization standards (cf. *ibid*, UKAS 2015).

The medical tourism industry gained from the emergence of these accreditation groups (cf. NAFISA/ SAMIR 2011, 216) as it gives travelers a certain measurable security due to the lists of standards. Nearly every designated provider already has this kind of accreditation (cf. EHRBECK/ GUEVARA/ MANGO 2008, 6).

Usually medical tourists come from industrialized nations like the United States, Canada, Great Britain, Western Europe, Australia or the Middle East. But in the last years also people from other countries are looking for places where they are able to combine vacation and medical care at an affordable cost. Because of this rapidly increasing number of medical tourists the receiving regions and providers offer numerous options for touring, shopping sight-seeing and more, combined with a medical treatment (cf. KUMAR 2009, 11f).

There are Medical Tourism Associations which brings together hospitals, medical facilitators and insurers; this phenomenon exists especially in the U.S., where it is reported that more and more health insurers offer packages to receive cheaper treatment overseas (cf. YAP/ CHEN/ NONES 2008, 9). But also other companies of the tourism branch follow the trend of healthcare packages abroad. Especially after the Asian financial crisis some hospitals and governments agencies targeted overseas clients by placing advertisements in airline magazines (Figure 8) (cf. CONNELL 2013, 5).

Travel and Health Industries Commingling – The Case of Thai Airways

A number of travel and leisure companies have invested in the health sector and/or offer their clients packages that include some health care. For example, Thai Airways offers a number of health packages through its Royal Orchid Holidays program. These include:

Package in Bangkok

- Superior Physical-Check-Up at Bangkok Hospital (3 hours)
- Medical Check-Up: Hearth Care Programme at Bangkok Hospital (3-4 hours)
- Premier Health Examination at Bumrungrad International (3-4 hours)
- Physical Check-Up at Ramkhamhaeng Hospital (3-4 hours)
- The Dental Examination and Cleaning at Bumrungrad International (30 minutes)

Package in Chiang Mai

- Physical Check-Up at Chiang Mai Ram Hospital (3-4 hours)
- Check-Up at Rajavej Chiang Mai Hospital (3-4 hours)

Package in Phuket

- Medical Check-Up at Bangkok Phuket Hospital (3-4 hours)

Source: www.thaiair.com

Figure 8: Medical Vacation Packages; Source: CATTANEO 2009, 12

Furthermore, providers offer extra services like translators or airport pickups to relief the patient's arrival to a foreign destination and culture. The first contact with the physicians is often ahead of time so that patients have the chance to get to know their doctor's oversea, they receive the doctor's CV and can ask questions or talk about concerns they have. It happens that travelers know more about their doctors in the chosen treatment destination than about their physicians at home (cf. EHRBECK/ GUEVARA/ MANGO 2008, 9).

Most of the time procedures are linked with the duration of the stay of a patient. If the procedure takes less than a day it does not involve a hospital and fits therefore in the broad understanding of medical tourism, with a focus on leisure activities. But also travelers with a serious purpose can through entering in the medical tourism experience a celebratory ending of their stay abroad (cf. CONNELL 2013, 3) as “[t]ourism offers added value” (ibid).

“Destination hospitals focus on high-quality care, reliability and competence, although other institutions, including the facilitating MTCs [(Medical Tourism Companies)] and destination countries, seek to emphasize ‘normal’ touristic elements [...] that the experience will be pleasurable” (CONNELL 2013, 3).

The variety of medical treatments the tourists obtain start from simple medical check up to elective procedures such as breast augmentation up to larger and life-saving procedures such as hip replacements, organ transplants, and heart surgeries (cf. KUMAR 2009, 12).

That is why additionally a shift is recognizable especially concerning the follow-up care after certain treatments. That means medical procedures become more complex where follow-up care is required. Due to the aging population and the rising demand for more complex treatments this shift will continue and is therefore going to gain in importance in the near future (cf. YAP/ CHEN/ NONES 2008, 4).

Medical tourists can nowadays receive almost every type of medical treatment or surgical procedure abroad in a safe and effective way for an affordable price which is most of the time a fraction of the cost that people would have to pay in their home countries. In the United States you have to pay approximately \$50.000 for a private heart surgery while the same operation with comparable rates of success and complications costs around \$10.000 in a high-standard hospital in Mumbai, India. There are large price disparities for a numerous of medical and surgical treatments (cf. KUMAR 2009, 12f).

The data below (Table 4) shows the disparity between the U.S. and the Southeast Asian countries Thailand, Malaysia and Singapore for the costs of certain treatments:

Cost of treatment – Country comparison chart in USD (2011)					
	USA	Thailand	Vietnam	Malaysia	Singapore*
Heart Bypass	144,000	15,121	N/A	11,430	16,500
Angioplasty	57,000	3,788	N/A	5,430	11,200
Hip Replacement	50,000	7,879	8,250	7,500	9,200
Hysterectomy	15,000	2,727	N/A	5,250	6,000
Spinal Fusion	100,000	9,091	6,150	6,000	10,000
Rhinoplasty	8,000	3,901	2,100	1,293	N/A
Liposuction	9,000	2,303	2,850	2,299	N/A

*2007 price
Source: Medical Tourism Survey - August 2011

Table 4: Cost of Treatment 2011; Source: TUNGSUWAN 2012, 1; edited by author

It is recognizable that there are enormous differences between treatment costs in westernized nations and Southeast Asia. Furthermore the ASEAN framework provides a legal room for intra-regional free flow of health services and thus supports the medical travel industry in this

region. Moreover the cross border cooperation of health service providers leads to the formation of a platform for both to compete and gain from the health market which further results in a growth of medical tourism in the receiving as well as sending countries (cf. TUNGSUWAN 2012, 2).

Thus the provider destinations often focus on specific segments which emphasize the specialization and furthermore the quality of treatments they offer. This effects the reputation of a country on a regional as well as global scale whereby the provider's location, economic development, and infrastructure are as important as the reputation in the patient's country of origin (cf. EHRBECK/ GUEVARA/ MANGO 2008, 9).

3.2.2.2. Risks of Medical Tourism

“Medical tourism does carry risks that local medical procedures do not” (KUMAR 2009, 10). A risk is that nations such as Thailand or Vietnam have different infectious diseases and also different prevalence of these diseases than western nations such as Canada, US or European countries. This can be very dangerous for patients without having built up natural immunity, particularly for gastrointestinal diseases, e.g. Hepatitis A, bacteria, but also mosquito transmitted diseases, influenza, TB, etc., which could eventually weaken progress. Because in the tropical nations doctors are used to diseases like mentioned before, they seem to be more open to the possibility of an infection than in the West where patients get constantly misdiagnosed because most of the diseases are very rare.

Also travelling right after surgery increases the risk of complications enormous as well as vacation activities like a full packed sight-seeing program or too much sun and water. Scars are darker especially noticeable if they sunburn during the healing-process.

Long flights after a heart surgery can cause complications such as thrombosis or breathing problems (cf. *ibid*, 10f).

Unexpected side effects from surgery and medication could occur especially in the postoperative period and could lead to a necessary expanded stay in hospital, which raises the costs of the treatment.

Certain illness and treatments or arising complications need longer term care, which is impossible when patients live abroad and savings and insurances are exhausted or do not cover the necessary supervision (cf. BUSHELL/ SHELDON 2009, 215).

Additionally the involvement of more healthcare providers and individual practitioners has an effect of quality and standards of medical procedures and they may vary widely due to the diverse set of providers (cf. YAP/ CHEN/ NONES 2008, 5).

Patients often seek for more information about treatment options as well as destinations in the internet (cf. EHRBECK/ GUEVARA/ MANGO 2008, 9). Several websites offer lists of medical services, prices or packages and aggressively promote medical services abroad. But also government sponsored sites advertise for their countries as medical treatment destinations (cf. WHITTAKER 2008, 276).

“Websites utilize a range of appeals to authority and quality” (ibid). They are full of stereotypes and images like happy faces of patients and doctors. The language is usually English and sometimes there are some other languages and include recommendations of patients who already experienced medical treatment in these facilities, usually patients from the UK and USA. Often these websites also provide search options to compare the facility conditions with other countries or sometimes even to see videos of specific surgical procedures (cf. ibid, 277).

Thus, news reports on medical travel, blogs, letters and comments are important sources for potential patients (cf. EHRBECK/ GUEVARA/ MANGO 2008, 9).

That is why the internet can cause huge effects, because negative news reports are reaching people across borders immediately and this is important for the reputation of a country’s quality. The news about individual cases of medical procedures gone wrong may quickly spin out of control and affect the industry’s reputation as well as the confidence of potential patients (cf. YAP/ CHEN/ NONES 2008, 5). Hence, the internet can be seen as a risk for both, consumer and provider.

3.2.2.3. Medical and Ethical

“History shows that tourism is one sector in which the wealthy really are early adopters and innovators” (KUMAR 2009, 38). The medical tourism industry is growing very fast, because of that it is important to create a high-tech, professional image to position the country in the global competitive market and further to attract people to come for treatments. Especially the low costs and the flexibility concerning legal aspects play a major role in choosing a country for medical reasons. For example organs transplantations are very strict controlled in western industrialized nation that is why some people travel in a foreign country to avoid long waiting

lists and complicated administrative procedures. The British Transplantation Society reported the case that organs of executed prisoners in China got removed for transplantation without the permission of either prisoners or their families. It developed into a big lucrative trade industry which survives because of the shortage of donor organs in the patient's countries (cf. *ibid*, 38f).

Thus, it brings together patients seeking for organs and impoverished donors who sell their organs for a certain amount of money. Furthermore poor people have less chance to receive organ transplantations as they cannot afford the treatment.

Medical Tourism with a focus on organ transplantation is problematic in general as failure rates are particularly high due to possible indigestibility and/or infections.

Other concerns are experimental or controversial procedures which bring up complex bioethical questions. Thus, it is not only the risks of the spread of infectious diseases but also how the media presents changes of the body, like for example gender-reassignments, cosmetic surgeries or stem cell therapies.

Another aspect is the sudden change of reputation of certain countries and hospitals. Especially the Asian region and hospitals were famous for cautionary notes by professionals from industrialized nations. Since the enormous increase in the medical tourism sector these notes developed into positive testimonials as (cf. CONNELL 2013, 9) “[r]eal rates of success and failure are immeasurable” (*ibid*).

Further local health care systems are suffering because of the medical tourism industry as privatization is affecting the budgets for public health expenditures. A dual medical system emerged with certain specializations on sophisticated procedures targeting foreign and wealthy patients while the local population has no access to any health facilities or even basic primary care such as clean water (cf. *ibid*, 10).

4 Southeast Asia

4.1 An Introduction

The perception of Southeast Asia as a unit only started to develop in the last decades. It is characterized by a mixture of cultures due to historical cross-border activities with neighboring countries like India and China and of course due to the colonization by western states. Hence, there is a big ethnical, religious, and socio-economical diversity.

Southeast Asia consists of eleven states such as Brunei, Cambodia, East-Timor, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand, and Vietnam. The region covers about 4, 48 million square kilometers of land whereby approximately 30.000 islands are implied.

The term Southeast Asia came up during the Second World War. After 1945 China started to expand its power, hence, countries with a pro-western attitude decided to cooperate. Therefore Thailand, Malaysia, Singapore, Indonesia, and the Philippines developed an economical and political collaboration which can be seen as the beginning of the ASEAN. The following years the ASEAN grew due to the joining of the five other member states, thus the ten countries plus East-Timor, which is independent from Indonesia since 1999, can be seen as Southeast Asia.

The agreement does not cover the cultural and geographical borders of the region. The defined borderlines are results of the period of colonization and therefore create potential conflict areas especially concerning the demarcation on the seaside but also minorities living in borderlands (cf. VORLAUFER 2009, Xf, 16).

As “Southeast Asia is land of diversity” (DUTT 1996, 329) it developed its character in a setting of several international events and features. Especially after the Second World War a period of political unrest started and brought some of the Southeast Asian countries away from a freely-elected democratic government into a military dictatorship.

The economies of course reflected these political systems, and hence ran in isolation; protectionism and underdevelopment were the consequences (cf. *ibid*, 329ff).

The ASEAN declaration set its focus primarily on economic collaborations and thus, did not cover any political cooperation. On the one hand collaborations within the region as well as dealing with other countries or organizations outside the region were emphasized. On the other hand the economies between the member states were highly competitive. Especially the less industrialized members struggled with unequal competition conditions. Therefore the

ASEAN developed their intra-regional trade liberalization, AFTA, to promote economic advance.

Another aspect of the ASEAN was to limit political interventions from outside, which was important as the region could develop their regionalism and moreover their integrity as well as sovereignty (cf. TARLING 2001, 161f).

The capitalistic world system with its market liberalization finally led to an increase in privatization and market-based economic settings. Following the model of The Four Dragons, Taiwan, Hong Kong, South Korea, and Singapore, the region started to develop industrialized status and by the beginning of the 21st century Malaysia, Thailand, Indonesia, and the Philippines have already approached their economic success (cf. DUTT 1996, 331-332).

4.1.1 Tourism in Southeast Asia

Southeast Asia sets its focus primarily on tourism as it creates an essential surplus in the region which further leads to development and economic benefits.

The region struggled with unemployment due to the loss of agriculture and the growing population. The industrialization led to economic growth which further caused an increasing demand in the service sector to serve especially the emerging tourism and tourism-related industry. Accordingly, the region started to develop a high quality in the hotel industry as well as a variety of shopping and pleasure-related areas.

Additionally, Southeast Asia has certain components important for tourism, like:

- Cultural diversity including religious and architectural manifestations such as temple, pagoda or king cities, e.g. Angkor in Cambodia or Ayutthaya in Thailand.
- Exotic in the sense of lifestyle and religion compared to the tourist's destination.
- Fascinating nature such as coasts, islands and beautiful beaches for vacationing activities. As well coral reefs with an intact fish fauna for snorkeling or diving but also mountains for trekking tours, rivers for rafting tourism or volcanoes and caves.
- Ethno tourism is also an important component, for example a visit to the indigenous peoples in North Thailand and Vietnam.
- The flair of the colonialism in certain cities can be seen as attractive to tourists as the European style of certain buildings in an Asian landscape may be fascinating, examples could be Hue and Hanoi in Vietnam.

- The postmodern architecture and skylines of the emerging metropolises such as Kuala Lumpur.

Hence, the rate of growth in tourism increased from 2,9 % in 1980 to 6,6 % in 2007, that is disproportionately high, especially compared to the world tourism growth rate (cf. VORLAUFER 2009, 191ff, 203).

Also the latest data show a steady increasing number of tourist arrivals in the ASEAN region in the last years. Table 5 implies intra and extra-ASEAN tourist arrivals.

Total tourist arrivals in ASEAN					
-as of January 2015					
in thousand arrivals					
Country	2009	2010	2011	2012	2013
Brunei Darussalam	157.5	214.3	242.1	209.1	224.9
Cambodia	2,161.6	2,508.3	2,881.9	3,584.3	4,210.2
Indonesia	6,323.7	7,002.9	7,649.7	8,044.5	8,802.1
Lao PDR	2,008.4	2,513.0	2,723.6	3,330.1	3,779.5
Malaysia	23,646.2	24,577.2	24,714,3	25,032.7	25,715.5
Myanmar	762.5	791.5	816.4	1,059.0	900.2
The Phillippines	3,017.1	3,520.5	3,917.5	4,272.8	4,681.3
Singapore	9,681.3	11,638.7	13,171.3	14,491.2	15,567.9
Thailand	14,149.8	15,936.4	19,098.3	22,353.9	26,546.7
Vietnam	3,772.3	5,049.9	6,014.0	6,847.7	7,572.4
ASEAN	65,680.3	73,752.6	81,229.0	89,225.2	98,000.6

Table 5: Total tourist arrivals in ASEAN; Source: ASEAN 2015; edited by author

Due to the number of total tourist arrivals three Southeast Asian countries have to be highlighted, such as Malaysia, Singapore and Thailand as they are responsible for two thirds of the arrivals. But also the other countries of the region have noticeable growing tourist numbers and regarding to the data of this five-year period these numbers are expected to continue rising.

4.2 Medical Tourism in Southeast Asia

The changing demographic as well as social structures in Southeast Asia can be seen as the main factors for the growth in the medical tourism industry. The life expectancy increases, chronic and ‘lifestyle’ diseases appear linked to a growing affluent middle class who seek for modern and technologized medical services. Thus an increasing percentage of people cross borders within the region to receive medical treatment or access to better medical facilities than available in their home countries. For example (Table 6) Malaysian and Indonesian wealthy elite’ preference for medical services is Singapore whereby a lot of Indonesians also choose Malaysia as a medical destination (cf. WHITTAKER 2008, 274f). The largest parts of medical tourists in Thailand are Japanese followed by patients from the United States, United Kingdom as well as the Middle East (cf. HEUNG/ KUCUKUSTA/ SONG 2011, 998). “Healthcare costs are 50% cheaper than in Singapore, three times cheaper than in Hong Kong, and five to ten times cheaper than in Europe and the United States” (KITTIKANYA 2004 cited by *ibid.*).

	Number of patients	Origin of patients
Malaysia (2003)	More than 100,000	60% from Indonesia, 10% from other ASEAN
Singapore (2002)	210,000	45% from Indonesia, 20% from Malaysia, 3% from other ASEAN
Thailand	470,000 in 2001, 630,000 in 2002, 974,000 in 2003	42% from Far East (mostly Japan), 7% from ASEAN

Table 6: Number of Patients within Asia; Source: CATTANEO 2009, 15; edited by author

Outside Asia particularly the phenomenon of demographic aging and overburdened healthcare systems are responsible for the increasing demand to travel for medical reasons to countries with similar treatment standards for lower costs (cf. WHITTAKER 2008, 274f).

Compared to the worldwide trade in services as well as consumption of medical and health services, medical tourism is relatively small but in destinations such as the main hubs in Southeast Asia it is the fastest growing tourism segment (cf. BOOKMAN/ BOOKMAN 2007, 2).

Of course the emergence of today’s medical tourism in Southeast Asia was supported by a variety of other influences like the effects of the Asian economic crisis but also due to the GATS agreement which changed certain trade regulations within the region.

The Asian economic crisis was in 1997 and had enormous negative effects on the tourist trade as well as on high-tech private hospital care. It came to an underutilization of necessary healthcare infrastructure including well-equipped private hospitals which back then, focused on affluent local as well as foreign patients from especially neighboring countries (cf. WHITTAKER 2008, 274f). The crisis caused a reduced purchasing power of the local families (cf. CHEN/ FLOOD 2013, 290) and further to a decrease in the tourism sector and this effected the growth in trade rates. Hence, Asian governments had to seek for alternatives to attract people to travel to their countries (cf. WHITTAKER 2008, 274f).

“At a broader level, neoliberalism manifested in privatization, capital market liberalization, and social-sector reforms has created the conditions spawning the growing trade“ (ibid, 275). Especially trade agreements introduced by the WTO concentrated on privatization as well as commercialization of healthcare issues. Due to the free trade principles of the GATS, involving services and commodities, particularly foreign private corporations could access the competitive market in the Asian healthcare sector more easily. This led to an increase in foreign investments in private health services throughout Asia which finally encouraged foreign patients to travel in this region (cf. ibid, 276).

Figure 9 shows the flow of people seeking for medical treatment in the ASEAN region, which implies the top medical tourism destinations worldwide such as Thailand, Malaysia and Singapore (cf. CATTANEO 2009, 15).

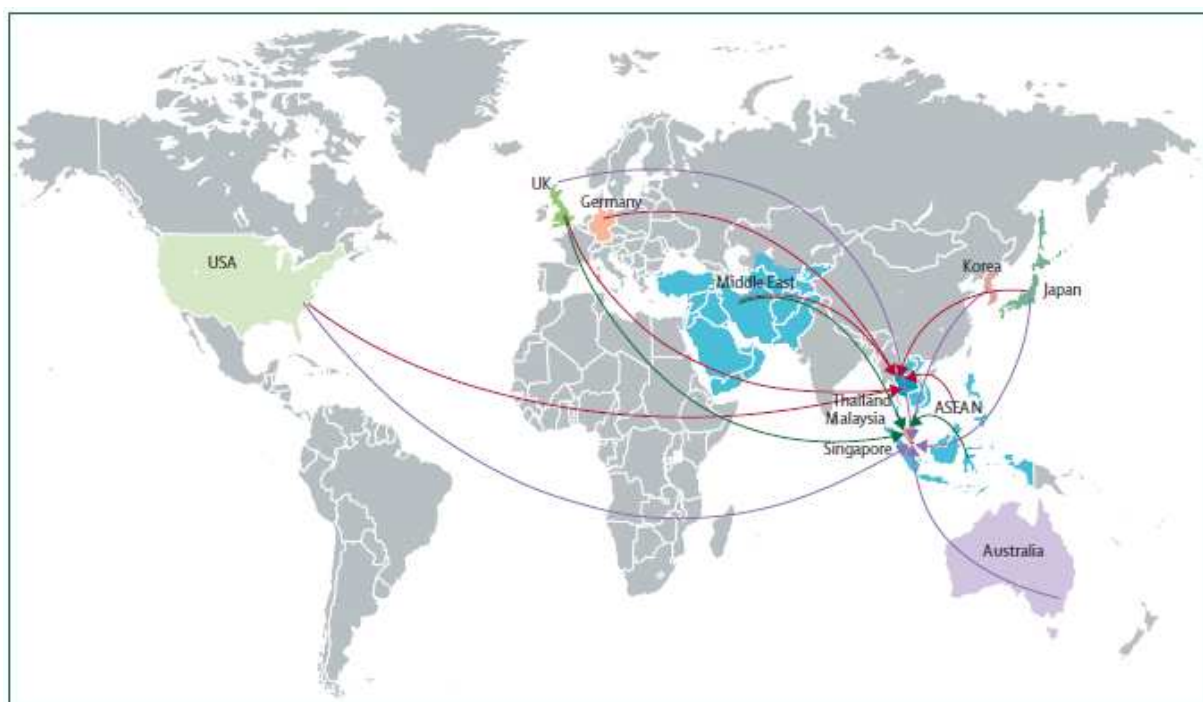


Figure 9: Intraregional and international patients flow; Source: KANCHANACHITRA et al 2011, 774

Under consideration of the portability of health insurances and weak or not affordable health systems, the USA can be seen as the largest western consumer group of health services in Southeast Asia, followed by some European countries such as the UK where a two-tier health system also already exists.

But the North-South trade is actually only about 30 percent of the Asian health tourism market; the major part is in the South-South trade, especially concerning qualitative investments in the health sector (cf. *ibid*).

These trade movements have advantages as well as disadvantages for both sides, North and South. Advantages for the North result from lower labor and living costs in the developing countries of the South, therefore the prices for certain treatments are noticeably lesser than in developed nations. The risks for the North are in the lack of malpractice insurances and laws which offers medical tourists almost no options if malpractice really happens.

Advantages for the South can be seen in trickle-down effects for the country's economy which further leads to a growth in the health, tourism, and infrastructure industries. Another benefit is a reduction of the migration numbers of medical professionals to more developed countries. Medical Tourism helped some developing countries like for example Singapore to specialize on specific advanced medical treatments and technologies even though there is only low domestic demand.

Of course there are also disadvantages for the South especially noticeable in the inequality of access to health care for the broad population. Due to the emerging two-tier health system with a focus on private and expensive sophisticated treatment options the public health sector gets more and more neglected (cf. HOPKINS et al 2010, 188-193).

Another aspect is the emerging market of foreign retirees coming to Asia with the intention to stay in so called retirement villages or facilities for international retirees. Attracted by low living costs and medical services with high quality, people from all over the world come to the region. Thailand, Malaysia and the Philippines actively promote their countries as retirement destinations, often in cooperation with private healthcare companies overseas (cf. WHITTAKER 2008, 275). Also here are the International Health Accreditations beneficial as they assure western quality of healthcare in these facilities and therefore become more attractive to potential western medical tourists or retirees (cf. HEUNG/ KUCUKUSTA/ SONG 2011, 997).

As Thailand, Singapore and Malaysia are the most advanced medical tourism destinations in the region the table 7 focuses on the major services provided in these countries.

Country	Major services provided
Thailand	Cosmetic surgery, organ transplants, dental treatment, joint replacements
Singapore	Liver transplants, joint replacements, cardiac surgery
Malaysia	Cardiology, cardio-thoracic surgery, cosmetic surgery

Table 7: Major services provided; Source: HOPKINS et al 2010, 192; edited by author

Thailand wants to become the regional medical hub with a special focus on cosmetic or plastic surgeries as well as dental treatment but also gender reassignment. Thus it promotes its beaches and landscapes for combining medical treatments with vacationing. Recently it starts to develop in organ transplants as well as diverse joint replacements due to the demand of especially elderly travelers. Further Asia’s largest private hospital is located in Thailand, Bangkok, with a third of its patients from international destinations, around 350.000 patients each year.

Singapore is providing services mainly to wealthy Asians seeking high quality treatments not available in their country of origin. Singapore started to lose market share because of limited attractions as a traditional tourism destination. To encourage tourists to repeat their visit, medical tourism is seen as a solution to attract travelers for longer stays or even to return one day.

As Singapore cannot compete with the prices of Thailand, it markets itself particularly on the quality of its services and treatments in the health sector. This includes as well special clinics and hotel-style accommodations. The country promotes its medical expertise in especially liver transplants and cord blood transplants but also cardiac surgery and joint replacements.

Malaysia emphasizes expertise in cardiology, cardio-thoracic surgery, orthopaedics as well as cosmetic surgery. The country promotes particularly the foreign training and education of their medical staff. Malaysia used to position itself as a medical destination for the local regional market like Indonesia, Brunei, Vietnam, and Myanmar but started to extend its focus on the Middle East as well as Western states. As check-ups are the most famous procedures for foreigners, the country offers special packages like check-ups and golf to attract more international tourists (cf. WHITTAKER 2008, 279-282).

Medical tourism needs certain infrastructures and employees which have to be provided not only by private companies or institutions but also by the public sector. Thus, shortages of health workers as well as a low density of doctors and nurses due to policy regulations influence a country's entry into the medical tourism market.

Laos, Cambodia and Myanmar are such examples, the low production and employment capacities impede the development of a health-related tourism industry compared to Thailand, Singapore and Malaysia. In some Southeast Asian countries medical training stopped completely, thus the case in Laos from 1976 to 1981 in the period of national reconstruction as well as in Cambodia between 1996 and 2002. These shortages of professionals in the health sector remain until today.

The Philippines on the other hand have restricted capacity for employments in the health sector which further leads to a massive outmigration as for example in 2009 approximately 400.000 licensed nurses could not find a job in the nursing profession.

Consequently, the Philippines and also Indonesia started to focus on export-led production of licensed nurses and doctors as a respond to the international demand of the health market. Nursing programs and schools are private and export-driven and at any time adjustable to the global demand.

Since the medical tourism industry developed into a lucrative business, countries in Southeast Asia started to specialize on certain treatment options, special educations or technologies to stay competitive in the region (cf. KANCHANACHITRA et al 2011, 773f).

4.3 Policy Implications for Local Health Systems

The government plays a major role in the marketing of the medical tourism industry, especially in Southeast Asia is a clear trend visible as in for example Thailand, Singapore, and Malaysia visas for particularly medical tourists are available. Additionally there have been established certain government agencies with the mission to increase the countries or regions inflows of medical tourists (cf. POCOCK/ PHUA 2011, 2).

As already mentioned “[t]ravel for health purposes is not new” (WHITTAKER/ MANDERSON/ CARTWRIGHT 2010, 337) but the way of promoting and organizing medical services for paying travelers no matter which citizenship they have is a new phenomenon. The movements in the healthcare sector have implications for the health

systems in the receiving as well as sending countries (cf. *ibid*). Depending on a country's health system structure there are comparative advantages when specializing on the medical tourism branch (cf. POCOCK/ PHUA 2011, 1f). The challenges accompanying the medical tourism sector are in the inconsistency and volatility of the foreign demand. It is not only the dependencies of the national income which is closely linked to tourism but also the investments in the tourist industry often financed by foreign sources (cf. BOOKMAN/ BOOKMAN 2007, 34). Thus “[t]he more dependent the destination countries [...] the greater the preconditions set by foreign investors” (*ibid*, 35).

Table 8 shows the organizational structure of health systems in Thailand, Malaysia and Singapore in comparison and their policy impacts on a national level. These countries are challenged by the national strategies to gain from medical tourism and the fact of a lack in providing basic health services to their own citizens (cf. POCOCK/ PHUA 2011, 1f).

Health systems in comparison			
Country	Thailand	Malaysia	Singapore
Organizational structure	Pockets of excellence in some private Bangkok hospitals	Growing private health sector with movement of qualified workforce	Balanced public-private mix, corporatized public sector
National strategy	Regional health hub Extensive tourism infrastructure	Industrial strategy to develop tourism	Economic growth strategy to develop biomedical industries Regional service hub Medical R&D support
Policy impact	Issues of growing inequity and urban-rural divide	Public-private divide Racial inequities between public and private sectors	Narrow income gaps of public and private sectors

Table 8: Health systems in comparison; Source: POCOCK/ PHUA 2011, 2

The organizational structure of Thailand combined with the national strategy is to become a regional medical tourism hub. The tourism infrastructure extended, especially in urban areas which further results in a growing inequity especially between urban and rural regions.

Malaysia has a massive growing private health sector which leads to an increasing movement of highly skilled professionals from the public to the private sector and therefore a visible division between public and private health services emerged.

Singapore is focusing on medical research and development and wants to become the regional hub in this field. The organizational structure of Singapore is a corporatized public sector with a mix of the private and public sector which also minimizes the access to certain facilities for poorer citizens.

However the national strategies show an impact of medical tourism on health systems in Southeast Asia, particularly concerning access to medical services or facilities for both foreign and especially local consumers.

But the economic benefits of medical tourism make it to an attractive option for governments to follow the strategy as it (cf. POCOCK/ PHUA 2011, 2f) “can contribute to wider economic development, which is strongly correlated with improved population health status as a whole” (ibid, 2). Medical tourism encourages foreign direct investment which especially favors the healthcare infrastructure furthermore it creates revenues for additional investments which benefits the health care sector of a country in general (cf. ibid).

The multiplier effects of these foreign investments “result in forward and backward linkages throughout the economy” (BOOKMAN/ BOOKMAN 2007, 32). Thus, health related tourism has linkages going far beyond the tourism or health sector as it rises employment, income as well as demand for certain services. This further increases production and therefore the economic growth which is important to attract tourists as a certain environment and range are necessary. Especially concerning tourism as it gets consumed where it is produced additionally in combination with services or products from other sectors (cf. ibid).

4.4 Impacts on the Health Care Equity

“Medical tourism has a socioeconomic impact in destinations where it occurs and may become a contentious issue if there is a widespread feeling that it is absorbing scarce resources” (SHELDON/ BUSHELL 2009, 215). In the first instance the lowering of trade barriers in the health service industry has driven to the rapid growth in the medical tourism sector. Regarding this circumstances, investment in the sector is favorable, especially in this competitive environment. But it is not clear if the host country will experience similar economic benefits if tax concession and other benefits are not matched by economic returns (cf. SNYDER et al 2014, 1f).

Medical tourism can cause imbalances in a country’s national healthcare system as investments are taken away from residents’ welfare and given to projects and services specially designed for tourists and wealthy people (cf. SHELDON/ BUSHELL 2009, 215). Hence, increased investment in the private health sector is often accompanied with decreased public sector investment (cf. SNYDER et al 2014, 2). The results are increasing prices out of the reach of the majority of citizens, thus they will only have access to rudimentary medicine

or even worse no access at all. Furthermore services for locals slowly improve and get harmed as nurses and doctors are increasingly turning to private institutions, which is economically rewarding (cf. SHELDON/ BUSHELL 2009, 215f). For example the number of high-tech-machines like Gamma-Knife machines, computed tomography (CT) scanners and mammography equipment is increasing because private health facilities import this kind of technology to support the transformation of a country into a medical tourism hub. But this growing emphasis on special high-tech equipment for secondary and tertiary care of medical tourists could have a negative effect on rising health care costs for primary and preventive care for locals (cf. CHEN/ FLOOD 2013, 289).

Due to the high paying jobs in the medical tourism sector there is an increasing flow of workers from the public to the private sector but also and even worse from the rural to the urban areas. Furthermore not only the high-tech equipment but also the highly trained health workers are especially targeted at privileged locals and foreign patients and more or less not accessible to the majority of the local population in Southeast Asia (cf. SNYDER et al 2014, 1f). Thus, local patients get ‘crowded-out’ of the healthcare system (cf. CHEN/ FLOOD 2013, 289). Hence, “medical tourism may actively worsen health inequities in these countries” (SNYDER et al 2014, 2).

Table 9 shows the disparities between public and private investments in three Southeast Asian main hubs of medical tourism Thailand, Singapore, and Malaysia. There is a steady growth of the private hospital sector due to the increasing demand of medical tourists (cf. POCOCK/ PHUA 2011, 6).

	Hospitals		Beds		Beds per 1000 population	Primary care clinics	
	Public (%)	Private (%)	Public (%)	Private (%)		Public	Private
Thailand	67.9%	32.1%	69.3%	30.7%	2.2	80.5%	19.5%
	(2007)	(2006)	(2006)	(2006)	(2002)	(2007)	(2006)
Singapore	63.6%	36.4%	80.6%	19.4%	3.2	1.5%	98.5%
	(2009)	(2009)	(2009)	(2009)	(2007)	(2005)	(2005)
Malaysia	40.6%	59.4%	77.9%	22.1%	1.8	32.1%	67.9%
	(2008)	(2008)	(2008)	(2008)	(2007)	(2008)	(2008)

Table 9: Disparities between public and private investments; Source: POCOCK/ PHUA 2011, 6

The private sector in primary care dominates in Singapore and Malaysia and is mostly concentrated in urban areas. Hospital services are controlled by the public sector especially concerning the share of beds, 70- 80 percent, but private hospital providers are expanding constantly. Private hospitals are usually smaller in size and located in urban areas, focused on middle to high income patients as well as patients from overseas (cf. POCOCK/ PHUA 2011, 6). “In general, the public private mix of healthcare provision in this region reflects the country’s level of economic development” (ibid). Because of economic growth the demand for private providers focused on wealthier people increased, thus the public sector has become more pro poor as some parts of the population cannot afford private care. The result is an emerging two tier healthcare system with a high quality private and a low quality public sector (cf. ibid).

The revenues generated by medical tourism have not been taxed sufficiently, that is why reinvesting back into public health care is missing which harms the country’s public health system in the long term. High- quality medical care remains only available for financially secure medical tourists, rather the majority of the population cannot benefit of it.

Another challenge is the internal brain drain caused by the medical tourism industry as many health workers are attracted by private providers and facilities offering higher wages and pleasant settings including working conditions. A consequence of these internal movements is an unfilled public health system because of missing medical practitioners.

Additionally medical tourism can result in a financial burden to the public as the training of medical practitioners is costly because usually these people are trained in subsidized public facilities (cf. HOPKINS et al 2010, 193f).

Other arguments are that also residents benefit from advances in medical knowledge and capabilities, as well as economies of scale. International contacts enrich the experience, knowledge as well as the competences of the local medical community (cf. SHELDON/ BUSHELL 2009, 215f).

At the same time the question arises whether medical tourism undermines traditional and culturally specific local health care approaches and imposes western medical models on Southeast Asian nations (cf. HOPKINS et al 2010, 195).

Further, medical tourism reduced the outflow of professional health workers to more developed nations as the career opportunities abroad were much more attractive. This international brain drain caused financial challenges in the labor-sending countries because of the loss of health professionals for the local market. Since the emergence of medical tourism

there is a significant return rate of doctors working abroad. But this does not solve the problem of the distribution of these health workers within a country as mentioned before an internal brain drain replaces the outflow (cf. CHEN/ FLOOD 2013, 293f).

4.5 Medical Tourists

The phenomenon of medical tourism is not new, affluent people from developed countries crossed borders for better quality of medical services ever since. In less developed Southeast Asian countries people traveled favorable to Singapore as it used to be the medical hub back then.

What is new is the trend that people from developed nations travel to developing countries to seek for affordable and available medical services. Additionally they combine their stay with vacationing activities or other touristic opportunities.

Reasons for this reversed travel behavior within the medical tourism sector could be the challenging circumstances in the health care systems in developed countries due to the demographic aging. The rapid increasing demand for medical treatments caused enormous pressure on public medical services in these countries. Thus they are not able to serve certain medical services to their citizens, either they are not affordable, covered by insurances or available. Therefore people seek for their medical desires, such as for example cosmetic surgery or dental treatment which is both often not included in public national insurances, abroad.

However the term is often misused especially in statistical reports as they include all foreigners who received medical treatment abroad. This leads to exaggerated results concerning the average scope of medical tourism because long-term foreign residents are then defined as tourists as well.

Regarding to the extent of the role of medical treatments in tourist's motivations for traveling abroad relative to a usual holiday trip, a typology of medical tourists is necessary (cf. COHEN 2008, 25).

4.5.1 Typology of Medical Tourists

Cohen (2008) distinguishes between five types of medical tourists (Figure 10):

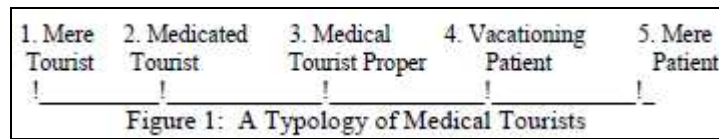


Figure 10: A Typology of Medical Tourists; Source: COHEN 2008, 25

1. The mere tourist makes any use of medical services and his/her only intention is making vacation in the host country.
2. The medicated tourist is an individual who receives medical treatment in the host country because of incidentally occurring health problems.
3. A medical tourist proper is a tourist who combines tourism and treatment. It could be the case that the individual travels with the intention to receive treatment while vacationing or the decision for a treatment comes when he/she is already in the country of vacation.
4. The vacationing patient on the other hand is the one who travels to another country with the only purpose to receive medical treatment but this tourist type makes use of vacationing opportunities incidental as some treatments need a certain recovery period.
5. The mere patient is a person who travels solely to seek for medical treatment abroad and makes no use of any vacationing activities (cf. COHEN 2008, 25f).

Actually Cohen distinguishes between two main categories of medical tourists. The first category implies people who travel exclusively for medical services whereby the second group combines treatment and vacation. Thus, also business trips should be considered as off-time could be used for medical treatments (cf. WONGKIT/ McKERCHER 2013, 8).

Depending on the purpose and the decision horizon of the trip it is either a medical or a pleasure trip. Under consideration of Cohen's typology Wongkit and McKercher (2013) suggest following categorization (Table 10):

Trip Purpose \ Decision Horizon	Medical (equally to exclusively for treatment)	Pleasure Trip (mostly to exclusively for pleasure)
Pre-plan Treatment	Dedicated Medical Tourist	Holidaying Medical Tourist
Decision after Arrival	Hesitant Medical Tourist	Opportunistic Medical Tourist

Table 10: Trip Purpose; Source: WONGKIT/ McKERCHER 2013, 8

The first category implies the medical trip purpose. The dedicated medical tourist makes the decision for seeking treatment abroad before traveling to the destination and it is the main reason (cf. *ibid*, 7) “or as equally important a reason as a holiday for pleasure, for their travel decision” (*ibid*). The hesitant is similar to the dedicated medical tourist concerning the trip motives but makes the final decision for the treatment after arrival in the country of choice, even though the person was aware of the treatment options before.

The second category considers the pleasure trip as main purpose. The holidaying medical tourist identifies the vacation as main reason for travelling, nevertheless also this tourist type pre-plans treatment in the final destination. The opportunistic medical tourist travels only for holiday and decides spontaneous in the country of vacation to seek treatment (cf. *ibid*).

4.5.2 Role of Networking and Communication

The number of people travelling for medical reasons is growing and the contribution to national economies by medical tourism will increase accordingly. As a consequence, government agencies in Asia are becoming active promoter for the medical tourism industry. These could result in multi-agency-government-industry partnerships, which mostly include ministries, economic departments as well as international enterprises. The main focus is to strengthen the country’s position as a leading medical centre in Asia. This should happen through publicity and branding of the healthcare industry’s quality and standards.

The Tourism Authority of Thailand’s official website for example offers information on medical tourism and shows direct links to pages promoting medical tourism in Thailand. Malaysia on the other side combines ministries and private hospitals to promote itself as a destination for medical tourism. The Malaysian government even extended the medical visa from 30 days to 6 month (cf. YAP/ CHEN/ NONES 2008, 5). It is noticeable that governments play a strong marketing and promotional role in the emerging medical tourism

industry (cf. POCOCK, PHUA 2011, 2). “The potential economic benefits of medical tourism make it an attractive option for governments” (ibid).

The government agency support is largely through information provision while the main part of the medical tourism industry is in the hand of the private sector. Further involvement of government agencies could probably improve the competitive advantages for a country (cf. YAP/ CHEN/ NONES 2008, 5).

Promoting medical tourism means also supporting neighboring industries such as infrastructure for transport, communication, water and sanitation systems as well as electrification. As well secondary products and services, these could be banal things like tennis balls or sun creams, but also trade in health related goods like medical equipment and pharmaceuticals.

Hence, investments in water systems and waste management are crucial to provide the western-oriented medical tourist industry. Insufficient water, a lack of sanitation or electricity influences the flow of tourists. This means that tourists avoid destinations where this kind of infrastructure is missing and therefore has negative effects on the country. It is important to manage these procedures and built up certain infrastructures by public and private services (cf. BOOKMAN/ BOOKMAN 2007, 72, 115).

Medical tourism implies besides the medical procedures and treatments of the patient often also some ‘standard’ tourist activities, especially considering accompanying travel partners and/or medical tourists intending to engage in these leisure activities.

Thus, also so called ‘hospitels’, elite hospitals, emerged where the hospital comes close to a luxury hotel by adding to cure and care the characteristics of consumption and consumerism. Furthermore some hospital-chains evolved as they started to become integrated into the international tourism industry. They offer serviced apartments, airport transfers and they book hotels for relatives and other accompanying people or arrange local tours for them (cf. CONNELL 2013, 5ff). Visitor expenditure includes the services outside their hotels too and therefore the internal as well as external infrastructure of these providers and destinations is crucial (cf. BOOKMAN/ BOOKMAN 2007, 28). That is why key hospitals developed into medical tourism companies with special arrangements with the hotel and airline industry as well as other related companies (cf. CONNELL 2013, 7).

“Language barriers, financial constraints and lack of information limit willingness to travel” (ibid, 8). Accordingly, word-of-mouth communication plays an important role whereby four types can be distinguished:

1. Consumer to consumer (communication in close circles)
2. Business to consumer (employees talk about products and services of a company)
3. Business to business
4. Facilitated business to business producing and purchasing information

(YEOH/ OTHMAN/ AHMAD 2013, 197)

In the case of the tourist’s choice of a destination for treatments especially type 1 has a significant influence. The information flow is usually an informal and personal communication. Further this communication can have both, positive and negative effects as very close and trusty relationships between the communicating partners are possible. Thus word-of-mouth communication developed into an important strategy for medical tourism destinations to promote their hospitals and treatment offers. This further leads to the argumentation that the main source of information comes from personal experiences with medical tourism. Thus, organizations with a lot of advertisement via word-of-mouth communication have a better chance to create sustainable growth rates (cf. ibid).

4.5.3 Motivations of Medical Travelers

Factors as costs, healthcare quality and expertise are particularly important for selecting a destination as a medical tourist (cf. HEUNG/ KUCUKUSTA/ SONG 2011, 996). Further motivations to seek medical care overseas are to reduce waiting time, experimental or controversial care, convenience and privacy or care that is unavailable or illegal in the home country (cf. COHEN 2010, 11f).

Figure 11 illustrates the relative size of medical traveler segments whereby most advanced technology is with 40 percent more than four times higher than lower-cost care for necessary procedures. Also a better-quality care seems to be more relevant for the traveler’s choice than lower-costs. Quality and technology are significant for the decision making process followed by quicker access for medically procedures.

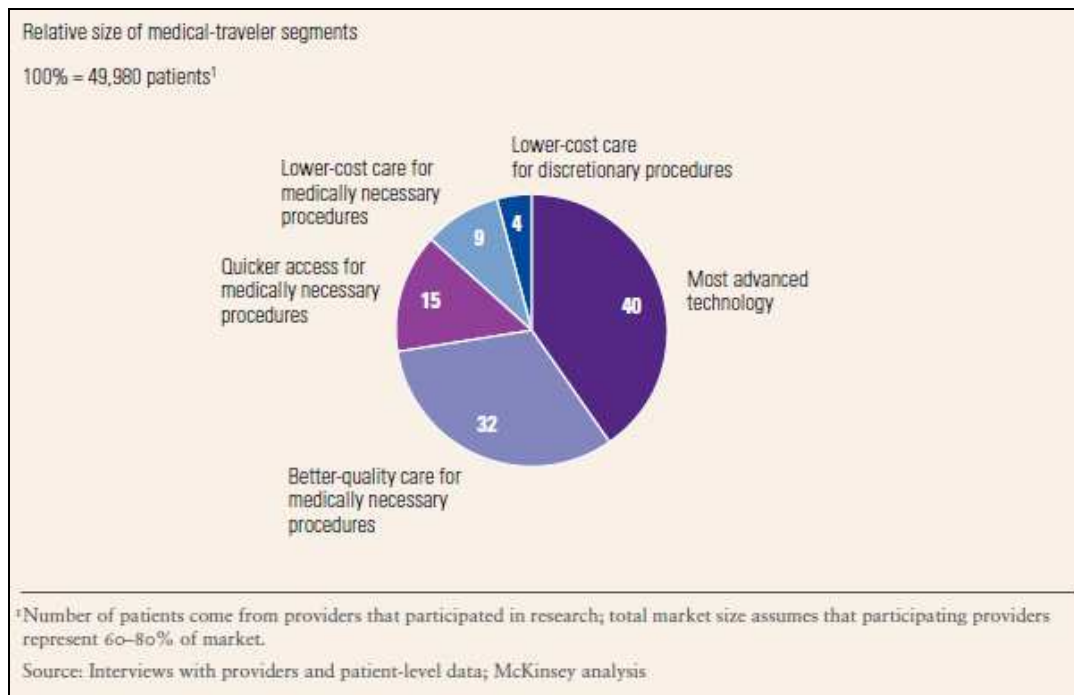


Figure 11: Motivation for Medical Travel, Source: EHRBERT/ GUEVARA/ MANGO 2008, 4

“A ‘geography of the body’, income, culture and language influence choice of destination for different procedures” (CONNELL 2013, 5). Hence, medical tourists rather choose countries with the same language or at least where English is spoken and with a similar cultural environment like in their home countries. That is why many of the medical tourism destinations have already responded to these requirements through language and culture trainings for their staff as well as the consideration of religious contexts (cf. *ibid*, 8).

When choosing a country for medical tourism, the regulatory and economic condition of the host country plays also a major role.

Supply and demand are the main elements of the medical tourism model (Figure 12). On the one hand these are factors that affect tourist’s destination choice and drive the medical tourist’s decision. On the other hand it shows the conditions and preparations of a country concerning the special demands of medical tourists (cf. HEUNG/ KUCUKUSTA/ SONG 2011, 996).

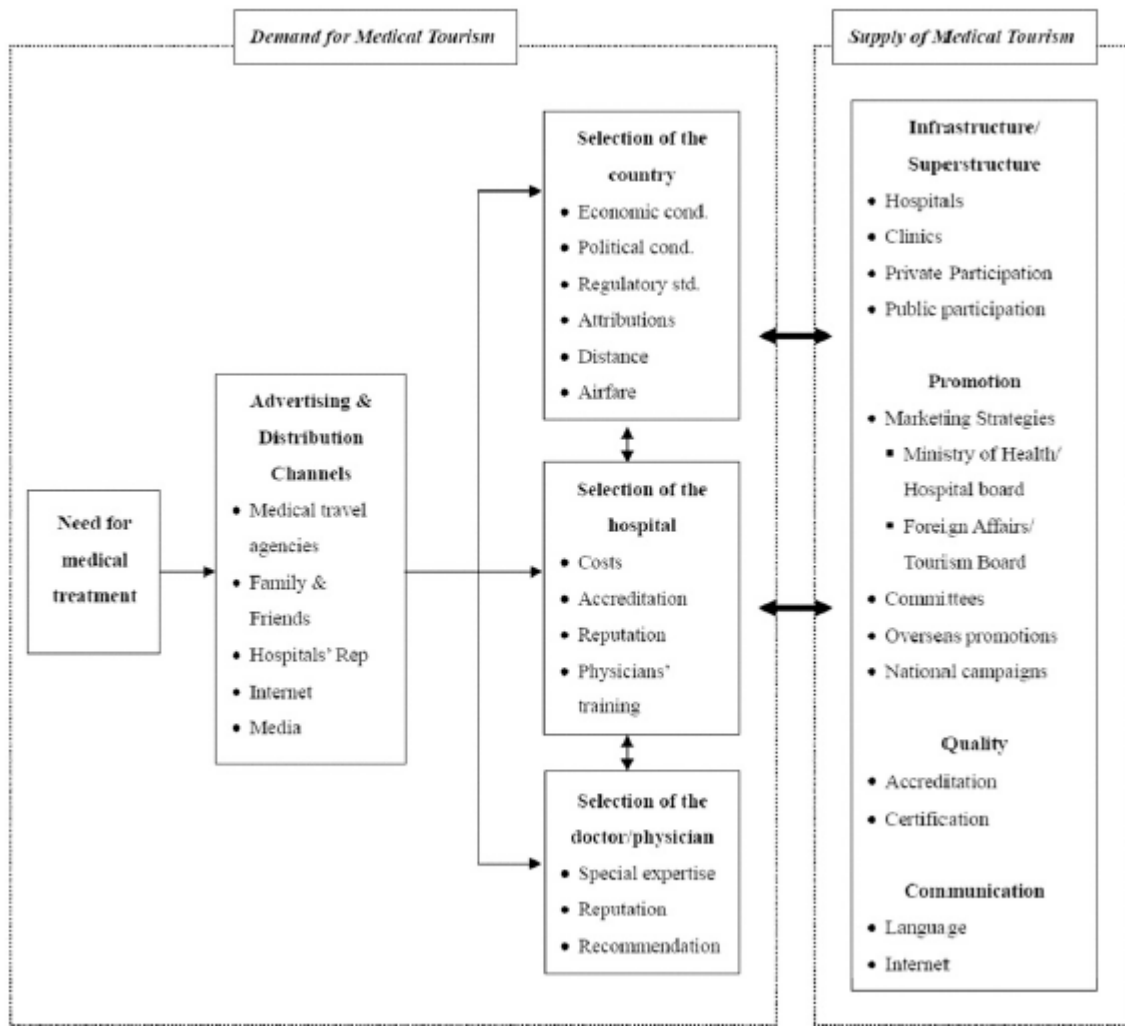


Figure 12: A supply and demand model of medical tourism; Source: HEUNG et al., 2010 in HEUNG/ KUCUKUSTA/ SONG 2011, 997

The distribution channels play a significant role as they are in the beginning of the medical tourism machinery. Here the internet, media, family, and friends are important sources especially because word-by-mouth experiences wander between these groups of people.

Further the selection of the country depends on certain factors like the economic and political condition of a country as well as the availability by transport as for example airplane. Once the country is selected the hospital and doctor have to be chosen. Thus, accreditation, costs and of course the reputation and special expertise of the hospital as well as doctor are important.

On the supply side the medical tourism destination has to offer the infrastructure to satisfy the needs of the medical tourists and is responsible for a smooth and trouble-free information flow. This implies next to language skills also necessary certifications and international accreditations as well as good overseas promotions to win the trust of foreign patients (cf. HEUNG/ KUCUKUSTA/ SONG 2011, 996f).

5 Empiricism

5.1 An Explanation

Scientific work is based on empirical research, thus the empirical social research is a crucial factor for social decision making processes and therefore can be seen as a systematic recording, documentation and interpretation of social facts. This could be human behavior like opinions, information about experiences, value judgments or intentions (cf. ATTESLANDER 2008, 3f).

There are three principles the empirical social research follows:

1. Research hypothesis have to be formulated which further serve as orientation for the scope of the research field as well as the selection of the research method.
2. Comprehensibility must be given, means the context between the theoretical and methodical approach of a research project has to be clear and understandable.
3. The instruments used for the research have to be described as the nature of these instruments is crucial for the results (cf. MANGOLD 1967, 11).

The written survey is an important method for the social research whereby the focus is set on the postal survey as it is relevant as a research instrument for this thesis.

There are some advantages as well as disadvantages in using the postal survey as a research instrument. Some issues of written postal surveys are the fact that there is no guaranty for complete filled and returned questionnaires. Further it is impossible to provide additional information about the aims and confidentiality of the survey. Moreover, there is no evidence for the reliability of the respondents as someone else could have filled out the questionnaires.

The questions have to be easy to understand to guaranty respondents are able to answer them without support or special effort. Otherwise the returns are not complete, wrong filled or even worse they do not return at all. In general about 50 percent of the distributed questionnaires return.

Further empirical social research sources are documents such as newspaper reports, letters, books, movies, papers, etc. Thus, the analysis of these documents serves as a substitute for the own observation under consideration of interpretation criteria of the document's author (cf. *ibid*, 63f, 71).

5.2 Starting Point and Implementation of the Survey

The survey focused on a quantitative examination and was accomplished by questionnaires. These questionnaires were distributed in hardcopy. The choice of questionnaires in hardcopy was taken because in the course of the preparations for the survey, conversations with some people from the target group led to the exclusion of an online-survey. Primarily because these people were not familiar with the computer at all furthermore the snowball principle worked out quite well, as people could take as much printed questionnaires for their friends and relatives as they liked.

The distribution of the questionnaires started in the circle of the family and friends of the author and continued to expand to friends of friends etc. The period of distribution and returns of questionnaires lasted for about four month.

As already mentioned the questionnaire's aim was to find out more about the willingness of Austrians at the age of 50 and above, to travel for medical reasons to Southeast Asia. Besides the age of 50+, the criteria included at least an interest in the region Southeast Asia but the perfect result would be people who already have been there. This led to an exclusion of certain people who were willing to fill the questionnaires but could not meet the criteria of some knowledge about Southeast Asia.

For some of the potential participants who would have been in the target group the questionnaire was just too long, as it implied almost five A4-pages whereby the last page was intentionally left blank for additional notes of the respondents. Thus, even though the formulated questions contained multiple choice answers and only if the respondent wanted to he/she could add further answers, the questionnaire met rejection.

Out of 100 questionnaires more than 50% were returned, which result in 71 filled out questionnaires.

Most of the questions consider scales to measure the intensity of certain attitudes. This could be dichotomous answers such as a simple yes or no but also answers like high or low, more or less, etc. (cf. MANGOLD 1967, 22).

5.3 Results and Interpretation

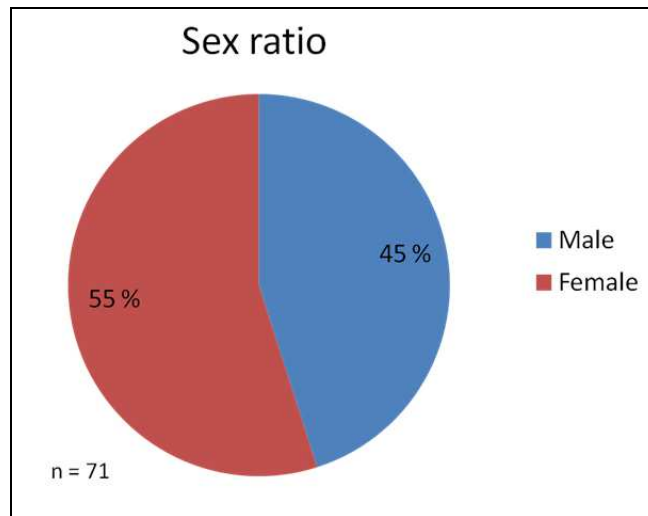


Figure 13: Question Nr.1- Sex ratio of respondents

Figure 13 shows a symmetrical sex ratio is almost given; female respondents are dominating with 55% while male respondents represent 45%.

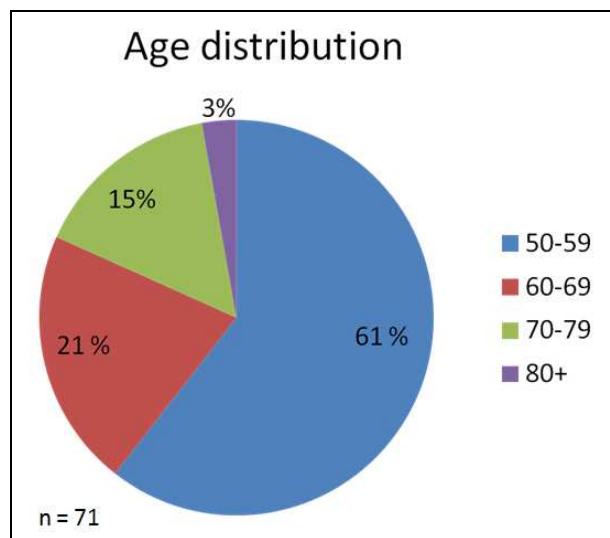


Figure 14: Question Nr.2- Age distribution of respondents

As shown in figure 14, the majority of the respondents can be found in the age group less than 60 years with about 61%. The second group with 21% is the 60-79 years old of the respondents. Also the age of 70-79 years is represented by 15%.

Ages of 80 and older represent the smallest and the oldest participant group of this survey with approximately 3%.

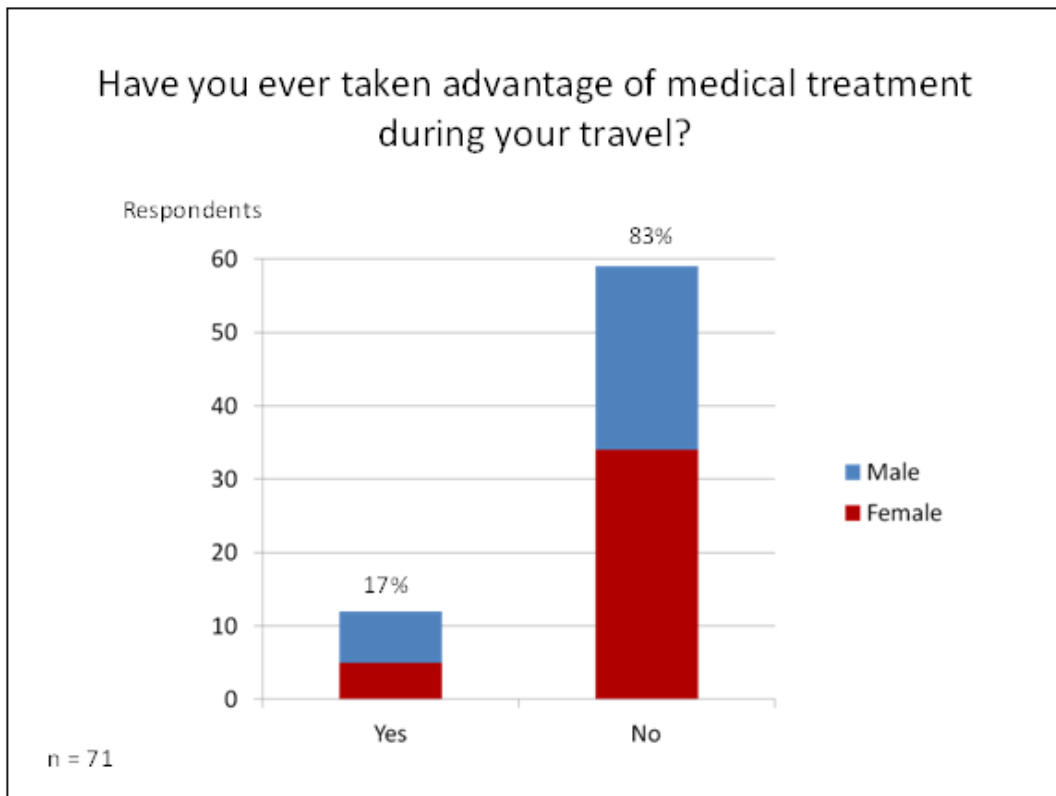


Figure 15: Question Nr.5- Have you ever taken advantage of medical treatment during your travel?

As figure 15 shows, the significant majority of the respondents have never taken advantage of medical treatment during their travel (83 %), neither females nor males.

Only 17 % of the respondents have taken medical treatment during their stay abroad whereby almost two thirds of the 17 % are male.

The reasons for medical treatment while traveling differentiate from each other, as seen in figure 16. Hence, there are three main categories such as the decision for a treatment was made in the tourism destination, illness and accident.

57 % of the respondents answered with illness for the reason of their medical treatment abroad and 36 % had an accident in the destination. The remaining 7 % decided having a treatment while they already have been in the tourism destination whereby particularly dental care, ear cleaning and back massage was mentioned by the respondents.

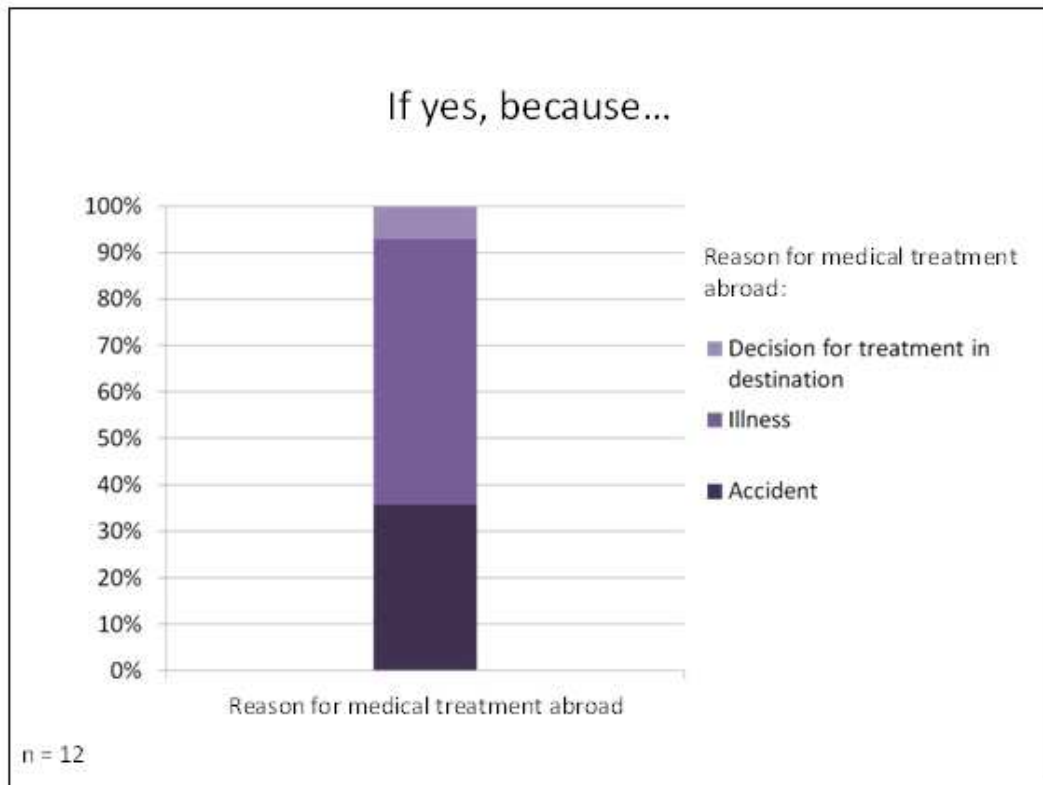


Figure 16: Question Nr.5- If yes, because?

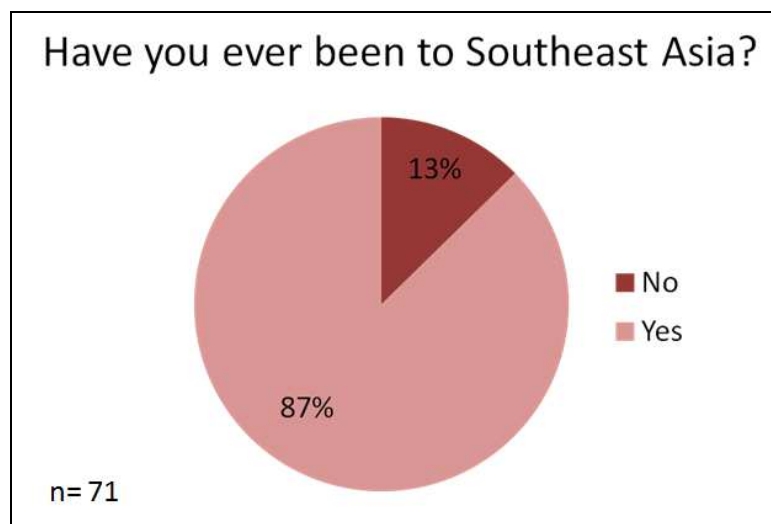


Figure 17: Question Nr.4- Have you ever been to Southeast Asia?

The majority of the respondents have already been to Southeast Asia, only 13 % of the respondents have not been to the region at all (see figure 17). This result is especially concerning further questions a perfect starting point as about 87 % of the respondents have visited the region and therefore know at least one Southeast Asian country because of their own experiences.

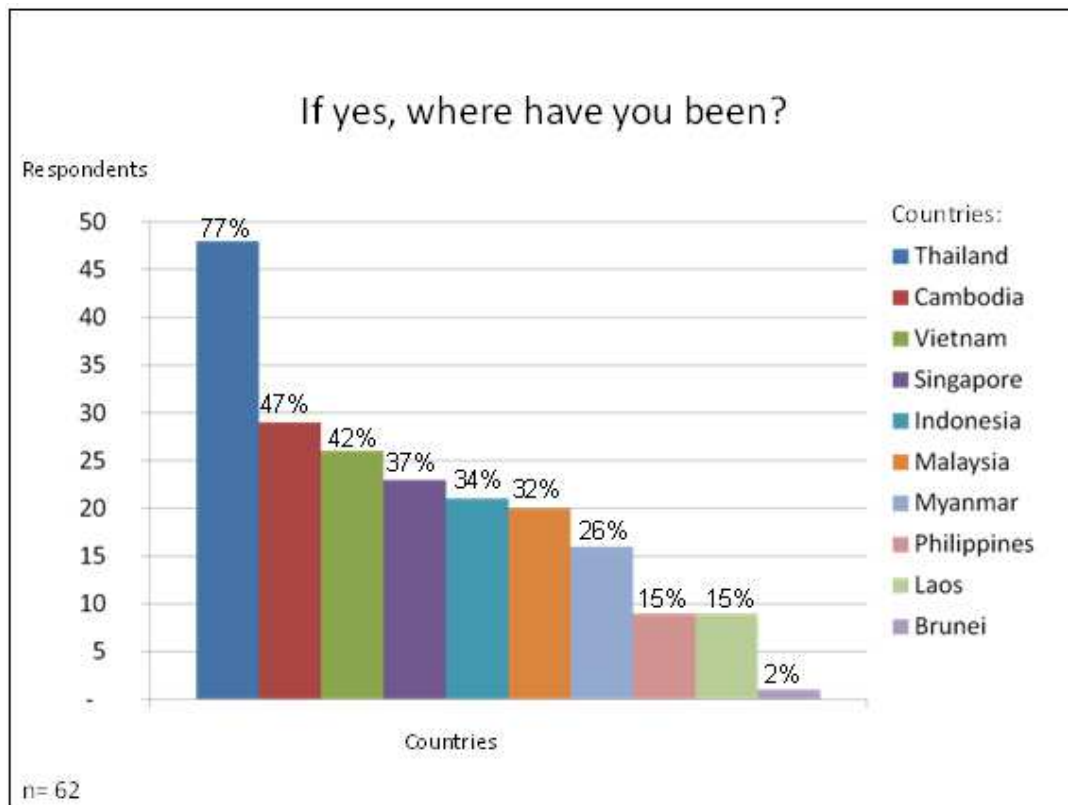


Figure 18: Question Nr.4- If yes, where have you been?

Figure 18 shows, the majority of the respondents have already been to Thailand with approximately 77%. An explanation could be the frequent flight connection between Austria, in particular Vienna, and Bangkok as well as the good working tourism industry promoting Thailand already for years. But also other countries like Cambodia (47%) and Vietnam (42%) are starting to become more attractive for the respondents followed by Singapore (37%), Indonesia (34%) and Malaysia (32%). An expanding tourism infrastructure in these countries could be a reason for the emerging tourism flow. Also Myanmar (26%) is on the list of the countries which have been already visited by a representative number of respondents.

The Philippines (15%) and Laos (15%) are compared to the other countries less visited by tourist. Brunei has been visited by only 2% of the respondents and East Timor did not appear on the list at all, probably because of the fragile political situation which made travelling to the country more difficult and less attractive for tourists.

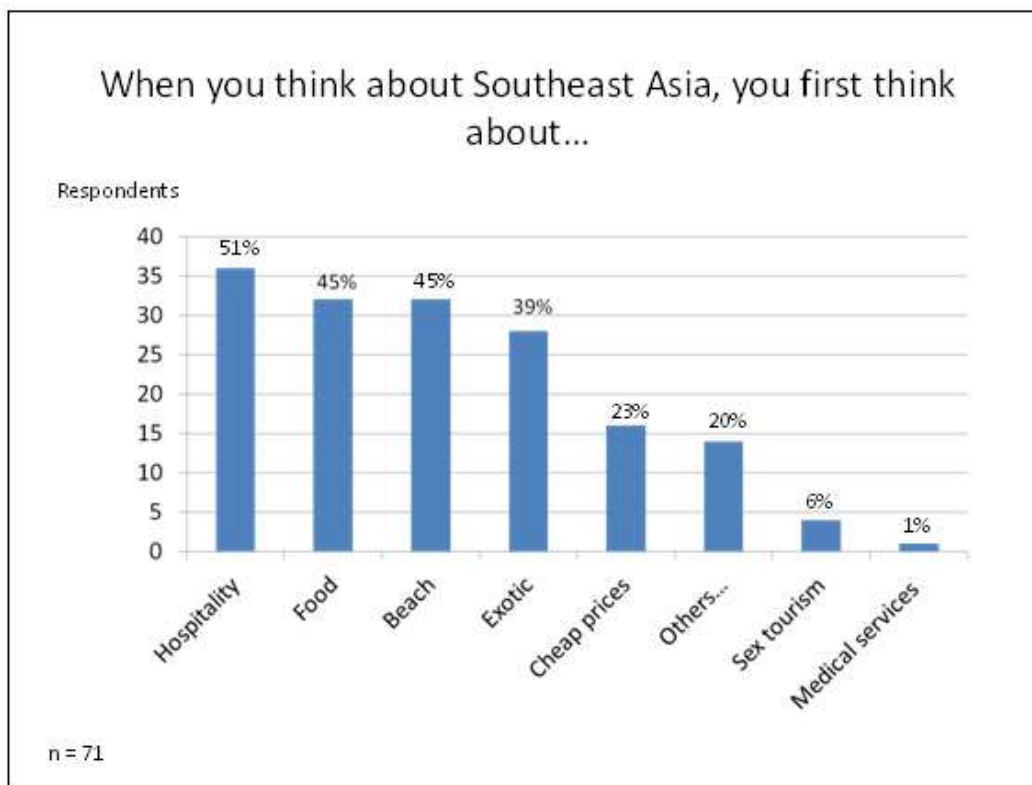


Figure 19: Question Nr.3- When you think about Southeast Asia, do you first think about?

To find out more about the general attitude of the respondents about Southeast Asia they should complete the sentence what first comes to their mind when thinking about the region (Figure 19). The questionnaires gave the respondents the opportunity either to choose one or more given answers and/or others, whereby the respondents could add something else.

Approximately 51% of the respondents think about hospitality considering Southeast Asia, followed by food and beach with 45%. Also exotic are thoughts which come to the respondents mind immediately when thinking about Southeast Asia with 39%. 23% of the respondents think of cheap prices.

Also 20% of the respondents chose the option others which implied subjects such as landscape, culture, holiday, temple, mentality, geographical conditions, soups, massage, sightseeing, foreign culture, foreign people, street food, humidity, Tuk-Tuk, Buddha, Buddhism and authoritarian regime.

Approximately 6% of the respondents chose sex tourism when thinking of Southeast Asia and only 1% of the respondents think of medical services in combination with the region.

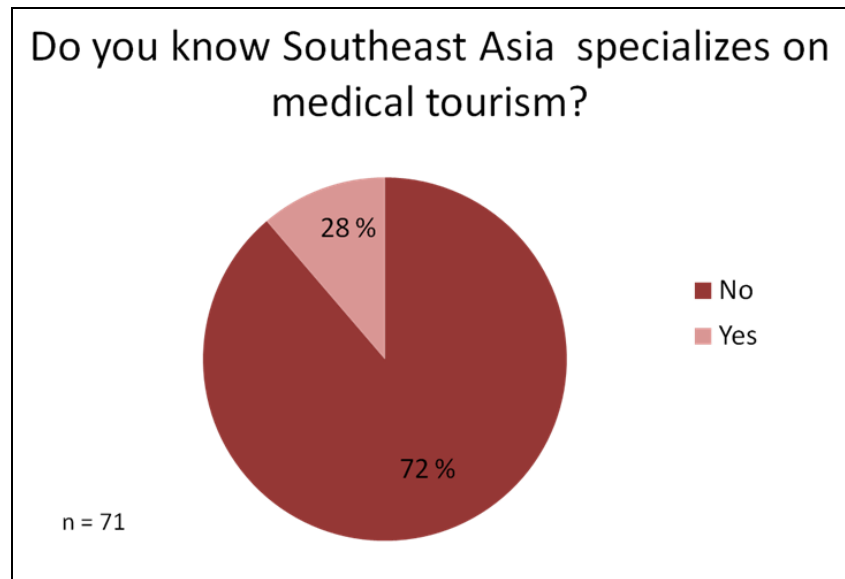


Figure 20: Question Nr. 6- Do you know Southeast Asia specializes on medical tourism?

About 72 % of the respondents do not know Southeast Asia specializes on medical tourism (Figure 20). However almost 28 % already heard about medical tourism in the region and thus it is assumed they know about the extension of this tourism niche, which is an interesting result considering the general attitude about Southeast Asia where no respondent thought about medical services at all.

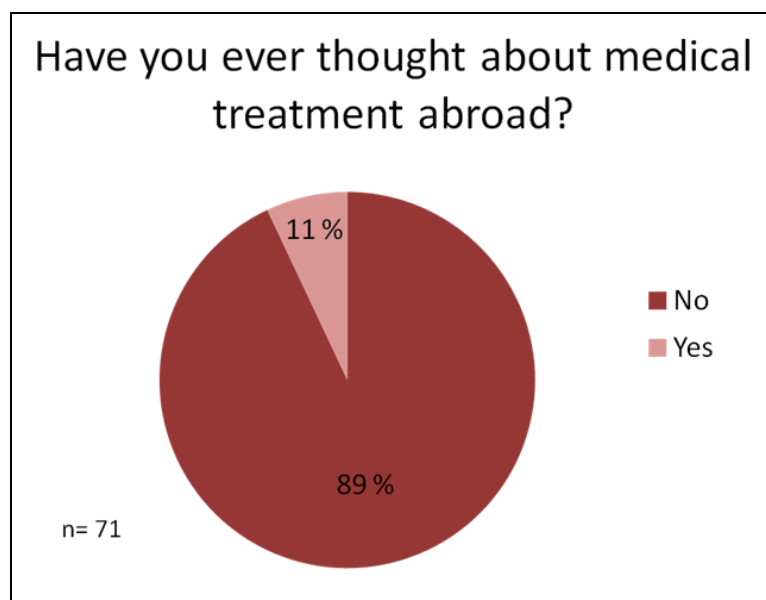


Figure 21: Question Nr. 8- Have you ever thought about medical treatment abroad?

A significant number of the respondents have never thought about medical treatment abroad (89 %). 11 % have thought about the option of a medical treatment in a foreign country (Figure 21).

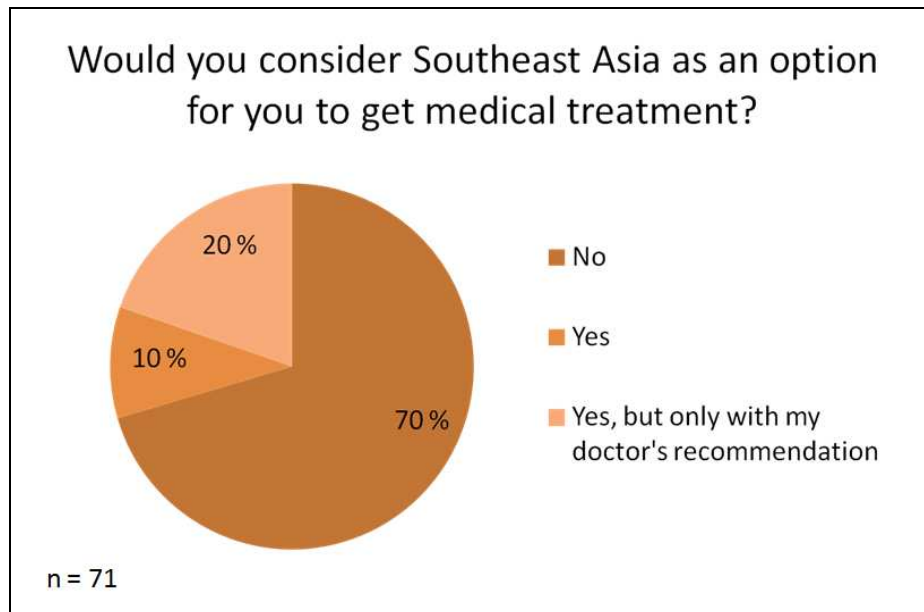


Figure 22: Question Nr. 9- Would you consider Southeast Asia as an option for you to get medical treatment?

Under consideration of medical tourism as a combination of leisure activities of the traditional tourism sector, like sightseeing, shopping, swimming, wellness programs etc., and serious medical treatments, only 10 % of the respondents would choose a Southeast Asian country as a destination for treatment abroad (Figure 22).

From the current point of view, the majority of 70 % would never choose Southeast Asia as a destination for medical treatment. Especially with a view on figure 21 the result is not surprising as apparently a general tendency against medical treatments abroad is given.

Anyhow 20 % would consider Southeast Asia as an option to get medical treatment but only with their doctor's recommendation. Thus, examples like the United Kingdom or Singapore where doctors and governments recommend affordable treatment abroad could be possible future scenarios also in Austria.

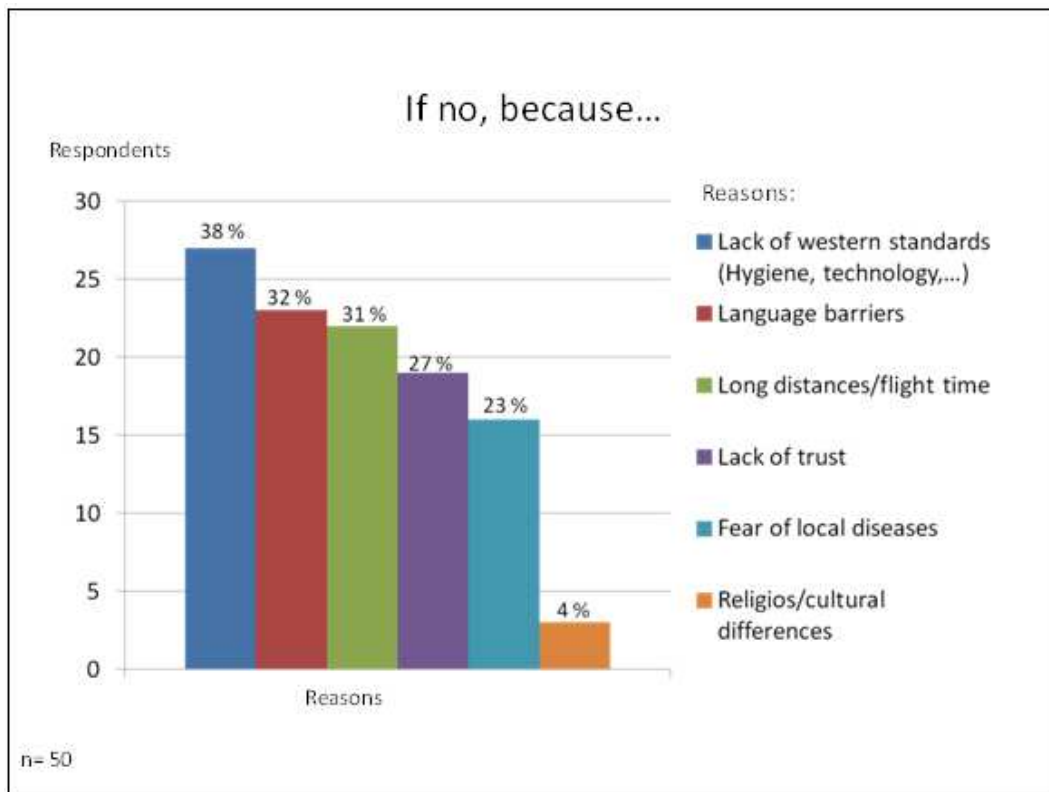


Figure 23: Question Nr. 9- If no, because ?

If the answer for the question, would you consider Southeast Asia as an option for you to get medical treatment was no, the respondents could choose for a possible reason why (Figure 23). Hence 38% are worrying about a lack of western standards such as for example hygiene and technology. For 32% of the respondents the reasons not to consider Southeast Asia as a treatment destination are language barriers especially concerning medical and surgical procedures. The long flight times as well as the distance between Austria and Southeast Asia is for 31 % a reason to reject a treatment in the region. There is also a lack of trust for about 27% of the respondents especially in regard to the medical staff and health workers and their skills, education or experiences. 23% are afraid of local diseases in Southeast Asia and only 4% think about religious or cultural differences as a reason to avoid travelling for medical treatment in a Southeast Asian country.

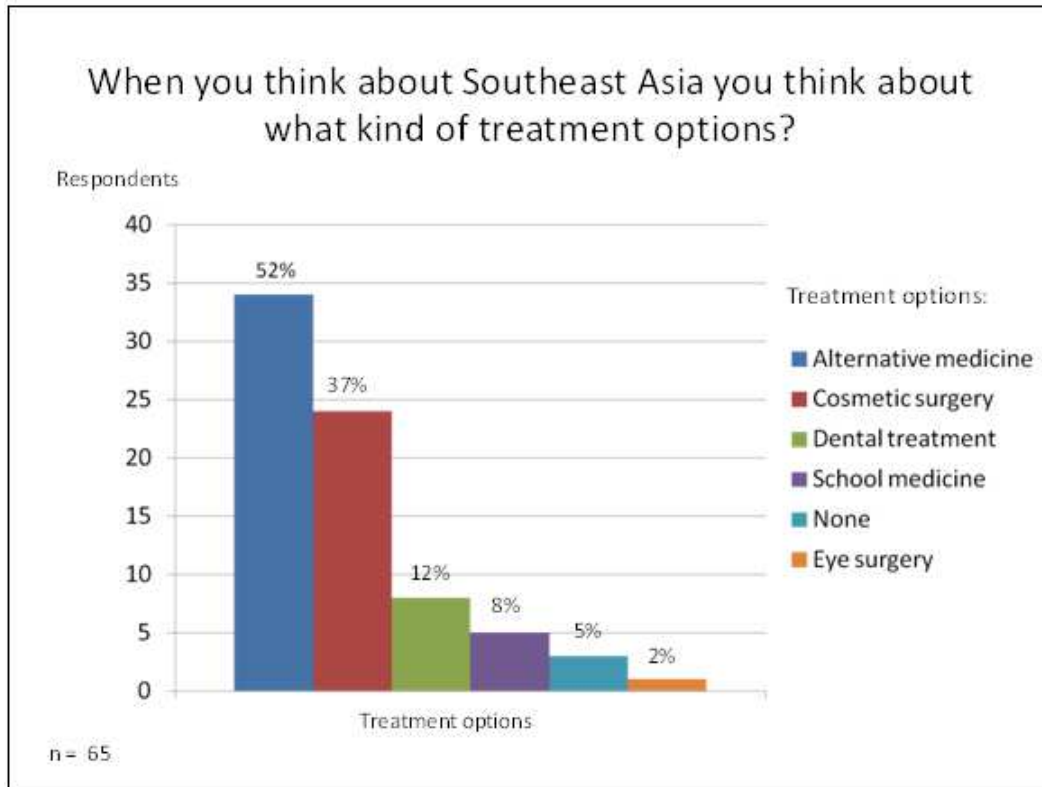


Figure 24: Question Nr. 7- When you think about Southeast Asia you think about what kind of treatment options?

By answering the question about what treatment they think in combination with the region, the attitude and existing knowledge about Southeast Asian treatment options should be highlighted.

Thus, figure 24 shows, 52% of the respondents think of alternative medicine which can be seen as the majority, followed by cosmetic surgery chosen by 37% of the respondents. There should be considered, no explanation was given for the term alternative medicine, hence this could include all alternatives to the variety of treatment options of the home country, spiritual processes, nature based medicine, homeopathy, or something else.

Dental treatment is a treatment option 12% of the respondents think about in combination with Southeast Asia, and school medicine only 8%. 2% of the respondents named eye surgery when answering the question, while 5% of them think of no treatment at all.

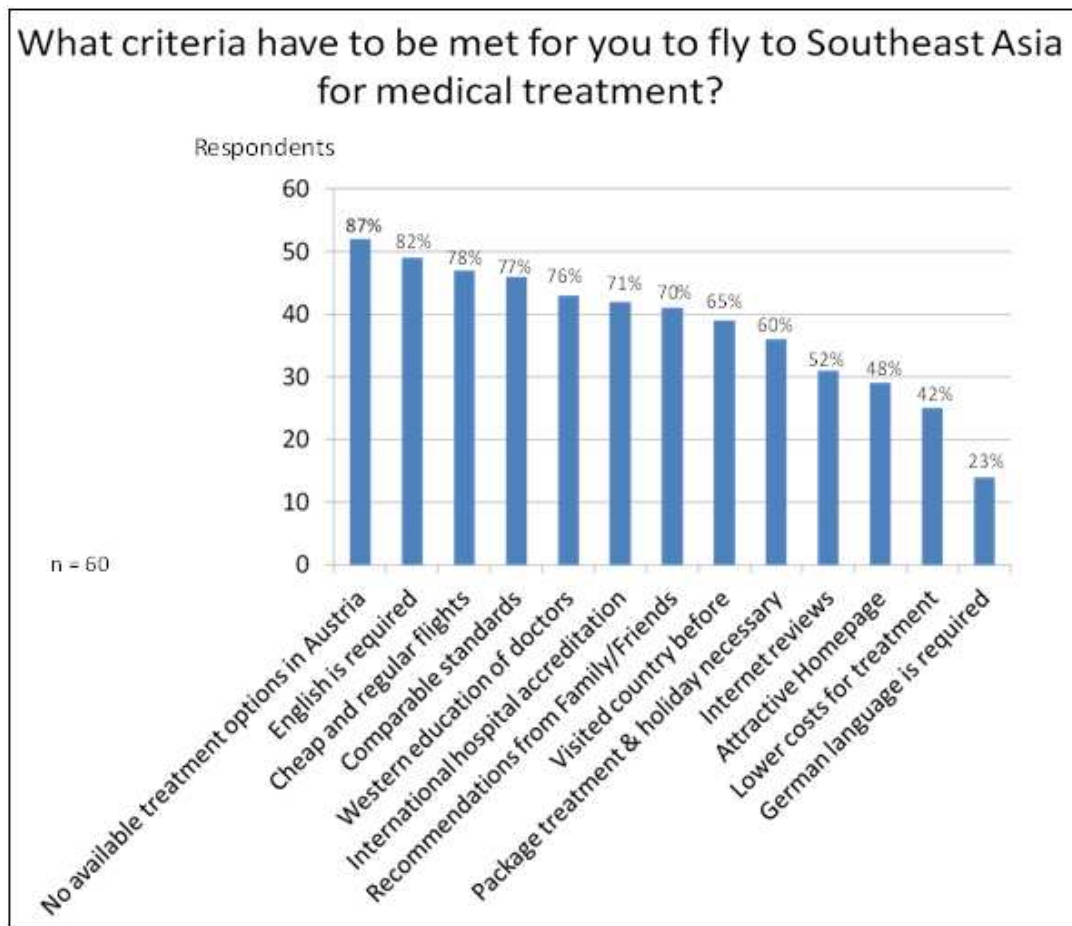


Figure 25: Question Nr.10- What criteria have to be met for you to fly to Southeast Asia for medical treatment

The criteria have to be met to travel to Southeast Asia for medical treatment, are distinguished in 13 categories (Figure 25). The category no available treatment options in Austria can be seen as the main factor for a decision to fly in the region as several respondents (87%) emphasized the perfectly working Austrian health system and therefore there is no need to go abroad for healthcare issues. Thus, only if the health system reduces its range of services the willingness to travel would probably increase.

Another important aspect is the language whereby at least English is required (82%) as especially concerning medical treatments of all variations, detailed explanations and descriptions about the treatment processes are necessary and desirable. Moreover English as a universal language dominates also in the generations 50 +.

Comparable standards with European hospitals and treatment processes are with 77% one of the four most important factors going to Southeast Asia for medical treatment, whereby also cheap and regular flights (78%) can be seen as crucial for the decision making process.

International accreditation of hospitals is also very desirable for the respondents (71%) as well as recommendations of friends and family (70%) about medical treatments in a Southeast

Asian country. Required is as well western education of doctors which implies traditional school medicine (76%).

The option for a medical tourism package where tourism activities are combined with a medical treatment would be a serious criteria in the decision making process to fly to Southeast Asia as 60% of the respondents show.

The country should be visited before by at least 65% of the respondents, therefore also this category is important to be considered.

Internet reviews would not play a major role for the decision going to Southeast Asia for medical treatment, but it can still be seen as an information source for 52% of the respondents. The preparation and attractiveness of the homepage of hospitals or other health related facilities is even less important as criteria going abroad for treatment, but anyhow a representative percentage of 48% see it as a relevant factor which should be considered in the decision making process.

The lower costs for treatments are not as important as comparable standards, probably because of the existing health system in Austria, but still for 42% of the respondents it is a criterion to even go abroad for medical services.

German as a spoken language in these facilities or hospitals is not a main request; only 23% of the respondents would see this language skill as a necessary condition to fly to Southeast Asia for treatment.

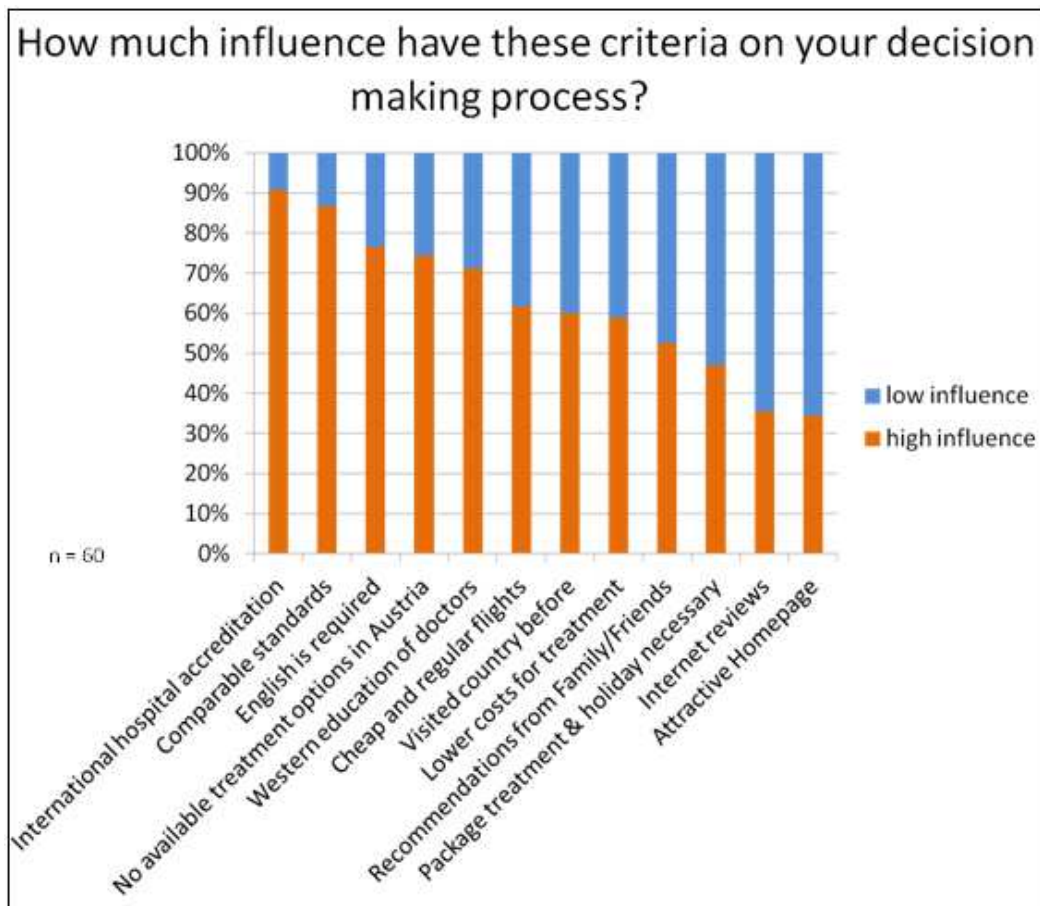


Figure 26: Question Nr. 10- How much influence have these criteria on your decision making process?

Considering the influence of these criteria (Figure 26) it is noticeable that an existing international hospital accreditation would have a high influence on the decision making process of the respondents as 90 % have indicated. This further links to the comparable standards which also can be seen as a crucial condition for deciding to go for medical services abroad, thus approximately 88 % gave this criterion a high influence.

More than 70 % of the respondents have indicated that the criteria English as a language, no available treatment options in Austria as well as a western education of doctors would have a high influence on their decision to fly to Southeast Asia for treatment.

Cheap and regular flights, lower costs for treatment and visited the country before are with about 60 % high influence conditions which still have to be considered as determining factors for the respondents.

A medical treatment combined with a holiday has more than 50 % of low influence thus less of the respondents see the medical/holiday package as crucial for their decision making process. Approximately the same holds for the recommendations of family and friends.

Internet reviews and an attractive homepage have even less influence, more than 60 % of the respondents have indicated less influence for these criteria.

6 Conclusion

6.1 Research-based Evaluation and Interpretation

This section of the thesis deals with answering the research questions and either verifies or falsifies the hypothesis. Considering the theoretical background which was built by detailed literature analysis and the results of the questionnaires the processing and interpretation of the research outcomes should be ensured.

The formulated research questions and hypothesis are cited again to answer them with the support of the already gained research contents.

6.1.1 Subordinate Research Questions and Hypothesis

Research question 1: What challenges are related to medical tourism and to what extent does it influence the local providers in the health sector?

Seeking medical treatment abroad is not a new phenomenon but the rapid growth and development of medical travel are recent. Health care reforms in developed economies influence the medical tourism and travel manners (HELBLER 2010). “Medical travel is challenging our traditional ways of thinking about public health” (ibid.).

It is not only the increasing medical tourism but also the fact that medical care continues to be privatized. The results are increasing costs for the local population as well as a decreasing quality of medical staff and treatments.

The demand for overseas surgeries continues to expand therefore also the demand for overseas services. Additionally western insurance companies encourage overseas treatment to reduce costs (cf. CONNELL 2006, 1099).

Hypothesis 1.1: As a consequence of the trade & buying of services as well as the global commodification of health issues, medical tourism tends to be health-off the shelf for a select number of people.

The rapid growth in the medical tourism sector has shown that the provision of healthcare is starting to be globalized as many other service activities. The improvement of technology, the emergence of private enterprises as well as “the attitude that health care can be bought ‘off the shelf’” (CONNELL 2006, 1099f) are the main reasons for the growing demand of medical treatment overseas (ibid).

Furthermore, as Rubio (2004) reveals, health and healthcare are considered as consumable products which can be purchased like any other goods and services. Hence, especially money and market are significant and determining factors influencing the health sector with its entire medical and health related treatments and services (cf. RUBIO 2004, 245f). Timmermans and Almeling (2009) assume the dehumanization and moreover objectification of human bodies results in disproportions of quality, availability and accessibility to healthcare (cf. TIMMERMANS/ ALMELING 2009, 24f).

Another important aspect is the marketization and particularly the trend to consumer-oriented healthcare. Tonkens (2013) argues it changes the handling and attitude of health as there are strong connections to the economic sector which further directs to deal health as a commodity.

Accordingly, the commodification of health issues, especially the consumer-oriented healthcare which implies health to be purchased and consumed like any other goods as well as the increasing privatization of the health sector lead to the consequence medical treatments are available off the shelf for those who can afford it. (cf. TONKENS et al 2013, 369f; WILDES 1999, 307f).

Hypothesis 1.2: The foreigner-oriented medical business causes brain drain and “quality tourism” which provokes an expanding gap between foreigner and local clientele.

The number of countries developing a medical tourism sector is growing rapidly. Especially Asia has shown success in this niche of tourism and has triggered a global interest as well as competition in medical tourism.

The medical market is focused on the high-end tourism. There is a rise of the private health sector in the medical tourism destinations, regarding to the economic benefits from employment in this sector (cf. CONNELL 2006, 1099). On the other hand the “[e]xpansion of the private sector may be at some cost to the public sector, where patients have very limited ability to pay, if skilled health workers move out of that sector” (ibid).

Moreover Connell (2013) notes, the increasing privatization of health care systems due to the medical tourism industry lead to budget cuts in public health expenditures (cf. CONNELL 2013, 10). This causes imbalances, as Sheldon and Bushell (2009) argue, because financial resources intended for the national healthcare system become redistributed and target primarily projects and services particularly designed for tourists and wealthy people while

some local people have no access to health facilities at all (cf. SHELDON/ BUSHELL 2009, 215f). Additionally Hopkins et al (2010) claims, high-quality medical care benefits only financially secure medical tourists (cf. HOPKINS et al 2010, 193f).

Consequently, an expanding gap between foreign and local clientele is noticeable as “quality” especially in regard to health is strongly connected to the willingness and much more the ability to pay for it.

Furthermore, as Hopkins et al (2010) has already stated, attracted by private providers offering higher wages and better working conditions, medical practitioners move from the public to the private sector, hence medical tourism causes brain drain, in particular internal brain drain. Unfilled public health systems and financial burden to the public are results of these internal movements. Especially because highly skilled health workers prefer working in the private sector, mainly wealthy and/or foreign patients who can afford private treatments benefit from their skills. This results in increasing prices for primary and preventative care for locals and slows improvements of the public health services due to the developing medical tourism industry in the private sector. (cf. HOPKINS et al 2010, 193f).

Hypothesis 1.3: Medical tourism causes internal brain drain but at the same time it provokes an increasing return of highly skilled people in their home countries which further leads to an uplift of a country’s general medicine level.

As mentioned above as well as by Snyder and Fraser (2014), due to high paying jobs and attractive working conditions, the flow of highly skilled health workers from the public to the private sector is increasing. Moreover the movement of these workers implies also the decrease of health personal in rural areas. Thus, it could be said, medical tourism worsens the access to health facilities and healthcare actively (cf. SNYDER et al 2014, 1f).

On the other side, Sheldon and Bushell (2009) claim, residents can benefit too from the medical tourism industry, as advances in medical knowledge and capabilities enrich the local medical community and therefore also the health system (cf. SHELDON/ BUSHELL 2009, 215f).

Medical tourism also reduces the outflow of professionals to developed countries. The international brain drain challenged especially the labor-sending countries as they lost their highly skilled health workers for their own market. Chen and Flood (2013) found out, since the emergence of medical tourism the return rate of health professionals working abroad increased significant (cf. CHEN/ FLOOD 2013, 293f).

Probably the higher wages the medical tourism industry implies, lead to fewer traditional brain drains as this factor used to be the main motive for high-educated people to move, especially in developing countries, where many of the highly skilled people migrate overseas (cf. CONNELL 2006, 1099).

As the research outcome shows, medical tourism causes internal brain drain due to an increasing privatization of the health industry. Nurses and doctors prefer working in the private sector which leads to a decrease in the public sector and especially effects vulnerable local people who cannot afford private healthcare.

But then again medical tourism attracts highly skilled people to return to their countries of origin as it opens new perspectives to work in the health sector. Furthermore, due to the advanced technologies and medical knowledge of the returning health workers the local medical community gains but as health related facilities are highly privatized it is not clear if the general medicine level of a country lifts up or only the private foreigner oriented health sector.

Research question 2: Which country-conditions are crucial to attract medical tourists?

Connell (2013) found out, income culture and language are determining factors for the patient's choice of a destination for medical treatment (cf. CONNELL 2013, 5, 8). But also regulatory and economic conditions are crucial elements for potential patients to choose a destination for medical procedures since they show the development status of a country, which implies a certain infrastructure in all fields. The authors Heung, Kucukusta and Song (2011) showed, supply and demand are main characteristics of the medical tourism model, as they are the core factors to drive the industry (cf. HEUNG/ KUCUKUSTA/ SONG 2011, 996f).

Hypothesis 2.1: Westernized environment is a crucial condition to attract people from developed countries to seek for medical treatment in a certain destination.

Medical tourists tend to choose an environment similar to their home country, at least considering culture, behavior and communication, so Connell (2013). Hence, the medical tourism destinations started to highlight these requirements by adjusting their health facilities to industrialized standards which can be proofed via international accreditation systems and

certificates. But also languages, cultural and religious trainings for the local health staff are strategies to attract potential medical tourists (cf. CONNELL 2013, 5, 8).

Considering the results of the questionnaires, particularly the criteria of international hospital accreditation to measure a certain standard turned out to be one of the main factors for the decision making process to seek medical treatment abroad. Also comparable standards of health facilities, western education of doctors and language skills, in this case at least English, are crucial for the respondents which further links to the assumption, a certain environment is desired by potential patients.

Consequently, the environment in the medical tourism destination plays an important role. The research showed, dependent on the treatment specializations and the target groups of the medical destinations the medical tourism environment gets adjusted.

Thus, in the case of the questionnaires the hypothesis can be verified as from an Austrian perspective a westernized environment is for the majority of the respondents desirable and therefore a crucial condition to seek for treatment abroad.

Considering medical tourism as a global phenomenon a certain environment is a necessary criteria to attract potential patients but it cannot be reduced to only westernized characteristics.

Research question 3: How and to what extent does the country's reputation influence the patient's choice as a medical tourism destination?

The reputation of a country can change immediately as regions and facilities are dependent from notes by professionals especially of developed nations. Connell (2013) claims further, since the increase of the medical tourism sector these opinions and statements of professionals from the health and governmental sector developed primarily into positive testimonials.

The medical tourism destinations focus on specific segments to highlight their specialization and moreover the quality of treatments they offer, whereby the media and particularly the internet are useful instruments for information distribution and therefore for their reputation (cf. CONNELL 2013, 9f).

Another important role for a country's reputation plays also the word-of-mouth communication since it is responsible for an information flow; the common form is the informal and personal communication. Yeoh, Othman and Ahmad (2013) showed this form of

communication can have positive as well as negative effects due to the interconnections and typically close relationships between the communicating people (cf. YEOH/ OTHMAN/ AHMAD 2013, 197).

Hypothesis 3.1: A country's reputation influences the decision making process for medical travel more than the (affordable) price for the treatment.

The country's reputation contains as well personal attitudes built by opinions and stories heard, read or experienced. The questionnaires focused on the stereotypes about Southeast Asia, and resulted mainly in hospitality as a typical character in the respondents' minds for the region. Seeking for medical treatment abroad makes most of the people feel unsecure, thus probably a friendly environment could have a positive effect on the decision making process. Considering prices and costs the results show that the general cheap prices of a country are not as important for the respondents, rather people welcome low living costs when arriving in a destination. Concerning medical treatment costs the price criterion exists but is located in the latter third of the scale of influencing criteria.

The attitude of the Austrian respondents when thinking about medical tourism in Southeast Asia resulted in 72 % who would, from the current point of view, never choose the region for medical treatment whereby only 7 % would ever think about medical treatment abroad. Thus, there is a significant tendency against medical treatment in a foreign country noticeable.

Hence, considering the results of the questionnaires, it is not only a country's reputation but also the attitude of medical tourism in general which is finally deciding.

Of course the economical and regulatory condition of a country, certain media reports as well as word-of-mouth influences the opinion of a person. Furthermore the starting point of the seeking person is relevant as people without existing health systems in their own countries have a different attitude and focus on determining factors as for example Austrians.

Hypothesis 3.2: The people's unawareness of the range, quality and affordable costs of medical services in Southeast Asia affects their judgments and estimations for medical travels.

Heung, Kucukusta and Song (2011) argue costs, healthcare and expertise are main factors for medical travel (cf. HEUNG/ KUCUKUSTA/ SONG 2011, 996). Thus, especially taking the questionnaires into account the results show, the existing healthcare system in Austria never forced people to seek for treatment abroad, therefore the general attitude as mentioned above,

tend to be negative. Furthermore this could be seen as the reason for a certain unawareness of options and possibilities of medical treatments in for example a region like Southeast Asia. The absolute majority of the respondents think of alternative medicine concerning Southeast Asian countries, followed by cosmetic surgeries. Thus, it seems as medical services in Southeast Asia have not the same personal ranking as in the home country of the respondents and therefore a lack of trust in overseas treatments exists.

Additionally the criteria have to be met for flying to Southeast Asia include primarily comparable standards of health facilities and practices as well as international accreditation to measure these standards. Some of the respondents even mentioned these accreditation commissions namely; however a certain awareness of existing instruments to measure quality is given whereby the awareness of the range of medical services in Southeast Asia seems to be limited.

This is of course different for people, e.g. coming from the United States, seeking for medical treatment abroad because of a weak or not existing health system. These people are aware of particularly the costs but also the range and quality of treatments as most of the international accreditation commissions and private health insurance companies have their origin in North America. Life saving medical treatment abroad gets promoted very well while in Austria these circumstances are not conceivable at this point. Even though dental or eye care are only partly covered by the national health system, the preference for medical treatments in this field would be probably a neighboring country like Hungary instead of an oversea flight to Southeast Asia.

Considering the hypothesis, the fact of an existing health system in Austria makes it difficult to find out more about the respondents' expectations about medical travel as most of the interviewed people at the age of 50+ do not even think of treatments overseas. Under this aspect the unawareness of costs, range and quality of medical services in Southeast Asia exists due to the negative trend concerning medical treatment abroad in general, which further affects the judgments for medical travel.

6.1.2 Main Research Question

What makes Southeast Asia attractive as a medical tourism destination and which factors influence the willingness for medical travel in this region?

To answer the main research question the focus was set on the subordinate questions and hypothesis which serve the necessary contents and results for further presumptions.

Hence, the research concentrated primarily on medical tourism and health related issues in Southeast Asia. Therefore the research outcomes result in Southeast Asia as an increasing tourism destination with a growing service sector. Especially the economic growth due to the industrialization and moreover the financial Asian crisis led the region start to develop a high quality tourism industry which also highlights traditional tourism components like, fascinating nature, architecture, exotic, cultural diversity, and many more.

In a next step, Southeast Asia concentrated on the emerging medical tourism sector which developed into a lucrative business due to the changing circumstances of patients coming from developed nations and seek for medical treatment in developing countries. Reasons for these changes are demographic aging which stresses national health systems of particularly developed nations. Further a considerable part of the affluent middle class is at the age of 50 and older, which implies an increasing need for medical services and the willingness to pay and travel there for. Accordingly, people start travelling to foreign countries to receive healthcare.

Southeast Asia used this window of opportunity to position itself in the competitive market and developed an attractive medical tourism landscape. Particularly Thailand, Malaysia and Singapore emerged as the main medical tourism hubs in the region as they provide a wide range of treatment options at high international standards. Therefore specific international accreditation systems help to measure these standards which also help to attract potential international patients.

Due to the treatment specializations of certain medical tourism destinations also the health workers are highly skilled in their fields; furthermore they often gained experience in developed nations and returned into the private sector of their country of origin. This emphasizes the state of the art in the medical tourism sector.

Thus, the main conditions influencing the willingness going to Southeast Asia for medical treatment are already mentioned as they are comparable standards of health facilities and services to the patient's country. Another important factor is the lack of available treatment

options in the home country, in this case Austria, which would have a crucial influence choosing a foreign country for medical treatment. As Southeast Asian countries respond to the demands of their target group of the medical tourism sector, they promote their specializations in specific treatments which are usually one of those are not available or affordable in the patient's home country, this implies complex treatments as well as simple check-ups.

Southeast Asia can offer nature given components which attract tourists like beaches, landscapes and of course warm temperatures. Additionally the region improved its tourism industry, and particularly considering medical tourism lifted up standards and treatment options. As the environment in the medical tourism destination plays a significant role these factors are crucial to attract potential patients. Most of the Southeast Asian countries are economical and political stabile; provide an expanded infrastructure and highlight cultural needs, language or religion of the patients.

6.2 Resumé

Medical tourism is a fast growing industry on a global scale consisting of people who are willing to finance their own medical treatment abroad. The occurrence of the steadily increasing demand for specific health services is going to turn into a global issue.

Interconnections in almost all fields are main characteristics of temporary globalization, thus also healthcare is part of this process. Due to the shifting perception of health, particularly the view of health and healthcare as a commodity and not as a human right, the impacts on access and availability of health related services increases. Moreover the commodification of health results in inequalities as due to the growing privatization of the healthcare industry, which leads to an exclusion of certain population groups, especially the vulnerable poorest people get harmed by denied access to healthcare.

The emergence of today's medical tourism can be seen as a consequence of the changing circumstances caused by the demographic aging of the world population. The public health systems of particularly developed nations start to get stressed by the older people's requirements, especially concerning health related services. Hence, people start to travel to satisfy their medical needs abroad.

The increasing number of medical tourists seeking for treatment overseas can be seen as a driver for economic growth in the treatment destination but it also challenges the health system as the focus is set on specific sophisticated medical processes which primarily target wealthy tourists. This reduces the public expenditures for healthcare as the expansion of the private health sector is particularly favored by governments to attract potential patients which furthermore help to position a country in the medical tourism niche of the competitive market.

It is not only the economic component which has to be taken into account but also the individual view of a patient seeking for treatment overseas. Possible risks as well as ethical balancing acts are stress factors for medical tourists, especially under consideration of the terminological issues connected with the phrase medical tourism. Consequently, there are several factors influencing the medical travel as well as the decision making process of patients seeking for treatment in a foreign country. Particularly highlighted by the questionnaires outcome is the environment, such as comparable standards of medical services and facilities, as a crucial condition for the destination of treatment. This leads to the assumption that not necessarily touristic elements are required rather familiar cultural and medical standards. Medical tourism often involves an unsecure character for the traveler as a stay in a hospital because of a surgery presupposes trust in doctors, services and facilities provided by a destination.

Especially in Southeast Asia medical tourism emerged as a niche industry which offers new possibilities. Thus, it reduces the traditional brain drain, moreover highly skilled health workers even return to their home countries to work there as specialists in the private sector. The internal brain drain caused by the medical tourism industry is a new challenge the region has to face as particularly the rural areas are affected by the internal movements of health workers to urban places.

Nevertheless medical tourism can be seen as an appropriate solution for the issue of the aging population, the increasing income gap as well as the emerging two tier health systems. Even though it has an effect on local populations such as increasing prices or decreasing access to medical treatments, it can also result in increasing incomes for the local staff and higher employment rates in the health as well as tourism sector, which further leads to benefits for the economy, the driver for growth and development in the existing world system.

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8 Appendix

8.1 Questionnaire

1. Geschlecht: männlich weiblich

2. Alter: unter 50 50-59 60-69 70-79 80+

3. Wenn Sie an Südostasien denken, denken Sie zuerst an

- Gastfreundschaft
- Sextourismus
- Günstige Preise
- Medizinische Dienstleistungen
- Essen
- Strand
- Exotik
- Anderes...

4. Haben Sie Südostasien schon mal bereist?

Ja Nein

Wenn ja, in welchem/n südostasiatischem/n Land/Ländern waren Sie?
(mehrfaches Ankreuzen möglich)

<input type="checkbox"/> Malaysia	<input type="checkbox"/> Philippinen
<input type="checkbox"/> Singapur	<input type="checkbox"/> Laos
<input type="checkbox"/> Thailand	<input type="checkbox"/> Myanmar
<input type="checkbox"/> Indonesien	<input type="checkbox"/> Brunei
<input type="checkbox"/> Vietnam	<input type="checkbox"/> Kambodscha
<input type="checkbox"/> Osttimor	<input type="checkbox"/> Anderes...

5. Haben Sie im Zuge einer ihrer Reisen medizinische Dienstleistungen angenommen?

Ja Nein

Wenn ja, weil

- Unfall
- plötzliche Krankheit
- geplante Reise, um Behandlung in Anspruch zu nehmen
- Anderes...

Medizintourismus:

Als Medizintourismus wird eine Kombination aus Gesundheits- und Tourismusindustrie verstanden. MedizintouristInnen sind Personen, die aus medizinischen Gründen ins Ausland verreisen (inkl. Nächtigung und Aufenthalt) um dort medizinische Behandlungen jeglicher Art in Anspruch zu nehmen. Schließlich werden diese medizinischen Aufenthalte mit touristischen Aktivitäten verbunden, wie etwa Sightseeing, Badeurlaub, Shopping etc., die von den PatientInnen und/oder deren Begleitung in Anspruch genommen werden.

6. Wissen Sie, dass sich Südostasien immer mehr auf Medizintourismus spezialisiert?

- Ja Nein

7. An welche medizinische Behandlung denken Sie in Verbindung mit Südostasien?

- Schulmedizin
 Alternativmedizin
 Vorsorgeuntersuchung (Check-up)
 Kosmetische Behandlung
 Zahnbehandlung
 Keine
 Anderes...
-
-

8. Haben Sie schon einmal darüber nachgedacht sich im Ausland behandeln zu lassen?

- Ja Nein

9. Unter Berücksichtigung des Konzepts von Medizintourismus, wäre Südostasien eine Option für Sie, um sich medizinisch behandeln zu lassen?

- Ja
 Ja, aber nur mit Empfehlung meines Arztes
 Anderes...
-
-

Nein

- Wenn nein, weil...
- Vertrauen zu den Ärzten fehlt (Fähigkeiten, Ausbildung, Erfahrungen,...)
 - Angst vor lokalen Krankheiten
 - Sprachbarrieren
 - westliche Standards könnten fehlen (Sauberkeit, Hygiene, Technik, Prozeduren,...)
 - lange Flugzeiten/ zu große Distanz
 - religiöse und/oder kulturelle Unterschiede
 - Anderes...
-
-

10. Welche Voraussetzungen muss(t)en erfüllt sein, damit Sie nach Südostasien (SOA) für eine medizinische Behandlung fliegen?

Wesentlich günstigere Preise für die Behandlungen

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

Vergleichbare Standards wie im Heimatland

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

International anerkannte Akkreditierung des Spitals muss vorhanden sein

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

Westliche Ausbildung der behandelnden Ärzte

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

- Keine vergleichbare verfügbare Behandlungsoption im Heimatland

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

- Deutsch muss auf jeden Fall gesprochen werden

- Zumindest Englisch muss gesprochen werden

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

- Attraktive, ansprechende Homepages müssen vorhanden sein

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

- Günstiger und regelmäßiger Flugverkehr zwischen Destination und Heimatland

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

- Vorhandene Erfahrungsberichte aus den Bekannten-/Familienkreisen

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

- Vorhandene Erfahrungsberichte aus dem Internet

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

- Sie müssen dieses Land zumindest schon ein- oder mehrmals vorher besucht haben

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel wenig keinen

Angebote/Pakete in denen der Urlaub mit einer Untersuchung/Behandlung jeglicher Art vereint werden kann

Wie viel Einfluss würde das auf Ihre Entscheidung nach SOA für eine medizinische Behandlung zu fliegen, nehmen?

viel

wenig

keinen

Anderes...

Platz für weitere Anmerkungen...

Vielen Dank für Ihre Unterstützung!

8.2 Abstract in German

Medizintourismus ist kein komplett neues Phänomen, neu ist, dass Menschen aus entwickelten Ländern in weniger entwickelte Länder reisen um dort medizinische Dienstleistungen in Anspruch zu nehmen. Dabei spielen Globalisierung und demografische Veränderungen eine wesentliche Rolle, vor allem in der Kommodifizierung von Gesundheitsdienstleistungen. Besonders Südostasien macht sich diese Neuorientierung von potentiellen Patienten auf der Suche nach medizinischen Behandlungen zu nutzen, da sich der Medizintourismus zu einer sehr lukrativen Geschäftsoption, um sich im globalen Wettbewerbsmarkt zu positionieren, entwickelt. Die Strategie des Medizintourismus hat Vor- als auch Nachteile für die Region. Demnach fokussiert die vorliegende Arbeit auf Hindernisse sowie Herausforderungen denen sich Südostasien stellen muss, um MedizintouristInnen anzulocken. Des Weiteren werden die bestimmenden Faktoren des Entscheidungsprozesses für eine Reise nach Südostasien um medizinische Dienstleistungen in Anspruch zu nehmen, unter besonderem Augenmerk auf die österreichische Perspektive, ermittelt.

8.3 Abstract in English

Medical Tourism is not a completely new phenomenon, what is new is that people from developed nations seek for medical treatment in low- and middle income countries. Globalization and demographic changes play a major role in the commodification process of health services. Especially Southeast Asia makes use of potential patients seeking for medical treatments, as it emerged as a lucrative business opportunity to position a country in the global competitive tourism market. The strategy of medical tourism causes advantages as well as disadvantages for the region. Thus, this thesis focuses on the obstacles and challenges Southeast Asia has to face by attracting medical tourists. Further it deals with the determining elements of the decision making process of potential travelers to Southeast Asia in Austria.

Curriculum Vitae

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EDUCATION

since 2012 **Master Geography**
Human Geography: Urban/ Population Research
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2009- 2012 **Bachelor Development Studies**

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