CHAPTER III

REVIEW OF LITERATURE

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3.1 Introduction

Health tourism is a new concept in tourism and gaining importance now. It denotes the emerging trend of healthcare travel. People are visiting health tourism destinations because of varying reasons. An attempt is made to collect available literature regarding the concept of health tourism, reasons behind the development of health tourism, criticism against health tourism, components of health tourism, health tourism potentials in India and Kerala and need for analysing service quality for developing a health tourism destination.

3.2 Concept of Health Tourism

William Bies and Lefteris Zacharia (2007)\(^1\) opined that a trend emerging in recent years has been travel from industrialised nations to developing countries such as India and Thailand for purposes of undergoing medical procedures, a phenomenon called medical tourism. Medical tourism offers the prospect of greatly reduced expenses for healthcare as well as other advantages such as reduced waiting times, but there are risks associated with seeking healthcare overseas. The researchers find that self selected medical tourism is preferred over employer – or government sponsored programmes and over the status quo.

Laszlo Puezko and Marin Bachvarov (2006)\(^2\) classifies health services are those used for relaxation, form of stress release and for curing well definable illnesses. Medical or therapeutic tourism involves using the services available at a site for providing therapy, or staying at a medical resort where the minimum length of stay is normally defined typically for the purpose of curing certain diseases. The main focus of therapeutic services, which are typically based on a natural curative factor (e.g. medicinal water, medical cave, and medicinal mud), is therapy, which is only complemented by
tourist’s services and attractions. The most important difference between wellness and medical tourism is that wellness services are used on a voluntary basis.

Devesh Kapur (2007)\textsuperscript{3} gives an idea about the evolution of medical tourism

- Until mid-1990s: affluent consumers from developing countries travel to industrialized countries for medical treatment
- Early 1990s-about 2001: Consumers travel to countries such as Argentina, Brazil, and Israel for cheap cosmetic procedures
- Post-2001: Wealthy from the Middle East, SE. Asia and S. Asia seek treatment in Asia
  - Emergence of medical tourism in Thailand, Malaysia, Singapore, and India
- Emerging Trends: Medical Outsourcing
  - Un and underinsured consumers from industrialized countries seek 1st world care and quality at developing country prices

John Connell (2006)\textsuperscript{4} opined that some of the earliest forms of tourism were directly aimed at better health and increased well-being. However, with the partial exception of some spas, none of this has involved actual medical treatment, but merely assumed incidental benefits in amenable contexts. He attempted to examine a contemporary elaboration of the rise of medical tourism where tourism is deliberately linked to direct medical intervention. A new and distinct tourism niche has emerged satisfying the needs of a growing number of people, mainly in developed countries with destinations in developing countries being the main beneficiaries. In less than a decade the
rise of medical tourism has demonstrated that the provision of the healthcare can now be globalised like so many other service activities. The trade in health services is expanding becoming more competitive and creating new dimension of globalisation, all elegantly packages and sometimes actually functioning as the new niche of medical tourism.

Rupa Cahndra (2002), examines ways in which health services can be traded in the light of the increasing globalisation of the health sector, using the mode-wise characterisation of trade defined in the General Agreement on Trade in Services. The trade modes include cross border delivery of health services via physical and electronic means, and cross border movements of consumers, professionals and capital. Trade in health services via consumption abroad has mixed implications. It may enable exporting countries to improve their national health systems, by generating foreign exchange and additional resources for investment in health care. It can also help in overcoming shortages of physical and human resources in the importing countries particularly for specialised health services. But consumption of trade abroad could also result in a dual market structure, by creating a higher quality expensive segment that caters to wealthy nationals and foreigners, and a much lower quality resource constraint segment catering to the poor. Availability of services including physicians and other trained personnel, as well as the availability of beds may rise in the higher standard centres at the expense of the public sector, resulting in a crowding out of the local population.

Laura Gater (2006) distinguishes day spas from medical spas. Day spas do not offer medical and surgical procedures and focus mainly on aesthetic treatments such as facials and massages. Medical spas on the other hand employ at least one physician and medical assistants and have dedicated surgical facilities or contract with a nearly private hospital. Most medical spas
offer a wide variety of plastic surgery procedures for both males and females. Many also offer Lasik (reshapes the cornea of the eye in order to produce clearer vision) and dentistry procedures such as teeth whitening and even root canals. Face slimming, nose enlargement, sex reassignment and calf slimming are all surgeries of choice in various countries. Medical spas offer plastic surgery in a relaxed, vacation like atmosphere of luxury and pampering.

Leigh Turner (2007)\(^7\) opined medical tourists include patients trying to avoid treatment delays and obtain timely access to healthcare. Medical travellers also include uninsured Americans and other individuals unable to afford healthcare in their home settings. Destination nations regard medical tourism as a resource for economic development. However attracting patients to countries such as India and Thailand could increase regional economic inequalities and undermine health equity. With globalisation, increasing numbers of patients are living their home communities in search of orthopaedic surgery, ophthalmologic care, dental surgery, cardiac surgery and other medical interventions. Reductions in health benefits offered by states and employers will likely increase the number of individuals looking for affordable medical care in a global market of privatised, commercial healthcare delivery.

S.Rajagopalan (2006)\(^8\) opined that the health tourism market has three segments-1, Surgeries like orthopedic surgery, by-pass surgery, cancer therapy, eye surgery, organ transplantation.2, Plastic surgery or cosmetic surgery and 3, health spas, weight loss exercise centers, hot springs and holistic treatment including wellness therapies. He identified that inadequacy of healthcare provision in relation to need is the major push factor for people in developed countries to seek treatment abroad. He identified certain risks in health tourism like commercializing doctors’ profession, issue of recuperation after treatment, insurance cover will available only if when the standard of
services is the same as the patients’ home country, recourse to legal action is difficult in countries that have weak malpractice laws or not feasible if the legal process is slow.

Louise Chang (2006)\(^9\) opined that dismayed by high surgical costs in the U.S, increasing numbers of American packing their bags to have necessary surgery performed in countries such as India, Thailand and Singapore.

Anna Gracia-Altes (2005)\(^10\) outlines some of the challenges and opportunities ahead, as health tourism finds its prominence in the practical and conceptual domains of tourism. She identified that population aging; lifestyle changes, tourism alternatives, particularities of health care system etc contribute to the demand of health tourism. The challenges faced by health tourism sector are regarding regulations, commercial strategy, quality of care, professional licensing, technologies, taxes, labour, infrastructure, easy arrival procedures etc.

Borman (2004)\(^11\) identified that long waiting lists, high costs, lack of insurance and under insurance are causing some to go abroad to seek medical care. This is a major driver of demand from off shore sources when local health system cannot provide appropriate or timely options. This is seen both as an opportunity to develop an economic sector and as a problem in some national health care systems.

John Connell (2006)\(^12\) opines that medical tourism where patients travel overseas for operations has grown rapidly in the past decade, especially for cosmetic surgery. High costs and long waiting lists at home, new technology and skills in destination countries alongside reduced transport costs and Internet marketing has all played a role. Several Asian countries are dominant, but most countries have sought to enter the market. Conventional
tourism has been a by-product of this growth, despite its tourist packaging, and overall benefits to the travel industry have been considerable. The rise of medical tourism emphasises the privatisation of health care, the growing dependence on technology, uneven access to health resources and the accelerated globalisation of both health care and tourism.

Hansruedi Mueller and Eveline Lanz Kaufmann (2001)\textsuperscript{13} opined that the term ‘wellness’ is widely used in European tourism. The principal observations regarding the wellness industry concern an expanding supply of and an insufficiently researched demand for wellness programmes. The quality dimension of wellness services is increasingly becoming the decisive competitive factor. For this reason quality management plays an important role. Market research shows that average three- to five-star hotels provide fairly comprehensive wellness facilities. Wellness hotels should therefore specialise in health information, individual care and a wide range of cultural and relaxation programmes. Although the same hotel can host cure and wellness guests at the same time, these two segments have to be considered separately when deciding on the marketing strategy. It is therefore assumed that wellness is pursued solely by ‘healthy’ people, the prime aim being prevention. ‘Normal cure’ guests aim to heal their illness.

Winkelman, Michael (2005)\textsuperscript{14} conducted research addresses the question of whether Westerners who seek traditional spiritual medicine known as ayahuasca can be best characterized as "drug tourists" or as people pursuing spiritual and therapeutic opportunities. Participants in an ayahuasca retreat in Amazonia were interviewed regarding their motivations for participation and the benefits they felt that they received. These findings from the interviews were organized to reveal common motivations and benefits. Contrary to the characterization as "drug tourists", the principal motivations can be characterized as: seeking spiritual relations and personal
spiritual development; emotional healing; and the development of personal self-awareness, including contact with a sacred nature, God, spirits and plant and natural energies produced by the ayahuasca. The motivation and perceived benefits both point to transpersonal concerns, with the principal perceived benefits involving increased self awareness, insights and access to deeper levels of the self that enhanced personal development and the higher self, providing personal direction in life.

Ivy Teh and Calvin Chu (2006)\textsuperscript{15} examines the actual potential that health tourism represents based on volume and costs, investigates the role of government in several markets and purposes three broad areas of consideration for health care providers –1, medical quality, supporting services and marketing reforms. They classify medical services as intellectual output of hospitals, logistics arrangements, and hospitality services, training to staff, bedside manners, religious, dietary and cultural needs. Medical services include specialties in specific clinical areas, strong medical research, excellent medical equipments and marketing reforms include referral agencies, advertisement, and internet marketing, word of mouth, medical break through fixed price surgery, tax treatments and visa customs clearance.

Prosenjit Datta and Gina Krishnan (2006)\textsuperscript{16} opined that medical travel could ameliorate much of the demand-supply imbalance in global healthcare. Developed nations benefit as costs or waiting time or both come down for a significant chunk of their population. Developing countries benefit as it brings in revenues and provide the right spur to improve their healthcare sector apart from reducing brain drain in their medical fraternities.

David Gibert and Junaida Abdullah (2004)\textsuperscript{17} ascertain whether the activity of holiday taking has any impact on the life satisfaction or subjective well being of those taking vacations. The results indicated that such activity changed the sense of well being of those participating in it. A comparison
between holiday taking group and non-holiday taking control group provided evidence that the former experienced a higher sense of well being prior and post their travels when compared to the latter. Although the effect of sizes are mostly small, the evidence suggests that holiday taking has the potential to enhance the level of happiness of those enjoying it not causing individuals to feel any worse off than before traveling.

Xinran Y Lehto (2006)\(^{18}\) opined yoga tourism has emerged and grown with the travel to fell well trend. This study explored data by interviewing and surveying a group of yoga retreat participants in central Indiana, U.S.A. This research while exploratory in nature delineated the socio-demographic and motivational characteristics of yoga tourists and provided empirical evidences that an individuals involvement level with yoga, physical health as well as mental well being positively contribute to the propensity to travel for yoga.

Gina S Krishnan (2006)\(^{19}\) opined certification of service standards is becoming an imperative for hospitals vying in the growing medical tourism market. She mentions how corporate hospitals of Asia are seeking accreditation with JCI (Joint Commission International) of the US that gives a seal of quality to hospitals. JCI standards are based on the twin pillars of patient safety and care.

Jon A. Chilingerian and Grant T. Savage (2005)\(^{20}\) conducted a study that focuses on three themes, to underscore the significance of international health care management are: the problem of global blindness; global health care challenges and opportunities; and learning from international health care management. The problem of global blindness highlights how health care managers’ inattention blindness to competitors’ operational performance and market strategies lead to avoidable and expensive failures. To address global challenges and opportunities, health care organizations are employing two different strategies: (1) building and marketing a world-class health care
facility internationally, and (2) organizing and integrating multinational health care operations. The first strategy exploits the medical tourism market. The second strategy requires either multinational health care networks or transnational health care organizations. One of the lessons to be learned from international health care management is that an organization can create a meta-national competitive advantage. Another lesson is that by examining best practices from around the world, health care organizations can obtain new insights and become more innovative within their home markets. A corollary and third lesson is that while health care organizations can learn a great deal from examining international best clinical practices, sometimes the most important management lessons are lost in clinical translations. The fourth and last lesson is that worst cases – serious international management failures – offer perhaps the most valuable insights into the role of culture, complexity, and leadership for health care organizations.

Rod Sheaff (1997) opined that European Union (EU) policy on mobility requires ensuring healthcare access for EU residents who travel between EU states. This case study investigates how this policy has been implemented in respect of EU visitors to the UK. EU visitors to the UK have similar access to ‘immediately needed' National Health Service (NHS) healthcare to UK residents. For non-urgent healthcare, the NHS has official systems to discourage medical tourism and divert such patients to the private sector or to reclaim the costs of NHS hospital treatment for EU visitors. Yet these official systems contrast with the flexibility and liberality of actual NHS practice towards EU visitors. Research on health policy implementation mostly examines reasons for ‘implementation failure'. However, the present study indicates a health policy being implemented more fully than policymakers may have anticipated. In the case of healthcare access for EU visitors to the UK, an implementation surplus is evident rather than an implementation deficit.
Alison Hope (2007)\textsuperscript{22} opined that one further advantage that puts Poland ahead of its neighbours in Central and Eastern Europe as a destination for medical tourism is its abundance of natural spas. Spa resorts that are located close to natural resources such as salt caves and healing mineral waters make the perfect location to recover from major surgery.

Zaher Hallab (2006)\textsuperscript{23} identified that the healthy living lifestyle has been gaining momentum in the USA and in various parts of the world, more than ever, programmes, products and regulations are being developed and implemented to cater to members of the mentioned lifestyle and to support the overall well-being of the societies. In the field of travel and tourism health has been approached from the angle of tourism experiences effects on an individual’s well-being.

Dr. C. Rajkrishnan (2007)\textsuperscript{24} opined that out of all the specialities, it is dental speciality that can be coupled with tourism very well as dental procedures are less complex and do not need much follow up. Most of the dental procedures are done in multiple sittings and are managed on outpatient basis. This enables the tourist to be on a sight seeing tour if required in between the clinical visits.

Dr. Philip Augustine (2007)\textsuperscript{25} opined that outsourcing healthcare is fast becoming a global phenomenon. Patients from developed nations are turning to developing nations with the right kind of infrastructure and expertise for cheaper and safe treatment packages. It is estimated that 75000 Americans will travel out for surgeries of some kind in 2007.

Dr. Roshan (2007)\textsuperscript{26} opined that medical tourism was the brainchild of travel agencies initially. Now it’s a global give- and- take phenomenon. Hospitals in Asia score with good medical infrastructure, English speaking people with lower labour costs and relative safety of travel. Medical tourism
especially in ophthalmic surgery carries risks that a local medical practice doesn’t have to face. Lack of immunity and non-compliance on post operative treatment regimen amidst holiday excitement can lead to problems.

Swathi Soni and Markarand Upadhaya (2006)\textsuperscript{27} opined that medical tourism has risen from the rapid growth of an industry where people from all around the world are travelling to other countries to obtain medical, dental and surgical care while at the same time touring, vacationing and fully experiencing the attractions of the countries that they are visiting. They list out factors such as exorbitant costs of healthcare in industrialised nations, ease and affordability of international travel, favourable currency exchange rates in the global economy, rapidly improving technology and standards of care in many countries of the world and most importantly the proven safety of healthcare in select foreign nations etc lead to the recent increase in popularity of medical tourism.

3.3 Potentials of Health Tourism in India and Kerala

‘Destination India’ is well known for tourism and now emerging as a health tourism destination because of its ability to provide high quality treatment at low cost. India is unique as it offers holistic medicinal services such as yoga, meditation, Ayurveda, allopathy and other systems of medicine. Health and Medical tourism is perceived as one of the fastest growing segments in marketing destination India today. Kerala is pioneered health and medical tourism in India through Ayurveda.\textsuperscript{28}

Dakshi Mohanty and T Phani Madhav (2006)\textsuperscript{29} opines that the Indian health care industry began to emerge as a prime destination for medical tourists by upgrading its technology, gaining greater familiarity with western medical practices and improving its image in terms of quality and cost. They classified medical tourists in to four major geographical groups who traveled
for distinctly different reasons. First group consists of medical tourists from America who came for cosmetic surgery, as no insurance cover is available for cosmetic surgery in USA. Second group include of medical tourists from UK come for medical treatment because of long waiting lists- could not wait for treatment by the National Health Service and they cannot afford costs of private hospitals. Third group consists of medical tourists from West Asia who come for medical treatment because medical services unavailable or short in supply in the country. Fourth group consists of medical tourists from underdeveloped nations like Nigeria, Bangladesh etc, who come for medical treatment because of poor medical facilities in these nations. They also pinpoint certain weakness of Indian medical tourism such as lack of standardization and accreditation, charging of different prices in different hospitals for the same procedure.

Kavitha Bajeli- Datt (2006)\textsuperscript{30} gives a picture of medical tourism in India. The private sector has already rolled out the red carpet. The make over is striking and hospital floors are squeaky clean and interiors compete with those of five star hospitals. Many hospitals have prayer rooms, translators, visa extension and currency exchange services. Some hospitals are also tying up with travel agents and insurance agencies. She also mentions the difference in pricing of same treatment in various cities in India. A heart surgery costs in Mumbai up to Rs.4lakhs and at Kochi it costs up to Rs.1.5 lakh and it would cost a lakh more in Chennai and up to Rs.2 lakh in Delhi.

CII (2003)\textsuperscript{31} found that India has the potential to attract one million tourists per annum, which could contribute up to US$ 5 billion to the economy. CII is of the opinion that India must leverage its competitive edge, especially its cost advantage. India is unique as it offers holistic medicinal services. With Yoga, Meditation, Ayurveda, Allopathy and other systems of
medicines, India offers a unique basket of services to an individual that is difficult to match by other countries.

Nakul Jain (2006)\textsuperscript{32} opined that health tourism is a concept where a patient travels to another country for medical treatment in order to save costs, or get treatment faster or even to avail of better medical facilities. Most patients from countries like USA and UK travel to developing countries such as India for treatment because India offers some of the cheapest pricing options of treatment, offers a good holiday, there are no waiting lists or queues to stand in, the doctors are comparable to anyone in the world and finally, language does not pose a problem as most people speak English. Although the cost difference between treatment in India and Thailand is not much, India offers what you call a language advantage - a patient would surely prefer a country where English is widely spoken. Also, it is believed that the facilities in India are more suited for International patients.

Mahananda B. Chittawadagi and Sangappa K Nashi (2007)\textsuperscript{33} focuses on the implications of trade in health services under GATS with special reference to medical tourism in India and opined that GATS and privatization of health services in India caused for the growth of medical tourism in India. They opined that medical tourism in India is booming because of affordability of international travel, favourable exchange rates and high quality care at a fraction of cost.

Kundu (2004)\textsuperscript{34} opined that spa holidays are becoming a rage. However, the latest trend is that the corporate sector is considering it as apt incentive for their employees. While the employee enjoys his holidays and come back rejuvenated, they deliver and thus contribute to the growth of the company.
R. Srivastava (2006)\textsuperscript{35} opines that Apheresis has now become an internationally popular mode of treatment for multiple immune complex disorders. However, the treatment remains quite expensive in Western Europe and the US. Apheresis tourism is a part of medical tourism specially related to therapeutic apheresis (TA) treatment in a foreign country on a cost effective basis. In the last couple of years, medical tourism has become an upcoming and growing enterprise in India. The Indian Society for Apheresis (ISA) has taken a plunge at the opportune time and is trying to promote apheresis tourism in India. ISA is a member of various international apheresis organizations globally including the World Apheresis Association (WAA), the International Society for Apheresis (ISFA), and the International Society for Artificial Organs (ISAO) and an associate of other national apheresis societies. The Indian Society for Apheresis (ISA) and the Ludhiana MediCiti (LMC) at Ludhiana Punjab are taking a big step in this direction. The therapeutic apheresis (TA) center at LMC is being set up as a Therapeutic Apheresis Institute and Research Center of excellence.

EXIM Bank of India (2006)\textsuperscript{36} identified features of health tourism that it is not an impulsive activity and it is non-seasonal. Health Tourism depends on the willingness to spend; cost of packages may be attractive to wealthy people and may not be attractive for healthcare tourists from poorer countries. Health Tourism is not a one time business and for getting repeat business depends on successful treatment associated with satisfactory services is needed. Identified potential for associated activities like preventive healthcare, outsourcing of laboratory and diagnostic tests, BPO activities- medical billing, disease coding, forms processing, claims settlement and telemedicine.

G. Ramesh (2006)\textsuperscript{37} opined that a positive side to health tourism developments is that they may bring discipline to the hospital industry and
force it to adopt world-standard systems and standardise processes. In the hospital industry a key element is cost that has a tendency to rise, taking medicare beyond the reach of many. One reason for the high cost of care is the low capacity utilisation of hospital infrastructure. Higher volumes in the private hospitals will help bring down the costs. One possible scenario is that Non-Resident Indian medical professionals will start returning as they might find India lucrative enough.

K. Sujatha and K. Siva Kumar (2006)\(^{38}\) opined that globalisation has really opened many vistas for India to emerge as a centre of excellence in the field of health care. The scope of medical tourism in India is so vast as 10% of the medical professionals in USA and UK are Indian medical professionals. Irrespective of the country from which the medical tourists originate, the feel homely in India. Indian doctors are well-versed in English and combined with Indian hospitality, Indians are second to none in the care industry. Indian doctors in USA and UK act as conduit pipes and ambassadors for the growth and promotion of medical tourism in India. Longer waiting time, medico-legal jurisdictions, post operative care of patients, objections to medical practitioners by the respective countries, government incentives and sops, medical negligence and subsequent liability, heavy compensation claims and medical insurance coverage and medical insurance agency conditions etc. are roadblock in medical tourism.

Dr. Sampad Kumar Swain and A. Suresh Babu (2007)\(^{39}\) identified challenges before Indian medical tourism.

1) No active co-operation or support from Government to promote Medical tourism.

2) No world class infrastructure

3) Lack of International or global accreditation
4) Different pricing policy in hospitals.

5) Lack of co-ordination between various players in the industry – Airlines, Hotels and Hospitals

6) Strong competition from other countries like Singapore, Malaysia, Thailand and Philippines.

N. Janardhanan Rao and Feroz Zaheer (2006)\textsuperscript{40} highlight the problems faced by health tourists and opined that getting a foreign accreditation alone would not suffice in attracting medical tourists. A change in the time period allowed for a foreigner to stay back post treatment is needed. Currently due to government policies, they have to leave India within a short period of time once the treatment is over. But they need more time to recoup and recover and may need the concerned physician’s guidance. Therefore a change in visa policies would certainly go a long way in attracting medical tourists to India and an accreditation certainly demonstrates the commitment of the hospitals towards quality healthcare.

Ray Marcelo (2003)\textsuperscript{41} opined that merging medical expertise and tourism became Government policy when finance minister Jaswant Singh in year 2003 budget, called for India to become a global health destination. Yet cost savings may not be enough to foster a trade in medical tourism as most foreigners would not think India as a land of good health. The sight of country’s over crowded public hospitals, open sewers and garbage-littered streets would unsettle most visitors’ confidence about public sanitation standards in India.

Pheba Chacko(2006)\textsuperscript{42} highlights certain issues need attention in medical tourism such as up gradation of basic amenities and hospital infrastructure, co ordination between the health care and tourism sectors, creating a resource pool of highly skilled and cordial manpower,
standardization of services and accreditation of hospitals and the impact on the domestic healthcare services. The number of medical tourists is increasing, which means demand for private healthcare services will increase. Private hospitals will need more medical professionals to meet the increasing demand and the lucrative offers and the work environment offer will attract many. The public healthcare sector that is disadvantaged vis a vis the private hospitals on these counts will be put under further strain. If more subsidies are given to private hospitals and changes in regulation made to suit them, their concentration in the sector will increase. The public healthcare system will remain neglected. Thus, there is apprehension about the benefits of medical tourism to the Indian public.

Amitsen Gupta (2006)\textsuperscript{43} opines that in countries like India the corporate private sector has already received considerable subsidies in the form of land, reduced import duties for medical equipment etc. Medical tourism will only further legitimize their demand and put pressure on the government to subsidise them even more and this is worrying because the scarce resources available for health will go in to subsidising and why should developing countries be subsidising the health care of developed countries.

Daksha Barai and Chandana Rao (2005)\textsuperscript{44} stressed the role of CII and IHCF (Indian Healthcare Federation) in promoting India’s share in medical tourism. CII could further suggest uniform price band in major specialities which are indicative pricing to the government.

P.N. Hari Kumar et.al (2007)\textsuperscript{45} examined the impact of Ayurvedic rejuvenation in promoting backwater tourism and found that there is significant impact of the introduction of Ayurveda centres on attracting more tourists into the backwater spots than before introducing this facility.
Dr. A Marthanda Pillai (2007)\textsuperscript{46} opined that health tourism is growing exponentially year by year. With high quality healthcare, state-of-the-art hospitals with internationally experienced and qualified clinicians and substantial cost saving, India, especially, Kerala is well equipped to ride this health wave. Kerala is particularly well suited to host medical tourists since it is recognised for its healthcare standards by world bodies such as World Health Organisation and has some of India’s most outstanding doctors and hospitals. The salubrious climate, the inspiring environs as well as the good air connectivity of the state are added advantages.

Dr. Azad Moopen (2007)\textsuperscript{47} opined that apart from the sea, the mountain and the rivers in the backdrop of the lush green vegetation, Malabar (Kerala) has its own ingredients for tourism development, which are not effectively utilised. An example of the utilised potential of Malabar is Kottakkal Arya Vydya Sala, which is the bench mark for Ayurveda in India. Even without promotion Kottakkal is well – recognised healthcare destination both for domestic and international tourists.

P.V. Antony (2007)\textsuperscript{48} opined that Kerala has been the home to two strong systems of medical practice, namely Ayurveda and modern medicine. Ayurveda, the indigenous health delivery system is today counted as cure for several ailments which modern medicine silently sidelines. The efforts of various stakeholders has resulted in attaining global recognition for its system of medicine, modern medicine hospitals have also attained global standards in healthcare. A judicious and cautious approach is required for the effective utilisation of the potentials of health tourism on a sustainable and globally accepted scale. While focussing with the unique strengths of the healthcare delivery system of Kerala, we should be careful in living up to the expectations of the international patients. The advantage arising out of the purchase power parity alone can make substantial difference for overseas
healthcare providers and health seekers. In fact, the procedures performed in institutions of Kerala are truly on par with expected international standards using quality implants, surgical and prosthesis.

Trivedi Rohit H (2005)\textsuperscript{49} opined that many foreign countries have begun looking to India for understanding the Ayurveda and incorporating it through education, research and practice to meet the overwhelming desire of consumers to access complementary and alternative medicine.

T. D. Babu, Dr. G. Jayabal (2004)\textsuperscript{50} opined that in order to realise the maximum potential of health tourism in India encourage the corporate hospitals to tie up with airlines, hotels and railways to get concession rates of travel and boarding and lodging for medical tourists. Subsidies should be provided for the acquisition of land and other basic infrastructural facilities to promote corporate hospitals in the tourist spots.

V. Selvam (2006)\textsuperscript{51} opined that India have an advantage in medical tourism over others, apart from the cost factor, most foreign nationals are used to getting treated by Indian nationals abroad. He pointed that the biggest challenge in medical tourism industry is to position India as a favourable healthcare destination by setting high standards and work in association with the government and the medical council to see to it that all hospitals keep up to those standards. To promote healthcare tourism India should have more frequent direct flights in and out of India particularly connecting to potential destinations.

Priya Ravikanth (2006)\textsuperscript{52} opined that Ayurveda is a significant money earner for Kerala tourism as it has been a key to a substantial increase in the number of visitor arrivals in to the state. In order to retain this competitive edge in Ayurveda tourism, the Kerala tourism board and the state government needed to address a lot of challenges like bringing in state- of- art quality
control standards and standardisation in the ayurvedic treatments given in the state to cope with the demands of modern times. Most spas offer guest pampering rather than a complete wellness programme with many packages that are tailor made to suit the budgets and needs of tourists. Some unauthorised ayurvedic parlours do not follow the prescribed norms. Many of their treatments are not scientifically designed or do not have trained masseurs, they employ female masseurs to lure clientele. Diet regimen is not strictly followed. Widely differing rates are charged for treatments and patients and foreigners especially are deceived with the basic principle of Ayurveda getting ignored.

Dr. V. Kubendran (2006)\textsuperscript{53} opined that apart from advanced healthcare facilities, doctors, nurses and paramedics, the hospitals should maintain excellent hygienic standards. Foreign visitors are accustomed to a number of comforts, which hospitals need to address by upgrading the technology and hiring the qualified staff to make every visitor feel at ease. All hospitals that want to be centres of medical tourism need to increase their exposure and be constantly updated on internationally accepted standards of healthcare service delivery to the international clientele. For the benefit of health tourists, the immigration authorities at Indian International airport should provide quick clearances of immigration formalities. The government may introduce a new category of medical visas to promote medical tourism. The services of the tour operators and hospitals should be synchronised so that the patient receive a string of services that make them feel comfortable.

Dr. V. Manickavasagam and G. Ramesh (2006)\textsuperscript{54} opined that since many specialists in reputed private hospitals are normally drawn from the public health sector, medical tourism may divert potential personnel to the corporate houses instead of serving the common people. This can devalue the existing healthcare system in the country. One cannot manage a third
generation industry like medical tourism with first generation strategies and professionals. To cope with the requirements of medical tourism, one has to work with its full potential. With increased competition level, hospitals cannot retain their old guards. This will make many medical practitioners either unemployed or under employed.

Hemamalini Venkatraman (2008)\textsuperscript{55} opined that global health and wellness business, pegged at $ 3 trillion, is unleashing an entrepreneurial wave in India that could change the healthcare delivery mechanism. It is the replication of the Technology Business Incubator (TBI) model in the IT sector, which is expected to bring the paradigm shift. Healthcare outsourcing opportunities from the US is expected to touch $ 4834.8 million in 2008. It is expected to create more than 7 lakhs jobs in India this year.

Shardual Nautiyal and Sapna Dogra (2005)\textsuperscript{56} identified that with world class healthcare professionals, nursing care and treatment cost almost one-sixth of that in the developed countries, India is witnessing 30 percent growth in medical tourism per year. India is the most touted healthcare destination for countries like South- East Asia, Middle East, Africa, Mauritius, Tanzania, Bangladesh and Yemen with 12 percent patient inflow from developing countries. And the most sought – after super-specialities are cardiology, neuro-surgery, orthopaedics and eye surgery.

3.4 Relevance of Service Quality in Tourism Destination Development

Destination image is the sum of beliefs, ideas and impressions that a person has of a destination.\textsuperscript{57} Tourists can be classified into three types on the basis of the psychological dimensions of their personality. Allocentrics are individualistic, active and adventurous travellers. Psychocentrics are the opposite, conservative and passive tourists who choose common, popular and safe destinations and activities. The mildcentrics are hybrids that need some
sense of individualism at their destination but with organised travel arrangements and safety ensured by the use of a travel agent.\textsuperscript{58}

Dr. Sampad Kumar Swain (2006)\textsuperscript{59} opined that the destination image is influenced with the two important attributes of tourist behaviour, one is atmospheric and another is environmental attributes. Atmospheric attributes are related to the climate, weather, temperature, humidity etc. and the environmental encompass the socio-cultural, economic, political aspects of a destination. The push-pull construction of idea generation has been taken as a model to assess the range of attributes that motivate the desire of to go on holiday as per the destination choice. Push factors are socio-psychological factors that motivate the individual to travel and the pull factors are qualities of destination that attract the tourist such as infrastructure or cultural attractions.

A.P. Williams & A.J.Palmer (1999)\textsuperscript{60} discusses the impact of electronic commerce on the development of strong tourism destination brands. Electronic media have the potential to create strong direct links between individual tourism suppliers and their customers, there by possibly undermining collective efforts to create strong destination brands. In addition, electronic media may have the potential to strengthen the process of destination brand creation, by facilitating interaction and cross selling between complementary producers within a destination. A case study methodology is used to evaluate recently developed brand Western Australia marketing campaign. It shows that despite the enormous growth in the use of electronic commerce, it is not being used to its full potential. Suppliers appear to be using the internet in a random, disorganised and un cooperative way.

Manat Chaisawat (2006)\textsuperscript{61} describes the growth rate of tourism industry in Thailand. The major features that contributed to the increase of
tourist arrivals to Thailand were aggressive tourism promotions and mass marketing. To create added value for the customers or tourists, tourism products are associated with ideas, with knowledge for the customers or tourists, innovation and the creativity of frontline staff that have direct contact with tourists.

Gavin Eccles and Jorge Costa (1996)\textsuperscript{62} opined that sustainability could be seen as a fundamental requirement for countries attempting to develop their tourism industry.

In the process of developing a tourism product, planners must ensure harmony with the local environment. Sustainability needs to evolve through effective planning with clear guidelines on the breadth and depth of the development. This goal can be achieved by educating and training people involved with tourism and by the actions of governments and organizations in sponsoring initiatives that address the relationship between tourism and the environment.

Vasanti Gupta (1999)\textsuperscript{63} suggests a programme to improve modern tourism in six points.

1. Assist the local communities to build tourism complexes, with simple hostel facilities. These would become the focus of tourism along treks, near wildlife reserves or at other destinations. These could become centres for the sale of local crafts, foods and other necessities of tourists. These complexes should complement rather than compete with private guesthouses and restaurants owned by local residents. 2. These complexes could be designed to double up as community centres, training schools or meeting places during the low season for tourism. They should also act as natural meeting places for tourists and local people, apart from having formal programmes that would allow an intermingling of ideas and culture. 3. Provide training in tourism
management, including training in management of facilities for the tourists, such as good housekeeping, and in catering and tour guidance, creating and maintaining a habitat that would attract tourists. The training can be provided at one or more of the community-based tourist complexes. 4. Evolve a long-term strategy for diverting income from tourism for building economic assets. Near forests it could be used to strengthen agriculture and horticulture and for evolving village-based industries. This would provide a sustainable source of income, something that would endure even if tourism were to become less popular. It could also assist in taking the pressure off the forests, allowing its natural wilderness to return and thus making them even more popular for the tourists. 5. Build up an environment and programmes for attracting tourists for longer periods. While there, the tourists could assist the villages with their skills. Study the flora and fauna, introduce appropriate technologies, do participatory planning, hold a theatre workshop. There is a wide range of possibilities. 6. The more expensive “fancy” tourist resorts can also pitch into the effort, simply by not stopping with the development of infrastructural facilities such as water, sewage and landscaping at the resort boundaries but by extending them into the residential and natural habitat of the community where they are located. This could be a first step towards playing a more active role in the development of the community and community-based tourism.

Graham Hankinson (2005) identifies brand images from a business tourist perspective (people visiting destinations for business meetings, incentive events, conferences and exhibitions) and tests their relationship with perceived quality and commercial criteria. Factor analysis identified three underlying dimensions – overall destination attractiveness, functionality, and ambience. While all three were correlated with perceived quality, commercial criteria were dominated by a destination’s functional rather than ambience attributes.
Frank M. Go and Kuldeep Kumar (2007) examines the role of tourism promotion as a component of destination image function. After conducting a study in which 1100 respondents from around the globe described their pre-visit perceived image of seven sample destinations as well as the information sources they used, they suggest that tourism promotion does not have a major impact upon the perceptions of travelers and that other sources of information have a much greater bearing on the formation of destination image. Successful tourism promotion is dependent on a broad range of external influences. The impact of marketing communication decisions on measurable such as revenue, market share and costs must be carefully assessed.

Yuksel Ekinci and Sameer Hosany (2006) opined that tourism destinations become more substitutable due to increasing competition in global tourism markets; destination personality is seen as a viable metaphor for building destination brands and crafting a unique identity for tourism places. Perception of destination personality is three dimensional: Sincerity, excitement and conviviality. Destination personality has positive impact on perceived destination image and intention to recommend. In particular, the conviviality dimension moderated the impact of cognitive image on tourists’ intention to recommend.

Graham Hankinson (2004) assesses the relative saliency of image attributes associated with history, heritage and culture in shaping the perceptions of places as tourism destinations. Changing a negative organic image requires a change in the destination product itself. Destinations seeking to reposition themselves need to maintain and enhance that image through public relations, working closely with the media and the education system.

Klaus Weiermair (2000) opined that in order to create and market internationally appealing tourism products, to achieve competitive advantages.
and to sustain competitiveness against global or transnational tourism firms, a number of tourism and hospitality management knowhow gaps have to be specified and corrective management measures must be undertaken. These include: . Intercultural management skills and know-how in managing the interface of the service encounter across the four tourism related cultures (culture of sending region, culture of host region, tourism and leisure cultures, organization culture of tourism enterprises). . Know-how concerning proper choice and implementation of market entry strategies in foreign markets (franchising versus management contracts, joint ventures or greenfield investments, etc.). . Know-how concerning regionally/ culturally differentiated travel motivations and tourism behaviour of customers.

Essam E. Ibrahim and Jacqueline Gill (2005) conducted a research study with the objectives of measure the perception and satisfactions of consumers of the tourism product of Barbados, and to identify potential niche markets that could be used in the development of the destination’s positioning strategy. Four possible niche markets are identified that can inform the development of the destination’s repositioning strategy: recreational, sports, culture and eco-tourism. The results indicated that the most important factor that influenced tourists’ satisfaction was the quality of service and atmosphere; it is recommended that tourism managers should ensure the provision of top quality service, first class hotels and restaurants, and a restful and relaxing environment to accompany the selected niche markets. International Quality Assurance Standards should be used to benchmark the quality of service and ensure that it is maintained at the highest standard. The influence of the socio-demographic variables should also be considered by tourism marketers when planning their marketing and promotional strategies in order to ensure the delivery of appropriate tourism products and appealing messages to the various target groups. Systematic marketing intelligence relating to major target groups will help tourism marketers to better
understand their customers and hence contribute significantly to the process of planning a destination’s positioning strategy.

Mohammed I. Eraqi (2006) conducted a study aims to evaluate the customer’s views related to tourism quality in Egypt. It attempts to measure the extent to which tourism business environment is creative and innovative as necessary conditions for internal customer satisfaction. The main conclusions of this study are: quality can be considered as a philosophy for guiding tourism organization/destination when taking decisions related to tourism services; tourism business environment in Egypt does not support the internal customer satisfaction because the absence of a suitable system for encouraging people to be creative and innovative; and in the area of the external customer satisfaction there is still a need for things to be done such as the environmental conditions improvements, internal transport quality enhancement, increasing people awareness, and improving the level of safety and security conditions.

Erdener Kayanak and Edward E. Marandu (2006) conducted a study that explores what would be the most probable scenario for the tourism industry in Botswana by the year 2020. A modified Delphi technique was used to generate data from 68 industry exports. The findings show that the experts forecasts progressively more changes and higher impact as one moves from values, structures and events. The implications for policy makers and industry operators is that efforts aimed at increasing tourism may prove more fruitful if focused on changing structures and hosting events, rather than changing values of the people.

Xavier Font and Tor E. Ahjem (1999) argues that there is a need to take into account the public sector, the private sector, non-profit organizations and the residents in order to design sustainable tourism strategies. Tourism development planning requires careful coordination and cooperation of all
tourism decision-makers, and in both the public and private sector, in order to carry out a development that will remain sustainable over time. However, reaching this agreement point will not be easy, and each destination will choose a strategy depending on their short-term needs and their ability to preserve part of their resources for the future. The private sector tends to use a market-oriented approach, while the public sector tends to take a supply oriented (resource based) approach. There is a natural contradiction between the danger of destroying environment (what the tourists come to and the commercial wishes (both in terms private profit maximization and governments’ urges for more national incomes, through taxes, balance of payments.

Jay Kandampully (2000) conducted a study to examine the appropriateness of the use of "service packaging", a concept capable being adopted by tourism organisations to assist them their ongoing effort to match capacity with demand, the quality of services offered with that of tourists' expectations. It is proposed here that adoption of the concept of packaging renders it possible for service organisations to manage demand fluctuation while, simultaneously, offering services which will consistently meet customer expectations. This study concludes that customer satisfaction can be enhanced if tourists' needs and expectations are considered during the design of tourism packages offered. A tourism organisation's strategic decision to adopt customer oriented concepts will ensure the effective management of resources.

Ronald James Ferguson and et.al (1999) assessed the technical (tangible) and functional human interaction) quality of services in a first-class international health resort and related these to service management effectiveness. Service management is effective when customers judge the overall service quality to be good, they are highly satisfied, they are willing to
recommend the firm to others and they intend to repurchase or are predisposed to purchase additional services from the firm. The technical and functional aspects of services quality and their relation to service management effectiveness were found to be different between the core and supplementary services, between customers and service personnel and between customers with and without experience. The results support the statement that competitive advantage in this industry can be obtained by improving the functional aspects of services management, by better performance of supplementary services and by reducing the gap in perceptions between customers and contact personnel.

Syed Saad Andaleeb (2001)\textsuperscript{75} opined that patient’s perceptions about health services seem to have been largely ignored by healthcare providers in developing countries. A field survey was conducted in Bangladesh and several dimensions of perceived service quality obtained- responsiveness, assurance, communication discipline etc. Using factor analysis and multiple regressions, significant associations are found between five dimensions and patient satisfaction.

Vivek Gupta and K. Prasanth (2006)\textsuperscript{76} conducted a case study on the health care services marketing strategy of the Thailand-based Bumrungard Hospital Public Co. Ltd., the largest privately managed hospital in South-East Asia. From a significantly adverse financial situation in mid-1997 due to South-East Asian currency crisis, Bumrungard has emerged as a market leader in the health care industry in South-East Asia. The case study discusses how Bumrungard was able to overcome its problems by promoting its health care services globally, and covers at length the service experience provided to Bumrungard’s customers- i.e by attracting patients from foreign countries, marketing through net, opened representative offices in various countries to provide assistance to foreigners, helping them to procure visas and make
travel arrangements and providing cost estimates to patients intending to get treated.

Klaus Weiermair, Matthias Fuchs (1991) measures tourist judgments on service quality in Alpine ski resorts. An attribute-based method was employed in order to estimate weighting schemes both for quality judgments across different tourism activity domains and different quality dimensions within winter resorts and to quantify an overall quality measure. A linear regression and sirgy’s congruity model of customer satisfaction/dissatisfaction were adopted. The results indicate that there exists a linear relationship between the overall quality measure and the partial judgments of each domain/dimension. This allows deciphering the relevance of different domains of tourism activity and quality dimensions within the process of making quality judgments. Domains of tourism activity are food and accommodation, sports activities, culture, transportation aspects to and within resort, skiing and related activities, enjoyment with nature and landscape, shopping activities. Quality dimensions are aesthetics/appreance, security/satisfy, and freedom of choice, authenticity/honesty, service orientation in terms of punctuality and reliability, variety, fun, accessibility of services.

Atilla Akbaba (2006) opined that it is vital for the hotel managers to have a good understanding on what exactly the customers want. The researches identified five services quality dimensions such as tangibles, adequacy in service supply understanding and caring, assurance and convenience. The findings showed that business travellers had the highest expectation for the dimension of convenience followed by assurance, tangibles, adequacy in service supply and understanding and catering. The research findings also confirmed that, although the SERVQUAL scale was a
very useful tool as a concept, it needed to be adopted for the cultural context within which it was used.

Woo Gon Kim (2006) examines the relationships among elements of relationship management activities (predictors) and relationship quality (a mediating construct) and relationship outcomes (commitment, loyalty and word of mouth) Structural equation analysis on the data collected from a survey of 887 dinner patrons and 21 luxury restaurants show that relationship quality is the primary mediating construct between relationship management activities and relationship outcomes. The effective use of a relationship management strategy may increase customer commitment, spread positive word of mouth and generate loyalty.

Shane C. Blum (1996) discuss how change (demographic, technological, societal, legal, cultural or ethical) is likely to influence the industry in relation to six themes: human resource management, service quality, hospitality education, the food service sector, strategic management and legislation. The findings of the study implies that hospitality organizations to remain competitive in the future they must become more responsive to the changing needs of their employees and guests. Increased competition, globalization, and a diverse workforce may also cause management to re-evaluate the way their organization is structured. Management must be prepared to identify and meet changing customer preferences resulting from changes in the demographic characteristics of our society.

Martin MacCarthy and Ronald Groves (2000) opined that success would be determined by not only what is delivered but also how it is delivered to customers. Operators must understand that in most instances the customer receives a combination of both material and personal service. Material service might best be likened to the more tangible, technical and objectively
measurable elements of the service product. Personal service, on the other hand, refers to what might best be described as the more intangible, functional and/or relational elements of the service encounter.

Rob Law and Cathy H.C (2006)\(^{82}\) opined that the recent introduction of Internet technology to general business has led to its wide-scale application in the hotel industry. Consumers have been increasingly using the Internet to search for accommodation-related information on hotel websites. He examined two groups of international hotel website users on their perceived importance level of specific dimensions and attributes on hotel websites (online browsers and online purchasers). Findings indicated that most hotel website users had made online purchases and there was not a great deal of difference of the perceptions between online browsers and online purchasers.

Bongkosh Ngamsom Rittichainuwat (2008)\(^{83}\) conducted a study aims to 1; examine travel motivation of travellers to revisit Thailand and 2, to determine whether there is a significant difference in travel motivation between first time and repeat travellers and among travellers with different demographic profiles. The result shows significant difference in travel motivations between first time and repeat travellers and among travellers with different demographic profiles and significance of positive impressions of the good food value, shopping and a variety of things to do and novelty seeking on the likelihood of travellers to revisit Thailand.

Wan-Erth Chiang (2006)\(^{84}\) Performance evaluation serves as an important reference for planning and construction policies. Data Envelopment Analysis is a powerful method of performance evaluation. This research aimed at measuring hotel performance by this method. 24 Taipei international tourist city hotels were selected, and grouped according to their hotel management styles, whether they are part of a franchise, internationally managed and independently owned and operated. The results show that the
average efficiency score across all 24 hotels is .921 with the most and least efficiency score of 1 and .687 respectively. The results indicate that the inefficient hotels did not fully or efficiently utilize their rooms. More efforts on promotions, marketing mix or managerial strategy/control would stimulate the performance of rooms.

Cromption J (1979)\(^{85}\) identified nine motives for travel such as the escape from a perceived mundane environment, exploration and evaluation of self, relaxation, prestige, regression, enhancement of kind relationship, facilitation of social interactions, novelty and education.

Michael Ottenbacher (2006)\(^{86}\) conducted a study to gain insight into factors that contribute to the success in high contact new service development (NSD) projects. This study outlines the importance of human resource management factors in high contact NSD success. Data were collected via questionnaires from hospitality managers knowledgeable about NSD in their organization. Discriminant analysis was used to identify the factors that are responsible for successful high contact NSD projects in the hospitality industry. Research results indicate that seven factors play a distinctive role in the outcome of high contact NSD: market attractiveness, strategic human resource management, market responsiveness, empowerment, and training of employees, employee commitment and marketing synergy.

Olympia Kyriakidou and Julie Gore (2005)\(^{87}\) conducted a study to provide positive benchmarking examples of hospitality, tourism and leisure small management enterprises in the area of organizational culture. Extreme case sampling was used; locating information-rich key informants or critical cases. A total of 89 small businesses were researched including hotels (and guest houses), restaurants, pubs, visitor attractions and leisure opportunities. Results suggest that best-performing small to medium-sized (SME) operations in the hospitality, tourism and leisure industry share certain elements of culture including: supporting values such as building the future together,
cooperative setting of missions and strategies, development of teamwork and organizational learning.

Li-Jen Jessica Hwang and Andrew Lockwood (2006) conducted a study to provide insight into the barriers to the application of best practices in hospitality and tourism small- and medium-sized enterprises (SMEs) in the UK. In-depth interviews were conducted with owners, managers and staff in 89 award-winning businesses in the hospitality and tourism industry. Results suggest a model identifying seven key capabilities that underlie the adoption of best practices and six barriers to their implementation. The seven key capabilities for hospitality and tourism SMEs are customer focused goals, planning and control, partnering and networking, internal and external communication, achieving consistent standards, strategic workforce management, cash flow and performance management. The six barriers to implementing best practices were identified as changing demand, limited resources, and lack of skilled labour, lifestyle, and lack of competitive benchmarking and location, all of which could create turbulence in the operational environment.

Conclusion

Reviews of available literature about health tourism reveal that it is a trend of travelling in search of affordable healthcare at right time. Health tourism market has two segments, medical tourism and wellness tourism. The term medical tourism denotes patients seeking ailment of complex diseases out side their home country. Wellness tourism includes taking holistic treatments like Ayurveda spa, meditation etc to rejuvenate body, mind and soul. Kerala is a well known tourism destination and is famous for Ayurveda which is a major contributor to wellness tourism. Multi speciality hospitals in private sector also engaged in health tourism now. Health tourism destinations should focus on service quality maintained by providers by determining quality standards and monitoring them to achieve those standards through accreditation programmes.
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