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Research paper

The effect of cultural distance on medical tourism

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ABSTRACT

This study analyses the relationships between the origin countries of international patients and their cultural distance from the destination country in the context of medical tourism. A novel panel dataset is used, covering 109 origin countries whose citizens came to Turkey and received medical treatment during 2012–2014. After accounting for control variables such as religious similarity, Turkish diaspora in the origin country, physical distance, GDP per capita and number of inbound tourists, the study finds that cultural distance has an impact on the choice of destination for medical tourism. This impact persists at the medical specialty level.

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1. Introduction

Medical tourism has grown tremendously in the last decade and international health care has become a global industry (Connell, 2013; Horowitz, Rosensweig & Jones, 2007). Factors contributing to the expansion of this industry are related to the health-care provision problems of the origin countries, which are mainly high costs of care, health care users with low income, health care excluded by insurance, long waiting times and low-quality health care (Connell, 2006; Gan & Frederick, 2011; Runnels & Turner, 2011). The affordability of air travel to overseas destinations and favourable exchange rates are also contributing to the internationalisation of medical tourism (Connell, 2006).

Researchers aspire to better understand the demand factors of international patients and supply characteristics of destination countries in the face of the development of the medical tourism market. The most frequently mentioned demand factors are the relatively high cost of medical care in the origin country (Connell, 2006; Gan & Frederick, 2011; Heung, Kucukusta & Song, 2010; Smith, Martínez Álvarez & Chanda, 2011; Turner, 2007) and the quality of medical care in comparison with that of the destination country (Glinos, Baeten, Helble & Maarse, 2010). As far as supply factors are concerned, hospital accreditation (Smith & Forgione, 2007), geographical distance (Adams & Wright, 1991) and cultural

familiarity (Glinos et al., 2010) emerge as important determinants of destination country selection in the literature by patients. Geographically and culturally related issues are often analysed in conjunction with other factors that affect international medical tourism. For instance, Connell (2013) shows that this could be the case for medical travel in Europe, Thailand, India and Singapore through bordering countries with cultural affinity in order to minimise travel costs. Medical tourism in China has also attracted international patients, mostly from culturally and geographically close countries such as Taiwan, Hong Kong and Macau (Houyuan, 1998). Likewise, India receives patients from nearby countries such as Bangladesh, Mauritius, Nepal and Sri Lanka, which share similar customs to those of India (Gupta, Goldar & Mitra, 1998).

Even though culture has been emphasised as being an important factor in shaping patterns of medical tourism (Glinos et al., 2010; Jagyasi, 2010; Liu & Chen, 2013), few studies have analysed the effect of culture on the destination choice of international patients. In particular, the effect of quantified cultural distance between origin and destination countries on medical tourism movements remains mostly unanswered. Some empirical studies (Goodarzi, Takkhvai & Zangiabadi, 2014; Hanefeld, Lunt, Smith & Horsfall, 2015; Lee, Kearns & Friesen, 2010; Yu & Ko, 2012; Zhang, Seo & Lee, 2013) have addressed the effect of culture on medical tourism. However, they have only explored patient intentions or cross-cultural perceptual differences on destinations with survey methods using a micro approach.

Yu and Ko (2012) reported significant cross-cultural perceptual differences between Chinese, Japanese and Korean medical

tourists in terms of selection of destination, inconveniences and preferred health-care services. Other studies have confirmed the impact of culture on medical tourism. For instance, Goodarzi et al. (2014) found that cultural affinity was an important factor in medical tourist preferences for visiting Iran. The role of cultural familiarity could also be as important as satisfactory health-care quality in the decision of international patients going to the motherland, such as in the case of the Korean population living in New Zealand (Lee et al., 2010). In addition to cultural familiarity with the destination country, Hanefeld et al. (2015) found that ability to speak the native language of the destination country and the presence of a family member in the origin country near the treatment centre can be important determinants of destination country selection for medical treatment. Although cultural distance is very important, Zhang et al. (2013) showed that the degree of severity of the illness can be relatively more important than cultural factors and, consequently, Chinese patients in their study tended to choose destinations culturally distant from China in more-developed countries than their country of residence.

Religion plays a strong role as an important element of cultural proximity, which can affect the choice of medical tourism destination. For example, the sensitivity of patients from the Middle Eastern and Arabic countries to ancillary services (halal food kitchen, Islamic employee-orientation programme) to medical treatment is taken into consideration in South Asia to attract international patients from these places (Bookman & Bookman, 2007; Cohen, 2008). Jordan and Malaysia, which take these factors into consideration besides having high-quality medical services, have thus become attractive to Muslim patients (Bookman & Bookman, 2007; Connell, 2013).

A stream of research underlines the importance of diaspora populations in international medical tourism in relation with cultural links for a number of reasons (Connell, 2013; Horton & Cole, 2011; Macias & Morales, 2001; La Parra & Mateo, 2008; Lee et al., 2010; Wallace, Mendez-Luck & Castaneda, 2009). First, social and historical connectedness to a native country can affect people's health-care travel destination plans (Eyles & Williams, 2008). Second, communicating with physicians and health-care personnel in their native tongue in the origin country is often an appealing factor (Bergmark, Barr & Garcia, 2008; Bookman & Bookman, 2007). For example, cultural proximity and health-care system familiarity have been found to tilt the decision of Mexicans in the United States, Indians and Middle Easterners worldwide, Koreans in New Zealand, and British people living in Spain in favour of their native country (Connell, 2013; La Parra & Mateo, 2008; Lee et al., 2010). The same tendency has been observed among the second generation of immigrants (Connell, 2013). Finally, personal ties may be significant when diaspora patients are choosing the clinic or the physician for treatment (Hanefeld et al., 2015). Not surprisingly, Middle Eastern patients prefer their native country for gamete donation during fertility treatment for cultural reasons (Inhorn, 2011).

Geographical proximity seems to be one of the decisive factors in the decisions of diaspora communities because of travel costs. Most cross-border medical tourists opt for destinations near their country of residence rather than distant medical tourism destinations (Ormond, 2008). For instance, Mexicans in the United States prefer Mexico not only because of their cultural affinity but also because of its low cost (Horton & Cole, 2011; Macias & Morales, 2001; Wallace et al., 2009). The fact that the proportion of the diaspora population has been the largest in the total amount of medical tourists in countries such as India, Mexico, Turkey and the Philippines (Connell, 2013) shows that the impact of diaspora on medical tourism should be incorporated in studies.

To sum up, various factors can exercise influence on the decisions of international patients in selecting the destination country for their medical treatment. Of these factors, cultural distance often comes up as an important determinant in the literature. However, few existing studies have incorporated this factor into their empirical research. These studies, typically using small samples, measure cultural distance qualitatively based on the attitudes, perceptions, intentions and experiences of international patients. Verbal or written statements from international patients reflecting on the cultural aspects of their own personal experiences can be taken as being subjective opinions; these are not independent from the temporal and contextual factors present at the time of the survey. Even so, the subjective evaluation of international patients in choosing medical destinations can offer valuable insights. However, further studies are needed that incorporate alternative measures of cultural distance based on secondary data to show more strongly the presence of the impact of cultural distance on the choice of destination. A study in this tradition comes from Johnson and Garman (2015), who estimate determinants of inbound medical tourists to USA using two variables to measure cultural distance: fluency of English among the population of the origin country and the number of outbound travellers from USA to that country. According to their study, none of these variables had an influence on medical tourism. Their study excluded Mexico and Canada: two neighbouring countries; hence they disregarded one of the important factors. Moreover, despite being informative of destination choices of international patients in general, their study provides no information with respect to destination choices at the specialty level.

The present study differs from that of Johnson and Garman (2015) in four ways. First, cultural distance is measured based on Hofstede's cultural framework. Second, the study uses panel data, which can smooth out the temporary and contextual effects. Third, neighbouring countries are included in the sample. Fourth, the data were aggregated at the specialty level in order to explore the effect of cultural distance on different specialties. Similar to Johnson and Garman (2015), this study also accounts for other country characteristics, such as national income per capita, number of diaspora, religious similarity, number of inbound tourists and physical distance.

The remainder of the paper is structured as follows. The next section discusses the methods, variables, model and data. The third section presents the results of the study. The fourth section discusses the implications of the results and summarises conclusions. The last section then evaluates the limitations of the data and explores further research areas.

2. Variables, model and data

There is no consensus as to what variables should be included in a study that analyses the determinants of destination choices of international patients. This study will therefore draw on the literature reviewed above to select the variables that are assumed to affect the number of international patients from the origin country. Accordingly, the study specifies the following model to estimate:

$$lnnumofpat_{it} = \propto_i + \beta_1 \ln GDPpc_{it} + \beta_2 \ln CD_i + \beta_3 \ln CDsq_i + \beta_4 relsim_i$$
$$+ \beta_4 lnphydist_i + \beta_5 diaspora_i + \beta_6 tourists_{it} + \epsilon_{it} \qquad (1)$$

where $lnnumofpat_{it}$ is the natural logarithm of the number of international patients from country i at time t, $\ln GDPpc_{it}$ is the natural logarithm of one year lagged value of purchasing power