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ABSTRACT

Medical tourism is a niche market. Non-invasive aesthetic medical tourism is a type of cosmetic medical tourism with no surgery involved. This type of global interconnection is a relatively new phenomenon within the context of the current sphere of internationalism, thus explaining why few have explored the economic and health factors in a deeper context than simply a cost/ benefit analysis. Therefore, the purpose of this research is to investigate how risk of stakeholders may act as a barrier to the development of aesthetic medical tourism, and to establish how competitive advantage may be sustained in Bangkok.

Semi-structured interviews with 15 non-invasive aesthetic clinic owners, 25 English-speaking international tourist-patients, and five government representatives have been conducted in Bangkok. The findings from fieldwork were coded and analysed thematically using a framework derived from the literature review. This research identified six factors related to Thailand's competitiveness and six barriers to the development of this industry. The research made a significant original contribution to academic and practitioner knowledge in that it examined and evaluated risk perception in a new tourism context and with a new group of tourists. This research has established a classification of six types of risk in relation to non-invasive aesthetic medical tourism: functional, physical, financial, time, psychological and social risk. It also demonstrated how interpretivist qualitative approach can make a contribution to aesthetic medical tourism research practice. A framework of risks in relation to the development and management of aesthetic medical tourism in Bangkok was also established for both consumers and service providers in order to realise related risks and develop risk reduction strategies appropriately.

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CHAPTER 1

INTRODUCTION TO THE RESEARCH

1.1 Introduction

As background to the dissertation, this chapter begins by introducing a number of core concepts pertinent to the study: tourism, international tourism, medical tourism, tourism in Thailand, medical tourism in Thailand, non-invasive aesthetic medical tourism and non-invasive aesthetic medical treatments in Thailand respectively. The chapter goes on to clarify the rationale for the research project, and to set out the research aim and objectives. A summary of the research methodology is also provided. To complete the chapter, the structure of the dissertation is explained.

1.2 Background of tourism

Many types of tourism are represented in the literature. Li and Tsai (2013) suggest that people choose their desired tourism destinations and types according to their interests, intentions and preferences. They also suggest that personality is a strong influencer of tourism consumers' behaviour. In other words, the type of tourism chosen depends on the reason for travel such as sport tourism, religious tourism, rural tourism, slum tourism, film tourism, adventure tourism, sustainable tourism, health and well-being tourism and many more. In addition, Bezruchka (2000) states that tourism has generally been used to imply travel to access services and goods. However, Pennings (2002) argues that tourism has been used in the context

of travel for an economic activity to avail services while Bass (2005) states that it can be seen as an economic activity to avail goods. In both cases, it can be argued that the end point of tourism is the attainment of well-being of the individual, whether consuming goods or services. Linked to this, Carrera and Bridges (2006) suggest that engagement in tourism entails a movement away from one's home environment.

1.3 Health and medical tourism

Sheaff (1997) and Singh (2014) consider the different variants of health-oriented tourism and state that a common denominator is the web of transactions that transpires between several parties. Such parties may include the provider of services or goods, the consumer of the services or goods and an intermediary between the two. These actors directly or indirectly interact with one another, and are all seen as integral to the process of engaging in health-directed travel. In this respect, travel may include destinations which are domestic or international.

Definitions of medical tourism are by no means standard, and vary from one researcher to the next. For instance Melendez (2008) defines medical tourism as the practice of travelling to a different country for medical procedures or products, while according to Rutherford (2009) a medical tourist is an individual who seeks health-care for lower cost and/or reduced waiting periods outside their country of origin, combined with the intention of enjoying a post-operation vacation. There are, however, many other labels given to those pursuing medical treatment while on vacation, such as medical traveller or health tourist. However, regardless of the term used, such individuals are

seen as patronising a new branch of the tourism industry known as medical tourism. Chambers and McIntosh (2008), for example, suggest that medical tourism offerings should focus on health and well-being treatments, but avoid the offer of invasive surgical procedures.

There are number of possible reasons for travelling to seek medical treatment. Singh (2008) claims that if individuals are paying for their own health care, then the cheaper price of medical treatment offered in countries serving as medical tourism destinations will be a significant factor in their choice of destination. He suggests that low cost medical treatment is as important a factor in tourism as economic growth, employment and savings. For instance, due to the high cost of medical treatment and long waiting-lists in developed countries, patients are increasingly going to developing countries for medical care (Carrera and Bridges 2006; Chanda 2001; Chanda 2002; Chuang, Liu, Lu and Lee 2014; Connell 2011; Freire 2012, Goodrich and Goodrich 1987; Hall 2013; Han and Hyun 2015; Lunt and Carrera 2011; Lunt *et al.* 2011; Singh 2008). The sale of high technology medical care to foreigners is currently a major source of revenue in numerous developing countries and has come to be called medical tourism. Bookman and Bookman (2007) state that it is an economic activity that entails trade in services and represents the amalgamation of two of the largest world industries: medicine and tourism.

Sury and Montriwat (2007) and Hall (2013) observe that the industry of medical tourism is expanding at a rapid pace, and that its appeal is continuously glamorised by advertisers who promote the concept of going abroad for medical treatments. The affordability of the endeavour is highlighted, with the concept of vacation offered as a bonus. In this respect, while globalisation has provided a forum for cultural exchange, it has also facilitated the production of medical tourism across national and cultural boundaries.

Williams and Balaz (2015) suggests that the analysis of risk in tourism is fragmented and uneven and focuses relatively narrowly on risk as a set of negative outcomes to be avoided by individuals, firms or destinations. To this end, a review of risk (functional, physical, financial, time, psychological and social), risk perception and risk reduction will provide the theoretical underpinning for this research (Jacoby and Kaplan 1972; Lunt and Mannion 2014; Taylor 1974; Wang, Law, Hung and Guillet 2014; Williams and Balaz 2015). Ideas derived from this literature serve to provide the most appropriate theoretical underpinning for this research, since they have already been used extensively in generic development and management research. More importantly, there appears to date no study of risk (functional, physical, financial, time, psychological and social) with respect to non-invasive aesthetic medical tourism. One of the major considerations in competitiveness is the lowering of consumer perceived risk (Chapter 3). However, there is no risk-free treatment in the world, and that includes non-invasive aesthetic medical treatment for tourist-patients.

In order to serve the interests of such individuals, and in order to better develop and manage the medical tourism industry in medical tourism destination countries, it is vital to understand the risks and motivations of tourist patients. In particular, concerns have been voiced regarding the risk of complications resulting from travel and vacation activities in the post-treatment period of medical procedures (Bies and Zacharia 2007; Horowitz, Rosensweig and Jones 2007; Lunt and Carrera 2010; Lunt and Mannion 2014). Further understanding is therefore needed in order for both consumers and service providers to be able to identify and manage potential risks associated with non-invasive aesthetic medical treatments (Chapter 6).

1.4 Tourism and medical tourism in Thailand

Located in the centre of Southeast Asia, Thailand is ideally situated as a popular tourist destination. The map in Figure 1 shows the location of Thailand in relation to neighbouring countries. Thailand, known as the land of smiles, is seen as the heart of the region, with Bangkok, its political, economic, cultural, culinary, and spiritual capital city representing both old and modern Southeast Asian lifestyles. As such, it is unsurprising that tourism has become a major economic factor in Thailand. The contribution of travel and tourism to Gross Domestic Product (GDP) was THB1,037.03 billion, which is 8.6% of GDP in 2014, and is forecast to rise by 6.7% per annum, from 2016-2025, to THB2,045 billion in 2025 (World Travel and Tourism Council 2016).

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FIGURE 1.1 Map of Thailand and its neighbours

Source: Phukhao (2016)

The number of tourists visiting Thailand has increased 55% from 19,230,470 in 2011 to 29,881,091 in 2015 (Department of Tourism Thailand 2016). The advertising literature for Thailand features Buddhist temples but also an abundance of beautiful beaches and islands. Pukkalanun, Inkapatanakul, Piputsitee and Chunkao (2013) state that there are 691 islands in Thailand, more than 214 are used for tourism. As well as its associations with Buddhism and pleasure beaches, Thailand is also seen to have a long history, and a unique culture that includes Thai food and massage.

According to Connell (2011), the main region for medical tourism is Asia. Thailand offers different types of tourism, including medical tourism, which is a significant contributor to Thailand's economy (Hall 2013). Phu-ngamdee (2010) states that tourism in Thailand may benefit people who need some rest, special care and mental improvement. The idea is promoted that travelling with family or friends to an environment that offers access to tranquil places such as temples in Bangkok may encourage relaxation and improve mental and physical health. Connell (2006) argues that Thailand became known as a destination for medical tourism as early as the 1970s when it specialised in sex change operations, later moving on into cosmetic surgery. Hall (2013) observes that Thailand is one of the countries in Asia that appears to have attracted the largest number of medical tourists. In addition to this the standards and technology of medical treatment in medical tourism destination countries are seen as crucially important (Whittaker and Leng 2016). Singh (2014) suggests that the standard of medical treatment and technology in Thai hospitals is high while the prices are mostly lower than in other countries that provide similar quality and technology.

However, Sury and Montriwat (2007) state that medical tourism, in contrast to general tourism, faces obstacles to growth, such as high barriers to entry and a long list of requirements for example, licensing to operate a hospital or clinic at medical tourism destination countries. In addition, there is the challenge of keeping the costs of medical services low. Although these are crucial factors for a competitive medical tourism destination country, Dunn (2007) has pointed out that some hospitals may be able to compete on one variable but not the other.

An additional obstacle, as observed by Sury and Montriwat (2007) is that religion has continuously intersected with medicine to create controversy. In Thailand, Buddhists believe in the importance of abstaining from beautification. But while official adherence to Buddhism is widespread, only a small portion of people in Thailand actually practice, therefore the presence of beauty pageants and advertisements about cosmetic surgeries and treatments are becoming more acceptable. In addition, Thai cultural exchange with other countries has facilitated and influenced Thai openness to obtaining cosmetic treatments (ibid.). The acceptability of these practices is still subject to debate in Thailand, and creates barriers to the development of medical tourism (see Chapter 6 for more details).

According to Head (2015), Thailand has become a medical tourism destination country for foreigners in need of essential medical treatments, as well as those seeking elective medical procedures. In the 1980s and 1990s Thailand experienced unprecedented investment in private hospitals and clinics, the main target market being wealthy individuals in Thailand and the wider region. However, following the 1997 Asian financial crisis, domestic and regional spending on private care was depressed and service providers were forced to change their target markets, to expand their services and to market them to long haul international tourist-patients (Bookman and Bookman, 2007). As a result, Thailand is currently the world's leading medical tourism destination country in terms of price and location. In 2015, the number of medical treatments provided to international tourists by Thai private hospitals is 2.81 million medical treatments, which means that medical tourism should generate earnings in excess of US\$3 billion (IMTJ, 2015).

Huang (2012) on the basis of 1.5 million health tourists in Thailand in 2008, stated that in 2013 the number would more than double to 3.2 million. In addition, Hanefeld and Smith (2016) state that 7 million foreign patients being treated in Thailand in 2015. However, reliable estimates of the annual number of medical tourists are difficult to identify. NaRanong and NaRanong (2011) explain that this is because Thailand breaks data down into Thais and foreigners but not into foreigners who are medical tourists and other foreigners seeking medical care.

It can be argued that medical and health tourism is one of the fastest growing areas of academic research interest in both tourism and health and medical studies (Connell 2011; Crooks *et al.* 2010; De Arellano 2007; Hall 2013; Hanefeld and Smith 2016; Karuppan and Karuppan 2010; Leahy 2008; Lunt and Mannion 2014; NaRanong and NaRanong 2011; Reed 2008; Whittaker 2008). A vast quantity of literature has been written regarding international trade, implications of globalisation and economic development trends throughout the world. Such research reflects the economic significance of this type of tourism (Hall 2010), and a growing recognition of the consequences of increased human mobility (Hall 2013; Hall and James 2011), as well as the real effects on people and places (Huang 2012). However, one subject area that is currently lacking sufficient exploration is the burgeoning industry of exporting and importing non-invasive aesthetic medical services across international borders. This type of global interconnection is a relatively new phenomenon within the context of the current sphere of internationalism.

According to Freeman (1984), stakeholders are any group or individual who can affect, or are affected by the achievement of an organisation's objectives. In this research, the primary stakeholders are aesthetic clinic owners and aesthetic treatment international tourist-patients. Government representatives are categorised as secondary stakeholders. For this research, a tourist patient refers to a tourist who is visiting Thailand and receiving an aesthetic medical treatment. A tourist-patient is not to be confused with those individuals holidaying abroad who use health services in their country of destination as a result of an accident or a sudden illness. Such individuals are regarded merely as unfortunate tourists (Lunt *et al.* 2011). Nor to be confused with tourist-patients are those whose first intention or reason to go abroad is for medical care. Such individuals are defined as medical tourists. Tourist patients then are people who are neither ill nor subject to unfortunate accidents but who have elected to go abroad for aesthetic medical treatment.

In order to be able to understand the current situation of medical tourism industry in Thailand, the research settings have been selected to focus on non-invasive aesthetic medical tourism in Bangkok. This was because the researcher's former employment with an aesthetic medical equipment manufacturer in Bangkok has facilitated access to the clinic owners and government representatives. In addition to this, the clinic owners agreed to provide access to the international tourist-patients in their respective clinics.

A range of authors have examined reasons for individuals travelling abroad for medical treatment, from the perspective of the patients' home countries. This literature discusses the growth of medical tourism in developing

countries, and how medical tourism destination countries may benefit from this industry (Bookman and Bookman, 2007; Burkett, 2007; Carrera and Bridges, 2006; Chanda, 2001; Cochrane, 2008; Singh, 2008). However, in such studies, complex invasive surgery and invasive and non-invasive health and well-being procedures are commonly discussed as a singularity. To date few attempts have been made to examine the development and management of non-invasive aesthetic medical treatments. Even fewer studies have examined the development and management of this type of medical tourism in Bangkok and, to date, no studies have evaluated stakeholder risk in relation to the development and management of aesthetic medical tourism in Bangkok, or how competitive advantage can be sustained.

The purpose therefore of this research is to investigate how risk (functional, physical, financial, time, psychological and social) of stakeholders may act as a barrier to the management of non-invasive aesthetic medical tourism, and to establish how competitive advantage may be sustained in this industry. Specifically, this research examines the motivations, decision-making and risk reduction strategies of English-speaking international tourist-patients who have purchased non-invasive aesthetic medical procedures in Bangkok, Thailand.

1.5 Research aim and objectives

The aim of this research project was to evaluate risk in relation to the management of non-invasive aesthetic medical tourism (international) in Bangkok.

In order to undertake this research the following objectives were set:

1. To evaluate literature and key theories relating to medical tourism, aesthetic medical tourism and risk
2. To determine the factors that act as advantages or barriers to the management of aesthetic medical tourism in Bangkok
3. To identify the relevance of selected theories and models related to risk for understanding the management of aesthetic medical tourism in Bangkok
4. To extend the theory of risks by developing a framework in relation to the management of non-invasive aesthetic medical tourism in Bangkok for primary and secondary stakeholder groups to gain an insight understanding of the industry

1.6 Research methodology

Adopting an interpretivist approach (Saunders, Lewis and Thornhill 2009; Easterby-Smith, Thorpe and Lowe 2002), this research investigates how risk (functional, physical, financial, time, psychological and social) perceived by primary and secondary stakeholders (Freeman 1984) may act as a barrier to the management of non-invasive aesthetic medical tourism (international) in Bangkok, Thailand. In reference to this study, the individuals represented in the pilot study and main fieldwork involve 15 non-invasive aesthetic clinic

owners, 25 English-speaking international tourist-patients, and five government representatives. This sample was purposively selected, and added to by means of a snowballing technique (Neuman 2010; Saunders *et al.* 2009). Interview themes and questions were drawn from the literature review. The findings from fieldwork were coded and analysed thematically using a framework derived from the literature review. This framework revolved around issues of risk (functional, physical, financial, time, psychological and social).

1.7 Structure of the dissertation

In the following chapter, medical tourism, aesthetic medical tourism and non-invasive aesthetic medical treatments will be examined. Literature on risks, risk perception and risk reduction will be critically evaluated in the third chapter. How risks, risk perception and risk reduction are related to non-invasive aesthetic medical treatments are also explained, the research philosophy, research methodology and any problems arising during the preliminary and main fieldwork, as well as how such problems were resolved, will be explained in the fourth chapter. The interview processes and schedules are also included.

The research findings are presented and discussed in Chapter 5 and Chapter 6. The findings from the interviews are analysed and interpreted. The analysis and interpretation of the research findings are guided by themes identified during the review of literature. The fifth chapter discusses the findings from the competitiveness of Thailand as a medical tourism destination country and barriers to the development and management of non-invasive aesthetic

medical tourism industry in Bangkok. Primary and secondary stakeholders' views on issues/ challenges will also be discussed. The risks (functional, physical, financial, time, psychological and social) associated with non-invasive aesthetic medical tourism in Bangkok are reported and discussed in Chapter 6. The last Chapter is the research conclusion. It provides the analysis of the research, research contributions, limitations and problems from the primary research, research suggestions and recommendations for further study.

CHAPTER 2

MEDICAL TOURISM AND

NON-INVASIVE AESTHETIC MEDICAL TREATMENT

2.1 Introduction

In order to contextualise the relevance of the research topic, this chapter begins by reviewing the literature on various definitions of tourism, medical tourism, non-invasive aesthetic medical tourism and different types of non-invasive aesthetic medical treatments. Following this, possible motivations and means of motivating English-speaking international tourist-patients to visit/ travel to Bangkok for non-invasive aesthetic medical treatments will be explored. A number of crucial benefits to be derived from non-invasive aesthetic medical tourism to Bangkok as a medical tourism destination city will then be critically analysed. The potential benefits, possible complications and side effects of different types of non-invasive aesthetic medical treatments will be investigated, and finally, the concept of competitive advantage will be evaluated.

2.2 Tourism

According to the World Tourism Organization (2016), tourism can generally be defined as the *“activities of persons travelling to and staying in places outside their usual environment for not more than one consecutive year, for leisure, business and other purposes not related to the exercise of an activity*

remunerated from within the place visited". A new type of tourism is medical tourism. The interpretation of the medical tourism industry is slightly different from general tourism when it is related to medical treatments and procedures.

2.3 What is medical tourism?

According to Woo and Schwartz (2014), medical tourism is a fast growing niche market. There are various definitions of medical tourism. Many researchers (Alsarabi 2015; Bookman and Bookman 2007; Connell 2006; Hall 2013; Hanefeld *et al.* 2014; Lunt and Carrera 2010; NaRanong and NaRanong 2011; Singh 2014) have tried to provide a definition that covers all aspects of the medical tourism industry. Goodrich and Goodrich (1987) state that medical tourism is the attempt on the part of a tourist facility (e.g. hotel) or destination (e.g. Baden, Switzerland) to attract tourists by deliberately promoting its health-care services and facilities, in addition to its regular tourist amenities. Linked to this, Sheaff (1997) proposes a definition of medical tourism from the demand perspective, that medical tourism should refer to travel for the purpose of obtaining a medical treatment. In addition, Burkett (2007) offers another definition of medical tourism as offering non-emergency medical procedures for a comparatively low cost. These medical procedures range from elective cosmetic treatment to complex surgery. Chuang, Liu, Lu and Lee (2014) conclude that combining the very polarized purposes of pleasurable travel and potentially stressful health care services, medical tourism is an emergent and growing business worldwide.

Chanda (2001) explains medical tourism from the supply perspective, which is, seeing medical tourism as engaged in the business of providing medical care to foreign patients. In addition to the definitions above, Bookman and Bookman (2007) posit that medical tourism is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism. In other words, health resorts partner with hospitals, which provide surgical and rehabilitative treatments at economical prices. Patients then receive the bonus of vacationing and sightseeing in a foreign country and experiencing an exotic culture as part of a health care package that typically includes their treatment plus air transport, transfers, accommodation and a postoperative vacation.

On the other hand, Chanda (2002) classifies medical tourism into two forms, based on the country of origin of tourist/patients. One form represents affluent patients from developing countries seeking specialised high quality treatment in developed industrialised countries with superior health care standards. For example, patients from Thailand travel to the U.S., U.K. or Switzerland for high technology and advance treatments. The second form represents patients from industrialised countries who seek affordable, high quality treatments, or alternative medicines and treatments in developing countries such as Thailand, Singapore, Malaysia and India.

In summary, Hanefeld *et al.* (2014) and Lunt and Carrera (2010) conclude that medical tourism can be defined as a means whereby consumers elect to travel across international borders with the intention of receiving some form of medical treatment. These treatments include cosmetic and dental surgery; cardio, orthopaedic and bariatric surgery; and organ and tissue transplantation. There are many developing countries promoting medical tourism such as Hungary, Turkey, Jordan, India, Malaysia and Thailand. Figure 2.1 gives a regional overview of which countries most promote medical tourism. More importantly, different countries have promoted different types of medical treatments. Table 2.1 illustrates worldwide medical tourism destination countries and different countries' specialism.



FIGURE 2.1 Countries promoting medical tourism

Source: Singh (2014)

Country	Treatment
Antigua	Addiction and Recovery
Barbados	Fertility/ IVF
Belgium	Cardiology
Brazil	Cosmetic Surgery
Budapest	Dentistry
Czech Republic	Cosmetic Surgery, Dentistry
Costa Rica	Dentistry
Germany	Cardiology, Hip Replacement Surgery, Orthopedics
Hungary	Dentistry
India	Cardiology, Cosmetic/ Plastic Surgery, Health Screening, Orthopedics
Iran	Cardiology, Orthopedics
Israel	Fertility/ IVF
Jordan	Dentistry, Oncology
South Korea	Cosmetic Surgery
Malaysia	Dentistry, Fertility/ IVF
Mexico	Bariatric, Dentistry
Philippines	Cosmetic Surgery, Dentistry
Poland	Dentistry
Singapore	Cancer, High-end procedures
Spain	Fertility/ IVF
South Africa	Cardiac, Cosmetic Surgery
Taiwan	Cosmetic Surgery, Fertility/ IVF
Thailand	Cardiac, Cancer, Cosmetic/ Plastic Surgery, Dentistry, Fertility/ IVF, Gender Reassignment Surgery, Health Screening, Orthopedics
Turkey	Vision

TABLE 2.1 Worldwide medical tourism destination countries and specialism

Source: Connell 2011; Hanefeld *et al.* 2014; Horowitz *et al.* 2007; Horton and Cole 2011; Hudson *et al.* 2011; Jeevan *et al.* 2011; Lee and Hung 2010; Nassab *et al.* 2010; Piazzolo and Zanca 2011; Siddiqi *et al.* 2010; Smith *et al.* 2012; Snyder and Crooks 2010; Turner 2011; Whittaker and Leng 2016

In order to gain a deeper understanding of the medical tourism industry, it is necessary to consider the development and management of medical tourism. This includes background of medical tourism (section 2.4), the reasons to consider using medical tourism (section 2.5), the impact of medical tourism (section 2.6), the rise of global medical tourism (section 2.7), and the recent status of medical tourism in medical tourism destination countries, in Asia in general (section 2.8), and in Thailand in particular (section 2.9).

2.4 Background of medical tourism

According to Alsarabi (2015), over the ages and across the continents, people have visited warm dry climates to improve their health and to avail themselves of thermal and mineral waters. This type of travel was first designated as a commercial activity in 1973. In addition, Singh (2008) states that it was common for patients from developing countries to travel within home countries, and sometimes even to the developed countries such as the U.S., to seek health related treatments not available in their home countries. However, Bookman and Bookman (2007) and Hall (2011) argue that what is different in the twenty-first century is that tourists from developed countries are travelling longer distances to developing countries, and for medical care that is invasive and highly technological (this is discussed below in section 2.5). In other words, for patients in developed countries, medical tourism is the process of travelling abroad to receive superior medical, dental and

cosmetic care by highly skilled surgeons at a fraction of the price if compared with the price in their home countries e.g. the U.S., U.K. and Canada.

2.5 Reasons to consider using medical tourism

According to Singh (2014), medical tourism is a growth area of tourism in which travellers arrange a trip abroad specifically to have surgical or any medical treatment during their stay. However, it is interesting to question why travellers do this, what exactly draws people to consider the risk (see more details in Chapter 3) and inconvenience of visiting a medical tourism destination country for essential medical surgery or cosmetic medical treatment. The reasons for travelling abroad for medical care are different from one traveller to another. This is because different patients have different motivations for travelling. There are a number of reasons that influence patients to take medical treatments and procedures outside their home countries. It depends on the patient's background, medical condition, available information, financial plan, risk perception (Chapter 3) and many other factors. However, some of the main reasons for considering medical tourism may be lower cost (section 2.5.1), no waiting lists (section 2.5.2), and the absence of medical treatments at home (section 2.5.3). The details of each reason will be evaluated in the following sections. However, it is worth noting that there are the limited insights on why some patients do not travel for medical treatment outside their home countries (Hanefeld *et al.* 2014).

2.5.1 Lower cost

According to Chuang, Liu, Lu and Lee (2014), Healthbase (2009) and Horowitz, Rosensweig and Jones (2007), saving money on overseas medical treatment and procedures is the first motivation to travel abroad. Lower cost is a major motivator for medical travellers, from developed countries to seek medical treatment abroad in a developing country, (Chuang *et al.* 2014; Healthbase 2009; Horowitz *et al.* 2007), and is a growing trend especially amongst those in a middle class earning bracket (Gray and Poland 2008).

For patients in developed countries such as the U.S., the U.K. and Canada, the medical cost at home is sometimes not affordable (Bookman and Bookman 2007; Burkett 2007; Chanda 2002; Chuang *et al.* 2014; Connell 2006; Connell 2011; Freire 2012; Hall 2011; Horowitz and Rosensweig 2007; Howze 2006; NaRanong and NaRanong 2011; Singh 2014). According to Yanhee (2016), it can be seen, for instance, that breast augmentation, one of the most often sought out procedures performed at Yanhee Hospital in Bangkok, Thailand costs US\$2,900 whereas the same procedure performed in the U.S. or other developed countries would cost approximately US\$10,000-20,000 (Breastprocedures 2016). In other words, the medical cost in Thailand is about 3-7 times cheaper than the cost in developed countries.

According to Centers for Disease Control and Prevention (2016), in developed countries such as the U.S., where 35.7 million citizens under age 65 were without health insurance for some part or all of 2015-2016, travelling abroad for medical purposes may be cheaper than paying for the medical

treatment at home. Linked to this, Chuang *et al.* 2014; Connell (2011) and Hall (2013) suggest that medical procedures in Thailand and Malaysia cost 50% to 200% less as compared to similar procedures conducted in the U.S., and even less in India.

In addition to this, Teicholz and Cohen (2014) state that medical insurance companies are taking notice of the new opportunities for savings by sending clients abroad, while many major self-insured employers are also recognising the benefits and are providing coverage to employees willing to travel abroad. Medical plans on offer also may include coverage for a family member to accompany the patient abroad, with hotel stay, and nearly all travel arrangements made through the insurer, thus decreasing stress (see more details in Chapter 3) and transaction costs for patients and family. Therefore going abroad for medical treatment is seen as an economical procedure for potential patients from developed countries.

2.5.2 No waiting lists

In countries with socialised health-care, citizens may face lengthy waiting periods for surgeries, elective treatments or other treatments. Medical tourism allows these patients nearly instantaneous care at lower cost. In addition to this, countries that provide free medical services for their citizens create the problem of long waiting lists, which could take from weeks to months for patients to be treated. Chanda (2001), Chuang *et al.* (2014) and Singh (2008) further explain that patients faced with long waiting lists especially those from

developed countries, are increasingly seeking treatment across national boundaries. This is because they do not want to wait in their home countries.

Linked to this, Hutchinson (2005) states that in Britain or Canada, for example, the waiting period for a hip replacement can be a year or more, while in Thailand or India, a patient can be in the operating room the morning after getting off a plane. Therefore, some medical tourists seek medical care overseas because of the immediate availability of medical treatments and procedures at a medical tourism destination country and sometimes the unavailability of certain medical treatments and procedures at home (section 2.5.3).

2.5.3 The absence of medical treatments at home

There are two reasons why medical treatments might not be available in the patient's home country. Firstly, Horowitz *et al.* (2007) and Howze (2006) suggest that in the past the main reason for patients travelling abroad for medical treatment was that services were unavailable at patient's home country due to lack of technology in less developed countries such as Bangladesh.

Secondly, Gray and Poland (2008) state that for some potential patients, some medical treatments and procedures are not available in their home countries because those medical treatments are illegal. For example, patients in developed countries such as Belgium, the Netherlands and Switzerland need to travel abroad for medical care due to the legal problems of having a

particular treatment at home. In addition to this, Howze (2006) concluded that medical tourism should not become a regular feature of the present U.S. health care system because of the legal risks, should a patient from the U.S. go to a particular medical tourism destination country such as India, where law and rule are not the same as in the U.S.

Linked to this, Gray and Poland (2008) also agree that this could be another potential problem as there is no legal recourse when procedures that are illegal in originating countries have been conducted at the medical tourism destination country (see more details in Chapter 3). Mirrer-Singer (2007), building on Havighurst's and Richman's work (2006), explains a number of problems with litigation and liability involving foreign defendants. Mirrer-Singer (2007) concludes that legislation is needed for medical tourism regulation. Many scholars suggest that the level of paternalism reflected in medical tourism regulations should parallel the development of medical tourism industry (Chan *et al.* 2011; Hanefeld *et al.* 2014; Harling *et al.* 2007; Roger *et al.* 2011; Smith, Lunt and Hanefeld 2012). As more information about medical tourism becomes available, there will be less need to protect medical tourists. However, this conclusion is based on the fact that information on the quality of the foreign medical service providers is sparse.

In summary, whether it is motivated by reduced cost, no waiting period or absence of medical treatment at home, currently medical tourism is a phenomenon that would not have been possible in earlier times. Although Connell (2006) points out that some of the earliest forms of tourism were directly aimed at increasing health and well-being, on the premise that

vacational rest and rejuvenation indirectly lead to better health, today, medical tourism differs by directly improving health through specific medical procedures performed by specialists. In other words, despite the fact that the world context of jet-setting in search of medical procedures is new, this should not ignore that travelling great distances for medical attention is an ancient human practice. As a result, the impact of medical tourism on medical tourism destination country (localisation) and the countries around the globe (globalisation) needs to be explored (section 2.6).

2.6 The negative impacts of medical tourism

The negative impacts of medical tourism can be discussed in two main parts: negative impact of medical tourism on medical tourism destination country (section 2.6.1) and negative impact of medical tourism on patient's home country (section 2.6.2).

2.6.1 Negative impact of medical tourism on medical tourism destination country

It can be argued that medical tourism brings many positive impacts such as jobs and income to the medical tourism destination country (Hall 2013; Singh 2014). However, there are some issues that need to be concerned. Firstly, there is speculation that medical tourism may begin to lessen the effects of the brain drain phenomenon (Whittaker and Leng 2016), by providing more desirable and lucrative employment opportunities for medical tourism destination country health professionals. Brain drain refers to the exodus of individuals from their home countries, typically from developing countries,

who move towards developed countries to pursue higher and professional education and who afterwards choose to stay to live and work in those countries. In the past, this phenomenon has drawn thousands of highly trained and educated personnel away from the developing world where educated professionals are desperately needed (Connell, 2006; De Arellano, 2007). Countries on the exporting side may see a reversal if the medical tourism industry successes as predicted.

In addition, like any type of tourism, medical tourism can have negative impacts on the medical tourism destination country. According to Noree *et al.* (2016), one of the greatest challenges, at the most basic level, is to ensure that trade in health services benefits not only the local population but also effectively improves the quality and equity of the health care system for locals as well as foreigners (Crooks *et al.* 2010; Hanefeld *et al.* 2014; Pennings, 2002).

Moreover, investment in hospitals catering to foreign patients in developing countries can only be appropriate if the host country has a sufficient number of physicians per capita. Otherwise, poor local people will suffer as physicians will be drawn to affluent foreign patients (Noree *et al.* 2016). Chanda (2002) for instance warns that constraints on resources and personnel in hospitals may result in the local population in medical tourism destination countries being crowded out and denied treatment.

2.6.2 Negative impact of medical tourism on patient's home country

Much of the current literature (Connell 2011; Hall 2013; Hanefeld *et al.* 2014; Lunt, Horsfall and Hanefeld 2016; Smith, Lunt and Hanefeld 2012; Woo and Schwartz 2014) is constructed to inform the patients of the existence of the medical tourism industry; what services are available, which countries specialise in specific procedures or areas of medicine, and what procedures a potential medical tourist should undergo in planning a medical journey. Another area being researched more thoroughly is the investigation of domestic health situations in outflow countries, and the potential impetus for sending citizens abroad. This branch of work encompasses the presence and implications of inadequate health care delivery systems in developed countries which opt for the solution of sending medical tourists abroad. Some of this literature is highly recommend to developed nations that are unable or unwilling to provide sufficient or timely care for their populations, and points toward the possibility of future medical outsourcing (Kher 2006). In addition to this, Singh (2014) states that thousands of medical tourism agencies exist across the world and more are being established daily. These organisations are able to provide a wealth of country-specific information for both tourists and tourist destinations. Most agencies prefer to focus on only a few countries, or specialise in planning and publishing trip itineraries for those seeking a particular procedure to better ensure quality of service and information dissemination.

According to Hanefeld *et al.* (2014), 100 papers were selected for the inclusion in this article. The sample was filtered based on the criteria, which

can be seen in the diagram in Figure 2.2. The findings illustrated that risks in health outcomes for patients are covered in 29 papers. However, there are only six of these papers discuss risk in more depth and provide the references. Three papers (Chan *et al.* 2011; Harling *et al.* 2007 and Rogers *et al.* 2011) describe the recent outbreak of NDM1 bacteria following patients receiving treatment in India. NDM1 is a new metallo-beta-lactamase that readily hydrolyses carbapenems, penicillins and cephalosporins. Its rising incidence has been reported in many countries around the world. Due to the lack of effective antibiotic regimes to treat these infections, Harling *et al.* (2007) investigate a nosocomial and community outbreak of hepatitis B to establish how the infections might have occurred from patients who had been in India. Chan *et al.* (2011) describe a case of NDM1 infection in an immunocompromised foreign patient, and discuss its implications. Rogers *et al.* (2011) provide the documented NDM1 outbreak in the UK highlighted the potential of infections that may result from medical travel.

A fourth (Smith, Lunt and Hanefeld 2012) describes an outbreak of hepatitis B in London hospital traced to a patient recently returned from surgery in India, pointing to potential risks of diaspora travel. Only two papers (Turner 2011 and Whittaker 2010) review the regulation systematically. Both point to a vacuum in regulation, with no one specific regulator or quality assurance standard in place, but rather a number of private companies offering quality assurance through affiliation, creating a market for quality assurance rather than independent standards. They conclude that in order to avoid potential harm to patients and health systems, more informed policymaking on aspects of medical tourism is urgently needed. As a result, research on risks associated with medical travel proved limited (Hanefeld *et al.* 2014).

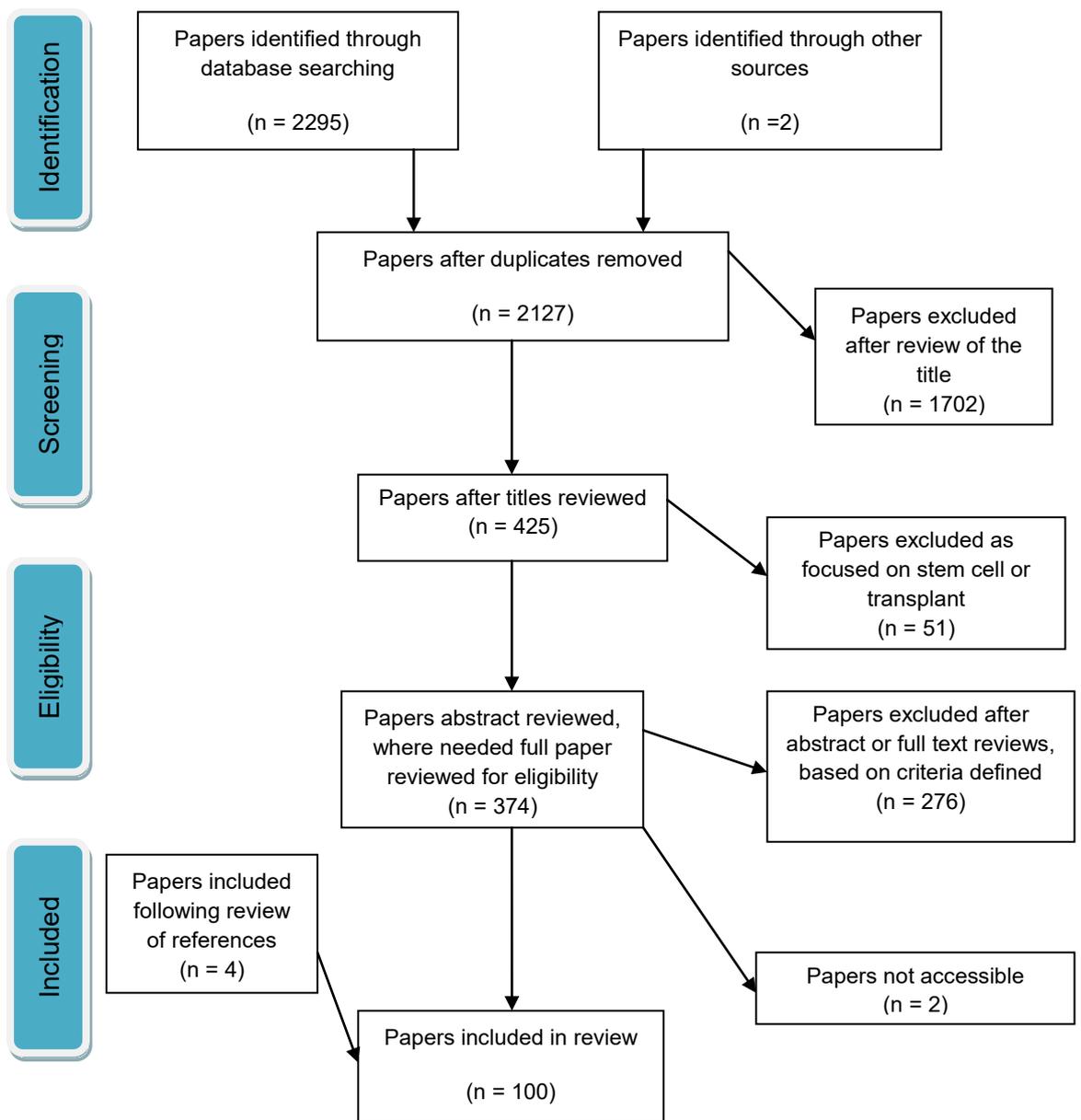


FIGURE 2.2 PRISMA flow diagram for literature review medical tourism

Source: Hanefeld *et al.* (2014: 412)

The problem of post-treatment is an important issue for patients from developed countries. According to Hanefeld *et al.* (2014), the review of 100 medical tourism papers also demonstrated that U.K. patients travel abroad to receive treatment and return home with complications or infections that require follow-up in the public sector. In addition to this, Jeevan, Birch and

Armstrong (2011) state that the department of health in the U.K. clarified that National Health Service (NHS) teams should not undertake any elective revision procedures. They claimed that aesthetic procedures had high minor complication rates and that post-operative travel is associated with increased risks (see more details in Chapter 3). Their solution for minimising the potential risk for U.K. patients is to better inform those UK patients who are considering travelling abroad (see more details in Chapter 6). More importantly, Hanefeld *et al.* (2014) conclude that there is an absence of research examining the long-term health outcomes of medical tourists when compared to patients treated within their country of residence.

Given positive and negative effects on medical tourism system of patient's home country and medical tourism destination country, medical tourism is a highly significant and contested phenomenon. As a result, further qualitative and quantitative research is needed to provide the evidence on the comparative effect of treatment received from home and medical tourism destination countries (Hanefeld *et al.* 2014). This is because further research will help to better understand impact on health services and outcomes of medical tourists. Moreover, additional primary research on the effects of medical tourism is needed if the industry is to develop in a manner that is beneficial to citizens of both departure and destination countries (Crooks *et al.* 2010).

2.7 The rise of global medical tourism

The rise of global medical tourism is a considerable issue. Bookman and Bookman (2007) suggest that there are four principal reasons for the rise in global medical tourism. The first reason is based on the demographic principle that people are living longer. The second reason is based on the medical principle that non-communicable illnesses requiring the help of a specialist are on the increase, as is the number of people who elect for treatment. The third reason is based on the economic principle that people have more disposable income and sometimes even portable health insurance. Finally, the last reason is based on the social principle that people know more about their world and are more willing to travel.

These principles explain why the medical tourism industry is experiencing marked growth. However, Hanefeld and Smith (2016), Lunt *et al.* (2012) and NaRanong and NaRanong (2011) caution that despite an increasing number of countries offering relatively low-cost treatments, there are no authoritative data on the number and flow of medical tourists between nations and continents. Although these statistics are admittedly estimations, they may serve as useful indicators of growth in this sector of tourism.

To sum up, high costs of treatment, and long waiting lists in patients' home countries attract patients to the new technologies and skills available in medical tourism destination countries, alongside the added attraction of reduced transport costs. Such considerations, enhanced by internet marketing, have all played a significant role in increasing the number of

medical tourists in medical tourism destination countries and particularly in Asia.

2.8 Medical tourism in Asian destination countries

Medical tourism plays a significant role in the current Asian tourism market. According to Connell (2006), the main region for medical tourism is Asia, with several Asian countries such as Singapore, India and Thailand emerging as dominant destinations for the medical tourism industry (Singh 2014), although most Asian countries have sought to enter the market (Connell 2006; Lunt, Horsfall and Hanefeld 2016; Singh 2008; Whittaker and Leng 2016).

Health travel to Asian countries is quickly gaining recognition in the U.S. According to Healthbase (2009), nearly half a million U.S. citizens visit Asia each year to seek high quality medical treatment at a relatively low price and combine it with exotic vacations in the medical tourism destination country. In addition to this, Kasriel-Alexander (2016) states that 1.2 million Americans seek overseas medical care in 2014. This will result in U.S. providers losing revenue of over US\$200 billion by 2017. Tourists from developed countries travel to Asia for organ transplants, plastic surgery and artificial insemination. Asian hospitals and clinics that cater to the tourist market are often amongst the best in the world. These hospitals are often staffed by physicians who have been trained at major medical centres in America and Europe. For example, Bumrungrad hospital in Bangkok, Thailand has numerous surgeons who are board-certified in the U.S. (Connell 2006). Some hospitals are also branches of prestigious hospitals in the U.S. such as Johns Hopkins

University and the Mayo Clinic. Linked to this, Demicco and Cetron (2006) argue that the Escorts Heart Institute and Research Centre in Delhi and Faridabad perform approximately 15,000 heart operations every year. They also state that the death rate during surgery is only 0.8 percent. That figure is less than half of that of most major hospitals in the U.S.

During the Asian economic crisis in the mid-1990s, many healthcare facilities in Asia sought economic diversification. This was because local patients were no longer able to afford private health care. Private hospitals in Asia then searched for rich patients and expanded the market to patients outside their countries. Singapore, for example, competed with Malaysia and Thailand, setting medical rates just below those in Malaysia and Thailand and opening a booth at the airport with fliers, medical treatment information and advice for transit passengers (Connell 2011).

In summary, in order to become a global medical tourism destination country, a number of Asian countries have upgraded technology (Bookman and Bookman 2007), absorbed western medical protocols (Connell 2006) and emphasised low cost (Singh 2008; Singh 2014) and promised prompt attention to patients from developed countries (Hall 2011).

2.9 Medical tourism in Thailand

According to Connell (2006) and Pocock and Phua (2011), Thailand became known as a destination choice for medical tourism as early as the 1970s because it specialised in sex change operations, and later moved into cosmetic surgery. During the economic boom of the early 1990s, Thai personal income level increased and public demand for good quality health care increased because of the improvement in economic conditions. This in turn led to private hospitals expanding their capacity to accommodate wealthy Thai patients. Linked to this Harryono, Huang, Miyazawa and Sethaput (2006) state that the total number of hospitals in Thailand increased from 422 in 1991 to 491 in 1997, and the number of beds more than doubled, from 14,927 to 38,275 during the same period.

However, the 1997 financial crisis significantly affected the domestic market, resulting in a drop in personal health expenditure as economic conditions deteriorated. Private hospitals were obliged to make up for the loss of their domestic patients by shifting their focus to patients from abroad. As a result of economic liberalisation in the mid-1990s, Asian private hospitals have found the opportunity to promote themselves as preferable destinations in medical tourism destination countries that have a relatively weak currency against GBP or U.S. dollars. In 1997 in Thailand, for example, the exchange rate was changed from 40 to 76 Thai Baht per one GBP, which meant that British patients could seek medical treatments in Thailand at about half the price of those available in the UK during that period (Leightner 2015). In addition to this, the local currency devaluation made the total price of the medical treatment in Thailand less than half that in the U.S. This included the costs of

travel and accommodation (Hall 2013). As a result, Henderson (2014) concludes that Thailand used its currency crisis to attract medical tourists from other countries.

In order to be able to compensate for their declining revenue, private hospitals such as Bumrungrad Hospital in Bangkok brought in a new management team from overseas, designed to attract more international patients and to help the hospital out of its financial difficulties (Harryono *et al.*, 2006). As a result, in February 2002, Bumrungrad hospital became the first hospital in Asia to be internationally accredited. It had already served 50,000 international patients by 1997, which the number had increased over 10 times to 520,000 from over 190 different countries in 2013 (Bumrungrad 2016). These statistics demonstrate the development of medical tourism in Thailand, where people were seen to travel to obtain medical services at the lowest cost (Harryono *et al.*, 2006).

The number of international patients in Thailand was first published by Balfour, Kripalani, Capell and Cohn (2004) who claimed that 308,000 patients from abroad were treated in Thailand's private hospitals in 2002, which generated some US\$280 million in revenue. Linked to this, Lin, Lee and Huang (2009) state that in 2003 the production value increased to US\$490 million, which attracting 730,000 visitors seeking treatment in Thailand. Linked to this, Pocock and Phua (2011) estimate that Thailand earned Baht 36 billion (US\$ 1.1 billion) from 1.4 million foreign patients in 2006. In addition, the number of international patients in Thailand increased to 3.2

million in 2013 (Huang 2012) while Hanefeld and Smith (2016) state that 7 million foreign patients being treated in Thailand in 2015.

Notwithstanding this, Hanefeld *et al.* (2014) and Lunt *et al.* (2012) argue that these figures are not reliable for any country, given that none of these authors provided the sources of their figures. Moreover, the lack of data also restricts analysis about possible cost and benefits of medical travel. Such was not the case however in Lin *et al.*'s (2009) study which provided different results based on secondary data obtained from the Department of Export Promotion (DEP) in Thailand. These verifiable numbers, covering the period from 2002 to 2006, were used by Lin *et al.* to create an equation proposing the figures for medical tourism demand in 2015. The calculations showed that the international medical tourism demand in Thailand would have a strong growth rate. The authors stated that medical tourism demand in Thailand would most likely service over three million patients in 2010, and that the output value of this medical tourism would bring in revenue of over US\$1,400 million. With respect to their calculations, it is estimated that 7.4 million international medical passengers visit Thailand by the end of 2015. Linked to this, Hanefeld and Smith (2016) support the calculation that 7 million foreign patients being treated in Thailand in 2015.

The actual numbers of international medical passengers in Thailand from 2001 to 2006 (Lin *et al.* 2009; Smith, Chanda and Tangcharoensathien 2009) and propose numbers (Lin *et al.* 2009) of international medical passengers in Thailand in 2015 are illustrated in Table 2.2.

Year	Actual number from DEP	Propose number from the equation
2001	550,000	
2002	630,000	
2003	730,000	
2004	790,000	
2005	1,000,000	
2006	1,400,000	
2015		7,400,000

TABLE 2.2 The number of international medical passenger demand in Thailand

Source: Lin *et al.* (2009) and Smith *et al.* (2009)

2.9.1 Why Thailand?

According to Klyuev (2015), Thailand has developed into one of the most prosperous countries in Southeast Asia, its economy shifting from its agricultural base into the industrial and service sectors. In addition to this, Maung and Walsh (2014) state that Thailand is currently the world's leading medical tourism destination country. Medical tourism in Thailand was a popular successful niche sector, which growing rapidly at a rate of 16% per annum (Henderson 2014).

Tourists or patients from developed countries travel to Thailand for many reasons. Going to Thailand for medical treatments and procedures is seen as a good choice firstly because Thailand is already one of the most popular tourist destination countries in the world (Sile 2016). The country is seen as friendly and welcoming and is known as “the land of smiles”. Connell (2011)

points to the fantasy of Thailand as a place of beautiful order and orderly beauty where people are responsive to all desires.

Secondly, hospitals and clinics in Thailand provide tourist patients with overseas qualified medical staff (Hall 2013; Lunt *et al.* 2016; NaRanong and NaRanong 2011; Singh 2014). Many Thai doctors are American Board Certified and a number are Australian Board certified as well. They have studied, trained and practiced medicine at the Cleveland Clinic, the Mayo Clinic, Cedars-Sinai, Johns Hopkins, Harvard, Columbia and Roswell Park Cancer Institute, to name but a few (Bookman and Bookman 2007; Henderson 2014). All Thai doctors must also have medical licenses. Thailand has its own Medical Council which is the equivalent of the American Medical Association (AMA) (The Medical Council of Thailand 2016). This is another crucial reason to explain why Thailand attracts more international patients these days (Pukkalanun *et al.* 2013).

Thirdly, patients can obtain surgery or medical treatments in Thailand for a price up to 70%, 80%, or even 90% less than patients would pay in their home countries (Chuang *et al.* 2014; Connell 2011; Hall 2013; Singh 2014). Considering medical tourism, if patients cannot afford the medical treatment charges in France, Italy or in the U.S. but need a quality treatment with international qualified doctors, then medical tourism in Thailand is a viable alternative. Thailand medical tourism gives patients access to trained doctors from all the respected places in the U.S. and is now providing treatment and services in clean, hygienic, and ultra-modern hospitals in Bangkok (Henderson 2014).

Apart from the three reasons above, accreditation and safety procedures are another considerable motivation for medical tourists. Hospitals in Thailand must be licensed by the Ministry of Health. In addition to this, many Thai hospitals have already achieved the International Standards Organisation's ISO 9001:2000 accreditation (Bookman and Bookman 2007; Connell 2006; Harryono *et al.* 2006). Leading hospitals have their own quality assurance department, which regularly audits the health care facility, and their other departments. However, there are different types of accreditation. This will be explained in the following section.

2.9.2 Standards and accreditations

Many researchers (Burkett 2007; Carrera and Bridges 2006; Hall 2011; Horowitz, Rosensweig and Jones 2007; Singh 2014; Whittaker and Leng 2016; York 2008) suggest that standards and accreditations are another important reason for patients to consider medical tourism. According to Rutherford (2009), standards and accreditations allow patients to make informed decisions and feel an increased sense of security before they decide to travel. This has led to a greater emphasis and import placed on global standardisation of nearly every industry. In addition to this, Murphy and Yates (2009) state that the greatest difficulties in the flow of products from one company to another occur at the transition points, points at which the product is sold to another company or to the final consumer. The main function of standards is to facilitate the flow of product through these transition points. Standards are thus both facilitators and integrators.

A well-known international standard is the International Organization for Standardization, or ISO. This began in 1926 as the International Federation of the National Standardizing Associations (ISA) and was renamed as ISO in 1946 (ISO 2016). In relation to standards, ISO provides a set of benchmarks for institutions to observe in ensuring consistency of standards across institutions. The ISO boasts a network of 159 national standards institutes, and is at the forefront of the discussion regarding why standards matter (Rutherford 2009).

In addition to this, accreditation is one form of External Quality Assessment (EQA). It employs external reviews of quality which lead to the accreditation. The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, and still known more commonly by the acronym, JCAHO, founded in 1951, is an independent and not-for-profit organization which evaluates and accredits more than 15,000 healthcare organizations in the United States (The Joint Commission 2016). JCAHO's Joint Commission International (JCI) was founded in the late 1990s to survey hospitals outside of the United States (ibid.). JCI is also a not-for-profit organisation, which oversees medical tourism's specific locations. To date, JCI has accredited over 275 hospitals and other healthcare facilities centres in more than 33 countries (JCI 2016). Linked to this, Pafford (2009) also states that the first hospital in Asia with JCI accreditation was Bumrungrad Hospital in Bangkok, Thailand. To date, there are 37 hospitals accredited by JCI in Thailand (JCI 2016).

Accreditation reassures patients and families that the medical care they receive outside of their home countries maintains the same, if not higher, standards of care and responsibility as they would receive at home. Accreditation may have played a large role not only in determining the locations where people seek care, but also in making many thousands of patients feel comfortable travelling abroad at all. It may also have contributed to the exponential increase in medical tourism in the past few years.

2.10 Other perspectives of medical tourism in Thailand

There are different types or perspectives of medical treatments and services available in Thailand. This research explores their definitions, differences and details in the following sections.

2.10.1 Health tourism and Wellness tourism

According to Horner and Swarbrooke (2016) and Bookman and Bookman (2007), health tourism may be broadly defined as people travelling from their place of residence in order to experience medical therapies that will help to make them well or improve their health. From the research point of view, this means that health tourism should be recognised as medical tourism. However, if the main purpose for travelling abroad is medical tourism, then medical treatments and procedures could be separated into two types, those which are necessary and those which are elective.

Quintela, Costa and Correia (2016) define wellness tourism as “the sum of all the relationships and phenomena resulting from a journey to, and residence in a destination, by people whose main motive is to preserve or promote their health”. This includes elective medical treatment and procedures that are not urgent or necessary. Linked to this, Chiwangkul (2010) suggests that wellness tourism requires a comprehensive service package including physical fitness (exercise)/ beauty care, healthy nutrition/ diet, relaxation/ meditation and mental activity/ education. These service packages require specific facilities for example, a swimming pool, sauna, sport/ fitness activities, and steam baths.

In addition to this, Hall (2013) sees health, spa and adventure tourism types as functionally related in terms of travel motivations and social values, since they all emphasize improving an individual's quality of life. It can be concluded that these three types of tourism have the same purpose for travellers/ tourists. In other words, the improvement or maintenance of one's health is a major motivation for participation and travel (Hall, 2011). Wellness tourism is a broader term. Within this definition, there are different types of activities and treatments involved, such as travelling abroad for beauty care and healthy nutrition/ diet. This type of wellness tourism is identified in this research as aesthetic medical tourism (section 2.9.2). The different types of services in medical tourism are illustrated in Figure 2.3. These are based on definitions from different scholars (Chambers and McIntosh 2008; Cochrane 2008; Connell 2011; Bookman and Bookman 2007; Costa and Correia 2016; Hall 2011; Hall 2013)

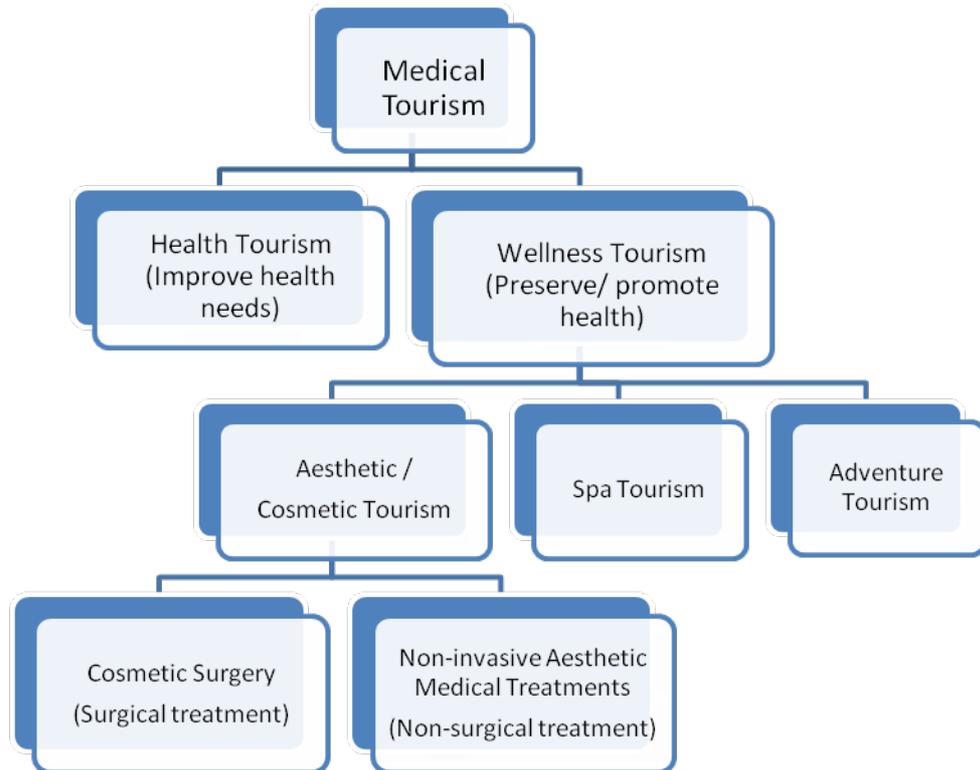


FIGURE 2.3 The different types of services in medical tourism

Adapted from: (Chambers and McIntosh 2008; Cochrane 2008; Connell 2011; Bookman and Bookman 2007; Costa and Correia 2016; Hall 2011; Hall 2013)

2.10.2 Aesthetic medical tourism

According to Atiyeh, Rubeiz and Hayek (2008), one of the basic characteristics of humans is their desire and ability to change, alter, and in most cases, improve almost everything in their surroundings as well as themselves. Practices designed to enhance appearance go back at least to the time of the Pharaohs and have always been determined by the culture of the period. Nowadays, it is difficult to pick up a paper or magazine or turn on the television without being reminded that we live in a culture of youth and beauty. Cosmetic surgery and other medical procedures can be defined as interventions that revise or change the appearance, colour, texture, structure

or position of bodily features (ibid). They also mention another term, “cosmetic plastic surgery”, to refer to specialised surgery that focuses on improving appearance. It includes procedures such as breast augmentation, face-lift, ear correction, fat reduction and many more.

Kerscher and Williams (2009) also point out that aesthetic or cosmetic dermatology focuses on the appearance-related aspects of dermatology and represents an overlap between the traditional medical treatment of skin diseases and cosmetology. Aspects of aesthetic medical treatment may include the maintenance of healthy skin, the prevention and treatment of skin ageing and photo-damage, rejuvenation treatments and many more. In other words, aesthetic medical treatment is a term that has been used by medical professionals to describe medical treatments and procedures that aim to improve a person’s appearance or subjective well-being. Indeed, it is regarded as a practice of “medicalised” beauty therapy (Tan 2007). In a society where beauty is increasingly seen as an essential ingredient of health (Moosa 2002), more doctors are providing aesthetic services as part of their medical practice.

The role of aesthetic or cosmetic dermatology has expanded in recent decades in both clinical aspects and research. According to Kerscher and Williams (2009), it is a rapidly growing field throughout Europe with significant impact on dermatology and other medical areas, as well as significant economic impact on the cosmetics industry. Cosmetic dermatology has not only changed the face of traditional dermatology but has also enhanced the quality of life of patients who feel a distinct improvement in their psychological

and physical well-being after aesthetic treatments (Kerschler and Williams, *ibid*). Because of increasing interest in minimally invasive aesthetic medical procedures such as botulinum toxin injections, and filler injections, many fewer patients are prepared to undergo invasive aesthetic medical therapy such as face lifts. The implication of this increased demand for non-surgical aesthetic procedures has meant dermatologists increasingly look for ways to help their patients easily realise their aims in hospitals and clinics.

In summary, non-surgical or non-invasive or minimally invasive aesthetic medical tourism is another type of aesthetic or cosmetic medical tourism with no surgery involved. For this research, the term non-invasive aesthetic medical tourism will be utilised in order to explore the risks (Chapter 3) related to this kind of practice. This type of medical tourism has become an integrated part of everyday dermatology practice and is set to become even more important in the future. This is because non-invasive aesthetic medical treatments are not only available in hospitals but also non-invasive aesthetic clinics.

2.10.2.1 Non-invasive aesthetic clinics

In this research, a non-invasive aesthetic clinic is defined as a clinic that provides non-invasive aesthetic medical treatments and procedures which are related to bodily perfection treatments, and which aim to reduce the signs of ageing without surgery. According to Klatsky (2001), patients who visit aesthetic clinics are normally between 35 to 40 years of age, or younger, who are seeking treatments such as Botox[®] injections, a light peel or some laser

facial resurfacing treatments. Such patients will normally return ten years later, when they have reached the age of 45 to 50, for whatever needs to be done to counteract gravity and to give them a psychological lift. This leads to the definition of aesthetic surgery as healthy maintenance (Klatsky 2001).

According to Heights (2016), the American Society of Plastic Surgeons (ASPS) released statistics demonstrating that 1.7 million surgical cosmetic procedures were performed in the U.S. in 2015, while 14.2 million minimally-invasive (or non-invasive) cosmetic procedures were performed in the same period. 14.2 million non-invasive aesthetic procedures included for example, Botulinum toxin type A 6.7 million procedures, soft tissues fillers 2.4 million procedures, chemical peel 1.3 procedures, laser hair treatment 1.1 million procedures, microdermabrasion 800,340 procedures (ibid). In addition to this, Klatsky (2001) reported that only six million aesthetic medical treatments and procedures were conducted in 2000 (up nearly 2,650 percent in 15 years), this still suggests that the wider acceptance of cosmetic treatment has also fostered the expansion of aesthetic surgical practices to include a wide array of ancillary procedures, such as injectable medicines, light peels, microdermabrasion, non-ablative skin resurfacing, hair removal, fat reduction therapy and many more treatments (see appendix A for more details of treatments). A summary of these treatments will be explained in section 2.11. Such services have met patients' demand for non-invasive treatments in that they produce immediate, though often temporary and less dramatic results than invasive surgery. That this is an expansion area for doctors is illustrated by Saniotis (2007) who observed that while only 10 cosmetic physicians in the whole of Thailand claimed to be United States board certified in the

1970s, in 2015 hundreds of physicians were operating aesthetic clinics and hospitals in Thailand (Head 2015).

2.11 Non-invasive aesthetic medical treatments: What are they?

It is generally accepted that more people than ever seem to pay close attention to the sign of ageing on their skins. Ageing skin starts off with lines, develops into wrinkles, then settles in folds, as shown in figure 2.4. Holford and Savona (2010) explain that as humans age or mature, two components of their skin, collagen and elastin, begin to degenerate, provoking the appearance of wrinkles, creases, folds and furrows, which people wish to slow down to appear younger and slimmer. Non-invasive aesthetic medical treatment is a medical procedure that helps patients maintain a youthful appearance, reduce signs of ageing, or reduce unwanted body fat and cellulite. The onset of these features can be partially offset by aesthetic procedures which do not involve surgery, or provoke wounds or bleeding. Thus a major attraction of non-invasive aesthetic medical treatment is that patients have no need to stay for long periods in a clinic or hospital after treatment but can resume their regular activities as soon as such treatment is completed.

This is especially important for those of the baby boomer generation, whom Henderson (2004) describes as people exposed to strong pressures in modern society to conform to idealised images of bodily perfection and who feel obligated to resist the signs of ageing. At the same time, the time factor is very important for such patients, who wish to improve their appearance

without the prolonged periods necessary for healing in invasive surgery procedures (Bosniak, Cantisano-Zilkha and Nestor 2001; Jeevan and Armstrong 2008; Nassab *et al.* 2010; Pollard 2011; Turner 2012). For such people, even if non-invasive aesthetic treatments achieve less dramatic results, they have the advantage of incurring less downtime, and offering the individual the option of returning as convenient for multiple treatment sessions. Patients can avail themselves at will to a number of types of non-invasive aesthetic medical treatments, varying from single to multiple visits, minimum to advanced technology, injected medicine to gas and with or without aesthetic medical devices. Thus the increased values put on sustaining a youthful physical appearance, combined with efficient use of time and convenience, also serve to explain the increasing numbers of alternative choices of non-invasive aesthetic medical treatments being made available through medical tourism (Aizura 2009; Clarke, Repta and Griffin 2007; Kerscher and Williams 2009).

It must not be ignored however, that even if aesthetic medical treatment to reduce the signs of ageing is quicker, and does not involve surgery, it is nevertheless a medical procedure that should be administered in a clinic or hospital rather than in a spa, hair salon or on private property (Head 2015; Pollard 2011; Smith 1999; Turner 2012). Such procedures, for instance a non-invasive face lift carried out by means of a radio frequency technique (explained in Appendix A), requires the services of a qualified dermatologist, surgeon or doctor. It is an important issue that aesthetic medical treatments are seen as related to medicines, drugs and medical equipment, rather than to beauty products or treatments that might be encountered in a spa, a salon or a beauty shop.

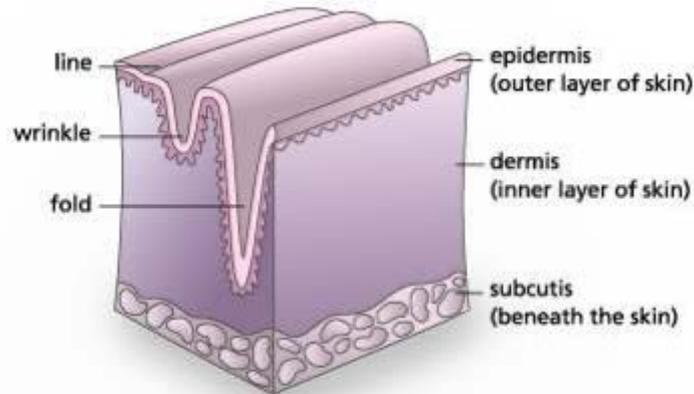


FIGURE 2.4 Types of ageing in human skin

Source: Holford and Savona (2010)

One aspect of this issue is that the term “non-invasive” can be misleading. For instance, while some non-invasive aesthetic medical treatments, such as Iontophoresis and Phonophoresis (section 2.11.1), are completely pain-free, many others are not. In other words, some kinds of procedures provided in hospitals and clinics would better be called “minimally-invasive” rather than “non-invasive” aesthetic medical treatments. This is because patients may experience pain when having a treatment, such as laser treatment or a chemical peel. In order to perform these aesthetic medical treatments, aesthetic medical devices such as Intense Pulsed Light (IPL), CO₂ laser and Fractional 1550 nm laser are needed (an explanation of these aesthetic medical treatments and the equipment involved is provided in Appendix A), which do change the surface of the skin for a time.

For this research, non-invasive aesthetic medical treatment does not therefore refer to completely non-invasive or pain-free treatment in all

respects, it may be partially invasive. A good example of such a treatment is erbium glass fractional laser skin reconstruction system, which adopts the use of a fibre laser with 1550nm wavelength. The fractional 1550 nm laser is a new type of laser, gaining significant acceptance in the dermatological profession as a preferred method for skin resurfacing (Narurkar 2007). Use of the fractional 1550 nm laser is quite aggressive and invasive, and there is a strong likelihood that patients will experience pain, although the pain scale is subjective and variable. For instance, the impact of the fractional 1550 nm laser might be experienced as a little more painful than an Intense Pulsed Light (IPL) procedure, but the actual degree of pain experienced will depend on various factors including the patient, the treated area and the depth of the laser. What is true is that any pain experienced can be significantly alleviated by the application of a local anaesthetic cream to the treated area 30-45 minutes before the start of each laser treatment. Most patients have rated the pain from fractional 1550 nm laser treatment as a 3-4 out of ten, which is seen as an acceptable and bearable pain level (Narurkar 2007). Overall, a fractional 1550 nm laser treatment is very well tolerated as relatively non-invasive.

In summary, this literature review has expanded the definition of non-invasive aesthetic medical treatment to describe medical treatments and procedures which aesthetically improve an individual's physical appearance without surgery, wounds and bleeding. For such procedures, no prolonged post treatment downtime is required. Lastly, although there are varying degrees of what can be described as "non-invasive", the pain of marginally invasive aesthetic medical treatments, coming under the label of non-invasive, can be managed and reduced significantly by local anaesthetic creams.

2.11.1 Types of non-invasive aesthetic medical treatments

According to Pickett (2012), it can be argued that over the past ten years the anti-ageing weapons of choice for the baby boomer generation have been non-invasive procedures such as Botox[®], Thermage[®], Fraxel[®], fillers, chemical peels and laser treatments (details of each treatment are in Appendix A). These have become popular for patients who wish to go about their regular activities straight after the treatment has finished. More importantly, the associated risks are seen to be less than those of cosmetic surgery as there is no surgery involved. The duration of each treatment is short. Patients can in fact have a procedure done during their lunch break, allowing them to go back to work as usual (Carruthers *et al.* 2002; Kerscher and Williams 2009). Although some treatments require more than one visit to complete a course of treatment, others will achieve their full effect after one visit, thus further reducing time away from work, or from home. These benefits help to increase the acceptability of different types of non-invasive aesthetic medical treatment, in terms of patients' individual requirements, which in turn will have been motivated with respect to different ethics, cultures, social and economic conditions. Types of non-invasive aesthetic medical treatment are illustrated in Figure 2.5 and their details are explained in Appendix A.



FIGURE 2.5 Types of non-invasive aesthetic medical treatments

Adapted from Carruthers *et al.* 2002; Clarke, Repta and Griffin 2007; Kerscher and Williams 2009; Teitelbaum *et al.* 2007

According to the previous section, non-invasive aesthetic medical treatments can vary from pain-free to minimally invasive. Regardless of the degree of pain involved, this research recognises all these as non-invasive aesthetic medical treatments as long as there is no surgery involved. As to the availability of these different types of treatments, this very much depends on the location of service providers and also on the types of consumers seeking treatment. In Thailand, many types of non-invasive aesthetic medical

treatments are provided to Thai and tourist-patients at non-invasive aesthetic clinics in Bangkok. Each treatment offers different kinds of benefit in helping patients achieve a more youthful look or preferred appearance. At the same time, each treatment comes with specific types of side effect, potential complications and limitations.

In addition to the predictable side-effects of each type of treatment, tourist patients may experience unexpected side effects which differentiate between fake and genuine products. A good example of risk related to Botox injections is how far it can be ensured that the botulinum toxin is genuine. Images of genuine Botox and fake Botox[®] samples are illustrated in Figure 2.6 and Figure 2.7 respectively. According to Coleman and Zilinskas (2010), only seven companies in the world have licenses to produce pharmaceutical-grade botulinum toxin for use on humans. However, in China alone, the authors found 20 entities which represented themselves on their website as certified suppliers of botulinum toxin type A, with a right to offer cosmetic products for sale. Pickett (2012) meanwhile discovered 34 Internet sites selling fake botulinum toxin type A, including sites from China, the United Kingdom, Canada, Sweden, Turkey and the U.S.



FIGURE 2.6 Example of the genuine Botox

Source: Allergan (2016)



FIGURE 2.7 Examples of fake Botox[®] from USA (Left) and China (Right)

Source: Coleman and Zilinskas (2010) and Pickett (2012)

Moreover, the rapid expansion in the medical tourism industry heightens risk. As the numbers of individuals seeking inexpensive care grow, the numbers of pharmaceutical counterfeiting businesses which seek to profit from this business also increase. From a security perspective therefore, the availability of fake botulinum toxin type A challenges the aesthetic medical tourism industry much more than any need for exotic equipment or high technology (Pickett 2012).

According to Horsfall *et al.* (2013), the fact that such products are becoming more easily available on a global level raises a number of issues. Advertisement via the Internet leads to unrestricted access, generally for low-cost reasons. Pickett (2012) argues that there have been several reports of accidents caused by practitioners acquiring unregulated, look-alike products. According to Coleman and Zilinskas (2010), the long term cost for people buying counterfeit products is potentially much higher than the immediate costs of genuine treatments. For example, in 2004, four people in Florida were admitted to hospital for few months after being injected with vials of

counterfeit cosmetic botulinum toxin type A, only too vividly reminding patients that botulinum toxin type A is not only an injected aesthetic medicine but also a toxin. In addition to this, Pickett (2012) states that in the U.S. physicians may be sentenced for injecting patients with fake Botox.

Without adequate means therefore of verifying the quality of ingredients in each vial of botulinum toxin type A vial, there remains always a risk for both patients and physicians, since the amount of injected toxin cannot be exactly calculated and verified. A massive overdose of toxin creates a near death situation with severe botulism and a need for mechanical ventilation. Coleman and Zilinskas (2010) state that fake botulinum toxin type A contains gelatine, which has not been approved for use in aesthetic injectable medicines. They conclude that the use of injectable botulinum toxin type A products including gelatine should be avoided because patients' safety, paramount at all times, might be put at risk.

In Appendix A develops in more detail what other types of non-invasive aesthetic medical treatments may be provided at non-invasive aesthetic clinics. The Appendix also elaborates on the respective benefits, advantages, results, methods, side effects and complications of such treatments.

2.11.2 Non-invasive aesthetic medical tourist

According to Lunt and Carrera (2010), vacationing is not the primary purpose of medical tourism. However, while medical tourists are recuperating, they usually take advantage of the opportunity to spend an inexpensive vacation in the medical tourism destination country. On the other hand, a holiday-maker might spontaneously decide to become an aesthetic patient at an aesthetic clinic in a medical tourism destination country, and profit as much from this opportunity as from their planned vacation. It appears that tourists approach aesthetic medical treatment and procedures as a result of many different personal persuasions and motivations. For instance, these could be driven by advertising through the media, personal perceptions and comparisons of risks taken, lower costs of medical treatment, or autonomy of choice in opting for the medical tourism destination country.

2.12 Conclusion

Medical tourism is an economic activity which entails trade in a combination of at least two sectors, those of medicine and tourism. In order to gain a deeper understanding of the medical tourism industry, it is necessary to consider this broader development and management of medical tourism, to include reasons for considering using medical tourism, the impact of medical tourism, and the rise of global medical tourism. It also includes the recent changing status of medical tourism in medical tourism destination countries, such as in Asia, and in Thailand in particular. Medical tourism provides an opportunity for patients to have necessary or elective treatment outside of their home countries at a lower cost, with the added advantages of zero waiting lists and sophisticated technology.

Saving money on overseas medical treatment and procedures is the first motivation to travel abroad. Medical tourism destination countries can treat such opportunities as means to develop their resources and motivate more patients to use their services. Non-surgical aesthetic treatments, or non-invasive or minimally invasive aesthetic treatments, varying from pain free to bearable and manageable treatments, promise to help medical tourism destination countries to achieve these aims, as well as to help patients to achieve their aims in having a desired appearance. This is a complex process, which is underpinned by the knowledge that the treatments offered in this sector are not complication free. Thus for success in this sector, consideration of risks associated with non-invasive aesthetic medical treatments and tourism is crucial (Chapter 3).

CHAPTER 3

PERCEIVED RISKS AND RISK REDUCTION STRATEGIES

3.1 Introduction

Following on from the previous chapter discussing medical tourism, this chapter begins by examining the concept of customer motivation and decision-making in purchasing non-invasive aesthetic medical treatments. The chapter then moves on to reviewing the literature relating to risks of such treatments as perceived by consumers, and considers risk reduction strategies associated with various treatments. This is followed by an evaluation of six types of perceived risks, that is: functional, physical, financial, time, psychological and social risks, and how these relate to non-invasive aesthetic medical treatments.

3.2 Motivation and decision-making

According to Mishra (2014), the forces that drive people to buy and use products are generally straightforward. However, even the consumption of basic essentials, such as food products, may be influenced by a number of wide-ranging beliefs regarding what is appropriate or desirable. In some cases, consumer beliefs will provoke an emotional response and a deep commitment to one product over another, even if the holders of these beliefs are not fully aware of the forces that drive them toward some products and

away from others. To understand consumer motivation is to understand why consumers do what they do. That is, motivation refers to the processes that lead to consumer behaviours which arise when a need is aroused which a consumer wishes to satisfy (Greenberg and Baron, 2003). The desired end state is the consumer's goal. The factors that combine to create a want, as one manifestation of a need, are said to be cultural but also personal.

Smallman and Moore (2010) acknowledge decision-making in relation to perceived need as a process that can be understood in at least two ways. First, the decision-making process can be viewed through an ontological realism lens, that is, in relation to real objects, entitlements or things which tend to interact in a reasonably orderly, if often complicated, manner. Second, this process can be understood being fundamentally real in itself; that is, in relation to the kinds of objects, entitlements or things that might emerge or be socially constructed by a researcher. Linked to this, Decrop and Kozak (2014) suggest that today every textbook on consumer behaviour or principles of marketing describes a model of consumer decision making. Such a model would typically refer to five steps, which are problem recognition, information search, evaluation, choice and outcomes. As a result, Smallman and Moore (2010) argue that there is a need to understand tourist decision-making from these alternative theoretical perspectives.

Before making the decision, consumers should consider risks related to the service/ product. The definition and the types of risks will be explored in the following section.

3.3 Risk and uncertainty

According to Spiegelhalter (2012), even though none of us knows what is going to happen in the future, either to ourselves or to society, we nevertheless still have to make decisions related to risk and uncertainty. The literature suggests that the concept of risk in consumer research differs from that in other disciplines, such as economics and psychology (Harwell, 2006; Mitchell, 1999; Stone and Gronhaug, 1993), in that while for economics and psychology research, the concept of risk is related to choice situations involving both potentially positive and negative outcomes, risk studies in the field of consumer behaviour focus on potentially negative outcomes only. Another difference is the way that different fields distinguish between the ideas of 'risk' and 'uncertainty'. In the consumer studies literature, the term 'uncertainty' is used when the probability of the outcome is not precisely known, while the term 'risk' is used when the probability of the outcome is exactly known (Cunningham, 1967; Spiegelhalter, 2012; Stone and Gronhaug, 1993; Taylor, 1974).

While risk studies in economics commonly attempt to capture the probabilities and outcomes of consumer choices in a multiplicative model (Mitchell, 1999; Stone and Gronhaug, 1993), in consumer behaviour literature the distinctions between 'risk' and 'uncertainty' have become blurred, the terms being used interchangeably (Mitchell, 1999; Stone and Gronhaug, 1993; Taylor, 1974). Taylor (1974) saw risk and uncertainty as equivalent concepts in consumer behaviour research.

Notwithstanding this, Knight (1948) defined the concepts of risk and uncertainty differently in consumer behaviour research. Knight proposed that 'risk' had a known probability while 'uncertainty' would arise when knowledge of a precise probability was lacking. In other words, the premise is that a consumer will make a decision related to risk if he knows the probability of loss. On the other hand, if the consumer does not know the probability of loss then the decision will be made based on uncertainty. The distinction between these two words had been drawn in terms of distribution of outcomes, where marketers have allowed the two concepts to be used synonymously (Mitchell, 1999). This is because marketers feel that consumers never really know the exactly probability of an outcome.

However, if the consumer could calculate accurately the probability of risk involved in a purchasing situation, it is argued that an objective weighing of risks would be less likely to motivate the consumer's behaviour than his or her subjective impressions of the situation. Nevertheless, Cunningham (1967) argues that uncertainty may involve either a known or unknown probability. It is noticeable however that known probabilities are extremely rare in purchase behaviour, and that even when they are available, the consumer is unlikely to think in terms of these probabilities.

3.4 Definitions of risk

The concept of “risk” appears to have begun in the field of economics in the 1920s (Knight 1921), since which time it has been successfully used in theories of decision making in economics, finance and decision science. In 1960, Bauer introduced the concept of “perceived risk” (section 3.5) to the marketing literature (Bauer, 1960), followed by Kogan and Wallach (1964) who wrote their major work on risk taking. In marketing literature, Cox (1967) introduced information handling in consumer behaviour in regard to risk taking. This was followed by the development of several conceptual models of consumer risk perception and handling (Stern, Lamb and MacLachlan, 1977; Taylor, 1974). More recently, perceived risk has been used as an explanatory variable in empirical research into consumer behaviour (Chiu, Wang, Fang and Huang, 2014; Rao and Farley, 1987; Sheeran, Harris and Epton, 2014).

In regard to decision theory, risk is commonly conceived as reflecting variation in the distribution of possible outcomes (Arrow, 1965; Pratt, 1964). It is measured by the variance of the probability distribution of possible gains and losses associated with a particular alternative (Arrow, 1965). Decision makers have the choice of opting for small risks or larger risks. Linked to this, Taylor (1974) suggests that risk can be defined in terms of possible loss, a given in human life where all activities entail possible losses. Stone and Winter (1987) go further viewing risks as an expectation of loss. This can be interpreted as saying that the more an individual expects, the greater the risk this expectation will entail. This understanding differs from the normative expectancy-value orientation that often views risk as probability times pay-off (Mitchell, 1999).

In the field of marketing research, Cunningham (1967) and Bettman (1973) developed schema for specifying the components of risk. Cunningham (1967) specified these components as certainty and consequences. Bettman (1973) built a theoretical model and measurement system for perceived risk, including inherent risk and handled risk, and its related components. Risk has therefore tended to be defined as a subjectively-determined expectation of loss; the greater probability of this loss, the greater risk involved for a consumer (Mitchell, 1999).

3.5 Objective and subjective risks

In the literature, there are two distinct types of risk that can be found, namely objective risk and subjective (perceived) risk. According to Weegels and Kanis (2000), objective risk can be defined as the ratio of a particular number of accidents to a measure of exposure, while subjective risk can be defined as the perception and awareness of risks by the person(s) involved. Stone and Winter (1985) argue that there is no such thing as objective risk; except perhaps for physical risk. That is, they believe that it is impossible to have any real world or objective risk, be it social, psychological, or financial, or linked to time or performance.

Mitchell (1999) argued that objective risk must exist in theory, but that what was lacking was the ability to measure it. While some phenomena such as time, money and physical harm can be measured by experts using specific measurement tools. Psychosocial risk on the other hand is less easily calculated. Although psychometric scales could be devised to measure such phenomena, the factors contributing to risk would still be complex and

potentially changeable, and as such, difficult to measure accurately. This leaves subjective or perceived risk as the only risk that can be easily measured. The different ways of perceiving objective risk and subjective risk can be situated between relativistic and positivistic approaches to analysis, as illustrated in table 3.1. In positivistic research, measuring is needed for both objective and subjective risks. However, in terms of relativism, subjective risks are the only ones acknowledged to exist and to be measurable. As a result, it is often assumed that behaviour is more directly determined by subjective estimates of risk than by objective risk (Howarth, 1988).

	Relativism	Positivism
Objective risk	Not willing to admit objective risk exists	Attempts should be directed at conceptualising and measuring objective risk where possible
Subjective risk	The only risk which exists and that can be measured is subjective	Willing to accept its existence and the need to measure it

TABLE 3.1 Philosophical beliefs about perceived risk

Source: Mitchell (1999:165)

3.6 The concept of perceived risk

In the consumer behaviour literature, perceived risk has been defined in different ways. Kogan and Wallach (1964) suggested the concept of risk as potentially having two different aspects, namely, that of chance and that of danger. These authors interpreted chance as a probability and danger as

leading to negative consequences. Putting it another way, Cunningham (1967) identified two components to the concept of perceived risk, namely, the amount that would be lost and the individual's subjective feeling of certainty that the consequences would be unfavourable.

Cox and Rich (1964) see perceived risk as being the nature and amount of risk perceived by a consumer in contemplating a particular purchase decision. They based the concept of perceived risk as based on the notion of buying goals. For example, a consumer is motivated to make a purchase in order to attain some set of buying goals. In addition to this, Peter and Ryan (1976) suggested that perceived risk may be conceptualised in terms of expected negative utility associated with brand preferences.

Research undertaken by Gemunden (1985) argued that perceived risk is not often a major influence on information searching, although conversely, Dowling and Staelin (1994) found that perceived risk may well influence intended search behaviour. Their results extended to the cross category findings of Beatty and Smith (1987) which involved more search activity in high-risk categories. These findings raise new issues as to the conceptualisations of risk perception for many consumer researchers. For example, Rubio, Oubina and Villasenor (2014) have studied brand awareness-quality inference and consumer risk perception in relation to store brand food products. Quintal and Phau (2014) have examined consumer risk perceptions of prototypical brands versus me-too brands. Sheeran *et al.* (2014) have analysed experimental evidence in order to address the understanding of risk and people's intentions and behaviour.

In summary, the concept of perceived risk most often used by consumer researchers defines risk in terms of the consumer's perceptions of the uncertainty of outcomes, and in terms of adverse consequences of buying a product or service. In this way, consumer researchers implicitly assume that both the probability and the outcome of each purchase event are uncertain (Carroll, Connaughton, Spengler and Byon, 2014; Dowling and Staelin, 1994).

3.7 The element of risk

The element of risk is often present because the consumer cannot always be certain that the planned purchase will lead to the achievement of the buying goals. The uncertainty may result from factors inherent in the product, the brand, the place of purchase, the mode of purchase and so on (Cox and Rich, 1964).

The amount of risk perceived by the consumer is a function of two general factors (Cox and Rich, 1964). These are the amount at stake in the purchase decision and the individual's feeling of subjective certainty that the consumer will win or lose all or some amount at stake. The amount at stake in a buying situation is determined by the importance of the buying goals.

The economic cost of a bad decision is the most commonly discussed element of risk (Cox and Rich, 1964). But it is not the only one, and may not be the most important. For example, a consumer may know that a purchased product can be returned if it proves to be unsatisfactory and consequently may not perceive any financial risk. However, this same consumer may

perceive substantial risk of time loss in a purchase. In other words, if it proves unsatisfactory, the consumer will have to waste time in returning the goods and experience delay in obtaining the required item. In addition, the consumer may be faced with ego loss and frustration and probably not achieve the buying goal in the end.

In many instances, consumers will be faced with a completely new purchase which they have never encountered before, making it difficult to predict whether the quality of the goods will be satisfactory. This makes accurate assessment of risk almost impossible. Even if the consumer could calculate accurately the risk involved, it is not this objective risk which has motivated behaviour, but the consumer's subjective impressions of the risk. Linked to this, Mitchell (1999) concludes that any measurement of risk perception must be developed with these limitations in mind.

3.8 Perceived risk as a travel determinant

As in any intangible service product, the purchase of a tourist product involves a certain level of risk taking (Cooper *et al.*, 2008; Moutinho, 1987; Nepomuceno, Laroche and Richard, 2014; Roehl and Fesenmaier, 1992). In tourism studies, as in other marketing studies, the concept of risk and perceived risk are strongly associated with consumer decisions and travel behaviour. These concepts arise in a variety of disciplinary and/or interdisciplinary studies such as economics, psychology, decision sciences, insurance, public policy and finance. Each discipline uses a different theoretical approach and focuses on different aspects of risk (Conchar *et al.*, 2004).

Linked to this, Moutinho (2000) states that perceived risk is defined as a function of uncertainty and consequences, which include (1) uncertainty inherent in the product (2) uncertainty in place and mode of purchase (3) degree of financial and psychosocial consequences and (4) the subjective uncertainty experienced by the tourists undertaking the travel.

The discourse on risk taking by tourists may be approached from various angles depending on the scope of the study. However, Jonas *et al.* (2011) suggest that in most research work on this issue, two main perspectives have been most intensively used. Firstly, a behavioural approach (section 3.8.1) which looks at the tourists' perceived risk, and secondly, a supply approach (section 3.8.2) which examines possible events and circumstances that might put tourists in jeopardy.

According to Mitchell and Prince (1992) and Murray (1991), services are typically regarded as a riskier purchase than a physical product because of their essentially intangible nature. Distinguishing between search, experience, and credence attributes, Hoffman and Bateson (1997) argue that a large proportion of the properties of services can be evaluated only during and after the consumption process. Therefore, service buyers only know what they have bought after the buying decision, which is obviously risky.

In relation to this research which investigates non-invasive aesthetic medical tourism products (see Chapter 2 for details), many patients with ageing skin wish to improve the appearance of their face by procedures other than

surgical (Naoum and Dasiou-Plakida, 2001). In order to achieve this goal when buying a service, the buyer as consumer may perceive and deal with many different types of risk. This may include non-invasive aesthetic medical treatment, as one type of service in the medical tourism industry. However, it is worth noting that in some cases patients might see non-invasive aesthetic medical treatment as a product. This is because some treatments are very popular so that consumers rely on associated reputation. This is particularly the case in relation to services widely recognised by their global brands, such as Botox[®], Thermage[®] and Fraxel[®].

In such cases, patients as buyers may opt for these treatments by reference to their brands, rather than by reference to the type of the treatment itself. Requesting a particular brand of well-known product such as Botox[®] instead of botulinum toxin injection can be confusing since it gives rise to the question as to whether non-invasive aesthetic medical treatment should be classified as a product or as a service. On the one hand, it can be seen that Botox[®] is a product. However, the patient who buys this is unavoidably buying the service of Botox[®] injection from a clinic. In this respect, it can be argued that the patient is buying a service, rather than a particular product from a service provider.

Although a customer may initially be attracted to a brand image of a product, it cannot be ignored that non-invasive aesthetic medical treatment is a type of medical service, which by its nature will entail some risks. These will be perceived by the patient as part of the process of going forward to achieving their buying goal. The nature of non-invasive aesthetic medical tourism then,

(Chapter 2) is different from other types of tourism industry in the types of risk undergone.

3.8.1 A behavioural approach

From a behavioural perspective, it is apparent that perception of risk is both individual and situational and it is characterised in the literature by type and intensity (Pizam *et al.*, 2004; Reisinger and Mavondo, 2005). Many researchers also claim that perceived risk is shaped by consumers' past experiences, lifestyle, sociocultural and demographic background characteristics, and the culture of each tourist consumer (Pizam *et al.*, 2004).

The categories of perceived risks mentioned in this dissertation are obtained from a literature review. It appeared that Roselius in 1971, and Roehl and Fesenmaier in 1992, were the first to observe and document four and seven different types of perceived risk in tourism respectively. In consumer behaviour research, Roselius (1971) defined four types of tourist loss as time loss, hazard loss, ego loss and money loss. In marketing literature, Moutinho (1987) reviewed and divided tourists' perceived risks into five categories, that is, functional risk, physical risk, financial risk, social risk and psychological risk. In addition, the study of the relationship between risk perceptions and pleasure of travel from Roehl and Fesenmaier (1992) identified seven categories of risk, namely equipment risk, financial risk, physical risk, psychological risk, satisfaction risk, social risk and time risk.

3.8.2 A supply approach

According to Jonas *et al.* (2011), when the supply approach is taken, the literature observes five generators of potential risk that might impinge on the safety and the level of customer satisfaction. These generators of potential risk are terror (Sonmez and Graefe, 1998; Tarlow and Goldblatrt, 2002); natural disasters (Sharpley, 2005; Specht, 2006); politically and security-induced instability (Wall, 1996; Mansfeld, 2006); crime (Pizam and Mansfeld, 2006; Pizam, 1999); and impeded health (Carter, 1998; Leggat, 2006). Since the level of tourists' susceptibility to those risk generators is determined by both behavioural and environmental conditions, and since risk is something to be avoided or at least mitigated, it is important to study both their relative role in shaping perceived risk and the tourist behaviour performed in its wake (Ryan, 2003).

Many researchers have done research regarding consumer behaviour in terms of risk perception, risk reduction, perceived risk and decision making process (Cox, 1967; Cox and Rich, 1964; Maser and Weiermair, 1998; Mitchell and Greatorex, 1993; Mitchell and Vassos, 1997; Roselius, 1971; Rubio *et al.*, 2014; Sheeran *et al.*, 2014; Taylor, 1974). Though the marketing literature offers an abundance of research on the topics of perceived risk, information search, and purchase intentions, very few researchers have empirically examined these constructs in the context of medical tourism. Earlier research on risk and risk relievers has focused on attempts to identify and explain differences in risk perceptions. Risk relievers may, however, operate at different levels that have not been adequately investigated (Boshoff, 2002).

On the other hand, there are many researchers who have discussed the development of the medical tourism industry in developing countries. Their research has reviewed a variety of crucial reasons for travelling abroad for medical treatment, such reasons depending on the context of patients' home countries (Bookman and Bookman, 2007; Burkett, 2007; Carrera and Bridges, 2006; Chanda, 2001; Cochrane, 2008; Hanefeld *et al.*, 2014; Lunt and Carrera, 2010; Singh, 2008; Singh, 2014; Whittaker and Leng, 2016). Mostly, such studies seek to explain why people from developed countries need to go to a medical tourism destination in developing countries, in particular Asia, and how developing countries might benefit from medical tourism industry.

However, there is very little literature that discusses the topic of long term development of the medical tourism industry in developing countries (Burkett, 2007; Hanefeld *et al.*, 2014; Singh, 2014). In other words, the researcher found that there is no literature providing an empirically tested and appropriate business strategy for responding to the baby boomer generation, a generation of consumers who as never before desire to maintain a perfect body and youthful look beyond their chronological age. Moreover, there is no literature adapting the issues of risk perception, risk reduction and perceived risk to the medical tourism industry. A major conclusion of this literature has been that experience and credence qualities of services and goods dominate the travel decision making process, as there is no possibility for tourists to define and evaluate or even measure the output of a tourism product before consumption.

In terms of risk related to price and quality, Burkett (2007) noted that all clinics offer a choice of products and services to consumers on the basis of price and quality. Consumers will tend to favour those clinics offering lower prices while at the same time a high quality of service. The risk however is that there is a tension in this for both consumers and clinics: how can a clinic afford to offer high quality services if the lower prices offer little profit margin? Although the price may be clear and competitive, how does the patient or the clinic define or ensure high quality? For that matter, how does the customer know that the standard is reliable? These questions are highly pertinent to the current research, as is a related issue: there is evidence that patient consumer groups who opt for aesthetic medical tourism are prepared to take risks when they buy aesthetic medical treatment and procedures from clinics that offer a price which is lower than the equivalent service in the patients' home countries, even if they cannot be entirely sure of the claims for a high quality service. Considering the reality of this situation, government policy makers, business owners, medical staff and other related stakeholder groups in the industry must fully understand how consumers perceive risk, how any such risks can be reduced, and most importantly how to ensure that the consumer is satisfied with the service.

The aim of this research is to fill certain gaps in knowledge that exist between that related to consumer behaviour and that related to service from the non-invasive aesthetic medical tourism industry. Thus the research will focus on the management of non-invasive aesthetic medical tourism industry in Bangkok, Thailand, with a view to using a case study to illustrate the issues and answer the research questions.

In order to truly understand the risks related to non-invasive aesthetic medical tourism and treatments as practiced in Thailand, the focus of the study will be divided into three main areas, related to consumer behaviour in terms of risks, risk perception and risk reduction; the competitive environment of the medical tourism industry; and the internal factors of this industry as exhibited in Thailand. To this end, six distinct aspects of perceived risks associated with non-invasive aesthetic medical tourism and treatments have been identified from the literature. These six types are functional risk (section 3.9.1), followed by physical (section 3.9.2), financial (section 3.9.3), time (section 3.9.4) psychological (section 3.9.5) and social (section 3.9.6) risks respectively.

3.9 Six categories of risks related to non-invasive aesthetic medical tourism and treatments

Risk has been usefully applied as a concept in theories of decision-making in economics, finance, and the decision sciences (Dowling and Staelin, 1994). In terms of medical tourism, when faced with a purchasing situation such as choosing a medical destination country and a package of aesthetic medical treatment directly from a hospital or clinic or medical tourism company, a tourist can be seen to take a certain number of risks in the process of making choices and decisions. The concept of perceived risk most often used by consumer researchers defines risk in terms of consumer's perceptions both of the uncertainty and the magnitude of the possible adverse consequences (Cox, 1967; Cox and Rich, 1964; Dowling and Staelin, 1994).

According to Lunt and Carrera (2010), the rapid growth of the medical tourism industry creates its own set of risks. Non-invasive aesthetic medical tourism is no exception in posing risks for travellers, the degree of risk in this type of tourism depending upon several factors. These include the means of transportation used, the type of non-invasive aesthetic medical procedures purchased, the facilities offered at the hospital or clinic of choice, the environment of the sightseeing areas visited. Since it is impossible to eliminate risk entirely, Tsaur, Tzeng and Wang (1997) suggest that perceived risk may be reduced if advance warning can be obtained through risk evaluation. In order to be able to reduce potential risk in medical tourism, the categories of risks related to non-invasive aesthetic medical treatments are critically explored and explained in the following section.

The goal of non-invasive aesthetic medical treatment is to alter some part(s) of the body to create a more satisfactory appearance on the part of the purchaser. Tan (2007) posits that these alterations might carry a certain risk of harm. Travelling to an aesthetic medical tourism destination country in order to undergo these alterations is associated with additional risks (Reddy, York and Brannon, 2010). As such, any information serving to allay concerns about perceived risks would be beneficial to international tourist patients. This research therefore, will focus on six distinct aspects of perceived risk, as derived from the literature. They are functional (section 3.9.1), physical (section 3.9.2), financial (section 3.9.3), time (section 3.9.4) psychological (section 3.9.5) and social (section 3.9.6) risks respectively. Since the criteria of risk evaluation are endowed with diverse connotations and meanings, there is no logical reason to treat them as though they are of equal importance. The

linkage between each category of risk and non-invasive aesthetic medical treatment will be discussed in the following section.

3.9.1 Functional risks

Functional risk or performance risk refers to the possible failure of the chosen product to perform as desired and to deliver the benefit promised. There is limited data on clinical outcomes associated with English-speaking international tourist patients, and equally on affordable non-invasive aesthetic medical treatments and procedures in medical tourism destination countries. Although the popularity of such destinations appears to be because they offer cheaper treatment, expense is not necessarily related to quality, and Turner (2011) posits that it is an error to assume that inexpensive health care in such countries is necessarily inferior to higher cost health services elsewhere.

However, a growing body of scholarship indicates that in general, some patients undergoing non-invasive medical aesthetic treatments do suffer serious medical complications and require costly treatment as a result of travelling abroad and purchasing health services (Birch, Caulfield and Ramakrishnan, 2007; Jeevan and Armstrong, 2008; Lunt and Mannion, 2014; Reed, 2008). Current evidence suggests that poor outcomes are attributable to substandard surgical care. One cause of poor results may be inadequate infection control in the surgical settings. Long-distance travel shortly after surgery and inadequate post-operative care may also lead to complications (Cheung and Wilson, 2007; Handschin, Banic and Constantinescu, 2007; Hanna *et al.*, 2009; NaRanong and NaRanong, 2011; Newman *et al.*, 2005). These outcomes, in addition to causing considerable anxiety and suffering for

international tourist patients are often quite costly for individuals requiring extensive care after receiving treatment abroad.

These problems may be confused in tourist patients' home countries. For instance Jeevan *et al.* (2010) in the U.K. suggest it is unwise for British National Health Service (NHS) teams to undertake any elective revision procedures because aesthetic procedures have high minor complication rates. Since travelling after an operation is associated with increased risks, it is the patient's responsibility to consider associated risks before travelling abroad for medical care. According to Jeevan *et al.* (*ibid.*) medical staff and hospitals in the U.K. should serve patients who need necessary medical treatments, and those treatments should be operated within the country.

Although some non-invasive aesthetic medical treatments and procedures may require less time for recovery than invasive treatments, thus allowing more time for vacationing (Reddy *et al.* 2010), non-invasive aesthetic medical treatments and procedures carry risks of complications and failure rates like any other medical treatments. Indeed, IMTJ (2009b) claim that cosmetic patients are more at risk than ever before, including minimally invasive treatments. Functional risk related to non-invasive aesthetic medical treatment is crucial for this research. In order to be able to understand it well, the details of potential complications in relation to each non-invasive aesthetic medical treatment, which raise their functional risk, will be explained and discussed in the following section.

3.9.1.1 Botulinum toxin injections

It is indicated that Botox® can be injected into specific muscles with the effect of temporary relaxation, with a resulting inability for the skin overlying the treated muscle to contract or wrinkle (Allergan, 2016). Botox® is only said to be helpful for dynamic wrinkles, also known as wrinkles in motion. It is not as effective on static wrinkles, also known as wrinkles at rest. However, it is thought that prolonged use of botulinum toxin type A may help prevent wrinkles in motion from becoming wrinkles at rest. Nonetheless, such procedures carry risks: Carruthers *et al.* (2002) confirmed that Botox injections can lead to bruising and blepharoptosis. Blepharoptosis is abnormal low-lying upper eyelid margin with the eye in primary gaze. While the Expert Working Group on Cosmetic Surgery recommended that botulinum toxin injections should be monitored by the Healthcare Commission to safeguard patient safety (BBC, 2007a). These cautioning voices reflect the fact that under current regulations, almost anyone at the time can set up a clinic in the local high street and offer botulinum toxin injection services. In the cases where things go wrong, some patients can be left scarred physically or psychologically for life.

3.9.1.2 Mesotherapy injections

According to Lee, Daniels and Roth (2016), mesotherapy is a minimally invasive technique based on the introduction of pharmacologically active compounds in the superficial layers of the skin. Tan (2007) supports that the most controversial of all non-invasive aesthetic medical procedures is probably mesotherapy. Mesotherapy has evolved into a body-contouring procedure and a form of therapy for skin ageing and male-pattern baldness

(Kalil, Dewandre and Delune, 2005). Despite its growing popularity, Luthra (2016) argues that there is insufficient scientific evidence to establish the safety and effectiveness of mesotherapy. Just as importantly, there are currently no standard mesotherapy formulations. In the U.S., no pharmaceutical preparation is licensed or approved by the US Food and Drug Administration (FDA) for use of mesotherapy for anti-ageing or adipose tissue reduction purposes (Tan, 2007). Linked to this, Chang (2016) states that currently no mesotherapy product has an FDA approval as a cosmetic treatment.

3.9.1.3 Dermal filler treatments

Another well-accepted non-invasive aesthetic medical treatment is facial filling. According to Singh, Wang, Yee and Larin (2016), Facial fillers have become one of the most popular treatments in cosmetic or aesthetic practices, since overall they have a very effective record and a very safe profile compared to many other medical treatments. Fillers are substances that are injected into the lips or under the skin to plump up these areas, giving a younger and more hydrated look. Notwithstanding this, the side effects of aesthetic filler injections range from allergic reactions and permanent lumps to serious complications like blindness and cerebral artery embolisms (Ahn and Rao, 2014; Andre *et al.*, 2005; Egido *et al.*, 1993; Medical News Today, 2004; Silva and Curi, 2004). In addition to this, Wagner, Fakhro, Cox and Izaddoost (2016) and Naoum and Dasiou-Plakida (2001) state that permanent lumps or bumps or irregularities due to over correction or misplacement, of filler could prove to be far more distressing than the original defects and may be difficult to remove or correct.

3.9.1.4 Chemical peels

According to Lee *et al.* (2016), one of the factors which contribute to vibrant and radiant skin is constant cell turnover. Every day the skin constantly sloughs off thousands of dead cells and replaces them with new ones. In babies this cyclical process replaces the surface skin every few days whereas after the age of 20 this process slows down to about every three weeks and in older people, to about a month or more. The result of slower skin turnover is duller and uneven skin tone, with a higher preponderance of blemishes and fine lines. This coupled with a decrease in other factors that keep the skin looking fresh and young such as elastin and collagen production, leads to skin that called aged. This is where medical skin care treatments such as microdermabrasion and chemical peels are important. However, Monheit (2004) argues that even simple aesthetic procedures like chemical peeling can have significant side effects such as bacterial skin infections, herpes simplex reactivations and delayed wound healing.

3.9.1.5 Laser treatments

According to Husain and Alster (2016), Intense Pulsed Light (IPL) has been used extensively to brighten facial skin. Today, the use of lasers and (IPL) devices in aesthetic treatments for this purpose is on the increase. Concomitantly, Vanaman Fabi and Carruthers (2016) state that the number of patients who suffer adverse reactions from IPL treatments is on the increase. Patients have experienced adverse reactions such as burns requiring immediate attention, or long-term changes in pigmentation. Adverse reactions also entail the pursuit of medico-legal claims and the need for expert witness reports. Vanaman *et al.* (ibid.) argues that if any change in regulation is to be

made, it should be to control more stringently the use of such aesthetic treatment devices, not less so.

In Thailand, aesthetic clinics in terms of service providers currently do not even need to register with the Healthcare Commission to offer these aesthetic treatments and procedures. Although lasers and IPL can be safe if administered in a controlled and appropriate environment and by a properly trained clinician, the public must be aware that these procedures do create risks, which can range from irritated skin and blisters, to burns, pigment scarring (black spots) and sores.

Crabb, Chan, Taranath and Huilgol (2014), suggest that the outcome of treatment with lasers and IPL devices depends almost entirely on the skill of the operator. In other words, for each treatment, the parameters must be carefully selected according to the patient's skin type and the problem for which they seek treatment. Allowances must be made not only for the colour of the skin, but also for the colour of the hair in depilation, for example, and for the depth of the lesion when treating pigment spots. The thickness of the skin, the age of the patient, their current medication and their medical history are also important considerations. Inappropriate treatment, either with the wrong laser or with the right laser set to the wrong setting, can result in burns and permanent and disfiguring changes in the skin.

According to Naovaratpong, Boonyaroonate and Nathakarannakule (2015), the Fractional 1550nm laser is the latest and most currently used laser

technology for skin resurfacing. This procedure uses a collimate dual axis special narrow beam that produces tiny invisible dots which damage the skin on targeted areas, leaving mostly undisturbed surface while decisively stimulating the body's own regenerating processes. The damaged skin is replaced with new healthier skin, the collagen emerging to allow the skinto rejuvenate gradually. This procedure is seen as minimally invasive, and with minimal side effects such as Post Inflammatory Hyper (PIH) pigmentation, as well as allowing for a fast recovery time. However, the procedure comes with some risk: for instance, Dijkema and Van der Lei (2005) report that Intense Pulsed Light and laser treatments have been shown to cause burns and pigmentation problems in many cases.

The complication after non-invasive aesthetic medical treatment is a critical issue in non-invasive aesthetic medical treatment and procedures because of patients' expectations regarding the time involved. Normally such procedures do not require patients to stay in the clinic or hospital for days or even for hours. They can go back home or engage in regular daily activities immediately after having the treatment. However, in order to achieve the best results, patients need to follow a proper skin care process, with practical suggestion given doctors post-treatment. If the patient follows instructions, then they will have the best or expected results. Concerns on the other hand have been voiced regarding complications that might result from patients engaging in vacation activities or travel in the post-treatment period that might interfere with such safety post-operative procedures (Ben-Natan, Ben-Sefer and Ehrenfeld, 2009).

Complications may arise after a laser or IPL facial treatment if a patient disregards the doctor's instructions to avoid exposing the face directly to sunlight, for instance at the beach. Similarly, patients may experience complications after having botulinum toxin injections if they undergo facial massage immediately or soon after having this treatment, since the pressure from the massage risks moving the botulinum toxin substance to unwanted areas. This leads to an imbalanced result in many cases.

3.9.2 Physical risks

Despite being a key factor for many developing countries, the tourism industry is considered a highly fragile economic sector. According to Jonas *et al.* (2011), vulnerability in the tourism industry stems from possible political, security and health risks. The non-invasive aesthetic medical tourism industry is no exception to this rule. In this instance, physical risk refers to the possible harm that may come to the consumer as a result of the purchase of a product or service. Tsaur, Tzeng and Wang (1997) explain that physical risk refers to the possibility that an individual's health may be exposed to risk, injury or sickness because of conditions such as break-down in law and order, adverse weather conditions or hygiene problems arising during a tour and so on.

Research in the past two decades has confirmed that once affected destinations transmit an image of insecure tourist environment, the impact on the destinations themselves remains detrimental (Avraham and Keter, 2008). This information is important for both primary and secondary stakeholder

groups of the non-invasive aesthetic medical tourism industry, in that it will focus their attention on any potential issues in regard to physical risk in this market. Successful prediction of potential risk allows for successful reduction and management of such issues.

3.9.2.1 Political and security issues

According to Prasirtsuk (2009), despite being a major player in the medical tourism market, Thailand's political turmoil has resulted in a significant drop in the number of tourists and medical tourist arrivals in the country, particularly after the shutdown of the two main airports in Bangkok in December 2008. Research data gathered from Andersen and Jayanama (2014) in Bangkok has indicated that the sector had yet to see any signs of recovery, since a large number of its foreign markets, such as the United Kingdom, the United States, Canada, New Zealand and Australia, were still in 2012 cautioning their citizens against travelling to Thailand due to high political risk. Even in the event of stabilisation of the Thai political landscape, such political disturbances have the ongoing problem of offering great opportunities to other medical tourism destination countries, such as Malaysia, to capture some of Thailand's market share in medical tourism.

The problem with the current situation in Thailand is that the focus is very much on political reforms by military government (Shaffer, 2015). The elections likely would not be held before that latter end of 2017, at the earliest. The delay in the general election is unpleasant news for Thailand's economy. In addition to this, Morris and Porter (2016) report that there were a series of explosions seemingly targeting tourist areas, including Phuket, Hua

Hin and Phang Nga in August, 2016. It appears that the attacks have been coordinated to target the tourism industry. However, The Foreign Office in the UK states that the majority of Thailand is safe to visit (Morris and Porter, *ibid.*).

3.9.2.2 Epidemic crises

Epidemic crises that may break out in a country, such as swine flu (H1N1), are a serious issue in tourism. To deal with tourists' perceptions of such health hazards, bodies such as the World Health Organization (WHO) publish guidance documents, under titles such as "Is it safe to travel?" (World Health Organization, 2014). In addition, Jonas *et al.* (2011) have stated that health authorities in many countries publish alert and response notifications in the arrival areas of major airports. Consequently, it is clear that studies on tourists' perception of health risk are a significant research area of growth.

According to Jonas *et al.* (2011), a review of the situation in the world in recent years indicates that the outbreak of various infectious diseases and epidemics today crosses borders and is not only a characteristic of continents such as Africa and Asia. Western continents, like Europe and North America, are also no longer immune to the spread of diseases from elsewhere. Similarly, tourist countries are not safe from the influence of epidemics, which may impact on their tourist industry. Whichever country serves as the primary host for an epidemic, the impact on tourists and tourism is global and detrimental. Ritchie *et al.* (2004) offer the example of the foot-and-mouth disease that plagued southwest England in 2001, an outbreak which caused extremely heavy losses not just in agriculture but in the prosperous tourism

industry of that area. Importantly, it also impacted on neighbouring unaffected areas. Similarly, Wall (2006) described the harsh effect on the Canadian tourism industry of the Severe Acute Respiratory Syndrome (SARS) epidemic, which broke out in 2003 in Toronto. In that same year, SARS had already affected the human and economic health of economies in the Asia-Pacific region and beyond (Coker and Mounier-Jack, 2006).

In addition, World Health Organization (2014) notified an outbreak of Ebola virus disease in Guinea. This outbreak has since evolved into the largest, most severe and most complex outbreak in the history of the disease with over 900 deaths as of August, 1. While the threat of Ebola to Thailand is considered low, health officials are taking serious precautions in screening travellers for the virus. However, this should be noted that this disease is only spread through contact with blood and bodily fluids, which makes it unlikely for the disease to be spread through air travel.

3.9.2.3 Health risks

Thailand could be seen as a distance destination for aesthetic medical tourists from countries such as Canada, the U.K. and the U.S. It cannot be ignored that despite immense progress in medicine, the contemporary tourist is still susceptible to health risks as an integral part of the nature of travel (Jonas *et al.*, 2011). Some researchers such as Leyland, van Wersch and Woodhouse (2014) have investigated health issues related to long haul flight travel. Carabello (2008) outlines various risk factors of long-distance air travel, such as deep venous thrombosis or even more life-threatening pulmonary embolus, brought about by the effects of dehydration and

immobility for long periods. Ben-Natan *et al.* (2009) also identify health risks such as lung disease and thrombosis. Lower oxygen levels in airplanes on long haul flights have been argued as especially problematic for patients with respiratory disease (Reed, 2008).

While such physical risks related to long distance travel are a general risk for medical travellers, and especially for surgical patients (Chan *et al.* 2011; Harling *et al.* 2007; Hanefeld *et al.* 2014; Reed 2008; Roger *et al.* 2011; Smith *et al.* 2012), such risks may be significantly lower for non-invasive aesthetic medical tourism travellers, since these are not preparing to undergo surgical cosmetic processes. This research is therefore confined to the risks brought about specifically in regard to non-invasive aesthetic medical treatments, that is, which aim aesthetically to improve an individual's physical appearance without recourse to surgery (see Chapter 2 for more details).

Wilks (2006), also looking at health risk factors which may endanger the safety and security of travellers, includes risk in their host communities. The WHO (2014) also identifies the level of risk as not only determined by traveller characteristics and behaviour, but by the environmental conditions prevailing in the destination country. Others have identified health challenges as subject to a more refined list of tourists' personal characteristics, such as age, culture, race, social status and level of education (WHO, 2014; Wilks, Pendergast and Leggat, 2006).

The relationship between health risk and travel has been examined not only from a tourism perspective but also from a health science perspective (Jonas *et al.*, 2011). During the past decade, the literature on health-oriented studies has focused on the link between health risks, travel patterns and travel behaviour. For example, Laver, Wetzels and Behrens (2001) examined the extent of knowledge of malaria prevention, risk perception and prophylactic behaviour among visitors in malaria-endemic destinations. Hamer and Connor Bradley (2004) analysed how U.S. travellers perceived health risks associated with travel and how they prepared for their international journeys. Similar studies were conducted by Wilder-Smith (2006) on travellers in the Asia Pacific region and by Lopez-Velez and Bayas (2007) on Spanish travellers to the tropics.

As far back as 2005, the World Health Organization (2005) decided to make tourists and tour operators aware of the health risks involved in travelling, nominating five key factors in health risk, namely destination, duration of visit, purpose of visit, standards of accommodation and food hygiene, and travellers' behaviour. This acknowledges that a tourist's perception of risk might be shaped not only by their knowledge of health-induced risks while travelling, but by their experience of a given destination. This subjective experience might also shape the tourist's perception of risk and consequently channel destination choice and travel behaviour.

Every risk generator encourages tourists and vacationers to seek information (Jonas *et al.*, 2011). The purpose of searching information is to help consumers choose their preferred destination, improve the quality of their trip,

and more importantly, reduce risks and uncertainties pertaining to trip results (Mansfeld, 2006). Tourists have access to a very wide range of information sources that expose them to knowledge of various types of risks and hazards. However, many studies investigating the reliability of information sources have found that there is a noticeable lack of reliable and professional information on health risks available to the tourist (Jonas *et al.*, 2011). Handszuh (1994 in Maclaurin, 2004) affirms for instance, that while that information included in tourist guides may refer to sites, scenery, shopping and the attitudes of the local population, little is mentioned regarding the safety of food at tourist destinations.

Exemplifying this, the Internet site of the U.S. Department of State may be regarded as a useful source of information search regarding health risks to tourist (Jonas *et al.*, 2011). However, the site is intended only for English speakers, and does not cater to readers who do not have command of that language. If one assumes that health-related travel information is ideally intended to reach global as well as local tourists, whatever their language, it raises a question as to how such information gets to tourists in the first place, let alone how tourist perceptions of health risk are shaped, or how such perceptions might influence tourists' destination choice and travel behaviour.

3.9.3 Financial risks

The lack of regulation in the health sectors of many medical tourism destination countries is a factor in maintaining low costs (Turner 2011; Whittaker 2010). According to Smith (1999), in Cambodia anyone can open a clinic and perform an operation without having any qualifications, which is

why there are so many clinics there offering bargain aesthetic medical treatments and services, at a fraction of the price of similar treatment in other countries. As a result, more than 1,300 unlicensed clinics were shut down in 2015 and the remaining 900 will be closed in 2016 (The Cambodia Daily, 2016).

It has been suggested that even ignoring extreme health risks, such as contracting HIV/AIDS or Hepatitis B, the performance of aesthetic treatments in such countries is less than 100 percent successful (Smith, 1999). This may be because the competitively low cost of treatment does not correlate to assurance of high quality or the meeting of benchmarked standards in deregulated medical tourism destination countries.

A further risk factor, identified by Ben-Natan *et al.* (2009), is the financial risks which patients may run on leaving the medical destination country. If, once home, some patients encounter ongoing problems arising from their aesthetic treatment, it is not always clear how or where such complications may be resolved, or what to do if the patient incurs further remedial costs. Such issues may remain unresolved, and merit further investigation to better establish the true economic benefit of medical tourism for patients (MacReady, 2007).

3.9.4 Time risks

According to Mitra, Reiss, and Capella (1999), time risk involves the possible loss of convenience or time associated with the satisfactory delivery of a

service. Since services are administered by human beings there must always be a risk to the consumer in terms of human error every time they purchase a service. Such errors may lead to possible loss of time when a patient buys non-invasive aesthetic medical treatments during their vacation. Featherman and Pavlou (2003) state however, that time-conscious consumers are aware of time risks and travel to medical destination countries as time-conscious tourists.

Regarding the nature of non-invasive aesthetic medical tourism in Thailand (see more detail in Chapter 2), the tourist's first motivation to visit Bangkok may be less about the medical treatment they will receive as a patient as about the vacation they will enjoy as a traveller.

3.9.5 Psychological risks

According to Stone and Gronhaug (1993) psychological risk refers to the possibility that product consumption may harm the consumer's self-esteem or perceptions of self. Self-esteem is a term used in psychology to reflect a person's overall evaluation or appraisal of his or her own worth. Self-esteem encompasses such beliefs as "I am competent" or "I am incompetent" and emotions such as triumph, despair, pride and shame. A person's self-esteem may be reflected in behaviours such as assertiveness, shyness, confidence or caution. Self-esteem can apply specifically to a particular dimension, for example, "I believe I am a good writer, and feel proud of that in particular" or extend to global beliefs of self, for example, "I believe I am a good person, and feel proud of myself in general". Specifically in terms of tourism, Jonas *et al.* (2011) present the possible failure of a travel experience

to fulfil the tourist's aspirations, as a psychological risk. Similarly, Roselius (1971) mention the potential loss to ego when a consumer buys a product that turns out to be defective. Ego loss may occur if the buyer feels foolish, or is made to feel foolish by others.

It seems clear that self-appearance must be implicated in potential ego loss and other psychological risks when consumers engage in non-invasive aesthetic medical treatments and procedures. The decision-making process when it comes to purchasing a non-invasive aesthetic medical service may be complex, involving a variety of personal perceptions and expectations which will vary from one consumer to the next (Mishra, 2014). Linked to this, Honigman, Phillips and Castle (2004) state that patients who purchase such medical services may perceive psychological risk in two different ways; (1) that after buying the service they will find the service not worth buying or (2) that after buying the service they will receive negative feedback from others regarding the result, the process, the price, or the necessity of undergoing the process. Any of this feedback risks making a consumer feel foolish or anxious, and lead them to question the advisability of having purchased the service.

3.9.6 Social risks

According to Livingston (2016), social risk refers to the possibility that product choice may result in social embarrassment. Embarrassment is an emotional state experienced by someone who has acted socially or professionally in an unacceptable way, which has been witnessed by or revealed to others. Usually some amount of loss of honour or dignity is

involved; how much depends on the situation. For instance, embarrassment may arise; this usually carries the connotation of being associated with a socially unacceptable action. Shame, on the other hand, may also be a risk; unlike embarrassment, shame may be associated with an action known only to oneself, and moreover, seen as perhaps morally wrong.

In terms of the societal impact of non-invasive aesthetic medical treatment, fears have been expressed that the continual rise in the popularity of such services may create unnecessary public demand, which may impact negatively on the cultural and moral values of people in the society in which the process is practiced. For instance, Kanter *et al.* (2001) observe that societal attitudes toward the concept of beauty may become perverted, so that people become disproportionately dissatisfied with their looks. As such they may be encouraged to resort to aesthetic treatments to resist age-related physical changes. This is already seen in certain countries; for example in South Korea, approximately one in five Koreans has undergone plastic surgery while 80% say they would consider it (Smith, 2014). In cultures where appearance has become paramount, customers will keep coming back for more aesthetic medical treatments, which may not be necessary on the physical level.

According to IMTJ (2009a), there has been a massive increase in marketing for aesthetic procedures, including promotional strategies such as discount vouchers, 2-for-1 offers and holidays with surgery. This is certainly not the case in other areas of medicine. There is no such kind of advertising for general surgery e.g. heart surgery, or liver transplants. IMTJ (*ibid*) suggests

that if service providers have to sell anything, they should sell advice, not procedures. Therefore, if they cannot self-regulate then regulation will eventually be imposed.

The increase in global marketing of medical procedures may be attributed to the growth in excellent healthcare facilities around the world, and the ease of international border-crossing. International tourist patients are increasingly offered a choice between buying medical treatment and procedures directly from hospitals and clinics, or from medical tourism agencies or brokerages which will make all the arrangements as part of the package. In spite of this ease, however, there is still a lack of any overview of practice in the medical tourism industry, or of investigations into how far quality benchmarks and regulatory procedures are applied. Such lack of clarity can hardly be thought to decrease the risks facing international medical tourists seeking to obtain medical care outside their home countries (Turner, 2011).

According to McGeorge (2016), the consultant plastic surgeon and past President of The British Association of Aesthetic Plastic Surgeons (BAAPS), people considering aesthetic treatments should be aware that no procedure is without risks. Although it is recognised that appropriate aesthetic medical treatment, performed under the right circumstances, can achieve positive physical and psychological results, it is by no means obvious what is meant by 'the right circumstances'. It needs to be clarified whether this refers to the level of competence amongst medical staff operating the aesthetic medical treatment, or to the quality of the medical equipment itself, or some other criterion. Without clarification and precise definition as to what is meant by

quality and “rightness”, the development of aesthetic medical tourism risks being held back.

There is no doubt that developing countries such as Thailand wish to follow in the footsteps of developed countries such as Switzerland and Germany in offering the gold standard of medical care in aesthetic medical tourism. But at the same time, they must market their own assets, such as provision of luxurious amenities at a low price, or tempting background scenery (Bookman and Bookman, 2007; Singh, 2014). The downside of this type of medical tourism however, is that it may be less concerned with the medical services than those associated with tourism services. Dr. Mukesh Haikerwal, vice president of the Australian Medical Association, warns potential tourists thinking of undergoing foreign operations that they do so at their own risk. While many hospitals indicate that their doctors were trained in Western nations, they may be less transparent as to whether their nursing and ancillary staff are equally well qualified.

Hanefeld *et al.* (2014) and Lunt *et al.* (2014) argue that in certain developing tourist destination countries, standards are well below those in more developed nations. For example, an Associated Press article from February 6, 2005, reported that some Mexican plastic surgeons (drawing on trade from Texas) operated in an unregulated manner, with neither licensing standards nor adequate facilities. The article described mishaps such as disfigurement and even fatal infections often linked to unaccredited hospitals and unlicensed surgeons.

In summary, this research focuses on six categories of risks related to non-invasive aesthetic medical tourism and treatments, which are functional, physical, financial, time, psychological and social risks respectively. The review of literature explores the relationship between different risks. Figure 3.1 demonstrates a summary diagram of risks associated with non-invasive aesthetic medical tourism and treatments. Many scholars suggest that functional risk creates (1) physical risk (Hanefeld *et al.* 2014; Head 2015; NaRanong and NaRanong 2011; Turner 2011), (2) financial risk (Ben-Natan *et al.* 2009; Birch *et al.* 2007; Head 2015; Jeevan and Armstrong 2008; Lunt and Mannion 2014; NaRanong and NaRanong 2011; Reed 2008), (3) psychological risk (Honigman *et al.* 2004; Mishra, 2014) and (4) time risk (Featherman and Pavlou 2003; Head 2015; NaRanong and NaRanong 2011). It can be concluded that functional risk or in other words the complication from non-invasive aesthetic medical treatments is a crucial barrier to the management of non-invasive aesthetic medical tourism industry.

In addition to this, physical risk leads to the issue of financial risk (Bookman and Bookman 2007; Chan *et al.* 2011; Connell 2011; Hall 2011; Hanefeld *et al.* 2014; Harling *et al.* 2007; Jonas *et al.* 2011; Lunt and Carrera 2010; Prasirtsuk 2009; Roger *et al.* 2011; Smith *et al.* 2012). It is worth noting that physical risk, which refers to political issues, epidemic crises, and health risks is the crucial reason for tourist-patients to lose money during their vacation in medical tourism destination country as the main reason for tourist-patients is to travel (see section 2.11.2 for definition).

Finally, many researchers (Hall 2013; Jonas *et al.* 2011; Lunt, Green, Mannion and Horsfall 2012; Lunt, Horsfall and Hanefeld 2016; NaRanong and NaRanong 2011; Singh 2014) confirm that financial risk and time risk have two-way relationship. In other words, once tourist-patients are losing money such as the aesthetic medical treatment charge at medical tourism destination country, this means that they are wasting time for doing something else such as travelling to the beach during their vacation too. With respects to this conceptual framework, the findings from interviews will be discussed and illustrated in Figure 6.1 on page 277 (see Chapter 6 and 7 for details).

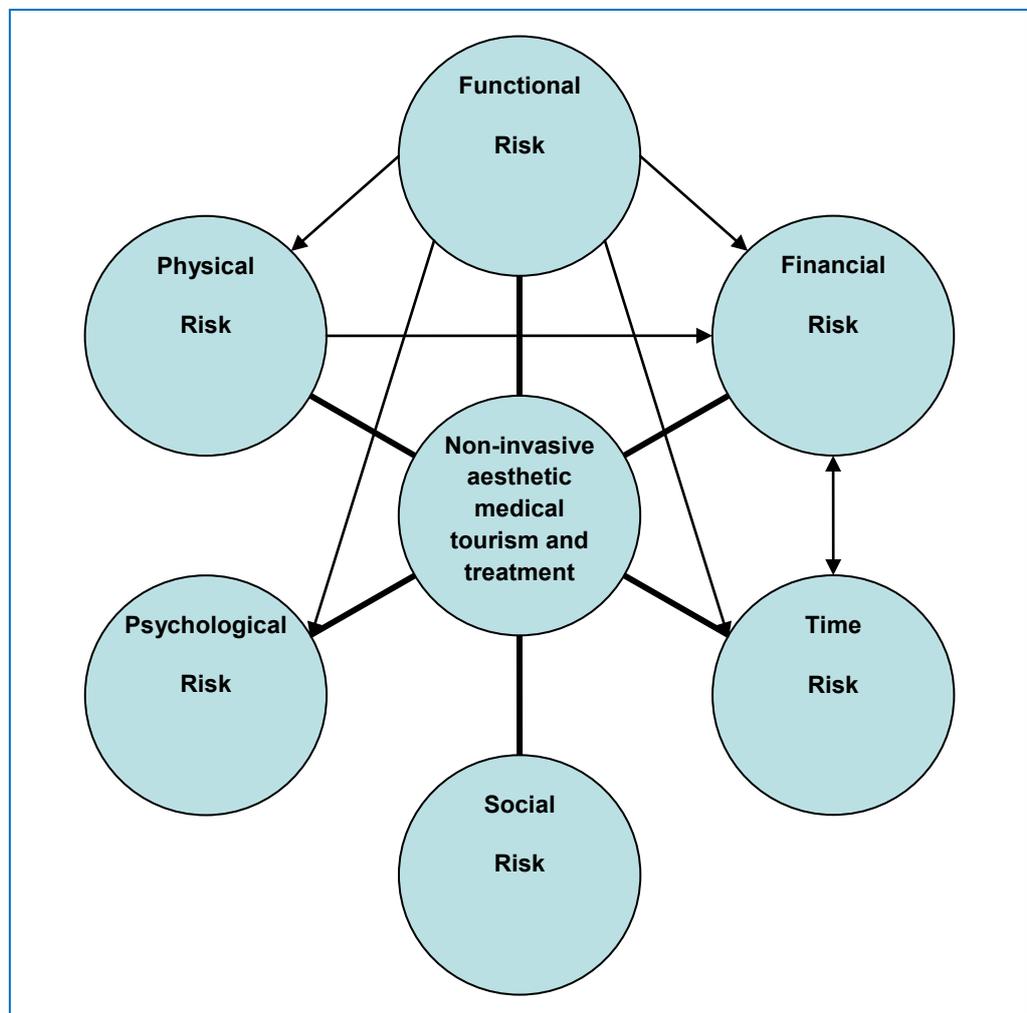


FIGURE 3.1 Summary diagram of risks associated with non-invasive aesthetic medical tourism and treatments

Sources: Ben-Natan *et al.* 2009; Birch *et al.* 2007; Bookman and Bookman 2007; Chan *et al.* 2011; Connell 2011; Featherman and Pavlou 2003; Hall 2013; Hanefeld *et al.* 2014; Harling *et al.* 2007; Head 2015; Honigman *et al.* 2004; Jeevan and Armstrong 2008; Jonas *et al.* 2011; Lunt and Carrera 2010; Lunt *et al.* 2012; Lunt *et al.* 2016; Lunt and Mannion 2014; Mishra, 2014; NaRanong and NaRanong 2011; Prasirtsuk 2009; Reed 2008; Roger *et al.* 2011; Singh 2014; Smith *et al.* 2012; Turner 2011

3.10 Strategies of risk reduction

According to Cox and Rich (1964), there are two ways to reduce perceived risks. One is for the consumer to take action to increase the predictability of the consequences following his or her decision to purchase. Another is for the consumer to take action to reduce the amount at stake in the purchase. Cox (1967), refining this view, examined consumer attempts to reduce uncertainty, and found two salient consumer strategies for reducing perceived risks. Firstly, consumers would seek out information as to the probable consequences of a buying decision. Secondly, consumers would rely on the existing information, based on personal past experience or on the experiences of others. In the case that uncertainty could not be reduced, a second strategy came into play, which was to reduce the amount at stake (Cox and Rich, 1964), generally by foregoing the purchase entirely.

Buyers often face the dilemma of wanting to purchase a product, but hesitating to buy because this act may involve risk or loss. When faced with this situation, the buyer is confronted with a variety of methods which could be used to reduce the risk or loss. According to Roselius (1971), when buyers

perceive risks in a purchase, they could pursue one of four different strategies of risk resolution. Firstly, they could reduce perceived risk by either decreasing the probability that the purchase would fail, or by reducing the severity of real or imagined loss suffered if the purchase did fail. Secondly, buyers could shift from one type of perceived loss to another type for which they had more tolerance. Thirdly, buyers could postpone their purchase, in which case they would be shifting from one general risk type to another. Lastly, buyers could make the purchase and absorb the unresolved risk.

In this, a risk reliever could be deployed, as a device or action initiated by either buyer or seller (Roselius, 1971). A risk reliever is used to execute one of the first two strategies of the Roselius's risk resolution. From his research in 1971, Roselius measured eleven methods of risk relief for product buying process, namely, Endorsements, Brand loyalty, Major brand image, Private testing, Store image, Free sample, Money-back guarantee, Government testing, Shopping, Expensive model and Word of mouth. Roselius concluded in his study that, buyers tended to favour one or more of these risk relievers but were relatively unimpressed with others. More importantly, it was found that the buyers preferred some relievers to others, depending on the type of loss involved. Brand loyalty and major brand image for instance, appeared to evoke the most consistently favourable response and were ranked first and second in terms of time loss, hazard loss, ego loss and money loss. Therefore, the attitude towards relievers could be seen to differ between different types of buyers.

In turn, it can be argued that marketers can reduce risk in a variety of ways, including providing general or specific information, guarantees and/ or warranties, money-back offers, endorsements, branding, and use of store image (Hoffman and Bateson, 1997; Mitchell and Boustani, 1992; Shiffman and Kanuk, 1997; Solomon, 1992). Linked to this, Boshoff (2002) divides risk reliever tactics into two broad categories, these are minimising the consequences of product and/or service failure, and those that enhance the certainty that a product and/or service will perform adequately. Boshoff's study investigated consumer perceptions of these two broad categories when confronted with an advertised service; the aim of the study being to assess the value of accepted market tactics in influencing consumers' risk perceptions in a service environment. Boshoff conducted interviews with 540 randomly selected experienced tourists at shopping mall, finding that a service guarantee appeared significantly to reduce risk perceptions. In addition it appeared that general information would reduce risk perception to a 5% level, although price information on its own did not seem to reduce risk perceptions.

The strategies of risk reduction will be explored in the following section: these strategies are risk and service guarantees (section 3.10.1), risk and general information (section 3.10.2) and risk and price information (section 3.10.3).

3.10.1 Risk and service guarantees

According to Hoffman and Bateson (1997), one factor which contributes to the perception of services as riskier than a physical product, is the absence of standardisation. This may be because services generally rely on a high level

of human interaction, which is unpredictable. This in turn makes standardisation of services difficult, if not impossible (Boshoff, 2002). To attempt a formalised commitment to standardisation, Zeithaml and Bitner (1996) proposed the use of service guarantees to promise customers greater service consistency than is typically true of services. That is, a service guarantee would be presented as a tangible manifestation of the reliability of the service. The study from Boshoff (2002) showed that such a service guarantee reduced risk perceptions significantly. Zeithaml, Parasuraman and Berry (1990) have suggested that the service dimension is particularly important to consumers, as it serves to reducing potential service buyers' anxiety and uncertainty, prior to an actual purchase (Boshoff, 2002).

3.10.2 Risk and general information

Service marketers have considered various means of reducing risk perceptions (Hunf, Cheng and James, 2016; Kim, Ferrin and Rao, 2008; Mitchell, 1999). Mitchell and Prince (1992) argue that the use of risk relievers is more important in the services sector than in the goods sector. It is argued that, due to the limited information available to service buyers, the associated risks level in the services sector is higher than the goods sector (Hoffman and Bateson, 1997; Murray and Schlacter, 1990). In order to reduce risk, Havlena and DeSarbo (1991) suggest that additional information needs to be supplied to service buyers.

However, the efficacy of information searching varies between different types of consumers prior to purchase (McCarthy and Henson, 2005; Mitchell and Greatorex, 1993; Sharifpour, Walters and Ritchie, 2014; Solomon, 1992).

Much depends on factors such as personal knowledge or previous experiences (Brucks, 1985). Solomon (1992) and Lepp and Gibson (2008) conclude that high risk perceptions tend to increase the amount of information searching that customers actually engage in. Service buyers in particular demand relatively higher levels of information searching than product buyers (Deshpande and Krishnan, 1977). While Boshoff (2002) argues that general information will reduce risk perception by 5%, others argue that different perceptions or risks have a different impact on the volume and sources of communication which the consumer will use to collect pre-purchase information (Sharifpour *et al.*, 2014; Solomon, 1992). Mitchell and Groatorex (1993) and Williams and Balaz (2015) note that consumers will often use mass media advertising as a means of collecting information and of reducing risk perceptions. It can be concluded that as the volume of information collected increases, perceived risk decreases.

3.10.3 Risk and price information

Price is an important type of information supplied by service marketers to prospective buyers, with a view to influencing their expectations of service levels (Boshoff, 2002). Zeithaml and Bitner (1996) argue that a price which is perceived as too low for credence, of products in particular, may suggest inferior quality and by extension, higher risk. Hoffman and Bateson (1997) argue that service buyers are prepared to pay more for a service to reduce the uncertainty associated with unfamiliar service providers.

Thus it has been demonstrated that potential consumers perceive a service as a riskier purchase than a physical product because of the nature of service

buying. Berry and Parasuraman (1991) conclude that prices are a visible indicator of a service's level and quality and thus a means of reducing perceived risk. Notwithstanding this, price information on its own will not reduce risk perceptions (Boshoff, 2002). In other words, it has to be combined with other risk relievers to create an effective risk reduction strategy.

3.11 Conclusion

It can be concluded that intangible products are seen to create more risks to consumers than tangible ones. Such intangible products include non-invasive aesthetic medical treatment, as a service provided within the medical tourism industry. In order to serve the interests of stakeholders in the industry, and to develop and manage the medical tourism industry in medical tourism destination countries, it is vital to understand more fully the risks and motivations of tourist patients. This research considers six types of risk in relation to non-invasive aesthetic medical tourism, based on those identified in the literature. These risks are functional, physical, financial, time, psychological and social. Figure 3.1 on page 98 lays out the risks associated with non-invasive aesthetic medical tourism and treatment. Such risks arise not only because of the nature of the service itself but also because of the nature of the service operator.

In the fourth chapter which follows, the research philosophy, research methodology and the challenges encountered during the preliminary and main fieldwork from conducting the interviews is explained, as well as how such problems were resolved, will be explained.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

The quality of research design is crucial to the results of research, and as such requires evaluation independently of research findings. This chapter will therefore clarify methodological choice and consider the impact of this on the processes and outcome of the research. In discussing the methodology undertaken to complete this research project, the main stages of decision-making as to the research approach will be considered, along with a rationale for the chosen research approach, an identification of data requirements and subjects, and an explanation of the techniques by which data were gathered and analysed. The limitations and problems experienced during the research process will also be highlighted.

4.2 Research aim and objectives

The aim of this research project was to evaluate risk in relation to the management of non-invasive aesthetic medical tourism (international) in Bangkok.

In order to undertake this research the following objectives were set:

1. To evaluate literature and key theories relating to medical tourism, aesthetic medical tourism and risk

2. To determine the factors that act as advantages or barriers to the management of aesthetic medical tourism in Bangkok

3. To identify the relevance of selected theories and models related to risk for understanding the management of aesthetic medical tourism in Bangkok

4. To extend the theory of risks by developing a framework in relation to the management of non-invasive aesthetic medical tourism in Bangkok for primary and secondary stakeholder groups to gain an insight understanding of the industry

4.3 Research philosophy

According to Saunders, Lewis and Thornhill (2009), research philosophy contains important assumptions about the way in which the researcher views the world. They note that these assumptions will underpin the research strategy and the methods that the researcher chooses as part of that strategy. Linked to this, Johnson, Onwuegbuzie and Turner (2007) suggest that business and management researchers need to be aware of the philosophical commitments they make through their choice of research strategy, since the choice of philosophical approach will have significant impact not only on their use of research instruments and data collection methods, but also on their understanding of what is being investigated. Moreover, the researcher's philosophical orientation will most likely in turn to be influenced by the particular researcher's view of the relationship between knowledge and the process by which it is developed.

Academics and researchers propose a variety of different potential approaches when conducting research. Jennings and Greenberg (2009) argues that the philosophical orientation of research in the social sciences may stem from one of the two main paradigms; these are positivism and

interpretivism. The distinction between positivism and interpretivism is discussed in the following section.

4.3.1 Positivism

According to Remenyi *et al.* (1998), if the research reflects the philosophy of positivism then the researcher will probably adopt the philosophical stance of the natural scientist, that is, a preference will be shown for working with an observable social reality. In addition, the end product of such research will tend to produce law-like generalisations, similar to those produced in the physical and natural sciences. In order to generate a positivist research strategy, the researcher is likely to use existing theory to develop one or more hypotheses, which will be tested and subsequently either confirmed, in whole or part, or refuted. The outcome would ideally lead to further development of theory by means of further research.

Saunders *et al.* (2009) suggest that an important component of the positivist approach to research is that the research is undertaken in a value-free way. In other words, the researcher is independent of the outcome of the research, neither affecting nor being affected by the subject in hand (Remenyi *et al.*, 1998). However, it is also recognised that complete freedom from personal values in researchers is virtually impossible, in which case it is frequently advocated that the positivist researcher would be best served by a highly structured methodology in order to minimise bias, and in order to facilitate the replication which will provide validity and lend itself to statistical analysis (Pathirage, Amaratunga and Haigh 2008).

4.3.2 Interpretivism

According to Saunders *et al.* (2009), interpretivism is an epistemology which leads the researcher to seek to understand differences between humans in their role as social actors. This approach, emphasising research which focuses on human interactions as opposed to the behaviour of objects, sees social phenomena involving people as socially constructed. This philosophy is particularly oriented to generating meanings and gaining insights into those phenomena, and how humans make sense of the world around them. Interpretivist philosophers believe that reality is not “out there” but “in” the minds of people. By extension, researchers who use this approach require the use of imagination in their research, that is imagining others in their natural context in order to better understand why people do what they do (May and Williams, 2002).

Crucial to interpretivist epistemology is the requirement for researchers to adopt an empathetic stance which will enable them to enter the social world of research subjects and understand it from that point of view (Saunders, Lewis and Thornhill, 2007). In this process, the researcher is required to bracket his or her own experiences as personal in order to understand those of the participants in the study as other (Payne and Williams, 2005). Saunders *et al.* (2009) reflect a research argument for the interpretivist perspective as highly appropriate in the case of business and management research, particularly in regard to organisational behaviour, marketing and human resource management.

Interpretivism has several advantages in research of social contexts, one of which is to focus on socially constructed meaning, that is, an in-depth understanding of what is happening amongst participants of the research in

relation to the research topic. This approach allows the research process to be flexible, and helps the researcher to adjust to new issues and ideas as they emerge. The method of collecting data tends to be informal and to flow naturally, facilitating a high level of human interaction. However, this philosophy has also some weaknesses that researchers must take into account, for instance that it leads to research processes that generate a huge amount of data, both time-consuming and difficult to analyse. The reliability and validity of findings generated by such methods have also been open to question, one perception being that interpretation of data collected by these methods may be open to a high level of subjectivity (Easterby-Smith, Thorpe and Lowe, 2002).

In terms of the research philosophy which has formed the basis of this research study, the choice of approach is phenomenology, which has emerged from one of two intellectual traditions of interpretivism. Phenomenology refers to the way in which we as humans make sense of the world around us. It is seen as appropriate for this research, since the aim is to understand the crucial barriers to the development and management of non-invasive aesthetic medical tourism in Bangkok. As such, it was found appropriate to conduct interpretivist research as this philosophy helps the researcher to achieve the research aim and objectives of the study. And as such, a positivist research approach would not have been helpful.

4.4 Research design

According to Jupp (2006), the research design outlines and justifies the structure, the research methodology and methods relating to the research question(s) of a study. It involves planning and executing a research project which will address the question of what is being researched, as well define

why and how the research will be achieved. Saunders *et al.* (2007) suggest that a research design should clearly represent the plan of how the researcher will go about answering the research question(s). Crucially, the design should reflect the researcher's thought process as to why a particular research design is being employed, and offer a series of valid reasons which underpin all research design decisions. With respect to research question(s), research objectives and research philosophy, the researcher should differentiate clearly between quantitative and qualitative data collection techniques, and subsequent quantitative and qualitative data analysis procedures.

4.4.1 Exploratory research

According to Hair, Bush and Ortinau (2003), there are three types of research. Exploratory research focuses on collecting secondary or primary data using informal procedures to interpret them; a descriptive research design collects raw data and creates data structures to describe the existing characteristics of a defined target population or market structure; and finally a causal research design collects raw data and creates data structures to model cause-and-effect relationships between two or more populations. With respect to the niche market nature of this study, non-invasive aesthetic medical tourism, exploratory research was conducted.

According to Saunders *et al.* (2007), the principle methods of conducting an exploratory study are a search of the literature, followed by interviews with experts in the subject and subsequently by interviews with participants. The researcher has applied this principle to this research project, as shown in Figure 4.1 below. Critically the stages of reviewing the literature and making contact with experts allowed the researcher to reconsider the ideas of the

research project and more importantly to adapt the interview questions. This helped the researcher to achieve the research aim and objective more effectively. This research utilised all of these methods to obtain both qualitative and quantitative data regarding non-invasive aesthetic medical tourism in Bangkok, Thailand.

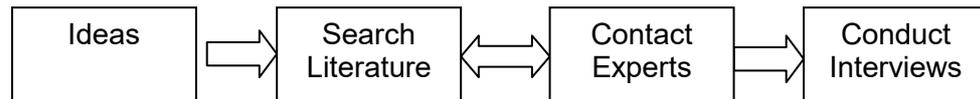


FIGURE 4.1 Principle of this exploratory research project

4.4.2 Research strategy

Every strategy can be used for exploratory, descriptive and explanatory research (Yin, 2003). The most suitable strategy for this research was considered to be a case study, following the rationale of Robson and McCartan (2016) who defined the case study as “*a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence*”. Yin (2003) also highlights the importance of context, adding that, within a case study, the boundaries between the phenomena being studied and the context within which it is being studied are not clearly evident. The case study strategy also has considerable ability to generate answers to the question ‘why?’ as well as questions as to ‘what?’ and ‘how?’ (although ‘what and how’ questions tend to be more the concern of the survey strategy). Most importantly, the value of a case study is in potentially gathering and triangulating multiple sources of data; triangulation refers to the use of different data collection techniques within one study in order to ensure that the data are telling you what you think they are telling you (Saunders *et al.*, 2007).

4.4.3 Research approach

4.4.3.1 Deductive and inductive approach

There are two types of research approach, which are deductive (testing theory) and inductive approach (by way of reasoning). According to Saunders *et al.* (2007), a research project should adopt a deductive approach if the researcher has developed a theory and hypothesis(s), and wishes to design a research strategy to test the hypothesis(es). On the other hand, the researcher should adopt an inductive approach, if the researcher collects data and then goes on to develop theory as a result of that data analysis.

The intention of this study was to investigate situations related to the research questions in order to develop conclusions which would achieve the research aim and objectives. The research approach selected for this research study was induction, although it must be noted that a deductive approach was initially used for certain purposes, for example, to define the use of theory on risk, risk perception, risk reduction and the development and management of medical tourism. Using an early deductive approach helped determine which research process should be adopted (Saunders *et al.*, 2009). However, at the same time, the development and management of non-invasive aesthetic medical tourism industry in Thailand is a relatively new occurrence that has not been extensively researched, so that no theory has been developed around this topic. An inductive approach which would allow theory to develop from results was therefore adopted in order to allow the researcher to discuss the nature of non-invasive aesthetic medical tourism development in Thailand. This approach was intended to lead to an in-depth understanding of the factors that affect the implementation of non-invasive aesthetic medical

tourism in developing countries, and to permit inferences to be drawn in regard to the situation of this industry in Thailand.

An inductive approach has several strengths and shortcomings; these were considered while undertaking the research study. One strength of this approach is that it allows researchers to make a cause-effect link between particular answers and the way in which humans interpret these meanings in their social world. In addition, it is flexible in facilitating the identification of alternative theories on the research subject, and in permitting changes in the research emphasis as the research progresses. It allows research of topics that have very little existing literature support (Saunders *et al.*, 2007). It also uses empirical evidence as the beginning of the reasoning process and can be easily applied (Blank *et al.*, 1984). On the other hand, the shortcomings of this approach are firstly that although it is more effective with a small sample, this limits the sample size and thus the generalisability of data. Generally this approach is also more time consuming, as ideas are generated over a much longer period of data collection and analysis. In other words, the risk of the research yielding no useful data patterns and theories is higher than that of deductive research (Saunders *et al.*, 2007).

4.4.3.2 Quantitative approach

According to Saunders *et al.* (2009), quantitative data in a raw form, that is before they have been processed and analysed, convey very little meaning to most people. They therefore need to be processed, analysed and interpreted to make them useful. Quantitative analysis techniques assist the researcher in this process. They range from creating simple tables or diagrams that show the frequency of occurrence, to using statistics such as indices to enable

comparisons, from establishing statistical relationships between variables, to complex statistical modelling.

'Questionnaire' is a term used to include all techniques of data collection in which each respondent is asked to provide answers to the same set of questions in a predetermined order (De Vaus, 2002). The term therefore is used to include structured interviews, telephone questionnaires and online questionnaires. The use of questionnaires is discussed in many research method texts such as Saunders *et al.* (2007) and Dillman (2000). According to Saunders *et al.* (2009), the questionnaire is one of the most widely used data collection techniques within the survey strategy. They also point out that because each respondent is asked to answer the same set of questions, it provides an efficient way of collecting responses from a large sample prior to quantitative analysis.

It is worth noting that it is difficult to produce a good questionnaire (Bryman and Bell, 2015). The researcher needs to ensure that it will collect the precise data that are required in order to answer the research question and achieve research objectives. This is because the researcher is unlikely to have more than one opportunity to collect the data. Linked to this, Saunders *et al.* (2007) recognise that the researcher will be unable to go back to individuals and collect additional data using another questionnaire.

With regards to the characteristics of quantitative research and the objectives of this research project, it was not thought appropriate to employ the quantitative approach as a research approach for this research. This is because quantitative methodology is based on the positivist philosophy (Riege, 2003), the preferred method for natural sciences but normally less

suitable for social research (Morgan and Smircich, 1980). This is illustrative in this research, which involves the study of social actors and their behaviour. This type of data, which looks at human behaviour as enacted by non-invasive aesthetic clinic owners, tourist-patients, and government representatives, is open to subjectivity of interpretation on the part of both participants and researcher. As such, the use of a quantitative approach was not appropriate for the analysis of data.

4.4.3.3 Qualitative approach

According to Myers (2013), qualitative research methods are designed to help researchers understand people, what they say and do, and the social and cultural contexts within which they live. Since people act according to context, it is in context that we can best understand why individuals act as they do. Accordingly, qualitative research lends itself best to talking to people in context, interviewing them in order to understand through their experiences, their perspectives and their histories (Ritchie *et al.*, 2013). On the other hand, qualitative research is seen to be more challenging, more stressful and more time-consuming than quantitative research, since it involves close contact between the researcher and the participants and as such requires a great deal of commitment on the part of the researcher (Delamont, 2002).

Qualitative research is usually undertaken using semi-structured interviews, in-depth interviews or discussion groups (focus groups) among a relatively small number of people. Its purpose is to provide in depth exploratory, explanatory and diagnostic information (the how and the why). Such interviews need to be conducted by a knowledgeable researcher, preferably face-to-face, although telephone and on-line methodologies are also acceptable.

This approach is seen to have drawbacks. One observed weakness is that researchers presume to be able to interpret the reality of other people. In order therefore to retain quality and integrity in the research, it is important to remain true to the intention and purpose of the project throughout the research. Golafshani (2003) however is reassuring in saying that a qualitative researcher is not an objective, politically neutral observer of the social world, but historically and locally situated within the very processes being studied. Although this is a valid and valuable position for adding to human knowledge, for the very same reason the researcher has to be cautious when interpreting and analysing collected data, since the researcher's initial motivation for carrying out the research, and associated preconceptions, may influence and condition the research results.

With such caveats recognised, it is argued that for the purpose of this research, qualitative research methods have been the most appropriate means of gaining the information required. This is because qualitative methods are responsive to situations, allowing for a large amount of data to be collected from a small number of sources. Linked to tourism research, Dann and Phillips (2001) suggest that this is moving away from pure quantification and towards a more qualitative approach, using research strategies such as case studies. This strategy had been adopted for this research in order to benefit from various data collection methods appropriate to qualitative research, to include interviews, observation and documentary analysis. Qualitative research is inherently multi-method in its approach (sometimes referred to as triangulation), in order to better acquire an in-depth understanding of the phenomenon under study. It can be seen that a multi-method approach adds breadth and depth to any investigation.

Runeson and Host (2009) defines case study as a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context, using multiple sources of evidence. The case study strategy has considerable ability to generate answers to the question 'what?' as well as 'how?' questions. The data collection methods employed may be various, to include interviews, and documentary analysis. As such, the "...*case study can be a very worthwhile way of exploring existing theory. In addition, a simple, well-constructed case study can enable you to challenge an existing theory and also provide a source of new research questions...*" (Saunders *et al.*, 2007, p.140)

4.5 Medical tourism research: Qualitative and quantitative studies

According to Bookman and Bookman (2007), medical tourism is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism (see section 2.3 for more details). Possible medical procedures range from an elective cosmetic treatment to complex surgery (Burkett, 2007). At this point it is worth noting that several investigations have already been undertaken in medical tourism and aesthetic medical treatment research. Clarke *et al.* (2007), for example, conducted in-depth interviews with 44 women aged 50-70 in Canada regarding their perceptions of and experiences with non-surgical cosmetic procedures such as Botox injections, laser hair removal, chemical peels, microdermabrasion and injectable fillers. The interviewees were divided into two groups, a group of women who had had non-surgical cosmetic procedures and another who had not had any cosmetic procedures. The number of respondents was 21 and 23 respectively for each group. The women in the non-probability sample were recruited using advertisements in fitness centres, senior citizen centres,

newspapers and snowball sampling methods. The sampling criteria precluded men as eligible for this research, and also limited the ages of the female interviewees between 50 to 70 years old. These factors may significantly have influenced the results of the research in that the conclusion and recommendations neglected to cover the perception of cosmetic procedures from male perspectives and also from the perspectives of women aged below 50. This issue was discussed in Chapter 3.

A second study, conducted in Hong Kong by Heung, Kucukusta and Song (2010) aimed to determine the factors influencing the development of medical tourism in their home country. For this research qualitative data were collected through in-depth interviews with 8 hospital representatives, 2 chief executives and directors of medical organisations, and 2 representatives of relevant authorities in the healthcare sector. For this study, patients were not interviewed. As a result, the opinions and information from consumers were not investigated.

Using a different methodological approach to the same subject, a number of researchers have used semi-structured interview as a data collection technique. Lautier (2008), for example, conducted semi-structured interviews with the director and/ or the main owner of 30 private clinics, government offices and other organisations in Tunisia. This research aimed to fill a gap in empirical data in this research area by providing reliable data on consumption of health services in Tunisia. This case study was useful in highlighting the regional dimensions of external demand for cosmetic health services.

A third study, (Karuppan and Karuppan 2010), conducted semi-structured phone interviews with 9 out of 16 medical travel facilitator companies in the U.S. in order to develop a demographic and psychographic profile of medical travellers and to identify participants' underlying motives for seeking medical care overseas. A list of propositions to be tested in further research was usefully presented as well as a number of practical implications for the healthcare industry. However, although the abstract of the article stated that this study involved in-depth interviews, lack of precision led to confusion as to whether their method used semi-structured or in-depth interviews.

A fourth study, (Alleman *et al.* 2011) conducted a 15-30 minute telephone survey with 45 out of 63 medical tourism companies engaged in facilitating overseas medical travel for US residents. The questionnaire contained both open and closed ended questions, the aim being to characterise the nature and practices of business entities promoting medical tourism, and to investigate the types and costs of procedures being offered. However, the authors confined the search for their selection of engaged medical tourism companies to PubMed using keywords such as medical tourism, health tourism and travel medicine only.

In a fifth study, similar research was conducted in 2010 by Johnston *et al.* (2011) using semi-structured telephone interviews with 12 medical tourism facilitators from 10 companies. However, instead of conducting the research in the U.S., this research was conducted in Canada. The authors aimed to understand Canadian patients' involvement in medical tourism and the implications of this involvement for public health. Similar research can be found in Snyder *et al.* (2011), since the authors are the same, though in different order. The main differences are the title of article and the journal.

In order to understand the different research methods used in the medical tourism research, a summary of qualitative research on medical tourism is illustrated in Table 4.1. This demonstrates that no single study investigated both primary and secondary stakeholder groups at the same time. . This study on the other hand, is innovative in engaging both primary and secondary stakeholder groups in interviews, In order to obtain data from both perspectives.

Research method	Respondents	Number of respondents	Research setting	Researcher
In-depth interview	50-70 years old women	44	Canada	Clarke <i>et al.</i> (2007)
In-depth interview	<ul style="list-style-type: none"> •Hospital representatives •Medical organisations •Representatives of relevant authorities 	8 2 2	Hong Kong	Heung <i>et al.</i> (2010)
Semi-structured face to face interview	<ul style="list-style-type: none"> • Director and/or owner of private clinic • Government offices • Other organisations 	30 N/A N/A	Tunisia	Lautier (2008)
Semi-structured telephone interview	Medical travel facilitators	9	United States	Karuppan and Karuppan (2010)
Semi-structured telephone interview	Medical tourism companies	45	United States	Alleman <i>et al.</i> (2011)
Semi-structured telephone interview	Medical facilitators	12	Canada	Johnston <i>et al.</i> (2011) Snyder <i>et al.</i> (2011)

TABLE 4.1 A summary of medical tourism research using qualitative research methods

Apart from the qualitative research on medical tourism cited above, there are also available a number of quantitative research documents on medical tourism. Bies and Zacharia (2007), for example, developed an Analytic Network Process (ANP) model in order to determine whether medical tourism was worth promoting in the U.S. and in what form. An ANP model was built with a goal, strategic criteria and benefits, opportunities, costs and risks. All cluster and node comparisons were made using the questionnaire format. Ratings were determined on a scale from poor to average, above average and excellent. However, this study did not explain the background of the respondents, leaving the recruitment of participants and the selection of sample selection open to question. In addition to this, Nassab *et al.* (2010) investigated public opinion by using a questionnaire for those seeking information about cosmetic surgery abroad, exploring the information patients were likely to encounter on the Internet when searching for services. A poll of 197 members of the general public was conducted in the United Kingdom. An Internet search, including the terms 'plastic surgery abroad', was also conducted with the first 100 relevant sites interrogated. Most of the Internet sites appeared to lack information for potential patients in regard to potential complications of the treatment, and aftercare. In addition the researchers approached 200 people at a local retail centre. However, in this instance the gender, age and background of participants were omitted, which calls into question the reliability and credibility of the information and results.

In order to understand the different research methods used in the medical tourism research, a summary of quantitative research on medical tourism is illustrated in Table 4.2.

Research method	Respondents	Number of respondents	Research setting	Researcher
Questionnaire	N/A	N/A	United States	Bies and Zacharia (2007)
Questionnaire Internet search	General public Relevant sites	200 100	United Kingdom	Nassab et al. (2010)

TABLE 4.2 A summary of medical tourism research using quantitative methods

In addition to such studies using primary research methods, a number of researchers have relied upon secondary data for medical tourism research. Crooks *et al.* (2011), for example, reviewed a total of 53 promotional brochures, booklets and flyers in an attempt to identify and understand the messages and images that companies use to market India as a global destination. This study conducted a thematic content analysis of the promotional print material distributed at the first medical tourism trade show in Canada in 2009.

Moreover, Hall (2011) reviewed relevant health and medical tourism and cognate literature with the aim of identifying the main issues emerging from the academic literature in this rapidly developing field. The paper identified some of the interrelationships between different areas of health and medical tourism, including wellness and wellbeing tourism, dental tourism, stem-cell tourism, transplant tourism, abortion tourism and others. Key themes that

emerged from this review were regulation, ethics, the potential individual and public health risks associated with medical tourism, and the relative lack of information on the extent of medical tourism. Linked to this, Smith, Alvarez and Chanda (2011) carried out a systematic literature review on medical tourism from the perspective of a bi-lateral trade relationship, using the U.K. and India as a case study. The researchers aimed to consider the issues that might arise from the debate of a bi-lateral perspective.

In summary, with regards to the previous qualitative and quantitative primary research and secondary data research, it can be argued that for both qualitative and quantitative research on medical tourism, more research is required. This is because in order to understand, develop and manage the medical tourism industry more effectively, empirical research using appropriate research methods should be conducted to describe and understand medical travellers (Karuppan and Karuppan, 2010). Linked to table 4.1, it can be argued that the respondents for the cited research studies were either mainly medical tourism facilitators or service providers. As a result, and in view of the methodological gaps and limitations identified in previous research, there can be identified a need for better understanding of current medical tourism issues in order that stakeholders and other researchers can benefit from good quality results.

In particular, empirical research into non-invasive aesthetic medical tourism with primary stakeholders e.g. aesthetic clinic owners and international tourist-patients, would appear to need further investigation. As suggested by Freeman (1984), stakeholders are any group or individual who can affect, or are affected by the achievement of an organisation's objectives. In this research, the primary stakeholders are non-invasive aesthetic clinic owners

and aesthetic treatment international tourist-patients. Government representatives are categorised as secondary stakeholders. This is because they do not directly benefit from nor are directly affected by non-invasive aesthetic medical tourism business activities.

4.5.1 What method is missing from non-invasive aesthetic medical tourism research?

The literature on risk (functional, physical, financial, time, social and psychological), risk perception and risk reduction provide the theoretical underpinning for this research (Chiu, Wang, Fang and Huang, 2014; Cunningham, 1967; Sheeran, Harris and Epton, 2014; Jacoby and Kaplan, 1972; Spiegelhalter, 2012; Stone and Gronhaug, 1993; Taylor, 1974). Although such studies have been influential in generic development and management research, they have not been applied to medical tourism research, or particularly to the non-invasive aesthetic medical tourism context.

On the other hand, a range of authors have discussed the reasons that individuals travel abroad for medical treatment, from the perspective of patients' home countries. Discussion has ranged from the growth of medical tourism in developing countries to how medical tourism destination countries can benefit from this industry (Bookman and Bookman, 2007; Burkett, 2007; Carrera and Bridges, 2006; Chambers and McIntosh, 2008; Chanda, 2001; Cochrane, 2008; Hall, 2011; Hanefeld *et al.* 2014; Lunt and Carrera, 2010; NaRanong and NaRanong, 2011; Singh, 2008; Singh, 2014; Whittaker and Leng, 2016). However, to date few attempts have been made to examine specifically the development and management of non-invasive aesthetic

medical treatments, while even fewer studies have examined the development and management of this type of medical tourism in Bangkok.

Linked to this, Chambers and McIntosh (2008) suggest that aesthetic medical tourism destination countries need to determine the factors that may facilitate or act as barriers to the development of aesthetic medical tourism. As a result, this research has set out to investigate how risk (functional, physical, financial, time, social and psychological) on the part of stakeholders may act as a barrier to the development of aesthetic medical tourism, and to establish how competitive advantage may be sustained.

4.6 Data collection

Data collection is a key part of a research plan and often represents the biggest cost of primary research. In order to be cost and time efficient, data collection methods need to be mastered by the researcher and her supervisors. As mentioned previously this research was conducted on a qualitative basis, employing the use of semi-structured interviews and the use of secondary data. The details of these two types of data collection are given below.

4.6.1 Secondary data collection

To gain the necessary background knowledge for this research, an extensive library research was conducted (Robson and McCartan (2016)). Library databases and internet search engines were used to identify key words leading to relevant literature. The search began in September 2008 with a search of the term 'medical tourism' on Google Scholar, producing about 140,000 web addresses and covering journal articles, books, newspapers

articles, research projects, dissertations and many more. Many articles provided good information in terms of definitions of medical tourism and background for the medical tourism industry. Other articles usefully illustrated ways in which medical tourism destination countries could benefit from the industry and provided reasons for people travelling abroad for medical care. Some articles focused on post medical treatment care and complications, whilst others took a critical position on standards of medical care and quality assurance in hospitals and clinics of less developed countries.

In order to narrow the scope and focus of the research topic, the word 'Thailand' was then added, resulting in a dramatic drop to 20,300 web addresses. The majority of identified articles (Burkett, 2007; Carrera and Bridges, 2006; Chambers and McIntosh, 2008; Chanda, 2001; Cochrane, 2008; Cohen, 2008; Connell, 2006; Singh, 2008; Sinhaneti and Pullawan, 2008; Svantesson, 2008; Whittaker, 2008; York, 2008) presented Thailand as one of the leading medical tourism destination countries in Asia, highlighting the extremely cheap medical treatment cost when compared with developed countries. Quicker medical services, easier availability, good sightseeing, good location and many more factors were also mentioned.

However, since the aim of this research was to focus on non-invasive aesthetic medical tourism, which was a specific focus on medical tourism industry in Thailand, the term 'medical tourism' seemed to be too broad. Because of this, the words 'aesthetic and non-invasive aesthetic' were also identified and added in order to focus the results, with 2,190 websites, from which 33 articles were found providing background and knowledge of the non-invasive aesthetic medical tourism in Thailand.

In addition to the focus on this topic, the research project also aimed to investigate the theories of risk, risk perception and risk reduction. Therefore these key words were also used for gathering data from Google Scholar. Using similar key word search techniques to focus on these themes, the amount of non-related information was considerably reduced. In order to combine the two themes (non-invasive aesthetic medical tourism and risk), and to observe how these two subjects might be influencing each other in the literature, an advance search was then applied. Importantly, it had yet to be established whether there was in fact any existing research linking these two subjects.

This data search method did not give rise to any primary research on non-invasive aesthetic medical tourism linked to the topic of risk, risk perception and risk reduction as applicable to Bangkok, Thailand as a non-invasive aesthetic medical tourism destination country. Therefore, other sources were utilized, for example, library and electronic sources, in order to search further any journal articles and dissertations which might throw light on the existence of primary research in this area. Key texts such as Bookman and Bookman (2007), Connell (2006) and Singh (2008) were found to be invaluable for providing initial and general literature and offering information on the wider context. As the research progressed and became more focused, more relevant articles were sought.

Information gathered from records produced by non-invasive aesthetic clinic records, public organisations and web sites also proved to be informative. Added to this documentation were other sources such as area-based and time-series based government publications, national journals and industry

statistics and reports. Some of the literature was published in Thai and had to be translated to English.

In the course of the fieldwork, internet searches continued to be carried out, backed up by several email contacts with other PhD students and researchers who were interested in this research area. Research conferences and forums, for example, the International Congress of Aesthetic Dermatology at the Central World Convention Centre in Bangkok on 22 January 2010, the Research Methods Summer School in Turkey on 6-13 September 2010, and the Medical Tourism Postgraduate Forum at the University of York on the 8th of September 2011, provided invaluable opportunities to meet other researchers. Moreover, having the opportunity to present at related research conferences and forums allowed the researcher to deliver and disseminate details of this research topic to others, and in turn to receive feedback from other researchers. Such feedback included critical reflection on the research methods used, with the result that both primary and secondary data were included to answer the research question and to meet the research aims and objectives.

4.6.2 Collecting primary data using semi-structured interviews

As mentioned earlier, an inductive approach was believed to be the most appropriate methodology for this research, since this approach would allow the research to focus on the context in which researched events took place, and to work with a small sample of subjects. This view is backed up by Easterby-Smith, Thorpe and Lowe (2002) who state that the inductive approach is more suitable than the deductive if one is particularly interested in understanding why something is happening, rather than being confined to describing what is happening. In this qualitative approach, an appropriate

data collection method is understood to be by means of semi-structured interviews, where standardised questions are asked to all interviewees, and where the researcher as the interviewer asks the questions face to face.

According to Brinkmann (2014), an interview is a purposeful discussion between two or more people. The use of interviews can help researchers to gather valid and reliable data that are relevant to the research question(s) and objectives (Saunders *et al.*, 2009). In qualitative research, interviews usually involve some form of conversation which is flexible and fluid while focused on a purpose, to discuss relevant issues, topics and experiences during the interview itself (Mason, Augustyn and Seakhoa-King, 2010). Interviews maybe highly formalised and structured, using standardised questions for each respondent, or they may be informal and unstructured conversations. There are potentially three types of interviews available for this kind of research approach: structured interviews, semi-structured interviews, and unstructured or in-depth interviews (Saunders *et al.*, 2007).

Structured interviews involve one person (“the interviewer”) asking another person (“the interviewee or respondent or participant”) a list of predetermined questions about a carefully-selected topic. The interview questions for this type of interview are standardised, using an identical set of questions for every interview (Saunders *et al.*, 2009), although the interviewer is allowed to explain things to the interviewee if he or she does not understand the question or finds a question confusing. Once the interview questions are asked, the response is recorded on a standardised schedule. For replicability, the interviewer should read out the questions exactly as written and in the same tone of voice for every respondent to reduce any indication of bias. This emphasis on uniformity and replicability is because structured interviews are

generally used to collect quantifiable data. As a result, they are also referred to as quantitative research interviews (Saunders *et al.*, 2009).

By comparison, Cohen and Crabtree (2006) recommend that qualitative research interviews consist of unstructured interview and semi-structured interview format, for the very fact that, in contrast to structured interviews, such interviews will tend to be non-standardised. As such, they offer enhanced opportunities for exploring in-depth data on peoples' perceptions, and for enabling interviewees to talk freely about their experiences, feelings, behaviours and beliefs in relation to the topic area (Saunders *et al.*, 2007). Linked to this, Easterby-Smith *et al.* (2002) suggest that these two types of interviews also allow the researcher to achieve a deeper understanding of the interviewee's world.

Such informal unstructured interviews are used to explore in depth a general area in which the researcher is interested, so they are alternatively known as in-depth interviews. There is no predetermined list of questions to work through in this situation, although the researcher will need to have a clear idea about the aspect(s) that they want to explore. To achieve this clarity of focus without risking waste of time, it is suggested that time and care be taken to conduct unstructured interviews (Bryman and Bell, 2015).

The semi-structured interview, on the other hand, has the advantage of offering better time control, as it follows an interview guide without being rigid (Saunders *et al.*, 2007). Generally, researchers will have a list of themes and questions to be covered, although these may vary from interview to interview. This means that the researcher may omit some questions in particular interviews. Ordering of the questions may also be varied depending on the

flow of the conversation, which may lead to additional questions being required in order to explore the research question and objectives. Data are recorded by audio-recording and/ or note taking.

Conducting primary research through semi-structured interviews has many benefits. Unlike the questionnaire framework, where detailed questions are formulated ahead of time, a semi-structured interview starts with more general questions or topics. The major benefit of a semi-structured interview is to allow both interviewer and interviewee the flexibility to probe for details or discuss issues. In general, the beginning of the interview serves to identify relevant topics and to explore the possible relationships between these topics and issues arising, such as availability, expense, effectiveness and so on. These in turn become the basis for more specific questions, which do not need to be prepared completely in advance. An additional benefit is that the use of semi-structured interviews encourages two-way communication, where the questions posed by the interviewer can function as an extension tool to obtain information in return. In other words, this type of interview provides an opportunity for learning, in that information obtained from semi-structured interviews not only provides answers, but the reasons behind the answers as well (Saunders *et al.*, 2009).

Such interviews may be conducted on a one-to-one basis, between the interviewer and a single participant. This can be done by meeting the participant 'face to face', but there may be some situations where the researcher conducts an interview by telephone or electronically via the Internet. Conducting a telephone or internet interview has many crucial advantages associated with access, speed of data collection and lower cost,

which would all be prohibitively expensive if the interview on a face-to-face basis involved travelling long distances (Saunders *et al.*, 2007).

This research was accordingly able to benefit from telephone interviews where long distances and shortage of time might otherwise provide barriers. However, specific to the international context of this study, associated with the non-invasive aesthetic medical tourism industry in Bangkok, it was noted that where the situation involved a request to undertake a telephone interview with an overseas participant, there needed to be awareness of cultural norms relating to the conduct and duration of telephone conversations. However, in any case, when more clarity was needed from a particular interview, and the distance seemed a potential barrier in the moment, then the telephone interview was used as the most the appropriate tool for gaining further clarification within the required timeframe.

Semi-structured and unstructured interview techniques also lend themselves to being conducted on a group basis; this is also known as 'focus group' research, where in a small number of participants can explore an aspect of the research topic through a group discussion. However, when individuals are interviewed, they may more easily discuss sensitive issues.

It can be concluded that each form of interview outlined above has a distinct purpose. In order to conduct the primary research successfully the researcher should differentiate between types of interview related to the research aim, research objectives and the nature of interaction between the researcher and those who participate in the research. The summary of the differences between these three types of interview can be seen in Table 4.3. In medical tourism studies, qualitative interviews have been used regularly in order to

gain deeper inner information (see section 4.5 for more details). Previous research indicated that interviews were a good research method for medical tourism studies.

	Structured Interview	Semi-structured interview	Unstructured interview
Type of research	Quantitative	Qualitative	Qualitative
Research categories	Descriptive/ Explanatory	Explanatory/ Exploratory	Exploratory
Interview questions	Very well prepared Standardised schedule	Partly well prepared Can be improvise	Prepare a list of topics to discuss
Time spent for each interview	Low	Medium	High
Sample size of the research	High	Medium	Low
Type of collected data	Answer	Answer/ reason/ explanation	In-depth information
Leader of the interview	Interviewer	Both interviewer and interviewee	Interviewee

TABLE 4.3 A summary of the differences between three types of interview

Adapted from: Bryman and Bell, (2015); Cohen and Crabtree (2006) Easterby-Smith et al., (2002); Mason *et al.*, (2010); and Saunders et al., (2009)

In summary, considering the benefits of semi-structured interviews linked to the research aim and objectives, qualitative research interviewing approach was employed as a key data collection method for this research project. This was because semi-structured interviews provided the researcher with the opportunity to probe answers, where an explanation from interviewees such as clinic owners, tourist-patients, and government representatives was

needed. Saunders *et al.* (2007) confirm that this is important if you are adopting an interpretivist epistemology, where you will be concerned to understand the meanings that respondents describe to various phenomena.

More importantly, the researcher used semi-structured interviews for tourist-patients instead of other methods such as questionnaire or focus groups because semi-structured interviews allowed tourist-patients the freedom to express their views in their own terms individually. Questionnaire was not appropriate for tourist-patients as the researcher needed detailed answers rather than yes/no answers. The researcher have gained experiences from previous research and recognised that many respondents would leave blank for open-ended questions such as 'please provide further explanation' or 'please provide suggestion'. Bryman and Bell (2015) support that partially answered questionnaires are more likely, because of a lack of prompting or supervision, than is possible in interviews. It is also easier for tourist-patients to decide not to answer a question when on their own than when being asked by a researcher. If questions are not answered, this creates a problem of missing data for the researcher. In addition to this, it was not appropriate to use focus group for tourist-patients because it was not possible to keep a tourist-patient waiting for other tourist-patients became available for focus groups interview.

Upon receiving the ethics approval (section 4.12) from the University Research Ethics Committee (UREC), a list of questions for each stakeholder group was prepared and revised, based on the literature review (section 4.7). Following this the initial stage of primary data collection was conducted in Bangkok. The average interview duration was approximately between 20-30 minutes. Although it was initially envisaged that 50-60 interviews would be

conducted, 45 interviews were undertaken during the preliminary and main stage of fieldwork.

4.7 Interview questions development

In line with the epistemology of interpretivist research, existing theory was studied in order to generate and develop appropriate interview questions. Accordingly, the researcher developed a number of interview questions based on an initial review of the medical tourism literature, to include the themes of aesthetic medical tourism, non-invasive aesthetic medical treatments, risks related to tourism, risks related to non-invasive aesthetic medical tourism and treatments, and risk perception and risk reduction. The interview questions contained both open-ended and closed-ended questions, designed to capture the development and management of non-invasive aesthetic medical tourism in Bangkok with six categories of risks: 1) functional risk; 2) physical risk; 3) financial risk; 4) time risk; 5) psychological risk; and 6) social risk. These questions also focused on obtaining information about the current practices of the non-invasive aesthetic medical tourism industry in Bangkok. A full copy of interview questions and transcripts with a non-invasive aesthetic clinic owner, a tourist-patient, and a government representative are available in the appendix B, C and D respectively.

The interview questions were initially pilot tested in Bangkok on five respondents; these were two non-invasive aesthetic clinic owners, two tourist-patients, and a government representative. Subsequently, the interview questions were revised by the researcher to maximise clarity of each question and associated responses. This helped to generate interview questions more appropriate for the main stage of fieldwork. In other words, the interview

questions were redesigned for better understanding for each group of interviewees. As a result, data were collected more effectively.

4.8 Sampling techniques

The target population of this research consisted firstly of primary stakeholders, that is, the owners of non-invasive aesthetic clinics, and tourist-patients. Secondly, government representatives were categorised as secondary stakeholders. In some research cases, it is generally considered possible to interview an entire representative population of stakeholders if it is of a manageable size. However, in other research cases, as in this research, the entire population of primary and secondary stakeholders could well amount to millions. For instance, figures from Lin *et al.*'s., (2009) research illustrated that the actual number of international medical passengers to Thailand in 2006 was 1.4 million. They extrapolated that this number would reach over 7.4 million by the end of 2015. Given the reality of this, it would simply be impossible within the time limits of a PhD research study to conduct interviews with the total number of tourist-patients, non-invasive aesthetic clinic owners and government representatives in Bangkok. As a result, Saunders *et al.* (2009) suggest that selecting a representative sample would become a key issue in allowing for the collection of relevant and effective primary data, and also importantly, in achieving the research aim and objectives.

On the other hand, it is sometimes argued that sampling may be problematic, in that reduced numbers of interviews may lead to a loss of accuracy of results. This is because a good selection of respondents can provide a richer quality of information. In addition to this, careful sampling can free up time for a researcher to focus better on each interview and to collect more detailed

information. It also importantly provides more time for obtaining data from more difficult to reach cases. Having more time to analyse data and reflect on findings from interviews is another crucial benefit to be derived from effective sampling. Indeed by extension, for exploratory research, this extra time can facilitate discoveries which will form the foundation for further work.

Two other types of sampling techniques were available for the researcher to choose from: probability or representative sampling, and non-probability or judgemental sampling. Saunders *et al.* (2009) suggest that probability sampling is often associated with survey and experimental research strategies, which helps the researcher to achieve objectives that require statistical estimations. On the other hand, non-probability sampling is not useful if the researcher wishes to achieve objectives requiring statistical inferences about the characteristics of a population. Therefore, the researcher considered non-probability or judgement sampling as the most appropriate sampling technique, which helped to achieve the research aim and objectives.

4.8.1 Non-probability sampling technique

According to Saunders *et al.* (2009), non-probability sampling or non-random sampling provides a range of alternative techniques for selecting samples, based on the researcher's subjective judgement. They also suggest that in the exploratory stages of some research projects, in particular business research projects such as a pilot survey, non-probability sampling is the most practical technique. This research therefore employed a non-probability sampling technique as the most appropriate sampling technique for the pilot study. In order to meet research objectives, the researcher needed to undertake an in-depth study focussing on a small number of selected cases

rather than the whole population. This provided the researcher with an information-rich case study that helped to explore research questions and gain theoretical insights.

There are five types of non-probability sampling techniques for a researcher to consider: quota, self-selection, convenience, purposive and snowball techniques. But because the interviewer can choose within quota boundaries whom they interview, the researcher's quota sample may be subject to bias (Saunders *et al.*, 2009). With respect to the process and the weakness of quota sampling, it was considered that for this study quota sampling was not appropriate.

Secondly, self-selection sampling occurs when the researcher allows each case, usually individuals, to identify their desire to take part in the research (Saunders *et al.*, 2009). In order to do this, the researcher needs to advertise the need for cases through appropriate media or face to face requests to take part in the study, followed by collection of data from those who respond. With regard to this research, the researcher, upon advice from the University Research Ethics Committee (UREC) carried out the above procedure, after careful consideration, by presenting the logo of Oxford Brookes University to a non-invasive aesthetic clinic in Bangkok and asking permission of the clinic owners to advertise the logo on their premises to collect participants. Unfortunately, the clinic owners responded that it would not be appropriate to advertise any logos other than their own on their premises, for fear that it might confuse their prospective customers. The researcher therefore did not employ this sampling technique as the researcher could not get permission from the owners of the premises.

Thirdly, convenience sampling is considered the easiest means of obtaining a sample (Saunders *et al.*, 2009). This technique of sampling is used widely, to include any individual who is interested in taking part in the research. A researcher can continue this sampling process selection until the required data size has been reached. Although convenience sampling has the advantage of gaining access easily to participants, it also has the disadvantage that data can be more easily biased if the source of the sample is not fully representative of the wider target population. In other words, neither the views and opinions of interviewees derived through convenience sampling, nor their range of knowledge and experience of the research area, might prove appropriate to the research aim and objectives. For this reason, and given that convenience sampling may have been insufficiently reliable to ensure achievement of the study's research objectives, the researcher did not go on to employ convenience sampling as a sampling technique.

Fourthly, purposive or judgemental sampling refers to a sampling approach that enables the researcher to use their judgment to select cases that will best enable them to answer their research question and to meet research objectives. According to Neuman (2010), this form of sampling is often used when working with very small samples, such as in case study research and when the researcher wishes to select cases that are particularly informative. However, Saunders *et al.* (2009) state that the researcher needs to bear in mind that such a sample cannot be considered to be statistically representative of the total population. In this case the selection of cases for a purposive sample should be dependent on the research question and objectives. Considering the perspective of purposive sampling for this research, this sampling technique was selected as the most appropriate to

gain the required information from respondents. A focus on this sampling approach enabled the researcher to select the interviewees effectively with respect to research question and objectives.

A final type of sampling known as snowball sampling is commonly used when it is difficult to identify members of the desired population (Saunders *et al.*, 2009). This research has gained advantage from employing this technique together with purposive sampling. This was because snowball sampling provided a good opportunity to identify further interviewees when the arranged interviewees were not available as scheduled. It was an important sampling technique to employ during the main stage of fieldwork, when the researcher was faced with the problem of not having enough interviewees. This was because some arranged interviewees such as non-invasive aesthetic clinic owners and government representatives were too busy with their business to make time for the interview.

However, in spite of recourse to two sampling methods, it was found that there was an insufficient number of interviews to reach saturated data. This problem was compounded as regards the tourist-patient sample, since the data collection occurred at a time when the number of tourist-patients in Bangkok was significantly reduced as a result of political issues, such as the closure of Suvarnabhumi international airport by Yellow Shirt in 2009, and the closure of leading department stores at Ratchaprasong and Ratchadumri area by Red Shirt in 2010 (Figure 4.1). In order to solve this problem, the researcher made contact with previous interviewees who were government representatives and clinic owners, asking them to identify further potential interviewees. The researcher continued this process in order to increase the number of interviews until the information from the fieldwork was saturated.

Thus it appeared that in terms of making initial contacts, a combination of purposive sampling and snowball sampling proved more successful than snowball sampling alone. However, as the research went on, saturation of fieldwork was achieved mainly by purposive sampling.



FIGURE 4.2 The political issues in Bangkok between 2009 and 2010

Left: The closure of Suvarnabhumi international airport by Yellow Shirt in 2009; Right: The closure of leading department stores at Ratchaprasong and Ratchadumri area by Red Shirt in 2010

4.8.2 Determining sample size

Bryman and Bell (2015) suggest that the selected sample size is dependent on the research question and objectives. In order to decide on the size of sample, the researcher considered varying factors, including the issues to be investigated, the outcomes considered most useful, the types of information with most credibility and the quality of data that could be collected for analysis, given the researcher's available resources.

Saunders *et al.* (2009) identify as that an appropriate selection of a sampling size is also an issue when the researcher is intending to collect qualitative data using interviews. Mason *et al.* (2010) point out that the validity,

understanding and insights from data will be more to do with data collection and analysis skills than the size of the researcher's sample. It is recommended by scholars (Bryman and Bell 2015; Cohen and Crabtree 2006; Easterby-Smith *et al.* 2002; Saunders *et al.* 2009) that the researcher should conduct additional interviews until data saturation occurs. In addition to this, Myers (2013) states that qualitative data collection is a circular process. This circular process continues until the research reaches the point of saturation.

This means that the researcher in this study had to be prepared to continue to interview the three groups of target respondents, which are, non-invasive aesthetic clinic owners, tourist-patients and government representatives, until there was no additional collected data to be gained from the interviews. Although a precise number of samples is never laid out in research literature, Saunders *et al.* (2009) suggests that in general 12 in-depth interviews should be sufficient to understand commonalities within a fairly homogenous group. In addition to this, Cohen and Crabtree (2006) suggest that for a general study, the researcher should expect to undertake between 25 and 30 interviews. Considering these suggestions carefully, the researcher then conducted a total of 45 interviews, including those with 25 tourist-patients, 15 clinic owners and 5 government representatives. These interviews were divided into two stages: the pilot study and main stage of fieldwork.

During the pilot study, semi-structured interviews were conducted with two clinic owners, two English-speaking international tourist-patients and a government representative. This sample size was adequate for the researcher to be able to gather sufficient data to gain a preliminary

understanding of the topic and to generate a framework to guide the main stage of fieldwork.

During the main stage of fieldwork semi-structured interviews were conducted with a further 13 clinic owners, 23 English-speaking international tourist-patients and 4 government representatives. This sample size was adequate to attain in-depth understanding of the research topic, and to draw robust conclusions.

In theory, a good sample size should allow the researcher to document uniqueness and discuss more general information (Saunders *et al.*, 2007). Even though in qualitative research, a small sample size (if compared with quantitative research) is sometimes open to question, Bryman and Bell (2015) argued that purposive samples must be judged according to the purpose and rationale of the study and not on an arbitrary ruling on the logic, purpose, and recommended sample sizes of probability sampling. Based on the richness of data obtained from the interviews in this study, it can be said that the sample was appropriate for the research undertaken.

4.8.3 Recruiting participants

According to Saunders *et al.* (2009), an integral part of the research design is the general approach to selecting data sources. Ensuring that collected data from fieldwork will meet research aims and objectives is important. For this research, interviewees were divided into primary and secondary stakeholder groups. The primary stakeholder group consisted of non-invasive aesthetic clinic owners who were experienced in dealing with English-speaking international tourist-patients for more than five years, and English-speaking international tourist-patients who had undergone non-invasive aesthetic

medical treatment in Bangkok. The secondary stakeholder group was formed of a government representative.

The interviews for the pilot study and main stage of fieldwork took place in Bangkok, Thailand between 1 August 2010 and 30 April 2011. Interviewees were at least 18 years of age. Informants for both the pilot study and the main stage of fieldwork were selected using two requirements: firstly, individuals were either a primary or secondary stakeholder in the non-invasive aesthetic medical tourism industry in Bangkok, Thailand; and secondly, informants had to be able to communicate fluently in English or in Thai. Other than this the most important criterion was that interviewees should have working experience and knowledge of the non-invasive aesthetic medical tourism industry. In order to select this sample, sample planning and sampling methodology were key skills of this research project. The recruitment of participants was divided into two stages: those used for the pilot study (section 4.8.3.1) and those used for the main stage of fieldwork (section 4.8.3.2).

4.8.3.1 Stage one: Pilot study

In December 2008, two government representatives and three clinic owners were purposely selected, and tentatively approached to take part in the research. Verbal agreement was obtained, after which it was decided that a government representative and two aesthetic clinic owners should be interviewed during the pilot study stage.

The pilot study was conducted in August 2010. Twenty to thirty minute semi-structured interviews were conducted in either a coffee shop or in a hotel lobby. The individuals concerned were contacted again and asked to read the

relevant Participant Information Sheet (PIP, see Appendix E, F, and G for details). They then signed the consent form (Appendix H) which enabled them to take part in the research. A government representative and clinic owners were contacted via either face to face or telephone. In each case, 20-30 minute semi-structured face-to-face interviews, which were audio recorded, were arranged in a public place and at a time suitable to each informant (clinic owners, and government representative). Clinic owners also agreed to provide access to English-speaking international tourist-patients for recruitment purposes in their respective clinics.

In the non-invasive aesthetic clinics, two tourist-patients (i.e. one from each clinic) were approached individually (face-to-face) after they had received non-invasive aesthetic medical treatment. The research was explained verbally, and then via a Participant Information Sheet, and consent forms were signed. Interviews with tourist-patients were audio recorded and were conducted after the individual had returned to the clinic for a post-treatment check-up (usually after 24-48 hours). Conducting the interviews on the day of post-treatment check-up was a good strategy, and appeared to help the tourist-patients to gain a better understanding of the questions related to risks, risk perception and risk reduction in respect of non-invasive aesthetic medical treatment and tourism. The collected responses were very important to the research. The researcher found that this strategy was very useful and continued to use it at stage two (section 4.8.3.2) of the research project.

4.8.3.2 Stage two: Main stage of fieldwork

Results from the pilot study showed that the interview questions were useable. During the main stage of fieldwork the informants were recruited using the same strategies adopted in the pilot study along with snowballing, if

required. It was envisaged that the data would be collected during semi-structured interviews with a further 12 clinic owners, 36 English-speaking international tourist-patients and three government representatives although, in line with the tenets of interpretivist research, numbers were finalised in the field. The finalised numbers of interviews were illustrated in Table 4.4. It can be seen that the numbers of interviews from the main stage of fieldwork was close to the planned numbers for both clinic owners and government representatives. However, the actual number of English-speaking international tourist-patients was lower than planned. This was because the researcher found that the data from the interviews with English-speaking international tourist-patients were saturated after the 21st tourist-patient was interviewed. In other words, the researcher found that further interviews with this group brought little new knowledge or no new data. Since research theory indicates that at this point it is allowed to terminate the interview process, the researcher stopped conducting the interview after the 23rd tourist-patient.

Interviewees	Pilot study	Main stage of fieldwork
Primary stakeholders Clinic owners Tourist-patients	2 2	13 23
Secondary stakeholders Government representatives	1	4
Total	5	40

TABLE 4.4 A summary of the number of the interviews from the pilot study and main fieldwork

4.9 Seeking access

During her employment with an aesthetic medical equipment manufacturer in Bangkok (2002-2007) the researcher developed connections with clinic owners and government representatives. These relationships, which had been maintained during her time studying in the UK, facilitated access to necessary informants who were purposively selected. Two government representatives and three clinic owners were tentatively approached and verbally agreed to take part in the research in 2008.

The researcher's former employer in Bangkok facilitated access to other clinic owners and government representatives. Further potential interviewees were contacted during the pilot study stage. The latter verbally agreed to provide access to aesthetic treatment international tourist-patients in their respective clinics. Research was conducted according to University Research Ethics Committee requirements.

In the initial stage of the investigation the researcher decided to approach the owners of non-invasive aesthetic clinics who had at least five branches in Bangkok to request their cooperation with the study, the aim being to gain a deeper understanding of the development and management of the non-invasive aesthetic medical tourism market in Bangkok from the perspective of multi-branch business owners.

It was understood that the pre-selected interviewees might not be in a position to talk about their perceptions of risks associated with non-invasive aesthetic medical treatment, if they had not had any such experience of risk or indeed perceived any need for reduction of risk. As a result, in order to be able to achieve the research objectives, the researcher sought access from

those non-invasive clinics that could provide the possibility of gaining experienced interviewees, rather than from any pre-selected ones recommended by multi-branch non-invasive clinics.

In addition to this, arranging the interviews with government representatives proved a challenge. Initially, the researcher had planned to conduct interviews with three directors of the dermatology department from three public medical schools, two food and drug administrators from the medical equipment section, and from the new clinic registration section at the Department of Health. However, the researcher experienced considerable difficulty in gaining access to one of the directors at a particular public medical school. At the time of the appointment, the director suggested the researcher should conduct the interview with another staff member. This was because the director believed that this research did not need the information from him in particular. It seemed to be the attitude that information from his assistant should be enough for a PhD research project.

This recalls Saunders' *et al.* (2009) suggestion that the researcher should be mindful that such associations and organisations may receive literally hundreds of requests from students every year and so may not have sufficient time or resource to respond. In this case, because the researcher was fortunate already in being accepted to conduct the research at this public medical school, it was decided to conduct the interview with an alternative staff member as appointed by the director without asking for reasons or putting up any objections on that day. This was because this public medical school is the forerunner medical school in dermatological research in Thailand. In the event, the researcher was fortunate in being provided with a knowledgeable interviewee for this aspect of the research project.

4.9.1 Gatekeepers

According to Saunders *et al.* (2007), a gate keeper refers to a person, often in an organisation, who controls research access. They usefully observe that in the nature of business and management research, many researchers are likely to be dependent on a gatekeeper for access. This does however give rise to a question of power relationships in business and management research, which might raise the need to consider ethical issues when the researcher must rely on organisational gatekeepers.

However, in this research such power issues did not arise, given that the gatekeeper was not working for or representing any particular clinic. Rather, she was the owner of an aesthetic equipment manufacturing company in Bangkok with whom the researcher worked for five years. This individual was useful in knowing every owner of every chain clinic in Thailand, as well as having custom with single branch clinic owners. The researcher contacted her during main stage of fieldwork, and as a result was advised to attend conferences in order to conduct interviews with clinic owners attending the conferences. With help from the gatekeeper, the researcher was able to attend two conferences where useful contacts were made.

On a conference day, the clinic owners were free during lunch and coffee breaks to have a drink and snack while waiting for the following presentation. The researcher took these breaks as opportunities to conduct interviews with clinic owners, who remembered the researcher from previous contact. This helped the researcher to skip the introduction part and move directly on to the signing of a consent form. The interviews were conducted either in a corner of the conference room, or in the lobby of the hotel.

Another advantage of this access was that government representatives also attended these conferences, so that the researcher was able to gain access and conduct interviews with this part of the sample also. As a result of this access route, there was a small amendment to the original data collection plan, to stipulate that instead of conducting interviews in the clinics or public places, interviews with some clinic owners and government representatives were conducted during two conferences: these were the 2nd International Bangkok Congress on Anti-Ageing and Regenerative Medicine (BCAARM), and the Hair-in Hair-out: All about Hair conference.

4.10 Interview duration and recording data

All information and documentation that interviewees provided was kept confidential within the limitations of the law and was not used for purposes other than academic research. The interviewee information is illustrated in table 4.5. 45 informants were provided with a summary of the interview transcript within 48 hours of the interview. The only people that could have access to the interview records were the PhD researcher and her supervisory team based in the UK. Individual participants were not identified in the results unless they gave written consent to do so. Data generated in the course of this research will be kept securely in paper or electronic form for a period of up to five years after the completion of the research, after which period it will be destroyed. In Thailand data were security encrypted onto a laptop computer and USBs securely stored, and then returned to Oxford Brookes University for onwards safe storage in the UK.

Name (pseudonym)	Gender and Approx. age	Date of interview	Duration of interview (minute)	Place of interview
GR1	M (50+)	12.08.10	32	MOPH
GR2	M (40+)	14.08.10	28	MOPH
GR3	M (50+)	10.04.11	30	MOPH
GR4	F (30+)	10.04.11	22	Hotel lobby
GR5	F (40+)	11.04.11	23	MOPH
CO6	M (40+)	12.08.10	35	Clinic
CO7	F (40+)	13.08.10	30	Clinic
CO8	M (40+)	15.08.10	32	Clinic
CO9	M (30+)	11.04.11	26	Clinic
CO10	F (30+)	12.04.11	25	Clinic
CO11	M (40+)	14.04.11	24	Clinic
CO12	F (50+)	14.04.11	25	Clinic
CO13	F (30+)	15.04.11	23	Coffee shop
CO14	F (30+)	16.04.11	22	Clinic
CO15	M (40+)	18.04.11	21	Coffee shop
CO16	F (40+)	19.04.11	20	Clinic
CO17	M (30+)	20.04.11	24	Hotel lobby
CO18	M (40+)	22.04.11	23	Hotel lobby
CO19	F (30+)	22.04.11	22	Hotel lobby
CO20	F (50+)	23.04.11	22	Hotel lobby
TP21	F (30+)	12.08.10	28	Clinic
TP22	F (20+)	13.08.10	26	Clinic
TP23	F (30+)	11.04.11	27	Clinic
TP24	F (50+)	12.04.11	27	Coffee shop
TP25	M (40+)	12.04.11	22	Coffee shop
TP26	F (30+)	13.04.11	24	Clinic
TP27	M (40+)	13.04.11	20	Clinic
TP28	M (40+)	15.04.11	24	Hotel lobby
TP29	F (30+)	16.04.11	22	Clinic
TP30	F (50+)	17.04.11	21	Clinic
TP31	F (50+)	18.04.11	25	Hotel lobby
TP32	F (20+)	18.04.11	28	Hotel lobby
TP33	F (30+)	20.04.11	27	Coffee shop
TP34	F (30+)	20.04.11	25	Coffee shop
TP35	M (30+)	20.04.11	22	Coffee shop
TP36	F (30+)	22.04.11	21	Clinic
TP37	M (40+)	22.04.11	24	Clinic
TP38	F (40+)	24.04.11	23	Clinic
TP39	F (40+)	24.04.11	22	Clinic
TP40	F (30+)	24.04.11	21	Clinic
TP41	M (30+)	25.04.11	24	Hotel lobby
TP42	M (40+)	25.04.11	22	Hotel lobby
TP43	M (30+)	27.04.11	20	Hotel lobby
TP44	F (40+)	28.04.11	22	Hotel lobby
TP45	F (40+)	28.04.11	24	Hotel lobby

TABLE 4.5 Interviewee information

4.11 Interview settings and process

While the interviews with clinic owners, tourist patients and government representatives required a somewhat different structure, certain principles and techniques were applicable to all. Each interview followed three major sections in the format: the opening, the body and the closing. The opening always sought to make the respondent/interviewee feel welcomed and relaxed, and to clearly indicate the objectives of the interview, as well as what topic areas would be addressed. Motivating the interviewees involved offering an explanation for how the information would be valuable to the academic and non-invasive aesthetic medical tourism industry. Finally, the opening indicated the expected length of the interview. The summary of the opening interview schedule for clinic owners, tourist patients and government representatives is illustrated in Table 4.6.

Interviewees	The opening
Clinic owners	<p>A. (Establish rapport) [Thai greeting] My name is Dararat and as a PhD student from Oxford Brookes University, it would be good for my research project to interview you, so that I can better understand the situation of non-invasive aesthetic medical tourism in Bangkok.</p> <p>B. (Purpose) I would like to ask you some questions about the experiences you have had, and to gather some of your comments in order to understand more about non-invasive aesthetic medical tourism in Bangkok.</p> <p>C. (Motivation) I hope to use this information to understand the situation/ problem in this industry and then be able to propose a developed model for the industry.</p> <p>D. (Time Line) The interview should take about 20-30 minutes. Are you willing to undertake the interview?</p>
Tourist patients	<p>A. (Establish rapport) [shake hands] My name is Dararat and as a PhD student from Oxford Brookes University., I would like to interview you for a research project. This is so we can better understand the perception and attitude of non-invasive aesthetic medical tourism in Bangkok from the consumer perspective.</p> <p>B. (Purpose) I would like to ask you some questions</p>

	<p>about the experiences you have had, and gather some of your comments in order to understand more about non-invasive aesthetic medical tourism in Bangkok.</p> <p>C. (Motivation) I hope to use this information to understand the current situation/ challenges to this industry and then be able to propose a developed model for the industry.</p> <p>D. (Time Line) The interview should take about 20-30 minutes. Are you available to respond to the questions at this time?</p>
Government representatives	<p>A. (Establish rapport) [Thai greeting] My name is Dararat and as a PhD student from Oxford Brookes University, I would appreciate if I could interview you for my research project. I am looking to better understand the situation of non-invasive aesthetic medical tourism in Bangkok.</p> <p>B. (Purpose) I would like to ask you some questions about the experiences you have had, and gather some of your comments in order to understand more about non-invasive aesthetic medical tourism in Bangkok.</p> <p>C. (Motivation) I hope to use this information to understand the current situation/ challenges in this industry and then be able to propose a developed model for the industry.</p> <p>D. (Time Line) The interview should take about 20-30 minutes. Are you available to respond to the questions at this time?</p>

TABLE 4.6 A summary of interview schedule: The opening

The body of the interview schedule listed the questions to be covered. The number of questions and the exact wording of the questions depended on each interview (see Appendix B, C and D for details). The researcher relied on a moderately scheduled interview that contained major questions and possible probing questions under each. This schedule still allowed some freedom to probe into answers and adapt to the situation. Finally, the closing stage maintained the tone set throughout the interviews. The researcher summarised the main issues discussed during the interview and appreciated the respondent for his or her time.

The researcher contacted respondents of each group either directly face to face or indirectly by telephone and/ or email. The aim was to schedule a 20-30 minute interview with non-invasive aesthetic clinic owners, tourist-patients and government representatives. With regards to the criteria of interviewees (see more details in section 4.8), all interviews were conducted by the researcher between 01 August 2010 and 30 April 2011. The interviews were audio recorded. For open ended questions detailed notes were taken during the interview and entered verbatim into a Microsoft Access database for subsequent coding. The completed transcript was then emailed back to each participant within 48 hours from the date of the interview so that the interviewee could review it and make corrections to the transcript if desired.

Interviewees	Where	When
Government representatives (GR1-GR5)	Public medical school Coffee shop Conference	GR1: August 2010 GR2-GR5: April 2011
Clinic owners (CO6-CO20)	Clinic Conference	CO6-CO7: August 2010 CO8-CO20: August 2010 and April 2011
Tourist patients (TP21-TP45)	Clinic Coffee shop Hotel lobby	TP21-TP22: August 2010 TP23-TP45: August 2010 and April 2011

TABLE 4.7 A summary of research process

This research was an inductive study, involving semi-structured interviews, which means that the researcher endeavoured to address a list of themes and questions. Although these might have varied from interview to interview, owing to omission of some questions in particular interviews, this was admissible given the specific organisational context encountered and its

relationship to the research topic. Further questions tended to arise out of what said, and follow the trend of the conversation (Higgins, 1996). Prior to the interview, introductions and an explanation of the research were offered and explained through the PIP. To reduce biasing informants' answers, it was explained that the research was being conducted in order to share views and opinions about the non-invasive aesthetic medical treatments and services in Bangkok, Thailand only.

The purpose of the study was clarified to the interviewees. It aimed to evaluate the development and management of non-invasive aesthetic medical tourism (international) in Bangkok and subsequently to investigate how sustainability could be achieved. Thus the data collected throughout the interviews directed the theoretical part of the research. There were two areas of concern that needed to be addressed when conducting interviews, which were to minimise forms of bias for both interviewer and interviewee.

However, some of the answers overlapped occasionally, depending on the experience of the respondent in a particular non-invasive clinic. The interviews were transcribed within 48 hours after the interview was conducted, in order to analyse the data (See Appendix B, C and D for the transcripts of clinic owner, tourist-patient and government representative respectively).

4.12 Ethical issues

An application for ethical approval was submitted to the University Research Ethics Committee (UREC) and successfully received full approval from UREC on 26th May 2010 to begin fieldwork. The purpose of an Ethics Committees is to review proposed research in order to minimise potential harm, and to

anticipate potential risk. Ethics and access were critical aspects for any research and were indeed critical to this research. Ethical concerns emerged as the researcher planned the research, sought access to organisations and to individuals and collected, analysed and reported the data. The appropriateness or acceptability of the researcher's behaviour needed to be examined as affected by broader social norms of behaviour (Zikmund, 2000). The researcher considered these ethical issues throughout the period of the research and remained sensitive to the impact of the research work on those who were approached to help, those who provided access and cooperation, and those who were affected by the result of this research.

In addition to this, Sapsford and Jupp (2006) state that the right use of friendly and trusting relationships is not only a necessity of research, but also a powerful tool. The extensive cultivation of friendly and trusting relations with people in all kinds of settings has been vital in building affection and trust in this study. More importantly, the comments of the volunteers involved in the study would not be given to any clinic to improve their commercial practices. The only information that would be given to the clinic would be a summary of the interview undertaken with that clinic. Upon completion of the PhD a summary of the research findings would be sent (if contact details provided) and a full copy of the dissertation would be available via email on request.

Prior to the research it was made clear that if any participant wanted to pull out of the research or did not feel comfortable then this would not reflect upon their offer of support in any way. All informants remained unnamed throughout the research in order to ensure confidentiality.

4.13 Potential risks to participants and risk management procedures

According to Neuman (2010), social research investigation often involves a consideration of issues, data and perspectives that may impact on the feelings, views, attitudes and values held by people involved in the research process. During this research process it became a concern that no interviewee should suffer any physical, psychological, social, legal or economic risk, whether they were clinic owners, tourist patients or government representatives involved in this research. Above all, the researcher was concerned that the nature of the treatment discussed would leave tourist-patients in a positive state of mind. The researcher respected the wishes of all tourist patients regarding participation in the research, in that informants were free to withdraw from the research at any time.

Risk management procedure was another issue under ethical consideration, in that the UREC required the researcher to demonstrate a clear procedure before conducting the research. In such a procedure, when meeting volunteer interviewees the researcher is required to carry a mobile phone at all times, and if appropriate, parents of minors are provided with information relating to the location, timing and anticipated duration (20-30 minutes) of the interview prior to it taking place. The procedure is that individuals are telephoned immediately before the interview commences and contacted again as soon as the interview is concluded. If the time lapse between the two calls (i.e., before and after the interview) is more than 40 minutes it is agreed that parents would contact the police. However, this procedure was not necessary in the case for this research. Nevertheless, the interviews were conducted completely and safely.

4.14 Interpretation and data analysis

4.14.1 Interpretations

Interpretation is symbolic. Experiences always have at least two levels of meaning: a surface and a deep meaning. What a choice of phrase or answer to a particular question means on the surface may be different to what is meant at a deeper and more symbolic level (Denzin, 2001). Thus, an interaction e.g. an interview, can be interpreted in many ways. For this reason a researcher must be aware of the multiple meaning of words, intonations, gestures and phrases used by the interviewees. As a result, it is important to contextualise the research and describe the events in as much detail as possible. Thus, as part of the methodology, transcripts were made as soon as possible after the finalisation of each interview, while the material was still fresh in order to provide an expanded account of field notes (Kirk and Miller, 1986).

In addition to the interview transcripts a contextual description e.g. in Appendix B, C and D were also written up within 48 hours from the date of each interview. This ensured that the researcher would not forget important details. More importantly, this helped the researcher to be able to send transcriptions to the interviewees via email within 72 hours from the date of interview as promised. It was found that interviewees were satisfied with the transcripts provided. This consisted of the setting in which the interviews took place, initial thoughts and feelings and interpretations of the informant and the information provided.

4.14.2 Data analysis

Based on Saunders' *et al.* (2009) suggestions for qualitative analysis strategies, the information from the literature review was used to establish key themes. These key themes were used in the primary research and in the analysis. The qualitative findings were collected and categorised as drawn from themes in the interviews. This meant that information from various questions was merged to form sub-themes under the specific categories. In general, to generate a theory on the basis of the data, and to explain the central themes that emerge from the data, is an inductive strategy. Thus in analysing qualitative data obtained through interviews the nature of qualitative data needs to be considered, as this is based on meanings expressed through words.

On the other hand, this research involved some numerical data or contained data that could usefully be quantified to answer the research question and to meet objectives. The quantitative analysis techniques were able to be depicted in the form of simple tables or diagrams showing frequency of occurrence, establishing statistical relationships between variables, and demonstrating complex statistical modelling.

According to Saunders *et al.* (2009), there are four processes that need to be considered for analysing quantitative data. Firstly, preparing the data for analysis then choosing the most appropriate tables and diagrams to explore and present the data. The third stage is choosing the most appropriate statistics to describe the data and lastly, choosing the most appropriate statistics to examine relationships and trends in the data. In this study, analysis and interpretation of the research findings were guided by themes

identified during the review of literature. As a result, the 4th objective of the research was achieved at this stage.

Qualitative approaches are associated with flexibility and the use of an emerging design to capture complexity, context and persona (Myers 2013). As such, qualitative data analysis can entail various processes such as examining, coding, categorising, conceptualising, abstracting, tabulating, comparing, pattern-matching, dimensionalising, integrating and iterating to draw conclusions. These processes enable researchers to organise data and extract meaning in order to draw conclusions and to develop theory. However, they are neither discrete nor sequential since there is no one way of analysing qualitative data and different models and stages have been proposed (e.g. Bryman and Bell 2015; Neuman 2010; Ritchie *et al.* 2013).

The analysis of this research based on a sequence as follow:

1. Affixed codes to interview transcripts
2. Noted reflections or other remarks in the margins
3. Sorted to identify similar phrases, relationships, patterns, themes, differences and common sequences
4. Separated identified patterns and took them out to the field in the next interview
5. Gradually detailed a small set of generalisations that cover the consistencies noticed in the database
6. Confronted those generalisations with the literature

Stages	Key activities	Main steps undertaken	Rationale
Analysis of individual interviews and transcripts	<ul style="list-style-type: none"> • Initial coding • Categorisation 	<ul style="list-style-type: none"> • Organised interview data • Read individual transcripts, made notes, and wrote initial codes in margins • Compared and combined related codes into broader themes 	<ul style="list-style-type: none"> • Became familiar with data • Reduced data into meaningful segments • Examined data through multiple lenses and reduced codes to themes
Identification of shared themes	<ul style="list-style-type: none"> • Categorical aggregation • Search for patterns 	<ul style="list-style-type: none"> • Searched for relationships between categories • Identified patterns and explored them in the next interview 	<ul style="list-style-type: none"> • Established patterns • Identified conceptual labels and a core theme that subsumed all themes

<p>Analysis of shared themes</p>	<ul style="list-style-type: none"> • Pattern-matching • Enfolding literature 	<ul style="list-style-type: none"> • Developed identified patterns along their properties and dimensions within the data • Developed a small set of generalisations in the data and created a chronological view • Compared with literature 	<ul style="list-style-type: none"> • Searched for evidence to explain relationships • Developed explanatory framework • Raised theoretical level of framework
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TABLE 4.8 The analytic strategy adopted for data analysis

4.14.2.1 Analysis of individual interview and transcripts

The first stage started with labelling the interview records and listening carefully to the digital voice recorder as soon as possible after the interview while reflecting on all verbal and non-verbal experiences. The central points that related to the research question and whatever words that seemed to represent an idea that was important to the research question in each interview were noted. The interviews were listened to again during the long hours of transcription while noting any further observations. The intention was to become familiar with the data and to help the researcher to become fully aware of the contents of each individual transcript. Each interview took approximately four hours to transcribe and transcripts consisted of five pages of text on average.

Secondly, the transcribed data was read and reviewed in order to understand what people were experiencing so that appropriate codes could be assigned. This was done through close examination of the data while noting initial thoughts and possible codes in the left margins. The transcripts were then re-read and this time the researcher tried to identify emerging themes using key words in the right hand margins. At this initial coding stage, all codes were provisional and flexible for further analysis and interpretation.

The following step was to generate categories by grouping together themes that appeared to be relevant to the same phenomenon from each interview transcript. The themes that were identified in the second wave of ten interviews were compared to the themes and categorized derived from the first wave of five interviews. The researcher attempted to understand the multiple interrelationships between the different aspects of the topic that emerged from the data. For example, the informants' definitions of barriers to

the development and management of non-invasive aesthetic medical tourism often contained phrases asserting what was bad about the service and what should be done to make a better service. As a result, these reflected stakeholder concerns in many ways. The coding scheme was useful for thinking about the categories in which codes were developed. The categories are presented as a typology of responses that emerged during analysis and which highlight the informants' experiences (Appendix I). Table 4.9 is an example of the outcome of analysis.

Initial Coding	Problem
Similar codes	bad services, not understand
Theme	language barrier
Group category	barrier to the development and management

TABLE 4.9 An example of the outcome of analysis
Source: Adapted from interview data

The element that is deemed to be the most important for quality in qualitative research is 'trustworthiness'. This tends to address issues of credibility, transferability, dependability and confirmability (Bryman and Bell, 2015; Guba and Lincoln, 1994). Trustworthiness makes qualitative and interpretive tourism studies more rigorous and more acceptable (Decrop, 2004). This research used the benefit of triangulation and member checks and three groups of interviewees for credibility; purposive sampling for transferability; the use of audit trails for dependability and showing the interplay between the data and the researcher's interpretations for confirmability. Throughout data analysis the researcher had meetings with her supervisors at least once in a month to discuss the development of the data analysis process and its

outcomes (expert checks). In addition, the interview findings were discussed with the gatekeeper and some informants (member checks). Furthermore, the research process and the interview findings were also presented and discussed at various internal research forums at the researcher's university and at external events. The use of purposive sampling provided a broad range of relevant information which led to clear pattern recognition of the central themes, relationships and the logic connecting them to the core theme. These measures enhanced the credibility and the potential for transferability.

4.15 Validity and reliability of the research

For semi-structured interviews, data quality issues which arise relate to reliability, forms of bias, and validity. Saunders *et al.* (2007) state that reducing the possibility of getting the answer wrong means that attention has to be paid to two particular emphases in the research design: validity and reliability. A concern is that lack of standardisation in semi-structured interviews may lead to loss of reliability. Robson and McCartan (2016) asserts that there are four threats to reliability, that is, participant error, participant bias, observer error and observer bias.

To overcome the reliability issue, the researcher made and retained notes relating to the design of the research, the reasons underpinning the choice of strategy and methods, and also the data obtained. These records can be referred to by other researchers in order to understand the processes that have been used and also to enable them to reuse collected data. To minimise bias in responses, the researcher established a rapport with respondents and asked unbiased questions. These were the ideals followed in this research.

And in order to attempt to avoid sources of bias in qualitative interviews, the following key measures were taken into account: personal preparation and readiness for the interview on the part of the researcher, an appropriate level of information supplied to the interviewee, appropriateness of appearance of the interviewer, the nature of opening comments to be made when the interview commenced, the approach to questioning, the ability to demonstrate attentive listening skills, the scope to test understanding, and the approach to recording information (Saunders *et al.*, 2007).

Apart from the reliability question, there are various types of bias that need to be considered. Related to interviewee or response bias, this type of bias may be caused by perceptions about the interviewer on the part of the interviewee; the cause of this type of bias is not necessarily linked to any perception related to the interviewer's person, but may be from the process, since taking part in an interview is in itself an intrusive process. As Saunders *et al.* (2009) state, this is especially true in the case of semi-structured interviews where the researcher's aim is to explore events or to seek explanations.

4.16 Reflection on research method

In the initial days of conducting interviews with a view to achieving the research aim and objectives, the researcher faced a number of challenges. These included refining and clarifying the research questions, sampling techniques, recruiting interviewees and gaining access so that the research was achievable in the available time and also met the research objectives. It engaged with the very different approaching styles of the various interviewees from two stakeholder groups. Selecting the most appropriate communication skills and approaching technique was crucial. What actually happened during

the primary data collection process, however, was radically different from what the researcher had expected, for example, the problem of gaining access as mentioned earlier, as well as the postponing or cancelling of interview schedules.

As a parallel to this, it was not easy to extract facts from secondary data as embedded in previous studies. This was because medical tourism is a new form of tourism study, with a limited academic literature. The picture outside of academic literature was confusing, given the enormous amounts of conflicting data on medical tourism to be found in non-academic articles, where each author was free to explore his/her view of medical tourism aspects from a different angle to any other authors and without any peer reviewing. In such articles, figures and numbers were claimed in many different ways without any sources or other means of verification. As such, although there was no shortage of print on this research topic in the popular press or on the internet, it was difficult to lend any credibility to such data, to cite it or to rely on it, or indeed to establish any serious links between the different perspectives of such authors and the broad elements of medical tourism.

As mentioned earlier, non-invasive aesthetic medical tourism studies are rarely mentioned in the literature, and there appears to be even less written regard to non-invasive aesthetic medical procedures (Clarke *et al.*, 2007). Moreover, there is to date no detailed information on the inflow and outflow of aesthetic medical tourists in Thailand or even how these might be defined. Given numbers of medical tourists are very general; furthermore, such sources provide no reliable information on numbers of foreign patients within the Thai medical tourism industry, nor insight into the exact purpose of their visits, nor the exact nature of the medical treatment they undergo while in

Thailand. The available information on medical tourism appears moreover to be on a regional level, rather than on a national industrial level.

4.17 Summary

This chapter presented the research philosophy, research methodology and the problems arising during the preliminary and main fieldwork from conducting interviews for data, as well as how such problems were resolved. The interview processes and schedules have also been included. The researcher conducted a total of 45 interviews, including those with 25 tourist-patients, 15 clinic owners and 5 government representatives. These interviews were divided into two stages: the pilot study and main stage of fieldwork. The findings and discussions from 45 interviews will be presented and analysed thematically in Chapter 5 and Chapter 6.

CHAPTER 5

FINDINGS ANALYSIS AND INTERPRETATION: COMPETITIVE ADVANTAGES AND BARRIERS

5.1 Introduction

The findings from this research have been analysed and interpreted with reference to the relevant literature and appropriate secondary data. The findings and analysis are presented together and divided into two chapters: the first (Chapter 5) addresses the theme of competitiveness and barriers to development and the second (Chapter 6) addresses the theme of risks as the barriers to success and risk reduction strategies. Both themes relate to the development and management of non-invasive aesthetic medical tourism in Bangkok.

This chapter comprises three main sections. The first section discusses the facilitating factors which enhance the promotion of long-term non-invasive aesthetic medical tourism development in Thailand, and also competitiveness within the industry. The second section explains in more detail the kinds of barriers and obstacles which limit the development of medical tourism in Thailand. The final section moves on to discuss anticipated trends in this industry.

5.2 The benefits of Thailand's location

5.2.1 Unique tourist features

It can be argued that in the international field of non-invasive aesthetic medical tourism, the geographical location of Thailand offers a distinct advantage in attracting potential customers. Located in the centre of

Southeast Asia, Thailand's popularity as a tourist destination is not only acknowledged in the literature but is also reinforced by interview data arising from this research, with tourist-patient participants confirming their attraction to Thailand as a prime tourist location.

Tourism is recognised as a major economic factor in Thailand. As such, it is unsurprising that tourism has become a major economic factor in Thailand. The contribution of travel and tourism to Gross Domestic Product (GDP) was THB1,037.03 billion, which is 8.6% of GDP in 2014, and is forecast to rise by 6.7% per annum, from 2016-2025, to THB2,045 billion in 2025 (World Travel and Tourism Council 2016). The richness of Thailand as a potential tourist destination is explained by its unique features such as Buddhist temples, exotic wildlife, and spectacular islands. Pukkalanun *et al.* (2013) state that of the 691 islands in Thailand, more than 214 are used for tourism. This view is underpinned by the views of tourists' in this study who recognised "*the benefits of Bangkok with its reputation of city-tours, great river sightseeing, temples, Thai-massage, handcraft and souvenir markets*" (CO8).

5.2.2 A strong history of medical tourism

In regard to medical tourism in particular, Asian countries are the main region for medical tourism (Connell, 2011) and amongst these, Thailand appears to have attracted the largest number of medical tourists (Hall, 2013). Connell (2006) observed that Thailand had already become known as a destination for medical tourism as early as the 1970s, specialising first in sex change operations, and then moving on into cosmetic surgery.

These views from the literature are reinforced by the findings of this study; interview data taken from government representatives suggest that *“Thailand is one of the best destinations for medical tourism because of its location”* (GR2), *“with many extremely beautiful beaches on the south Thailand coast”* (TP35). Equally the growth of non-invasive aesthetic medical tourism is seen as *“a growing phenomenon in Thailand where medical tourism is used to boost the arrivals to Thai beach resorts”* (GR5). In the view of these representatives, patients are drawn to the idea of adding a few weeks or more to their recovery in a luxury hotel with offers of a beautiful beach and excellent services.

5.2.3 Facilitative infrastructure

In addition, participants in the study pointed out that Thai infrastructure is designed to facilitate this therapeutic process, providing both convenience of access and straightforward bureaucracy; it is approximately a one hour flight from Bangkok to many south Thailand provinces, travelling with low cost airlines which charge from £20 per journey. Furthermore, as reported, *“it is very easy and convenient to get an extended visa when patients and their relatives want to stay longer in Thailand”* (CO15).

A standard tourist visa is considered sufficiently appropriate for tourist-patients to stay in Bangkok or extend their stay to finish non-invasive aesthetic medical treatments during their vacation. Furthermore, it is recognised that a tourist-patient rarely travels alone. It is common for another relative to accompany the patient and, therefore, in terms of visa allowances, the accompanying person or entire family may travel to the selected destination and stay for the duration of the medical treatment. Lee and Spisto (2007) state that governments of medical tourism destination countries

encourage medical tourism by allowing visas to be easily obtained and by not hindering the process, including accompanying family.

5.2.4 Cost

Location and ease of access are not the only features which appear to attract medical tourists to Thailand. Cost is another consideration in motivating individuals to travel for medical treatment. Due to the high cost of medical treatment and long wait-list in developed countries, it would appear that patients are increasingly going to developing countries for medical care (Carrera and Bridges, 2006; Chanda, 2001; Chanda, 2002; Chuang *et al.*, 2014; Connell, 2011; Goodrich and Goodrich, 1987; Hall, 2013; Hanefeld *et al.*, 2014; Lunt and Carrera, 2011; Lunt *et al.*, 2011; Singh, 2008; Singh, 2014; Teicholz and Cohen, 2014).

5.2.5 Ease of access

While individuals shopping for value in medical treatment may be attracted to Asia, Thailand is also seen as attracting the opportunistic tourist patient who does not initially set out to find treatment. One of the tourist-patients said that *“a certain group of tourists represented individuals who initially come to Thailand for vacational purposes only”* (TP33). Thus it can be argued that while not setting out with an intention to undergo some type of non-invasive aesthetic medical treatment while in Bangkok for holidays, this type of tourist-patient nevertheless may discover that Bangkok, as well as being a popular tourist destination city, offers opportunities for international tourists to undergo non-invasive aesthetic medical treatments. A number of non-invasive aesthetic medical treatments are widely available to passing tourists, who can find them in most clinics in Bangkok, located in the city centre, shopping malls

and leading department stores. One interviewee reported her experience of this:

“...First of all, I did not have the intention to have Botox® injections during my stay in Bangkok at all. It was not my plan but, as I saw many aesthetic clinics at Central World I decided to ask for prices and details. The price was unbelievable. I couldn’t believe my ears. It was cheaper than the U.S. by more than 50%. So then I thought there was no reason why I shouldn’t have it done here in Bangkok” (TP36).

5.2.6 Privacy

In addition to ease of access, convenience and cost, a further advantage of Thailand’s location was that it is far from the homeland of many potential tourist patients, thus giving the tourist-patient/ individual/ consumer the chance to undergo treatments without being observed. Participants saw Bangkok, for instance as a good place to undergo beauty and youth-enhancing appearance treatments secretly, with one tourist-patient saying that *“it was good to have an aesthetic medical treatment in Bangkok as there was no one there who knew me. They were all strangers to me. Friends and colleagues at my workplace will only notice that I look better and more beautiful but they will not know why and how, which is great. I like that”* (TP39). Lee (2007) supports that many patients travelled overseas to undergo aesthetic procedures before returning to their home country. Participants seemed therefore to see the location of Thailand, as far from the U.S. and Europe, as being a distinct advantage rather than a disadvantage. One tourist-patient mentioned that *“a 14-hour flight is good enough to escape myself from friends to do the treatment that I need”* (TP28).

According to Connell (2006), distance offers anonymity, and may explain why certain medical procedures, such as sex changes, have become a small but significant part of medical tourism, especially in Thailand, where recuperation and the consolidation of a new identity may be better experienced at a distance from standard daily life. Similarly, non-invasive aesthetic patients may prefer recuperation in a relatively unfamiliar environment (GR2 and CO9). Distance also offers an opportunity for tourist-patients to choose more complicated aesthetic medical treatments such as facelifts and fat reduction programmes. The international travel offers the advantage that foreign patients have no need to worry about what people think about these procedures.

For example, CO6 stated that *“if a forty-five year old woman wants to have hair removal from her underarms or wishes to look whiter then she can easily pop into an aesthetic clinic in Bangkok and have this done. Although she may also have as a young woman wanted such procedures, it might only be now that she had the time and money to do so, and yet fears that relatives and friends would question the sense or motives of having aesthetic procedures at her age.”* Resorting to an aesthetic clinic far from home would allow such a patient to be free from concern about what people think about her age, status or occupation. *“Sometimes you want to keep something secret and let people see when it is done”* (TP34).

5.3 Non-invasive aesthetic medical tourism: Thailand as leader

The interviews with tourist-patients and government representatives in this study confirmed that Thailand's success as a favourite international tourist destination is not only due to its diverse attractions, efficient tourism

infrastructure, excellent food and friendly people, but that it is also recognised by medical tourists as a leader in the medical tourism market. Thailand consistently rises to the top of the listings in Asia, with a continually growing number of medical tourists. Balfour *et al.* (2004) claimed that 308,000 patients from abroad were treated in Thailand's private hospitals in 2002. In addition to this, Hanefeld and Smith (2016) state that 7 million foreign patients being treated in Thailand in 2015. In spite of such studies, it is worth noting that the number of non-invasive aesthetic medical tourist-patients in Thailand has not yet to be specifically reported or published.

Findings in this study identified a number of issues mentioned by interviewees in relation to the products purchased. The picture emerging reflected and illustrated not just the variety but also the competitiveness of the non-invasive aesthetic medical tourism industry in Bangkok. In addition, the findings from the fieldwork demonstrated various reasons why tourists regard Thailand as a world destination for non-invasive aesthetic medical tourism. Based on the 40 interviews conducted, the researcher categorised these reasons / motivations into six categories: 1) internationally accredited medical facilities, 2) highly qualified medical professionals, 3) cost saving, 4) the benefits of Thailand's location, 5) state-of-the-art technology and 6) excellent service provision. The six categories of competitive advantages are illustrated in Table 5.1. The discussion of each category with respects to literature will be explained in the following section, with a view to illustrating how these six categories may serve to increase the competitiveness of non-invasive aesthetic medical tourism in Thailand.

Competitive Advantages
1. Internationally accredited medical facilities
2. Highly qualified medical professionals
3. Cost saving
4. Benefits of Thailand's location
5. State-of-the-art technology
6. Excellent service providers

TABLE 5.1 The competitive advantages of non-invasive aesthetic medical tourism in Bangkok

5.3.1 Internationally accredited medical facilities

Findings suggested that potential tourist-patients may determine the quality of care at foreign hospitals by considering the international standards. *“It appears that international patients have relied on the accredited hospitals rather than the ones without it” (TP 33).* In Asia, Thailand was the first country to achieve JCI accreditation in 2002 (Pafford, 2009). To date, there are 37 hospitals accredited by JCI in Thailand (JCI, 2016). As a result, having more accredited hospitals in Thailand and particularly in Bangkok helps to promote Bangkok as a medical tourism destination city.

It seems to be generally accepted that hospitals in Bangkok are internationally accredited as being of high quality. *“Lower costs of medical treatment in a medical tourism destination country do not necessarily translate into reduced quality. The facilities have been certified and qualified”* (CO9). Carabello (2008) suggests that healthcare in developing countries such as Thailand and India is comparable to that of the U.S. in that it is of high quality. In order to make this comparison, and to ensure that the quality of medical care in developing countries meets U.S. standards, the Joint Commission International (JCI) was applied to developing countries such as Thailand. JCI is a non-profit organisation in the United States which has been accrediting hospitals around the world since 1990s (JCI, 2016). Specifically organised to continuously improve the safety and quality of medical care in the international community, JCI recently formed a partnership with the World Health Organization (WHO) to develop international standards for patient safety so that hospitals and doctors in different countries would have uniform standards on which they could be judged.

What motivates medical tourists to access information on accreditation of medical tourism services varies (Solomon, 1992). Some studies have identified factors such as personal knowledge and previous experience (Brucks, 1985), with high risk perceptions more likely to lead to increased information search by potential customers (Solomon, 1992). That service buyers tend to engage in relatively higher levels of information search than product buyers (Deshpande and Krishnan, 1977), seeking evidence of quality (Bookman and Bookman, 2007; Burkett, 2007; Carrera and Bridges, 2006; Horowitz, Rosensweig and Jones, 2007; York, 2008). This is backed up by this study's findings: patients searched for information before making a medical plan and journey (TP16, TP31 and TP33).

JCI is not the only accrediting body recognised in the literature, as ISO is also used as a standardising procedure. JCI's evaluation is based on outcomes, waiting times, infection rates, patient safety goals, and business procedures that directly affect patients. This includes safety records, quality indicators, patient satisfaction and consumer complaints. On the other hand, it is recognised that ISO is an alternative bench marker, focusing on structure, facility management, and on processes, document control, and internal audit. *"The standard of ISO9000 has been applied in many hospitals in Thailand (GR5).*

However, unlike JCI, ISO has never focused on quality health care; nor it is patient-focused. Instead it concentrates on evaluating processes and system control. It could be argued that JCI and ISO therefore present totally different stories, in that ISO is not organised to pay attention to patient care outcomes in the way that the JCI survey process does. Nevertheless, achieving ISO standard is recognised as serving to assess the risk reduction strategies which will ensure a hospital's ability to serve patients safely (Rooney and van Ostenberg, 1999).

It is recognised that non-invasive aesthetic clinics are a different issue from the hospitals. *"None of the clinics in Bangkok have been accredited by the JCI" (GR4).* The reason behind this lack is that the cost of the survey for such establishments is too high, a crucial factor that prevents accreditation. The Joint Commission International (2015) states on its website that the average fee for a full hospital survey in 2013 was US\$46,000 which is only for the survey itself, not including the costs of transportation of the accrediting team, their accommodation, food and local transportation costs on-site. Such a compound cost is prohibitive for most non-invasive aesthetic clinic owners.

Although there may be appropriate ways to link the practices of non-invasive aesthetic clinics in Bangkok to JCI accreditation, it needs also to be acknowledged that the needs for safety quality assurance are less stringent. The risks posed by non-invasive aesthetic medical treatment are totally different from those that might be incurred by a necessarily invasive medical procedure such as heart surgery or knee replacement surgery, or other invasive medical procedures that would have to take place in a hospital. In contrast, it seemed to be recognised in the study that the medical treatments provided in a clinic are non-surgical aesthetic medical procedures (see Chapter 2 for more details), with fewer associated risks. *“It appears that waiting times for patients at an aesthetic clinic are very low and the infection rate is very rare” (CO14)*. As a result, apart from the audit charge, international standards such as JCI may not be an appropriate international standard to regulate non-invasive aesthetic clinics.

The key benefit of having many accredited and ISO verified hospitals in Bangkok for the non-invasive aesthetic medical industry is that clinic owners are able to employ more knowledgeable medical staff such as doctors, nurses and nurse assistants. In addition, medical staff hired to work in non-invasive aesthetic clinics are able to contribute their Joint Commission and ISO knowledge and experience from working in a hospitals. In turn this input of medical expertise may enhance opportunities for other non-medical staff working in non-invasive aesthetic clinics to learn new quality assurance ways of discussing patient care, by constant reference to standards, measurable elements, and policy. This quality assurance was recognised as beneficial by participants in the study: *“nowadays many doctors, dermatologists, surgeons and nurses work in both accredited hospitals and private clinics” (GR2)*. The implication of having clinical staff who bring working experience from verified

or accredited hospitals is that possible risks to patients will be minimised, and ensure the likelihood that customers will go away satisfied with the service provided.

The findings in this study suggest that tourist-patients tended to investigate the experience of the doctor in each clinic considered, before making their decision as to whether to accept treatment at that particular clinic or not. The interviews with tourist-patients confirmed that they preferred non-invasive aesthetic medical treatment at the hands of a doctor currently also working in an accredited hospital, rather than one working full time at a non-invasive aesthetic clinic (TP34, TP40 and TP42). They suggested that the hospital employed doctor would be more knowledgeable and experienced in dealing with unexpected circumstances and would be more likely to consider statutory health rules and regulations than doctors who had not yet gained the knowledge and experience of working with world-class hospital standards.

It can be concluded from this that even if a clinic did not have accreditation from any non-profit quality assurance organisation in the U.S., there would be circumstances where tourist-patients would not have a problem in being treated at non-invasive aesthetic clinics in Bangkok. This offers a different perspective from that hitherto held in medical tourism, that is that risks associated with medical aesthetic procedures would be automatically lower if undertaken in a hospital rather than in a clinic.

A key issue that helps ensure that international patients will receive the best information on qualified medical treatments with minimum risk (Chapter 6) is awareness of the international standard of a hospital. Thus patients become aware that *“hospitals advertise their accreditations, certificates and medical*

facilities on their websites” (CO8). This source helps to provide required information to international patients. Comparing Thai accredited hospitals and other non-accredited hospitals in Thailand’s competitor neighbour countries, it can be argued that accreditation helps tourist-patients in terms of building up confidence and belief that medical services in Thailand will be conducted safely, appropriately and professionally.

5.3.2 Highly qualified medical professionals

The interviews showed that skin treatments were very popular with English-speaking participants: *“dermatology is a well-developed medical specialisation widely practiced among doctors in Thailand” (CO9).* Thai doctors are seen normatively as trained abroad and able to employ the latest techniques and applications. Skilled doctors and specialists are recognised to operate in environmentally controlled clinics, whether in private or public hospitals as well as clinics. The public and private hospitals are known to operate entire wings dedicated exclusively to dermatology. In addition, it is recognised that some clinic owners are also doctors or dermatologists, and as such have received their training in a medical school run by the public hospital. *“Being a teacher at a medical school provides a good opportunity to learn new medicines and technologies more quickly than others” (CO10).*

It is also recognised that in Thailand, medicine and medical equipment will be tested at a medical school before being used in any products being launched by clinics and private hospitals. To prospective clients, the findings suggested that whether the medicine or medical equipment has originated in a developed or less developed country. What is considered more important is the culture of ethical testing of products which is undergone by researchers

and expert medical trainers before such products are sold to other doctors. This culture creates an opportunity for teachers to learn how to develop expertise and skill in using equipment and to disseminate it throughout the local medical profession, in order to provide the highest quality medical treatment to domestic and international patients.

Also in regard to patients' views on whether internationally accredited medical facilities were necessary, one of the tourist-patients said that it was "*safer to be treated by a dermatologist who works at medical school*" (TP23). These criteria served for such tourist-patients as insurance that their non-invasive aesthetic medical treatment would be conducted effectively and safely. That is, such considerations were seen to reduce the likelihood of risks for tourist-patients having medical treatment outside their home country. "*When being treated by a medical professional, it is guaranteed that the non-invasive aesthetic medical treatment will be performed well and that the results will be as good as expected*" (TP33). An added advantage from being treated by such medical professionals was that it was understood that these doctors would have had considerable experience of performing these medical treatments on volunteer patients at medical school in order to learn how to use the aesthetic medicine and aesthetic medical equipment properly and more effectively. It was recognised that in this "apprentice" culture, doctors would also learn how to control the associated factors or parameters to get the best results from the aesthetic medicine and aesthetic medical equipment. It is a given that other doctors not having the opportunity to work in a medical school would have fewer chances to try out aesthetic medicine and aesthetic medical equipment with patients, meaning that their experience of aesthetic medical treatment would be significantly different. That is, although they might

be able to create effective results in any single treatment, there would be no absolute guarantee that this treatment would be reliably replicated. More importantly, one good treatment could not guarantee the best result for every patient. Therefore, gaining skills while working at a medical school is seen as critical in the development of skilled doctors.

The interviews with government representatives and clinic owners confirmed that *“many Thai doctors have international qualifications and western experience that could be advertised to make potential tourists more comfortable with receiving aesthetic treatments and services in Thailand”* (GR2). But this picture may be changing: although doctor qualifications have traditionally been obtained from medical schools abroad, certification *has become “another issue”* (GR2 and CO9). *“It means that there is a new alternative choice to make patients more comfortable as well, which is getting certifications instead of qualifications. This is useful for doctors who do not have qualifications from abroad, whether because they are too old to apply, or have had limited time or financial problems”* (CO8). *“It was reported that taking a short course, training, or attending meetings or international conferences organised by international medical schools or private organisations may be a good alternative”* (CO12). For example, if a Thai doctor is interested in the technology of radio frequency lifting for skin tightening treatment (named “Thermage” in the U.S), he / she can opt for a four-week training course with a professor in this area in the U.S., then return to his / her home clinic having acquired a high skill in this particular area, and with the capacity to offer effective treatment in this area to patients. A certification derived from this type of training will normally be published and advertised at the reception area in each clinic as a way of reassuring

international tourist-patients that a skilled and specialised doctor will operate the required treatment.

According to Bookman and Bookman (2007), when shopping around for medical tourism products, potential patients seek evidence of quality. Findings from a government representative confirmed that evidence of practitioner qualifications is an important issue for increasing sales. This means that tourist-patients consider the qualifications and certifications of doctors before making their decision. If doctors or clinics cannot provide a satisfactory demonstration of quality, it is understood that tourist-patients will take their business elsewhere.

However, it would appear that some Thai qualifications and certifications such as training certificates issued by private hospitals are not considered truly acceptable by potential tourist-patients (GR2 and CO11). Bookman and Bookman (2007) suggest that to break through these barriers, private and public institutions in developing countries have to abide by international standards to ensure certification and licensing.

5.3.3 Cost saving

The interviews confirmed that treatment in Bangkok was considered significantly cheaper than the costs of similar treatment in patients' home countries. *"Thailand has cornered a substantial part of the market because its medical fees and non-invasive aesthetic medical treatment charges are significantly lower than those of other possible medical tourism destinations"* (CO11). According to Horowitz, Rosensweig and Jones (2007) and Healthbase (2009), saving money on overseas medical treatments and

procedures is the first motivation to travel abroad. For patients in developed countries such as the U.S., the U.K. and Canada, the medical cost at home is not affordable (Bookman and Bookman, 2007; Burkett, 2007; Carrera and Lunt, 2010; Chanda, 2002; Connell, 2006; Connell, 2011; Hall, 2011; Horowitz and Rosensweig, 2007; Howze, 2007; Singh, 2008; Singh, 2014). Thus it was found that the cost of medical treatments in Thailand is significantly lower compared to the medical treatments in developed countries (Bookman and Bookman, 2007; Connell 2006; Hall, 2011; Singh 2008). In comparison to the U.S. most cosmetic treatments are around 50% less expensive in Thailand than in the U.S. The average cost of a facelift in the United States is US\$6,556 (Chuang *et al.*, 2014) compared to US\$3,000 in Thailand (Yanhee, 2016). This includes non-invasive aesthetic medical treatments.

Findings taken from Government representatives and tourist-patients stated that in Thailand, cheaper treatment has led to the increasing number of tourist-patients. Price differentials between most Asian states and more developed countries are considerable and are presently diverging even further (GR2 and CO8). It can be concluded that the price differentials for non-invasive aesthetic medical treatments and services are particularly significant since these procedures are not normally covered by regular health insurance. For example, *“a face-lift in Thailand costs about a third of that in the United States”* (CO10). A facial resurfacing treatment by microdermabrasion which would be about £95 per treatment in a UK clinic was found to be only £20 at a luxury aesthetic clinic in Bangkok (TP43 and TP44).

In addition, a government representative pointed out that in regard to cost issues, *“currency fluctuations can be another significant influence”* (GR3). Since the Asian economic crisis in 1997, the weaker Thai Baht has played an important role in keeping the price low in the opinion of international patients. For example, after 1997 US\$ 1 could be exchanged for up to 35 THB, which could only be exchanged for 25 THB before that period; this makes a difference of 40%. Head (2015) and NaRanong and NaRanong (2011) stated that during the Asian economic crisis, many Thai hospitals and clinics needed economic diversification because local patients could no longer afford private health care. In seeking therefore to diversify their offerings to an international market, another government representative confirmed that *“the weaker Thai Baht is one of the main reasons for creating Thai’s strength and competitiveness”* (GR5). Bookman and Bookman (2007) support this study in observing that the price of a service export reflects the value of the currency in which it is sold. As a result, although since 1997 the Thai currency has been weak on international markets, it has enjoyed certain advantages over other countries with strong currencies (CO14).

Cohen (2012) and Hun and Hyun (2015) suggest price differentiation between countries for similar procedures has allowed patients to shop around for the best treatment at an optimal price. This has led to a rise in the number of aesthetic clinics in Bangkok taking advantage of the chance to serve potential tourist-patients at lower cost. Price differentials between all Asian countries and the West remain considerable. This was confirmed by a government representative who explained that *“Thailand can offer liposuction and breast enhancement surgery for a fifth of the rate this would cost in Germany, hence it has focused on this particular European market”* (GR4). The reason for this is a lower labour cost in Thailand. In addition to this, Lee and Spisto (2007)

state that labour, in a large population, is relatively cheap in developing industries. Therefore, many of the activities involved in financing a hospital can be managed at a cheaper cost because salaries are generally lower and, in turn, the savings are passed along to the patient who pays much less for the same healthcare service than that found in their home country.

“The promotion of half price and buy one get another one for free is a very attractive marketing strategy” (CO13). “It has attracted tourist-patients in many cases as price is a sensitive issue” (CO15). In addition, “as long as tourists can afford to visit Thailand for vacations, in particular staying in a luxury hotels in Bangkok, it is not that difficult to motivate them to buy non-invasive aesthetic medical treatments with half price promotion” (CO12). This segment of the tourism patient market has both the money and the will to buy aesthetic medical services. One tourist-patient mentioned that “We have to maintain our beauty and youthful look in order to stay in our society. It is normal for me to have both invasive and non-invasive aesthetic medical treatments. I am considering the price and quality as the most important issues. I knew that the cost of the medical service in Thailand is much cheaper than in my country but when combined the advantage of the promotion of buy one, get one free, then I can be certain that I cannot resist it” (TP32).

Another crucial factor in keeping costs low is the low cost of production of medical drugs relative to the Western market. Although charges for drugs used in aesthetic treatment charges are not cheap for Thais (GR2) this is less the case for potential foreign patients. For example, in Bangkok the botulinum toxin injection would cost about 6,000THB (\$US200 or £120) per treatment area. In terms of Thai income, the minimum wage in Bangkok being only

300THB (\$US9 or £6) per day, there are few chances for the average Thai person to indulge in such luxuries. On the other hand, the minimum wage in developed countries is much higher than in Thailand, making it more likely that an average wage earner there would be able to afford aesthetic medical procedures. For example, since October 2015 the wage for workers aged 21 and over in the U.K. is £6.70 per hour (GOV, 2016); by contrast, it is only 78 pence per hour in Thailand.

Therefore, it can be concluded that the cost of labour, that is the cost of paying Thai workers, has kept the cost of the treatment down in Bangkok. One of the clinic owners said "*the non-invasive aesthetic medical treatment charges in Bangkok are cheap because of the low cost of production such as labour costs*" (CO16). This finding supported the study from Carabello (2008) that employee wages are relatively low in developing countries. Bookman and Bookman (2007) also suggest that the medical tourism destination countries have to keep the cost of labour low to be competitive.

The benefits of keeping production costs down are obvious. Linked to this, Connell (2006) argues that low production costs translate into savings that can be passed on to patients in the form of lower prices. When the cost of providing medical treatment is low, aesthetic clinics can hire more nurses and support more staff per doctor than in developed countries where the labour cost is higher. *This helps the clinic's owner to employ more skilled and non-skilled staff to provide a better service for tourist-patients* (CO17). In addition to this, Ramirez de Arellano (2007) concludes that trade in health care services now includes countries promising first-class services at third-world prices.

Of course, price-cutting is an integral part of international medical tourism. According to Bookman and Bookman (2007), a similar pricing strategy is pursued by suppliers of medical tourism around the world, whose aim is to maintain or increase market share by reducing prices. Thus, at an aesthetic clinic in Bangkok, price reductions may come with other promotions or packages (CO9). For example, the clinic will offer a non-surgical face-lift programme along with a free non-surgical fat and cellulite reduction programme by carboxy therapy (CO11). It can be argued that the number of aesthetic clinics in Bangkok has dramatically increased (GR5) by means of this competitive strategy. Therefore, aesthetic clinics use price to compete with each other, as the main non-invasive aesthetic medical treatments and equipment are the same from clinic to clinic. This is another crucial reason for keeping the price down.

Where price is a major consideration, this may call into question the quality of what is being offered (GR4 and CO10). This question can be answered by the competitive price strategy, low production costs and the currency fluctuation. As mentioned in the previous section, the price of non-invasive aesthetic medical treatment in Bangkok is cheaper than in other countries because the weaker Baht and low cost of labour. Therefore, in this case the low price of treatment is not an issue, nor is it linked to any lowering of the quality of aesthetic treatments (GR2 and CO12).

5.3.4 State-of-the-art technology

The high technology facilities at non-invasive aesthetic clinics in Bangkok are increasingly attracting international tourist-patients from both developing and developed countries (GR2 and CO10). For example, "*Apex Skin Center*

recently built a Thai traditional house-based clinic at Sukhumvit area with a hundred million Thai Baht (not including land) investing on medical equipment and facilities, to be reserved entirely for foreign patients” (CO9). To keep their customers satisfied, non-invasive aesthetic clinics in Bangkok often look more like luxury spas than sick bays. More importantly, international patients are treated using the newest equipment and technologies, which they may already be familiar with in their home countries (GR2 and CO9).

For Thailand to become the most competitive global non-invasive aesthetic medical tourism destination country, Thai doctors understand that they need to upgrade technology regularly, and absorb western medical protocols (GR4 and CO9). Since economic liberalisation in the mid-1990s, private hospitals and clinics have expanded and have found it easier to import technology and other medical goods from overseas, thus bringing infrastructure in the best hospitals and clinics to western levels (GR2 and CO10). This is because these hospitals have potential international patients who have ability to pay for expensive treatments.

While technology has become much the same as in the developed countries, Thai doctors and nurses are experienced and well trained in western technology, processes and procedures (GR5). In other words, there are plenty of training courses, medical meetings and conferences. These are provided by well-known medical equipment manufacturing companies from abroad. This means Thai medical staff can easily gain knowledge of new technology from overseas by attending meetings, many of which are free of charge or sponsored by the medical equipment companies (GR2 and CO9).

In Bangkok, the medical equipment manufacturing companies provide free conferences and meetings to doctors and clinic owners because they want to promote their products and motivate medical business owners to buy the medical equipment, which they sell to aesthetic clinics around the world (GR2 and CO12). As a result, the doctors and clinic owners will gain the latest knowledge from a medical professor or the product expert from overseas such as new protocol of acne treatment by fractional laser or new technique for Botox injection.

5.3.5 Excellent service providers

Non-invasive aesthetic medical treatments and services commonly received by tourist-patients at non-invasive aesthetic clinics in Bangkok include botulinum toxin injections, mesotherapy injections, fat and cellulite treatments, microdermabrasion, chemical peels, laser skin resurfacing, facial revival and nourishment, facial line correction, skin rejuvenation, skin tightening, hair removal, tattoo removals and anti-ageing face-lifting using radio frequency to lift skin and stimulate collagen (see each treatment detail in Chapter 2). In this context, *“non-invasive aesthetic clinics or clinic chains have become integrated into the non-invasive aesthetic medical tourism industry (CO9)”*.

In addition, *“the service providers also arrange airport transfers, reserve the hotels and help to organise local tours for their tourist-patients and relatives (CO14)”*. For example, *“the hospitals and clinics in the south of Thailand offer special packages, which focus on aesthetic medical treatments and services to revitalise the medical tourism industry; this happened after the 2004 tsunami (CO8)”*. *“It provided scheduling of medical treatment; arranged travel and accommodation, car hire, cruises, tours or other vacation services too. I*

found that this service provider was excellent and I was very happy and satisfied with the services (TP34)". In such a highly competitive business environment, the quality of service is also seen to play an important role in ensuring the success of the non-invasive aesthetic medical treatment business in Bangkok.

It is understood that in many developing countries, the service sector has become an increasingly major contributor to the economy, while the previously strong agriculture sector is gradually being replaced by the industrial sector. *"This includes what has recently happened in Bangkok, Thailand (GR2)*". With regards to this, Harryono *et al.* (2006) state that in 2006, the service sector contributed 46% to Gross Domestic Product (GDP) in Thailand, which was higher than that of the industrial and agriculture sectors. In addition to this, the contribution of travel and tourism to GDP was THB1,037.03 billion, which is 8.6% of GDP in 2014, and is forecast to rise by 6.7% per annum, from 2016-2025, to THB2,045 billion in 2025 (World Travel and Tourism Council 2016). *"Medical tourism and particularly non-invasive aesthetic medical tourism has played a significant role in the service sector for Thailand's economy (CO13)*". According to Turner (2007), private hospitals in Thailand started expanding their international customer base after the Asian financial crisis devastated Thailand's economy. Linked to this, NaRanong and NaRanong (2011) state that as the Thai baht was devalued, the Thai stock market plunged, many Thai families lost their savings, the cost of importing medical devices into Thailand multiplied and local citizens could no longer afford to purchase private health care.

In summary, this research found that Bangkok has the ability to compete with other medical tourism destination cities. It has competitiveness and potential facilitating factors. These crucial factors have the capacity to contribute to the development and promotion of non-invasive aesthetic medical tourism industry in Thailand.

5.4 Barriers and obstacles to the development and management of non-invasive aesthetic medical tourism in Bangkok

According to Sury and Montriwat (2007), a synopsis of medical tourism shows that currently there is a lack of identifiable stakeholders, global governing legislation and a concise benchmark definition for medical tourism enterprises. In addition, this form of medical tourism relies on inputs from well-known medicines and overseas equipment, which is a knowledge specific industry (GR2 and CO9). Therefore, investment in medical tourism requires certain competencies (Bookman and Bookman, 2007). Sufficient knowledge within the non-invasive aesthetic medical tourism industry and knowledge of marketing cosmetic care and leisure together are also prerequisites for operation within this niche market (Sharpley, 2005).

Apart from the above six categories that have helped to promote Bangkok as a non-invasive aesthetic medical tourism destination, this research also found that there are some other factors which arose from the data as influencing the development and management of medical tourism in Bangkok. These factors were presented in Table 5.2 as barriers and obstacles to the development and management of non-invasive aesthetic medical tourism in Bangkok. The details of these factors will be explained in the following sections.

Barriers
1. The need for better foreign-language communication skills
2. Shortage of staff in public hospitals
3. Performance of medical treatments in non-clinical locations
4. Missing follow up
5. Common selling points and over supply
6. Law and regulations

TABLE 5.2 The barriers to the management of non-invasive aesthetic medical tourism in Bangkok

5.4.1 Communication skills

Marketing communication is seen to be a crucial barrier to medical tourism, and in particular to non-invasive aesthetic clinic in Thailand (GR2 and CO10). According to Sharpley (2005), globalisation and improved communication technology are externalities within the global economy that may help to develop this kind of tourism. This is because people from countries where health tourism is pursued can access information about health treatments abroad and even consult with doctors and experts in foreign countries by video conferencing among many other such communication media.

“English is not the first language for Thai people, so this is a big barrier to communicate with patients who come from developed countries such as U.K. and U.S.” (GR2). In general, it would appear that the ability of medical staff to

be able to communicate with foreigners in English is seen as acceptable for general social purposes, but is as yet underdeveloped as far as medical matters are concerned. There are many technical words and terms related to medical processes which need to be learned, the communication skills needed to discuss unexpected results and complications. Thus a well-developed set of English language and communication skills is considered essential in order to make conversations with Thai practitioners truly understandable to native English speakers.

An obstacle is that nurses, nurse assistants and other staff in the clinic may have difficulty of achieving an appropriate medical English standard because this is only taught in medical school. As a result, the lack of appropriate language skills can be seen as a barrier to the development of customer services in this sector. For instance there is a danger that tourist-patients may get confused easily when they question staff other than a doctor. A further complication is that *“people who are from one of the main sources of medical tourists, the Middle East, particularly Dubai, Bahrain and Lebanon would prefer to communicate in their own languages rather than in English” (GR2 and CO9).*

In general although many Thai doctors are trained overseas and most can speak English fluently, this does not include most Thai nurses and nurse assistants. Yet these are the individuals who attend to patients' day to day needs, and most need the language to communicate. Linked to this, one of the tourist-patients said *“difficulties communicating between the patients and medical staff are all too common and these breakdowns can sometimes have tragic consequences” (TP39).*

There is a cultural issue seen to be arising from this language barrier, how to express cultural expectations and differences. It is understood that different countries have different religions and culture, incorporating diverse beliefs, traditions, and practices. Aspects of potential difference must be considered when serving international tourist-patients from different religions and cultures (GR2 and CO8). Given that the majority of Thai people are Buddhist, they find it difficult to conceive of the Muslim need to pray five times a day, to observe the restrictions of halal food, and rules of modest decoration and dress. Therefore, in order to be able to attract more international patients from different religions, Thai business owners have to overcome this culture gap.

Another issue is the quality of service. The problem of quality may come from the rise in numbers of un-professional aesthetic doctors rather than from the cheapness of prices. In other words the rise in new aesthetic clinics being opened by doctors who do not have enough experience in non-invasive aesthetic medical equipment and medicine may lead to unexpected and unsatisfying results for patients. It does happen that doctors are not qualified and certified, nor specialised in dermatological treatment, offer their services in this area.

Linked to this, according to NaRanong and NaRanong (2011) and Sury and Montriwat (2007), an increasing tendency to discredit cosmetic medicine comes mainly from clinicians who do not practice and do not want to practice. These doctors often deliberately close their eyes to progress as well as to the constantly occurring changes in medical knowledge but they are concerned only about profit (GR2 and CO9).

5.4.2 Law and regulations

Law and regulations are seen as another barrier to the development and management of non-invasive aesthetic medical tourism in Thailand. The interviews confirmed that *“law and regulations in Thailand are not really protecting patients”* (GR4). *“Although legal procedures for obtaining compensation do exist in Thailand, they are often inconvenient and impractical particularly when the injured patient is a foreigner”* (GR2). However, *“the amount of money for damages awarded by courts is often less than what exists in Western countries”* (TP34). Moreover, *“tourist victims of medical malpractice also have limited options upon their return to their home countries, as most insurance plans will not cover repairs needed to fix overseas treatments”* (TP40).

Clearly, given instances such as these, international tourist-patients may feel insecure of the outcomes in undertaking any complicated, high technology or advanced treatments in Thailand. One of the tourist-patients mentioned that *“Looking at the images of some celebrities that have paid for the treatments and its gone wrong is enough to put anybody off. But if people want it, it should be regulated to protect the consumer”* (TP41).

On the other hand, participants noted that non-invasive aesthetic medical treatments had fewer side effects and complication in comparison to cosmetic surgery procedures. It was however, acknowledged that if for some reason a treatment or post-treatment went wrong, this could create risks for tourist-patients. One interviewee argued that *“The Thai government urgently needs to create new regulations and laws for this industry that protect patients and in particular tourist-patients. The issue is wider than just cosmetic surgery, as*

non-surgical cosmetic procedures and laser treatments are also used to treat patients. The key issue here is knowledge of medical anatomy, which takes years of training and experience” (TP35).

In addition, concern was voiced that *“in Thailand, the clinic owner has no need to be a doctor, but by law all medical treatments must be administered by a doctor” (GR5).* This implication being made at this point is that the quality of medical care may depend on the consideration of the clinic owner. In other words, *“the quality of medical care may deteriorate if business owners, in considering their profit as more important than the quality of medical care and patient's safety, resort to employing unqualified medical staff or using fake or duplicated medicine” (GR3).* Such practices would inevitably lead to unsatisfactory or unexpected results and complications.

Where there does exist cause of complaint, this problem is a crucial issue for the doctor and clinic owner who have performed the treatment and managed the business. It is considered their responsibility to solve any problems arising from side effects and complication, or indeed to find evidence to establish their innocence in cases of unwarranted blame. In such instances, it falls directly to the owner and practitioner to seek compromises and to negotiate with their patients. Compensation is then considered as an alternative choice where the problem cannot be solved by other methods. In some cases, if the compensation is significantly high, this problem will be in the end a severe financial risk (see more details in Chapter 6) to the doctor and clinic owner.

On the other hand it can be argued that *“Thai doctors pay very little for malpractice insurance, compared with Western doctors, which in turn helps keep the cost of medical care down” (CO9).* In order to protect the doctor and

the clinic owner from paying too much compensation, *“aesthetic clinics in Thai’s neighbouring countries, such as Singapore, have obtained support from insurance companies, in case clinics are sued by their patients”* (GR2). When the compensation becomes an issue, money will be paid to the patients by the insurance company rather than by the doctor or clinic owner. The insurance can be bought yearly with different options, terms and agreements.

In spite of such protective solutions, it was found that *“the majority of non-invasive aesthetic clinic owners in Bangkok do not buy insurance to protect themselves or their doctors from being sued by their customers”* (CO8). One of the informants said *“There is no need to buy insurance for non-invasive aesthetic clinics as there is little to no risk regarding the nature of the treatments”* (CO11). This may explain why the buying of insurance for clinics is not popular in Thailand. It is instead generally believed that because non-invasive aesthetic medical treatments are not surgery, its procedures are not complex, serving merely to help patients look more youthful. It is generally considered that treatments such as hair removal, tattoo removal and carboxy therapy do no harm to patients at all. Therefore, *“buying insurance is just wasting money for nothing”* (CO8).

Notwithstanding this, employed doctors have purchased insurance to protect themselves as it is required by the private hospitals in Bangkok (GR5 and CO9). Personal insurance can be an advantage for doctors working in a non-invasive aesthetic clinic on a part-time basis. When the problems of side effects and complications present to doctors who performed the procedures the insurance is a guaranteed protection against doctors having to pay excessive compensation. *“Working in the clinic for an average £40 per hour*

most doctors will not be able to cover the cost of compensation, which might be worth up to £20,000 in some cases” (CO10).

It can be argued that Thai law and regulations will not be a barrier to promoting non-invasive aesthetic medical tourism in Bangkok if they are stringently applied. At times it appears that Thai people tend not to respect the law and regulations. But the process of auditing non-invasive aesthetic medical clinics via the Thai FDA, should ensure that clinics operate with respect to law and regulations. This would include examples of good practice such as doctors staying in the clinic during opening hours at all times; treatments always being performed by a doctor or well-trained nurse; infected waste being appropriately disposed, the clinics should not advertising themselves as skin clinics unless they employ a trained dermatologist; and many more practices.

Moreover, employing doctors only during peak hours is another considerable issue which may pose barriers to success. Having regard to the cost of labour, clinic owners have to minimise these costs in order to make the most profitable business. *“Early in the day from 10 am to 12 noon and late evening from 7 to 9 pm there will be few patients and sometimes there will be no patients at all especially on weekdays” (CO12).* Therefore, *“Operating the clinic by well-trained non-medical staff will be another potential option to save the cost of labour as the salaries of well-trained staff are up to 50 times cheaper than those paid to doctors” (CO13).*

Obviously, it is seen as very risky to operate a clinic without doctors, and patients will normally consult with the doctors if the treatment is new for them (TP23 and TP24). However, in many clinics it is not the doctors themselves

who administer some treatments such as carboxy therapy, Iontophoresis and Phonophoresis, but other staff in the clinic. That is, after making the decision to buy the service, tourist-patients will be brought to the treatment room, where sometimes the treatment may be observed by the doctors; but not every time. Participants in the study did not report having a problem or feeling uncomfortable about this issue, (TP26 and TP28) since their treatment has gone well for the first visit. And so it was not anticipated that following treatments, also administered by medical ancillary staff rather than a doctor, would be a problem for tourist-patients.

Moreover, it is worth noting the view of some participants that *“some well-trained and experienced medical staff know how to operate some non-invasive aesthetic medical equipment such as Iontophoresis, Phonophoresis and carboxy machines better than doctors”* (CO14). It was understood that these machines were easy and uncomplicated to use, in spite of the fact that by Thai law, such medical equipment must be operated by a doctor. *“Comparing labour costs of a doctor and other medical staff, operating a £20 treatment for 45 minutes by a doctor would not be a profitable choice for the clinic owner”* (CO15). From this perspective, the problem of not following Thai law and regulations becomes more real. It can be seen that non-invasive aesthetic medical treatment is not a risk-free treatment if not monitored properly, In addition, by definition it could be argued that the treatment comes with some kind of risk as it is described as a type of medical procedure. *“When it comes with the word ‘medical’ it means there will be some scientific result with human being”* (CO8). The implication is that there should be no exceptions to the safety ruling for any type of medical treatment. In the worst case scenario, any medical treatment may pose a life risk to patients. Therefore, *“considering only saving labour costs to make the most profitable*

business from the medical industry creates risks not only for the business operators but also for valuable customers” (GR5) who may end up lodging complaints and claiming compensation.

The principle government body overseeing the medical community in Thailand is the Thai Medical Council. Statistics are kept concerning doctor misconduct and there is also a complaint procedure (GR2 and GR3). In cases where a patient claims that he or she has been a victim of medical malpractice, the Thai Medical Council will first investigate the claims against the doctor or doctors in question in order to determine, in their judgment, whether malpractice did indeed occur. The council may then advise the police as to the necessity of a criminal investigation. These processes take a long time to finalise the result from judgement. Tourist-patients may have difficulties in finding the evidence to prove their rights, as they are not in their society and culture. However, *“these problems would not arise if clinic owners showed appropriate concern for the safety of tourist-patients rather than only for the clinic’s profit and money in their pockets” (GR2).*

5.4.3 Performing medical treatments in non-clinical locations

There are a number of spas in Bangkok identifying themselves as “medical-spas” in order to provide medical treatments for their customers. One of the clinic owners confirmed that *“medical-spas offer medical procedures such as skin peel, carboxy therapy and botulinum toxin injections as well as standard beauty treatments” (CO12).* Another one also observed that *“it appeared that untrained staff often give the medical treatments to patients in the spa even though that is illegal” (CO14).* It is worth noting that in order to perform any type of medical treatment by any type of medical equipment in Thailand, the

legal position is that it has to be done by a doctor and secondly it has to be conducted in a clinic or hospital.

However, medical-spas increasingly offer medical procedures as their traditional treatments such as facial massages and hair removal by waxing are no longer attractive to customers. Their loss of popularity is ascribed precisely to their not being medical treatments, so that they only serve a temporary purpose of relaxation or pleasure. Such treatments are not seen to offer any scientific results on customers' skins, unlike medical procedures. One of the government representatives suggested that *"It is good to stop and think. Seeking the medical treatments, patients must check the location. The medical treatment should not take place in someone's home, a hotel room or at a party. Medical staff should always be on hand for the rare occasion that something goes wrong"* (GR2). Another government representative also added a remarkable point that *"The public should seek environments under the care of a properly qualified physician rather than at a shop or hair salon"* (GR3). In addition, *"Non-surgical does not mean non-medical. Injectables, peels and lasers should all be performed by a properly trained clinician, a plastic surgeon or a dermatologist. It is essential that people do their homework as these treatments can affect not only their appearance but health and safety as well"* (GR4).

5.4.4 Shortage of staff in public hospitals

The findings showed that a majority of Thai doctors and nurses would prefer to work in the private sector in the city, rather than the public sector in a rural area with at least 250 outpatients per day, in the meantime receiving very low pay from the government (GR2 and CO8). This discrepancy of rewards leads

to an inevitable brain drain from the public to the private sector, and worryingly, represents a problem “*unequal system for Thai local people because some business owners, doctors and nurses would prefer to serve foreign patients rather than Thai local people*” (GR2). That is, it has been noticed that international tourist-patients have the ability to pay for services, which many local people cannot afford.

Thus, the inequitable medical system for local Thai people might be seen as another barrier to the success of the non-invasive aesthetic medical tourism industry in Thailand. Undoubtedly, money from international patients has provided several improvements for Thai hospitals and clinics (GR2 and CO14), in both the quality of technology and the quantity of resources (GR2 and CO9). Alongside this it can equally be argued that the economies of countries like Thailand have profited from the exchange. But there still remains an issue that while the industry of medical tourism has aided the economic system in Thailand overall, the provisions available to foreigners are often unattainable to the country’s own citizens. Linked to this, Sury and Monriwat (2007) state that prioritising the interests of foreigners over its own citizens raises issues of justice and health equity. Although there is a two-tiered system, where a price difference exists between services offered to foreign patients and Thai patients, the latter are not always able to pay for the same procedures. The allocation and affordability of medical resources is also seen as increasingly inequitable.

Because of the difference in the monetary values of Eastern and Western nations, what international patients declare as a cheap service is still considered quite unaffordable to many Thai clients. Moreover, while doctors are attracted to the promise of rich patients from urban cosmetic tourism,

many rural areas in Thailand lack modern medical equipment and the low number of physicians available in these clinics often lack experience. As the best doctors and medical staff are serving medical tourists, their attention is diverted to these foreigners and the quality of care to locals often suffers as a result. Although NaRanong and NaRanong (2011) state that the income generated from medical tourism is ultimately beneficial, only the wealthy Thai citizens and international patients who travel to Thailand for services are able to reap the benefits. This exchange further delineates the social classes in Thailand.

One outcome has been the more rapid rise of a private health sector in medical tourism destinations, as the economic benefits from employment in this sector have become even greater. According to Whittaker and Leng (2016), a higher earning capacity plays a small part in reversing the brain drain from the public to the private sector. A significant issue in Thailand is that many doctors and nurses do not want to work in remote areas.

Another barrier is the inequitable public medical policy. It cannot be argued that aesthetic medical treatment is ever done in urgent circumstances, given that patients do not come to a clinic for such procedures with a high temperature, high blood pressure or any difficulty breathing; if so, then patients can wait for the treatment until their health improves (GR2 and CO14). But resources come to this area of medicine while genuine areas of need for more urgent medical treatment are neglected. Pocock and Phua (2011) suggest that medical tourism is a growing phenomenon with policy implications for health systems, particularly of destination countries. While the private sector and governments in Southeast Asia are promoting the medical tourist industry, the potential impact on health systems, particularly in terms of

equity in access and availability of good medical care to local consumers, is unclear. Finally it would appear that doctors and nurses will run slightly higher risks of being sued by patients in the public sector, for example, as a result of a patient's having an allergic reaction to an emergency injection or other medication. This is another motivation for doctors and nurses to escape from the public sector.

Ramirez de Arellano (2007) states that the increasing numbers of doctors moving to the private medical sector in Thailand has decreased equity in access to health care for the local population. The effect of these trends thus reinforces a two-tiered health system, with different standards for different economic classes. In addition Cochrane (2008) points out that expansion of the private sector may be at some cost to the public sector, where patients have very limited ability to pay, if skilled health workers move out of public sector. The recent boom in medical tourism has occurred in a context where most of Thailand's population lives below the poverty line and has no access to basic health care and where infant and mortality rates are high.

Linked to this, Henderson (2004) states that ethical issues have become significant, both in terms of equity and in the more competitive involvement of the market in medical care. In Thailand, there is a huge drain on the health public sector (GR2 and CO10). To practise medicine in Thailand doctors must pass a Thai language examination, so the booming private sector can take staff from only one place. Hence in the past where there was a brain drain from doctors wanting to emigrate abroad to make more money, now the brain drain exists as part of their own society, as they only have to leave the country to move to the city and the private sector (Whittaker and Leng, 2016).

5.4.5 Common selling points and over supply

Currently, leading non-invasive aesthetic clinics in Bangkok look quite similar to each other (CO9). They have similar equipment, aesthetic medicines and aesthetic treatment packages. For example, if a customer wants to undergo a facelift without surgery, clinics would offer the Thermage® programme and finalise it with Botox® injections to get the best result. *“It is a very common selling point so that finally this could create over supply in the non-invasive aesthetic medical tourism industry”* (GR2). Running a business in the competitive market situation at present, one of the clinic owners suggested that *“aesthetic clinics need to be different and unique in terms of products and services, but it seems that this is very difficult to do in practice because most of the aesthetic clinics in Bangkok continue offering the same patterns of product and service with no new creations at all”* (CO10).

5.4.6 Missing follow up appointments

It is a fact that non-invasive aesthetic medical treatments need a follow-up to observe the actual results. This may take from days up to four weeks before final results appear (GR2 and CO15). Although some treatments are advertised as needing only one visit to complete the treatment, this may be reduced over the reality that any ensuing complications and post-treatment costs may have to be managed in the international tourist-patient's home country, if they may not be able to stay longer in Bangkok. It means that international tourist-patients are in a sense responsible for any additional cost themselves.

5.5 Future market trends

In the light of the recent political crisis that has affected the country's tourism sector, Thailand seeks to promote itself as a leading destination for medical tourism. Over the past ten years, Thailand has been one of Asia's hotspots for medical tourism, with its leading hospitals known for offering a high standard of healthcare at a reasonable cost (GR2 and GR3). The number of foreigners visiting Thailand for treatment has increased significantly. Lin *et al.* (2009) state that in 2003 the production value of medical tourism increased to US\$490 million, which attracting 730,000 visitors seeking treatment in Thailand. Linked to this, Pocock and Phua (2011) estimate that Thailand earned Baht 36 billion (US\$1.1 billion) from 1.4 million foreign patients in 2006. In addition, the number of international patients in Thailand increased to 3.2 million in 2013 (Huang 2012) while Hanefeld and Smith (2016) state that 7 million foreign patients being treated in Thailand in 2015. The growing popularity of traditional Thai and alternative medical treatment has also contributed to the country's renown for medical tourism.

In Thailand, Bangkok remains the leading destination for medical tourism, with Phuket becoming the second preferred destination for medical treatment in terms of patient volume (CO9). In the near future, if international tourist-patients can choose, *they will prefer non-invasive aesthetic medical treatment, instead of the invasive ones. This is because they do not want to suffer any pain from aesthetic medical treatments or surgery at all* (GR2 and CO11). For example, carboxy therapy is a new choice of injecting CO₂ to reduce fat and cellulite. The results can obviously see within 7-10 visits with no scar, no pain and no recovery time. This is totally different from fat and cellulite removal by liposuction. *"We believe there will be another choice that*

provides a better result and much less pain in the near future" (GR2 and CO12). An aesthetic medical treatment has been developed rigorously in the past ten years. It has been transferred from a cosmetic surgery to an alternative non-invasive aesthetic medical treatment, which has less pain. As a result, bleeding, pain and needed recovery time will not be the considerable issues. Then, cosmetic surgery will only play a significant role in particular areas such as nose and breast enhancements.

Furthermore, *"The trend of having brighter skin by using the technique of Iontophoresis, Phonophoresis and a chemical peel such as AHA and a concentrated vitamin C were too basic and too simple"* (CO12). The results from these treatments are not sustained stay for a long period of time, since they treat only the epidermis. This trend will then be shifted from skin brightening to wrinkle reductions and anti-ageing (GR2). It is a more complex treatment and more difficult to treat (CO9). This is because it needs to consider the complexity and the history of the patient's skin. Cosmetic surgery was a popular option in the past. However, the results from surgery are dramatic (GR2). Anyone would be able to tell and recognise the changes. In some cases, the results from cosmetic surgery are initially worrying and strange looking. This is because the wrinkles will be reduced dramatically.

On the other hand, alternative non-invasive aesthetic medical treatment is believed to provide a more natural look than cosmetic surgery. Patients' skin improves gradually, rather than there being any immediate result. In some treatments for example, Intense Pulse Light (IPL) treatment, Radio Frequency (RF) lifting, botulinum toxin injection and carboxy therapy, patients will be able to notice the results within few days or up to several weeks, depending on the

treatment area, patients' age, skin type, reason for treatment and type of treatments.

The alternative aesthetic medical treatment such as the ultra v lift (fine thread lifting) is the newest technology for the purpose of skin tightening. This is attractive to patients who cannot bear the pain of cosmetic surgery, or fear the side effects and complications of surgery. These range from not being able to work for days or many weeks to having to escape from community and society during the recovery period. As a result of perceptions that cosmetic surgery comes with a lot of disadvantages, including physical risks, patients increasingly choose alternative treatments, with the result that the popularity of cosmetic surgery has dropped dramatically.

5.6 Conclusion

In conclusion, it is necessary in order to systematically appraise the present position of the non-invasive aesthetic medical tourism industry in Bangkok to identify the various factors which results in Bangkok achieving competitive advantage and barriers to this industry. This research identified six factors related to Thailand's competitiveness in promoting itself as a medical tourism destination country. These factors are internationally accredited medical facilities, highly qualified medical professionals, cost saving, the benefits of Thailand's location, state-of-the-art technology and excellent service provider. However, a number of barriers to the development of the industry were also identified: these were the need for better foreign-language communication skills, law and regulations problems, performance of medical treatments in non-clinical locations, shortage of staff in public hospitals, common selling points and over supply, and missing follow up appointments. The comparison

of the findings of the competitive strengths and barriers of the development and management of non-invasive aesthetic medical tourism in Bangkok is illustrated in table 5.3. The interviewees also predicted that this market is on the rise, and forecast that the development of new technology would help patients to achieve their aesthetic objectives with less pain and more effective results.

Competitive Advantages	Barriers
Internationally accredited medical facilities	The need for better foreign-language communication skills
Highly qualified medical professionals	Shortage of staff in public hospitals
Cost saving	Performance of medical treatments in non-clinical locations
Benefits of Thailand's location	Missing follow up
State-of-the-art technology	Common selling points and over supply
Excellent service providers	Law and regulations

TABLE 5.3 Comparison of the findings of the competitiveness and barriers of the management of non-invasive aesthetic medical tourism in Bangkok

The next chapter will present the findings and analysis of risks associated with non-invasive aesthetic medical tourism and treatments.

CHAPTER 6

FINDINGS ANALYSIS AND INTERPRETATION: RISKS AND RISK REDUCTION STRATEGIES

6.1 Introduction

The previous chapter presented the findings and analysis of the primary research on non-invasive aesthetic medical tourism development in Bangkok, with respect to competitive advantage in the field and barriers to its development. This chapter aims further to communicate the value of the findings obtained by critically evaluating data in the light of previous research. The main focus will be on the risks, risk perception and risk reduction strategies reported by participants in regard to non-invasive aesthetic medical procedures. The discussion of risk is divided into six categories: functional, physical, financial, psychological, time and social risk. This includes the gathered perceptions of primary and secondary stakeholders who participated in the study, and how they believed such risks could be overcome.

6.2 Risks from travelling abroad for medical care

It could be argued that medical tourism is associated with risks (CO9). According to Carabello (2008) and Jonas *et al.* (2011), travelling overseas for medical procedures involves inevitable risk. In addition, Head (2015) and Horowitz *et al.* (2007) state that such risk is most likely to be as a result of complications in travel for medical procedures. Watson (2007) offers two broad categories of potential risk, which are travel risk and surgical risk. To clarify, travel risk is taken to refer to risks which uniquely arise as a result of travelling abroad; such risks would include the unknown quality of healthcare

provided in overseas hospitals by overseas doctors, as well as the risks associated with travelling long distances by airplane.

As regards this research project, it is useful to subdivide travel risk into two more types of risk. These are functional risk, linked to specific types of selected medical procedure; and physical risk, linked to the act of travelling outside of the patients' home country. The discussion of these two types of risks will be explored in the following section of the chapter. As to considerations of surgical risk, these will not be further discussed in this dissertation, as this research is not involved in examining any surgical treatments (see Chapter 2 for more details).

According to GR3, the clinics' websites highly emphasised benefits while downplaying the risks. In spite of risk being seen by some researchers as endemic to travel for aesthetic medical purposes, there are other researchers such as Lee *et al.* (2012) and Mason and Wright (2011) who observe that medical tourism organisations largely promote the benefits of medical procedures while downplaying the risks. Specifically, despite offering consumers complicated and risky medical treatments, the websites failed to report postoperative or legal concerns associated with them. These authors found moreover that the presentation of benefits and risks differed according to region and type of facility. This also includes the region of Bangkok, and the facility of minimal or non-invasive aesthetic medical tourism products.

Finally, it is reiterated here that although this research refers to non-invasive aesthetic medical treatment as a non-surgical procedure, this is not to imply that it is a risk free procedure. The following section presents and discusses

risks associated with non-invasive aesthetic medical treatments in Bangkok, Thailand.

6.3 Risks related to non-invasive aesthetic medical treatments

A view put forward by one participant in the study was that “*Any non-invasive aesthetic medical treatment, regardless of where, by who and how it is performed, is accompanied with risks*” (GR2). This view is corroborated by previous researchers as being especially common amongst older women considering non-surgical cosmetic procedures. Clarke, Repta and Griggin (2007) illustrated that older women tended to view the procedures as excessively risky, even while they were attracted to using non-surgical cosmetic procedures as a means to increase their physical attractiveness and self-esteem. These researchers found that treatments focusing on the surface of the body tended to be perceived as less risky and more acceptable than those involving injections of foreign substances into the body, such as botulinum toxin or collagen injections (see definitions in Appendix A).

Apart from the perceptions of possible risks that might be incurred during the medical treatment procedures themselves, GR5 stated that “*there is the risk of insufficiently planned access to such medical treatments*”. In regard to Bangkok, for instance, it can be argued that many international tourists travel there initially for leisure pursuits (TP31 and TP33), only deciding to have medical procedures and treatments later (TP28), with only superficial research and planning in regard to the best treatment facility (TP41 and TP42). This kind of risk can then snowball if the selected doctors or clinic owners provide inadequate safety and care, directly affecting the success of the chosen medical procedure (CO9 and TP33).

Having taken such risks into consideration, this research found and classified six categories of risk that are commonly associated with non-invasive aesthetic medical treatments. These are functional (section 6.3.1), physical (section 6.3.2), financial (section 6.3.3), time (section 6.3.4), psychological (section 6.3.5) and social risks (section 6.3.6). The detail of each risk will be respectively explained in the following section.

6.3.1 Functional risks

Functional risk refers to the possibility that a chosen product or service might not perform as desired and thus not deliver the benefit promised. According to the interview with GR4, *“the unknown quality of non-invasive aesthetic medical treatments in Bangkok has brought related risks to both domestic and international patients”*. This is because patients do not know whether the selected treatments will be performed to their best expectations (CO8 and CO10). If these are based on the type of non-invasive aesthetic medical treatments that they might have had at home, even experienced tourist-patients cannot always be sure the results from non-invasive aesthetic medical treatments in an aesthetic clinic in Bangkok will be to a similar standard (GR2). The findings reflect this view: *“tourist-patients perceive risk when non-invasive aesthetic medical treatment is not performed well, or in many cases if not performed as well as it would be in the tourist-patient’s home country” (CO12)*.

The findings from this research identified various factors and reasons why patients may not enjoy the results from non-invasive aesthetic medical treatments that were promised or advertised. The discussions of each factor

or reason in relation to different types of non-invasive aesthetic medical treatment are discussed below.

6.3.1.1 The quality of aesthetic medical equipment

According to GR3, *“the quality of some aesthetic medical equipment in non-invasive aesthetic clinics in Bangkok does not come up to international standards. Basically, patients for aesthetic medical treatments, in particular the international English-speaking tourist-patients, have very good knowledge about the treatments and procedures already”*. It is postulated that international tourists travel to Thailand for vacations and then benefit from aesthetic medical treatments. This is because the cost of the treatments is cheaper than comparable procedures in their home countries. The research found three crucial factors that may influence tourist-patients’ consideration of services at non-invasive aesthetic clinics in Bangkok.

First is the consideration of medical competence. It was reported that *“tourist-patients would normally look at the certificates of the doctors to ensure that the doctors are well trained, experienced and specialised in the field”* (GR5). Doctors’ certificates are normally placed on a wall in the clinic or at the reception area to advertise expertise.

Second is the consideration of price. This was a considerable issue for tourist-patients in this study, who compared prices of a large number of clinics in Bangkok (TP26 and TP33). This is easy to do since in Thailand, there are numerous non-invasive aesthetic clinics in each shopping mall or shopping centre. For example, there are eight non-invasive aesthetic clinics located on the third floor at Central Rama II, Bangkok. In addition, some clinics are

chains with clinics throughout the country; the Rajdhevee clinic for instance has 48 branches in Thailand, one third located in Bangkok (Rcskinclinic, 2016). In some cases, aesthetic clinics have more than one branch in the same building or in a shopping area; such is the case with the Romrawin Clinic. Romrawin had two branches at Central Chidlom, located on different floors (Romrawin, 2016). Such a proliferation of clinics creates a highly competitive market for the non-invasive aesthetic medical treatment industry in Bangkok.

A third consideration is the quality of the equipment used for non-invasive aesthetic medical procedures. This is a major selling point for luxury aesthetic clinics, and one of the potential tools for maximizing tourist-patient motivation is advertising (CO8 and CO10). Tourist-patients tended to choose one aesthetic clinic over others on the strength of their advertised aesthetic medical equipment. Many aesthetic clinic owners advertised that they have specialist use of equipment imported from the U.S., including photographs of the machinery and its brand in their brochures and television advertisements and on their websites. By this means they hope to motivate tourist-patients and encourage them to believe that the treatment will be delivered by branded equipment that they have already seen or have been treated by in their home countries.

However, advertisements alone are no guarantee of quality or safety, and not enough to convince a potential customer to choose to be treated at one particular non-invasive aesthetic clinic in Bangkok (GR4 and CO9). Such caution appears justified, in that some luxury non-invasive aesthetic clinics buy only a single unit of U.S. aesthetic medical equipment (CO9). While this will be visibly installed and operated in the main branch, other branches may

have equipment purchased from other countries, such as China, Taiwan and Korea. The moral and medical question is whether this non-advertised equipment performs similarly and is equally effective. Perceptions appear to be that the use of such equipment does not reassure. *“How could a £10,000 machine perform as well as a £40,000 one? There is no possibility at all. (GR2)”* The main components such as the laser source and the electronics circuit board are totally different in terms of quality and design. *“Core technologies are also different” (GR3)*. The main risk here is that tourist-patients may be inexperienced, and unable to recognise the difference between U.S.-manufactured equipment and cheaper versions. Even for experienced tourist-patients this may be difficult, because *“the clinic owner covers the cheap machine with a luxury cover or even stickers that make it look the same (GR2)”*.

In addition, it is perceived that *“in the case of laser facial treatment, being treated by the same level of energy from two different machines provides two different results (CO9)”*. This is because *“the power from cheaper equipment may not operate at the highest level of energy promised on the product’s nameplate” (GR2)*. The only available evidence of performance that a machine is operating at a required level of energy is what is shown on the screen. The only way of accurately measuring the degree of laser output is by using laser measurement equipment (GR2). *“The cheaper machine provides a lower level of energy when compared with the U.S. machine using the same settings.” (CO11 and CO14)* The intensity of the laser output can be easily distinguished by exposing both laser machines’ output on testing paper. *“Then not only doctors can see the difference but patients can also feel the difference during the treatment. In other words, I would say that the pain levels were not equal.” (TP28 and TP34)*

Feeling a difference in the quality of equipment input may also indicate that patients could feel different levels of pain as a result of being treated by a cheaper or more expensive machine. As evidence for this consideration, an experiment conducted in a non-invasive aesthetic clinic in Bangkok found that at the same settings for a facial tightening treatment, an Intense Pulsed Light (IPL) machine from China caused a pain level of 2 out of 10 while an IPL machine from the U.S. provided a pain level of 4 out of 10 (CO8). This experiment was tested on patients' cheeks, with one machine treating the left, the other the right cheek. Apart from the level of pain experienced by the patient, the degree of redness was measured as an indicator of the degree of intended skin damage. At the end point of the treatment, each of the patient's cheeks looked different. The expensive machine provided a redness that indicated a more aggressive degree of damage than the cheaper machine. This is important as in such treatments, a deeper injury of the skin means a better result (CO9). The lesser degree of damage inflicted by the cheaper machine suggested it was only capable of treating the epidermis. But for effective results, the laser must impact on the underlying dermis, without which result the skin cannot be tightened.

Although the quality of treatment and equipment is therefore a crucial consideration, this consideration gives rise to a tension in regard to the consideration of cost. It can be argued, for example, that using cheap and unbranded devices incurs lower medical equipment costs for clinic owners, and that these savings can be passed on as lower costs of aesthetic treatment for customers who are looking for the best price. That is, the cost of facial laser treatment in a clinic that uses cheaper machine is likely to be lower than the cost in other clinics using an expensive machine. Since this may be up to 50% less (CO12 and CO13), the cost may motivate tourist-

patients looking for low-cost treatments, although it leaves unresolved the issue of quality of treatment provided by cheaper aesthetic medical equipment from China, Taiwan and Korea.

In technical terms, it would possibly be understood by a trained technician of such equipment that *“a cheaper machine can provide the same level of energy as a branded machine if the operator sets the level of energy at about 30-50% above the expected level”* (CO14). For example, *“in order to operate a laser machine at 40mJ, the operator needs to know that the power of the cheaper machine must be set at 55mJ”* (CO9). This will compensate for the lower power level of the cheaper machine. On the other hand, this is not always an ideal way of using a machine, since operating a laser machine at a high level of energy will very often reduce the machine’s life. As a result, the component parts of the machine such as the laser source, power supply and head tips will need to be changed more quickly than when operating at a lower level of energy. This becomes an extra cost for the clinic owners and the doctors later on.

While it is important for the findings to understand that a potential difference in quality of treatment can result from different types of equipment, it is also important to take into consideration that this is not always the case, That is, not all cheaper aesthetic medical equipment provides a lower quality service. Many of the cheaper machines in clinical use are produced to international medical equipment standards, and have been selected by Thai medical schools and main public hospitals over alternative expensive equipment (GR2, GR4 and CO15).

Finescan[®] is a good example of this case. This machine is produced in Thailand to ISO 13485 and ISO 9000 standards. The published medical papers also prove that research on this brand's impact on humans, along with any side effects and complications has been rigorously conducted. Results published in medical journals, such as Rerknimitr, Pongprutthipan and Sindhuphak (2010) and Vaiyavatjamai and Wattanakrai (2011), have demonstrated that the performance of Finescan[®] gave no different results to those given by other more expensive branded machines. Two factors explain this, one being that Finescan has been produced to the same crucial specifications as more expensive equipment, the other being that user interface of the cheaper machine is more easily operated. The research indicated that Finescan was friendly to use, with no consumable parts e.g. head tips. That means the clinic owners and doctors could save on the operational cost of the treatment significantly reflected on the price of the treatment itself, thus helping to keep the price of the treatment competitive.

6.3.1.2 Renaming non-invasive aesthetic medical treatment

According to GR2, *“differentiation in the way non-invasive aesthetic medical treatments are named by different aesthetic clinics in Bangkok has caused a certain amount of confusion and error.”* In general, non-invasive aesthetic medical treatment programmes in clinics are named after the brand of the non-invasive aesthetic medical equipment and medicine being used for the procedure; such is the case with Fraxel[®] and Botox[®]. In addition, CO8 stated that *“These products are easily recognised by tourist-patients, since they are always promoted with the same brand logo, hand-outs, brochures, advertised result photographs, marketing communication and related devices. The brand is the same, whether encountered in a tourist-patient's home country or in Bangkok, Thailand.”*

In other cases, GR3 suggested that *“certain non-invasive aesthetic medical treatments have been linked to latest technology innovations launched by the aesthetic medical industry. For example, facial treatment by Intense Pulsed Light has been called IPL in many non-invasive aesthetic clinics in Bangkok for many years.”* This procedure involves basic non-invasive aesthetic medical equipment that can be used on the face, under arms, hands, neck and legs for skin rejuvenation and hair removal purposes. Thus, equipment that uses IPL is essential if clinic owners are to serve patients’ needs, and to attract customers. IPL can be found in almost every clinic in Bangkok (CO8 and CO9).

However, GR2 said that *“in order to have the leading edge in a very high competitive business environment, clinic owners in Bangkok will attempt to draw interest by naming the treatments in different ways.”* This reflects the pressure on clinic owners and doctors constantly to create new treatments for the business. One good strategy for competing with other clinics is to purchase new non-invasive aesthetic medical equipment with regards to cosmetic trends coming from developed countries such as the U.S., U.K., Italy and France. But because this strategy is expensive, clinic owners often have to resort to innovative uses of older equipment in order to interest patients and to get best value out of the equipment’s lifetime. In order to avoid unsuccessful investment, and to turn existing non-invasive aesthetic medical equipment to best profit, *“clinic owners resort to re-naming treatments to suggest a different product is being promoted”* (GR4).

As an example of this, the Apex Profound Beauty Clinic in Bangkok, offering facial rejuvenation by microdermabrasion, now names the procedure the ‘Diamond Treatment’; similarly, acne treatment by Blue Light has been

renamed 'I Clear' (CO10 and TP32). At the Meko Clinic, "*while microdermabrasion has not had its name changed, the IPL treatment for facial rejuvenation treatment has been re-labelled as 'Miracle Laser'; in addition, fractional Laser use is now called 'Smooth Laser'*" (CO8).

Another way of re-presenting a product is by combining new techniques of laser exposure, thus allowing the name of the facial treatment to be changed. Thus "*the Wuttisak Clinic calls its IPL facial treatments by different names, such as 'Advance IPL', 'Bio-Pure' or 'Clear-Max Laser', depending on variably applied levels of energy, techniques and purposes of the treatment*" (CO9). Although it is worth noting that in this clinic the three treatments are basically treated by similar non-invasive aesthetic medical equipment, there are other clinics such as "*the Rajdhevee Clinic, which names each aesthetic treatment differently based on the technology and the purpose of the aesthetic treatment*" (CO14).

Underpinning all these efforts is "*the desire to present the treatment of each clinic as different and unique*" (CO12), even though all clinics have purchased the basic non-invasive aesthetic medical equipment such as IPL, iontophoresis and phonophoresis machines. Since no single machine is able to create a unique signature treatment for any particular clinic, renaming products is the only alternative for attracting customers to updating and purchasing new machines.

However, according to TP28, "*the result of naming or renaming old non-invasive aesthetic medical treatment is very confusing for tourist-patients*", who experience difficulties in understanding the meaning of labelled treatments in different clinics in Bangkok (TP23, TP24 and TP34). This is

because they are more familiar with how treatments used to be named in their home countries, each treatment named similarly in every clinic, and in relation to the brand of the medical equipment. For example, facial rejuvenation by fractional laser has traditionally been called Fraxel[®], to reflect the brand of the medical equipment from the U.S. used in the treatment, but may be changed in different clinics.

It becomes clear that the tensions between the need to create treatments which appear unique to a clinic, while maximizing use of existing older medical equipment need to be balanced for clinic owners to stay in profit. But this creates collateral tensions for confused tourist-patients (TP33 and TP41). This confusion may also extend to misunderstandings between the service provider and the consumer. For example, the so-called “diamond treatment” at the Apex Profound Beauty Clinic may lead tourist-patients to believe that they are being treated by a machine using diamond materials (CO8). In fact, the diamond treatment is a microdermabrasive cosmetic technique which uses a mechanical medium for exfoliation, removing the outermost layer of dead skin cells from the epidermis. Medical microdermabrasion is performed by passing a hand-held device that uses a highly controlled flow of fine, medical grade crystals over the skin. The medical grade crystal is just like sand but more pure. But the material definitely does not contain diamonds.

In summary, while renaming non-invasive aesthetic medical treatments in such a way may render it more valuable or attractive in the patients’ perceptions, it may also be misleading them to believe that the treatment is being conducted using diamonds. If in such cases the tourist-patient finds out at the end of the treatment that it was just a regular microdermabrasion, to be found in any clinic (TP29 and TP44), this would be, to say the least,

disappointing. The functional risk in this case would be that the treatment would not have been found to deliver the quality of service that the tourist-patient had expected.

6.3.1.3 The quality of aesthetic medicines and injected medicines

According to GR2, aesthetic medicines and injected medicines play a significant role in increasing functional risk. A good example of this case is the use of botulinum toxin as a Botox[®] injection. This is a very popular procedure for wrinkle reduction (Allergan, 2016), well known to tourist-patients. In Thailand this is an easily accessed procedure, since customers only have to pop in to a clinic and ask the price. It is likely that most tourist-patients will have already been treated by Botox[®] in their home countries, for example to reduce fine wrinkles around the eyes (crow's feet) and the nose (bunny lines). Crow's feet are lines that form in the lateral canthal region and are caused by the contraction of the orbicularis oculi muscle (see more details in Appendix A). These lines appear around the eyes especially when patients smile. Several muscles contribute to bunny lines, but the nasalis is the most significant. Bunny line wrinkles appear on the lateral/ dorsal aspects of the nose, which may extend out to the lower eyelid. They present in some people as a natural part of their facial expression.

As mentioned earlier one of the three most significant factors regulating tourist-patient choice of service at an aesthetic clinic is the cost of the treatment. In Bangkok tourist-patients can easily compare the price of treatments. Considering cost, some tourist-patients may choose to have the botulinum toxin injections without applying anaesthetic cream prior to the treatments (TP28 and TP34), because this is cheaper. Not only this, but it is also quicker without the anaesthetic cream as the 30-45 minutes waiting time

for the injections to be applied is reduced. Tourist-patients only need to cover the treated area with an ice cube for a few minutes before receiving the injections.

The problems surrounding the purchase of Botox in Bangkok reflect the risks that can arise from favouring choice of low-price treatments. It was found that not every non-invasive aesthetic clinic in Bangkok uses the original branded Botox[®] (GR2, GR3, CO9, CO12 and TP35). Nowadays, there are many imitator brands of botulinum toxin type A available in the market, which may have been produced in the U.S., the U.K., China, Taiwan, India or many other countries. While it can be seen that almost all non-invasive aesthetic clinics in Bangkok advertise that they use botulinum toxin type A from the U.S. or the U.K., namely Botox[®] and Dysport[®] respectively, it is important to note that *“not every brand has received the US FDA approval. In fact some firms producing brands from China justify their product by claiming that the US FDA approval is in process and that is not true”* (GR2).

The reality of this situation, with impact on risk, is that results from the use of non-U.S. or UK brands and other brands are not similar (GR2 and CO8). Drug regulation bodies argue that it is very risky to use unapproved medicines and injected drugs (Singh, 2008; and Singh, 2014). It has not yet been approved. The only reason that Chinese botulinum toxin type A is available to the world market is that its much cheaper price attracts clinic owners who wish to maximize profit. The risk implication is that with no guarantee that the product has been tested on human skin to predict side effects, there is nothing to guarantee its performance, quality and safety.

According to GR2, *“This gives rise to a number of questions. What will happen to patients in the next 5-10 years? Will the treatment create cancer? Who would be responsible for the risk? In reality, there is no one who is responsible for these problems. Patients should not take the risks but may be ill informed that they are doing so.”* Doctors are the only people who may be aware of whether or not the injected medicine used in the clinic has been regulated, but are not accountable to the patients since they are unable to see the preparation process of injected medicines. Thus an unprincipled doctor who is only considering the profit can pose considerable functional risk and other possible types of risk to patients. This not only applies to botulinum toxin type A but also to other medical procedures such as weight loss medicine, acne medicine, vitamins, mesotherapy and many more.

Like Botox, mesotherapy has become a popular aesthetic medical procedure. Mesotherapy is a method of sculpting the body and eliminating cellulite (see more details in Appendix A). It is seen to have marked benefits over more invasive body contouring methods such as liposuction (Kalil *et al.*, 2005). However, although non-invasive, mesotherapy is not without its risks and side effects, it can include bruising, temporary numbness and other effects. More importantly, many experts such as Lee *et al.* (2016) are unsure of how safe and effective is the mix of drugs, vitamins, amino acid and enzymes used in Mesotherapy, as there is no standardized formula for its mixture. GR2 also stated that *“Different brands from different companies and countries offer different formulae with different claims as to their benefits.”* The risk is that while the benefits are freely advertised, the formulae are not divulged (Lee *et al.*, 2014).

According to GR4, *“It is difficult to understand what formula is being used by observation only.”* Liquid is mixed with a white powder in a small vial but specific ingredients or quantities cannot be distinguished, so it is difficult to assess which components provide the benefits in a procedure. Thus there is no guarantee whether or not any particular mixture has the capacity to reduce fat and cellulite. And yet there are strong claims made for the potential effects of mesotherapy. Makers of some types of mesotherapy go as far as to claim the product can eliminate sagging skin, treat skin conditions such as acne, eradicate stretch marks and diminish hair loss.

However, there appear to be cases where the claim does not match the reality. In this study, for instance, instead of reducing fat in the treated area of one informant, the fat was found to have increased. Consequently this informant believes that mesotherapy is a very risky treatment and that it cannot perform as well as promised (TP32). The reality is that while mesotherapy may have worked well with many patients in different countries, there is no guarantee as to consistent performance or that the treatment will work well with all patients. Logically speaking, given that patients from different countries may differ in skin type and ethnicity, it is unlikely that one drug mixture will have the magical capacity to treat everyone in the same way. This lack of predictability gives rise to concerns; for instance, a professor interviewed from the medical school in Bangkok was concerned with the uncharted long-term side effects of this therapy, especially since there is no medical study or research to guarantee that this is a cancer-free treatment. *“What will happen to the patients in the next ten years? If they have skin cancer or any type of cancer related to this treatment, which organisation or party will help them? Its functional risk is a good topic for further research”* (GR5).

6.3.1.4 The quantity of injected drugs

The quantity or dosage of injected drugs is another significant issue in terms of functional risk. Linked to this, CO8 stated that *“In order to achieve a satisfactory result, a doctor will need to judge the appropriate amount of drug to inject.”* The quantity of drug, rather than the drug itself, may influence the result as successful or not. For example, *“to reduce fine wrinkles around the eyes for a 30-35 years old patient, normally 15 units of Botox® would be required for each eye area (CO9).”* However, the result may vary not only depending on the amount of the drug that is injected but also on the doctor’s injection technique. If the doctor has trained in the appropriate expertise, then the only crucial factor will be the amount of the drug injected. However, the research literature reports instances where even this is problematic. It has been observed that some doctors or clinic owners tend not to use the amount recommended by medical research papers such as Naoum and Dasiou-Plakida (2001) and Pickett (2012). Although such practitioners may want to save some units of product in order to reduce their costs. In the long term this is a risky practice. Since the amount of the injected drug is one of the crucial factors in achieving a good result, if tourist-patients do not achieve the expected results, this will lead to their belief that the doctors have failed to treat them appropriately, and pose a risk to further business.

It is difficult moreover to perceive the difference between doctors who unethically wish to save money, and doctors who ethically avoid injecting too much of the drug into a first-time patient’s skin, in order to reduce the risk of having unnatural results (CO9, CO10 and CO12). Such doctors will err on the side of caution because they want the patient to look as natural as possible. The second drug injection in such instances can be arranged if the patient

requires a better result, even though this leads to the extra cost of more treatment and could be seen as wasting a patient's time.

According to TP33, *“Time of course is an important consideration as well as cost.”* Linked to this GR2 stated that *“Tourist-patients may not have time for a second treatment if they have to continue their travels or go back to their home countries.”* If the result from the first treatment turns out to be unsatisfactory from insufficient application of the drug, then this will have resulted in a functional risk for both the seller and the buyer. This type of dilemma occurs not only in relation to wrinkle reduction treatment by drug injection, but also in other drug injection treatments such as fat and cellulite reduction by carboxy therapy, skin treatment by mesotherapy, acne treatment by drug injection and many more treatments.

6.3.1.5 The skill and experience provided by the service provider

According to GR2, *“The skills and experience of service providers such as clinic owners, doctors, nurses, and nurse assistants are a critical issue in the successful outcome of non-invasive aesthetic medical treatment.”* Individuals in each of these roles contribute to the overall success of treatment, but in a different way.

Firstly, clinic owners are required to manage the efficient running of the clinic (GR2 and GR5). G2 also supported that *“In some cases, the clinic owners are not doctors, but rather investors or groups of investors or marketers. Thus their knowledge and understanding of human skin treatments such as anti-ageing, wrinkle reduction, fat reduction is highly limited.”* Although they might inform themselves of research, or become more familiar with technical medical issues by attending short courses, seminars or conferences provided

by a medical school, this does not add up to medical expertise. However, CO8 suggested that *“widening their understanding of the medical aspects of the service they provide will help them to create appropriate marketing campaigns for potential patients.”*

A second role is that occupied by the doctors, whose qualifications suggest that they should be able to diagnose a patient's skin problems precisely (GR2 and CO8). But in order to master this area of specialist knowledge, ideally the doctor should be a dermatologist, or at least have followed to master's degree level, studies in skin treatment, laser technology and dermatology.

In reality many doctors in the aesthetic clinics in Bangkok do not have a qualifying degree in dermatology. This is for many reasons, the predominant ones being financial and time constraints. Although specific subjects such as dermatology were reported to be very popular and in high demand in Thai medical schools (GR2, CO9 and CO12), not all doctors could gain acceptance to a dermatology course. In such instances, they would opt instead for a master's degree in dermatology from the public university (GR2 and CO8). A final alternative potential choice would be a short three to six months dermatology course abroad in a specific skin and laser treatment facility.

The final role is held by nurses and nursing assistants who should be trained properly (GR3 and GR4) in order to help doctors efficiently. This would entail their having a good knowledge of human skin, skin disease, technical aspects of pre- and post- treatment care, skin care medicine, and the basic medical equipment used in their clinic. In this study, however, tourist-patients reported that nurses seemed under-qualified, in that nurse assistants provided wrong

information regarding post treatment procedure (TP28, TP31 and TP34). The ideal that complex and complicated treatment should be explained to tourist-patients only by doctors was not observed in such cases.

In summary, non-invasive aesthetic medical treatment can be dangerous if applied by individuals who are lacking in the necessary skills and experience. It appears that the most common problem that creates functional risk is from individuals performing treatments without adequate skills and experience, whether on the part of doctors and nurses. That this poses risks is undeniable. For instance a patient may experience complications such as burning and hyper pigmentation if the doctor operating the laser machine has insufficient experience of working to avoid scarring.

In order to conduct this kind of work safely and ethically, the doctor needs not only the medical knowledge of skin diseases, but also the technical knowledge of how to use a laser machine appropriately. In addition if a drug injection is involved in a treatment, the doctor also needs a very high level of skill and knowledge to apply the drugs successfully. The botulinum toxin type A can help to reduce wrinkles but if doctors use an incorrect dosage or inject the product into the wrong muscle, it can create a dead muscle condition. *“This was the case for a patient participating in this study who reported difficulty in opening the left eye a few days after having had a Botox® injection”* (GR2). In some cases, using a high dosage creates an unnatural look, such as may occur in jaw line reduction by botulinum toxin injection. *“It may occur during this type of treatment that sometimes right and left jaws are not reduced symmetrically with the same amount of drug”* (CO10). In such cases doctors not only need to have very good experience of how to target problems specifically, but also to have good interactive skills, to be able to

understand what tourist-patients want and to be able to talk them through what to expect, including possible side effects of the drug. Failure of doctors in this capacity may not only create functional risk for failure to deliver promised results, but to lead to complaints and bad press from tourist patients as well.

6.3.1.6 Post treatment care and instruction problems

In general, non-invasive aesthetic medical treatments do not require patients to stay in a clinic or hospital for days or even for hours. After all, tourist-patients can enjoy sightseeing in the city centre or by the sea in Thailand immediately after finishing the treatment. Linked to this GR1 stated that *“This key benefit of non-invasive aesthetic medical treatment is one thing which makes it different from cosmetic surgery.”* Not all treatments require a high degree of post treatment care; for instance, Iontophoresis and Phonophoresis (see Appendix A for details) are treatments that use a small electric charge or radio frequency to deliver a medicine or other chemical through the skin, with few after effects.

“Other treatments however, do require good care after the treatment, not just for safety but to maximize results” (CO9). If this quality of post-procedure care is lacking, then this can lead to functional risk in the form of post treatment problems. Both doctors and tourist-patients may contribute to this risk: while it is a doctor’s responsibility to explain what patients can and cannot do after having a specific treatment, tourist-patients need to heed this advice.

6.3.1.6.1 Laser treatment

According to CO9, *“Skin tightening, skin contouring and facial rejuvenation are treatments which are very popular with tourist-patients. In order to receive*

such treatments, a laser machine is required, but after treatment, patients do not need any further procedures, being free to enjoy shopping or travelling around Thailand.” One of the greatest benefits of the laser skin tightening is seen to be the minimal amount of risk associated with the procedure. CO8 also supported that “This is the case even if side-effects include temporary reddening of the skin, a slight chance of scarring, and the possibility of brief lightening or darkening of the skin in the treated areas. Ideally, any associated risks should be recognised and discussed by the doctor before patients leave the clinic. If there is no sign of these risks then there is little likelihood of there being any side effects.”

However, CO11 suggested that *“even if patients are free to go off and pursue their interests, the changes to the skin as a result of treatment are still in process, and until they are complete, patients need to know about the advisability of taking extra care for the treated area. Normally tourist-patients will be appraised of this by a member of medical staff who will explain post-treatment care with instructions of what to do before and after having the procedure. Tourist-patients can ask all the questions they need, backed up by a set of instructions to take away once the procedure is over.”* However, some tourist-patients seem not to follow the instructions carefully (GR2 and CO12). In some cases, they do not remember what they have been told in the clinic, or details of what they can or cannot do. This can lead to problems. For instance, the pigmentation of the treated area may be different for a while and thus need added sun protection cream on their face. If tourist-patients fail to do this, with negative results, they may return and complain to the clinic, blaming the doctor for treatment not going well (CO13). In other words, failure of patient participation in the treatment may lead to functional risk that the treatment does not deliver the result as promised.

6.3.1.6.2 Chemical peels

According to CO9, *“Skin resurfacing by chemical peel is another treatment that can easily create functional risk. Chemical peels can vary in depth from very superficial to very deep. Post treatment care for chemical peels is dependent on the type of peel and the condition of the patient’s skin. In each case, doctors and medical staff normally give the tourist-patients post-treatment instructions that are specific for the type of peel undergone.”* Some peels are so superficial that they cause little to no peeling, and may not require a big change in the patient’s skin care regimen. However, a deeper level chemical peel necessitates a greater level of corrective care, without which there may be a risk of complications. Linked to this, CO10 stated that *“Most complications can be avoided by strict patient compliance, which means tourist-patients should follow their post treatment care instructions carefully and exactly as instructed. In some cases, tourist-patients need to use appropriate skin care products that have been approved by a skin health professional.”*

After a chemical peel the skin is more vulnerable to Ultra Violet Rays. That is, tourist-patients should be advised to avoid sun exposure as much as they can. However, since tourists come to visit Thailand to enjoy holiday sunshine, failure to avoid sun exposure features as the most common reason for functional risk (GR2 and GR3). Tourist-patients may avoid the instructions, or fail to put sunscreen on their treated area, as they want to have tanned skin when they return home. As a result, depending on the depth of the peel, tourist-patients may be asked to avoid sunscreens and sunshine until the skin has completed the peeling phase. Otherwise, the result of the chemical peel will not be appreciably effective on the skin. Not only that, it may lead to the doctor being blamed for failing to offer good treatment, or for the treatment

itself being blamed for being ineffective and not delivering the expected results.

6.3.1.6.3 Drug injection

Botulinum toxin type A treatment is a non-invasive procedure that can reduce or eliminate facial lines and wrinkles (see Appendix A for details). As with many other procedures, Botox treatment requires after care. In order to achieve the best results possible, CO9 suggested that *“tourist-patients need to follow their doctor’s post treatment instructions carefully. Although it is explained to tourist patients that there are some possibilities of side effects such as pain, bruising and swelling from this injected drug, if they carefully follow the after-care instructions, then recovery from the procedure is usually quick.”*

While this treatment does not require downtime, in that normal activities can be resumed immediately after the procedure, tourist-patients are advised to avoid lying down for four to five hours following the treatment and to avoid massaging the treated area. However, CO11 stated that *“as Thailand is a country that has a good reputation for massage, tourist-patients may not be able to resist indulging in massage at least once during their vacation period. For example, if tourist-patients have undergone a treatment in the very first week of visiting Thailand, then they might find it difficult to refrain from having any massage at all for the rest of the three weeks of their four week Thai visit.”* Linked to this, GR3 stated that *“The problem is that their decision to deviate in this way from the post-treatment instructions involves not only their own skin condition, but also the reputation of the doctor and the clinic. Facial massage may move the drug to other points on the face rather than remaining in the target muscle.”*

Other problems may occur. CO10 stated that *“In many cases, the patients sue the doctor and clinic for the fact that they are unable to open their eyes for a few days after treatment. In worst cases, patients may encounter problems after having already returned to their home countries, thus incurring a further cost of recovery treatment. Moreover, not following the post-treatment instructions carefully may lead to results other than those promised so that the treatment is considered a failure. This applies to other injected drugs such as those used for acne treatment.”*

6.3.1.6.4 Fat and Cellulite Reduction treatment

Fat and cellulite reduction are other treatments that can create functional risk. Tourist-patients may have already tried numerous therapies to eliminate their cellulite, including various creams and drainage massage (TP24, TP31 and TP33). However, none of these therapies correct the underlying physiological problems of poor circulation or a damaged collagen septal. On the other hand, an alternative therapy that has shown promise in eliminating this difficult problem is carboxy therapy. The only real possible side effect of carboxy therapy is the potential for bruising at the injection site, most common as a side effect in the treatment of arms and legs (CO8). For this reason, in the period following carboxy therapy it is not considered a good idea to wear a bikini during vacation activities.

According to GR5, there are no known risks associated with carboxy therapy. Carbon dioxide injection process involves a specific technique while allows carbon dioxide gas to access fat cells where it has a directly toxic effect. The treatment has been safely used for years to facilitate endoscopic surgeries of the abdomen (Zdinak, 2012). However, its safety is not absolute. *“There was a reported case of embolism with a Thai patient in one clinic in Bangkok”*

(CO13), which occurred that the treatment was operated by a member of the medical staff in the clinic who was neither a doctor nor a nurse. Although this employee had had extensive training and was very experienced with carboxy therapy, it is illegal and considered unacceptable if one is not medically qualified perform the procedure. In this instance, once the carbon dioxide had gone through the blood vessel, the treatment was stopped straight away. The patient did not feel any pain or recognise anything wrong during the treatment. At the end of the treatment, the staff informed the doctor but there was no information about the error this passed to the patient. Fortunately, there were no other complications to the patient at all. This explains why carboxy therapy might not deliver a promised result as the procedure was not delivered by a doctor or a nurse.

6.3.1.6.5 Weight loss programme

Patients can enhance the likelihood of weight loss by increasing their metabolic rate and burning more calories. But "*men and women who have persistently tried to reduce weight and failed*" (GR4) may opt for a more supported way of losing weight, by consulting with a doctor and taking a weight loss programme. Such weight loss programmes are bestsellers in many Bangkok clinics (CO8, CO11 and CO14). Tourist-patients are the main group of customers for this market segment. During their holiday, they want to have a more youthful appearance, a slimmer shape and tanned skin, and will look for a perfect solution to all these needs in one of the clinics in Bangkok.

A typical weight loss programme in these clinics involves a combination of use of medical equipment, cellulite reduction cream, Thai massage and weight loss medicines. The procedure requires more than one visit to complete the programme. One reason why some tourist-patients do not

achieve the desired end results is that they cannot finish the programme, needing to fulfil a travel itinerary to different parts of Thailand, or to return home early. However, the most important cause of failure, and functional risk for weight loss programmes is the eating habit of tourist-patients. It is known that Thailand is not just a beautiful country but has a delicious and unique local cuisine that tempts tourists. Not only this but *“the food is extremely cheap if compared with the food prices in developed countries”* (TP34). In many cases *“tourist-patients who cannot resist the taste of the food”* (TP32) end up eating too much. Indeed, rather than losing weight they might increase their weight dramatically. This brings a risk that tourist-patients will blame the programme for failing to perform as well as advertised. It is noted that *“generally tourist-patients are the key factor for failure of the weight loss programme”* (CO16), since without stopping eating or changing their behaviour, there is nothing that can help them to lose weight, whether at home or in a professional weight loss clinic in Bangkok.

Notwithstanding this, CO9 explained that *“another current risk in non-invasive aesthetic medical procedures is the functional risk of “No Result”, that is that the non-invasive aesthetic medical treatment and procedure fails to produce the result as promised or advertised. For example, while patients might expect dramatic results from a botulinum toxin injection such as those illustrated on marketing advertisements, in fact results can vary considerably from one person to another because of various factors and circumstances.”* In addition, CO11 stated that *“Patients who find that they have not achieved the expected result will assume that the purchased treatment has offered no acceptable results. This is a crucial concern not only for the disappointed patient but also for the aesthetic clinic owners and doctors. If the clinic owner or doctor is subject to complaints, this brings the risk of their reputation being*

destroyed by word of mouth, or in the worse cases, the clinic being sued by the patient.”

In summary, there are a number of different reasons and factors which may lead to non-invasive aesthetic medical treatment failing to perform as desired. This is sometimes known as ‘no result’. Thus it is possible for tourist-patients using clinics in Bangkok to experience different results, ranging from excellent to no result. This is without considering the added complications of potential side effects. It would appear that clinic owners and doctors are aware of the many potential factors which may increase or reduce the problems of functional risk.

6.3.2 Physical risks

Even though cosmetic surgery is an increasingly popular means of enhancing youth and attractiveness, GR2 stated that *“most people are aware that cosmetic surgery comes with pain and creates bleeding. But complications such as pain or bleeding are not a deterrent to prospective patients who have already made up their mind as to the results they want. The problem is that their expectations may be based on advertised and idealised photographs, exaggerated word of mouth and the exceptional appearance of celebrities. In reality, cosmetic surgery is complex and may sometimes leave patients with unexpected results on their faces.”*

Cosmetic surgery is a type of surgical procedure which, like many other surgical procedures, cannot be guaranteed to have foolproof results. Once cosmetic surgery has been undergone, the changes will be permanent, with no chance for patients to have back their old appearance, and will have to live with their new appearance until the end of their lives. Of course, correctional

work is possible, and in some cases, a surgeon will offer a second cosmetic surgery for free to a patient if the first cosmetic surgery has gone wrong. Many cases have been reported regarding unexpected results from cosmetic surgery, so that there can be no doubt that cosmetic surgery is risky. CO9 concluded that *“For this reason, people are increasingly attracted to the alternative of non-invasive aesthetic medical treatment.”*

However, GR2 suggested that *“non-invasive aesthetic medical treatment is not risk-free, and there are different types of risks associated with different types of treatments. The degree of risk also varies depending on how complicated each treatment is in terms of what kind of equipment is involved and what kind of medicine is taken.”* The most considerable risk is physical risk, referring to possible harm which may incur to the tourist-patient as a result of purchase. Such risks may even involve risk to health and life.

Of course, compared to cosmetic surgery, the physical risks of non-invasive aesthetic medical treatment are relatively low. Nevertheless, CO8 stated that *“if tourist-patients are in less than perfect health then there may be an increased risk during treatment. For instance, if a tourist-patient has a history of heart disease or is overweight then they may be at greater risk of complications from a general anesthetic. Such complications can take the form of a stroke due to raised blood pressure, or an abnormal heart rhythm. While such phenomena are still rare in non-invasive aesthetic medical treatment history, it cannot be ignored that some cases create a higher possibility of physical risk.”*

6.3.2.1 Laser treatment

Laser treatment can be used for treating acne, scars, hair removal, tattoo removal, red veins, skin resurfacing, skin tightening, lines, wrinkles and many more treatments (see Appendix A for details). The nature of laser treatment such as Intense Pulsed Light (IPL), Fractional erbium fibre laser e.g. Fraxel® and Finescan® is normally minimally invasive. However, some tourist-patients might feel that these are invasive treatments, in that they require anesthetic cream to be applied on the treated area before laser treatment. But this is to reduce pain and could not make the treatment completely pain-free.

Although some types of laser are safer for the eyes than others, it is noted that all types of lasers are harmful if eyes are directly exposed to the light source. For this reason, GR2 stated that *“during laser treatment patients’ eyes are normally protected from the laser by laser-protective glasses. That is, although technically there is a possibility of physical risk to patients’ eyes in laser treatment, no negative reports have emerged to date in regard to laser use in Thai clinics. Clinics normally will do whatever they can to ensure that patients’ eyes are safe during their stay in the clinic, it being understood that for some cases, merely closing the eyes will be insufficiently protective for tourist-patients who are sensitive to laser beams.”*

As to the effects of lasers on the skin, it seems that laser beams can be felt more aggressively by some tourist-patients. *“Some patients feel pain during the treatment while others do not”* (CO8). Although the physical effect has been described as being like a rubber ring hitting the skin, as it lands on different parts of the treated area, some tourist-patients report being afraid of the light as they wait for the next flash (TP28 and TP29). CO9 stated that *“Since these light flashes can increase the heart rate and blood pressure,*

doctors usually ask for medical information from each patient before the treatment”.

According to CO11, *“It would appear however, that real blood pressure checks are rarely conducted in an aesthetic clinic”, and “it was reported that there exists no temperature or blood pressure checking at most of the clinics in Bangkok (GR2).”* Tourist-patients who have high blood pressure and heart disease should not be allowed to take laser treatment (Narurkar, 2007). However, as there is no measurement of their real blood pressure some tourist-patients do not tell the truth about their state of health because they want the laser treatment. This may lead to the problem of physical risk at the end of treatment, or even during treatment, for instance if the doctor notes that the patient’s body is shaking. If such reactions occur, the doctor will stop the treatment straight away, as it is too risky to continue the treatment. No one is prepared to take risks with the tourist-patient’s life.

In addition to this, CO8 stated that *“A further physical risk of laser treatment is that it can cause scarring, an issue which doctors take every effort to minimise, but cannot always prevent.”* CO13 also suggested that *“Post Inflammatory Hyper-pigmentation (PIH) is another relatively common problem in darker skin types which are treated with a fractional erbium fibre laser. With darker skin types, one has to go slower, and hence more treatments are needed. Skin resurfacing treatment by fractional erbium fibre laser is especially prone to of creating this problem, because a very high level of energy is needed for the skin resurfacing.”* In addition, if the post treatment cooling process is not applied properly the tourist-patient’s skin risks being burnt, in which case the doctor and the tourist-patient will need to discuss an alternative available choice of treatment. It needs to be understood that if the

laser treatment does not go well, then instead of having youthful skin, the tourist-patient might have a scar on their face

6.3.2.2 Carboxy therapy

Carboxy therapy is used for the purposes of reducing stretch marks, cellulite and dark circles under the eyes, as well as sculpting fat in the face and body (see Appendix A for details). However, GR2 and CO8 stated that this treatment is believed by some to offer more risks than results. Indeed, some experts such as GR2 and CO14 say that it is riskier than mesotherapy, because it has not been FDA-approved for the purposes applied. However, in general many doctors argue that the medical grade gas only replicates the same natural gas that is already in the human body. The technique is designed merely to disturb the balance of the human body, which in turn will lead to reduced fat and cellulite as an indirect result. Most doctors believe that carboxy therapy is safer than Mesotherapy as it is a natural substance not a medicine, drug or invented vitamins. However, GR3 stated that *“there are some issues, one being that the ideal recommended quantity of CO₂ gas to be injected into the treated area is still unknown. Depending on the doctor’s experience the amount may vary, and this unpredictability can be dangerous to a patient’s health. Another issue is that carboxy therapy could potentially release gas bubbles into blood vessels, causing blindness if used around the eyes.”*

As it happens, going to a sauna is one of the factors that may create a physical risk associated with carboxy therapy. For this reason, CO11 stated that *“patients are normally reminded to avoid high temperature areas for four to five hours after the treatment, since high temperatures will expand the volume of the carbon dioxide gas in the treated area. Patients may have*

difficulty breathing if the treated area is around the breast, so that staying in a steam room with a temperature higher than 40 degree Celsius can lead to loss of consciousness and be life threatening. Doctors, nurses and staff in the clinic normally emphasise this risk to tourist-patients, but there is always the risk that tourist-patients might ignore instructions and put their lives at risk.”

6.3.2.3 Mesotherapy

Despite years of controversy surrounding the treatment of mesotherapy, it has become a popular choice for both men and women looking to melt fat and smooth away cellulite (see Appendix A for details). However, G2 stated that *“experts are unsure of how safe and effective this mix of drugs, vitamins and enzymes is, particularly when injected into human skin. Mesotherapy can be especially risky to tourist-patients’ health if the drugs used are not qualified as safe.”* It is the view of some experts, for example, Lee *et al.* (2016), Luthra (2016) and Tan (2007), that the reason the US FDA does not approve the use of mesotherapy is that it may even be harmful to the patient's life. This is especially a cause for concern because each company sells different type of drugs for mesotherapy and their formulas are still unclear. GR5 stated that *“Some brands may trade on the back of one of their formulae which has obtained medical and certified approval, by falsely advertising the logo of the certifying body in such a way that it appears to apply to all of their brand products.”* On the other hand, in spite of the caution shown by certifying bodies, many doctors (CO9, CO11 and CO14) argue that the technique has been safely used since its 1952 inception in France. The view is that its long history of use makes it acceptable and safe to use with patients looking for fat and cellulite reduction or for other purposes. As for how tourist patients themselves should solve such dilemmas, one of the participants advised that

to avoid risk, *“patients should look for professional dermatologists who are using certified drug products”* (CO8).

Such dilemmas clearly demonstrate that although non-invasive aesthetic medical treatment may be safer than cosmetic surgery, it is not without some physical risks from the product. But moving on to the impact of treatment on the body, it must be acknowledged that any type of non-invasive aesthetic medical treatment may create the risk of infection, which is also a physical risk. Although the risk of infection after aesthetic medical treatment is very rare, there being no surgery or blood loss entailed, in the rare cases that infection does occur, it can be very serious. CO8 stated that *“To reduce such risks doctors are prepared to prescribe antibiotics as needed for tourist-patients, for instance those who have acne treatment which carries a slightly higher if still rare possibility of infection.”* It also needs to be recognised that the longer and the more frequent the treatment, the more likely is the tourist-patient to risk infection. In order to minimize such risks, medical equipment and machines are cleaned regularly after use, and needles and other consumable parts are changed after every tourist-patient use. This is to ensure that the treatment at the aesthetic clinic in Bangkok will be absolutely infection-free.

6.3.2.4 Law and legislation on food and health safety

Apart from the non-invasive aesthetic treatments, another potential physical risk for prospective tourist-patients in Bangkok is a certain element that attracts many tourists to Thailand. That is, TP30 stated that *“there are easy opportunities for those who wish to indulge in debauchery such as drinking, drugs, and prostitution.”* CO12 suggested that *“Indulging in these can cause serious complications for tourist-patients in the preparation for and recovery*

from non-invasive aesthetic medical treatment.” Like any other medical treatment and procedure, non-invasive aesthetic medical treatment has fewer complications if tourist-patients do not associate with drinking and recreational drugs, which can exacerbate the risk of developing an unbalanced body or face shape. For example, if a tourist-patient is experiencing a strong sensitized reaction to alcohol or leisure drugs, this may cause generalised or localised edema.

If the patient is reacting to alcohol or drugs not long before having non-invasive aesthetic medical treatment, such as Botox® injections, this might create unexpected results. For instance, the shape of skin on the treated area may become bigger than normal, with the tourist-patient ending up with a fatty face as a result of their consumption and sensitivity to alcoholic drinks.

A further complication which arises when a patient has alcohol or other substances in the bloodstream is that it may be difficult to calculate the accurate amount of injected medicine needed to offset this condition. Over dosage may occur if the doctor conducting the treatment does not notice unexpected reactions in the patient's face. Having too much injected medicine leads to the problem of physical risk, and to disappointing results. Rather than gaining a more youthful appearance, patients may end up with a distorted face.

Botulinum toxin injection for jaw line reduction and facial slimming programme is a good example of this kind of complication. In order to conduct the treatment, doctors need to measure the muscle and size of the target area on the tourist-patients' face. It is on this basis that the amount of injected medicine will be calculated. However, if a patient is suffering temporarily from

a localised edema as a result of alcohol or other causes, this can potentially lead to over dosage calculation, which in turn may lead to failure in the expected reduction. In the worse cases, tourist-patients may even have difficulty chewing and talking. The mouth will not be able to move naturally, and cleaning teeth will be difficult. In some cases, tourist-patients cannot even close their mouth after they yawn. However, this is not a permanent result. It is not like a result from cosmetic surgery. Although this may be distressing and frightening, the patient will be reassured that over a number of weeks or months, they will recover from over-dosage of the medicine injection. Nevertheless, the period needed to return to normal will depends on how much the injected medicine has been miscalculated.

In addition to this, GR2 stated that *“there is a complication that tourist-patients may not realize that law and legislation in Thailand is not the same as in their home country, in particular if it is a developed country.”* Tourist-patients may be looking forward to participating fully in all that Bangkok has to offer, without realizing that some combinations of experience, such as alcohol, recreational drugs or purchased sex, and non-invasive aesthetic medical treatment may not be compatible. That is, they may be unaware of the degree of physical risk they are undertaking, either during or after their stay in Thailand (GR2 and GR3).

According to GR4, *“Another difficult circumstance is when a tourist-patient’s after-treatment is unexpectedly compromised by unforeseen accidents, or injury, or being subject to violence, or other life risks.”* Linked to this, TP33 stated that *“Dealing with the law and legislation in Thailand is not an easy issue for tourist-patients since not every Thai policeman or legal official can*

speak English very well". This may lead to delays and distress in trying to solve problems, which may take a long time to remedy.

It needs to be understood by tourists that Thai law and legislation regarding food health and safety is different from that in developed countries. GR4 stated that *"Thai street food in particular can cause physical risks for tourist-patients"*. This problem is not specifically related to non-invasive aesthetic medical treatment, but is part of a broader picture of what may happen to tourist-patients who come to visit Thailand for any vocational and/ or medical purposes.

Preparing food on the street is very popular in Bangkok, and very cheap. One dish of rice with curry would normally cost tourist-patients less than one pound. But since the food is cheap, this does not guarantee quality, including careful or completely clean preparation. GR2 stated that *"Under Thai food law and legislation it is only the chefs in luxury hotels who feel obliged to follow the rules of cleanliness, health and safety"*. TP34 supported that *"These regulations are not applicable to street food, so that tourist-patients from developed countries need to know that it would not be difficult to have food poisoning"*.

Having said this, TP28 suggested that *"in general it would appear that the tourists that eat street food are not usually tourist-patients."* TP38 also stated that *"Tourist-patients who have decided to take non-invasive aesthetic medical treatment in Bangkok do not generally eat street food as a main meal, since they are aware of the hygienic implications."* TP39 supported that *"Given that the cost of non-invasive aesthetic medical treatment, while not cheap for Thai average income earners, is considered extremely cheap for*

tourist-patients from developed countries". It seems generally the case that non-invasive aesthetic medical tourist-patients will be able to budget for better quality and safer Thai street food, such as is served at famous street seafood shops in Yaowarat Road. Prices here are much higher than for the cheap rice and curry street food sold on Sukhumvit Road (TP23 and TP25). The Yaowarat street food shops are oriented to affluent people, each seafood dish normally costing tourist-patients between five and twenty pounds, and there is less risk. However, CO8 suggested that *"whatever the price, it is a fact that food cleanliness is still a considerable issue. Since laws for Thai street food do not exist, consuming this type of food can create physical risk for tourist-patients as well as other types of tourists."*

6.3.3 Financial risks

According to GR2, *"Undertaking non-invasive aesthetic medical treatment can be a demotivating experience, since patients rarely see perfect results after a single visit with most treatments. Initially it is hard to believe in the effectiveness of non-invasive aesthetic treatment, so that some may discontinue treatment before the end of the course."* Doctors in this study sometimes found that it was very difficult to motivate their patients to keep coming to the clinic for follow-up visits (CO9, CO11 and CO14). *"What they need to convince patients of is that theoretically, the results of non-invasive aesthetic medical treatment are only at 10-20% of the potential maximum after the first treatment (CO9)."* Tourist-patients need to know that the result will increase dramatically from the second treatment onwards. As mentioned in the previous section in Chapter 2 and scientific information in Appendix A, the process can be speeded up: doctors can treat patients at a higher level of energy to get an 80% minimum of potential results after a single visit, but only at the price of considerable pain to the customer with added risk of side

effects and complications. Such an aggressive approach is not consistent with the envisaged non-invasive nature of these kinds of aesthetic medical treatment. G1 and CO7 stated that there is financial tension between using a lot of power to produce results in patients that may look effective but cause risks, and limiting the power of treatment in the best interests of safety, especially if this more cautious approach results in the 'no result' effect. In other words, it is not always clear what kind of treatment approach is best value for money, or posing the least financial risk for patients.

A second factor in financial risk is a gap in communication between doctor and patient who do not have a common first language. According to CO8, *"Communication errors may lead to patient over expectation, if non-medical staff cannot clearly explain procedures."* CO11 noted that *"Ideally, understandable information for each non-invasive aesthetic medical treatment would normally be explained by a doctor, not just to convey what will happen, but importantly to keep patients' expectations realistic."* However, CO15 mentioned that *"The reality is that information may be conveyed, and unclearly, by other medical staff in the clinic, to include nurses, assistance nurses, receptionists and sales people, none of whom may fully understand the clinical issues for each treatment."* GR3 also noted that *"Medical issues such as the treatment of human skin, the technology of lasers, the side effect of medicines and so on is the specialist provenance of doctors, too complex for non-medical degree staff to discuss. Although a sales person with a marketing degree is, for instance, well versed in his own field, this does not imply any authority on issues related to human skin treatments."*

According to CO8, *"In general the professional development training of staff of clinics in Bangkok is provided at the beginning of their employment by the*

clinic owner, to cover what they need to know about all of the available treatments and medicines used in the clinic. Alternatively, specialists will be brought in to provide the training. Ongoing training to update staff knowledge of new products and technology updates is provided as needed. This training is offered also to any doctors employed in the clinic. The typical profile of the doctors employed by clinics is that they have had general purpose medical training; they may be newly qualified in medicine, or may be experienced in general practice but without dermatology qualifications.” On the other hand, CO12 stated that “sometimes dermatologists are employed who have not yet acquired any knowledge of new technology in non-invasive aesthetic medical treatment. The training element in some cases can be a causative factor in patient risk. For instance, if the training has insufficiently covered the complexities of the treatments, then medical staff may experience a gap between what they are meant to know as experts and what they truly do know as only partially trained. If on the other hand they are able to explore issues and find appropriate solutions in ongoing training, this offsets the problem of insufficient initial training.”

However, CO9 suggested that “even here there is the risk of human error. Medical staff that have no medical degree may not seek to ask questions or further their knowledge, but be satisfied with the limited amount they know. They may be under the impression that they understand everything they need to until they come across a situation when they have to explain or answer about a technical question from an international tourist-patient that they are not qualified to answer. In such cases there is the risk that they will offer misleading information, leading to false impressions on the part of their patients as to the expected results of the treatment. This also poses a risk to the clinic: if the staff in the clinic are unable to deal appropriately with

international tourist-patients' questions and expectations, and the patients do not see the expected results, then these patients may feel they have not had their money's worth from the first treatment and decide not to continue, thus posing a financial risk to themselves and the clinic."

As a result, CO11 concluded that *"customers may consider that treatment is not worth paying becomes especially an issue in a recessive economic climate where every penny counts for consumers. When people are cutting down on unnecessary spending, this may impact on the kinds of elective treatments which go beyond basic health, such as non-invasive aesthetic medical treatment."* After all, people can live without satisfying their need to look slimmer or even younger, if they cannot afford it during a recession.

Even so, in regard to the ongoing financial health of the cosmetic market, GR2 and CO8 stated that *"the need to have a preferred beauty look still plays a significant role in customer expenditure."* CO10 supported that *"Certain sectors of the populations will always want to have a younger and slimmer appearance, whatever the state of the economic cycle."* It would seem that in particular, CO9 mentioned that *"older customers belonging to what is known as the baby boomer group, have no wish to deny themselves non-invasive aesthetic medical treatment, to look younger and better for as long as they can afford it."* The number of people qualified to be in the baby boomer group is not small, and if we add to this group, younger people, even teenagers, then one can see that the recession alone would not cause a problem to the development of non-invasive aesthetic medical tourism in Thailand.

In addition to the above considerations is the actual cost of the treatment. CO12 stated that *"Although for non-Thais, we have said that costs are*

relatively cheap, it is still true that the costs of some non-invasive aesthetic medical treatments are very high.” For example, in Thailand the costs of Fine Thread Lifting (FTL) or ultra v lift by thread (see Appendix A for details) is about £3,000 per course; this cost is similar to the cost of face-lift surgery. The treatment is popular for being remarkably efficacious for wrinkle-improvement, face-lifting and skin elasticity. Using a specialist type of absorbable thread, the treatment enables collagen to generate naturally and to improve elasticity of the skin tissue. Since this thread will dissolve inside the skin later on after treatment, further treatments will be required if patients want to maintain their youthful appearance. The results from ultra v lift by thread, being impermanent, may last for two years only.

On the other hand, GR2 stated that *“the results from a face-lift surgery will last for much longer than the non-invasive one. Comparing these two methods, patients come up with the question of value for money. However, considering these two methods for a long-term purpose the non-invasive one has more advantages in terms of no risk from operation, no pain and no risk to life.”*In addition, CO16 supported that *“the results from non-invasive treatments will look more natural. But most importantly, the medicine or any foreign material does not remain in the skin, which is different from surgical silicone implants that may leave silicone in the patient’s skin for life.”*

6.3.3.1 Hidden costs

As with any other medical treatments, patients need to do their research before making the decision to have non-invasive aesthetic medical treatment. It is clear to see that the standard of care, culture and quality of care differs from country to country. One of the government representatives in this study pointed that *“Tourist-patients need to do their homework, to check that the*

service provider has the appropriate qualifications, indemnity and expertise to carry out their treatment as there may also be hidden costs for patients. The factors such as travel, accommodation, travelling companions and the possibility that treatment has complications and side effects when returning home leaves the question of whether the true cost of non-invasive aesthetic medical treatment abroad is cheaper to that at home (GR5).

6.3.4 Time risks

According to GR4 and CO8, *“Non-invasive aesthetic medical treatment is in general a time saving process if compared with cosmetic surgery (GR4), since it can be done at any time of the day. As it is not an invasive treatment, there will be no operation, no wounds and no bleeding, which leads to operational time saving (CO8).”* But CO10 stated that *“alongside this is the main advantage of non-invasive aesthetic medical treatments, that in most cases, patients will suffer little to no severe pain during and after having the treatment. In case of laser treatment, anesthetic cream has been found to be useful prior to the treatment in order to reduce pain. Recovery time is not an issue as in many cases, patients will immediately after treatment be able to engage in their regular activities such as going to work, doing their job or meeting friends.”* There is no risk of infection or need to be isolated from others. Patients are also able to put make up on their faces if they like.

Notwithstanding this, CO12 stated that in some cases non-invasive aesthetic medical treatment can be a more time consuming procedure. Regarding its nature, the results from some treatments will not be perfect from a first treatment. For instance, the improvement to skin and shape in the case of fat and cellulite reduction by carboxy therapy only becomes gradually noticeable

over time. In such cases, patients will not see a perfect result in one day. Most non-invasive aesthetic medical treatments, that is, with the exception of botulinum toxin and filler injections, require more than one visit to complete the treatment (CO9). Treatment with the Fractional erbium fibre laser, Finescan[®] or Fraxel[®] for example, would require the patient to be treated four times for the perfect result (CO11). Each treatment can be done in a two to four week period. Indeed, instead of having all the treatments in one go, it is considered better to split the treatment into four well-spaced sessions. This is because the result from the first treatment can help the doctor more effectively to estimate the appropriate energy dosage for the following treatment.

If time is allowed for the treatment to be tailored over a period of sessions, then patients will be less at risk of complications such as a swollen face or burning sensations. These complications are more likely to happen if the treatment tries to go quickly, necessitating the doctor using a very high energy level to treat patients' skin; this energy is higher than the energy need to create a beautiful result over time (GR2). However, GR3 said that *"it is worth noting in this respect that there is no single formula, pattern or solution for treating a patient's skin, since every single case is different"*. For example, there will be no single perfect solution that can fit to a Thai patient's skin and a British patient's skin. Doctors can only determine the initial level of energy from recommended statistical results available from published medical journals or from their own experience. There can never be any guarantee that a generalized set of information is uniformly applicable to any patient, even if they have the same nationality, skin type, age, sex, and skin problem.

According to CO8, *“The other important issue with this treatment is that it is risky to use a very high energy level to treat a patient, even if they wish to create results quickly. The quicker the treatment, the more energy is needed and this risks creating a great deal of pain, which is quite other than the effect that non-invasive aesthetic treatment is designed to have.”* Moreover, CO12 stated that *“if a high level of energy is used for treatment, this may invalidate the effectiveness of the anaesthetic cream normally used to help reduce pain. Of course, the ideal for both doctors and patients would be to have zero pain from the treatment, administered at a low level of energy.”*

It is useful here to factor in the consideration that even if a four-visit treatment is less quick than a single visit, it is still time-efficient. TP28 stated that *“Normally in this treatment each visit would take no longer than 20 minutes; altogether this would consume less total time than cosmetic surgery generally takes”*. Therefore, in the near future, non-invasive aesthetic medical treatment will increasingly be advertised, and come to be seen as a time-effective aesthetic medical treatment in terms of fewer complications, less pain and providing a natural result.

6.3.5 Psychological risks

Psychological risk refers to the possibility that consumption of the product may harm the consumer’s self-esteem or perceptions of self. It is noted that non-invasive aesthetic medical treatment is not a necessary treatment like other medical procedures, but may be seen as psychologically necessary to the consumer. As having a psychological component, this kind of treatment, creating changes, can cause psychological risk to patients in different ways. As consumers in this market each tourist-patient will have their own self perceptions regarding non-invasive aesthetic medical treatment, so that they

will present for psychological risks in a number of ways. These are discussed below.

6.3.5.1 Addiction to maintaining a youthful look

According to GR5, *“Nowadays, the availability of non-invasive aesthetic medical treatment is not limited to a specific group of people or country. The service is widely open to patients from different backgrounds, and of different ages, genders, education, occupation and income. Regardless of any of these factors, it could be argued that good appearance is the first thing that creates a first impression for other people, and as such, if users of cosmetic procedures see a good reflection of themselves in a mirror, this will lead to self-esteem in the eyes of others.”* TP32 stated that *“Looking good helps people to have more confidence in order to look after their own interests, to compete and acquire the things that will make them happy.”* A tourist-patient reflected that *“The simple fact of the matter is that human beings have always been conscious of their appearance and some, who can financially afford to, will find opportunity for whatever modern, sophisticated means necessary to enhance it (TP24)”*. Linked to this, Kerscher and Williams (2009) explain that many individuals feel a distinct improvement in their psychological and physical well-being after having cosmetic treatments.

In addition, TP34 stated that *“It is not new that people want to enhance their appearance, and efforts to do so have been recorded as back as the time of Cleopatra and beyond. Dynastic figures in ancient Egypt covered their faces with gold every day as a beauty treatment, to protect from the elements and to maintain youthfulness.”* In Thailand, CO16 stated that *“there is a phrase used for describing a woman who can maintain a youthful look over the age*

of 50, as being a “2000-year old woman”. As it was thousands of years ago, so do people today also looking for ways to retain youth and beauty. The only real difference in the last decade is that people have come to rely much more on scientific results than the transmitted lore of generations, which may have been effective, but without any scientific or medical approval.

Thus, GR4 stated that *“the development of medical technology is seen to help people to achieve a more youthful look and they have access to an increasing number of techniques, from cosmetic surgery to elective non-invasive aesthetic medical treatment.”* GR5 supported that *“People tend to believe in scientific results more than anything so that increasingly, advertisements on television, in magazines, newspapers, on the radio, and on websites take care to report on clinical data to support their claims”*. Although there is legislation to prevent over claiming, advertisers promote new and possibly unrealistic results. This leads to a risk of over consumption by ill-informed or gullible consumers.

This means that the consumer’s mind set can be a factor that promotes risk. That is, while wanting to ensure one has a good or better appearance may be seen as a healthy thought, if it becomes compulsive, or based on anxiety, it is not, in that patients may be led to indulge in non-invasive medical treatment to an excessive extent. GR2 said that *“This also puts such patients at risk of developing body dysphoria, which can become mental illness”*. Crucially, one of the things which typifies non-invasive cosmetic treatment is that it should not lead to dramatic change. It is not designed to have instantly noticeable end effects, as does cosmetic surgery. But some patients will not be satisfied with looking ‘good enough’, and will always crave a better improvement of their skin and shape. *Such individuals may be driven to keep searching for*

the perfect treatment, trying out the same medical procedure at different clinics (GR3) in the hope of receiving a better result than the time before (TP36). In some cases, there is a need to try out every new non-invasive aesthetic medical treatment as though it were a fashion, *It is observed that this type of patient may continue to consume this type of medical treatment as long as they can afford it (CO9).* And certainly, as a result, some will gain a dramatically obvious change in their skin.

To show how the visibility of treatment is gradual, for example, the laser facial treatment process. Normally this requires one treatment every four to six weeks for an expected result; however, after two weeks of treatments some patients will not be able to notice any perceptible improvement of their skin condition. While this is the norm, GR2 and CO8 said that some patients may be sufficiently skeptical or impatient to seek another laser treatment from a different clinic, in the hope that they will achieve a better result. The reality, however, which such patients need to understand, is that the complex composition of the human skin does not change instantaneously like that, but takes time to develop. The recovery process will not be completed in one or two weeks as some patients wish. Patients need to understand that the process involves damaging skin by laser, then allow the process of skin fixing to start. At the end of the fixing process, patients' skin will tighten as the collagen shrinks. However, when patients consume laser treatment out of sequence, that is, interrupting one treatment to begin another, then there is the risk that the results will then overlap. When this occurs, results from the different treatments may be unexpected, or risky, such as the abnormal development of collagen. There is no medical journal that guarantees risk-free overlapping of laser treatment (GR2). In engaging in overlapping

treatments, patients run a physical risk, a functional risk, a financial risk and a time risk, all as a result of having psychological uncertainty as to the process.

“If psychological impatience can lead to patient risk, so also can over-consumption create psychological risks for tourist-patients in terms of distorted self-perception. In their quest for a more youthful look, for some patients ‘more’ treatment is never enough” (CO15). There are some different non-invasive aesthetic medical treatments which provide more or less the same result. For example, Iontophoresis and Phonophoresis are methods used for applying vitamins and other essential substances to the skin but by means of different techniques. Certain patients, under the impression that ‘more’ is better, undertake treatment using both methods, in the belief that the result will be doubled (TP33 and TP34). But *“if patients are in the habit of taking two similar treatments, or taking one treatment too often, they will eventually come to a point where no improvement is going to happen, however compelled they are to continue”* (CO8).

Compulsive use of non-invasive aesthetic medical treatment, or even addiction to the process, may create unnecessary need which may lead to other risks such as financial risk and physical risk. The purpose of having elective non-invasive treatment is to maintain a youthful appearance or to alleviate the signs of ageing or reshape disliked body parts such as the jaw line, or the size of the arms. However, when patients are addicted to the prospective result or the advertised result, they may continue to treat themselves compulsively in order to get rid of the signs of ageing or to reduce fat to a greater degree than they actually need to do. This could be seen as a form of self-harm, leading to psychological as well as physical risk.

6.3.5.2 Refusal to accept the effectiveness of results

According to CO8, *“The most difficult task for a doctor conducting non-invasive aesthetic medical treatment for tourist-patients is to determine the right parameters for each treatment”*. In order to do this, the dermatologist has to have very good knowledge of the type of the tourist-patient’s skin; non-Thai skin may be totally different from tourist skin. Since tourist-patients from abroad are unable to stay in Bangkok for a prolonged period, it is all the more important to establish appropriate parameters, factors, and dosages to achieve the desired results in the given period. It may happen, however, that tourist-patients are not happy with the results of the treatment, (CO8, CO9 and CO12) even if the results are those expected by the doctor, and serve as evidence that the doctors have performed the treatment well. *“The problem in such cases lies rather in the perceptions of the tourist-patient”* (CO11) who fantasises a dramatic result which is neither in keeping with the claims for, nor possible to achieve with this type of medical treatment. It is normal practice for doctors to take a photograph of or measure the treated area before conducting the treatment, in order to compare before and after changes in the results of the treatment. In some cases, *“the doctor might consider the result as very effective but find that the tourist-patient is dissatisfied and refuses to accept the result as successful”* (CO8). This may indicate that the patient’s self-perception is a crucial factor in determining whether a treatment is considered successful or not. If the tourist-patient has a psychological frame of mind that cannot accept a realistic result, then this creates a problem for them and the clinic.

In order to have good results from non-invasive aesthetic medical treatment, tourist-patients have to have the right treatment at the right time and be given the correct dosage by an experienced dermatologist. It would appear that it is

common for many tourist-patients to be ill-informed about the nature of their treatments. For instance, in the case of laser facial treatment they believe that a higher application of energy is better than a lower one in terms of effectiveness. Even *“if doctors are trying to keep the treatment safer by testing the sensitivity level of the patient’s skin, in order to determine the appropriate level of power to use for the laser facial treatment”* (GR2), *“some patients insist on maximum tolerance in the belief that they will profit more from being treated at a higher level of energy”* (GR3). The risk here is that the end results of the treatment can go wrong because of the crucial gap between what is the bearable point for patients, and what, eventually is beyond the bearable for their skin.

Similar misunderstandings of risk amongst patients is evidenced in the use of carboxy therapy (see Appendix A for details), a fat and cellulite reduction treatment which works by injecting carbon dioxide gas into the treated area. In this treatment, a tourist-patient will be treated according to an appropriately assessed volume of carbon dioxide gas. For example, CO11 stated that *“fat reduction in the upper arms normally requires about 200 to 300 cc per arm, but may be more, or less, depending on the size of the arms”*. It is worth noting that the quantity of gas is the key parameter for achieving good results in this treatment. Having said that, in order to ensure absolute safety for the patient, the amount of gas given is normally limited. However, the findings of this study indicate that in some cases tourist-patients asked for a greater volume of gas (CO8 and CO11) than the doctor had judged safe.

In Bangkok, carboxy treatment is charged per visit, not per volume of gas. It would appear, therefore, that *“some patients’ inappropriate demand to have more carbon dioxide gas is based on the belief that they will profit more from*

the clinic" (CO12). In some cases, *"tourist-patients required a higher volume of gas on a following visit"* (TP28) that is, having been treated with 300 cc of gas for the upper arm on the first visit, they then asked for 400 cc or more on the second visit. The lack of understanding that tourist-patients show in regard to the implications of carbon dioxide gas volume, or level of energy in laser treatment, is very risky, possibly leading to long term effects on their well-being.

It has been argued above that being ill informed about or having unrealistic expectations of non-invasive aesthetic medical treatment, may lead to psychological risk of the patient-user. It is important, however, to realize that *"this problem may be amplified by word of mouth"* (TP36), that is, if a potential tourist patient listens to the ill-informed experiences of others regarding the quality of the service, the effectiveness of the treatment and the side effects of non-invasive aesthetic medical treatment at a clinic, then *"there is a risk of this misinformation, or ill-founded beliefs, spreading from one tourist-patient to another"* (TP39). This builds up a set of commonly held inaccurate beliefs. One tourist-patient for example was reported to believe that laser facial treatment would reduce the thickness of her skin (CO8). Another was of the belief that after laser facial treatment, the skin would be more sensitive to sunlight, cosmetic creams and pollution (TP40). From the medical research viewpoint, neither of these beliefs is true, although a partial truth is that *"patients who have had laser treatment should take care for a few weeks not to expose themselves to too much sunlight"* (GR3). The scientific basis of this advice is that after the laser treatment, the fixing process under the skin is ready to begin, and if patients avoid sunlight, this will help them to have a smoother result on the skin. But after the healing process, the improved skin is well able to tolerate sunlight, cosmetic creams, pollution or anything else it

is normally exposed to. On the other hand, doctors are likely to remind patients who are not even having cosmetic treatment that too much sun is not good for the skin, that it leads to ageing, and that they should always put sun protection cream on their faces or stay in the shade.

The word-of mouth phenomenon can have a huge impact on the industry. *“Once one untrue story about non-invasive aesthetic medical treatment has been told to another tourist-patient, it is very difficult to change people’s perceptions and beliefs”* (CO9), and they tend not to question what they have been told. *“Not every tourist-patient reads about the effectiveness of each treatment from a medical journal article”* (GR5). Where an individual does not have enough knowledge to evaluate whether what they are hearing is right or wrong, they will more readily tend to believe the reported experiences of other tourist-patients who have had non-invasive aesthetic medical treatment. Word-of-mouth is seen as a useful potential source for future tourist patients to gather information, but they may not be aware of the psychological risks this entails to perceptions of self.

6.3.5.3 Hiding the fact of having had cosmetic treatment

Having non-invasive aesthetic medical treatment is a challenging activity for some people, who are happy to discuss with others about their experiences of treatment such as cost effectiveness, pain, side effects, the quality of the service and much more (TP24, TP33 and TP36). However, not every tourist-patient will likewise, some believing that it is not anyone else’s business that they are trying to enhance their looks (TP32 and TP35). Such patients would prefer others to believe that their youthful appearance derives only from healthy food and good exercise. If a tourist-patient has this outlook, then undergoing non-invasive aesthetic medical treatment outside the tourist-

patient's home country is a good choice, since no one need know how the wrinkles on the face have been treated and reduced. Other people may only noticed the more youthful look. Having this treatment in Bangkok is a popular opportunity for those who wish to hide the secret of their beauty enhancement.

However, respondents in this study were of the belief that this behaviour is based on delusion, that comes with psychological risk. It is not good behaviour. *"Non-invasive aesthetic medical treatment is not everything in life and it is not the most important issue to consider"* (CO8). It is just a medical treatment to help people achieve a youthful look. This happened with *"a twenty years old girl who did not want to tell others that she had Botox[®] injections to reduce her fine wrinkles and jaw line"* (CO10). She wanted to have a nice face shape and she found out that Botox[®] injection could help her to achieve this. She was telling relatives that she was on a diet and exercising more in order to have a nice face, which was not true. More importantly, *"patients should bear in mind that Botox[®] is a toxin and that may harm the development of good cells for teenagers"* (GR2).

6.3.5.4 How bargain prices create over-consumption

Unlike other medical treatments and procedures, non-invasive aesthetic medical treatments tend to come with discounts and promotions (GR2, GR3, GR5, CO8 and CO10). While the offer of "buy one, get one free" is generally applied to food, clothes, and household equipment, GR2 said that *"it rarely happens with medical treatment."* It would be unusual for a hospital to offer a promotion on heart surgery, knee replacement and any other medical treatment. However, the business environment of the medical cosmetic industry in Thailand is very competitive, so that many non-invasive clinics in

Bangkok are found to offer different types of promotion such as “buy one get one free” for the same treatment. Advertising inducements are common such as “come with mother to get yourself a free treatment”, “*buy a facial treatment and get a fat reduction course for free*”, “*half price on laser facial treatment*” etc. (TP28). “*Every clinic tries their best to take every opportunity to attract tourist-patients. This marketing strategy is seen as a tool for achieving target numbers*” (GR4).

The problem is that this type of marketing strategy, though foreign to every other type of medical treatment or procedure, may exacerbate potential psychological risks for tourist-patients. While “*a competitive price may attract and motivate tourist-patients to buy the services they want from a specific clinic*” (TP29), it may also create interest and demand from tourist-patients, who do not necessary need to be treated. Moreover, although the nature of non-invasive aesthetic medical treatment is to help people to achieve a more youthful look, it may have a limited capacity to rejuvenate people who are already in good condition for their age. That is, it may not be indicated as a necessary treatment for older people who have retained a good quality of skin tone for their age, through careful use of moisturising cream and avoidance of the damaging effects of sun light.

The findings include an account of a doctor who experienced a tourist-patient who fell into the category of well-preserved older women (GR4). This tourist, a woman of 42 years, came to the clinic and asked what the doctor could do to give her a younger look within two weeks as after that she had to go back to her country. Having checked her skin, the doctor told her that there was not much the clinic could do to make her look younger. She was advised to consult with a cosmetic surgeon if she wanted change. However, this woman

had been influenced by a friend who had had laser facial treatment which had made her look younger than her age, and was determined to have the same treatment. The woman had already made up her mind about this before coming to the clinic. An added incentive to her determination was that the laser facial treatment was on promotion at half price at that time, irresistible to tourist-patients who are aware that this price would be one tenth of the price of similar treatment in their home countries. When the woman in question requested this specific laser facial treatment, the doctor explained the probable minimal results it would have in the time available, partly to offset any disappointment on her part, but also to protect the reputation of the doctor and the clinic. In the event, at the end of the second week the tourist-patient was not happy with the results, and complained. It is true that the skin had only improved by about 10%, at which stage it would be difficult for anyone to discern much improvement, including the tourist-patient herself. Although there was nothing the doctor could do to help her, she was reminded that from the onset of treatment they had had a discussion about the likelihood of this outcome, but had disbelieved the doctor. It could be said then that in consuming this service she had not only failed to get the result she wanted, but had also harmed her self-esteem or perception of self.

The patient's belief set influence the treatment in other ways. For instance, although laser facial treatment is potentially successful in reducing the sign of ageing and helping to tighten the skin, it will not succeed unless another critical crucial factor comes into play: this is the behaviour of the patient him or herself, in terms of how they have treated their skin before and after treatment. This kind of cosmetic process is not a brief one, but a long-term development which requires the patient to take good care of their skin. Without this factor, *"no laser facial treatment has the capacity to help patients*

to look younger at the age of forty to fifty" (CO9). At that age, when the collagen on the face is already dead, any amount of laser facial treatment or Botox[®] cannot help such people to look younger naturally. The only means of doing this is by cosmetic surgery.

It was mentioned earlier that in some cases, tourist-patients look good already, but are tempted by the promotions from non-invasive clinics to have unnecessary treatments that do not even work to make them look younger. Thus having inappropriate treatment may cause them to waste money, put themselves in the situation of financial risk, as well as of physical risk, functional risk and other related risks. This is notwithstanding that they might have an unexpected result at the end of the treatment itself.

Botox[®] injections serve as a good example of this. "*One of the informants in the study recounted an experience of treating a twenty year old tourist-patient in August 2005*" (CO8). The tourist-patient was a UK resident visiting Bangkok with her family for four weeks. While she was waiting for her mother in the reception area, she was watching the Botox[®] programme on the television, which was explaining that Botox[®] injection could help women with emotionally induced wrinkles, that is, the kinds of wrinkles that appear on the face when people express their feelings, whether happiness, sadness, anger, or confusion. This programme motivated her to ask her mother's permission to have the treatment. Her mother, who had already been treated by Botox[®] injection in her home country, was also intending to have a Botox[®] injection during this vacation.

As it happened, the cost of Botox[®] treatment at that time was at half price, as it was mother's day on the 12th August in Thailand, during which period, the

most popular promotions were aimed at mothers and their children. This clinic was no exception, offering a promotion of “buy one get one free”. The condition was that the free treatment had to include a second person so that the same person could not take two treatments. By this combination of circumstances, the twenty year old tourist-patient was given permission to have the treatment, although she did not need it. As the tourist-patient was very young, the fine and deep wrinkles were not yet apparent on her face. Her emotional wrinkles were very small. After having had the Botox[®] injections, both tourist-patients were required to meet the doctor before they left the country. The result on the mother’s face was absolutely perfect. The wrinkles were difficult to see. Her emotional wrinkles were fewer than before having the Botox[®] injection, as a result of which she was very happy. Conversely, the results on the daughter’s face were strange, as she ended up with no expression, unable to change the shape of her eyes to reflect whether she was happy or angry. Her eyes could not illustrate her emotion. CO8 speculated that *“the patient had been too young to have Botox[®] injection treatment around the eyes”*. In the instance, as perhaps in others, buying an unsuitable product, even with the promotion at reduced price, could lead to risks to the consumer in the long run.

Such narratives as the above suggest that there is a clear risk to patients in regard to the indiscriminate promotion of non-invasive aesthetic medical treatment. One government representative saw this as a considerable issue, saying that *“there is a risk to the public here and one I come across regularly when dissatisfied people come for advice, after having undergone a procedure they regret: cross selling. While you may think there is nothing unethical about encouraging customers to buy two items from a shop when they intend to only buy one, it is highly unethical to cross sell serious medical*

procedures to an unwitting customer when she or he goes simply to have a non-invasive beauty treatment or injections to reduce wrinkles (GR3)."

6.3.6 Social risks

Social risk refers to the possibility of a product choice resulting in social embarrassment. Non-invasive aesthetic medical treatment can create social risk to consumers in a number of ways. The details of each one can be seen below.

6.3.6.1 Embarrassment of having too obvious a result

According to CO8, *"Tourist-patients may have too obvious a result if they take too many treatments at the same time or in a short period of time. This can happen when they take for example too many treatments of Botox® injection or mesotherapy within a few weeks during their holidays in Bangkok."* In order to look good or have a youthful look, GR2 said that *"tourist-patients should be very careful of what to take and how and when to take non-invasive aesthetic medical treatment"*. There are two sides to everything, which include this kind of medical treatment too. Tourist-patients might end up with a youthful look which is not appropriate to the user's age, so that the change is obvious; everyone can guess that there have been interventions to the patients' face or body. The main purpose of having non-invasive aesthetic medical treatment is to help patients to have a beautiful and youthful appearance without attracting negative attention from others. But TP26 stated that this cannot be guaranteed in the case of tourist-patients who take too many treatments over a short period of time. So for instance, a thirty-five year old tourist-patient may decide to have their skin tightened skin and so will decide to purchase a radio frequency treatment, a fractional laser treatment, a

Botox® injection and a mesotherapy. *“Each treatment has its advantages in promoting a youthful appearance. But no reputable medical research supports the advisability of having these treatments altogether in one go, nor would conceive that this combination would help patients to achieve what they want”* (GR3).

Tourist-patients who overdo their treatment may end up with a dramatic change in their appearance, ending up looking very much like a person who has had cosmetic surgery. In this case the result will look too obvious and anyone will be able to see the change.

6.3.6.2 Embarrassment from telling other people about non-invasive aesthetic medical treatment

According to TP36, TP37 and TP44, for some tourist-patients, it is embarrassing to let other people know what they have done with their faces. They prefer to keep these treatments secret, so that others will believe they derive their youth and beauty from a regular life style, and healthy living, eating more fruit and vegetables, taking vitamins, doing more exercise and positive thinking (CO14). Consequently it is embarrassing to tell people in their society that they have been treated by one of the non-invasive aesthetic medical treatments such as fat and cellulite reduction by carboxy therapy (TP40 and TP42). *“It is good to look slimmer but the most difficult part is how to have this look and more importantly how to maintain it when patients reach the age of forty or after a pregnancy period”* (GR5).

Each society has different beliefs about appearance and the life cycle. In some societies, *“it is absolutely normal for men and women to improve their*

appearance by having non-invasive aesthetic medical treatment, using body building medicines and having cosmetic surgery (GR3). For some families, *“it is considered absolutely acceptable to help children reach their maximum height by injecting medicines to interfere with their puberty development”* (TP39). For instance, a certain injected medicine will delay a girl’s menstruation, in order to help her grow taller than she is. Similarly other injections can stop boys from producing sperm. Not only is the cost of the injected medicine very expensive, but *“it can be a source of embarrassment for the families who use them; although they may believe that injecting this medicine is the only choice for them to help their child to be taller, it is difficult to tell this to others”* (TP41). Other people might not believe in the effectiveness of the medicine, but more importantly, might disapprove of this method as something unnatural (TP43). *“Relatives may put moral pressure on parents, or create arguments”* (TP45). But this is a tension for parents whose children have a height of only 155 cm or less. In some societies, *“many good jobs require minimum height of 165 cm for women, and being too small would mean that the opportunity for having good things in life would be reduced”* (TP38). Therefore, even if the product choice may result in social embarrassment for the parents, it will often be more important for them to go on with this treatment, as the future well-being of their child is more important to them than the negative comments from relatives (TP35).

As well as the injected medicine, body building medicine has a social impact and in turn carries social risk. If a patient would like to have more muscle than usual then an alternative choice to exercise is body building medicine. The most popular current product is whey protein powder.

Among the many reasons and purposes that cause tourist-patients to come to non-invasive aesthetic clinics, body building is an important one. In order to have more muscle, people are told that they should eat more protein and do more exercise. However, it is very difficult to tell how much meat or exercise should be taken daily by each individual for best results. People wish to know about what type of exercise is the most appropriate for creating upper body muscle, how long each session should be and how often this activity should be conducted, among other issues. The obvious solution for such people is to consult a doctor who will recommend what to do in order to have more muscle. If tourist patients come to clinics in Bangkok to receive this information, a daily guideline is normally provided as a formula for successfully increasing muscle. However, *“the patient usually asks for the quickest way to do this”* (CO8) because they are in Bangkok only briefly as part of their holiday.

“The choice of having whey protein powder is another instance where patient intervention changes the results” (CO10). Tourist-patients are normally recommended to stir the whey protein powder into milk or juice and to have it one to three times daily as a food supplement. However, some tourist-patients go beyond this, and treat the supplement as their main source of food (TP40 and TP42), desisting from eating other food, or even accompanying their diet with body exercise. Instead, *“they become fixated on whey protein powder as a magic body building powder”* (CO11). What such patients do not realise is that food supplements are not complete foods, and cannot provide all nutritional needs. More seriously, *“the ingredient list of many whey protein powder products do not show the ratio of animal protein to other source of protein in the product so people may not know what they are*

eating" (CO13). The product can only work if taken as a food supplement, in a way similar to taking vitamins.

On the subject of vitamins and minerals, it is recognized that these can be taken by consuming a variety of fresh food, fruits and vegetables as daily balanced food consumption. However, some tourist-patients visit non-invasive aesthetic clinics for a blood check up to see what vitamins and mineral are missing. The purpose of knowing this information is to buy a vitamin arrangement service from the clinic. The clinic will provide the list of vitamins and minerals that should be taken to compensate the ones that are missing. Some tourist-patients believe very strongly in the benefits of this service (GR2, GR3 and GR5). However, an experienced doctor contributing to the findings of this study said that tourist-patients from developed countries tend to believe more in the effectiveness of vitamins and minerals than in food (GR4). Although "*vitamins and mineral are cheaper to buy in the U.K. and in the U.S. than in Thailand*" (GR2), what "*tourist-patients expected from doctors in Thailand is to have a blood test and get a formula of vitamins and minerals*" (TP35) which will allow them, once back home, to buy the appropriate vitamins and minerals at a cheaper price in their home countries. "*The critical issue is that some tourist-patients end up taking too many unregulated vitamin and mineral supplements*" (CO9), ignoring the benefits of real food. They are fearful of most foods as contaminated with toxins. They hear reports of animals such as cows and chickens being injected with medicines or hormone to increase the meat yield and denature their food value.

TP33 stated that *“There does moreover seem to be a certain amount of status linked to special diets and tailor made supplements. Tourist-patients, like everyone else, enjoy differentiating themselves from other people”*. *“Sometimes this can be achieved by wearing lots of brand name and luxury products such as shirt, jeans, bags, earrings, watches and so on. But these things are easily acquired and do not demonstrate difference as much as they used to”* (TP32). TP22 suggested that *“They do not represent the uniqueness of each person”*.

On the other hand, *“the consumption of individual and tailor made formulae of vitamin and mineral supplements may serve to provide each tourist-patient with a sense of their uniqueness”*, (CO12) *“not to be the same as other people”* (TP23). On the other hand, being different from others can create a social risk if the product choice results in the social embarrassment. Conversely if the product choice is accepted and valued by other people in the tourist-patients’ society then social embarrassment is not an issue. The social risk will therefore not be a problem.

Notwithstanding this, people have different perceptions and opinions on product and service choices. What is good for one may be bad for another. This means that choosing a certain product may not be approved of by others as good or appropriate. In terms of the use of non-invasive aesthetic medical treatments for example, TP31 stated that *“this may create conflict in close social groups, for example family gathering events such as a Christmas party. “Some members of the family such as grandparents may be strongly against such treatments”* (TP30). *“And since it is difficult to explain the benefits of a product to people who are minded to disapprove”* (TP43), *“in some cases, not telling the truth is the only option available. Letting other people believe that*

the youthfulness and beauty has come about naturally is the way to minimise social risk” (TP41).

6.4 Framework of risks as the barriers to the management of non-invasive aesthetic medical tourism in Bangkok

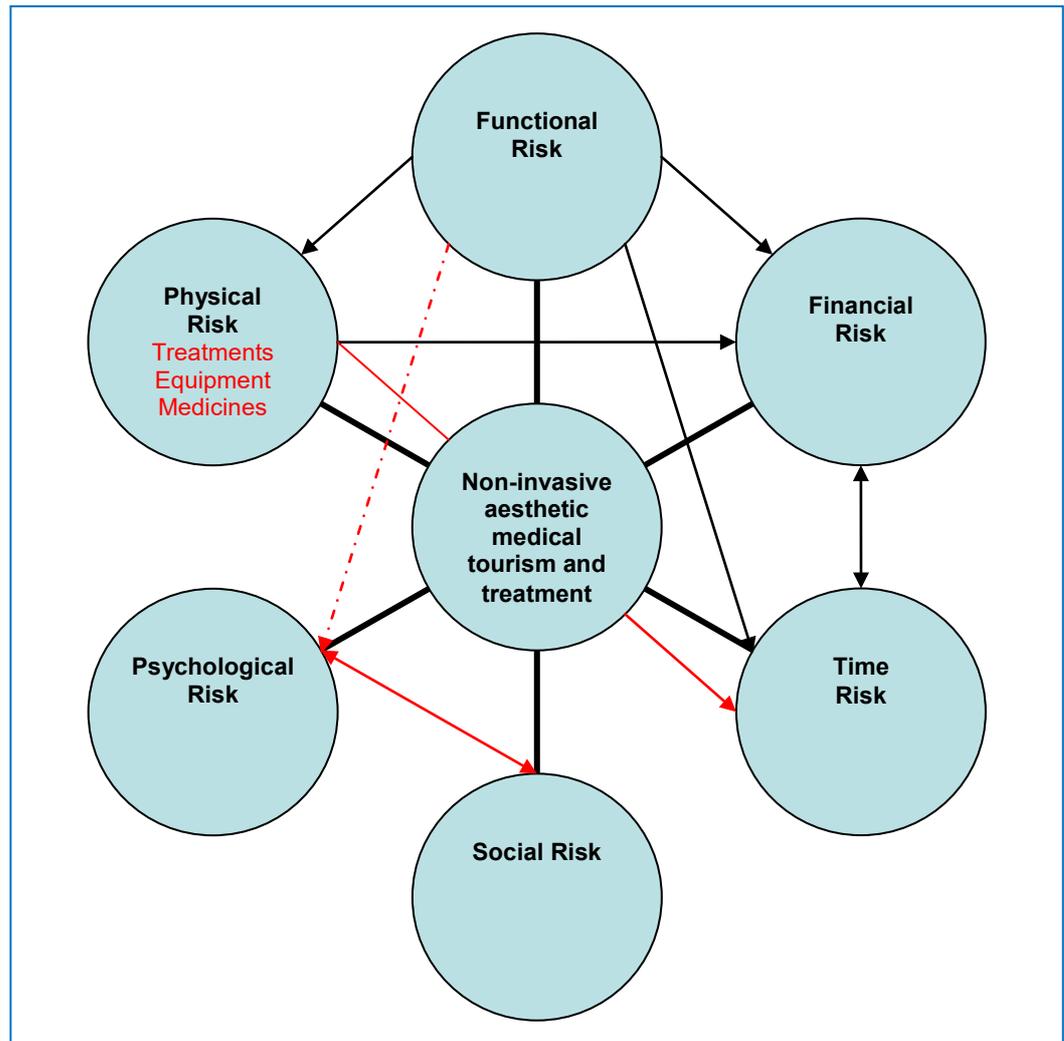


FIGURE 6.1 A framework of risks as the barriers to the management of non-invasive aesthetic medical tourism in Bangkok

As a result of the primary data findings, the researcher developed the framework as illustrated in Figure 6.1 in order to explain how the conceptual framework (Figure 3.1) has been modified. In comparison to Figure 3.1 in

Chapter 3 (a summary diagram of risks associated with non-invasive aesthetic medical tourism and treatments), the primary data findings highlighted three new elements. These elements are illustrated in red arrows in Figure 6.1. Firstly, physical risk led to time risk. One can note that the physical risks of non-invasive aesthetic medical treatment are relatively low. Nevertheless, CO8 stated that “if tourist-patients are in less than perfect health then there may be an increased risk during treatment. For instance, if a tourist-patient has a history of heart disease or is overweight then they may be at greater risk of complications from a general anaesthetic. Such complications can take the form of a stroke due to raised blood pressure, or an abnormal heart rhythm. While such phenomena are still rare in non-invasive aesthetic medical treatment history, it cannot be ignored that some cases create a higher possibility of physical risk.” As a result, physical risk leads to time risk: tourist-patients may have to admit to hospital and/or they may have difficulties travelling during their vacations to medical tourism destination cities.

Secondly, psychological risk and social risk are linked in a two-way relationship. The linkage between these two risks is not associated directly to non-invasive aesthetic medical tourism and treatment. However, it is an issue because when tourist-patients perceive psychological risk (or social risk) then social risk (or psychological risk) will be affected. In other words, each society has different beliefs about appearance and the life cycle (TP33). Consequently, in some societies it is embarrassing for tourist-patients to tell people in their society that they have been treated by one of the non-invasive aesthetic medical treatments such as fat and cellulite reduction by carboxy therapy (TP40). However, in some societies people believe that it is crucial to maintain the youthful and beautiful appearance (TP23). As a result, the

problems of over-consuming and addiction to non-invasive aesthetic medical treatments become an issue (CO9). In addition to this, compulsive use of non-invasive aesthetic medical treatment, or even addiction to the process, may create unnecessary need which may lead to other risks such as financial risk and physical risk.

Finally, functional risk led not directly to psychological risk (the red arrow has presented in dots). This is the case for botulinum toxin injection. Carruthers *et al.* (2002) confirmed that Botox injections can lead to bruising and blepharoptosis. Blepharoptosis is abnormal low-lying upper eyelid margin with the eye in primary gaze. The Expert Working Group on Cosmetic Surgery recommended that botulinum toxin injections should be monitored by the Healthcare Commission to safeguard patient safety (BBC, 2007a). Such cautioning voices reflect the reality that under current regulations (Honigman *et al.* 2004; Mishra, 2014), almost anyone can set up a clinic in a local high street and offer botulinum toxin injection services. In the cases where unexpected circumstances happen, some patients can be left scarred physically or psychologically for life (GR2). This case is very rare. However, tourist-patients have to bear in mind that functional risk may lead indirectly to psychological risk.

In addition to the above three new elements, the primary data findings also confirmed that functional risk creates (1) physical risk (Hanefeld *et al.* 2014; Head 2015; NaRanong and NaRanong 2011; Turner 2011), (2) financial risk (Ben-Natan *et al.* 2009; Birch *et al.* 2007; Head 2015; Jeevan and Armstrong 2008; Lunt and Mannion 2014; NaRanong and NaRanong 2011; Reed 2008), and (3) time risk (Featherman and Pavlou 2003; Head 2015; NaRanong and

NaRanong 2011). It can be concluded that functional risk or in other words the complication from non-invasive aesthetic medical treatments is a crucial barrier to the management of non-invasive aesthetic medical tourism industry.

Moreover, the primary data findings confirmed that financial risk and time risk are also linked in a two-way relationship to each other (the arrow has presented in black). Many researchers also suggested that financial risk and time risk have two-way relationship (Hall 2013; Jonas *et al.* 2011; Lunt *et al.* 2012; Lunt *et al.* 2016; NaRanong and NaRanong 2011; Singh 2014). Tourist-patients may not only buying a non-invasive aesthetic medical treatment that does not satisfy their needs (financial risk) but also wasting time during their vacations at medical tourism destination countries (time risk). Tourist-patients may also possibly have the complications from four-session laser treatment during their vacation. This means that they will not only wasting time for having the treatments (instead of spending time during vacation with family and friends at the beach; time risk) but also losing money for further treatment in order to recover from those complications (financial risk).

Lastly, physical risk (with reference to the treatments, equipment and medicines) led to financial and time risks. Many scholars also stated that physical risk leads to the issue of financial risk (Bookman and Bookman 2007; Chan *et al.* 2011; Connell 2011; Hall 2011; Hanefeld *et al.* 2014; Harling *et al.* 2007; Jonas *et al.* 2011; Lunt and Carrera 2010; Prasirtsuk 2009; Roger *et al.* 2011; Smith *et al.* 2012). In addition to this, physical risk, which refers to political issues, epidemic crises, and health risks, is another crucial reason for tourist-patients to lose money during their vacation in medical tourism destination country (financial risk). Despite being a major player in the medical tourism market, Thailand's political turmoil has resulted

in a significant drop in the number of tourists and medical tourist arrivals in the country, particularly after the shutdown of the two main airports in Bangkok in December 2008 (Prasirtsuk, 2009). Research data gathered from Andersen and Jayanama (2014) in Bangkok has indicated that the sector had yet to see any signs of recovery, since a large number of its foreign markets, such as the United Kingdom, the United States, Canada, New Zealand and Australia, were still in 2012 cautioning their citizens against travelling to Thailand due to high political risk. The problem with the current situation in Thailand is that the focus is very much on political reforms by military government (Shaffer, 2015). The elections likely would not be held before the latter end of 2017, at the earliest. The delay in the general election is bad news for Thailand's economy.

6.5 Conclusion

In the current aesthetic medical tourism industry, it can be argued that non-invasive aesthetic medical tourism is a new international service activity. It should be noted that there is no risk free medical treatment. This also includes non-invasive aesthetic medical treatment. This research has established a framework of six types of risk in relation to non-invasive aesthetic medical tourism: functional, physical, financial, time, psychological and social risk. These include the variable quality of aesthetic medical equipment, medicines and injected medicines, the confusion from renaming non-invasive aesthetic medical treatments, the undefined prescribed quantity of injected drugs, the variable skills and experience offered by service providers, the quality of post-treatment care and communication problems in giving post-treatment instruction. These five categories of potential risk have played an important role in defining categories of functional risk. The degree of physical risk related to medical treatment was identified as dependant on

the type of each treatment, including the equipment and medicine involved. As a result of functional and physical risks, financial risk and time risk were also identified as issues, in that there is a tension between travelling to Bangkok for vacation purposes and for medical purposes. If neither was fully achieved, this would be seen as money and time spend for inadequate return on the part of consumers. In terms of risks arising on the part of tourist-patients themselves, it was found that in cases where individuals might become addicted to this type of medical treatment, this might increase psychological risk to their mental well-being. Finally, embarrassment from telling other people about non-invasive aesthetic medical treatment and embarrassment of having too obvious a result were identified as social risk that associated to non-invasive aesthetic medical tourism and treatments.

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

This chapter presents the conclusions that have been drawn from a close investigation of primary and secondary data collections in this study, gathered from clinic owners, tourist-patients and government representatives in Bangkok, Thailand. This research contributes to methodological and theoretical knowledge in a new tourism context with a new group of tourists. The aim and objectives of the research were achieved and are restated in this chapter. The limitations and problems arising from this research are also reviewed. In closing, research suggestions and recommendations, based on the findings of primary and secondary research are highlighted.

7.2 Research contributions

This research made a significant and original contribution to academic (section 7.2.1) and practitioner knowledge (section 7.2.2) respectively.

7.2.1 Academic contribution

This research contributes to methodological and theoretical knowledge in a new tourism context with a new group of tourists. In other words, it is the first research that examined three main areas: (1) the management of non-invasive aesthetic medical tourism, (2) its advantages and barriers, and (3) associated risks with primary (clinic owners and tourist-patients) and secondary (government representatives) stakeholder groups, with the context of competitive market in Bangkok, Thailand.

It can be argued that medical and health tourism is one of the fastest growing areas of academic research interest in both tourism and health and medical studies (Botterill, Pennings and Mainil 2013; Connell 2011; Crooks *et al.* 2011; Hall 2013; Han and Hyun 2015; Hanefeld *et al.* 2014; Karuppan and Karuppan 2010; Lunt and Mannion 2014; Whittaker and Leng 2016). Such research reflects the economic significance of this type of tourism (Lunt *et al.* 2016), and a growing recognition of the consequences of increased human mobility (Hall 2010; Hall and James 2011), as well as the real effects on people and places (NaRanong and NaRanong 2011).

However, one subject area that is currently lacking sufficient exploration is the burgeoning industry of non-invasive aesthetic medical services across international borders. This type of global interconnection is a relatively new phenomenon within the context of the current sphere of internationalism, thus explaining why few have explored the economic and health factors in a deeper context than simply a cost/ benefit analysis. This current interconnection is a consequence of the increase in global communication, technology, and overall global interaction, facilitated, among other factors, by the greater availability of the Internet throughout the world. A range of authors (Bookman and Bookman 2007; Burkett 2007; Carrera and Bridges 2006; Cochrane 2008; Hall 2013; Henderson 2014; Noree *et al.* 2016; Quintela *et al.* 2016; Singh 2014) have examined reasons for individuals travelling abroad for medical treatment from the perspective of the patients' home countries. This literature discusses the growth of medical tourism in developing countries, and how medical tourism destination countries may benefit from this industry. However, in such studies, complex invasive surgery and invasive and non-invasive health and well-being procedures are commonly discussed

as a singularity. To date few attempts have been made to examine the development and management of non-invasive aesthetic medical treatments (Kerscher and Williams 2009; Livingston 2016; Nassab *et al.* 2010). Even fewer studies have examined the management of this type of medical tourism in Bangkok (Sinhaneti and Pullawan 2008) and, to date, no studies have evaluated stakeholder risk in relation to the management of non-invasive aesthetic medical tourism in Bangkok, or how competitive advantage can be sustained.

According to primary data findings, the theory of risks has been extended by this research. The findings from interviews illustrated the connections between six types of risk (functional, physical, financial, psychological, time and social risks) and non-invasive aesthetic medical tourism and treatment. The connections of risks as the barriers to the management of non-invasive aesthetic medical tourism in Bangkok can be seen in Figure 6.1. This research explored three new elements. Firstly, in terms of risks arising on the part of tourist-patients themselves, it was found that if tourist-patients are in less than perfect health then there may be an increased physical risk during treatment (Whittaker and Leng 2016). As a result of the complication from physical risk, tourist-patients may not be able to travel for days (time risk). This can be concluded that physical risk led to time risk.

Secondly, psychological risk and social risk are linked in a two-way relationship. The linkage between these two risks is not associated directly to non-invasive aesthetic medical tourism and treatment. However, it is an issue because when tourist-patients perceive psychological risk (or social risk) then social risk (or psychological risk) will be affected. Embarrassment from telling

other people about non-invasive aesthetic medical treatment and embarrassment of having too obvious a result were identified as social risk that associated to non-invasive aesthetic medical tourism and treatments (Leyland *et al.* 2014). In cases where individuals might become addicted to this type of medical treatment, this might increase psychological risk to their mental wellbeing. In addition to this, compulsive use of non-invasive aesthetic medical treatment, or even addiction to the process, may create unnecessary need which may lead to other risks such as financial risk and physical risk.

Lastly, functional risk led not directly to psychological risk (the red arrow has presented in dots in figure 6.1). In the cases where unexpected circumstances happen, some patients can be left scarred physically or psychologically for life (Luthra 2016, Nahai 2011, Vaiyavatjamai and Wattanakrai 2011, Vanaman *et al.* 2016). This case is very rare. However, tourist-patients have to bear in mind that functional risk may lead indirectly to psychological risk. These primary data findings have contributed to new knowledge and persuaded other researchers to examine and evaluate risks related to other types of tourism.

In terms of methodological contribution, this research also demonstrated how an interpretivist qualitative approach can make a contribution to aesthetic medical tourism research practice. This research was the first research that conducted semi-structured interviews with both primary stakeholder (clinic owners and tourist patients) and secondary stakeholder group (government representatives) in one research project. One can see that a vast quantity of researchers (Alleman *et al.*, 2011; Bies and Zacharia, 2007; Clarke *et al.*, 2007; Heung *et al.*, 2011; Johnston *et al.*, 2011; Karuppan and Karuppan, 2011; Lautier, 2008; Nassab *et al.*, 2010; Snyder *et al.*, 2011) has been

conducted with either primary or secondary stakeholder group. This research makes a significant and original contribution to the methodology part for future research projects.

7.2.2 Practitioner knowledge

When the results of the completed PhD are disseminated, Thai government representatives have the opportunity to gain a better understanding of the development and management of the non-invasive aesthetic medical tourism industry in Bangkok, both from the perspective of clinic owners and of consumers of the products/services. Similarly clinic owners have the opportunity to extend their understanding of the development and management of non-invasive aesthetic medical tourism industry in Bangkok from the perspective of government representatives and consumers of the products/services. The benefit to consumers as an immediate result of this study is more difficult to define but is likely to include an insight into the industry from the point of view of the product/service providers.

Results available from completion of the PhD will similarly enhance the understanding of government representatives in regard to the management of non-invasive aesthetic medical tourism industry in Bangkok from the perspective of clinic owners, and of tourist-patients as the consumers of the products/services. By the same token, clinic owners are able to gain an understanding of the management of non-invasive aesthetic medical tourism industry in Bangkok from the perspective of government representatives and of consumers of the products/services. The immediate benefit to consumers is difficult to define precisely, but would likely include insights into the industry from the point of view of the product/service providers.

7.3 Achievement of the aim and objectives

The aim of this research project was to evaluate risk in relation to the management of non-invasive aesthetic medical tourism (international) in Bangkok. In order to achieve the aim, four objectives have been set and achieved.

Objective 1: To evaluate literature and key theories relating to medical tourism, aesthetic medical tourism and risk. This has been achieved by the production of Chapter two and three. It began with evaluating the literature on various definitions of tourism, medical tourism, non-invasive aesthetic medical tourism and different types of non-invasive aesthetic medical treatments. The possible motivations and means of motivating English speaking international tourist-patients to travel to Bangkok for non-invasive aesthetic medical treatments were explored. A number of crucial benefits were derived from non-invasive aesthetic medical tourism to Bangkok as a medical tourism destination city. The details in terms of techniques, benefits, complications and side effects of different types of non-invasive aesthetic medical treatments also were investigated, compared and contrasted. Then, the concept of competitive advantage was evaluated. It also demonstrated that medical tourism provided an opportunity for patients to have a necessary or an elective treatment outside their home countries with lower cost, no waiting lists and sophisticated technology. Medical tourism destination countries can treat such opportunities as means to develop their resources and motivate more patients to use their services. Such services as non-surgical aesthetic treatments, or non-invasive or minimally invasive aesthetic treatments, varying from pain free to bearable and manageable treatments promise to help medical tourism destination countries to achieve these aims, as well as

to help patients to achieve their aims in having a desired appearance. This is a complex process is underpinned by the knowledge that the treatments offered in this sector are not complication free. Thus for success in this sector, consideration of risks associated with non-invasive aesthetic medical treatments and tourism is crucial (Chapter 3). Chapter three examined literature relating to perceived risks, risk perception, and risk reduction strategies associated with such products. The major part of the chapter explored the idea of perceived risk and then evaluated six types of perceived risks, and how these relate to non-invasive aesthetic medical treatment. The six categories of perceived risks; functional, physical, financial, time, psychological and social risks were discussed in detail. A number of risk perception and risk reduction strategies were evaluated in relation to tourism, medical tourism, and non-invasive aesthetic medical tourism.

Objective 2: To determine the factors that act as advantages or barriers to the management of aesthetic medical tourism in Bangkok. This has been achieved by the production of Chapter 5. In order to be able to achieve objective 2, research design was important and required evaluation independently of research findings. Chapter four therefore concerned with methodological choice and the impact of this on the processes and outcome of the research. It discussed the methodology that was undertaken to complete this research project. The main stages related to deciding the research approach, identifying data requirements and subjects, and the techniques by which data was gathered and analysed were examined. It also evaluated a rationale for the chosen research approach, primary data collection techniques and methods of data analysis used in the study. This research identified six categories related to Thailand's competitiveness in

promoting itself as a medical tourism destination country. These categories were respectively internationally accredited medical facilities, highly qualified medical professionals, cost saving, the benefits of Thailand's location, state-of-the-art technology and excellent service provider. However, a number of barriers to the development of the industry were also identified: these were the need for better foreign-language communication skills, the trend of overlook law and regulations, performance of medical treatments in non-clinical locations, shortage of staff in public hospitals, common selling points and over supply, and missing follow up. These findings demonstrated that the competitiveness could be barriers of the development and management as well.

Objective 3: To identify the relevance of selected theories and models related to risk for understanding the management of aesthetic medical tourism in Bangkok. This has been achieved by Chapter 6. The findings from the data collected in this study were analysed and thematically interpreted with reference to the relevant literature and appropriate comparable secondary research. In the current aesthetic medical tourism industry, it can be argued that non-invasive aesthetic medical tourism is a new international service activity. It should be noted that there is no risk free medical treatment. This also included non-invasive aesthetic medical treatment. This research has established a classification of six types of risk in relation to non-invasive aesthetic medical tourism: functional, physical, financial, time, psychological and social risk. These included the variable quality of aesthetic medical equipment, medicines and injected medicines, the confusing renaming of non-invasive aesthetic medical treatments, the undefined prescribed quantity of injected drugs, the variable skills and experience offered by service

providers, the quality of post-treatment care and communication problems in giving post-treatment instruction. These five categories of potential risk have played an important role in defining categories of functional risk. The degree of physical risk related to medical treatment was identified as dependant on the type of each treatment, including the equipment and medicine involved. As a result of functional and physical risks, financial risk and time risk were also identified as issues, in that there is a tension between travelling to Bangkok for vacation purposes and for medical purposes. If neither was fully achieved, this would be seen as money and time spent for inadequate return on the part of consumers. In terms of risks arising on the part of tourist-patients themselves, it was found that in cases where individuals might become addicted to this type of medical treatment, this might increase psychological risk to their mental wellbeing. Finally, embarrassment from telling other people about non-invasive aesthetic medical treatment and embarrassment of having too obvious a result were identified as social risk that associated to non-invasive aesthetic medical tourism and treatments.

Objective 4: To extend the theory of risks by developing a framework in relation to the management of non-invasive aesthetic medical tourism in Bangkok for primary and secondary stakeholder groups to gain an insight understanding of the industry. This has been achieved by the presentation of the framework in Figure 6.1. Many researchers suggested that financial risk and time risk have two-way relationship (Hall 2013; Jonas *et al.* 2011; Lunt *et al.* 2012; Lunt *et al.* 2016; NaRanong and NaRanong 2011; Singh 2014). The primary data findings also confirmed that financial risk and time risk are also linked in a two-way relationship to each other (the arrow has presented in black). Tourist-patients may not only buying a non-invasive aesthetic medical

treatment that does not satisfy their needs (financial risk) but also wasting time during their vacations at medical tourism destination countries (time risk). Tourist-patients may also possibly have the complications from four-session laser treatment during their vacation. This means that they will not only wasting time for having the treatments (instead of spending time during vacation with family and friends at the beach; time risk) but also losing money for further treatment in order to recover from those complications (financial risk).

Lastly, physical risk (with reference to the treatments, equipment and medicines) led to financial and time risks. Many scholars also stated that physical risk leads to the issue of financial risk (Bookman and Bookman 2007; Chan *et al.* 2011; Connell 2011; Hall 2011; Hanefeld *et al.* 2014; Harling *et al.* 2007; Jonas *et al.* 2011; Lunt and Carrera 2010; Prasirtsuk 2009; Roger *et al.* 2011; Smith *et al.* 2012). In addition to this, physical risk, which refers to political issues, epidemic crises, and health risks, is another crucial reason for tourist-patients to lose money during their vacation in medical tourism destination country (financial risk). Despite being a major player in the medical tourism market, Thailand's political turmoil has resulted in a significant drop in the number of tourists and medical tourist arrivals in the country, particularly after the shutdown of the two main airports in Bangkok in December 2008 (Prasirtsuk, 2009). The problem with the current situation in Thailand is that the focus is very much on political reforms by military government (Shaffer, 2015). The elections likely would not be held before that latter end of 2017, at the earliest. The delay in the general election is bad news for Thailand's economy.

7.4 Summary analysis

In the current aesthetic tourism industry, it can be argued that non-invasive aesthetic medical tourism is a new international service activity, available in many tourist destinations around the world. Of these, Bangkok is one of the most popular destinations. The findings from 45 semi-structured interviews with non-invasive aesthetic clinic owners, international tourist-patients and government representatives in Bangkok, Thailand illustrated the key competitiveness of Bangkok as a leading non-invasive aesthetic medical tourism destination city. The city was home to a number of internationally accredited medical facilities and highly qualified medical professionals, and as an aesthetic tourism destination, offers cost savings, benefits of location, state-of-the-art technology and excellent service providers.

This rise in the popularity of medical tourism has demonstrated that one form of the service provision, that is, the provision of cosmetic care, has changed (Connell, 2011). Once considered so labour intensive that the service would need to be highly localised, this service activity can now be globalised like so many others. This change has mainly followed a growing emphasis on the use of technology, the rise of private enterprise in providing the service, and a changing attitude in tourism consumers that health care can be bought 'off the shelf'. Along with this expansion in the trade of cosmetic services has come a growth in competition. Such competitiveness in turn has consolidated the emergence of a new niche of globalised medical tourism, elegantly packaged, and often successfully delivering its promises. In turn, an increase in conventional tourism to medical tourism destinations has been a by-product of this growth, and overall benefits to the travel industry have been considerable. The rise of medical tourism reflects other trends in the health care business, such as increasing privatisation, a growing dependence on

technology, uneven access to health resources and the accelerated globalisation of both health care and tourism.

This growth however gives rise to new service development challenges. Looking specifically to Bangkok as a case study, this research has identified certain crucial barriers to the development and management of non-invasive aesthetic medical tourism industry in that city. The main barriers found were a deficit in communication skills in service providers, constraints arising from the application of laws and regulations, unethical performance of medical treatments in non-clinic locations, shortages of qualified staff in public hospitals, a low diversity in selling points amongst different providers, over supply of services, and a negligence of follow up care.

To discuss these barriers in detail, firstly, there are a number of reasons for the need of improved communication skills, According to Carabello (2008) and Mason and Wright (2011), open communication between patients and teams of medical professionals is vital, not only to offer the tourist-patient peace of mind, but also to ensure good results of each medical treatment as well. Competence in communication is becoming more widely recognised as a vehicle to decrease human error and to increase patient safety. Over expectation on the part of the patient can also be managed by better open communication, and recently, an increase in videoconferencing or free online chatting such as Line, WhatsApp and FaceTime has been seen as popular. These help both patients and teams of medical professionals to reduce communication costs and to increase the follow up rates, to make sure that the patient is satisfied with the treatment and service.

In terms of the barriers related to laws and regulations, Sury and Montriwat (2007) and Cohen (2012) state that medical tourism, in contrast to general tourism, has high barriers to entry and a long list of requirements for its emergence, success and sustenance. Equally it can be argued that language, law and regulations, and shortage of staff in the public hospitals are crucial obstacles in the promotion of non-invasive aesthetic medical tourism development in Thailand.

However, to offset such threats, there is the low cost of labour in Thailand and the weaker Baht, both of which serve to offer excellent opportunities to promote medical tourism in Thailand. After all, in order to sustain or achieve a competitive advantage, every supplier must keep the costs of medical services offered as low as possible. The tension in this is how low a supplier can go in price without damaging the quality of the product. Connell (2011) and Hall (2013) for instance, argue that there are concerns with an over-competitive price situation, since the medical supplier must be able to compete on quality as well as price.

A further tension arises in the disparity of services offered to tourists and local residents. In promoting services in the interests of tourists, Thailand is at risk of neglecting the access to health care amongst its own citizens, and this must be re-balanced before an inequity becomes too far established in the future, threatening both local and tourist health care provision. Supporting this view, Johnston *et al.* (2010) and Sury and Montriwat (2007) suggest that in some instances, international tampering in local health care may threaten local culture, or make it difficult to maintain and preserve. This sums up briefly the growth factors, along with the tensions and barriers that arise with growth, in the Bangkok medical tourism industry. For the time being however, despite

the numerous ethical issues that arise in such an endeavour, medical tourism is considered functional and seemingly beneficial as an industry.

Apart from the above crucial competitiveness and barriers to the development and management of non-invasive aesthetic medical tourism in Bangkok, this research has arrived at a classification of six types of risk in relation to non-invasive aesthetic medical tourism: functional, physical, financial, time, psychological and social risk, risk perception and risk reduction.

Following on from these categories of risk in development and management, further specific risks associated with certain types of non-invasive aesthetic medical treatments have also been identified. These include the variable quality of aesthetic medical equipment, medicines and injected medicines, the confusing renaming of non-invasive aesthetic medical treatments, the undefined prescribed quantity of injected drugs, the variable skills and experience offered by service providers, the quality of post-treatment care and communication problems in giving post-treatment instruction. These five categories of potential risk have played an important role in defining categories of functional risk, as follows.

Physical risk in this study referred to risk arising from either non-invasive aesthetic medical treatments or from unclear laws and legislation on food and health safety in Bangkok. The degree of physical risk related to medical treatment was identified as dependant on the type of each treatment, including the equipment and medicine involved. As a result of functional and physical risks, financial risk and time risk were also identified as issues, in that there is a tension between travelling to Bangkok for vacation purposes

and for medical purposes. If neither was fully achieved, this would be seen as a waste of money and of time on the part of consumers.

In terms of risks arising on the part of tourist-patients themselves, it was found that in cases where individuals might become addicted to this type of medical treatment, this might increase psychological risk to their mental wellbeing. For instance, if a patient were to become addicted to maintaining a youthful look whatever the cost, this might lead to unobtainable satisfaction and a refusal to accept the results of the treatment as effective. Other psychological risks identified were fear of telling others the truth about having had appearance enhancing treatments, and unhelpful attitudes and beliefs regarding self-image.

Other risks were identified specifically in regard to the medical treatment on offer. It was found that when the business of aesthetic medical treatment resorted to bargaining on prices, this tended to create over consumption of products and a potential risk to patient well-being. A final risk identified in association with tourist-patients was social risk, in that they might perceive a social risk in terms of the embarrassment; that is if the result of a treatment was too obviously not natural, the individual would have to undergo the embarrassment of having to confess to others that they had sought non-invasive aesthetic medical treatment.

In summary, Lee and Spisto (2007) and Lunt *et al.* (2016) suggest that with lower costs and higher expertise, medical tourism is likely to be a new future global trend for providing medical services. This might result in a further risk to patient and practitioner protection in those rapid developments in medical tourism demands might leave the policing and legislation lagging behind

practice. If this is not to be a continuing barrier, it would be imperative for this legislation to change sufficiently to protect vulnerable individuals who find themselves insufficiently informed to make appropriate research-based decisions. It remains to be seen in the future which countries will adopt the proactive stance of legislation change in order strategically to avoid future problems and to maintain and protect their country's reputation in this important and growing area of healthcare.

7.5 Limitations and problems from the primary research

There is no lack of literature related to medical tourism and in particular to its development in the developing countries. However, reports arising from research in non-invasive aesthetic medical tourism, and particularly non-invasive aesthetic clinics and tourist-patients, is thin on the ground. Moreover, no literature has been identified to date which mentions any current issues in relation to aesthetic clinics in Thailand. As a result, although this means that the study is innovative, at the same time the lack of current relevant literature constitutes one of the main limitations of this specific research.

As to limitations inherent in the study itself, the small size of the sample makes generalisation difficult; due to the lengthy procedure of conducting semi-structured interviews and access requirements, it was possible to conduct only 45 interviews. Such a reduced sample size could be conceived as problematic in the attempt to generalise theories from the research. However, even with these limitations taken into account the researcher's position is that this research offers an interesting insight, not just in terms of responding to the research question but also in terms of addressing certain problems inherent in the majority of research techniques.

In terms of the research techniques used in this study, it could be argued that several limitations and problems arose from the use of the semi-structure interview method as a means of gathering data to answer the research question. Firstly, the collecting of qualitative data, in particular via interviews, is time and resource consuming and leads to a limited sample. Second, analysis of rich qualitative data is considerably more time consuming than quantitative data, in that the latter provides statistics which are readily analysable, in contrast to interviews which require triage and interpretation. Nevertheless, it was argued in this dissertation that the interview method provided the researcher with the better opportunities to collect complex data which would cast light on the research question.

In addition to the limitations surrounding qualitative data collection in this study, it was found challenging to gain access to some government representatives and to owners of large clinic chains, who appeared to have little free time for researchers. If the researcher was to complete the fieldwork and obtain the desired information for the study, an alternative solution had to be found. It was discovered that attending medical conferences was a useful route to gaining access to the target interview group. It was also found that gaining access to respondents who had an experiential understanding of the research question, which would allow them to answer interview questions in depth, were the most appropriate to work with.

7.6 Recommendations for practitioners

This part offers recommendations with the goal of safely and intelligently expanding non-invasive aesthetic medical tourism. The recommendations are based on the primary data findings. There are a number of recommendations for private and public organisations which promote non-invasive aesthetic medical tourism in Bangkok. It became clear in the course of the research that in order to achieve the target of being the leading medical tourism destination city in Asia, organisations working from Bangkok needed to co-operate towards a common goal. This research suggests the recommendations that can be seen below.

1. The government should establish legislation encouraging non-invasive aesthetic medical tourism.
2. The government should require non-invasive aesthetic clinic providers to obtain a license. This will provide a check on unscrupulous service providers and allow regulators to keep better records of non-invasive aesthetic medical tourism information.
3. The government should implement regulations that require doctors and nurses to spend time in both public and private healthcare in order to reverse the potential effects of brain drain. This will allow local populations to benefit from the advanced training of doctors and nurses.
4. The government should cross-subsidise health care for local populations in the public-health sector with revenue from tourist-patients. This action will raise revenue and improve quality of care for local population.
5. Clinic owners should identify quality management as a key component in non-invasive aesthetic medical tourism.

6. Clinic owners should organise overseas training and further technical training for all categories of the medical staff.
7. Clinic owners should provide language courses at all categories of the medical staff.
8. Establish co-operation between tourism organisations and clinic owners.
9. Consider and evaluate medical tourism and treatments, in particular non-invasive aesthetic medical treatments, as a tool for promoting the country as an optimum medical destination, rather than cosmetic surgery. Launch the promotion of product mix through marketing communication.
10. Educate potential foreign patients in terms of the quality and range of non-invasive aesthetic medical treatment and services, as well as inform them of realistic outcomes and possible complications.
11. Set a new standard of non-invasive aesthetic clinical practice in relation to the standard reflected in JCI accredited hospitals.

7.7 Recommendations for further study

This research presented an analysis of the barriers to the development and management of non-invasive aesthetic medical tourism in Bangkok, together with findings related to risk perception and risk reduction, based on interviews with aesthetic clinic owners, tourist-patients and government representatives. The competition in this field in Bangkok is increasing and future success will depend on the appreciation and satisfaction of the changing demands of the healthcare tourists, arising from their defining characteristics. As noted earlier, research on healthcare tourism and in particular on non-invasive aesthetic medical tourism is not extensive and there are many potential

directions for further study to improve knowledge and understanding. There is a need for standardisation of concepts and definitions, which would assist in the collection of reliable and comparable data. Motivations of participants and levels of satisfaction should also be assessed to gain insights into their expectations and experiences. More case studies will be useful, exploring regional healthcare dynamics and interactions with tourism, as well as comparative analyses across countries and cultures. Economic and social impacts of medical tourism should not be forgotten, in particular research into effective planning and ensuring that funds are allocated appropriately.

For future research, there are many potential questions which could be best addressed by engaging in more fieldwork as a means of better understanding and responding to the current market situation and consumer need. Firstly, there is needed an examination and evaluation of alternative types of aesthetic medical treatments, such as invasive aesthetic treatment, cosmetic surgery or other alternative medical procedures. New information arising from future fieldwork can be compared and contrasted with this research in order to generate a new approach. Secondly, conducting similar research by means of other methods such as a deductive approach using questionnaires or online surveys will likely generate a larger number of respondents to promote the gathering of more generalisable data. Lastly, similar research can be conducted in different research settings which also promote this industry, such as Singapore, India, Vietnam, Indonesia and Malaysia. This will likely generate a broader view and a better understanding, leading to further recommendations for aesthetic medical tourism industry in the context of developing countries.

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APPENDIX A

Hair removal

According to Mintel (2008), laser hair removal is the most popular non-surgical treatments. Hair reduction, treatment of vascular birthmarks, and tattoo removal can be achieved with both lasers and Intense Pulsed Light (IPL). However, it seems that IPL is suitable for hair removal from larger areas such as backs and legs. As suggested by Babilas *et al.* (2010) hair removal has become a key indication for IPL devices, which has advantages in terms of providing a large spot size and high skin coverage rate if compared with laser treatment. Apart from the advantages of the IPL device, Schultz, Adeson and Watson (2001) suggest that the combination between these two treatments provides a better result for hair removal treatment. Appropriately combining wavelength, energy, pulse duration and cooling from IPL and Nd:YAG at 1064 nm would result in safe and effective treatment of all skin types. An advance in technology, safety and efficacy allows patients to find permanent hair reduction treatment available in most non-invasive aesthetic clinics.

Laser tattoo removal treatment

According to Bernstein (2007), many millions of people throughout the world are sporting a tattoo. The earliest tattoos consisted of lines and dots forming patterns then developed to images and other complicated designs. The reasons for placing a tattoo are as varied as the designs themselves. One of the most common tattoos presenting for removal is the name of a significant other. Relationships may come and go, however the name of a once-loved one will

remain if it is tattooed in the skin. Cosmetic tattoos are another purpose to replace lost eyebrows or to substitute for eyeliner and to cover scars, birthmarks, unwanted tattoos or even the dirt from an accident.

The technology used to remove tattoos began with destructive methods of removal. Bernstein (2007) states that this technology wreaked havoc not only on the tattoo but more prominently on the skin containing that tattoo. The discovery of selective photothermolysis helped to remove tattoo more effectively. In other words, selective photothermolysis is a technique that enables physician to selectively remove target structures without disrupting the surrounding skin. At least, it increases the possibility of removing tattoos without destroying the surrounding skin and leaving a scar. Removing tattoos requires very short pulse duration and high light intensities. In addition to this, Babilas *et al.* (2010) suggest that only Q-switched lasers fulfil these requirements. However, it is very common that the wrong devices such as IPL and CO₂ laser are used to treat tattoos (Bernstein, 2007 and Babilas *et al.*, 2010). As a result of administering the tattoo removal treatment with inappropriate medical devices, instead of completing the tattoo removal treatment, a scarring issue is another potential risk to patients.

Vascular lesion treatment

Vascular lesion treatment is another non-invasive aesthetic medical treatment that is widely available at aesthetic clinics in Bangkok. There is evidence from literatures (Raulin, Schroeter, Weiss, Keiner and Werner, 1999 and Schroeter, Haaf-Von Below and Neumann, 2005) for successful treatment of vascular lesion by IPL. It is suggested by Babilas *et al.* (2010) that immediately after the treatment of vascular lesions, a dark blue to gray discoloration of the treatment

area can be expected, which is a sign for appropriate photophysical parameters. As well as this, the treatment experiences and photophysical understanding of the treatment administrator is important in terms of being able to treat the vascular lesion properly and effectively or not. This then directly affects patients in terms of perceived risk from this particular non-invasive aesthetic medical treatment.

Side effects from laser treatment

Compared to other non-invasive aesthetic medical procedures, Kauvar and Dover (2001) state that laser treatment has potential side effects. The common side effects, which may last for few days after having lasers and IPL treatments, are swelling and erythema. Other potential side effects that might last longer or may even be irreversible are pigmentary changes such as hypopigmentation or hyperpigmentation. In addition to this, Babilas *et al.* (2010) suggest that these side effects can be mostly prevented by adjusting wavelengths and fluences to the patient's skin type and treatment area. They also recommend that unsuitable patients due to suntan or skin type are excluded from IPL treatment as well as patients who are unable or unwilling to strictly avoid post-operative Ultra Violet (UV) exposition. They conclude that this group of patients should not be treated by any type of lasers or IPL.

Scarring is another possible side effect of operating lasers and IPL devices. Adamic, Troilius, Adatto, Drosner and Dahmane (2007) argue that scarring rarely occurs and is almost always evoked by over fluenced treatment or by crusting with subsequent manipulation and infection. In other words, the laser and IPL operator is a key problem of the side effect. In order to perform difficult

treatments successfully, Moretti (2004) states that the medical devices, such as the expensive and complex IPL device, need to be operated by knowledgeable doctors or nurses. Linked to this, it is then recommended by Babilas *et al.* (2010) that the most important measure to prevent side effects like this is the application of test shots for every chosen set of parameters applied at different parts of the body. It is because the skin thickness varies from region to region, which presents in individual skin resistance, skin temperature, blood perfusion, presence of hair follicles, presence of a tattoo, suntan and many more factors. Therefore, the incidence of side effects also changes from region to region, which is why it is worth testing the laser and IPL devices with patient's skin before conducting the laser and IPL treatment.

Radio frequency treatment

In addition, Sukal and Geronemus (2008) established that RF face lift treatment by Thermage[®] is a non-invasive aesthetic medical treatment option that has demonstrated that face, jowl, brow and neck can be effectively tightened without any visible signs of healing. More importantly, RF face lift treatment indicates that facial tightening; eyebrow lifting and neck lifting can be achieved without visible skin inflammation or bruising. This is an advantage of facial skin tightening by RF treatment, which avoids surgery, associated recovery time and potential complications such as pigmentary changes, scarring and infection.

In order to conduct skin tightening and skin contouring with RF face lift treatment more effectively, it is recommended that the low fluence and multi pass technique should be administered instead of high fluence and single pass technique (Sukal and Geronemus, 2008). Some studies note that twice the amount of collagen

denaturation occurred when three passes were performed at lower energy settings rather than one pass at higher energy settings (Zelickson, Kist, Bernstein *et al.*, 2004; Kist, Burns, Sanner *et al.*, 2006). They also confirm that even the highest energy settings did not produce as much collagen denaturation as three passes at the lowest settings. This is because the pain from high fluence technique would be a crucial barrier in conducting facial lift treatment completely. However, it is worth noting that that the higher the maximum temperature reached during heating means the greater the shrinkage of the collagen (Polder and Bruce, 2011, p.348). In other words, the more fluence or high level of energy, the more youthful the appearance results for patients.

Carboxy therapy

Carbon dioxide is infused subcutaneously into the affected areas using the 30G with 0.5 inch needles. The treated area is blocked by upper and lower rubber belts to ensure that the gas will remain in the target area and not diffuse to other unwanted areas. The depth of infusion is 10 to 13 mm. The programmable carboxy therapy devices such as Carbonnique® and Carbomed®, calibrated to measure the dosage of CO₂ in cc, regulate the flow rate and the infusion pressure. The infusion is administered at a velocity of 20 to 200 cc per minute, and the total quantity of CO₂ infused is 1,000 to 2,000 cc for the abdomen and 400 to 600 cc for each upper arm over a 20 to 30 minute period per area. The therapy is continuously monitored by qualified medical personnel. By injecting an appropriate amount of carbon dioxide gas below the surface of the skin, this tricks the body system into increasing the blood circulation to that area. Dark under-eye circles, cellulite, and stretch marks have all been shown to have some root cause in poor blood circulation (Zdinak, 2012).

Carbon dioxide is a natural constituent of our being. Humans breathe in oxygen, and exhale carbon dioxide. Plants take up the carbon dioxide, and in turn give humans the oxygen that humans need. As a result, using carbon dioxide as a substance to reduce fat and cellulite in humans seems to be safe as it comes from natural resources. CO₂ is widely used in medicine (Lee, 2010). It is the mainstay of minimally invasive surgery. During laparoscopic procedures, CO₂ is routinely used inside body cavities to provide a superb view and access for the ever-growing list of surgical procedures. From this point of view, it can be argued that CO₂ is safe to use with humans. However, another considerable issue is the safety of conducting and administering carboxy therapy treatment.

Golden thread

Golden thread is a non-permanent face lift treatment. With regards to Stark and Bannasch (2007), its short-term result may be the risk of non-invasive suspension technique. This is because patients need to repeat the treatment within a period of time, which is similar to other non-invasive aesthetic medical treatments such as botulinum toxin injection, mesotherapy injection, laser treatments and carboxy therapy. In addition to this, Prendergast (2012) supports that the non-surgical treatments only improve hyper dynamic and static wrinkles, volume loss, and skin surface imperfections but they do not address to a deeper tissue, which the surgical procedures do provide to patients for a longer period.

Notwithstanding this, Rondo *et al.* (1996) state that adverse chemical or immunologic tissue reactions are very unlikely with an inert implant material such as gold. It is worth noting that any foreign bodies may become infected. As well as this, Stark and Bannasch (2007) posit that the permanent introduction of

foreign bodies may lead to unexpected reactions with considerable morbidity and negative aesthetic effects.

APPENDIX B

Transcript of the key clinic owner on August 15, 2010

Interviewer: The researcher

Respondent: The owner of 12 branches aesthetic clinic in Bangkok

Interviewer: What is your main role in the clinic?

Respondent: Five years ago, I used to be a manager of the clinic but now I am the owner.

Interviewer: How many branches do you have at the moment?

Respondent: I have 17 branches in total and 12 of them are located in Bangkok.

Interviewer: In your opinion, what is the key competitiveness of non-invasive aesthetic medical tourism industry in Bangkok?

Respondent: At the moment, the most important factor is the price because of the Weaker Thai Baht, low labour cost and the highly competition among the aesthetic clinics in Bangkok. Location in Bangkok is another issue. This is because it's very easy to take flight to the famous beaches in Phuket, Samui, Krabi and Hat Yai. Flight duration takes about an hour or hour and a half from Bangkok to many main cities in the south of Thailand. The cost of air ticket is about 1,500THB with low cost airlines.

Interviewer: Are there any issues or concerns that Bangkok needs to improve or develop in order to compete with other aesthetic medical tourism destination cities?

Respondent: Right now, the market of aesthetic medical treatments needs big improvement in terms of marketing communication and marketing strategy. In Thailand, the public and private organisations work separately in terms of promoting and responsible for the problems of the industry. It needs good co-operation between these two sectors in order to control everything. I mean ethics, standards, law and regulations all need big improvement.

Interviewee: Why do you believe these issues are important?

Respondent: This is because at the moment there is no good cooperation between these two sectors. Some clinics then take this opportunity to use fake drugs such as botulinum toxin. There are a lot of them. They claim that it is a US drug but in fact it's a fake drug from US. It's not real Botox. It's cheaper that's why it's so popular. Without considering patient's safety, this would create problems. I mean problem of health, result and complications. What I can see now is this is an opportunity to create a good cooperation if we could. I believe that problems can also be opportunities: they allow you to see things differently, which particular skills are needed will vary, depending on the problem and ... a high level of these skills - this may be particularly important when applying to. The ability to use your own initiative, to think for yourself, to be creative and pro-active. The issue here is how clinic owners and the government sector can do this in an effective way. This is really important.

Interviewer: You mentioned about the marketing communication and marketing strategy. What were the problems regarding to these two issues?

Respondent: I refer marketing communication to the message that the clinics present or advertise to patients. Many of them are over-claiming. There is a big gap between fact and advertisement. Once patients believe in this marketing message, it's hard to change their attitude. If the treatment cannot deliver the expected results then the problem will come to the doctor. If the doctor cannot explain the difference between expected and actual results then the patients may ask for compensation. At the end this would cost a lot more than the doctor's expectation. Marketing strategy is another issue. This market is highly competitive. Many clinics use price to compete with others. The considerations of effectiveness, appropriateness, quality and quantity of the drugs have been neglected. These issues are seriously happening. Without serious concern from government organizations such as Thai FDA, and Health Ministry, this market seems to have lots of problems in the near future.

Interviewer: What are the crucial barriers to promote non-invasive aesthetic medical tourism in Bangkok?

Respondent: The first barrier is language because English is not our first language and medical words and terms are very difficult to teach nurse assistants. Nurse assistants have finished their high school or diploma. They don't actually have a medical degree or certificate. This leads to the communication problem and error between foreign patient and nurse assistants in my clinic. If the nurse assistants uses the wrong words, patients will misunderstand and interpret them incorrectly, which means I will lose that customer. In addition, if the issue related to the reason for any complications then I will lose my money for the compensation too. At present, there are

many aesthetic clinics in Bangkok. Some of them are good but many of them are not. That's because there are many investors who want to open a clinic, to earn profit as much as they could but they didn't have an appropriate knowledge, skill, experiences and understanding in terms of how to treat skin problems or how to respond to the patient's needs correctly. They just have money. The thing is our business is all about dealing with health and safety of patients. Therefore, the first consideration for the business owner or doctor should be patient's safety not profit. However, I think some of the owners may have different opinions about this issue. This really depends on what they believe and the policy of their company. The rise on this type of clinic will be a big barrier to promote Bangkok as a medical tourism destination city because these clinics will destroy our reputation. Many doctors and nurses are employed by those investors with very high pay so it will lead to the shortage of staff in the public section too.

Interviewer: Are there any problems from the international tourist-patients?

Respondent: At the moment, I think patients who come from abroad definitely have a problem of missing the follow-up. More importantly, they visit Thailand for vacation so it's not a good idea to have some treatments such as laser facial treatment before they go to the beach. It is not recommended. Patients will take their own risk if they decide to have it.

Interviewer: Are there any problems or barriers in supply side?

Respondent: There are many issues related to the supply side as I mentioned earlier. I believed we will face the problem of over supply very soon. That's because a new clinic can open very quickly and it's easy to open it. This is because you just have money and employ a doctor and that's it. In other words some of investors concern only about profit so they might use

fake medicine, un-skilled doctors because these can keep their costs down. It will lead to the problem of quality of treatment, which is a big barrier to overcome.

Interviewer: What would you do to overcome these barriers?

Respondent: In my opinion, we need help from private and public sectors. Government organisations could help to audit the clinics more often. Consumer law is another issue that could be helpful. The most important thing is we need to educate patients by using the appropriate marketing communication to let them know what should be treated and how to be treated in an appropriate method.

Interviewer: What is the future trend for non-invasive aesthetic medical tourism industry in Thailand?

Respondent: In terms of patients, they will look for something with less pain but providing better result. Anti ageing is another generation that would be coming because the cost of treatment is getting lower and the technology helps patients feel more comfortable.

APPENDIX C

**Transcript of the key English-speaking international tourist-patients
on April 12, 2011**

Interviewer: The researcher

Respondent: The international tourist-patient in Bangkok

Interviewer: What is the primary purpose of your visit to Bangkok?

Respondent: I'm on holidays with my family.

Interviewer: Is this the first time you come to Bangkok?

Respondent: No, it's not. I came here many times for business trips.

Interviewer: What was your motivation to choose Bangkok for your family trip?

Respondent: Bangkok's a great city to travel. Good food 24 hours a day and many places to visit all day. Big department store, community mall and shopping street are located near the hotel. It's very convenient.

Interviewer: How long will you stay in Bangkok?

Respondent: I'm staying in Bangkok for a week then will go to the south for two weeks.

Interviewer: What kind of aesthetic treatment did you choose today?

Respondent: I have facial laser treatment.

Interviewer: Did you decide to have it before or after you come to Bangkok?

Respondent: I decided to buy the treatment when I saw the advertisement in front of the clinic.

Interviewer: What factors persuaded or influenced you to have the treatment in Bangkok? Was it because of the price of the treatment, price of air fare and accommodation, high standard of treatment, personalised care, advertising or recommendation?

Respondent: I did not visit Thailand because of the cheap airfare and accommodation. The bought the treatment because I was attracted by the advertisement then the price of the treatment.

Interviewer: Was it cheaper in your home country?

Respondent: It was cheaper if you compare it with what I had at home. I used to have this kind of treatment before so I knew exactly what and how it should be treated. I only need to check the brand of the equipment and the knowledge of the doctor.

Interviewer: Is this your first visit at the aesthetic clinic in Bangkok?

Respondent: No, it isn't. I went to another clinic at Emporium when I visited Bangkok last year.

Interviewer: Were you satisfied with the treatments?

Respondent: Yes, I was.

Interviewer: You've mentioned about checking the equipment. What was your concern about?

Respondent: I was concerned about the quality of the equipment. There are many brands of laser equipment. They are from the US, Korea, China and many more. The performance is not the same. Then I need to check it first before I make the decision to buy or not to buy the treatment from any clinic.

Interviewer: Have you experienced the difference between them?

Respondent: Yes, I have. I used to be treated by Korean fractional laser from a clinic at Chidlom. The result was not appreciated. The machine couldn't deliver the high level of energy as it showed on the screen. It was very disappointing. It was my mistake. I was considering only about the price of treatment. I think I learnt that 'you get what you pay'. There is no way you could buy good treatment at a very low price. There must be something to make it cheaper than others and that's the quality of the treatment I believe.

Interviewer: Have you got any issue about the knowledge of the doctor or the staff in the clinic?

Respondent: Oh yes. In fact, I didn't buy the service from this clinic. I went there to ask for more details about the treatment. Again, I was attracted by the price of the treatment. But then when I spoke to the manager of the clinic, I found that she didn't have enough knowledge about the laser treatment. Then I asked to speak to the doctor. The doctor that I met only worked there part-time. It seemed that she's only knew what to sell from her training. She couldn't answer my question about the process and the development of the skin and the technology of laser equipment. I think she could do better than this by say no if she doesn't know anything. Not like this, she tried to show that she knew then gave the wrong answer to the patient. This is not including the issue of their language. The therapists at most of the clinics that I went to

are rarely speak English. I had difficulty to communicate with them. The doctor was not always with me. I had to take the dictionary with me at all time.

Interviewer: How often do you have non-invasive aesthetic medical treatment?

Respondent: At home, I visit the clinic once a week. When I travel overseas I always look for something new, something better and particularly something cheaper. In Bangkok, I found many clinics in one shopping mall. Then I took this opportunity to look around and see what else can help me to look younger. The technology of treatment in Asia is better than what I have in my home country. More importantly, it's a lot cheaper.

Interviewer: Is it compulsory to visit the clinic once a week?

Respondent: No, it's not. I go there because I want to. I don't need to go there that often but when I have free time I want to spend time for myself. This treatment can help me a lot. I'm not buying myself a new bag every month but I buy myself new facial treatment course every month. This is how I can treat myself after been working hard for years.

Interviewer: Do you believe that non-invasive treatment is a time consuming procedure?

Respondent: Normally the treatment only takes about 15-30 minute to finish. I don't think it is a time consuming process. I love to do it and love to try new treatment. You know, I bought the same treatments such as Iontophoresis from two clinics; one is next to my office and the other one is next to my house.

Interviewer: From your experience, what would you like to say about non-invasive aesthetic treatment?

Respondent: I would suggest this kind of treatment to anyone who loves to have a younger appearance and of course if you could afford it. The prices are varied from place to place. There is no standard about it. It is your own consideration to find out which one will suit you best. You will not lose your money and waste your time if you do more research about it at home before you make the decision to buy this kind of service.

Interviewer: Do you have any other problems or concerns about having non-invasive aesthetic medical treatment in Bangkok?

Respondent: I think I'm very lucky. This is because I knew the treatments very well. Apart from language, knowledge of the doctor, quality of the equipment, I can't see anything else. However, I think other tourists may not be as lucky like me. I mean if they have a problem from the treatment such as those medicine injections I think they will have very tough time in Bangkok. This is because we are foreigners. We don't know Thai, can't speak Thai and don't understand Thai consumer's law.

Interviewer: Is there anything else you would like to mention?

Respondent: I think Thailand should do better than this. This market is very big. I believe there will be new customers coming to this market every day. When people love it they will keep buying it. They just can't stop consuming it...just like me. There should be a public organization protecting international patients. Otherwise, there will be no one protecting us when thing goes wrong and that leads to other problems.

APPENDIX D

Transcript of the key government representative on August 14, 2010

Interviewer: The researcher

Respondent: The government representative from Department of Dermatology, Faculty of Medicine, Siriraj Hospital, Mahidol University

Interviewer: What is your main role in this organisation?

Respondent: I am working on many issues related to dermatological concern. I mean I write the academic papers, conduct the research with new technology in order to treat melasma, pigmentation and other skin problems, also organise the medical conferences, forums, workshops and exhibitions for both national and international attendances.

Interviewer: Do you work at any other place?

Respondent: Yes, I do. I work at Bumrungrad Hospital and also at my clinic.

Interviewer: How long have you been working in the aesthetic medical treatment industry?

Respondent: Since I graduated from Harvard Medical School, I think it's about 22 years.

Interviewer: From your working experience, how do you see this industry currently?

Respondent: There is a big change for these two decades. I mean a big development and movement in the last ten years. When I started there were very few clinics to treat skin disease by a dermatologist. Cosmetic surgery

was so popular. Non-surgical treatment was not that popular. Laser treatment was new and too expensive. Middle class patients couldn't afford it. Look at the market of non-surgical aesthetic treatment today, it's very big. It was estimated that this market generated 20,000 million THB last year, thousands of clinics now operate in Bangkok. They're everywhere, every road, every segment type of the consumers. People want to look brighter, younger and slimmer without having dramatic results.

Interviewer: For the change, what would concern you the most?

Respondent: What is a concern now and I would want anyone who wants to come in to this industry whether to buy the treatment or sell the treatment, I want to remind them to think about the quality and safety of each treatment. Some of the treatments have not yet been approved by the FDA and there is no clinical research to support the result. Do not believe the advertisement or what celebrities do. It's worth waiting to see whether it is good for you or not. I mean particularly with the medicine and injected medicine such as mesotherapy. The fact is there are hundreds of dermatologists in Bangkok only, which means most of the patients have not been treated by the dermatologist. I think it is very risky.

Interviewer: You mentioned about the risk, do you mean the risk for patients?

Respondent: Yes indeed. This is because not every patient has got knowledge on what they are buying. Some of them do the research before they make the decision but from my experience most of them make the decision based on the clinic's manager, the doctor, promotion and advertisement. My concern is these patients now are receiving the

information from a non-dermatologist, which cannot ensure that the information is right or wrong and more importantly they are being treated by the people who called themselves 'specialists'. Specialists are not dermatologists. This is the fact. Advanced laser treatment such as fractional laser facial resurfacing is a good example. If the treatment is not operated by the dermatologist then the patient will lose the money and waste the time because the laser operator can't identify the end point of the treatment. It can be under treated or over treated. If under treated, patients will definitely lose money and waste their time. If patient is over treated then scars and complications will be the case, big case. I know there are many clinics with problems, complaints and compensation following the treatments. It's hard to manage this. The thing is we need to think, check and do the research before we make the decision.

Interviewer: You mentioned that there are thousands of clinics in Bangkok. Do you think they're probably too much for Bangkok at the moment?

Respondent: No, I don't think so. This is not including the clinics that are on the queue for the new clinic's registration. If you submit your registration document today, you will have to wait for about at least six months for the registration team to go and check your clinic. It's very long queue now.

Interviewer: Are we having big numbers of patients?

Respondent: Yes, we are. The numbers of patients are enormous. This is not only Thai patients but also including international patients. Nowadays, tourists are not visiting Bangkok for only food and sightseeing but they also want to buy our medical facilities. Personal vitamins and medicines is a new trend of treatment to help patient looks younger and slimmer too.

Interviewer: Why there are so many patients for aesthetic medical treatments today?

Respondent: The reason is people live longer today and that's the reason why they want to keep themselves looking younger as much as they can. They love to buy this service as long as they can afford it. That's why the research tries to find out new solutions for anti-aging purposes.

Interviewer: Does Thailand currently have strength in order to compete with other aesthetic medical tourism destination cities?

Respondent: We have good doctors, high technology, good location, good reputation of land of smile, cheap labour cost and many more.

Interviewer: In that case, what could be barriers of the development of this industry in Bangkok?

Respondent: Like I mentioned before, we have limited number of dermatologists. This leads to the problem of quality of treatment and that will bring more problems to patients at the end.

Interviewer: Does the government have a strategy or plan to develop the non-invasive aesthetic medical tourism industry?

Respondent: Yes, we have. Right now, we open the scheme of 90 days free entry for medical tourists. Patients and four members of the family can apply to this scheme. Patients only need to bring the proof of appointment. This will help to increase the number of international patients.

Interviewer: How about the number of dermatologists? What can we do to increase this number?

Respondent: There is not much we can do about it. We have limited resource at medical school. That's why many Thai doctors go abroad; take a short course or a Masters degree in order to ensure that they will have the knowledge and ability to treat international patients.

Interviewer: In that case, the doctors at the public hospital to serving patients with non-skin disease will be reduced significantly, right?

Respondent: Yes, it is. Doctors tend to work with private clinics in Bangkok rather than go to work at the hospital in the remote area. The skin clinics are paying well. I mean they pay very good rate if compared to public hospital. It's about 8-10 times more than what they could earn from the public hospital. I think the government should consider increasing the wage of the doctor in a hospital again.

Interviewer: So you believe that Bangkok is ready to promote aesthetic medical tourism?

Respondent: I think so. Why not? We have potential, we have everything. We only need to manage them wisely and effectively.

APPENDIX E



DEPARTMENT OF HOSPITALITY, LEISURE AND TOURISM MANAGEMENT, BUSINESS SCHOOL

'Non-invasive aesthetic medical tourism in Bangkok: A qualitative analysis of stakeholder risk'

Participant Information Sheet - Clinic owner

I would like to invite you to take part in a research study, to share your views and opinions about the development and management of aesthetic medical tourism in Bangkok. Before you decide whether to agree to be interviewed, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Purpose of the study

The study will evaluate the development and management of non-invasive aesthetic medical tourism (international) in Bangkok and subsequently it will investigate how sustainability can be achieved. The research is being undertaken as part of my PhD at Oxford Brookes University.

Why have you been invited?

You have been invited to take part in an individual semi-structured interview because you are the owner of an aesthetic clinic in Bangkok. Your opinions on the non-invasive aesthetic medical tourism industry in Bangkok are really important to this research. It is anticipated that 15 clinic owners will be interviewed in this study.

Deciding to take part?

Your participation in the research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to you if you take part?

I would like to interview you. The semi-structured interview should take approximately twenty minutes. During the semi-structured interview you will be asked to express your views and opinions about the development, management and sustainability of non-invasive aesthetic medical tourism (international) in Bangkok. With your permission, I will take notes and also use an audio recorder. The interview will take place at a time convenient to you. You will be provided with a summary of the interview transcript within 48 hours of the interview. A full transcript will be available on request. Upon completion of the PhD a summary of the research findings will be sent to you and a full copy of the dissertation will be available via email on request.

Possible disadvantages and risks of taking part

It is anticipated that informants in this research will suffer no risk. Informants will not be controlled or manipulated in any way since an interpretivist not an experimental approach will be adopted throughout the research process, the researcher will be scrupulous about protecting the privacy of informants and

APPENDIX E

ensure nobody is embarrassed by the study. To this end data will be anonymised and any key identifiers omitted from the PhD dissertation. To further protect the research settings and the individuals involved, data analysis and interpretation will be undertaken on a concept by concept or thematic basis rather than an individual interview basis.

Possible benefits of taking part in the study

I hope you will enjoy the interview. It may help you to gain a deeper understanding of the development, management and sustainability of non-invasive aesthetic medical tourism in Bangkok. You may also be able to gain an understanding of the industry from the perspective of government policymakers and consumers.

Confidentiality and Ethics

All information and documentation that you provide will be kept confidential within the limitations of the law and will not be used for purposes other than academic research. The only people that will have access to the interview records are the PhD researcher and their supervisory team based in the UK. Individual participants will not be identified in the results unless they give written consent to do so. Data generated in the course of this research will be kept securely in paper or electronic form for a period of up to five years after the completion of the research, after which period it will be destroyed. In Thailand data will be security encrypted on a laptop computer and USBs securely stored, and then returned to Oxford Brookes University for onwards safe storage in the UK.

Organisation the research

The research is being conducted by a researcher, who is currently enrolled as a PhD student at Department of Hospitality, Leisure and Tourism Management, Business School, Oxford Brookes University, UK.

Contact for further information

The research has been approved by the University Research Ethics Committee, Oxford Brookes University. If you have any concerns about the way in which the study has been conducted, you can contact the Chair of the University Research Ethics Committee on ethics@brookes.ac.uk.

Should you require any further information regarding this project or need to contact the researcher about any aspect of the project, you can contact me directly at the following addresses:

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Email: dsimpattanawong@brookes.ac.uk

You can also contact members of my supervisory team, Mrs. Aileen French and Dr Jan Harwell at the above address, or by email: acfrench@brookes.ac.uk and jharwell@brookes.ac.uk

Thank you for taking time to read the information sheet. Date: 3/9/10

APPENDIX F



DEPARTMENT OF HOSPITALITY, LEISURE AND TOURISM MANAGEMENT, BUSINESS SCHOOL

'Non-invasive aesthetic medical tourism in Bangkok: A qualitative analysis of stakeholder risk'

Participant Information Sheet - Tourist-patient

I would like to invite you to take part in a research study, to share your views and opinions about medical treatments and services in Bangkok. Before you decide whether to agree to be interviewed, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Purpose of the study

The study will evaluate the development and management of non-invasive aesthetic medical tourism (international) in Bangkok and subsequently it will investigate how sustainability can be achieved. The research is being undertaken as part of my PhD at Oxford Brookes University.

Why have you been invited?

You have been invited to take part in an individual semi-structured interview because you are an English-speaking international tourist-patient in Bangkok. Your opinions on the non-invasive aesthetic medical tourism industry in Bangkok are really important to this research. It is anticipated that 45 English-speaking international tourist-patients will be interviewed in this study.

Deciding to take part?

Your participation in the research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to you if you take part?

I would like to interview you. The semi-structured interview should take approximately twenty minutes. During the semi-structured interview you will be asked to express your views and opinions about medical treatments and services in Bangkok. With your permission, I will take notes and also use an audio recorder. The interview will take place at a time convenient to you. You will be provided with a summary of the interview transcript within 48 hours of the interview. A full transcript will be available on request. Upon completion of the PhD a summary of the research findings will be sent to you (if contact details are provided) and a full copy of the dissertation will be available via email on request.

Possible disadvantages and risks of taking part

It is anticipated that informants in this research will suffer no risk. The researcher will protect the privacy of informants and ensure nobody is embarrassed by the study. To this end data will be anonymised and any key identifiers omitted from the PhD dissertation.

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Possible benefits of taking part in the study

I hope you will enjoy the interview. It may help you to gain a deeper understanding of the development of medical tourism in Bangkok. You may also be able to gain an understanding of the industry from the perspective of the product/service providers and government policymakers.

Confidentiality and Ethics

All information and documentation that you provide will be kept confidential within the limitations of the law and will not be used for purposes other than academic research. The only people that will have access to the interview records are the PhD researcher and their supervisory team based in the UK. Individual participants will not be identified in the results unless they give written consent to do so. Data generated in the course of this research will be kept securely in paper or electronic form for a period of up to five years after the completion of the research, after which period it will be destroyed. In Thailand data will be security encrypted on a laptop computer and USBs securely stored, and then returned to Oxford Brookes University for onwards safe storage in the UK.

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Contact for further information

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Email: dsimpattanawong@brookes.ac.uk

You can also contact members of my supervisor team, Mrs. Aileen French and

Dr Jan Harwell at the above address, or by email: acfrench@brookes.ac.uk and jharwell@brookes.ac.uk

Thank you for taking time to read the information sheet. Date:

APPENDIX G



DEPARTMENT OF HOSPITALITY, LEISURE AND TOURISM MANAGEMENT, BUSINESS SCHOOL

'Non-invasive aesthetic medical tourism in Bangkok: A qualitative analysis of stakeholder risk'

Participant Information Sheet - Government Representative

I would like to invite you to take part in a research study, to share your views and opinions about the development and management of aesthetic medical tourism in Bangkok. Before you decide whether to agree to be interviewed, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

Purpose of the study

The study will evaluate the development and management of non-invasive aesthetic medical tourism (international) in Bangkok and subsequently it will investigate how sustainability can be achieved. The research is being undertaken as part of my PhD at Oxford Brookes University.

Why have you been invited?

You have been invited to take part in an individual semi-structured interview because you are a government policymaker involved with the development and management of non-invasive aesthetic medical tourism in Bangkok. Your opinions on this industry are really important to this research. It is anticipated that 5 government policymakers will be interviewed in this study.

Deciding to take part?

Your participation in the research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to you if you take part?

I would like to interview you. The semi-structured interview should take approximately twenty minutes. During the semi-structured interview you will be asked to express your views and opinions about the development, management and sustainability of non-invasive aesthetic medical tourism (international) in Bangkok. With your permission, I will take notes and also use an audio recorder. The interview will take place at a time convenient to you. You will be provided with a summary of the interview transcript within 48 hours of the interview. A full transcript will be available on request. Upon completion of the PhD a summary of the research findings will be sent to you and a full copy of the dissertation will be available via email on request.

Possible disadvantages and risks of taking part

It is anticipated that informants in this research will suffer no risk. Informants will not be controlled or manipulated in any way since an interpretivist not an experimental approach will be adopted throughout the research process, the researcher will be scrupulous about protecting the privacy of informants and

APPENDIX G

ensure nobody is embarrassed by the study. To this end data will be anonymised and any key identifiers omitted from the PhD dissertation. To further protect the research settings and the individuals involved, data analysis and interpretation will be undertaken on a concept by concept or thematic basis rather than an individual interview basis.

Possible benefits of taking part in the study

I hope you will enjoy the interview. It may help you to gain a deeper understanding of the development, management and sustainability of non-invasive aesthetic medical tourism in Bangkok. You may also be able to gain an understanding of the industry from the perspective of clinic owners and consumers of the products/services.

Confidentiality and Ethics

All information and documentation that you provide will be kept confidential within the limitations of the law and will not be used for purposes other than academic research. The only people that will have access to the interview records are the PhD researcher and their supervisory team based in the UK. Individual participants will not be identified in the results unless they give written consent to do so. Data generated in the course of this research will be kept securely in paper or electronic form for a period of up to five years after the completion of the research, after which period it will be destroyed. In Thailand data will be security encrypted on a laptop computer and USBs securely stored, and then returned to Oxford Brookes University for onwards safe storage in the UK.

Organisation the research

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Contact for further information

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Should you require any further information regarding this project or need to contact the researcher about any aspect of the project, you can contact me directly at the following addresses:

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Email: dsimpattanawong@brookes.ac.uk

You can also contact members of my supervisor team, Mrs. Aileen French and Dr Jan Harwell at the above address, or by email: acfrench@brookes.ac.uk and jharwell@brookes.ac.uk

Thank you for taking time to read the information sheet. Date:

CONSENT FORM

Full title of Project:

'Examination of the development and management of aesthetic medical tourism in Bangkok: a consideration of stakeholder risk'

Name, position and contact address of Researcher:

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Fax: +44 1865 483878
Email: dsimpattanawong@brookes.ac.uk

Please Initial Box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.
2. I agree to take part in the above study.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without explanation.
4. I agree to participate in the interview consultation that is being an audio recorded.
5. I agree to the use of anonymised quotes from my focus group/ interview in publications.

Name of Participant

Date

Signature

Dararat Simpattanawong

Name of Researcher

Date

Signature

CONSENT FORM

Full title of Project:

'Examination of the development and management of aesthetic medical tourism in Bangkok: a consideration of stakeholder risk'

Name, position and contact address of Researcher:

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 Tel. +66 81 272 7799
 Fax. +66 2717 8123

Please Initial Box

- 1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.
- 2. I agree to let you use my premises to conduct your research.
- 3. I understand that I am free to withdraw the permission at any time, without explanation

Name of Participant	Date	Signature
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Dararat Simpattanawong

Name of Researcher	Date	Signature
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APPENDIX I: Example of Coded Transcript

This appendix comprises the coded transcript of the interview conducted with the international tourist-patient (TP). This was the twenty-fourth interview conducted in the overall process.

The column to the right of the transcript lists the initial codes assigned to the text. Reference to the codes listed demonstrates the style of coding used in the initial data analysis.

In the transcript certain changes have been made in an effort to protect the anonymity of the interviewee.

Interviewer: The researcher

Respondent: The international tourist-patient in Bangkok

Gender: Female

Age: 50+

<p>Interviewer: What is the primary purpose of your visit to Bangkok?</p> <p>Respondent: I'm on holidays with my family.</p>	International tourist
<p>Interviewer: Is this the first time you come to Bangkok?</p> <p>Respondent: No, it's not. I came here many times for business trips.</p>	Often visit Bangkok
<p>Interviewer: What was your motivation to choose Bangkok for your family trip?</p> <p>Respondent: Bangkok is a great city to travel. Good food 24 hours a day and many places to visit all day. Big department store, community mall and shopping street are located near the hotel. It's very convenient.</p>	Great location of Bangkok Convenient for shopping Facilitative infrastructure Ease of access
<p>Interviewer: How long will you stay in Bangkok?</p> <p>Respondent: I'm staying in Bangkok for a week then will go to Koh-Samed for another week.</p>	Travel to the beach after having treatment
<p>Interviewer: What kind of aesthetic treatment did you choose today?</p> <p>Respondent: I have facial laser treatment.</p>	Having facial laser treatment in

<p>Interviewer: Did you decide to have it before or after you come to Bangkok?</p>	
<p>Respondent: I decided to buy the treatment when I saw the advertisement in front of the clinic.</p>	<p>The advertisement in front of the clinic attracted tourist-patient.</p>
<p>Interviewer: What factors persuaded or influenced you to have the treatment in Bangkok? Was it because of the price of the treatment, price of air fare and accommodation, high standard of treatment, personalised care, advertising or recommendation?</p>	
<p>Respondent: I did not visit Thailand because of the cheap airfare and accommodation. I bought the treatment because I was attracted by the advertisement then the price of the treatment.</p>	<p>Price of the treatment is the reason of buying the service.</p>
<p>Interviewer: Was it cheaper in your home country?</p>	
<p>Respondent: It was cheaper if you compare it with what I had at home. I used to have this kind of treatment before so I knew exactly what and how it should be treated. I only need to check the brand of the equipment and the knowledge of the doctor.</p>	<p>Cost-saving Have knowledge of non-invasive aesthetic medical treatment and equipment. Qualified equipment/ doctor</p>
<p>Interviewer: Is this your first visit at the aesthetic clinic in Bangkok?</p>	
<p>Respondent: No, it isn't. I went to another clinic at Emporium when I</p>	<p>Had non-invasive aesthetic medical treatment from another clinic in</p>

<p>visited Bangkok last year.</p> <p>Interviewer: Were you satisfied with the treatments?</p> <p>Respondent: Yes, I was.</p> <p>Interviewer: You've mentioned about checking the equipment. What was your concern about?</p> <p>Respondent: I was concerned about the quality of the equipment. There are many brands of laser equipment. They are from the US, Korea, China and many more. The performance is not the same. Then I need to check it first before I make the decision to buy or not to buy the treatment from any clinic.</p> <p>Interviewer: Have you experienced the difference between them?</p> <p>Respondent: Yes, I have. I used to be treated by Korean fractional laser from a clinic at Chidlom. The result was not appreciated. The machine couldn't deliver the high level of energy as it showed on the screen. It was very disappointing. It was my mistake. I was considering only about the price of treatment. I think I learnt that 'you get what you pay'. There is no way you could buy good treatment at a very low price. There must be something to make it cheaper than others and that's the quality of the treatment I believe.</p>	<p>Bangkok last year.</p> <p>Satisfied with the result from treatments</p> <p>Quality of the equipment from different brands is not the same.</p> <p>Cheaper machine could not deliver required performance / result. Did not satisfy with cheaper treatment.</p>
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Interviewer: Have you got any issue about the knowledge of the doctor or the staff in the clinic?

Respondent: Oh yes. In fact, I didn't buy the service from this clinic. I went there to ask for more details about the treatment. Again, I was attracted by the price of the treatment. But then when I spoke to the manager of the clinic, I found that she didn't have enough knowledge about the laser treatment. Then I asked to speak to the doctor. The doctor that I met only worked there part-time. It seemed that she's only knew what to sell from her training. She couldn't answer my question about the process and the development of the skin and the technology of laser equipment. I think she could do better than this by say no if she doesn't know anything. Not like this, she tried to show that she knew then gave the wrong answer to the patient. This is not including the issue of their language. The therapists at most of the clinics that I went to are rarely speak English. I had difficulty to communicate with them. The doctor was not always with me. I had to take the dictionary with me at all time.

Interviewer: How often do you have non-invasive aesthetic medical treatment?

Respondent: At home, I visit the

Communication problems
Language barriers
Knowledge of the manager / doctor is limited.

Searching for opportunity to have the

<p>clinic once a week. When I travel overseas I always look for something new, something better and particularly something cheaper. In Bangkok, I found many clinics in one shopping mall. Then I took this opportunity to look around and see what else can help me to look younger. The technology of treatment in Asia is better than what I have in my home country. More importantly, it's a lot cheaper.</p>	<p>treatment weekly. Looking for new technology Keep having the treatment Asia has better technology if compare to home country. Considering about the price</p>
<p>Interviewer: Is it compulsory to visit the clinic once a week?</p>	<p>Buying treatments as the rewards for working hard</p>
<p>Respondent: No, it's not. I go there because I want to. I don't need to go there that often but when I have free time I want to spend time for myself. This treatment can help me a lot. I'm not buying myself a new bag every month but I buy myself new facial treatment course every month. This is how I can treat myself after been working hard for years.</p>	
<p>Interviewer: Do you believe that non-invasive treatment is a time consuming procedure?</p>	<p>Non-invasive aesthetic medical treatments are not time-consuming procedures.</p>
<p>Respondent: Normally the treatment only takes about 15-30 minute to finish. I don't think it is a time consuming process. I love to do it and love to try new treatment. You know, I bought the same treatments such as Iontophoresis from two</p>	

clinics; one is next to my office and the other one is next to my house.

Interviewer: From your experience, what would you like to say about non-invasive aesthetic treatment?

Respondent: I would suggest this kind of treatment to anyone who loves to have a younger appearance and of course if you could afford it. The prices are varied from place to place. There is no standard about it. It is your own consideration to find out which one will suit you best. You will not lose your money and waste your time if you do more research about it at home before you make the decision to buy this kind of service.

Interviewer: Do you have any other problems or concerns about having non-invasive aesthetic medical treatment in Bangkok?

Respondent: I think I'm very lucky. This is because I knew the treatments very well. Apart from language, knowledge of the doctor, quality of the equipment, I can't see anything else. However, I think other tourists may not be as lucky like me. I mean if they have a problem from the treatment such as those medicine injections I think they will have very tough time in Bangkok. This is because we are foreigners. We don't know Thai, can't speak Thai and

No standard in non-invasive aesthetic medical treatment.

Information searching could help to save money and time.

Concerning language barriers, knowledge of doctor and quality of the equipment.

Communication problems

Law can be a problem, once patient has a problem from injected medicines.

don't understand Thai consumer's law.

Interviewer: Is there anything else you would like to mention?

Respondent: I think Thailand should do better than this. This market is very big. I believe there will be new customers coming to this market every day. When people love it they will keep buying it. They just can't stop consuming it...just like me. There should be a public organization protecting international patients. Otherwise, there will be no one protecting us when thing goes wrong and that leads to other problems.

END.

Public organization should protect international patients.