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Why do medical tourists travel to where they do? The role of networks in determining medical travel

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ABSTRACT

Evidence on medical tourism, including patient motivation, is increasing. Existing studies have focused on identifying push and pull factors across different types of treatment, for example cosmetic or bariatric surgery, or on groups, such as diaspora patients returning 'home' for treatment. Less attention has been on why individuals travel to specific locations or providers and on how this decision is made. The paper focused on the role of networks, defined as linkages – formal and informal – between individual providers, patients and facilitators to explain why and where patients travel. Findings are based on a recently completed, two year research project, which examined the effects of medical tourism on the UK NHS. Research included in-depth interviews with 77 returning medical tourists and over sixty managers, medical travel facilitators, clinicians and providers of medical tourism in recipient countries to understand the medical tourism industry. Interviews were conducted between 2011 and 2012, recorded and transcribed, or documented through note taking. Authors undertook a thematic analysis of interviews to identify treatment pathways by patients, and professional linkages between clinicians and facilitators to understand choice of treatment destination. The results highlight that across a large sample of patients travelling for a variety of conditions from dental treatment, cosmetic and bariatric surgery, through to specialist care the role of networks is critical to understand choice of treatment, provider and destination. While distance, costs, expertise and availability of treatment all were factors influencing patients' decision to travel, choice of destination and provider was largely the result of informal networks, including web fora, personal recommendations and support groups. Where patients were referred by UK clinicians or facilitators these followed informal networks. In conclusion, investigating medical travel through focus on networks of patients and providers opens up novel conception of medical tourism, deepening understanding of patterns of travel by combining investigation of industry with patient motivation.

1. Introduction

Medical tourism is a term commonly used to refer to the phenomenon of people travelling from their resident country to another with the expressed purpose of accessing medical treatment (J Connell, 2013). Wealthy people have always travelled in search of better treatment or in search of treatment unavailable to them in their resident country (Smith and Puczko, 2009). Yet, the current phase of medical tourism, roughly seen as incorporating the last two decades, is considered distinctive. This is in terms of the extent to which patients are travelling, its commercialisation with specific brokers and market segments, and the level to which it is associated with processes of globalisation (Hopkins et al., 2010).

While the literature on medical tourism is growing rapidly (Hanefeld et al., forthcoming) it has mainly focused on either individual case studies of patients (Miyagi et al., 2012) or investigation of specific aspects. This has included for example a focus on industry, such as facilitators (Johnston et al., 2011) and websites (N. Lunt et al., 2010). Research on medical tourism has also extended to investigating specific types of procedures for which patients travel, such as cosmetic, fertility or dental tourism (J Connell, 2013), and diaspora travel with patients who travel home for treatment (Lee et al., 2010). Many of these studies focus on a small number of individual patients and have documented their individual treatment journeys (Inhorn, 2011), explored their experiences (Whittaker,

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2008), or effect on recipient or originating health system (Alsharif et al., 2010; Hanefeld et al., 2013; Jones and Keith, 2006). A large part of this literature focuses on documenting the medical complications experienced by patients and the risks of medical travel (Miyagi et al., 2012; Vick, 2012), thus echoing popular perceptions of medical tourism, including media coverage of medical tourism, which mainly focuses on patients' risks (Imison and Schweinsberg, 2013). In the absence of reliable global estimates of how many patients are travelling for treatment (Hopkins et al., 2010) estimates of levels of complications in patients who travel do not exist. At the same time, documentation available highlights risks faced by medical tourists and the absence of regulation and mechanisms of redress where complications have occurred (Vick, 2012; Whittaker, 2011; Woo, 2009).

To date only a few studies have investigated a larger sample of patients who travel for treatment. A comparatively small number of studies have focused on identifying push and pull factors across different types of treatment (Crooks et al., 2010; Culley et al., 2011). Factors identified in this literature include focus on cost i.e. treatments being cheaper abroad and patients travelling to save money (J. Connell, 2006). They extend to patients travelling for treatment unavailable or inaccessible to them. This includes experimental therapies such as with stem cells, or fertility treatment where regulation differs between countries (Culley et al., 2011). Perceptions around quality of care are also of importance to patients, especially visible in diaspora patients who tend to return home to seek what is considered better or more appropriate care (Laugesen and Vargas-Bustamante, 2010; Lee et al., 2010). Some of the cases described point to anonymity of treatment received abroad being a factor in patient decision making. This often depends on the cultural norms of the originating country. For example it was of importance to patients from the Middle East seeking gamete donation during fertility treatment (Inhorn, 2011). Cosmetic tourism seems more closely linked to tourism elements or experience and in some cases the idea of travel to an exotic destination may carry as much appeal as the idea of improved body shape or facial features (Holliday et al., 2013). Glinos and colleagues identified four reasons why patients travel: availability, affordability, perceived quality and familiarity (Glinos et al., 2010). Looking across this body of literature highlights factors influencing patients' decision to travel are complex, and they vary by treatment type and between groups of patients. It also indicates that studies focussing on motivation pay less attention on *why* individuals travel to specific locations or providers.

As medical travel in the main takes place in the private sector without regulation and formal referral by public health providers and clinical gatekeepers, the role of informal linkages and pathways between patients and clinics is of importance in understanding patients choice. Research on networks, and more specifically social network analysis, is a vast, established and growing field of research (Scott and Carrington, 2011; Wassermann and Faust, 1994). Most definitions of networks concur that networks consist of actors or 'nodes' and ties or linkages between these. Much of network literature focuses on network structure and position of actors or nodes within these, and their effects on specific outcomes (Borgatti and Halgin, 2011). Network functions are often described in terms of flows between actors or by binding (combining) different actors, such as for example for collective bargaining. Networks, including referral networks have been explored in research focused on markets (Reingen and Kernan, 1986). Social networks have also recently been explored in health, for example in terms of patient management (Ferreira et al., 2013) or to understand clinicians' decision-making (Cohen et al., 2013). However, the analysis of networks has so far not been extended to further understanding of medical travel.

This paper addresses this gap. It draws on a sample of 77 in-depth interviews with outbound UK medical tourists, examines their motivation for travel more generally and specifically focuses on the *why* specific destination and providers were selected. Understanding this aspect of the medical tourism experience and market is critical to regulating such travel and addressing risks faced by patients. The paper focuses on the role of networks, defined as linkages – formal and informal – between individual providers, patients and facilitators to explain why and where patients travel. We draw on a network definition by Borgatti and Halgin who see "networks as a set of actors or nodes along with a set of ties […] that link them". As a first step in the analysis researchers identified different motivations for why patients travel. These are grouped here below by the categories of medical tourists emerging from the literature (Hanefeld et al., forthcoming) and confirmed by the patients encountered during the research. They are bariatric, cosmetic, fertility, 'diaspora'[1] and a category of 'other' patients. Evident from these categories is that patients motivations overwhelmingly linked to and were specific to the type of treatment sought, but that this differed for patients' reporting to travel 'to go home'. As a second step in examining why patient travelled, analysis extended to focus on reasons for patients selecting specific providers. As part of this second step in the analysis of interviews, the role of networks emerged.

In addition to interviews with patients, analysis drew on conversations and interviews with providers based overseas providing treatment to patients from the UK, as well as UK based medical tourism facilitators, to identify referral networks between countries. Analysis here focused on whether there are generic features of linkages or networks or whether these again differ by medical tourism type. It is worthy to note that the research did not set out to conduct a social network analysis, and thus did not follow the established methods of this field of investigation. Rather networks emerged from the thematic analysis of interviews (as detailed in the methods section). Results presented here identified that patients' decisions are made along a continuum of steps – starting from the conditions for which patients choose to travel – rather than facilitated by networks from the start. We therefore group results by case study before presenting findings relating to networks.

2. Methods

A total of 77 medical tourists were interviewed. 46 patients were interviewed individually across four treatment case-studies (cosmetic, dental, bariatric and fertility) and 'other treatment' categories. Patients interviewed individually were sourced through a variety of means. In the first instance a call for interviewees was posted on the medical tourism research project's website. The advert was unsuccessful and over the 18 months of the project the online contact form yielded four responses. Recruitment came to increasingly rely on posts made to online support or information forums. This proved particularly successful, especially in terms of the sample of bariatric and fertility patients. In some cases we made contact with those whose stories had been reported elsewhere, for example in media publications or as patient testimonials. The remaining 31 patients from diaspora communities were

[1] We apply the term of diaspora patients here to patients travelling for treatment to a country other than where they are normally resident, which patients refer to as 'home'. This does not simply include nationality or ethnicity, as we found for example second generation migrants referring to themselves as 'returning home' for treatment, even if this was not the country of their citizenship or birth. It rather marks a more complex cultural bond.