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'Not For Ten Million Dollars!' A Content Analysis of Medical Tourism Decisions

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Multiple drivers are assumed to motivate and factor into decisions to have medical procedures done in another country, regardless of incentive to save money. Content analysis of 114 respondents revealed 13 themes: those actively considering medical tourism, the perceived benefits, nature of procedures, follow-up care, quality of care, cost, safety, insurance, facilities, family support, language barriers, U.S. government policy crisis, and a final category of those who would never consider medical tourism under any circumstances. Implications for HR management of employee health plans and marketing in the hospitality industry are discussed.

INTRODUCTION

Why do some people fearlessly get on an airplane and fly to another country for surgery or serious medical procedures, whereas others refuse to even consider the possibility, even when an employer's medical plan is offering them incentives to do so? An assumption of much of the current literature on medical tourism, is that people will not seek medical care outside their western developed country unless there is significant financial incentive to do so (Demby, 2010; Konrad, 2009; Lerner, 2010; Rice, 2010). Monetary inducements are the primary influence on decisions people make (Woodman, 2010). However, multiple variables are likely to factor into decisions of this importance; outside of saving money, people are likely to ponder numerous other factors. Quality of on-site care and surgeon competence were ranked the highest importance in a study of over 1000 people (Davis, Yu, & Kurtz, 2009).

As Americans continue to experience recessionary layoffs from reductions in workforce (RIFs) and thus lose health insurance coverage, such decisions have become more common (Sobo, 2009). Families may have no other financial alternative than to cross borders to get procedures done affordably. In addition, more employer-sponsored plans now include incentives to have surgeries/procedures done at greatly reduced prices outside the U.S. and the employee receives a generous part of the financial savings. Blue Cross/Blue Shield has pioneered such insurance plans in recent years. (Einhorn, 2008; Wahlgren, 2009).

A 2011 review of 216 medical tourism articles found only five publications where actual data had been collected and analyzed, and those five examined Tunisia, Yemen, Thailand and the United Kingdom. All other publications were conceptual pieces, discussion papers, commentaries, law reviews, briefs, and newspaper articles, and mostly anecdotal and speculative. Thus there is a dearth of empirical work in this field and almost none has been done in the U.S. (Crooks, Kingsbury, Snyder and Johnston, 2010). In their review, Crooks, et al found the existing literature (n=216) on medical tourism to be focused on the themes of: decision making (push-pull factors such as cost and wait times), motivations, risks, and first-hand accounts.

Our research intends to add to the nascent empirical study of medical tourism. It was designed to empirically investigate factors that influence decisions to participate in medical outsourcing. Verbatim statements from study participants provide meaningful insight to managers working in all aspects of employee benefits, and those working in hospitality and tourism. As the numbers of medical tourists

grow, human resource managers and the hospitality industry will need to proactively address the needs of this anxious and often fearful niche of health seekers and travelers.

THE STUDY

To collect participants' responses about medical tourism, this study employed qualitative inquiry to document the complexity of responses for medical outsourcing. As Denzin and Lincoln (2000) have suggested, the qualitative method takes the contextual conditions and subjects' diversity into account and discovers principles grounded in empirical evidence. The qualitative approach is able to capture participants' subjective understanding and interpret their personal claimed thought-processes for seeking medical care abroad. Thus based on the study characteristics, a qualitative approach was the best inquiry for this medical tourism study.

Procedures

To address these questions, the survey research method was utilized to collect information. Responses were collected from participants in Midwest states in the United States. 1017 participated in a broader study on health care and insurance, and of those, 114 voluntarily responded further in commentary format for our data gathering purposes, an 11% response rate from this subset. To maintain confidentiality, all participants' identities were replaced by virtual numbers, five digits randomly assigned by the computer system. The virtual numbers ensured there was no connection between respondents' true identity and their survey answers; the virtual numbers protected their privacy and met the IRB human subject requirements for confidentiality.

Demographics of the sample are in Table 1. Not all respondents gave complete demographic information. The age distribution was bimodal, with more participants in their 20s and 40s. Ages ranged from 19-75. Gender was not equal, as more females responded and their comments were consistently far more lengthy than males. 91.6% were Caucasian; the other 9% of varied ethnicity. Income level was fairly high, with 38% earning more than $50,000 per year US. 87% had some college, a college degree or higher, thus the sample was fairly well educated. 93% had health insurance. Occupations were greatly varied and mostly professional: IT manager, optometrist, students, ed coordinator, self employed, administrative assistants, retired, construction, laser operator, RN, pharmacist, sales, small business owners, professor, laborer, business analyst, trucker, teacher, nanny, PCA, telecom tech, car sales, real estate, cable TV, software engineer, finance manager, engineer, tax preparer, hair stylists, bank teller, auditor, mechanical engineer, tech director and client liaison, thus a diverse pool.

DATA ANALYSIS

Content Analysis

As Flick (2006) and Silverman (2001) suggested, coding and categorizing are the main forms of data analyses for verbal passages. In this study, the content analysis was utilized to identify participants' opinions on medical tourism. For the data analysis of this study, we employed quantitative content analysis as a subjective interpretation of the text data derived from the open-ended questionnaire through the coding process of identifying themes. Content analysis has been conceptualized as an effective instrument to sort huge amounts of text from human communication into fewer categories through unobtrusive coding procedures (Berelson, 1952; Krippendorff, 1980; Stemler, 2001; Weber, 1990). Content analysis has served as an effective qualitative research tool to analyze textual data obtained from opened-ended survey questions, interviews, observation manuscripts, and printed media including newspapers, books, and manuals (Berelson, 1952; Kondracki & Wellman, 2002). Counting the words or calculating phrase frequency is not the only function of content analysis; it also has the capacity to

examine the meaning of the content and classify them into explicit categories with similar meanings (Hsieh & Shannon, 2005; Weber, 1990). Therefore, content analysis serves as the basis of the multi-method research and the first step for empirical examinations of data characteristics (Kolbe & Burnett, 1991) and it is an appropriate research method to objectively and systematically evaluate the content of qualitative data (Berelson, 1952; Kolbe & Burnett, 1991).

Table 1 Demographics of the Sample

Age	
< 20	1.0%
20-29	36.%
30-39	7.%
40-49	26.%
50-59	18.%
>60	12.%
Gender	
Male	42.5%
Female	57.5%
Ethnicity	
Asian	2.8%
Caucasian	91.6%
East Indian	2.8%
African	2.8%
Income	
<$25,000	31.%
$25,000-$50,000	31.%
$51,000-$75,000	16.%
$76,000-$100,000	6.0%
>$100,000	16.0%
Education	
High school	13%
Some college	39%
College degree	40%
Graduate degree	8%

As for the coding scheme in this study, we utilized a "top down" approach (King, 2004) by constructing a hierarchical system to analyze all text passages and categorize them into three levels: category, theme, and coded text. The hierarchy coding scheme would have acceptable reliability and validity and developing a new coding scheme might not be a necessary step as King (2004) suggested. Also, to have an inclusive scheme, the "bottom-up" approach was employed to explore possibility of any new category generated from the dataset. That is, review of the literature and empirical examinations on the verbal passages derived from this survey, were the main resources to construct the code scheme in this study. Some categories (such as concerns for and barriers to medical tourism) had emerged before the coding process, but the empirically coded texts or themes led to categories in this study which were not developed in previous studies.

In the hierarchy coding system, the highest level in the coding system is category, followed by theme and coded text. A category served as a description of a major response to medical tourism and consists of at least one theme with several coded texts in this study.

INTERCODER RELIABILITY

Since content analysis is an objective-oriented qualitative data analysis method, intercoder agreement or reliability evaluation is a key issue and is also the main research focus in many disciplines across natural and social sciences including education, medicine, and psychology (Abedi, 1996). Establishing sufficient intercoder reliability has been recognized as one of the important issues in text-based analysis (Gorden, 1992; Hruschka, Schwartz, St. John, Picone-Decaro, Jenkins, & Carey. 2004; MacQueen, McLelland, & Milstein, 1998; Perreault & Leigh, 1989; Tinsley &Weiss, 1975, Tinsley &Weiss, 2000). Neuendorf (2002) even suggested, "Without the establishment of reliability, content analysis measures are useless" (p.141). A single coder might intuitively categorize a text message into themes and utilize his or her own idiosyncratic methods to interpret the data set. It is hard to substantiate the consistency of coding judgments for a single coding process. To increase the quality of the final coded data, more than one coder who independently works on the same data set would reduce measurement errors made by one coder and raise the levels of measurement consistency in identification of themes in codes derived from text passages.

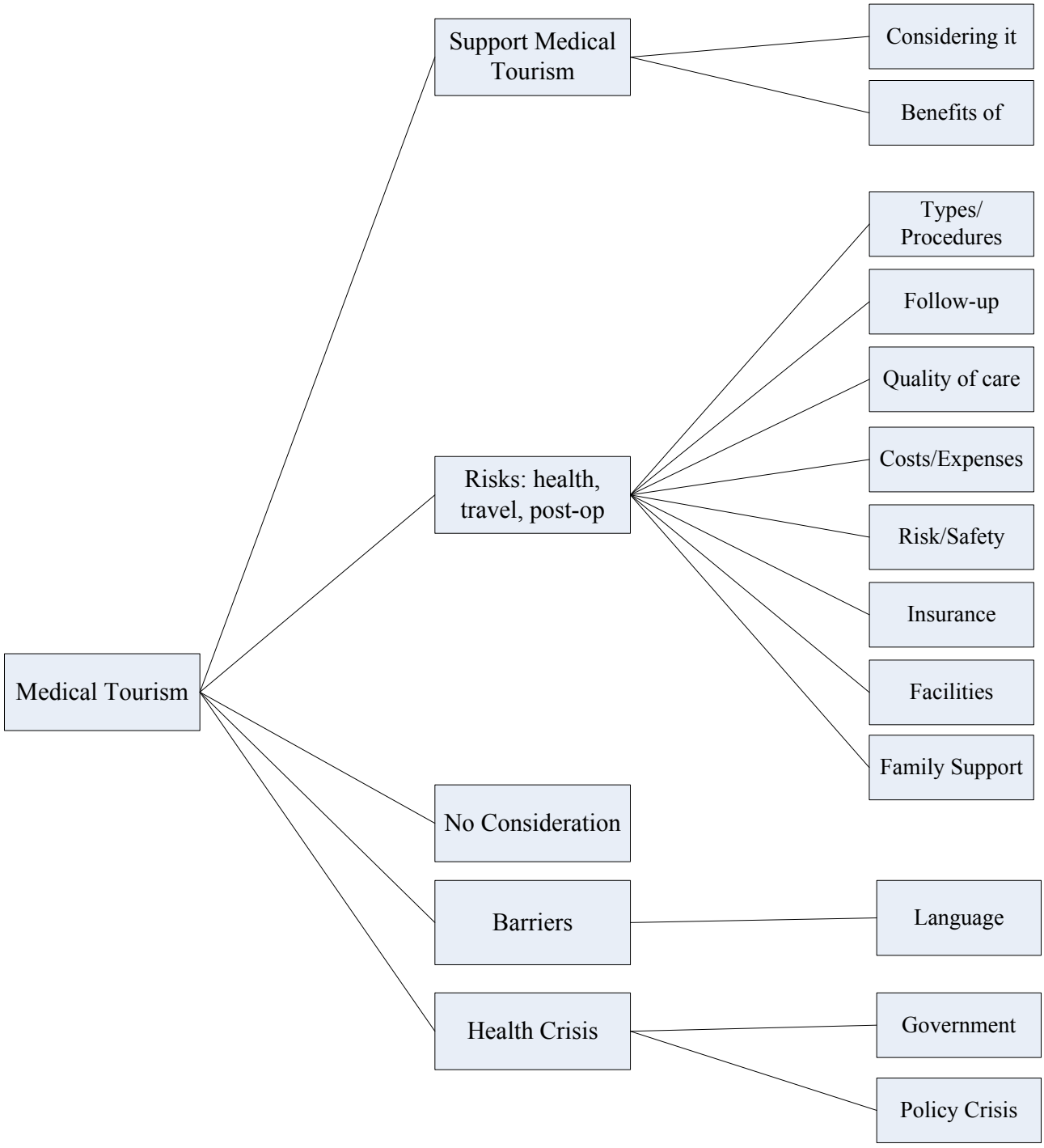
In this study, the inter-rater agreement or consistency was evaluated by "the extent to which the different judges tend to assign exactly the same rating to the object" (Tinsley & Weiss, 2000, p.98). To substantiate the degree of inter-rater consistency, the Cohen Kappa (Cohen, 1960) coefficient is recommended as the most effective evaluation tool (Dewey, 1983; Perreault & Leigh, 1989). The two coders made judgments across 114 text passages to see whether they were coded into predetermined categories or not. The SPSS software was used to calculate the Cohen coefficient and the result was .77. This is an acceptably high inter-coder consistency, as Krippendorff (1980) and Neuendorf (2002) suggested that it represents good reliability.

RESULTS

Five main topical categories were identified, further broken into 13 themes. Categories were: '*no' to medical tourism, support for medical tourism* (considering it, the benefits of), *risks* (types/procedures, follow-up, quality, costs/expense, risk/safety, insurance, facilities, and family support), *barriers* (language), and *U.S. health crisis* (U.S. government, policy crisis). Figure 1 illustrates the categories and themes and demonstrates the diversity in participants' open response.

Over 17 % (19/114) of participants were opposed to the medical tourism as they believed such outsourcing strategy would not improve the medical quality even if it could significantly reduce medical costs. Opposition was more outspoken from female respondents and elderly, while younger males reported interest in or lack of fear regarding medical tourism. About 12% of respondents indicated their major concern was costs/expenses of U.S. health care and that medical tourism might be an alternative way to reduce the medical costs, as more people do not have good health insurance coverage.

FIGURE 1 CATEGORIES AND THEMES FROM CONTENT ANALYSIS



MEDICAL TOURISM COMMENTS

Support Medical Outsourcing

Considering it. "I would consider care outside U.S. if treatment was not available in the U.S";

"Doctors in foreign countries are usually schooled in the U.S. so their training is excellent."; "I am currently considering elective surgery in a foreign country"

Benefits of. "I personally can see the benefit to outsource the expense of healthcare. I believe the talent and education in foreign countries to be equal if not better than what the medical industry in the U.S."; "If I were going to go into debt for the rest of my life and could avoid that--if I did not have health insurance"; "As the cost of health care and high insurance premiums continue to rise out of control, foreign medical treatments may need to be standard practice."

Concerns

Types/procedures. "The greatest benefit to overseas medical would be to allow for people to get medical treatments that are not allowed in the U.S. due to political reasons (i.e. pharmaceutical companies lining pockets of congressmen) and specialized treatment not being regulated by federal agencies. This also allows for overseas market competition to help curb/reduce medical & pharmaceutical costs. If I have to compete with overseas for U.S. jobs, why shouldn't the medical industry?"; "[It]Depends on the procedure and the country. Serious procedure –go to a developed country"; "This would depend on what type of surgery or procedure it would be. I know there are a lot of good doctors that are very knowledgeable and good in their field --also a lot of good hospitals worldwide"; "[Medical outsourcing]is only [for] a simple surgery"; "If and where I would go for medical procedures would depend on the procedure. I would go to Mexico for minor procedures such as dental but not major like coronary bypass surgery"; "My first choice will always be to have medical procedures done close to home"; "Any major complications (example heart) I would prefer to be treated in the U.S., although it may cost more. There are reasons why kings and ambassadors from foreign countries are electing to be treated in the U.S. at places like the Mayo Clinic."

Follow-up care. "What do you do for follow-up and what if there are problems after you are back at home and there has to be more surgery? Will your hometown doctors even be willing to assist in that kind of situation?" "I would be concerned with follow-ups if there are complications. Who would pay for travel expenses if you needed to return for care? I would also be concerned about foreign regulations. We have much more stringent rules and regulation."; "Flying home when not fully recovered would be an added burden."

Quality of care. "Health facilities would have to be extremely clean"; "Would consider it on any surgery over $5000. We aren't the only country in the world with good doctors. I'd prefer Europe. I'd look into the options in detail. I wouldn't be as worried about India, Thailand, etc"; "I would feel most comfortable w/ doctors who received their M.D. in the U.S"; "Would need to have very good incentives and a very simple and safe procedure to get me to go overseas"; "My main concern is the quality of the care. I have never had a major procedure done. So my answers might be different if I had actually experienced this. The cost of healthcare is definitely a concern to me, but quality of care is more important"; "Before deciding on overseas medical care, I would want feedback from others with my specific procedures with hospital, doctor's name, etc. so I could research them specifically"; "It really depends on what I know about the country, If I can take off work and use the idea of the procedures as a vacation as well. I want the security of my own knowledge that the services offered are the same as the U.S. and also use it as a vacation and I can afford it."

Costs/Expenses. "I would have no problems going outside of U.S. for a surgery if it saves money and travelling is always fun"; "I am also able to afford health insurance at this point. However, if I didn't have money, I would need to consider all the alternatives"; "I would only go if it would save a ton of money, and even then I'd rather have it done here than outside the country"; "Would need to have very good incentives and a very simple and safe procedure to get me to go overseas"; "Healthcare needs to be cheap here so this isn't an issue"; "The whole idea of medical outsourcing is a little scary, but it is not that horrible of an idea to think about especially if the medical treatment is practiced under the same standards & costs less"; "Considering health care & medical procedures are so expensive in the U.S. It would be possible that I would look outside the country for certain medical procedures"; "Being fairly low income as a student I don't know how apt I would be to go overseas compared to it if I was out of school making $40,000 – $50,000 + income"; "Have always had medical insurance so have never considered the questions seriously but if I had to pay for a major procedure, I seriously would look at overseas/ foreign doctors"; "When a society or nation seeks to secure medical services outside of its borders, simply because of its cost effectiveness, then it reveals a deeper internal demise of its structure. And scores another notch in the belt of health care greed. When health care pays a VP of Marketing over $100,000 annually, our focus in health has become one of self centeredness"; "At his point I think I would stay in the U.S. for medical care. But that could change if the costs change and I would need more surgeries."

Risk/Safety. "Why, when you are already facing the fact of having major surgery, would anyone want to go to another country to deal with it?!"; "Is the hospital in a safe area of the city?"; "[It is] not a good idea. Too many unknowns and possible risks"; "I am somewhat biased. I work in health care and I am very aware of risks here in the U.S.!" "At this point, this feels a little too "crazy: or "risky" for me. Maybe it is because I have been very fortunate not to be burdened with large medical bills. I did choose to have elective Lasik eye surgery and I didn't not even consider doing it outside the country even if it would have saved me tons of money"; "Having foreign medical attention could most likely deadly"; "I would want to talk with others who have tried medical tourism, speak with doctors before traveling to the location. My company could have to have proof that the place was safe and reputable."

Insurance. "I feel that insurance policy choices should remain in the hands of individual companies, and their respective unions. If a company wishes to "outsource" medicine, it is up to their discretion"; "Will insurance cover a percentage of the flights, hotel stays, taxi cabs and if not, where is the savings for the patient?" "I would only recommend overseas medical treatment for people who don't have insurance. I have been in hospitals overseas and don't like their practices"; "If an employer provides medical coverage that is equal or greater than the care received in the U.S. and the travel expenses paid, I would not mind foreign country treatment. If I am solely insuring myself with my own funds, I would probably consider any foreign country for treatment"; "Companion coverage would need to include recovery time: approval of companion's employer for time away from work and missed income"; "If there are complications from surgery (longer recovery time) will companion be give extended time away from work/missed income? Would insurance pay the full bill?" "Universal coverage of U.S. citizens will solve no problems;we are faced with and is fiscally irresponsible"; "Companion coverage would need to include time/income away from work. This would be during the procedure recovery + travel to and from the place for the surgery/procedure."

Facilities. "You have no idea of the cleanliness of the facility"; "What are the safety precautions in the facility?" "I think that I would need to see the hospital that I would be having the surgery at before I would actually do anything"; "I would want the facility to have some affiliation with U.S. hospitals."

Family Support. "I would consider surgery overseas if there would be guarantee of someone accompanying me."

NO CONSIDERATION

"Being a RN, I know how the health care system is in this country and heard positive things in other countries, especially in India and Philippines. My personal experience and thought on the topic: I would *never* recommend outside the country treatment for myself or my love ones. It is just not worth the risks"; "This was difficult to comment on due to the fact I am in the medical field"; "I would never volunteer to have surgery overseas, not for 10 million dollars!"; "I don't feel comfortable going overseas for surgery"; "I am generally not a big supporter of outsourcing anything, unless all employees are on the same pay scale. Equal pay for equal work"; "I feel that U.S. is still the best if we have a President and Congress that care about U.S. citizens"; "I would never go outside of the U.S. for treatment of any kind"; "I think we should keep medical care in our country for many reasons"; "Keep our health care and healthcare jobs in our country"; "I would never seek treatment for anything outside the U.S."; "I would not feel confident in going to another country to have any medical treatment"; "Travel time is not a huge issue, but I prefer to have American doctors treat me and stay here at home"; "I would never go out of the U.S. for any medical procedure"; "I would rather be in the United States for medical care, not another country"; "I would never have surgery in a foreign country"; "Having surgery in an unindustrialized nation is a bad idea"; "My thoughts toward America pursuing foreign health care--it would be very unfortunate. A very large percentage of our physicians here in the U.S. are from India, China. Why leave the country? We are already receiving international care"; "I would consider out of US care only if I was vacationing and it was an emergency, otherwise I would come back to the States for medical care"; "Outsourcing is not the answer, simply because it is the obvious. Our two-tiered system of economies of 'haves' and 'have-nots' is fast approaching. To remove "medicine" outside of the U.S. is to trump the U.S. "again" of its ability to take care of its own."

Barriers

Language. "[I consider] a language barrier"; "I had a few procedures done while I lived overseas. There is nothing worse than walking into an unfamiliar medical system and not being able to communicate fluently."

U.S. Health Crisis

Government. "I don't feel the government should be in the medical business other than to help ensure financial accountability"; "[It is] better to work toward health care-medical treatment/cost control, etc here in the U.S."; "My grandparents who don't receive good health care in the U.S. get all their dental work done across the border in Mexico. They also do their doctor check-up there as well"; "Bad enough our jobs are going overseas. Now the next game is to send the sick people over there because our government has let this health care crisis to get out of control. Perhaps we should fix this and keep our health care in this country. If not, let's start this with the politicians that refuse to fix it. Send them first!"; "We need medical insurance that all middle class can afford"; "I sincerely hope that companies and individuals in this country do not begin resorting to outsourcing medical procedures based on cost. I would much rather see us deal with fixing our broken system of extravagant lawsuits and settlements and bring costs back into line within our own country"; "Tort reform is needed to lower settlement amounts in malpractice suits and deregulation of health insurance, along with pricing like car insurance (if you go to the doctor, a lot you pay more, etc.) would greatly reduce costs. Let's not forget that of those 47 million Americans w/o medical insurance, 50% + make over $55,000/year and can budget for it. Priorities. I make less than $20,000/year and have it. So they definitely can. We have the best health care system in the world!"

Policy Crisis. "If we can't handle this in our country, why are we going out? Obviously, costs are rising in the United States. Maybe we should correct this problem with the insurance companies and our

ethnical policies"; "What would happen to U.S. health care and those working in healthcare if we sent everyone overseas?"; "The cost saving compared to the quality provided for the working people should never happen. For those that choose not to work and get coverage, is another picture. National medical insurance is another option that should not be considered. I understand this is not a simple problem but you can count greed is the big player."

DISCUSSION AND IMPLICATIONS

This content analysis on medical tourism, indicated that people must be able to perceive the rewards/benefits, financial or otherwise, to decide to participate. Such rewards might be new or experimental procedures available oversees that are not available in the U.S. and still pending FDA approval (common with some surgeries in India and Europe). Another benefit is the ability to get off long waiting lists for procedures and get them done quickly. Clearly these are benefits beyond the control of most HR Departments or tourism providers unless they are agents actively engaged in arranging medical travel for employees and general consumers. In that case, agents/brokers can contract only with the best medical providers in internationally accredited clinics and hospitals, with clear perceived rewards for participants.

The list of risks and motivators respondents had was lengthy. Depending on the type of medical procedures, some would choose to go overseas and for other procedures they would not. People might be comfortable having a knee joint replacement done in Thailand, but never consider life threatening heart or brain surgery. Respondents indicated 'it depends." Other concerns were assurances that they would have adequate medical facilities and adequate hotels prior to and after procedures, assurances of high sanitation standards in clinics and hotels, ability to have loved ones with for support and as patient advocates, the quality of care provided in clinic/hospital, and type of follow-up. Language was also seen as a major barrier by some.

Many commented on the status of 50 million uninsured U.S. citizens, criticized federal policy and wrote of the national health care crisis. And finally, several respondents, particularly those working in the medical profession, said they would not become a medical tourist under any circumstances. "Not for ten million dollars!" was the most emphatic response in our study, along with the inflammatory statement that, "having foreign medical attention would most likely be deadly."

The implications for employers moving toward offshoring more medical procedures to reduce health expenditures and the hospitality and tourism industry are numerous. HR's employee communication message, hotels, facilitators and agents play a huge role in whether or not people will ultimately choose to participate in medical tourism. First, agencies/brokers that coordinate medical tourism trips must acknowledge that they are working with a unique niche of people with needs much different than typical site-seeing traveler and accordingly, need to assist patients at multiple points. This is the case even if these tourists do site-seeing and beach time during recovery. Levels of fear, anxiety and insecurity are high amongst this niche market. Much can be done in advance to allay the concerns voiced, from overseas agents speaking perfect English on telephones, websites and literature with full disclosure and a plethora of information to aid in making informed decisions, guarantees of spotless hotel facilities, facilitators to make travel bookings and assist with selection of hospitals and surgeons, aiding completion of paperwork, and good translation services if needed. High standards of sanitation in hotels will also calm fears of infection during recovery.

Furthermore, assurances of excellent communication with family members in residence and back home, with appointed hotel, hospital or tour agency liaisons, are also essential for facilities/brokers working with employee health programs or non-insured consumers. Not only does the in-house communication need to be good, but also that with the medical facility, both prior to arrival, pre-

procedure and during recovery in the hotel—all providing informational continuity. Some medical tourists spend months in hotels waiting for an organ donor, thus far more time than the typical short-stay hotel resident (Lerner, 2010). Hotels and provider agencies need to provide top quality services to these long-stay guests.

This compendium of comments is important, as it can be used to inform and provide insight to employers and providers, as to what problems to avert before they arise, or to minimize them. The list can be useful in planning the marketing of medical tourism services to employees, to the general public and to attract international patients via brochures and websites, assuring high levels of trustworthiness and reliability (Riczo & Riczo, 2009). Good marketing informs potential patients about options and also provides shared experiences from former medical tourists.

Given the lack of empirical work on medical tourism from the U.S., the field is ripe for rigorous research from practitioners and academics from multiple disciplines, who can all aid in better understanding the patient experience. There is a need for data that confirms the speculative numbers of medical tourists, the size of the group and direction of travel flow, what and how information sources are consulted and evaluated, how decisions are made depending on the procedure type--home country of the patient--destination of medical travel, and the role of demographic variables such as gender or income. Important research contributions can be made to this nascent area that is complex, controversial and exciting.

CONCLUSION

The motivation to seriously consider medical tourism is greater than ever, as US businesses increasingly encourage offshoring of employee health procedures, Americans experience layoffs in unprecedented numbers-losing their health insurance that made procedures affordable, and health standards in some developing countries reach world-class levels at far lower cost (e.g India among others). More employees may now find incentives built into their employer-sponsored insurance plans, to have surgery abroad and in return, receive part of the savings. In 2009 Deloitte Center for Health Solutions predicted an increase in medical tourism of 35% annually. Unless insurance carriers, employers, and medical tourism coordinators address these areas of concern consumers and employees openly express, the numbers of participants will not increase substantially. As the U.S. healthcare crisis continues to mount and healthcare policy and financing continues to be debated, we can be assured that medical tourism will get increasing attention by Americans. The financial rewards for employee benefit programs and the hospitality and tourism industry could be substantial if the concerns of this niche market are met well in advance.

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