Tourism Management Perspectives 25 (2018) 29–40

Contents lists available at ScienceDirect

Tourism Management Perspectives

journal homepage: www.elsevier.com/locate/tmp

Sand, surgery and stakeholders: A multi-stakeholder involvement model of domestic medical tourism for Australia's Sunshine Coast

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ARTICLE INFO

Keywords:
Medical tourism
Sunshine Coast
Multi-stakeholder involvement model

ABSTRACT

This paper explores the developments of domestic medical tourism for Australia's Sunshine Coast. Most studies have characterised medical tourism to be an outbound phenomenon, where affluent tourists select mostly developing destinations for elective surgeries due to cost, quality or faster access to treatments. However, studies concerned with domestic medical tourism remain highly implicit. Employing a case study perspective of the Sunshine Coast, Australia, this research explored the potential for domestic medical tourism to be conceived. This research found that while most stakeholders considered the region to be well-suited for medical tourism, three issues presented some barriers to its development. The three issues were residents' access to hospital facilities, lack of cooperation and hostile attitudes between practitioners. This research shows the contested battlegrounds of domestic medical tourism initiatives, and how the development of a multi-stakeholder involvement model of medical tourism can bring desired outcomes to fruition.

1. Introduction

The understanding of domestic medical tourism remains an under-researched area. While Hudson and Li (2012) had investigated domestic medical tourism from within an American perspective, they asserted that there needs to be further studies of this phenomena elsewhere. The paucity of research related to domestic medical tourism may be attributed to the widely accepted notion that medical tourists are primarily travelling across international borders (Connell, 2013; Reddy, York & Brannon, 2010; Smith, Alvarez & Chanda, 2011). However, a broad definition of medical tourism reflects the primary purpose of travel for elective surgery (Wang, 2012; Wongkit & McKercher, 2013). As such, the value of incorporating both domestic and international medical tourism trends will provide rich insights to a fast evolving and lucrative tourism sector. Additionally, there may be wide variations in terms of quality and types of medical services across different regions within a country, as articulated by Gan and Frederick (2011). While official medical tourism statistics may not exist, Youngman (2015) estimated that there are 6 million international medical tourists, and another 4 million domestic medical tourists globally as at 2015. However, Australia is a relatively small player in this market, with the majority of medical tourism practiced in Asia-Pacific, Central Europe and South America (Ganguly and Ebrahim, 2017; Junio, Kim & Lee, 2017; Sandberg, 2017). Nonetheless, some media reports have emerged to show that more than 10,000 inbound medical tourists visited Australia in 2013 (West, 2014). These visitors were estimated to have contributed almost A$26 million to the nation on the back of direct and indirect economic initiatives (Medew, 2014). The literature reveals that data is somewhat available from an international mobility perspective, though domestic medical tourism remains under-reported. Such a gap in knowledge justifies the need for this research to be undertaken to better conceptualise the development of domestic medical tourism.

2. Literature review

To help frame this research, the review of the literature will examine the typology of medical tourists, motivations for medical tourism, destinations chosen and the concerns with these developments. Synthesising the literature will provide an overall state of medical tourism scholarly work, and highlight the existing gaps surrounding domestic medical tourism. The literature reviewed show that much of the knowledge is embedded from a demand-side perspective, which triggers the need to encapsulate the supply-side considerations from other stakeholders involved in domestic tourism practices. Each of these points will be separately analysed.

2.1. Typology of medical tourists

Some scholars have initiated discussions surrounding a typology of medical tourists (e.g. Connell, 2006; Esiyok, Cakar & Kurtulmusoglu,

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https://doi.org/10.1016/j.tmp.2017.11.002
Received 26 June 2017; Received in revised form 14 October 2017; Accepted 8 November 2017

Table 1
Medical tourist types.

Author	Year	Context	Method	Sample size	Sample characteristics
Alsharif, Labonte and Lu	2010	Medical tourists to India, China, Jordan and the United Arab Emirates	Surveys	406 (India) 100 (China) 212 (Jordan) 52 (UAE)	• Most medical tourists to India and China were from the USA • Middle Eastern medical tourists were visiting mainly Jordan or the UAE
Ye, Qiu and Yuen	2011	Chinese medical tourists to Hong Kong	Face to face interviews	9	• 8 visited to give birth, 1 for fertilization techniques • 7 from Guangzhou, 2 from Beijing • 7 stayed in private hospitals with the remaining 2 in public hospitals
Johnston, Crooks and Snyder	2012	Canadians going abroad for medical tourism	Phone interviews	32	• Just under half (15) visited India for medical tourism • Almost half travelled for orthopaedic surgery • Average age 53 • 19 female, 13 male
Yu & Ko	2012	Chinese, Japanese and Korean medical tourists in Korea	Surveys	677	• Slightly more than half were female • Most of the respondents were Korean citizens • Almost equal spread across age groups • Half of the sample possessed at least an undergraduate degree • Most earned between US$25,000–74,999 annually • More than half were on their first trip to the destination
Wongkit and McKercher	2013	Foreign medical tourists to Thailand	Surveys	345	• Most tourists decided equally on travelling for vacation and medical purposes • 60% of medical tourism decisions were determined prior to departure • Destination attributes were the key driver of medical tourism decisions
Yeoh et al.	2013	Foreign medical tourists to Malaysia	Surveys	441	• Around 95% of these tourists were from Indonesia or Singapore • 56% female • 76% aged between 31 and 60 • 60% repeat medical tourists • 65% have also visited Singapore for treatments

2017; Khan, Chelliah, Haron & Ahmed, 2017). While it is acknowledged that there are varying definitions of medical tourism, this research subscribes to a broader interpretation of a medical tourist as someone who travels to a destination (either domestic or international) outside their usual environment to undertake elective surgical treatment (Hudson & Li, 2012). Elective surgical treatment relates to non-emergency medical services rendered to patients (Carrera & Bridges, 2006). These include cosmetic surgery and in vitro fertilization (IVF) (Turner, 2007). For instance, Yu and Ko (2012) found that medical tourists were mostly women, with an almost equal age distribution across age groups, with tertiary qualifications and above average incomes. These demographic indicators were likewise corroborated in other studies (An, 2014; Gan & Frederick, 2013; Wongkit & McKercher, 2013; Yeoh, Othman & Ahmad, 2013). Nonetheless, the range of medical treatments could range from less complicated surgeries such as Botox, to more complex operations such as hip transplants. A plausible explanation as to why women appear to be more likely to undertake medical tourism is attributed to peer influence, where families and friends can have a strong effect as to social and relational norms of what is accepted as beauty personified (Viladrich & Baron-Faust, 2014). Table 1 provides a list of academic studies in chronological order that have documented various medical tourist types.

There are some commonalities observed within the six articles presented in Table 1. First, the context of medical tourism is largely confined to the Asia region. Apart from Yu and Ko (2012), the remaining five articles characterise medical tourism to be predominantly an international phenomenon. Third, these studies were exclusively dedicated to the perspectives of uncovering medical tourist decision-making and their associated experiences. There remains a knowledge gap of other stakeholders' perception of, and attitudes towards medical tourism developments. Even less is known as to how domestic medical tourism should be conceptualised.

2.2. Motivations for medical tourism

Three main themes emerge from tourism literature explaining motivations for medical tourism. These are cost (Moghavvemi et al., 2017; Mutalib et al., 2017), quality (John & Larke, 2016; Wu, Li & Li, 2016) and faster access to health and medical facilities (Abubakar & Ilkan, 2016; Fetscherin & Stephano, 2016). Each of these will be separately discussed.

Cost is arguably the most important motivation to undertaken medical tourism. Some studies have alluded to significant cost savings when medical tourists travel to less developing countries for medical tourism (Essier & Casken, 2013; Lunt, Mannion & Exworthy, 2013). Hence, the affordability of desired treatments outside of one's place of residence is a strong push factor in creating motivations for visiting medical tourism destinations.

Quality of healthcare is another antecedent that motivates medical tourists to action. In this paper, quality transcends all aspects of the medical tourism experience. These include service quality (hospitableness of staff involved in the whole experience), as well as technical quality attributes in terms of the surgery and procedural experience (Chuang, Liu, Lu & Lee, 2014; Debata, Patnaik, Mahapatra & Sree, 2015; Han & Hyun, 2015). These attributes of medical tourism matter because of the heightened perceived risks especially when the medical treatments involve unfamiliar environments. For this reason, there is a strong reliance on word-of-mouth as a credible source of information to influence the intangible, and high-involvement nature of medical tourism decisions (Connell, 2013; Lu, Wu & Chen, 2016; Yeoh et al., 2013). Nonetheless, providers of medical tourism have attempted to streamline the medical tourism experience by integrating the health and tourism sectors to provide some form of consistency where possible when dealing with medical tourists (Wernz, Wernz & Phusavat, 2014). Other leading practitioners seek international accreditation standards as a testament of quality (Woodhead, 2013). These efforts are aimed at reducing decision dissonance, and for providers to take a more