EXECUTIVE SUMMARY

The research work is focused on the objectives of analysing the medical tourist’s perception of service quality in Indian hospitals with specific reference to sultanate of Oman.

To have a common understanding, the researcher proposes the following operational definitions for the key constructs and terms used in this research work:

Medical Tourism: The activities of persons travelling to and staying in a place outside their usual environment for medical purpose.

Medical Tourists': Persons who are travelling to and staying in a place outside their usual environment to seek medical service.

Perceived Service Quality: The customer’s judgement about an entity’s overall service excellence or superiority

Indian Hospitals: The hospitals operating in India, catering to Medical Tourists.

Sultanate of Oman: An Asian country, part of Gulf Cooperation Council (GCC), located geographically closer to India.

Omani medical tourists: Persons from Oman who who are travelling to and staying in a place outside their usual environment to seek medical service.

A thorough study of the previous research works done at National and International levels was carried out by the researcher on the areas of service quality, medical tourism, service quality and its relationship with customer satisfaction, Hospital service quality among others. A brief review on the country “Sultanate of Oman” was done to present a cursory view of the country.
Based on the review, a theoretical research model of service quality for medical tourism was developed. The core of the model is the measurement of medical tourist’s perception of service quality in Indian Hospitals. Based on the input from the review and a preliminary study with medical tourists and experts, the research objectives, research questions and hypotheses were framed.

Also the researcher identified eight dimensions which determine the Service quality. They are Reliability, tangibility, assurance, empathy, responsiveness, core service, systematization of service delivery & social responsibility.

Based on the above input, a questionnaire was developed to measure the medical tourist’s perception of service quality in Indian Hospitals. Also sections on demography, travel related issues; treatment related issues were included in the questionnaire. A pilot study was conducted to make suitable amendments and then the questionnaire was tested for its reliability and validity.

Since the questionnaire developed was in English, to facilitate the smooth conduct of the research and to get better response rate the same was translated into Arabic. The reason for such translation is the language of the people of Oman is Arabic. To test the authenticity of translation, the Arabic version was again translated back to English and necessary modifications were done to the Arabic version of the questionnaire.

With the use of sampling techniques, a representative sample of 196 respondents was chosen from five important cities of Oman: Muscat, Sohar, Ibra, Nizwa and Salalah. The selected respondents were approached with a structured questionnaire consisting of constructs measuring the responses on a five point Likert scale.
The researcher encountered lot of hurdles while collecting data like cultural blocks, cross-country understanding and dealing with women respondents and the spread of respondents in different cities of Oman.

The data collected were tabulated and aggregated. The demographic details of the respondents were initially analyzed. The buying habits of the medical tourist’s such as preferred destination, information search, reasons for selecting a medical tourism destination, difficulties faced during the medical tourism process were analysed. Furthermore, the medical tourist’s perception of service quality in Indian Hospitals was analyzed against the demographic variables. The relationship between the service quality dimensions and customer (medical tourists) satisfaction were computed. Also the behavioural consequences of the customer (medical tourists) satisfaction analysed.

The key findings of the study are:

- The demographic profile of a typical medical tourist from Sultanate of Oman consists of male, particularly in the age group of 25 – 40 and employed with Government of Oman with income in the range of 400 – 800 Rial Omani (1 Rial Omani ≈ 120 INR).
- Most of the medical tourist from Sultanate of Oman preferred visiting Mumbai followed by Chennai and Hyderabad for Medical Treatment.
- Majority of the medical tourists’ preferred Allopathic medical system.
- The top most reason for visiting a foreign country for medical treatment is “Lengthy Waiting time” for treatment in home country.
- The top most reason for visiting India for medical treatment is “Quality” of treatment.
- If not India, Thailand is the next preferred medical tourism destination.
• Out of the six factors of reliability dimension “The necessary diagnosis is done right at the first time” is rated very high and “Medical treatment offered is error free” is rated low.

• Out of the six factors of core service dimension, “Counselling was given before and after the treatment” is rated high and “Hospital helps in visa processing and travel related services” is rated low.

• Male and female both perceive Responsiveness, Empathy, Social responsibility dimensions of service quality differently. Male rated the above dimensions relatively higher than the female.

• Difference in educational qualification does not bring out any significant difference in their perception regarding different dimensions of service quality.

• It is found that service quality influences customer satisfaction significantly.

• Assurance, Core service and social responsibility are the most significant dimensions of service quality that influences customer satisfaction.

• Majority of the medical tourists (65%) are satisfied with the service experience.

• Indian hospitals catering to medical tourism is on a profitable growth trajectory.

Based on the above inputs researcher developed a MED TOUR service quality model on an overall basis. Finally the researcher recommended certain strategies based on the findings for the improvement of service quality, which will help the Indian hospitals to be competitive, globally.
CHAPTER 1

INTRODUCTION
CHAPTER – 1

INTRODUCTION

The service sector is obtaining increasing importance in the global economy, particularly in most advanced countries, such as those in the European Union, Canada, Japan, and the United States. Bowen and Hallowell (2002) says that services have replaced goods as the building blocks of employment and gross national product in the economically developed world. The same is true in emerging economy like India. India’s economic development in the present scenario seems to be service led, especially in the fields of Information Technology, Software, Information technology enabled services, Tourism and so on.

Tourism, as a service sector, gains importance for its capability of employment generation, and hence economic development of the country. Basically tourism is broadly classified as Inbound, Outbound and Intrabound. India shows lot of interest in promoting inbound tourism (attracting tourists from outside into India) for its additional advantage of foreign exchange generation other than the employment generation opportunity.

One particular segment of inbound tourism which attracts the interests of India and its hospitals is Medical Tourism, where people from one place visit another place for medical treatment. Government of India is very keen in developing medical tourism (National Health Policy, 2002). This would be possible only if the medical service provider i.e. hospitals focus on the delivery of acceptable service quality. It is evident from the research that customer evaluations of service quality and their expressions of satisfaction are critical inputs to the development of marketing strategies (Ofir and Simonson, 2001). For the organizations operating in the Indian service sector, producing a quality service is imperative because of its strategic value of providing competitive advantage.
Following the above thought process, the present study aims at understanding how the medical tourists’ from Sultanate of Oman perceives the quality of service in Indian hospitals based on their experience with Indian hospitals. This would help Indian hospitals to understand the present position of their service quality as perceived by Medical tourists and to develop suitable management strategies to improve their service quality to make India, a formidable player in the Medical tourism market.

The research topic is as follows:

“Medical tourists’ perception of service quality in Indian hospitals: a Study with specific reference to Sultanate of Oman”

To have a common understanding, the researcher proposes the following operational definitions for the key constructs and terms used in this research work:

Medical Tourism: The activities of persons travelling to and staying in a place outside their usual environment for medical purpose.

Medical Tourists’: Persons who are travelling to and staying in a place outside their usual environment to seek medical service.

Perceived Service Quality: The customer’s judgement about an entity’s overall service excellence or superiority.

Indian Hospitals: The hospitals operating in India, catering to Medical Tourists.

Sultanate of Oman: An Asian country, part of Gulf Cooperation Council (GCC), located geographically closer to India.
**Omani medical tourists**: Persons from Oman who are travelling to and staying in a place outside their usual environment to seek medical service.

This study is all about understanding the perception of Omani Medical tourists about the service quality offered in Indian Hospitals. This is required to improve our Indian hospitals service quality, which in turn enhance the perceived value, leads to customer satisfaction, improve the repurchase intention, and improves the customer retention and loyalty.

The following sections build theoretical framework required for understanding this research work. This includes sections on Services, Quality, Service Quality and Medical Tourism.

1.1 **Services**

People in the western world are now living in a service economy. According to Euromonitor (2002), 68 % of the European Union (EU) gross domestic product in generated by services. This did not happen overnight. The industrial economy was gradually replaced by the service economy. One of the key publications on the shift from products to services is the “the limits to certainty” by Giarini and Stahel (1993). It describes the shift from the traditional industrial economy where value is essentially attributed to products which exist materially and which are exchanged, to the new service economy, where value is more closely related to the performance and the real utilization of the products integrated in a system. The growth of services is mainly the result of the specific and successive evolution of the production process itself.

1.1.1 **Definitions of Services**

Services are something which can be bought and sold but which cannot drop on your foot (Gummesson, 1987).
A service is any act or performance that any party can offer to another that is essentially intangible and does not result in the ownership of anything. Its production may or may not be tied to a physical product (Kotler, 1994).

The advance of technology, which changed production processes by enhancing efficiency, produced a great development of service functions at all phases of the transformation process. The largest share of product cost is in product development, storage and distribution, marketing & publicity, financial & insurance services, waste management and disposal systems – all services that are essential for the provision of its functionality. Therefore services have become indispensable in making available products that fulfil basic needs (Giarini and Stahel, 1993). The increased complexity of the production process has led to subsequent trends, like companies have to focus on their core competencies, since controlling the entire production process has become practically impossible.

1.1.2. Service: Historical perspective

The medieval concept of service

In this period (approximately 1500-1600) the most important aspect is the performance of one-to-one personalized service. Everybody performed this service according to the specification and needs of their customers or masters. It is very important in the medieval times to give each customer a personal attendance. This attendance refers to the deeds that one person does for the benefit of another person. In this period there were low status and high-status occupations. The low status occupations refer to the fact that people have to serve as in slavery because of subordination and obedience. The high-status occupation refers to the fact that people serve out of vocation because of charity & gallantry. Service in this time were thought in humanistic terms instead of in rationalistic terms and therefore it was not
possible to improve efficiency and the costs remained high. People serve other people because they want to do that (Levitt, 1972). The focus in this time was to improve the person who is providing the service and not improving the total system.

**The concept of service in the period of craftsman economy**

In the Craft-production period (approximately 1700-1800), all the products were manufactured according to the needs and requirements of the customers. Customer focus was therefore very important in this period. There was a lot of direct contact with client, suppliers.

Craft-production businesses, one especially present on the luxury end of the market, where customers want a unique image and the opportunity to deal directly with the factory in ordering their products.

There was only one disadvantage in the craft production period: high production costs (because every product was designed according to the unique needs of a customer's). That did not decrease with quantity. The prices of the products were very high and they refer only the products of craftsmanship.

**The concept of service in the period of mass production**

The period of mass production was approximately from 1800 till 1970. Henry ford played a very important role in the system of mass production. He invented a system (Assembly Line Production System) which could increase the efficiency of the production and which could decrease the production period. The drawback of this system was that the customers become less important. Fords system signalled that the production needs of the company were more important than the customers. The customers in this period were more than happy to buy
whatever companies offered them. They were always satisfied with the products. They did not demand high quality and service.

**The concept of service in the period of lean economy**

Approximately from 1980 till 2000 marked the period of lean economy. The expectations of consumers increased in the United States of America when foreign competitors (especially the Japanese competitors) entered the market with lower prices combined with much higher quality goods than the American goods. Moreover Japanese competitors introduced new products and levels of service that American firms could not match. This was called mass customizations, a system that would satisfy the existing segmented and global market better than the mass production of Henry Ford. In this system there was a very good combination of mass production, quality, price, selection and service. There were a lot of companies that also operated in the mass production period, and for them it was difficult to adopt their system to the mass customization system. The requirements needs and expectations of the customers defined the quality in this period. During this period an international certification of minimum quality standards was established, ISO 9000. This certification focuses on the satisfaction of all the customer requirements. To satisfy these requirements, it is important for a company to understand the requirements of the customer before it begins the design phase. This is possible with quality function deployment system (QFD).

Quality function deployment enables the company to reduce the time to design a new product, engineering changes, production costs, and to increase customer satisfaction. In this period the customers were gaining the upper hand in the relationships and had easy access to crucial information (for example: customer’s access to consumer reports).
The concept of service from now on into the future

Quality has become so deeply implemented in most companies processes; that it does not need reinforcement anymore. Some companies have strived to reach customers satisfaction excellence, but this objective remains stills difficult to achieve. Nowadays companies are wondering if it is worth to focus the whole production process on the needs of customers.

There has been a fundamental shift in how companies assess customer’s values and apply their resource. Companies now have access to specific information about the costs and purchases of the customers and this kind of information allows them to deliver a level of services which is based on each person’s potential to procure a profit. Customers’ services and satisfaction has become just another product for sale. It is very important for companies to consider if a customer is profitable enough for retention.

1.2. Quality

1.2.1 A brief history of Quality movement

American industry was facing a crisis in the late 1970’s and early 1980’s and was reeling under back to back recessions; deregulation; a growing trade deficit; low productivity; downsizing; and an increase in consumer awareness and sophistication; (Schlenker, 1998). Companies such as Ford Motor Company and Xerox were experiencing losses and sharp drops in market share and saw an attention to quality as a way to combat the competition. Ford has operating losses of $3.3 billion between 1980 and 1982. Xerox which had pioneered the paper copier saw its US Market share drop from 93% in 1971 to 40% in 1981 (Schlenker, 1998).
American Industry had followed Fredrick Taylor’s system of scientific management up to mid-twentieth century. Taylor’s goals were to take productivity out of the hands of the skilled craftsman and put it in the hands of the engineers and corporate administration. While the basis for a remarkable rise in productivity, the system had negative consequences on human relations and quality. To counter these consequences, managers created central inspection departments to keep defective products from reaching customers (Juran, 1995). The mass manufacturing push that was required during World War II put strains on this type of inspection system. Rather than build in systems to stop defects, materials and effort were being wasted in sending back defects. This model carried over after World War II when there were massive shortages of goods driven by a 5 year pent up demand. Manufacturers focussed on quantity and the quality of products declined precipitously.

As consumerism grew, complaints concerning the quality of products grew. As confidence in home made products waned, Americans looked to other countries to supply their goods.

The Japanese, while possessing an unwary ability to copy, also ranked poorly in the production of goods following the war. Japanese corporations, trying to stay competitive, turned to an American, W. Edwards Deming, to help rebuild their economy.

Deming, a statistician with Bell laboratories, was a devotee of Statistical Quality Control (SQC) and used the concepts of SQC to aid the Japanese in improving manufacturing quality. Deming had first visited Japan in 1947, summoned there by the occupation government to help Japan with its census. He was invited back in 1950 by the Union of Japanese scientists and Engineers to teach quality control. (Schultz, 1994). Deming’s philosophy of building quality into manufacturing system rather than performing quality assurance at the end of the manufacturing process, as was the accepted practice at the time, was the extension of other practitioners in the management field (Rosander, 1991). Walter Shewart, an engineer at Bell
Laboratories, preached in his “Economic Control of quality manufacturing products” (1931) that manufacturing could be improved by identifying and correcting problems during the manufacture of the product. Shewart identified ways of monitoring and evaluating manufacturing process that ran counter to existing processes, quality programs that winnowed out defects at the end of the process. Shewart identified variations in process as the source of most errors in quality and promoted statistics as the way to understand this variation (Deming, 1986). Shewart also devised the famous Plan, Do, Study, Act cycle that Deming was to use in subsequent teachings. Deming was employed at the same laboratory and taught statistical control to engineers and inspectors. Deming formed his ideas about quality based on Shewhart’s concepts but went on to add improvements. Deming claimed that customers were the driving force behind the definition of quality and that benchmarking other quality companies and processes would lead to even greater quality improvements.

Deming pointed out what he saw as flaws in the traditional model of management by objectives (MBO), which emphasized a chain of command in which objectives are translated into work standards or quotas. Deming cautioned that with MBO the performance of employees is guided and evaluated according to numerical goals. As a result, workers, managers and supervisors get caught up in protecting themselves. Looking good overshadows a concern for the customer or the organisation’s long term success. Employee’s desperate to meet quotas, lose sight of the larger purpose of work. After the war, Deming tried to promote his ideas about improving quality to American industry but found little response. There was, however a strong response from the Japanese. Deming guided Japanese industry through a period of strong growth and retooling, and developed core concepts of quality management that focussed on the customer, touted the benefits of teamwork and above all, espoused a commitment to quality (Rosander, 1991).
“Deming predicted the Japanese adoption of these methods would put their products in demand throughout the world in 5 years. He was wrong; within 4 years the Japanese had gained large share of some markets” (Schlenker, 1998).

Upon returning to America from Japan, Deming began formulating his 14 points of quality management, outlined in his 1982 book Quality, Productivity and competitive position and revised and updated in his subsequent 1986 publication “Out of Crisis”. “Out of crisis” provided a map for American Industry to build quality into products and services. In the years following Deming’s 1986 book, American Industry saw the resurgence in the levels of product quality and the regaining of lost market shares, although many sectors, especially the service sector, have been slower to adopt the needed measures (Martin, 1993). Following Deming’s and Shewhart’s principles, American Industry produced numerous success stories, which include that of Florida Power & Light, Lucent Technologies, 3M, and so on. One of the indicators of the success was the winning of Malcolm Baldridge National Quality Award instituted in 1987. The criteria of the award were designed to encourage companies to enhance their competitiveness through the delivery of ever improving value to customer and the improvement of overall company performance and capabilities (Evans & Dean, 2000). The evaluation process for the award was rigorous and competition among manufacturing companies was intense, the criteria on seven categories of excellence: leadership, strategic planning, customer and market focus information and analysis, human resource focus, process management and business results. (Evans, 1999). Winning the award not only meant recognition for excellence in quality, but could result in larger contracts, increased market share and an increase in stock price. Through the first ten years of the awards large corporations such as Motorola, Xerox, Cadillac and Boeing were successful in achieving recognition. Turned down for the award in 1989, IBM demanded change from its employees and was awarded the Baldridge in 1990.
An index of publicly traded companies that have received the Baldridge Award was developed. The Baldridge Index companies outperformed the S & P 500 by more than 2.1 to 1 (Ross, 1999).

1.2.2 Stages of Quality Movement

During 1970’s and 1980’s, the manufacturing sector experienced an extensive quality movement. This occurred in four stages. The first two phase focus on inspection and statistical quality control ensured product uniformity. The former focussed upon the outcome, whilst the latter on trouble shooting in order to prevent defects. The third stage quality assurance featured quality measurement and coordinated problem solving within the firm. Top management was peripherally involved with the design, planning and execution of quality policies.

The most recent stage – strategic quality management, recognises the impact of quality for building competitive advantage. The emphasis is on market and consumer needs and it is employed through strategic planning, goal setting, and mobilization of the entire organisation, including strong leadership (Garvin, 1988). By the 1990’s service organisations were also beginning to understand what their manufacturing colleague’s had discovered earlier the quality cannot be improved unless it is measured, and the best measurement is done by the customer (Reichheld & Sasser, 1990). Peters (1988) suggests that as a result of competitors moving faster, there is a need to listen to customers and respond instantly.

One approach is to document and measure customer complaints, which will begin to tell a story of how customers perceive the firm’s service quality. Improvements are then implemented to avoid similar future problems. Whiteley (1991) suggests that not all customers complain and this could be due to several reasons, such as they believe it won’t
make any difference, individuals feel they are awkward or pushy if they complain, and it may be easier to simply switch to another supplier. Achieving quality service in the eyes of the customer requires proactive organisational commitment.

According to Berry et al (1994) service plays a key role in providing value and drives a company’s success. Understanding customer expectations and measuring the organisational performance with regard to them are a central component of building service quality.

1.2.3 Defining Quality

While the evolution of quality has progressed from the manufacturing sector to the service sector and on to tourism, a definition of quality has not taken such a linear approach. Despite the amount of discussion in both academic and popular publications, the meaning of the term “quality” remains elusive. The original meaning of the word, as a defining characteristic, carried no meaning of worth, but has evolved to the point where it is used to imply some form of value judgement (Holbrook, 1994). “Conformance to requirements” (Crosby, 1984), “Fitness for use” (Juran, 1988), or “one that satisfies the customer” (Eiglier and Langeard, 1987) are some of the other prominent definitions of quality. As per the Japanese production philosophy, quality implies “zero defects” in the firm’s offerings.

In these cases, quality of a service or a product rates it against a standard, whether real or implied. This standard may be defined by the producer, the consumer, or set by other products or standards to which it is compared. Gabbott and Hogg (1998) take two broad approaches to evaluating quality. These approaches are characterised as ‘hard’ i.e. there exists objective quality, measured against a standard by a third party in some way, and ‘soft’, i.e. the quality is based on subjective perceptions operationalized in terms of consumer value. Service quality is most associated with the soft characteristics.
1.2.4 Evaluating quality: different approaches

Gronroos (1983) was one of the early researchers in the marketing theory arena to discuss the importance of the customers’ perception of service quality in defining quality. Gronroos developed a model in which he proposed that in evaluating service quality; customers compare the service they expected with the services they perceived they received. Gronroos identified factors other than outcomes, including the process itself, as important parts of service quality. Gronroos proposed that managing perceived service quality involved managing the gap between expected and perceived services. Enis and Roering (1981) had argued that consumers do not purchase goods or services but a bundle of benefits that the buyer expects to deliver satisfaction.

Therefore, only the buyer can assess the quality of a product or service. Other approaches to quality include the transcendent, product based, user based, manufacturing based and the value based. Product and manufacturing based definitions view quality as a precise and measurable entity and its conformity to pre set requirements. Value based quality is dependent on adding worth to a product or exceeding the products cost. Transcendent quality is readily recognizable but impossible to achieve. Transcendent quality is of the nature “I will know it when I see it”. User based quality is most distinctive for use in service based organisations and has been the most widely adopted in service organisations (Martín, 1993). This follows Deming, who as noted previously, defined strictly from the view point of the customer.

1.3 Service Quality

Academic literature on service quality is divided on how service quality should be conceptualised. Early work (Gronroos, 1982 and 1984; Lewis and Booms, 1983;
Parasuraman et al, 1985 and 1988) on service quality conceptualised it as disconfirmation process.

Generally all the definitions relate closely to one of the two conceptualisations. The first is ‘Nordic’ perspective, emphasizing the basic idea of functional and technical quality; and the second an ‘American’ perspective, which describes the service quality as a function of dimensions of quality that affect the service encounter (Brady & Cronin, 2001).

1.3.1 Service quality - Conceptualization and Operationalization

Though initial efforts in defining and measuring service quality emanated largely from the goods sector, a solid foundation for research work in the area was laid down in the mid – eighties by Parasuraman, Zeithaml and Berry (1985). They were amongst the earliest researchers to emphatically point out that the concept of quality prevalent in the goods sector is not extendable to the services sector. Being inherently and essentially intangible, heterogeneous, perishable, and entailing simultaneity and inseparability of production and consumption, services require a distinct framework for quality explication and measurement. As against the goods sector where tangible cues exist to enable consumers to evaluate product quality, quality in the service context is explicated in terms of parameters that largely come under the domain of ‘experience’ and ‘credence’ properties and are much difficult to measure and evaluate (Parasuraman, Zeithaml and Berry, 1985; Zeithaml and Bitner, 2001).

One major contribution of Parasuraman, Zeithaml and Berry (1988) was to provide a terse definition of service quality. They defined service quality as a ‘global judgement, or attitude, relating to the superiority of the service’, and explicated it as involving evaluations of the outcome (i.e. what the customer actually receives from the service) and process of service act (i.e. the manner in which services is delivered). In line with the proposition put forward by
Gronroos (1982) and Smith and Houston (1982), Parasuraman, Zeithaml and Berry (1985, 1988) posited and operationalized service quality as a difference between consumer expectations of “what they want” and their perceptions of “what they get”. Based on this conceptualization and operationalization, they proposed a service quality measurement scale called ‘SERVQUAL’. The SERVQUAL scale constitutes an important landmark in the service quality literature and has been extensively applied in different service settings.

1.3.2 Importance of Service Quality

Service quality has become an important topic for marketing practitioners and researchers over the past two decades. It is not an exaggeration to assert that service quality is one of the most heavily researched constructs in the field of services marketing with notable contributions from Parasuraman et al. (1986, 1988, 1991, 1993, 1994a and 1994b); Cronin and Taylor (1992, 1994), Brown et al (1993), Boulding et al. (1993), and more recently Dabholkar et al (2000), Zeithaml (2000) and Jiang et al (2000), Joseph et al (2001). While this is by no means a definitive list of the important contributions on service quality, it highlights the importance of the construct.

In the area of marketing, the concept of service quality plays a central role in understanding customer satisfaction and retention (Parasuraman, Zeithaml and Berry 1985). The growing recognition of the importance of quality in service industries has been driven by the realization that high service quality results in positive behavioural intentions as well as greater market share and profitability (Rust and Zahorik, 1993; Zeithaml, 2000). Service quality has important effects on customers purchase intentions through the mediating role of value perceptions attached to products and services. (Bolston and Drew, 1988; Zeithaml, 1984; Philips, Chang and Buzzel, 1983). Firms that are adept at service quality can build competitive positional advantages (Rapert and Wren, 1998). Service and service quality are
what differentiate undifferentiated products in the market place (Fitzsimmons & Fitzsimmons; 2001). Quality service makes obvious sense competitively and financially (Hesket et al, 1994). Thompson et al (1985) suggested that high service quality appears to result in measurable benefit sometimes directly detectable as increases in profit & market share.

1.3.3 Measurement of Service Quality and its importance

Chow and Luk (2005) listed the commonly used techniques for measuring service quality:

- Customer service Audits (Takeuchi and Quelch, 1983)
- Gap analysis (Zeithaml et al.1988)
- SERVQUAL (Parasuraman et al.,1988)
- Critical Incident Technique (Bitner et al 1990)
- SERVPERF (Cronin & Taylor, 1994)
- Sequential Incident Technique (Stauss and Weinlich, 1997)

Anything which cannot be measured, cannot be managed. Measurement of service quality is very important for a number of reasons

1. Establishing differentiation (Jayawardhena and Foley, 2000)
2. Delivering a superior quality of service compared to competitors, offers an opportunity to achieve competitive differentiation (Ranganathan and Ganapathy, 2002).
3. Attracting and retaining customers may be largely determined by the quality of service delivered (Liao and Cheung, 2002).
4. Effective measurement of service quality can be very useful in the allocation of resources and in segmentation of customers is well documented (Parasuraman et al, 1988).

5. Measurement allows for comparison before and after changes; for the location of quality related problems, and for the establishment of clear standards for service delivery. Edvardsen et al. (1994) state that, in their experience, the starting point in developing quality in services is analysis and measurement.

1.3.4 Difficulty in measuring service quality

Parasuraman, Zeithaml and Berry (1985) stated that service quality is more difficult for the consumer to evaluate than goods quality. Consumers are dissatisfied because of lack of quality service and researchers are still trying to uncover the underlying constructs that affects service quality (Brady & Cronin, 2001; Cronin & Taylor, 1992; Parasuraman et al, 1988, 1991, 1994).

Four well documented characteristics intangibility, heterogeneity, perishability and inseparability must be acknowledged for a full understanding of service quality (Parasuraman et al; 1985) and it is perhaps because of the nature of these characteristics it is so difficult to measure properly.

Problems in service quality measurement arise from a lack of clear and measurable parameters for the determination of quality. It is not the case with product quality since product has specific and measurable indicators like durability, number of defective products and similar, which make it relatively easy to determine the level of quality.

The concept of personal service is a difficult and elusive concept to measure precisely, in contrast to the goods quality which can be measured by indicator that are both objective and
precise (e.g., durability and number of defects), (Gronroos, 1990; Parasuraman et al, 1998; Smith, 1999). This difficulty in measuring service quality should not be construed as a reason or excuse for poor service quality.

Specific characteristics of services and their implications and difficulties they can cause on conceptualization and measurement of service quality

a. Inseparability of production and consumption

This involves simultaneous production and consumption, which characterizes most services. This inability to store services is a critical feature of most service operations. Since the customer must be present during the production of many services, inseparability forces the buyer into intimate contact with the production process (Carman, 1990). This simultaneous production and consumption eliminates many opportunities for quality control intervention.

b. Intangibility

Because services are performances, ideas or concepts rather than objects, they cannot be seen, felt, tasted, heard or smelled in the same manner in which goods can be sensed (Zeithaml et al, 1985). When buying a product the consumer is usually able to see, feel and oftentimes test its performance before purchase. However, with services, the consumer must often rely upon the reputation of the service firm. This thereby greatly influences the expectations aspect of quality measurement in services.

c. Perishability

This refers to the concept that a service cannot be inventoried. (Besson & Jackson, 1975; Thomas, 1978). Hotel rooms going vacant, empty airline seats and unfulfilled appointment times for a doctor are all examples of opportunity losses. This perishability
presents a problem of synchronizing supply and demand, causing customers to wait or not be served altogether. The implications for customer satisfaction are quite obvious.

d. Heterogeneity

Since the same service can be provided by various employees at the same facility or different facilities, the quality and the essence of the service can vary from provider to provider, customer to customer and from time to time. Attempting to offer a consistent service or to measure the variability of different performance types can be difficult. Unlike manufacturing, in which the product is inspected before delivery, services must rely upon a sequence of measures to ensure consistency of output.

1.3.5 Service Quality (Before 1985)

Efforts in defining and measuring quality have come largely from the goods sector. According to Japanese philosophy during 80’s, quality is “Zero defects – doing it right the first time”. Crosby (1979) defines quality as “Conformance to requirements”. Garvin (1983) measures quality by counting the incidence of “internal” failures (those observed before a product leaves the factory) and “external” failures (those occurred in the field a unit has been installed).

Researchers and managers of service firms concur that service quality involves a comparison of expectations with performance. Service quality is a measure of how well the service level delivered matches customer expectations. Delivering quality service means conforming to customer expectations on a consistent basis (Lewis and Booms, 1983).

Gronroos (1982) developed a model in which he contends that consumers compare the service they expect with perceptions of the service they receive in evaluating service quality.
According to Parasuraman et al (1985), knowledge about goods quality, however, is insufficient to understand service quality. Three well documented characteristics of services: intangibility, heterogeneity, and inseparability must be acknowledged for a full understanding of service quality (Parasuraman et al, 1985). Service quality has been discussed in only a handful of writings (Gronroos, 1982; Lehtinen and Lehtinen, 1982; Lewis and Booms, 1983; Sasser, Olsen and Wyckoff, 1978). Examination of these writings and other literature on services suggests three underlying themes:

- Service quality is more difficult for the consumer to evaluate than goods quality.
- Service quality perceptions result from a comparison of consumer expectations and actual service performance.
- Quality evaluations are not made solely on outcome of service; they also involve evaluations of the process of service delivery.

1.3.6 Gaps Model of Service Quality (1985)

Because the literature on service quality is not rich enough to provide a sound conceptual foundation for investigating service quality, an exploratory qualitative study was undertaken by Parasuraman et al (1985) to investigate the concept of service quality.

Specifically, focus group interviews with consumers and in-depth interviews with executives were conducted to develop a conceptual model of service quality. Four service categories were chosen for investigation: retail banking, credit card, securities brokerage and product repair and maintenance.
Insights obtained from the executive interviews and the focus groups formed the basis of a model summarizing the nature and determinants of service quality as perceived by consumers. Hence the birth of service quality assessment model.

Fig 1.1. Customer Assessment of Service Quality (Zeithaml, Parasuraman, Berry 1990)

The focus groups revealed that regardless of the type of service, consumers used basically similar criteria in evaluating service quality. These criteria seem to fall into 10 key categories which are labelled “service quality determinants”.
Table 1.1: Ten dimensions of service Quality

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tangibles</td>
<td>Appearance of physical facilities, equipment personnel and communication materials.</td>
</tr>
<tr>
<td>2. Reliability</td>
<td>Ability to perform the promised service dependably and accurately</td>
</tr>
<tr>
<td>3. Responsiveness</td>
<td>Willingness to help customers and provide prompt service.</td>
</tr>
<tr>
<td>4. Competence</td>
<td>Possession of the required skills and knowledge to perform the service.</td>
</tr>
<tr>
<td>5. Courtesy</td>
<td>Politeness, respect, consideration and friendliness of contact personnel.</td>
</tr>
<tr>
<td>6. Credibility</td>
<td>Trustworthiness, believability, honesty of the service provider.</td>
</tr>
<tr>
<td>7. Security</td>
<td>Freedom from danger risk or doubt.</td>
</tr>
<tr>
<td>8. Access</td>
<td>Approachability and ease of contact.</td>
</tr>
<tr>
<td>9. Communication</td>
<td>Keeping customers informed in language they can understand and listening to them.</td>
</tr>
<tr>
<td>10. Understanding the customer</td>
<td>Making the effort to know customers and their needs.</td>
</tr>
</tbody>
</table>

(Source: Zeithaml, Parasuraman & Berry, 1990).

1.3.7 SERVQUAL: An Instrument for measuring service quality

Building on the conceptual definition of service quality and the ten evaluation dimensions from their research, Zeithaml, Parasuraman and Berry sought to quantify customer’s perceptions of service quality by developing a quantitative instrument, named SERVQUAL. SERVQUAL was originally based on 97-item survey that used statement pairs in which half were positively worded, the other half negatively worded.
This survey consists of concise multiple item scale with good reliability and validity that companies can use to better understand the service expectations and perceptions of their customers. This instrument is designed to be applicable across a broad spectrum of services. As such it provides a basic skeleton through its expectations/perceptions format. The skeleton, when necessary can be adapted or supplemented to fit the characteristics or specific research needs of a company (Zeithaml, Parasuraman, & Berry, 1990).

The author used a seven-point likert rating scale with “Strongly Disagree” and “Strongly Agree” as anchors. The instrument was quickly refined to a 44-item scale: a 22-item section to measure customer’s service expectations of a particular, ideal retail sector and a corresponding 22-item section to measure customers’ perceptions of a company.

Service is measured on the basis of the difference score by subtracting expectations scores from the corresponding perception scores. The last seven dimensions (competence, courtesy, credibility, security, access, and communication, understanding the customer) were consolidated based on several statistical analyses and were consolidated into two broader dimensions labelled assurance and empathy. The remaining dimensions remained intact throughout the scale development and refinement process.

The following table shows the correspondence between the original ten dimensions and the new dimensions:
Table 1.2: Correspondence between SERVQUAL dimensions and the original ten dimensions

<table>
<thead>
<tr>
<th>Original Ten Dimensions</th>
<th>New SERVQUAL dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tangibles</td>
</tr>
<tr>
<td>Tangibles</td>
<td></td>
</tr>
<tr>
<td>Reliability</td>
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<td>Responsiveness</td>
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<tr>
<td>Access</td>
<td></td>
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<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Understanding the customer</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Zeithaml, Parasuraman & Berry, 1990)

While three of the dimensions remained same, two others now had new definitions, shown in the following table.
### Table 1.3: Five dimensions of service quality

<table>
<thead>
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<tr>
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<tr>
<td>3. Responsiveness</td>
<td>Willingness to help customers and provide prompt service</td>
</tr>
<tr>
<td>4. Assurance</td>
<td>Knowledge and courtesy of employees and their ability to convey trust and confidence.</td>
</tr>
<tr>
<td>5. Empathy</td>
<td>Caring individualised attention the company provides its customers.</td>
</tr>
</tbody>
</table>

(Source: Zeithaml, Parasuraman & Berry, 1991)

SERVQUAL quickly became the instrument of choice for measuring service quality in the service sector. “It has become the most widely used instrument for measuring service quality in profit and non-profit organizations. No other instrument has been tested as stringently and comprehensively as SERVQUAL” (White & Abels, 1995).

DeRuyter, Bloemer and Peeters (1997) were joined by many others in asserting that SERVQUAL led the field of service quality assessment: “On an operational level, research in service quality has been dominated by the SERVQUAL instrument, based on the so called gap model”. However, Babakus and Boller (1992) found problems with the dimensionality of the instrument when applied to electric & gas utilities. Kettinger and Lee (1995) used SERVQUAL in the information system service industry. Four of the five dimensions of the
SERVQUAL instrument were confirmed using second order confirmatory factor analysis, with tangibles being discarded.

SERVQUAL has also been tested in a variety of other service sectors (Orwig, Pearson and Coachran, 1997; Bebko & Garg, 1995; Clow, Fisher & O’Bryan, 1995; Licata, Mowen and Chakraborty, 1995; Bowers, Swan & Koehler, 1994; O’ Connor, Shewchuk & Carney, 1994; Headley & Miller, 1993; Babakus & Mangold, 1992; Lytle & Mokwa, 1992).

The widespread use of SERVQUAL did not mean that the instrument was without its critics. Criticisms of the SERVQUAL instrument centre on three key areas: the expectation – perceptions construct, the use of gap score measures and the independence, generality and stability of the five dimensions. Carman (1990) argued that SERVQUAL needed to be customized to the service in question in spite of the fact that it was originally designed to provide a generic measure that could be applied to any service. Carman also suggested that more dimensions were needed than the five currently found in SERVQUAL, that the item factor relationships in SERVQUAL are unstable and that the measurement of expectations was problematic.

1.3.8 Criticisms of SERVQUAL

Notwithstanding its growing popularity and widespread application, SERVQUAL has been subjected to a number of theoretical and operational criticisms which are detailed below (Buttle 1996):

1) Theoretical
   - Gaps model: there is little evidence that customers assess service quality in terms of P-E gaps
• Paradigmatic objections: SERVQUAL is based on a disconfirmation paradigm rather than an attitudinal paradigm; and SERVQUAL fails to draw on established economic, statistical and psychological theory.

• Process orientation: SERVQUAL focuses on the process of service delivery, not the outcomes of the service encounter.

• Dimensionality: SERVQUAL ‘s five dimensions are not universal; the number of dimensions comprising SQ is contextualised; items do not always load on to the factors which one would a priori expect; and there is high degree of intercorrelation between five RATER Dimensions.

2) Operational

• Expectations: The term expectation is polysemic; consumers use standards other than expectations to evaluate SQ; and SERVQUAL fails to measure absolute expectations.

• Item composition: Four or five items cannot capture the variability within each SQ Dimension.

• Moments of Truth (MOT): Customers assessments of SQ may vary from MOT to MOT

• Polarity: The reversed polarity of items in the scale causes respondent error.

• Scale Points: The seven-point likert scale is flawed.

• Two administrations: Two administrations of the instrument cause boredom and confusion.

• Variance extracted: The overall SERVQUAL score accounts for a disappointing proportion of item variances
1.4 MEDICAL TOURISM

1.4.1 Tourism

In general “Tourism” means travelling for pleasure. According to WTO (World Tourism Organisation) the word tourism comprises of “the activities of the persons travelling to and staying in place outside their usual environment for leisure, business and other purposes”.

Tourism can be broadly classified as follows:

![Classification of Tourism Diagram](Source: www.discovermedicaltourism.com)

**Fig 1.2. Classification of Tourism**

(Source: www.discovermedicaltourism.com)

The focus of this piece of work is Medical tourism, which forms part of Health Tourism. Hence to understand more about medical tourism it is important to explore health tourism.

1.4.2 History of Health Tourism

Healthcare Tourism dates back thousands of years where people travelled to places with thermal and mineral water for bathing and health enhancement. Ancient mythologies believed
in the powers of healing present in the natural springs, leading to the popularity of public baths in that era, and eventually, the evolution of spas in Europe in the 19th century.

Many people in ancient times travelled to nearby rivers and mineral springs for their alleged curative properties and for relaxation. For example we hear of people dipping and bathing in the Ganges, in the Nile, in the Yangtze and in the river Jordan to be cleansed physically and spiritually. The ancient Romans and English visited Bath in England to bathe in the warm springs and mineral waters and drink some of the water for its supposed health benefits (Hembry, 1990). Bath becomes a health resort for English Society in the 1700's.

Today some people believe that bathing in the Dead Sea is healthful because of its high mineral content (E.g.: Sodium Chloride, Bromine, Calcium Chloride and potassium Chloride). Health benefits are said to include cures for skin problems and several health resorts in the area provide facilities for bathers (World book Encyclopaedia, 1984).

In Europe many cities have grown up around mineral springs and health spas. Examples of such cities are Baden, Lausanne, St Moritz and Interlaken in Switzerland; Baden- Baden and Wiesbaden in Germany, Vienna in Austria; Budapest in Hungary (Goodrich and Goodrich, 1987).

Health tourism is defined as the deliberate attempt on the part of the tourist facility (e.g. Hotel) or destination (e.g. Baden in Switzerland or Bath in England) to attract tourists by promoting healthcare services and facilities in addition to regular tourist amenities.
1.4.3 Classification of Health Tourism

Healthcare tourism as the name suggests refers to travel for the purpose of enhancing health and general well being. In terms of services rendered, healthcare tourism can be broadly classified into three categories:

**Spas and Alternative therapies** which consists of acupuncture, aroma therapy, beauty care, herbal healing, homeopathy, massage, meditation, yoga and other general well being spa treatments.

**Cosmetic Surgery** which includes breast augmentation, facelifts, liposuction and other non-essential medical procedures.

**Medical Tourism** covering such medical services as health screening, heart surgeries, cancer treatment, joint replacement and other surgical procedures typically requiring hospitalization and professional medical care.

1.4.4 Understanding Medical Tourism

Medical tourism Definitions:

- Medical Tourism – the process of “leaving home” for treatments and care abroad or elsewhere domestically. (Paul H. Keckley, 2008).
- Medical tourism usually refers to the idea of middle – class or wealthy individuals going abroad in search of effective, low cost treatment (Tarun Khanna, 2007).

Medical tourism, the term refers to the increasing tendency among people from one country where medical services are either very expensive or not available, to leave their countries in
search of more affordable health options often packaged with tourist attractions. Broadly speaking, medical tourism is the art of travelling to obtain medical care.

Medical Tourism constitutes two words “Medical” and “Tourism”. To define Medical tourism, requires extensive understanding of these words. The word ‘Medical’ means treatment for illness, disorder or injuries. Understanding of word Medical and tourism individually is not sufficient to define medical tourism. Medical tourism is combination of various and definite activities and clear understanding of such activities is essential. Considering the above sets of definitions, the following can be observed: when a person travels across the border and outside their usual environment to seek medical service, the travel portion of the travel is called “Medical Travel”, and upon arrival such person is called “Medical Tourist”, and such activities in which includes utilization of medical services, hospitality, cultural exposure or site seeing is called “Medical Tourism” (Jagyasi, 2010)

Medical tourism is a term used to define the influx of foreign patients for health and medical care packaged with tourism (optional). Medical tourism has emerged from rapid growth of what has become an industry, where people travel substantial distances to overseas countries to obtain medical, dental and surgical care, while simultaneously being holiday makers in a more conventional sense.

1.4.5 Types of Medical Tourism

<table>
<thead>
<tr>
<th>Table: 1.4 Types of Medical Tourism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outbound</td>
</tr>
<tr>
<td>Patients from home country travelling to other countries to receive medical care</td>
</tr>
<tr>
<td>Inbound</td>
</tr>
<tr>
<td>Patients from other countries travelling to home country to receive medical care</td>
</tr>
<tr>
<td>Intra bound (Domestic)</td>
</tr>
<tr>
<td>Patients travelling within the country to receive medical care outside the geographical area, typically to a centre of excellence in another State or Region</td>
</tr>
</tbody>
</table>
As described in the table, there are three categories of Medical Tourism: Outbound, Inbound, and Intrabound (Domestic). Countries are focusing more on inbound medical tourism for its inherent economic benefits. (Source: Report on Medical Tourism by Deloitte Centre for health solutions 2008).

1.4.6 World trend in healthcare

Healthcare is an area in which individuals can take advantage of 21st century globalization. International travel for health purposes is becoming a way of life for many Americans, Europeans and Asians.

The medical tourism industry has been growing worldwide. It involves about 50 countries in all continents and several Asian Countries are clearly in the lead. In Asia, medical tourism is highest in India, Singapore and Thailand. These three countries, which combined comprised about 90% of the medical tourism market share in Asia in 2008, have invested heavily in their healthcare infrastructures to meet the increased demand for accredited medical care through first class facilities (www.medicaltourism.com).

The world is in a healthcare crisis and patients are starting to travel overseas in search of best quality and the most affordable medical care. More and more health insurance companies, employers, claim payers and health insurance agents are looking at medical tourism as the creative solution to the healthcare crisis. A recent report on medical tourism by McKinsey, a consulting firm stated that by 2017, over 16 Million Americans could be travelling overseas for Medical Care. With that being said, people from other countries equal to or greater than the amount will also be travelling around the world for medical care.
1.4.7 Medical Traveller groups of the World

The world’s medical travellers can be divided into **four distinct geographical groups** who travel for distinctly different reasons.

**The first** is made up of Americans. Indeed countries like Thailand, Malaysia, South Africa, which were the first to try and test medical tourists, all geared their systems to attract growing American clientele. The US system is predominantly insurance driven. But health insurance covers critical care – not cosmetic care. Vast number of Americans today who are looking for cosmetic surgery – whether it involves a facelift, liposuction or dental treatment for a bright smile. As the baby boomers – those 76 million Americans born between 1946 – 1964 are increasingly going for facelifts, Botox treatment, tummy tucks et al. Since cosmetic surgery is mostly not covered by medical insurance, many Americans prefer to travel abroad. A full facelift costs US $8,000 – $20,000 in US and only US $1,252 in South Africa. Thailand is slightly more expensive at $2,682. Best of all, going abroad means a vacation as well after the surgery is over (patientsbeyondborders.com).

**The second major groups** – the British – were being forced to seek medical treatment in other countries by sheer waiting lists caused by National Health Service (NHS). Unlike the US, the British healthcare system ensures free treatment to all its citizens.

The only problem is that the NHS which was set up in 1948 is struggling to cope because of a shortage of both doctors and hospital beds. Private medical facilities are available in the UK, but they are prohibitively expensive and also relatively fewer in number.

**The third big group** of medical travellers comes from the middle-east. These are citizens – of oil rich nations, like UAE, Sultanate of Oman flying abroad to seek medical facilities that
are either unavailable or short supply in their own countries. An agency in Saudi Arabia estimated that every year, more than 500,000 people from middle-east travel seeking medical treatment for everything from open-heart surgery to infertility treatments. They travel everywhere to Jordan, Saudi Arabia, Bahrain, US, India, Thailand and Malaysia.

Finally the last group of medical travellers form a motley lot. They are from the least developed countries with generally poor medical infrastructure. In 2003 it was estimated that at least 50,000 people from Bangladesh and Nepal came for medical treatment to India. A significant majority of the 1,26,000 medical travellers to Jordan came from neighbours with poor medical infrastructure facilities. (www.discovermedicaltourism.com)

1.4.8 Medical tourism in India

India is fast coming to the forefront as provider of world class healthcare facilities. These include a wide array of highly skilled healthcare professionals, trained in various specialised disciplines, state of the art equipment and modern amenities, impeccable service and personal attention to every need of the patient, and all these at a cost that is surprisingly affordable.

Medical tourism is perceived to be one of the fastest growing segments in marketing ‘Destination India’ today. India is on the threshold of a healthcare revolution and emerging as the global destination for medical tourists.

CII-McKinsey report says that Medical tourism alone contribute up to Rs.9,000 Crores by 2012 and Rs.18,000 Crores by 2017 in India. The industry grows at an estimated rate of 30% annually. Healthcare with tourism is new mantra that has seen foreigners flocking to India for treatment. In this direction, corporate hospitals, in cooperation with tour operators are promoting India as a healthcare destination from the Middle East to the Far East. India has a
potential to attract 1 Million health tourists per annum which will contribute US$ 5 Billion to the economy (CII Study).

1.4.9 Competition in Medical Tourism Industry

By understanding the economic opportunities of medical tourism sector, many countries across the world are vying for a piece of the global medical tourism market. Many Governments in developing countries see medical tourism as an excellent way to boost the local economy while improving their own health care systems. The following section reviews the benefits and challenges of the medical tourism sector for the host country. This will help us to understand why there is so much of interest shown in this sector.

1.4.10 Benefits and challenges of Medical Tourism to the host country

Any industry when it develops brings potential benefits and challenges. Medical tourism is no exception. It brings lot of tangible and intangible benefits along with some challenges as listed below.

Tangible Benefits

- Foreign exchange earnings which enable economic wealth of nation
- Increase in efficiency of patient care process and cutting edge treatment
- Improvement in hospital supply chain efficiency.
- Strategic alliances with business partners within and outside the country.
- Technology and knowledge transfer
- Creation of employment opportunities in the industry
- Better utilization of infrastructure and skilled man power.
- Opportunity for development of infrastructure in hotel, tourism and travel.
• Economies of scale.
• Better health standards at home.
• Scope for improved research and development to offer comprehensive medical solutions.

**Intangible Benefits**

• International acceptance of a country as a global health care provider.
• Social and cultural experience
• Brand Image of Nation as a world class health care destination.
• Public and private partnership.

**Challenges**

• Increased medical fees for domestic patients.
• Reduced access to quality and quantity medical services for domestic patients.
• Shortage of Health sector human resource

Source: India Brand Equity Foundation Report (www.ibef.org)

Having understood the benefits and challenges of the medical tourism sector the countries that are competing for the share of global medical tourism market are reviewed.

**1.4.11 Medical Tourism destinations of Asia**

**Thailand**

Thailand is the main competitor to India in Medical tourism. Thailand prices are bit higher on average than India’s, the main advantages being a better overall tourist experience and more
bundling of services. More and more hospitals are being accredited by JCAHO (Joint Commission on the Accreditation of Health Care Organisation), and the number of medical tourists is ever expanding.

Thailand is popular for alternative medical, cosmetic surgery, dental care, gender realignment, heart surgery, oncology, orthopaedics.

Thailand has all but established as king of the castle when it comes to international medical tourism. The affordable prices combined with high level of quality care in a country rich in culture, natural beauty and amazing food all combine to make Thailand the first choice for many seeking medical treatment abroad. In fact Thailand is one of the worlds preferred destinations for all type of treatment including Medical, Cosmetic and dental procedures.

Thailand as a country is long accustomed to receive foreign travellers. In the big cities English is understood, especially at private clinics that will interest tourist looking for treatment.

Care has to be taken while choosing the medical practitioners. Most of the medical practitioners are experienced and well qualified, but there are few whose reputations can be less than ideal.

Thailand is picking in alternative medicine. Thais have long being practising alternative medicine and the many practitioners using herbal medicine and holistic approaches are available.

This sector is beginning to attract foreign attention particularly the country’s wellness, retreats, yoga workshops and chiropractic treatments.
Thailand is also familiar for its health spas. Thus spas industry is big business in Thailand. Thais and foreigners alike take advantage of the main spas in the cities, where saunas, steam baths and every kind of massage are available for much less than the going rate in the west. Spas here are well suited for international tourists and cost saving packages are available at every establishment.

**India**

India is the most economical of any of the world medical tourism destinations, while being the equal of the major destination in terms of quality of staff and equipment. With many of the brand new state of the art hospitals and western trained doctors - it is easy to see why it is a leader in medical tourism. Medical facilities at India’s leading private hospitals are excellent and state – of – the art. Value for money offered here draws thousands of patients each year. India offers wide range of specialities. India is also known for its alternative medicines like Ayurveda, Siddha and Unani. India is also known for its ashrams and retreat centres that offers plenty of new age pursuits and ancient practices such as meditation, yoga, Ayurvedic treatment and more. Many of these practices originated in India and experts that can otherwise be hard to find in other countries are widely available here.

India is popular for its Ayurvedic spa treatment that allegedly heal mind and body, as well as its spa resorts which typically offer meditation and yoga, two practises which India excel.

India is enticing holiday destination characterised by myriad cultural traditions and historical attractions, spanning thousands of years. Travelling here to receive world class medical care followed by a site seeing holiday still costs significantly less than it would to undergo the same medical procedures in Europe or North America.
Philippines

Situated in South – East Asia, the picturesque and tropical Philippines offers visitors a high standard of medical treatment at very reasonable prices. The magnificent natural beauty of the many islands and beaches in the country make it a perfect place to relax before an operation and also to recover afterwards. Philippines have been growing in popularity in recent years, particularly with American and European tourists seeking inexpensive hospital treatment.

For many years the country’s top hospitals were all located in the capital of Manila, but nowadays many new modern hospitals have been built outside the capital including Luzon and Davao. These hospitals are positioned close to tourist areas with stunning beaches. There is an array of medical services available including plastic surgery, organ transplants, hip and knee replacements eye operations and dental care.

Philippines not only have the benefits of being inexpensive, however, but the standard of facilities is world class. The doctors and hospital staff are renowned for being caring, skilled and possessing great English skills.

The Philippines has a wealth of skilled cosmetic surgeons who specialize in facelifts rhinoplasty, abdominal tucks, liposuction and breast augmentation. Also Dental surgery is performed at an incredibly high standard. Throughout the Philippines, natural health spas and relaxation centres offering therapeutic healing of the mind, body and soul are available. The natural healing resorts offer alternative treatments.
Malaysia

Foreign visitors often choose Malaysia for medical treatment due to the low cost of procedures and care and also the attractive options available for the recuperation period. The Malaysian government promoting the country as a medical tourism hub and all kinds of treatments are available at world class facilities including general and cosmetic surgery as well as high quality dental care.

Many private clinics and medical centres in Malaysia are well equipped and staffed by highly trained specialists and medical staff. In fact Malaysian specialists rank among the best in the world in terms of training and expertise. English is spoken at all of these facilities. In addition, the country’s capital acts as a major Asian transport centre, making getting here easy. Surgery and accommodation compare very favourably with costs that would be incurred for similar treatments in western nations. Cardiac procedures draw a substantial number of patients to Malaysia.

While Kuala Lampur is the country’s hub for healthcare, Penang is catching up. Malaysia also offers treatments on facelifts, rhinoplasty, ear and eye surgeries. Many of the Malaysia’s leading hospitals have excellent dental centres that attract medical tourist with their low prices and high quality treatment.

Alternative treatments such as acupuncture and ayurveda can be found practiced in Malaysia. Malaysia is leader in Asian health spas and attracts many foreign visitors looking to indulge in pampering. Health spas typically offer stress management advice and a range of massage and hydro therapies.
Singapore

If the first consideration of a medical tour is not a stringent budget, Singapore is the place.

While some countries draw patients in with their low cost medical care, Singapore’s appeal lies in its world class medical facilities, fluent English staff and familiar infrastructure to westerners. Singapore offers medical, dental and alternative therapies to the world.

Singapore is a state deserving of its reputation for its cleanliness, order and its ultra high standard of private medical care. While it is by no means as cheap as say India or Thailand, medical staff here invariably speaks a high standard of English and the healthcare infrastructure is easily comparable with that of western countries.

Singapore’s ultraclean and structured environment contrasts sharply with its close Asian competitor India and Thailand. For many, this gives Singapore the edge over its two biggest competitors despite the prices of treatment are higher.

A reputation for state of the art equipment and the finest surgeons, many of whom are trained in US, is also a major draw card for many would be patients. Those visitors looking to make their trip both a medical tourist excursion and a regular vacation will find Singapore a fascinating country with modern amenities and entertainment, scenic beaches, great food and a rich culture.

Popular medical procedures include hip and knee replacements and cardiac surgeries. There are several clinics and hospitals in Singapore offering cosmetic surgery. Singapore has many quality dental clinics that offer everything from checkups and teeth whitening to more complex surgeries such as dental implants.
There is a sizeable Chinese population in Singapore and as such many alternative medicine clinics exist offering traditional Chinese medicine for all kinds of ailments. Herbal medicine and acupuncture treatments are popular for both locals and visitors alike.

Like any large city, Singapore has many health clubs and spas where specific treatments are available on the spot. Popular treatments include aromatherapy, hot stone massage as well as hydrotherapy.

**Vietnam**

Overshadowed until now by the medical tourism industries in other nearby Asian countries like Singapore and Thailand, Vietnam is slowly emerging as a potential challenge and all kinds of treatments are available including cosmetic and dental procedures. Vietnam is a leader in traditional Chinese medicine. Acupuncture is widely practised as a curative measure for many types of illness.

Although Vietnam is a relative novice on the medical tourism scene, it is gradually gaining a reputation for itself as a destination capable of offering a broad selection of surgical procedures with a high standard of expertise in pre and post operative care. Cosmetic surgery is the main field concentrated on, by Vietnam’s Medical Tourism industry.

Chinese traditional medicine is widely practiced in Vietnam and there are countless practitioners that prescribe herbs ailments. For more serious pain, most Chinese doctors are trained in acupuncture – a technique popular in the west – to relieve specific types of pain.

**1.4.12 Medical Tourism destinations of Europe**

Belgium and Germany lead in Western Europe offering convenient access, state of the art facilities and relatively low prices compared to the UK and US.
The attraction of Eastern Europe is mostly from its lower costs for medical and dental procedures, with Hungary in the lead especially in dental tourism. With more dentists per capita than any other country and rock bottom prices it gives many tourists plenty to smile about.

In general Eastern Europe offers cheap and reliable medical, dental and cosmetic surgery, but lacks some of the recovery vacationing options and tropical beaches of their Asian competitors.

**Belgium**

In terms of Medical tourism in the European Union, Belgium is a leader both in terms of value for money and standard of treatment. With its location at the heart of European Union, the country benefits from easy access which combined with its highly professional private healthcare system, makes it an attractive option for medical travel. Among medical procedures which Belgium is reputed offer at affordable prices are cosmetic surgery, dental work and kidney transplants. Heart bypass surgery is also popular, attracting patients from countries where extensive waiting lists might mean the difference between life and death.

With procedure costs up to 50 percent cheaper than in other European Countries, more and more patients are realizing the benefits of taking medical tourist excursions to Belgium. Dutch visitors are currently country’s most significant proportion of the market, making up 60 percent of the total volume, while French visitors come in second at 17 percent of the market. Other visitors hail largely from England, Germany, Italy and Luxembourg.

Brussels the country’s capital city is the epicentre of its medical industry and has a reputation for adopting and practising some of the world’s most up to date technologies and home to some of Belgium’s most talented medical professionals.
Smooth relationships between practitioners, hospitals, pharmaceutical companies and medical equipment manufacturers ensure consistency across all aspects of treatment.

**Germany**

Medical tourism to Germany is growing at a faster rate. There are a number of reasons why people travel to this country to have medical treatments. Many Americans find Germany a much cheaper option than treatment in their home country, while waiting list in British hospitals send medical tourists searching for less lengthy options.

An estimated 50,000 foreign travellers chose Germany as a destination at which to receive medical treatment away from home. Without any marketing plan, each visitor spends about €250 per day, which in turn generates revenue of €125 million for the German economy. Germans often complain about state of their health care system, but compared to other European systems and the American system, the German counterpart is impressive. There is a rigorous training process for all medical professionals in Germany, while medical equipment in hospitals is up to date and of the highest standards.

There are few procedures or treatments that aren’t offered, with everything from general surgery to joint replacements and hair transplantation available. Add to this the high success rate in treatments and compassionate patient care and you will find that Germany is among the top countries for American and European medical tourists to consider.

It is essential that surgical procedures in Germany can cost one fourth that of US and travel to and in country costs less than in other European destinations such as Britain and France.

In addition to excellent medical services, this EU member state offers a wide range of health spas and resorts, making the recovery period one of relaxation and luxury.
There are other upcoming medical tourism destinations in East and West Europe. They are France, Greece, Italy, Spain, Croatia, Cyprus, Czech Republic, Hungary, Latvia, Lithuania & Poland.

1.4.13 Medical tourism destinations of Latin America

Medical tourism is increasingly rapid in Latin American countries, particularly Argentina, Colombia, Costa Rica, Chile, Mexico and Panama, among other countries, where patients can undergo heart surgeries, cosmetic surgery or dental work at economical price, and with more personal attention. Central American nations are also marketing their dentistry, plastic surgery, and many surgical procedures along with a getaway vacation. People should be aware that only few hospitals in Latin America are accredited by the Joint Commission of India, the international branch of the US agency that accredits US Hospitals.

Mexico

For many years medical tourists have travelled to Mexico for treatment, and recent years have seen an even greater influx of patients from all parts of the world. Mexico’s physicians and dentists are well qualified with many having trained in the US. The country’s proximity to the US has lead to it become a top destination for Americans in search of quality, affordable medical, cosmetic and dental treatments.

In a number of Mexican cities, clinics and hospitals are very modern and feature state of the art diagnostic equipment. Many facilities are staffed with English speaking physicians and medical personnel are US board certified. Many medical tourists comment that their Mexican specialists and staff relate to them much more personally than health professionals in their own countries. The cost of medical procedures in Mexico averages at 30 – 35 percent of US costs. There are excellent savings in dental procedures as well.
Popular treatments include high tech eye surgery and bariatric surgeries such as lap band surgery. Cosmetic surgery in Mexico is particularly popular among US patients who have long been crossing the border for low cost plastic surgery. Tijuana in particular boasts several excellent clinics catering to medical tourists with breast procedures such as breast lifts and body and facial procedures such as vaginoplasty, tummy tucks and facelifts.

Dental treatments are widely available in Mexico and thousands of US citizens make the journey, south of the border each year for the quality services that is offered at very favourable rates.

Mexico boasts many resorts to choose from on pacific coast, and also along the Caribbean. A number of resorts are incorporating spas which now commonly feature in medical tourism packages.

**Brazil**

Brazil’s health system is one of the world’s largest, comprising an estimated 16,000 facilities, including clinics, hospitals and local health centres that are staffed by more than 200,000 qualified physicians. The country provides some of the most advanced medical care that you will find globally and treatment among the cheapest.

In particular, Brazil has become world famous for its cosmetic and plastic surgery procedures. The well to do have been visiting Brazil for procedures for years in order to maintain their youthful appearance and their anonymity while recuperating on Rio’s fabulous beaches. More hospitals in Brazil have received accreditation by the Joint Commission on the Accreditation of Hospitals than in any country other than the US, and rates are among the best in Latin America.
1.4.14 Medical Tourism destinations of Middle East

Competing along with global players, some of the Middle East countries are pushing to be major players in the global medical tourism market.

**Israel**

While not one of the world’s leaders in medical tourism, an increasing number of people travel to Israel each year for cost effective medical treatment. The country has many world class travel destinations, with more people choosing to take advantage of cheap medical care here before or after a leisurely holiday.

Israel has a number of leading medical institutions as well as a professional medical infrastructure; attracting patients from neighbouring middle – eastern countries where health care may not be up to the same standards. Additionally, waiting times are often shorter than in neighbouring countries and some procedures are cheaper. Popular treatments sought include heart surgery, knee, and hip replacements. While the quality of care and medical expertise is up to International standards in Israel, the safety of some destinations are questionable due to political tensions. This makes choosing the location of the hospital where you will receive treatment, important. With many important historical sites in Israel, combining a trip to see with inexpensive healthcare can be great money saver.

**Jordan**

The kingdom of Jordan is in the midst of a nationwide push to become a competitor in the blossoming medical tourism industry. It is one of the tourist friendly countries in the Middle East, making it a competitive Medical Tourism destination.
A total of 56 hospitals in Jordan are involved in the push for medical tourist dollars. Most medical tourists are scheduled for kidney replacements, orthopaedic procedures, neurological operations and heart surgeries. Dental work is also popular with incoming tourists. All in all, the facilities are increasingly state of the art and yet prices are still rock bottom – in many cases 10 percent of standard US prices.

Most, inbound medical tourists are arriving from nearby countries like Libya, Iraq, Sudan and the Gulf states. If Jordan is going to realise its goals of dominating the Middle Eastern health scene, then it will have to overcome some stiff competition from Turkey and Egypt.

1.4.15 Medical tourism destinations of Africa

**South Africa**

South Africa’s tradition in medical innovation is world renowned, as are its standards in providing world-class healthcare and expertise at reasonable costs. The country has been attracting foreign patients for numerous procedures in all health specialities and in particular for a variety of cosmetic and dental procedures.

The private and public healthcare systems, combined with the country’s medical schools, have worked together to produce internationally recognized medical specialists. South Africa’s leading position in international medicine was well established in 1967, when the first human heart transport was performed in Cape Town.

Europeans, in particular from Germany, Italy and UK have been visiting South Africa for years to undergo plastic surgery. They have been drawn to the country due to the highly-qualified surgeons available, the excellent private clinics and the reasonable prices.
Popular procedures include breast augmentation and reduction, face lifts, liposuction, and the nose and ear corrections. Dental surgery and tooth implants, eye surgery and laser treatments, and fertility treatments are popular with foreign visitors as well.

The country boasts sunshine throughout the year, extraordinary scenery, and of course, a wide variety of wild animals in their native habitats. These attractions, continued with the lower costs for treatment are major enticements of thousands of travellers. South Africa have realized that their country’s natural wonders can have a positive impact on the recovery process, for their patients and encourage both post operative relaxation & exploration.

1.4.16 Healthcare Accreditation

Healthcare Accreditation has been defined as “A self assessment and external peer assessment process used by healthcare organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve”.

Accreditation systems are structured so as to provide objective measures for the external evaluation of quality management. Accreditation schemes should ideally focus primarily on the patient and their pathway through the healthcare system – this includes how they access care, how they are cared for after discharge from hospital, quality of the service provided for them.

Some of the well recognised International healthcare accreditation agencies are:

1. Trent accreditation scheme (UK – Europe, Hong Kong, Philippines and Malta)
2. Joint Commission International (JCI)

4. Canadian Council on Health Services Regulation (CCSHA) based in Canada

5. National Committee for Quality Assurance (NCQA)

6. International Organisation for Standardization (NCQA)

7. European Society for Quality in Healthcare (ESQ)

8. Quality Health New Zealand

9. Netherlands Institute for Accreditation of Hospitals

10. Council for Health Service Accreditation of Southern Africa


International Society for Quality in Healthcare (ISQUA) is an umbrella organisation for such accrediting agencies providing International Healthcare accreditation.

1.4.17 other accreditation agencies and programs

1. ISO 9001:2000 Registration

The most widely recognised mark of quality in the business world today, ISO 9001:2000 registration. ISO registration is a rigorous process by which the hospital improves and monitors the delivery of patient care, continuously measures quality, and places the highest priority on eliminating medical errors.

2. NABH Accreditation

Quality council of India (QCI) and its National Accreditation Board for hospitals and healthcare (NABH) standard consists of stringent 500 plus objective elements for the hospitals to achieve in order to get the NABH Accreditation. NABH is now a member
of the International society for quality in healthcare and the NABH standard is at the threshold of being recognised globally. (www.indianhospitaltour.com)

1.4.18 Factors fuelling the growth of Medical Tourism

a. Demand side and Supply side

The growth is fuelled by both the supply side and demand side factors. Some of the demand side factors could be high cost of treatment in more developed countries, long wait list, unfavourable insurance, need for anonymity growing interest in cosmetic surgery involving such elective procedures as rhinoplasty, liposuction, breast augmentation, LASIK eye surgery, removal of tattoos, love to travel and sometimes non availability of expertise. On the other hand the supply side factors of this growth could be rapidly growing health care systems in growing countries due to adopting new technologies at an affordable cost, favourable economic exchange rates, emergence of new type of intermediaries, deliberate marketing of health care, and rise of internet among many.

b. Options available for Medical Tourists

Thailand, India, Singapore, Malaysia, South Africa, Hungary, Jordan, Israel, Argentina, Cuba, Philippines are some of the prominent players in this industry. Thailand became a well known destination for medical tourism as early as the 1970’s because of its specialty in gender change operations and later on moved to cosmetic surgery. Malaysia became involved after 1998 in the wave of the Asian economic crisis and need for economic diversification as did many Thai hospitals, when local patients were no longer be able to afford private healthcare. Singapore, competing with Malaysia and Thailand by deliberately lowering the price, was a late entrant in the scene. Other countries like Jordan focuses on serving the
Middle-East, Israel specializing in female infertility, in-vitro fertilization, and high risk pregnancies, South Africa and Argentina in cosmetic surgery, Cuba in skin diseases.

c. Private Hospitals at the forefront

Leading the growth in the medical tourism industry are private hospitals. The Apollo group hospitals and the Escorts Heart Institute and Research centre in India, the Bumrungrad hospital in Thailand, the Sunway Medical centre in Malaysia, and the Raffles hospital in Singapore are all leading private hospitals that attract a large number of medical tourists in their respective countries.

Table 1.5: Medical Tourism Revenue Earned

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Thailand</td>
<td>600,000</td>
<td>US, UK</td>
<td>$ 470 m</td>
<td>Cosmetic surgery, Organ transplants, dental treatment, joint replacement.</td>
</tr>
<tr>
<td>Jordan</td>
<td>126,000</td>
<td>Middle East</td>
<td>$ 600 m</td>
<td>Organ transplants, Feasibility, Treatment, Cardiac Care.</td>
</tr>
<tr>
<td>India</td>
<td>100,000</td>
<td>Middle East, Bangladesh, UK and developing countries</td>
<td>NA</td>
<td>Cardiac Care, Joint replacement, Lasik</td>
</tr>
<tr>
<td>Malaysia</td>
<td>85,000</td>
<td>US, Japan developing countries</td>
<td>$ 40 m</td>
<td>Cosmetic surgery</td>
</tr>
<tr>
<td>South Africa</td>
<td>50,000</td>
<td>US, UK</td>
<td>NA</td>
<td>Cosmetic surgery, Lasik, dental treatment.</td>
</tr>
</tbody>
</table>


1.4.19 Emerging Medical Tourism in India

India, with its overall strength of specialist and super specialist human resource, quality, availability of different medical specialties and affordability, is one of the prominent players
in the field of medical tourism. Some of the indicators that the medical tourism is catching up the attention of the country are stated below:

On July 25, 2006 ING Vysya Mutual fund announced the launch of a new closed ended fund called CUB (Competitive upcoming Business) fund. This new fund focused on emerging business like rural retail & finance, food processing, Logistics, alternative energy, KPO (Knowledge Process Outsourcing) and medical tourism. This is an indicator that medical tourism attracts the interests of the investing community. They strongly believe that medical tourism has a promising future. CII (Confederation of Indian Industry) McKinsey conducted a study on medical tourism and projected that medical tourism will be US$ 2 Billion industry by 2012 in India and its current growth rate is 30%. Government of India’s National Health policy 2002 emphasizes on promoting health tourism. Some of the state governments like Gujarat, Maharashtra, Kerala, constituted Councils/Boards for promoting Medical Tourism in their respective states. Private healthcare provides like Apollo-Group, MAX health care, Fortis Heart Institute jointly launched Indian Health Care Federation to promote India as a destination for Medical Tourism.

The study conducted by Associated Chambers of Commerce & Industry of India (ASSOCHAM ) predicts the market size of the Indian Medical Tourism sector is likely to be more than double to Rs.10,800 crore ($2.3 Billion) by 2015 from Rs.4500 crore ($1 Billion) at present ,2010. The inflow of medical tourism in India is also likely to cross 32 lakh by 2015 from the current level of 8.5 lakh (2010).

1.4.20 India – a unique Healthcare destination

India has the capability to deliver world class health care at an affordable cost, lesser waiting time and high success rate across specialties. Some of the salient features are
Over 60,000 cardiac surgeries are due every year with output comes on par with International standards.

Multi organ transplants are successfully performed at 1/10\textsuperscript{th} cost in comparison to the west

Patients from over 55 countries are treated at Indian hospitals.

Internationally qualified and experienced specialist and super specialist medical professionals.

Latest equipment and the infrastructure like the da Vinci surgical system for Robotic Cardiac surgery, 64 slice CT scan, Linear accelerators similar to Sloan Kettering, New York.

Strict blood safety and infection control processes.

Medical professionals now can consult specialists across the Globe, send images and have a video conference to arrive at the best decision for complicated cases.

Largest pharmaceutical industries base in the world, exporting drugs to more than 180 countries.

The average cost of healthcare in India is about 1/5\textsuperscript{th} to 1/10\textsuperscript{th} that of the west.

Zero waiting time for major surgeries.

Cost of advanced surgeries in India is 10-15 times lower than anywhere in the world.

(Source: India Tourism Promotional Brochure)

1.4.21 India’s Advantage in Medical Tourism

Today India has proved that it can offer quality medical treatment that can match some of the best in the world. For example Apollo hospitals, one of the top private hospitals in India has achieved 98.5 % success rate in heart surgeries, 87% in bone marrow transplantation and 95% in Kidney transplantation. Some of the best hospitals in India has been accredited by JCI
The Joint Commission International is the International arm of the Joint Commission accreditation for hospital organizations, US. The cost of medical treatment in India is in some cases as low as 10% of what they charge in UK or US. For instance to perform a heart surgery in India the treatment costs range from $4,000 - $10,000, whereas in UK and US it may cost you $20,000 - $40,000.

The table below gives us a comparative cost advantage of India.

**Table 1.6: Cost of Medical Treatment at different countries**

<table>
<thead>
<tr>
<th>Medical Procedure</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Bypass</td>
<td>1,30,000</td>
</tr>
<tr>
<td>Heart Valve Replacement</td>
<td>1,60,000</td>
</tr>
<tr>
<td>Angioplasty</td>
<td>57,000</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>43,000</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>40,000</td>
</tr>
<tr>
<td>Spinal Fusion</td>
<td>62,000</td>
</tr>
</tbody>
</table>

Note: Costs are for surgery, including hospital stay only.

Source: www.patientsbeyondborders.com
The waiting period in some of the western countries is as high as 18-24 months, whereas in India it could be done within weeks. It is reported that one 68-year-old British pensioner James Campbell who suffered from Osteo-Arthritis for both Knees was asked to wait for 36 months for the surgery in UK. He opted to come to India to get his surgery done and eventually saved US$ 18,000. India’s exotic locations are well known worldwide. It is rich in mountains, flora & fauna and all types of terrain and climate catering to all types of tourists. This is certainly an advantage for India.

India is also capable of offering a wide range of medical treatments from heart surgeries to hip replacement to tooth root canalling to Liver transplants. Indian doctors are highly qualified and experienced. One study found out that 60% of doctors in India’s leading corporate hospitals have international qualifications, thus increasing the acceptance and comfort levels among International Patients. A surgeon in US performs close to 2500 surgeries in his/her lifetime whereas in India a Surgeon in his/her 30’s would have similar number of procedures already. The recent trend shows that western tourists are attracted towards alternative medicines in India like Ayurveda and Siddha. Such alternatives already pervade many western societies, but tourists are often just as keen as to visit the origin of practice. Another important advantage India has is its English speaking, technically trained manpower.

1.4.22 Some initiatives by State Government and private hospitals to promote medical tourism in India

Understanding the potential benefits of medical tourism, both the government and private sector are gearing up with initiatives to groom the medical tourism industry.
Some of them are listed below:

1) Leading Indian travel houses like SITA, KUONI have launched tie-ups with overseas players that focus on medical tourism.

2) The Karnataka government is setting up Bangalore International Health City Corporation, which will cater to International patients for a wide variety of healthcare products and treatments.

3) The Asian Heart Institute at Mumbai’s Bandra-Kurla Complex offers state of the art facilities for all types of heart complications. It has been set-up in collaboration with the Cleveland Institute USA and offers five star services at a reasonable cost.

1.4.23 Opportunities for India and others

Booming medical tourism have thrown lot of opportunities for Indian and foreign individuals and companies. This sector needs lot of investments in infrastructure and technology. Companies and individuals can participate in creating infrastructure like Hospitals, Hotels, and Diagnostic Centres, Ambulance Services, beach resorts, domestic transportation etc., This growing sector calls for more professionally qualified medical, paramedical and support staff. This is a good opportunity for the educational and training institutions to cater to this demand. There is a great need for coordinating agencies that can bring healthcare and Tourism together. This provides new opportunities for the individuals and companies alike. Foreign medical tourists show lot of interest in Yoga and meditation. This gives ample opportunities for such institutions.

India’s cost effective world class medical treatment offers a good opportunity for foreign insurance companies. For example, A Kolkata based Indian Hospital has signed an
agreement with the British Insurance Company, BUPA. Travel Agents, Airlines, Hotels, Taxis etc., can also be benefited from this new lucrative niche.

1.4.24 Obstacles to be crossed by India

One important area where India needs to improve is marketing, as there is lack of information about our strengths abroad. Second important area of concern is accreditation. Even though institutions like JCI accredited few Indian hospitals, more and more hospitals need to be accredited in order to gain the confidence of the International Medical tourist and the International Insurance Companies.

Lack of country specific promotional strategies is the next area of concern. India treats every medical tourist from any part of the world equally. India must differentiate the tourists based on proper segmentation. For example the reasons for different group of people coming to India, as medical tourists are different. Americans and other European Countries are coming to India because of the high medical costs in their countries. Britishers are coming to India because of the long waiting period in the home country. West and Middle East Asians are coming because of unavailability or short in supply of medical facilities and tourists from Bangladesh, Nepal are all coming to India because of poor medical facilities in their home country. Understanding these differences and targeting them with the right product, pricing and promotional strategies will yield results.

In India, still the stakeholders in Tourism Industry and stakeholders in the Healthcare sector are operating independently to attract and retain medical tourists. Proper coordination between these two sectors will constantly benefit the medical tourism. Different hospitals are pricing their healthcare services differently which may lead to confusion in the minds of the medical tourists. Proper co-ordination between these two sectors will certainly benefit the
Medical tourism. Different hospitals pricing its healthcare services differently lead to confusion in the minds of the medical tourists. These needs some co-ordination among the health care providers in coming out with a standardized price band which will inject some amount of confidence in the minds of the medical tourists.

Recently Dubai has built a health care city to capture the Middle-East market and divert it from Asia. Sultanate of Oman has announced a similar Medical City in Muscat. Such initiatives bring in competition in this sector and to sustain the growth, India has to realign its strategies.

One of the major challenges for Indian healthcare service providers is to deliver consistent quality. It is imperative to measure quality from the customer’s perspective to find out the areas for improvement. Hence this study is undertaken to measure the medical tourists perceived service quality.

1.4.25 Prominent Medical Tourism destinations of India

Chennai

Chennai (earlier known as Madras) in India is placed well for the International medical travellers seeking treatment/ surgery at best hospital in India by most experienced surgeon. Being home to few of the most experienced doctors in India and the birth place of Apollo Hospitals, Chennai has few of the most comprehensive hospital in India. The cost of treatment is still cheaper in Chennai as compared to other cities in India. Chennai is also well placed for the convenience of medical travellers as being the technology hub, it is well connected to major air hubs, has some good shopping places, accommodation outside the hospital is not costly and tourist vehicles are freely available to move about. Plenty of excursion options are available, if interested. Chennai has few of the most comprehensive and
medical tourism promoting hospitals of South India. Major medical tourism promoting hospitals in Chennai are Apollo hospitals, MIOT hospital, Apollo speciality cancer hospital and Global hospital. These hospitals have been accredited by national and international hospital accreditation bodies and are well equipped to true medical and personal care of International patients.

**Bengaluru (earlier Bangalore)**

One of the fastest growing cosmopolitan cities in Asia also holds the status of being the silicon valley of the east. While it has several other reasons to be proud of, perhaps the most important one will be housing some of the most high technology industries in India. Bengaluru is also home to some of the India’s premier scientific establishments and hospitals.

Blessed with a wonderfully pleasant climate, gardens and parks, natural lakes and several tourist attractions it is definitely a place worth visit. In accordance to its cosmopolitan nature the city of Bengaluru is dotted with innumerable pubs, restaurants shopping malls, night clubs and other integral facilities that you would find in any major metropolitan.

Due to its cosmopolitan nature and the multicultural population Bangalore has something for everyone – music and dance concerts (Western and Indian), dramas, exhibitions, carnivals, conferences and much more.

Bangalore is also well placed for the convenience of medical travellers as being the technology hub of the east it is well connected to major air hubs, has some of the major shopping places, accommodation outside the hospital is not costly and tourist vehicles are freely available to move about. Plenty of excursion options are available, if interested. Bangalore is a hub to few of the finest and medical tourism promoting hospitals of South
India. Major medical tourism promoting hospitals in Bangalore are Apollo hospitals, Narayana heart hospital, Sparsh Orthopaedic and spine hospital, Global hospital and more.

These hospitals have been accredited by national and international hospital accreditation bodies and are well equipped to take medical and personal care of International patients.

**Delhi**

Delhi is also well placed for the convenience of medical travellers as being the capital it is well connected to major air hubs, has some of the major shopping places, accommodation outside the hospital is not costly and tourist vehicles are freely available to move about.

If interested in excursions, places like Taj Mahal in Agra, dessert cities of Udaipur, Jaipur etc, hill stations like Shimla, Kulu Manali, Mussourie are located within 4–8 hour driving distance.

The Escort heart institute and research centre in Delhi performs nearly 15,000 heart surgeries every year, and the post – surgery mortality rate is only 0.8% which is less than half of the most major hospital in the US. Major medical tourism promoting hospitals in Delhi are Indraprastha, Apollo hospitals, Fortis hospitals, Ranjan Dhall hospitals, Escorts hospitals, Artemis Hospitals, Max Hospital, and others. These hospitals have been accredited by national and international hospital accreditation bodies and are well equipped to take medical and personal care of International patients.

**Hyderabad**

Medical tourism at hospitals in Hyderabad combines care for your health with International Tourism. The primary reason behind its surging popularity is better health care services at an affordable budget. Other features include reduced waiting periods, quality and so on.
Major medical tourism promoting hospitals include Apollo hospitals, Global hospitals, Wockhardt Hospitals. These hospitals have been accredited by national and international hospital accreditation bodies and are well equipped to take medical and personal care of International patients.

Hyderabad is also well placed for the convenience of medical travellers. It is well connected to major air hubs, has some of the good shopping places, accommodation outside the hospital is not costly and tourist vehicles are freely available to move about. Plenty of excursion options are also available.

**Kerala**

Kerala is not only a beautiful destination in Southern India, also known for its scenic beaches and serene back waters. Kerala has gained International attention for Medical Tourism destination.

Kerala is famous for its alternative medical therapies such as Ayurveda, which help to rejuvenate and revitalize the body. What many tourists have now discovered is that Kerala has a pool of trained doctors and nurses and an excellent network of hospitals that offer international standard treatments at very affordable prices.

Kerala travel tourism offers tour packages that combine medical treatment with a restful holiday in Kerala, India. The world class hospital facilities, pre and post operative care and pleasant climate make medical treatment and recovery in Kerala, a positive experience.

Major medical tourism promoting hospitals in Kerala are Lifeline hospital, Malabar Institute of Medical sciences, Amrita Institute of Medical sciences, Ayurvedic centre of Kerala among others. These hospitals have been accredited by National and International hospital
accreditation bodies and are well equipped to take medical and personal care of International patients.

Kerala is also well placed for the convenience of medical travellers. It is well connected to major air hubs, has some of good shopping places, accommodation outside the hospital is not costly and tourist vehicles are freely available to move about. Plenty of excursion options are also available.

**Kolkata**

Geographically situated in the eastern part of the Indian subcontinent and on the east bank of Hooghly River and the capital of the state of West Bengal. It changed its name from ‘Calcutta’ to ‘Kolkata’ in the year 2001.

Hospitals in Kolkata are a major medical travel destination due to few of advanced hospitals and its proximity to its neighbouring country, Bangladesh. The doctors from Kolkata are known for their medical skills and hospital expertise.

Major medical tourism promoting hospitals in Kolkata are Apollo Gleneagles hospital and Wockhardt hospitals among others. These hospitals have been accredited by National and International hospital accreditation bodies and are well equipped to take medical and personal care of International patients.

Kolkata is also well placed for the convenience of medical travellers. It is well connected to major air hubs, has some of good shopping places, accommodation outside the hospital is not costly and tourist vehicles are freely available to move about. Plenty of excursion options are available, if interested.
Mumbai

Hospitals in Mumbai have been historically popular with patients from South Asian and Middle East countries to India. Now a growing number of people from USA, Africa and Canada are also visiting Mumbai for medical treatment.

Primary reason why Mumbai in India is now becoming such a popular medical tourism destination for the westerners is

- High quality of private medical care
- Low cost
- English is widely spoken
- Big pool of US and UK returned doctors & surgeons.
- Air connectivity

Major medical tourism promoting hospitals in Mumbai are Wockhardt hospitals, Saifee hospitals, Eye solutions eye hospital, Dr. L. H. Hiranandani hospital (Also upcoming Apollo hospitals, Anil Ambani group hospitals, and Wockhardt hospitals). These hospitals have been accredited by National and International hospital accreditation bodies and are well equipped to take medical and personal care of International patients.
Pune

Hospitals in Pune are at the forefront of Medical Tourism in India whereby people from all over the world visit Pune in India for medication and total healing solutions. The best known medical doctors and the latest of all medical and health facilities are available at Pune making it the favourite choice among the cities providing medical tourism. The advantage of Pune is the cost effectiveness and no quality compromise.

Major medical tourism promoting hospitals in Pune are Aditya Birla Memorial Hospital, Ruby Hall clinic, Apollo hospitals, Sancheti Hospitals among others. These hospitals have been accredited by National and International hospital accreditation bodies and are well equipped to take medical and personal care of International patients.

Pune is also well placed for the convenience of Medical travellers and well connected to major air hubs.

1.4.26: Some of the leading Indian hospitals promoting Medical Tourism

Table 1.7: List of leading hospitals promoting medical tourism in India

<table>
<thead>
<tr>
<th>S. No</th>
<th>Hospital</th>
<th>Location</th>
<th>Medical facilities offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apollo Hospitals</td>
<td>Chennai, Bangalore, Vizag,</td>
<td>Multi Specialty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hyderabad, Goa, Delhi, Mumbai.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Wockhardt Hospitals</td>
<td>Bangalore, Mumbai, Hyderabad</td>
<td>Multi Specialty</td>
</tr>
<tr>
<td>3.</td>
<td>Fortis Hospital</td>
<td>Delhi, Mohall, Noida, Mumbai,</td>
<td>Multi Specialty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bangalore.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Global Hospitals</td>
<td>Bangalore, Chennai,</td>
<td>Multi Specialty</td>
</tr>
</tbody>
</table>
1.4.27 Quality assurance in Medical Tourism

Most Indian private hospitals made efforts to improve quality by employing quality manpower, better salary structure, training and providing facilities to their doctors for continuing their education.

Analysis opined that while quality remained an issue for India in the past, it seemed to be improving since India’s economic liberalization in the early 1990’s. Private hospitals were finding it easier to import high – tech medical equipments. Therefore, medical technology, which used to differentiate the healthcare facilities available in developed countries with that of India, did not exist. “For instance, for our cardio unit, we have been able to acquire new solid–state flat–panel detector, the Digital Cath lab systems, that gives the best image quality with very few side effects to the human body. This is at par with what is offered in the best hospitals in the West, and now at least five major (Indian) hospitals have this system”, says R. Basil, Chief Executive at Bangalore’s Manipal Hospitals. Now, it is not only the clinical
talent and the technology here that is world class but also service standards, the way hospitals are being managed, patient services, administrative services, etc., said Vishal Bali, General Manager of the Bangalore based Wockhardt hospital and Heart Institute.

1.4.28 List of Internationally Accredited Hospitals in India

1. Apollo Hospitals, Bangalore.
2. Apollo Hospitals, Chennai
3. Apollo Hospitals, Hyderabad
4. Apollo Gleneagles Hospitals, Kolkata
5. Apollo Hospitals, Goa
6. Wockhardt Hospital, Bangalore
7. Wockhardt Hospital, Hyderabad.
8. Wockhardt Hospital, Mumbai
9. Wockhardt Hospital and Kidney Institute, Kolkata
10. Fortis Hospital, Delhi
11. Fortis Hospital, Mohall
12. Fortis Hospital, Noida, Delhi
13. Escorts Heart Institute Hospital, Delhi
14. Manipal Hospital, Bangalore
15. Narayana Hrudayalaya Heart Hospital, Bangalore
16. Artemis Hospital, Gorgon, Delhi
17. Max Super Speciality Hospital, Delhi
18. Max Devaki Heart and Vascular Hospital, Delhi.

(Source: Researcher’s compilation)
One of the world class Healthcare Accreditation recognised by International Community is by Joint Commission International (JCI). Some of the Indian Hospitals got accredited by the Joint commission International. They are

1. Ahalia Foundation Eye Hospital, Kerala, Palakkad
2. Apollo Gleneagles Hospitals WB Kolkata
3. Apollo Hospital, TN, Chennai
4. Apollo Hospital, AP, Hyderabad
5. Apollo Hospitals, Karnataka, Bangalore
6. Asian Heart Institute, Maharashtra, Mumbai
7. Fortis Escorts Heart Institute New Delhi
8. Fortis Hospital, Mohali
9. Fortis Hospital, Bangalore
10. Fortis Hospital, Mumbai
11. Grewal Eye Institute, Chandigarh
12. Indraprastha Apollo Hospital, New Delhi
13. Moolchand Hospital, New Delhi
14. Narayana Hrudayalaya, Bangalore
15. Satguru Partap Singh Apollo Hospital, Punjab
16. Shroff Eye Hospital, Mumbai
17. Sri Ramachandra Medical Centre, Chennai

Source: www.jointcommissioninternational.org

1. 5 Sultanate of Oman

Oman, officially called Sultanate of Oman is an Arabic State in South-West Asia on the Southeast coast of the Arabian Peninsula. It is bordered by the united Arabic Emirates (UAE) to the north-west, Saudi Arabia to the West, and Yemen to the South - West.

In November 2010, the United Nations Development Programme (UNDP) listed Oman as the most improved nation over the last 40 years from among 135 countries worldwide. According
to International indices, Oman is one of the most developed and stable countries in the region under the leadership of His Majesty Sultan Qaboos bin Said.

**History of Oman**

From 6th century to 7th century AD Oman was controlled and/or influenced by Persian dynasties the Omanis were among the first people to embrace Islam (7th century AD). Oman is known for their extensive trading and seafaring activities in East Africa and Far East, particularly during the 19th century, when it propagated Islam to many of East Africa’s coastal regions, certain areas of central Africa, India, Southeast Asia and China. Portuguese explorers arrived in Oman and occupied Muscat for 140 year period, between 1508 and 1648. Rebellious tribes eventually drove out the Portuguese, but were pushed out themselves about a century later, in 1741, by the leader of a Yemeni tribe leading a massive army from various allied tribes, beginning the current line of ruling sultans. Excepting a brief Persian invasion in the late 1740’s, Oman has been self-governing ever since.

Present Sultan His Majesty Qaboos bin Said, took over the country from his father Sultan Said bin Taimur in 1970. He introduced major social reforms and modernised the state’s administration. Since 1970, Oman has purchased a moderate foreign policy and expanded its diplomatic relations dramatically.

**Geography of Oman**

Oman lies between latitudes 16° and 28° N and longitudes 52° and 60° E. A vast gravel desert plain covers most of the central Oman, with mountain ranges along the north and southeast coast, Where the country’s main cities are located. (Muscat, Sohar, Salalah......)
Oman’s climate is hot and dry in the interior and humid along the coast, very little rainfall. Oman has a coastline of 2092 kms and the bordering countries are Saudi Arabia, Yemen, UAE.

Demographics of Oman

According to Oman census (2003), the population of Oman is 2.3 million, out of which around 0.5 million are foreigners, most of whom are guest workers from India, Pakistan, Bangladesh, Egypt and Philippines. The official language is Arabic and the religion is Islam, English is one of the important languages used for administrative purposes.

Economy of Oman

Oman’s basic statute of state expresses in Article II, that, “The national economy is based on justice and the principles of a free economy”. Oman has limited oil reserves. Other sources of income are agriculture, fisheries, tourism and manufacturing.

Since the slump in oil prices in 1998, Oman has made active plans to diversity its economy and is placing a greater emphasis on other areas of industry, such as Tourism. Oman’s proved reserves of petroleum total about 5.5 billion barrels, 24th largest in the world.

Oman has significant mineral resources which include chromite, dolomite, zinc, limestone, gypsum, silicon, copper, gold, cobalt and iron.

The industrial sector is a corner stone of the sultanate’s long term (1996-2020) development strategy for diversifying the sources of national income and reducing dependence on oil. There are industrial estates in Sohar, Sur, Salalah, Nizwa and Buraimi providing industries with the resources for expansion.
Tourism in Oman

Oman is known for its popular tourist attractions. Wadis, deserts, beaches, mountains are areas which make Oman unique among its neighbouring cooperation council for the Arabic states of the Gulf nations. Numerous forts and castles are included among Oman’s cultural landmarks. There are over 500 forts, castles and tower in various architectural styles, built to defend more than 3200 kms coastline from potential invaders.

Education in Oman

Before 1970, only three formals schools existed in the whole country with fewer than 1000 students receiving education in them. Since Sultan Qaboos come to power in 1970, the government has given high priority to education. Today there are over 1000 schools and above 650,000 students. The adult literacy rate was estimated at 28.1% for the year 2000 (Males 19.6% and Females 38.3%).

Health in Oman

As of 1999, there were an estimated 1.3 physicians and 2.2 hospitals per 1000 people. In 2000, 99% of the population had access to healthcare services.

Culture of Oman

Arabic is Oman’s official language. Other dialects spoken in Oman by sections of people are Balochi, Swahili. The country has adopted English as a second language. A significant number also spoke Urdu due to the influence of Pakistani migrants.
Oman is famous for its Khanjar Knives, which are curved daggers worn during holidays as part of ceremonial dress. During the Medieval era, Khanjar’s become highly popular as they symbolized Muslim sailors.

Omani men wear traditional clothing. This typically consists of an ankle length collarless robe called Disdasha that buttons at the neck with a tassel hanging down. Women wear Hijabs and Abayas. Some women cover their faces and hands, but most do not.

The sultan has forbidden the covering of faces in public office. On holidays, such as Eid, the women wear traditional dress, which is often very brightly coloured and consists of mid calf-length tunic over trousers.

**Oman India Relationship**

India and Oman have historically enjoyed very warm and cordial relations. Archaeological finds indicate the existence of maritime relations between the two countries since the period of Indus valley civilization. The treaties of Ibn – Batuta and Marco Polo also mention Indians residing here. In the late 18th century, the famous Sultan of Mysore, Tipu sent his emissaries to Oman. Indian business community has been settled here for generations, and some of them have even taken Omani citizenship. However formal diplomatic ties between the two countries were established in 1955. Oman is second home to 500,000 Indians who have earned love and admiration from their Omani brethren and the government for their diligence, sincerity, law abiding nature, and hard work. Many Omanis visit every year to India for higher education medical and leisure tourism as well as business. The two booming economies of India and Oman have opened up numerous horizons for further stronger relations to be developed upon.
People to people contacts are believed to have existed between Indians and Omanis as early as the seventh century. Indian merchants were already undertaking commercial activities in Muscat (The present capital city of Oman) in the fifteenth century. At that time, the Indian community consisted essentially of traders and financiers from Kutch and the Sindh.

It was only in the nineteenth century that some Khojas also arrived here. They are presently well integrated in Oman, Some of them even holding ministerial positions. Meanwhile, a few of the Old Indian trading companies have developed into big business houses. The oldest Indian family in Oman has been in the country for at least eight generations. Roughly 14% of the population of Oman are Indians. (2003 Census).

**Oman - India Trade relationship**

Indian exports to Oman jumped 80 percent to US$ 1.04 billion in 2007 from US$ 578 million in 2006. The main contributors to the significant jump in India’s export figures were steel pipes, copper products, rice, cement clinker and fuel oil for ships. Similarly, Oman exports to India jumped 60.5% percent to reach US$ 457 million in 2007 from US$ 323 million in 2006. Major Omani exports to India included urea, LNG, Poly propylene, lubricating oil, dates and chromites ore.

**Oman – India bilateral Cooperation**

Oman and India have signed many important bilateral agreements such as Treaty of friendship, commerce, and navigation (1953), Air services agreement (1973), Cultural agreement (1991), Agreement on Trade, Economic and Technical co-operation (1993), Agreement on Science and Technology (1996), MOU on cooperation in Agriculture (1996), Agreement in avoidance of Double Taxation (1977), Agreement on promotion and protection

Visa’s issued by Indian Embassy to Omanis

Table 1.8: Number of visas issued to Omanis

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Visas issued to Omanis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>31,463</td>
</tr>
<tr>
<td>2010</td>
<td>35,569</td>
</tr>
<tr>
<td>Up to June 2011</td>
<td>25,576</td>
</tr>
</tbody>
</table>

(Source: www.timesofoman.com)

The visa included tourist and medical visas. Medical visa (M visa) charges are high. So many Omanis visit India in tourist visas for medical treatment.

Zaid Al Siyabi, a senior official at the Department of Treatment abroad, Ministry of Health, Oman, says that out of 653 patients sent by the ministry for treatment abroad in 2010, 550 patients opted for India.

1.6 Organization of Thesis

This thesis is divided into seven chapters and the sequencing of chapters is done as follows:

Chapter 1 INTRODUCTION

This chapter introduces the research topic and discusses the concept of Services, Quality, and Service Quality with specific reference to its history, conceptualization, importance and measurement. Further a separate section is included on Medical Tourism. This section elaborates the meaning, types, importance of Medical Tourism. Also the key medical tourism destinations of the world and India were discussed. The opportunities and challenges thrown
by Medical tourism sector with specific reference to India were also discussed in detail. A brief section on Sultanate of Oman was also added. Finally a section of sequencing of thesis chapters and a brief explanation was included.

Chapter 2 REVIEW OF LITERATURE

This chapter reviews the research studies conducted at both International and Indian levels which are relevant to service quality, its measurement, relationship between service quality and customer satisfaction, customer satisfaction and its behavioural consequences. The gaps in previous research works is also discussed following which the research problem is stated.

Chapter 3 RESEARCH FRAMEWORK

This chapter discusses the objectives of the research, research questions and hypothesis framed. A research plan indicating the broad linking of objectives, supporting research questions/hypotheses and relevant statistical tools is also included. The limitations of the research are also stated.

Chapter 4 RESEARCH METHODOLOGY

This chapter highlights on the methodology adopted in this research with specific details such as research design, sampling plan, preliminary study conducted with tests of reliability and content validity of the research instrument.

Chapter 5 ANALYSIS AND INTERPRETATION

This chapter analyses the data collected from the respondents and relevant interpretations are drawn from the outcome to meet the research objectives. Appropriate tables, diagrams, charts are used.
Chapter 6 FINDINGS

A summary of findings derived from the data analysis and related interpretations are discussed in this chapter.

Chapter 7 RECOMMENDATIONS AND CONCLUSIONS

A list of recommendations which are useful for the stakeholders such as Hospitals, policy makers are proposed in this chapter. Also this chapter includes the concluding observations of the researcher with directions for future research in the area of Medical tourism and Service quality.