AALBORG UNIVERSITY

Aalborg University

Tourism, 10th semester

Topic: Master's Thesis

Title: Travel, treatment & trust in medical tourism

Subtitle: An explorative study on trust & distrust towards obtaining medical procedures abroad

Conducted by: Brigita Cseriova

Zofia Konieczna

Supervisor: Peter Kvistgaard
Pages of 2400 characters: 87.5 (240,084 characters)
Number of appendices: 11
Handed in: 30th May 2012

ACKNOWLEDGEMENT

We would like to thank all the people who helped us to create this master thesis. In particular, we want to express our gratitude towards all our interviewees for sharing their experience and their ideas about medical tourism with us. Secondly, we would like to thank Amanda Brooke Perino for proof-reading and correcting this paper linguistically, Jenny Janssen for translating our introductive summary to French language, and to Lennart Verstegen for helping us with the layout of this thesis.

We would like to acknowledge our lecturers at Aalborg University who gave us the taste of tourism as an academic field of study during the two-year programme. Special thanks go to our supervisor, Peter Kvistgaard, for his constructive criticism, helpful advices, communication style, and especially for his unique way of approaching the researched subject and his openness towards new ideas.

Finally, but certainly not the least, we want to thank our families and friends who supported us during this period and endured the long hours of writing. Moreover, we would like to show our appreciation to each and every one, who came into discussion with us about the researched matter, for all their valuable comments and productive feedbacks.

ABSTRACT

The purpose of this master thesis is to academically contribute to the understanding of the growing phenomenon of medical tourism, which impacts the tourism industry by forming a new type of niche tourism. Medical tourism refers to a practice of participants of mostly higher income countries engaging in medical treatments in developing countries with lower prices. The particular focus is set on exploring the generators of trust, respectively distrust, that influence the consumers' attitude towards undertaking a medical treatment in a foreign country. In this paper, we identify the importance of these aspects in the decision-making process of medical travelers. In order to provide sufficient academic background of the subjects overlapping in this particular research topic, this paper is divided into three theoretical chapters: medical tourism, theory of trust and decision-making processes.

This qualitative study is carried out by conducting qualitative semi-structured interviews with four medical travelers, whose first-hand experiences and perspectives enrich and complete the theoretical knowledge. Moreover, two potential medical travelers are interviewed for the purpose of learning about their perspectives on the phenomenon and the subject of trusting (distrusting) the idea of medical interventions abroad without being impacted by any personal experience. The interviewees are chosen from the Netherlands and Denmark as these two nations tend to act as exporters of medical tourists. Both countries represent high standards of living and thus higher costs of maintenance (including the costs of medical treatments). Lastly, an interview with a former employee of a medical travel intermediary is conducted in order to support and reflect the collected data with experiences of the supplier's side.

The answers show that trust and distrust play an important role in the decision-making process of medical travelers, mainly towards the practitioners/hospitals of a foreign country. On the other hand, general confidence in traveling to a certain country is needed for a successful experience. That

confidence is often based on destination awareness and the general image of the place. Even though, a destination characteristic itself seems not to attract medical tourists (because they are more concerned about the treatment), familiarity with a destination increases the likelihood of engaging in medical procedure there. This is either caused by friends or acquaintances living at that particular destination or by regular travels to a destination for holiday purposes. Family and friends recommendation is seen as another aspect that generates trust and stimulates engaging in a medical procedure abroad. The gathered materials suggest that medical travelers' first-hand experiences and advices influence the level of trust (distrust) towards medical treatments in a foreign country and act as trustworthy references.

The research also indicates that open-minded attitude and previous travel experiences of a potential medical traveler affect the participation in a positive way. Additionally, negative medical experiences in a source country as well as a general dissatisfaction with the health system tend to make individuals more open for alternatives. This does not refer to the fact that satisfactory medical care in a home country prevents or limits the likelihood to check the alternatives and decide on a medical procedure abroad. The findings confirm that low costs are seen as the prime motivators when traveling abroad for a medical treatment, however, it must be supplemented with high quality of the hospital or clinic (including the quality of medical equipment, the expertise and social attitude of medical labor with perfect communication skills) in order to comfort the patient. Service quality and professionalism seem to verify the given trust and makes the overall experience satisfactory.

During the study, difficulties of finding the relevant research sample were experienced, due to the limited availability of experienced medical travelers willing to participate in our research. However, the research sample used in this paper is believed to have provided sufficient information on the researched topic in order to signify the importance of this research area. Further investigations within this disciplinary subject will help to understand the attitude of medical travelers towards the phenomenon and offer valuable knowledge for medical tourism destinations, hospitals or intermediaries to reach the potential market by providing trustworthy and reliable medical care.

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The idea of traveling abroad in order to obtain a medical treatment is seen as a growing phenomenon all over the world. Aspects such as: lower costs, shorter waiting time and legal issues are seen as the prime motives for the development of medical tourism. Issues of trust and distrust play a significant role in the decision-making process of a medical traveler. Trust and distrust is seen as a personal state of mind and thus highly emotional. It is often unrecognized due to its subconscious nature that is frequently linked to intuition. Hence, this project focuses on analyzing and exploring the generators of trust and distrust in the field of medical tourism. This paper discusses general trust, previous medical experiences, communication, family & friends' recommendation and doctors' attitude as the main generators of trust and distrust in relation to medical tourism.

KEYWORDS: medical tourism, medical treatment abroad, trust, distrust, decision-making process, generators of trust and distrust, medical travelers.

Nous observons qu´il y dans le monde entier de plus en plus de gens qui décident d'aller à l'étranger pour y subir un traitement médical. Quelques aspects entrant en jeu dans l'essor de ce que nous appelons le tourisme médical concernent avant tout les moindres coûts, les listes d'attente moins longues et les aspects juridiques. Puis, dans le processus de décision auquel doit faire face le 'touriste médical', ce sont les sentiments de confiance ou, bien au contraire, de méfiance qui jouent un rôle primordial. Les sentiments très émotionnels et très personnels que sont la confiance et la méfiance sont des notions souvent méconnues pour être fortement liées à l'intuition ou au subconscient. Ainsi, le présent mémoire se focalisera sur l'analyse des aspects qui, concernant le tourisme médical, sont susceptibles de générer ces sentiments de confiance ou de méfiance. Par conséquent nous examinerons de près la notion de confiance dans un sens général, l'importance des expériences médicales vécues, le champ de la communication, les recommandations faites par les parents et les amis, ainsi que les relations que l'on entretient avec les médecins.

MOTS-CLES: tourisme médical, traitement médical à l´étranger, confiance, méfiance, processus de décision, touristes médicaux.

INTRODUCTION

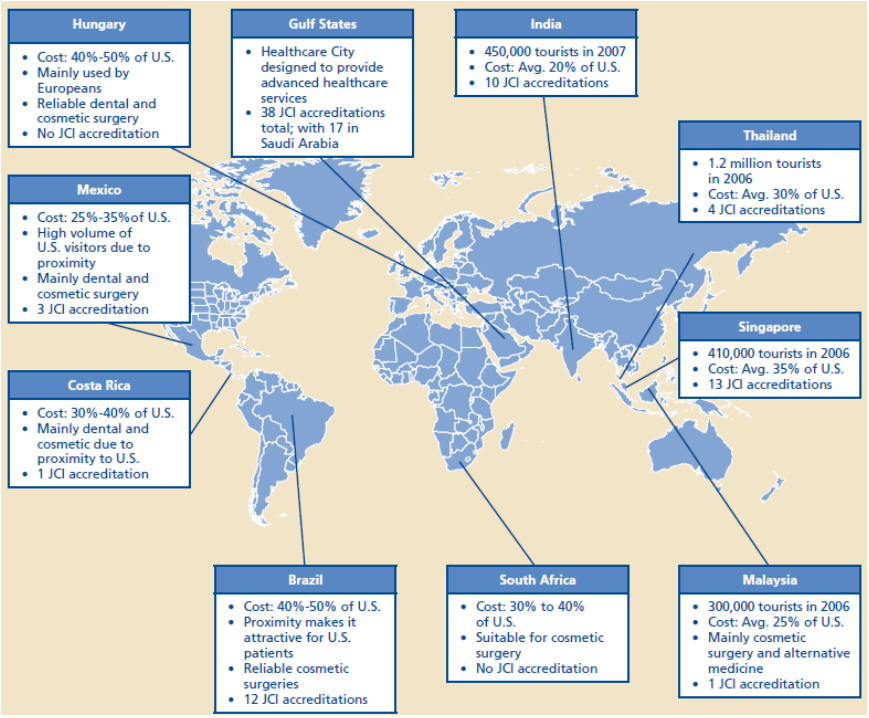
The goal of this paper lies in broadening the knowledge of medical tourism, which is a relatively new, yet growing phenomenon all over the world (Gill & Singh, 2011; NaRanong & NaRanong, 2011). In order to get a proper image of medical tourism, it is essential to understand what is actually hidden behind this concept. In this paper, medical tourism is seen as a practice of a patient purposely choosing to leave for a medical intervention abroad whereby he or she typically spends at least part of the recovery time at a tourist resort or engages in other form of tourism related activity. However, people who require medical care while traveling are not seen as medical tourists. Neither are emigrants or refugees, who access medical treatment in country or region where they currently live (Crooks et al., 2010).

The most frequently mentioned motives for participating in medical tourism are: significantly lower costs of treatments in developing countries, shorter waiting time and possibility of obtaining medical services not available in one's own country (Hopkins et al., 2010). Some authors also mention comparable or better quality care (Cormany & Baloglu, 2011) and opportunity for vacation as well as privacy and anonymity (Gill & Singh, 2011). Interesting motives are analyzed by Solomon (2011) in his paper entitled *Affective journeys: the emotional structuring of medical tourism in India,* where he discusses the importance of emotions and trust when dealing with medical treatment abroad. The author emphasizes the important role of trust when it comes to health and lives of medical patients. Consequently, this project explores the issue of trust and distrust in relation to medical tourism. Trust is here seen as a significant generator in the decision- making process of individual participants. As the authors of this thesis we elaborate on trust and its correlation to choice when going abroad for a medical treatment, hence we find it equally important to analyze distrust as another influential feature. In this paper, those two characteristics (trust and distrust) are used both as mutually opposed to each other, but also as coexisting elements which often influence one another during the decision-making process.

TOPIC OVERVIEW

Traveling for various purposes including health, business or leisure was possible and practiced back in the past, yet the scale of travel has been increasing ever since (Weaver & Lawton, 2006). Today, the tourism industry is one of the fastest growing and developing industries in the world (UNWTO, 2011a). Even despite the decline in the years of economic recession in 2008 and 2009, the World Tourism Organization (UNWTO) observed a very strong recovery. In 2010, international tourist arrivals reached 940 million creating 6.6% of increase over the previous year (UNWTO, 2011b: 3). Even though most of the touristic visits today - according to UNWTO's statistics - are related to leisure and holiday purposes (51%), the growing tourism industry also generates numbers of special interest tourism activities in order to please different types of traveler. Based on the statistics, 27% of travelers journeyed for other purposes than leisure or business. UNWTO lists health treatment besides visiting friends and relatives (VFR), and pilgrimage under this percentage (UNWTO, 2011b: 3), which indicates to the significance of seeking health treatments abroad. Additionally, the research by Deloitte group on medical tourism points out ten medical tourism destinations (shown on the map below with data on tourist arrivals, approximate cost saving of U.S. and number of accredited hospitals) that are in an importance within this industry. Hopkins et al. (2010:

192, app.1) also lists four Asian countries with their estimated earnings and major services provided. For example, India treated 450,000 patients in 2007 and earned US$ 480 million in 2005 for providing mostly cardiac surgeries, joint replacements and eye surgeries. Whereas Singapore generated an estimated earning of US$ 560 million in 2004 from patients engaging mostly in liver transplants, joint replacements and cardiac surgeries at the destination.



Model 1 Medical tourism destinations (Deloitte, 2008: 6)

The growing nature of the tourism industry and thus medical tourism industry is influenced by different factors. Firstly, economic factors such as affluence of the society which affects the attitude towards spending the remains of higher incomes on leisure activities or business price competitiveness that enables purchasing great bargains in other destination (as in case of medical tourism). It is also an effect of the social factor of increased discretionary time that enables tourists to travel for a longer period of time and take holidays more often. Demographic factors such as population increase and extending life expectancy also have a positive effect on tourism development. The latter may especially impact medical tourism as older people tend to have more problems with their health. They also have more time to research and get familiar with diverse possibilities and when taking into account Western societies, they often have the budget for travelling abroad. Moreover, urbanization causes consumers to escape from the urban congestion and thanks to technological improvements and information technology this pattern is more accessible.

Another important aspect that influences the development of tourism depends on political factors that allow freedom of traveling (Weaver & Lawton, 2006). This freedom of traveling and globalization grounds the phenomenon of health care services getting packaged and exported worldwide. The statistics also confirm the positive effect of technological developments on tourism by showing that more than half of the travelers use air travel to reach their destination (UNWTO, 2011b: 3). Technology improvements in aircraft industry influence the tourist decision to travel comfortably and quickly on either short or long distances. At the same time, the emergence and development of low-costs airlines makes flying more affordable to a wider travel market. This is particularly true when it comes to medical travel, as comfort, time, quality and cost factors provide relatively easy access not only to close but also to further destinations where one's health can be cured. In case of medical tourism, medical developments are also vital for targeting potential consumers.

As social, economic, technological and demographical factors alter and change the characteristics and interests of people's life, new types of niche tourism appear constantly. Therefore, it is not surprising that Connell (2006) recognizes medical tourism as a new form of niche tourism and Lautier (2008: 101) goes even further by stating it is a *"new export niche for developing countries"* as economic advantages of having treatment abroad and changed attitude towards the importance of our own health and appearance are one of the factors that cause the emergence of this phenomenon.

Tourism literature also distinguishes between mass tourism characterized by mostly large number of tourists and niche tourism that usually refers to small number of tourists who are *"identifiable by the same special needs or interests and defined as having a strong desire for the products on offer"* (Novelli, 2005: 5). Novelli (2005: 6) states that niche tourism is focused on a *"very precise small markets that would be difficult to split further"*. In this way, the offers are more tailored in order to target the particular segments as travelling can act as one of the determinants where individuals differentiate and express or assimilate themselves to a certain group that is likely to share their interests and social environment. However, one can argue that niche tourism is becoming a new mass as the questions are how big the niche market can be in order to stay niche or whether various niche markets comes to overtake the mass phenomenon (Novelli, 2005).

Novelli in her book on niche tourism lists numbers of tourism niches which she divides into four categories, namely special interest tourism, such as photographic, gastronomy, youth, transport or dark tourism; tradition and culture base tourism, such as heritage, tribal, research tourism; activity based tourism like sport, adventure, wildlife, volunteer tourism; and future of niche tourism namely space, virtual and ethical tourism. Despite the length of the list, she does not cover health or medical tourism in any ways in her book. It can be due to the complexity of these umbrella terms covering various types and severity of

health and/or medical treatments that are complicate to generalize due to their dissimilar nature (e.g. dentistry tourism, wellness tourism, reproductive tourism).

On the contrary, Hall in his book titled *Special Interest Tourism* dedicated a chapter to *Adventure, Sport and Health Tourism* concluding that all three types of tourism have a common denominator of being a *"desire for an enhanced quality of life and participation in relatively active recreational pursuits in outdoor setting"* (Hall, 1992: 143). The second part of the definition may be criticized for being too narrow to generalize all three types of tourism as they are not only limited to active outdoor setting. However, this gives us a starting point to dig deeper and differentiate health tourism and medical tourism.

As such, medical tourism does not fit by any means to the overall definition above as it is rather a passive activity indoors of a hospital with a probability of enjoying outdoors and the climate after the treatment and hospitalization. Despite this, medical tourism is being listed as the last component of health tourism (Goeldner, 1989 in Hall, 1992: 151). The term 'health tourism' therefore covers all forms of health-related tourism (Connell, 2006), namely wellness, spa, adventure, sport and even leisure tourism as it is a *"travel to make yourself or a member of your family healthier"* (Tabacchi, in Gill & Singh, 2011). Hall (2003 in Bristow et al., 2011) recognizes that progressing along from leisure health tourism to specific medical interventions, decreases the demand. Knowing the range of pleasure involved in health tourism, medical tourism signifies a controversy of combining fun and pleasure with a necessary must, seriousness and risk, where tourists not just travel for a better climate, but also for a medical treatment, where they decide to entrust their health into a foreign doctor's hands while wanting to benefit from the destination itself as well.

RESEARCH SCOPE

Health is one of the most significant part of our life and as Virgil[1] said *"the greatest wealth is health"* (Quotegarden, 2012). To entrust one's own health into someone's hands requires then either a complete confidence in that person or lack of other possibilities and forced reliance. Medical tourism is based on patient's choice on either being treated in own country (where he is more familiar with the procedures and regulations) or abroad (in a new environment and often among unknown customs). Therefore, trust seems to be a significant issue when deciding on a medical treatment abroad. Trust in medical tourism has been

[1] Publius Vergilius Maro- an ancient Roman poet.

discussed at the annual European medical tourism conference, where it has been stated that lack of personal bond between a patient and a doctor leads to decrease in confidence towards the surgery and the physician. One of the spokesman stated that an ideal way of developing trust is to create a personal connection with the patient by explaining the details of intended treatment, staying responsive to all appearing uncertainties, letting the patient feel relaxed and informed, and finally give him the impression that he/ she is the only one that matters. The conclusions of the conference acknowledged the fact that *"it is becoming more about trustworthy service and quality rather than the price or cost of the medical treatment itself"* (The Travelling Patient, 2010), thus the subject of trust in medical tourism has been noticed as an important generator for the development of this type of tourism. However, according to our (the authors) research in the above mentioned area of interest, there is a significant lack of explorative studies on influences of consumers' trust, respectively distrust in medical tourism.

Trust seems to be a very intangible characteristic which in our, authors eyes is seen as a liquid that changes its forms accordingly to a situation and to an area of study. As the researchers we ask ourselves: is there a difference between trust in business, relations, politics or healthcare? Or do we always talk about the same thing, regardless of its position, disguise and impact on a certain situation? It is very difficult to present a decent definition of trust because of its diverse shapes and applications. A psychiatrist Erik Erikson introduced a term 'basic trust', which refers to overall perception of the surrounding world and relations with our caretakers in early childhood (Solomon & Flores, 2001). As humans grow up and experience different kind of interactions with others (positive and negative), their perception, ability and will for trusting others is formed. The authors notice that beyond the closest relations generated in the childhood, trust must be learned. This process of learning to trust other people starts from observing the attitudes of one's nuclear family. However, in today's society we cannot limit ourselves to trust only the people we know and those who are considered by us as 'not strangers'. The evolution and globalization requires from people to become more trustworthy even towards those of different cultural backgrounds, beliefs, behaviors and many other unfamiliar features (ibid). In the world of new technologies and the Internet, we are encouraged to trust to those we have never met (e.g. internet sales) and so it becomes questionable if direct interaction is still really required for building trust (Solomon & Flores, 2001). Deciding on medical treatment abroad differs of course from online shopping, however, a question arises: does online marketing helps in creating trust towards the idea of medical treatment abroad or does it diminish the reliance in medical tourism?

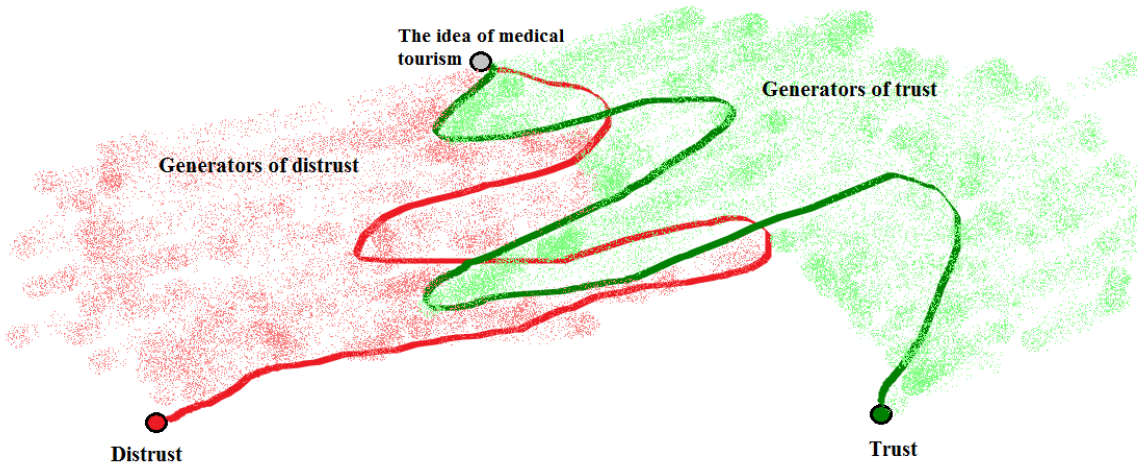
In the book *The Trust Crisis in Healthcare*, the author, David A. Shore, justifies that quality of medical treatment is one of the most vital parts in creating trustworthy relationships between patients and physicians. If the customer is satisfied with the final result – the process of building trust is progressing. What about the trust that must be created before curing the patient? When discussing issues of trust and

distrust in relation to medical tourism, the circumstances are different. When deciding for the first time on going abroad for a medical treatment, the patient chooses to trust someone who he or she has never met before and to give his or her trust for the whole concept of curing himself/ herself in another (often unfamiliar) country. There seems to be a significant relation between the influence of success and development of trust. However, this relation takes place only if there has been an earlier interaction between two or more parties (Hill & O'Hara, 2005). Thus, it seems that trust is (or rather should be) a part of medical tourism. Therefore, a question can be raised: should medical providers sell trust as a part of medical services? In what way can they pursue/convince patients to trust their quality, promises, intentions, etc. without having an earlier interaction? Even thought, this project does not focus on the supplier side, the above questions are seen as important indicators for analyzing consumer needs and their perceptions on generating trust towards a medical treatment in a foreign country, where there is a need not only to entrust unknown physicians, but the unfamiliar environment and culture as well.

RESEARCH QUESTIONS AND OBJECTIVES

Existing literature on medical tourism focuses mostly on general characteristics of the phenomenon. Discussions are often centered on external motivators in decision-making process, decisive factors in destination choice and general profile of medical tourists. This information is important in creating and expanding knowledge on medical tourism, however we, as the authors of this paper, observe lack of in depth research on the subject of trust and distrust regarding medical tourism. The purpose of this project is to research trust and distrust as an important aspect influencing the decision-making process when traveling abroad for medical treatments. One of the goals of this paper lays in identifying generators of trust and lack of trust/distrust.

For better understanding of the research area of this project, we created an illustration, which is presented below. It shows a process of decision-making in relation to trust and distrust in medical tourism. Firstly, an idea of traveling abroad for a medical treatment appears in persons' mind. The green and red lines symbolize the process of creating trust/ distrust in relation to the discussed subject. Further, the green and red dots represent possible aspects that influence the level of trust and distrust during the process. Those features determine whether trust/ distrust will increase or decrease during the decision-making process. Based on those features, the final judgment towards trust in medical tourism is made.



Model 2 Self-designed graph of generating trust and distrust towards medical tourism

As discussed above, trust is seen as an important aspect when deciding on going abroad for a medical treatment. However, it is noteworthy that trust is not the only aspect that influences patients' choice for medical tourism and thus it is not the only determinant for the final decision. It is often an intuition or a subconscious feeling that arises during the process of decision-making. Therefore, medical patients may have difficulties with defining the concept of trust and distrust, and thus it can be unrecognizable as a conscious feeling.

We focus on understanding the process of creating unconstrained trust or distrust towards physicians and towards the idea of traveling abroad for a medical treatment. Therefore, the main problem of this paper is represented by the below question:

What generates trust and lack of trust towards the idea of traveling abroad for a medical treatment? An explorative study on trust and distrust in decision-making process in relation to medical tourism.

This paper seeks to answer the above question as well as aims at creating a solid foundation for further studies on trust within the area of medical tourism. Below we present six hypotheses related to trust and distrust in medical tourism. Those hypotheses are based on the theoretical knowledge gained during our research as well as on an informal observation of the subject. The main purpose for creating those

hypotheses lies in giving ourselves a proper direction and possible outcome to our study in order not to lose the main focus of this paper.

H1: Trust and distrust play a significant role in decision-making process of medical treatment abroad.

H2: The opinions and recommendations of family and friends influence the amount of trust and distrust generated towards the idea of medical tourism.

H3: Medical background and previous medical experience influence the amount of trust and distrust towards the idea of traveling abroad for a medical treatment.

H4: Open minded people are more likely to participate in medical tourism.

H5: Destination is secondary to treatment and hospital/doctor reputation.

H6: People with previous travel experience are more likely to decide on having a medical treatment abroad.

As the authors of this thesis, we look for deep and meaningful insights to the subject matter and therefore we have chosen qualitative methods of research which enables us to achieve our goal. During the process of conducting interviews and analyzing the gathered materials, we try to prove or disprove the above hypotheses. The consistence/ lack of consistence of the above assumptions with the collected data will help us to answer our main question stated in the problem formulation.

STRUCTURE OF THE THESIS

This thesis is divided into four major parts. In the first part of the thesis (Part I), we introduce the research topic together with the problem formulation and hypotheses (Chapter 1) and then explain the methods used in our research for investigating the above matter as well as our approach towards the study (Chapter 2). Part II is the theoretical chapter which is subdivided into three chapters which represent the elected theories in order to answer our problem formulation, i.e. theory on medical tourism (Chapter 3), trust and distrust (Chapter 4) and decision-making process (Chapter 5). It is subsequently followed by Part III, which includes the analyses based on gathered materials from conducted interviews as well as examination and development of models used in the theoretical part. Lastly, the conclusion is presented,

where all findings are being summarized. In the final part, an attempt to answer the researched problem is made and possible ideas for stimulating further research studies in the area of trust/distrust in medical tourism are emphasized (Part IV).

The purpose of this paper lies in deepening the existing knowledge on trust and distrust in relation to medical treatments abroad. We hope that this thesis will contribute to the studies of medical tourism as well as the area of trust and distrust in the decision-making process.

METHODOLOGY

The academic purpose of this project is to research particular aspects of trust and distrust as important parts of the decision-making process in relation to medical tourism. This chapter explains the choices and considerations concerning the way this research is conducted. First of all, we introduce the topic and the reasons behind choosing the particular research area, as well as related terms. It is followed by a discussion on inquiry and its relatedness to a certain paradigm. Moving on, the research strategy and method of qualitative interviews are elaborated on, followed by argumentations behind the choice of the particular research sample. Lastly, sources and limitations of the thesis are discussed.

The goal of this thesis lies in deepening the existing knowledge on patients' trust towards the idea of traveling abroad for obtaining medical treatments. As the authors of this paper, we try to understand what the generators of trust and distrust are when deciding on treatment abroad. The reason for choosing this subject is the growing interest in medical tourism all over the world (Crooks et al., 2010; Solomon, 2011; Lunt & Carrera, 2010). People usually travel from developed countries (USA, Western Europe) to developing countries (India, Thailand, Eastern Europe) in order to obtain medical treatments. Many researchers studied the phenomenon of medical tourism in relation to destination choice, perception, website contents, and services (Hopkins et al., 2010; Yu & Ko, 2012; Cormany & Baloglu, 2011), nevertheless no unequivocal research on trust within medical tourism was found. Some sources mention the importance of trust within the area of medical treatment abroad, however no in-depth research has been conducted (The Travelling Patient, 2010). Moreover, much is said and written these days about trust as a crucial aspect in the development of social interactions (Fukuyama, 1995), as well as in medical settings of patient-physician relations (Hall, 2002; Leisen & Hyman, 2004). Some authors emphasize that we are facing the 'age of distrust' where *"trustworthiness or at least perceived trustworthiness is declining"* (Hardin, 2006: 1). As indicated by Hardin, trust as a concept is falling apart and losing its power. How then can trustworthy relationships be achieved in medical tourism? And does it really play a significant role in patient-physician relations? Lee Sang-jun, a pioneer of medical travel in Korea states that

> medical services are different from car sales, as they are related to health and life. Building trust is the primary thing for the specific tourism sector, and, in order to build trust, caring consideration for the single medical traveler is essential (Rahn, 2009).

Therefore analyzing the generators of trust and distrust in medical tourism becomes an alluring and exciting topic to work with and to explore.

In this thesis, the term 'medical tourism' refers to any travel abroad for a purpose of surgical, dental, or cosmetic treatments that are rather risky procedures and which require trust from the consumers' side. The paper will not distinguish between these procedures as our aim is to explore trust/distrust in general towards the phenomenon of medical tourism. On the other hand, we recognize the differing intensity of trust in regards to various treatments abroad. Consequently, the reasons behind using the expression 'medical tourism' over 'health tourism' is the fact that medical tourism refers to more severe medical interventions (as it is explained in details in Chapter 3). These more serious treatments call for higher levels of trust in order to consider participation in them. Hereby, 'trust' is defined as a *"firm belief in*

someone or something" (Soanes & Stevenson, 2006: 1549), i.e. a belief in the success of a medical procedure abroad that cures illness, or respectively changes the outlook of the patient, while meanwhile the patient obtains other benefits (e.g. costs, quality, vacation). On the contrary, 'distrust' is a discouraging component affecting medical tourism, in a sense of lacking the interest and belief in medical treatments abroad. In order to keep the thesis understandable and logical, but at the same time to avoid constant repetition, words of 'distrust' and 'lack of trust' are to be used interchangeably. Therefore, in this paper those two phrases represent the same meaning and replace each other in different parts of the assignment. Further on, as the authors of the project, we refer to ourselves by the personal pronouns of 'we' and 'our' in order to avoid repeatedly calling ourselves 'the authors of the project' and 'the researchers of this thesis'. Thus we will indicate when we refer to a broader social context in our text.

PHILOSOPHY OF SCIENCE

To start elaborating on the way this thesis is related to the philosophy of science, we introduce the term 'paradigm'. Paradigm is a concept that has no clearly defined statement of its meaning, but it is seen as the basic element of human actions which appears in different settings around individuals (e.g. paradigms guide the legal system, spiritual and moral life; Guba, 1990). It is also argued that paradigms are difficult to recognize due to being implicit and taken for granted because individuals are socialized into a paradigm which results in their views and feelings and therefore it is complicated to see in which way we humans look at our social life (Babbie, 2008).

Guba (1990: 17) uses its most common meaning when defining a paradigm as *"a basic set of beliefs that guides action, whether of the everyday garden variety or action taken in connection with disciplined inquiry"*. In disciplined studies, there are several paradigms that guide actions during research. Guba (1990) lists positivism, postpositivism, critical theory, and as an opponent paradigm to those, constructivism. Due to the nature of the topic and to study this research area in the best possible way, this paper is written in a constructivist paradigm that

> asserts that social phenomena and their meanings are continually being accomplished by social actors. It implies that social phenomena and categories are not only produced through social interaction but that they are in a constant state of revision (Bryman, 2006: 19).

To determine this disciplined inquiry and how it is to be practiced during the research, he suggests answering three basic questions about ontological, epistemological, and methodological consideration and

position; consistently what the nature of social entities is, what knowledge is regarded as acceptable, and how those can be found and researched.

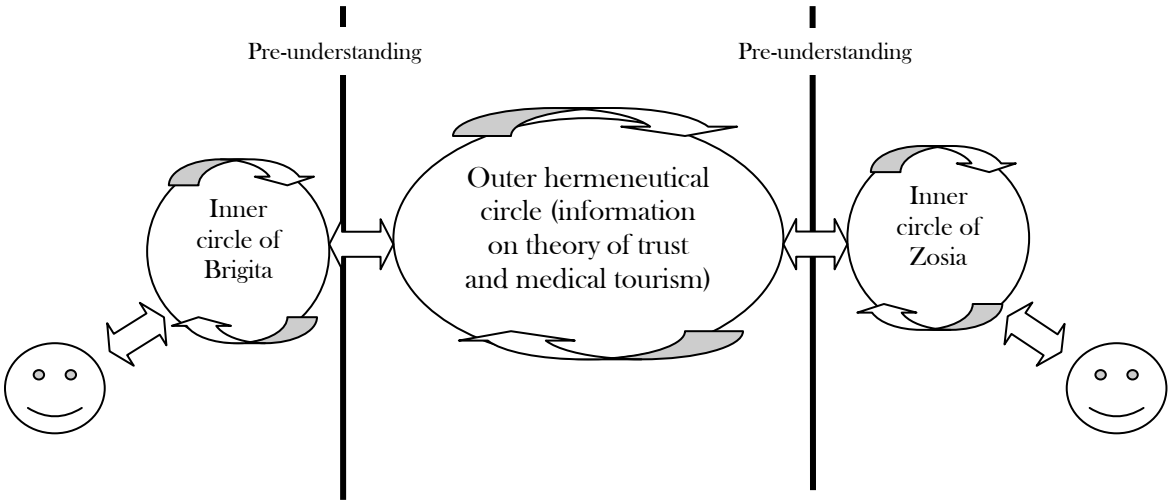
In this paper, we see social entities as constructed and not as given objective facts. The nature of social entities is depicted as consequences of human activity, meaning that human minds construct the knowledge and thus there is more than one truth as things can be interpreted differently. Therefore, the ontological position of this paper is rooted in relativism where – as discussed above – facts are relative, depending on the human who perceives them. It is especially applicable in the case of exploring the nature of trust in medical tourism, as trust is also perceived differently by each individual and there is not a single common way to experience it.

This research is then constrained to practice subjectivist epistemology (the study of knowledge), whereby acceptable knowledge is regarded to be acquired through reflecting on different perceptions about social reality because those realities only exist in respondents' minds. In addition, those realities are also influenced by the researchers' background (i.e. culture, language, formal knowledge, etc.) as there is an interaction between the researchers, the respondents, and the research process itself. Thus the knowledge and data gained and used in this thesis are to be interpreted by the researchers with an awareness of the need for their reflections in order to conclude a social reality based on the realities of our respondents and our own conceptions.

Guba suggests the most appropriate methodology for constructivists called hermeneutics that aims *"to produce as informed and sophisticated a construction (or, more likely, constructions) as possible"* (Guba, 1990: 26) and leaves communication open for improvements. According to the German philosopher Hans-Georg Gadamer, understanding of an unknown text or unfamiliar life is a holistic process which operates within a so called hermeneutic circle or spiral, where the researchers move back and forth between the parts of the 'text' and their own conceptions of it as a totality (Outhwaite, 1985). It allows the constructive process of moving upward from an earlier pre-understanding to a fuller understanding and then checks and reviews the preliminary understanding and changes it in case of collected materials giving additional meanings to the research (Thiselton, 2009). Gadamer (2004: 294) argues that *"the circle of understanding is not a 'methodological' circle, but describes an element of the ontological structure of understanding"* where researchers question entities and their relevance as they arise during the understanding process. The hermeneutic circle is a way to find the real knowledge and truth to the extent that such things exist. Based on Gadamer's view, Giddens (in Outhwaite, 1985: 34) claims that social science is a pre-interpreted world where meanings and their reproductions are conditions of the researcher who is a part of the process and therefore he/she is the first to grasp the concepts that he/she has to process. He also introduces the concept of double-hermeneutics where he adds an inner hermeneutical circle to the

single-loop hermeneutics saying that researchers are part of the investigation and their pre-understandings should also be understood in order to conclude the real knowledge and truth. The outer hermeneutical circle impacts both researchers with the new knowledge and the information that has to be processed, while the inner circles of researchers are in charge of the relation between the actors and their pre-understandings.

To illustrate this happening we also practiced such acts during the process of formulating the problem question and hypotheses. While our pre-understanding on medical tourism was slightly different (spiritual tourism vs. dental care tourism) in the beginning, we had to learn to get to know each others' pre-understandings and our personal ways of approaching challenges and the topic. The constant search for new information (literature served as an outer circle) drove us to a specific problem formulation that was both impacted by the new knowledge and our own inner circles of understanding. This process is to be implied throughout the research by questioning the appropriateness and relevance of our research sample, the questions asked during the interviews, and the way of understanding the findings in the analysis. The below illustration shows the interdependency of the researchers with their own and each others' inner circles that is influenced by the information (i.e. literature, data) in the outer hermeneutical circle.



Model 3 Self-created illustration of double hermeneutical circle showing the process of understanding during the research (the illustration is a modified version of a model presented by Norreklit, 2006: 6).

RESEARCH STRATEGY AND METHOD

This part of the chapter discusses a strategy of inquiry that connects the researchers to specific methods of collecting and analysing empirical materials and puts paradigms into motion (Denzin & Lincoln, 2011: 14).

In this paper, qualitative research strategy is used to answer the problem formulation. According to Bryman (2008: 366), it is a *"research strategy that usually emphasizes words rather than quantification in the collection and analysis of data"*. Exploring the concept of trust/distrust in medical tourism requires more qualitative data than statistics and numbers in order to gain deep insight into respondents' minds and their opinion on this issue. Quantitative data is used here only as supporting information in the form of basic statistics on medical tourism.

The main feature of qualitative research is that it examines and produces in-depth empirical knowledge about the social world. Denzin and Lincoln (2011:6) conclude that it *"is a set of complex interpretive practices"*. Behind qualitative research, the researchers stand with their particular class, gender, and racial, cultural and ethnic perspective and *"approach the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology), which are then examined (methodology, analysis) in a specific way"* (Denzin & Lincoln, 2011: 11). The double-hermeneutical task of questioning the researchers' knowledge and understanding is therefore believed to provide the most adequate study and conclusion on the research question.

The qualitative research method of having a humanistic inquiry approach where the researcher immerses the self within the research (Hirschman, 1986) is often criticized against positivist methods for being too subjective, for its difficulty to replicate and its nature of generalisation (Bryman, 2008: 392-3). On the other hand, Hirschman (1986: 244-6) emphasizes an appropriate set of criteria of humanistic inquiry that is different from positivists criteria. Firstly, dependability implies the fact that human being's internal consistency and temporal stability is being assessed in humanistic studies, knowing that there is no perfect correspondence among multiple interpretations of the same phenomenon due to unlike interactions between unique investigators and the phenomenon of study. It means that we are aware of our subjective influences being constructivists and conscious about the impacts of certain circumstances and the social environment on the respondents' temporal opinion about trust and distrust, as those are very personal inner feelings, connected with emotions and views. There are also difficulties with replication in humanistic research as different respondents (within our sample criteria) may have been having dissimilar opinions

about the investigated topic of trust and distrust towards medical tourism. Credibility then suggests that multiple constructed realities are to be credible to the constructors. As social contexts are never identical, humanists are not concerned with generalization, but with transferability of one manifestation of a phenomenon to another by comparing it with interpretations constructed in other contexts (we thereby contrasted literature from psychology, sociology, and tourism studies). With this in mind, the purpose of the paper is not to generalize findings of a population, but rather to try to give a ground for further investigation with a description of the study's complexity and internally constructed meaning of the phenomenon. Lastly, the criterion of confirmability suggests that a humanistic study relies on a judgement of external readers – preferably researchers familiar with the phenomenon with different professional social science backgrounds, who confirm or disconfirm the conclusion reached based on the collected information.

The research is based on collection of first-hand empirical data in the form of semi-structured qualitative interviews. This type of interview gives an openness to change the prepared scenario of questions during the interview in order to adjust to the answers with a goal for a better understanding (Kvale, 1996). The qualitative nature of the interviews suggests the importance of words and their meanings over the numerical facts, as described in the following definition on qualitative interview:

> Qualitative research is sensitive to the human situation, it involves an empathic dialogue with the subjects studied, and it may contribute to their emancipation and empowerment. The qualitative interview is a uniquely sensitive and powerful method for capturing the experiences and lived meanings of the subjects' everyday world. Interviews allow the subjects to convey to others their situation from their own perspective and in their own words (Kvale, 1996:70).

Since this project focuses on trust, a very personal and intangible state of mind, qualitative interviews are conducted in order to find the essential generators of trust and distrust for our interviewees and to let the interviewees share their personal thoughts and perception on the researched topic. Kvale explains that through qualitative interviews the researchers get the possibility to understand the interviewee and see the world from his/her point of view. The importance lies in trying to step into someone else's shoes, feel his/her feelings, experience his/her personal perception on the researched topic, and learn from his/her subjective beliefs and concepts of the world (Spradley, 1979 in Kvale, 1996).

Moreover, qualitative interview is seen more as a friendly conversation rather than insignificant investigation because *"the interaction is neither as anonymous and neutral as when a subject responds to a survey questionnaire, nor as personal and emotional as a therapeutic interview"* (Kvale, 1996: 125). Our interviews are conducted either personally (face to face interviews) or through Skype conversations. We are aware of the possible impact of using non-face-to-face interview methods (e.g. arising connection issues, misunderstandings, limited time), however this way we are able to conduct interviews despite the distance.

We both use a voice recorder and software named Call Graph as tools for recording the interviews. This form of data collection gives us the possibility to focus on the conversation instead of redirecting the attention into noting down the answers. After all interviews are recorded, complete verbatim transcripts are made (Veal, 2006).

Questions of validity and reliability arise when conducting primary data. We seek to ensure a good correspondence between our findings and the perceptions and experiences of respondents in order to validate our research. We believe that qualitative semi-structured interviews are measures that can reflect the concepts of trust/distrust towards medical tourism as it provides a platform for an open communication on this topic and insight to respondents' minds. Findings are therefore believable as the sample group share their own experiences and opinions on the matter, which is the goal of this thesis (i.e. to explore those attitudes towards trust/distrust in medical tourism). The data is reliable in the sense of this particular research, but as discussed above, due to the inability to influence people's minds, the future replications may be slightly diverse. Misunderstandings due to non-native English speakers may also arise, but with an openness to ask further questions, these misunderstandings are to be clarified during the interviews. However, incorrect English grammar or choice of terms may appear in responses which are quoted accordingly. In addition, a pilot interview with a native English speaker is conducted in advance to test the understandability of our proposed questions and also the overall context.

Due to human-to-human relationships and the sensitivity of our research topic on medical tourism and trust/distrust, ethical considerations are made in order to act morally right and not to offend or in any way judge the respondents and their opinions. First of all, privacy and confidentiality are kept. Respondents' real names are not stated in the thesis. Moreover, interviewees are informed about the nature and consequence of the research. Respondents have the possibility to refuse answering questions that may interfere with their privacy, yet questions are well-thought through in order to avoid such faults.

RESEARCH SAMPLE

We conducted six semi-structured, individual interviews: three of them with Dutch individuals and another three with Danish persons who have either personally participated in medical tourism or who demonstrate a personal interest in the subject and could be seen as potential medical tourists. By potential medical tourists, we mean individuals who have the knowledge and possibility of obtaining medical treatment abroad, however they did not yet participate in this type of procedure as there was not really a

need for them to think about such options due to their relatively minor health issues in general. Those six interviews are seen as a base for our empirical research and are predicted to deliver a significant amount of indepth knowledge on the internal generators of trust and distrust towards medical tourism. The below table summarizes the profile of our interviewees and serves as a description rather than as a tool for analysis, as we will not analyze the demographic characteristics of our interviewees in this paper.

	Nationality	Sex	Age	Occupation	Medical tourism experience
Interviewee#1	Dane	Male	33	Account Manager	Yes, dental
Interviewee#2	Dutch	Female	59	Teacher	No
Interviewee#3	Dane	Male	47	Manager	Yes, eye operation and dental
Interviewee#4	Dane	Male	31	PhD student	No
Interviewee#5	Dutch	Male	57	Customs officer	Yes, dental
Interviewee#6	Dutch	Female	61	Former nurse	Yes, knee surgery

Table 1 Profile of researched interviewees (own creation)

Our seventh interviewee is a previous employee of a medical company situated in Belgium. She [the interviewee] held the position of 'Bariatric Sales Manager' and was responsible for direct relation with the patients. The last interview is seen as an important part of the project since it contributes to the research from another angle. The main part of the thesis focuses on the perception of previous and potential patients of medical tourism. By interviewing a person from the supplier side, we delve deeper into the problem and we are able to present more compact picture of the issue of trust and distrust in medical tourism. Our last respondent worked in the medical company for more than three years. During this period, she experienced many medical cases, through which she learned how to maintain trustworthy relationships between the company and its patients. This experience makes her reliable for our research project and gives her opinion valuable meaning for further analysis.

For our research we have decided to choose two nations: Dutch and Danish. This choice was made due to the fact that those two countries demonstrate a strong willingness for traveling and they are seen as modern countries with open minded attitudes when trying new things. The choice was also influenced by the fact that we, as the researchers, have personal connections with these countries. Consequently, the

below described characteristics are our preliminary understandings of the two countries, their populations, and their attitudes towards medical tourism. Those aspects make the two nations suitable markets for this research.

a) Characteristics of the Dutch traveler market in relation to medical tourism

It has been researched that in Holland the interest in niche tourism has increased over recent years. Especially health and wellness tourism have become more popular due to the growing interest in healthy living as well as ageing society (Euromonitor, 2011a). Dutch travelers seem to be very open - minded and independent. Only 22% of Dutch people choose package holidays, whereas the rest decides either on tailor-made or self-planned vacations (NBTC, 2011). The Dutch travel mostly by plane (62%) or organize their own transportation (27%), which gives them freedom in moving between places (ibid).

In the Netherlands, the basic medical insurance is compulsory, therefore all citizens are covered with it. However, due to aspects such as: cost savings, possibilities to combine treatments with holiday, reduced waiting times and proximity of the destination country and language skills, many Dutch people seek for medical treatment abroad. The most popular medical destinations for the Dutch are: Belgium, Germany, and Turkey, although the exact numbers and statistics are not known due to limited availability of data related to medical tourism (caused by the fact that it is a pretty new phenomenon all over the world and has not been researched thoroughly yet) and patient confidentiality, which makes it difficult to obtain information about medical tourists. However, it has been researched that Dutch patients spent around € 80 million annually on medical tourism abroad (Hospitalscout.com, n/a).

b) Characteristics of the Danish traveler market in relation to medical tourism

Denmark, located in Northern Europe, is one of the wealthy Scandinavian countries. High levels of income and high standards of living influence the lifestyle of its population and impacts the purchase activities as well as the travel behavior of the Danes. Even though, due to the economic downturn, spending on non-essential items has declined (Euromonitor, 2011b), consumers continue to look for healthy, high-quality products (Euromonitor, 2011c).

From 2006 to 2008, surveys ranked Denmark as "the happiest place in the world," based on standards of health, welfare, and education (Surgery Planet, 2012). The healthcare system in Denmark is public, predominantly financed through general taxes, and provides universal, free and equal access for each resident. An international survey showed that 90% of Danes are satisfied with their healthcare services being efficient, of high quality, and enabling free choice of provider by users (Civitas, 2002). This fact, on the other hand, does not exclude the interest towards travelling abroad for medical treatments in order to save

costs (e.g. plastic surgeries, dental care that may not be covered by the insurance). For instance, the European Medical Travel Conference in Berlin will focus on medical tourism in Poland which sees Danes as one of the main markets to target (eMTC, 2012).

METHOD OF ANALYSIS

The verbatim transcripts of our interviews are evaluated by using a method called meaning condensation, which entails a shortage of the meanings expressed by the interviewees into compressed formulations (Kvale, 1996: 192). In this way, the main senses of what is said in long statements are rephrased in a few words or sentences. According to Kvale (1996: 205) this act involves five steps. Firstly, the whole interview is read through to get a sense of the whole. Afterwards, natural 'meaning units' are determined by the researchers and expressed by the subjects. We aim to structure the interviews by the subjects covered, so meaning units are more noticeable. These meaning units are then expressed in thematic statements or words and interrogated in terms of the purpose of study. Lastly, the needed, non-redundant themes will form descriptive statements for the analysis.

The analysis of the data is not linguistic-oriented. This is why our transcriptions do not indicate linguistic discourse such as pauses, intonations, stresses, or overlaps.

SOURCES

This research constructs coherent and clear answers to the problem formulated in the introduction by using theoretical and empirical data. Secondary sources of academic books and literature, such as journals and articles written on similar topics of the thesis (trust/distrust, medical tourism, health tourism, decision-making) are used to generate ideas and widen the researchers' knowledge. The analyzed theory is then seen as an important auxiliary material, which allows and helps to understand the researched subject from an academic perspective and provides a framework for the interviews and the analyses. Primary data gathered while conducting qualitative interviews are seen as the foundation for answering the raised problem questions and hypotheses with a reflection on the theoretical material.

LIMITATIONS

One of the major limitations of this research is its modest sample that is the consequence of the limited time and resources available for this study. Moreover, as medical tourism involves medical interventions that are always confidential in manner, data on medical travelers/patients are difficult to gain (see more in Ch.6). In spite of the limited number of respondents, sufficient in-depth qualitative information is provided on the research topic, yet the paper still lacks an adequate number of data for generalization of findings.

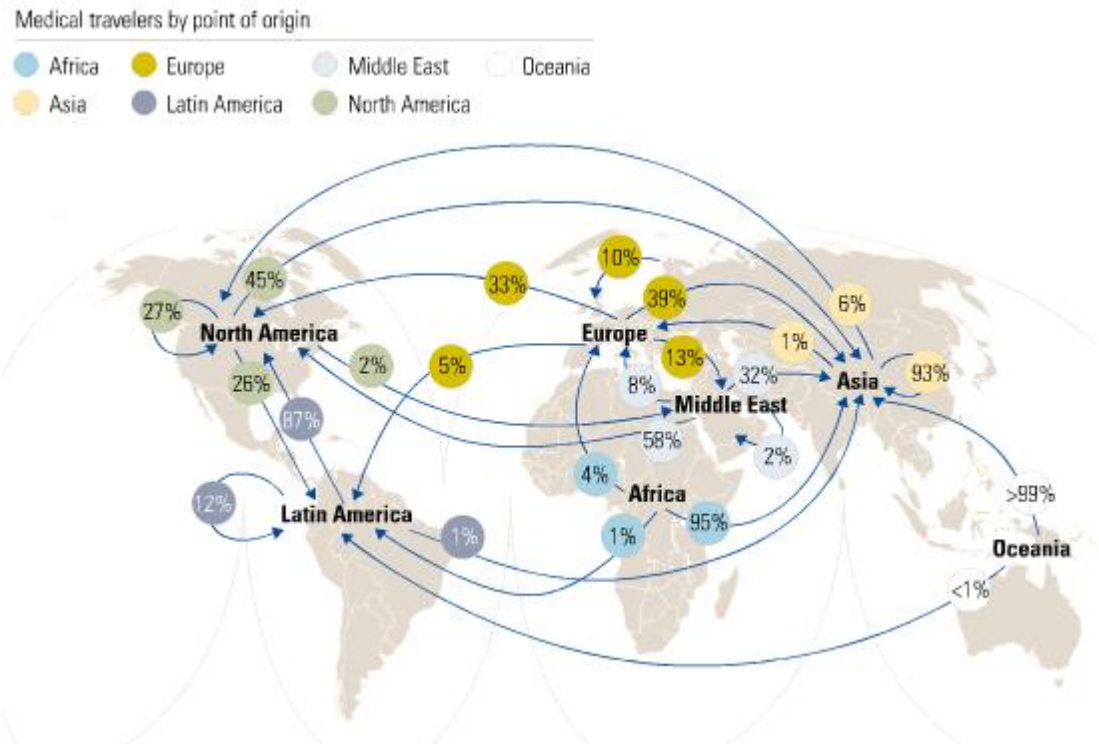
The delimitation for this study is set to explore factors and influences on trust, and respectively distrust creation from the consumers' point of view, and thus the research does not go deep into how medical tourist destinations utilize and perceive trust and distrust as factors determining the actual participation in medical treatment abroad.

MEDICAL TOURISM

Medical and health tourism is suggested to be one of the fastest growing areas of academic research both in tourism and in health studies (e.g. Crooks et al., 2010). Therefore, this chapter aims to give an overview over the phenomenon of medical tourism in order to provide a framework for the analyses. Definitions for both health and medical tourism are presented in order to understand the narrow meaning of the term 'medical tourism' used in this paper. In addition to definitions, similarities and differences of the concepts are identified. Moreover, reasons and factors for the growing emergence of medical tourism together with its critics are discussed. Lastly, categorization and types of medical tourism are listed. To begin the elaboration of the concepts, historical overview is given to comprehend the emergence of this form of niche travel together with outlining the contemporary flow of medical tourists.

Although, today's medical tourism is an emerging concept, it has its origin and roots in history of tourism and travel. The impressive achievements of Ancient Rome (between 200BC and AD200) which enabled traveling on roads and visiting spas, impacted not only tourism but health tourism as well. The popular spa destination at that time was the town of Bath in Britain (Weaver & Lawton, 2006: 58). Spa tourism then continued to expand during the Middle Ages serving the wealthy with several spa resorts around Europe with thermal and mineral water (Weaver & Lawton, 2006: 62; Bookman & Bookman, 2007: 5). Later on, sea bathing also became a healthy form of recreation (Gilbert, 1954 in Connell, 2006: 1093). Even though health tourism was first designed as a commercial activity in 1973, these travels aimed at well-being and leisure as a means for escaping from everyday work and stress (International Union of Travel Officials, 1973 in Bookman & Bookman, 2007).

The traditional model of the flow of medical tourists showed patients traveling from less developed nations to more developed countries, where quality of treatment was more advanced. However, this flow supported the wealthy and affluent individuals, who paid to have expensive treatments in well-known and reputable hospitals (ibid). Today's flow of medical tourists is in both directions (Gill & Singh, 2011). It can be also argued that recent trends mostly support travel from developed to developing countries where economic benefits are gained, which seems to impact the size of this form of industry. Hopkins et al. (2010: 186) also emphasize this trend by stating that *"the market for out-of-country care, notable the flow of patients from the wealthier 'north' to the developing 'south', is likely to increase"*. The following table by McKinsey&Company is developed to illustrate the flow of medical travelers and indicate the global nature of the industry, as patients are traveling not only within continents, but from continent to continent as well.



Model 4 The flow of medical tourists by point of origin (adapted from McKinsey&Company, 2008

Measuring the flow of medical tourists is complicated due to the missing common categorization and accurate statistics. However, Frost and Sullivan's report estimated that more than three million patients traveled for medical care in 2010 and this is predicted to grow 20-30% annually (cited in Vequist et al., 2012: 73). Their research also claims the Middle East to be a latent source market with 20% of healthcare seekers from Gulf and Arab states (ibid). The medical tourism industry today is worth around USD 100 billion based on the estimates by McKinsey&Company (Herrick, 2007: 2). NaRanong and NaRanong (2011) also argue that medical tourism involves about 50 countries, from which Asian countries are in the lead. The above illustration also supports this point.

UNWTO (2011c,d) also predicts that emerging economies such as Asia, Latin America, Central and Eastern Europe, Eastern Mediterranean Europe, the Middle East and Africa will receive more international tourist arrivals than the advanced economies by 2015 and on. Additionally, by 2030 North East Asia will be the most visited subregion in the world with 16% of total arrivals (UNWTO, 2011c,d). This data also supports the potential for the growing medical tourism market as these countries attempt to target travelers through medical tourism among other types of tourism activities.

Before moving on to defining medical tourism, the concept of health tourism must be addressed, because medical tourism is an outcome of a health seeking attitude, yet in this paper it is seen as differing from the notion of health tourism.

DIFFERENTIATING MEDICAL TOURISM FROM HEALTH TOURISM

Some writers tend to use the phrase 'health tourism' also when referring to medical tourism (e.g. Smith & Puczko, 2006). It may be due to the times when the phenomenon of seeking specific medical treatment abroad was limited to wealthy individuals and due to their small market it was named under the broader and better-known term of health tourism. However, this may be misleading in recent times as there are significant differences between the concepts of diverse health-related treatments sought abroad. On the other hand, health tourism still acts as an umbrella term that covers all forms of health-related tourism.

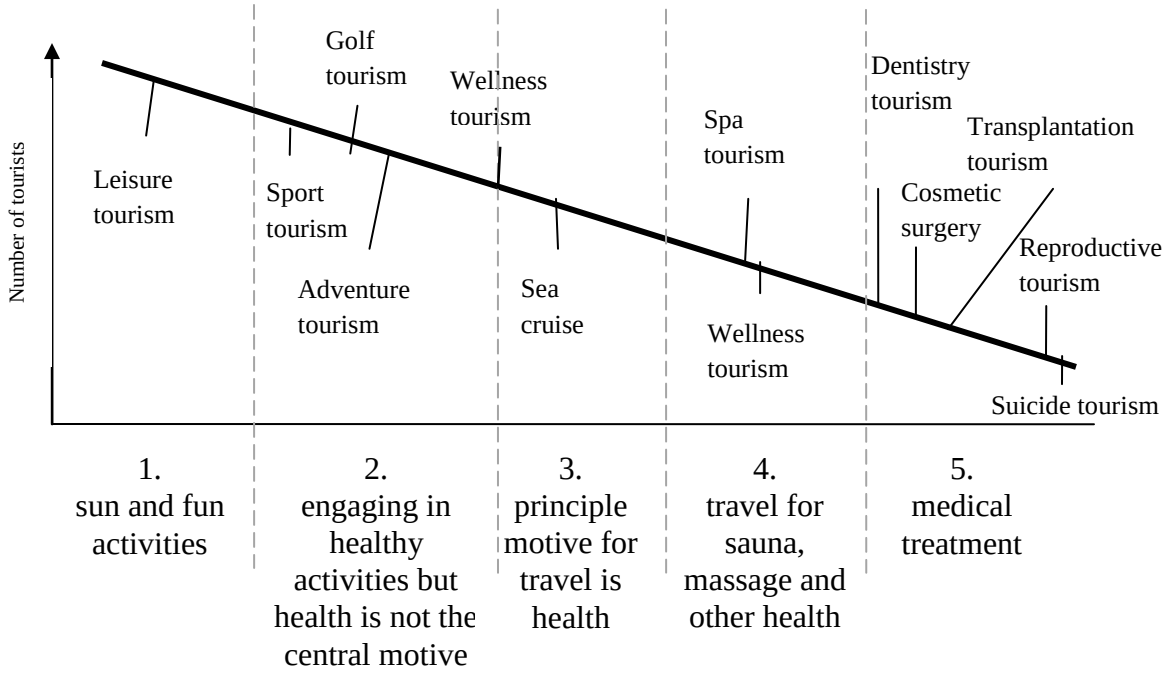
Hall (2003 in Hall, 2011: 6) defines health tourism as

> a commercial phenomena of industrial society which involves a person travelling overnight away from the normal home environment for the express benefit of maintaining or improving health, and the supply and promotion of facilities and destinations which seek to provide such benefits.

This definition does not provide a comprehensive approach for the term 'medical tourism' as it does not indicate specifically the curing and treating aspects and it lacks to emphasize the different push factors that arise when considering a rather medical-oriented treatment. For instance, there is a huge gap between traveling for a thermal water treatment that helps with curing asthma and going for a plastic surgery abroad. Health tourism therefore may be used as an umbrella term combining all aspects of health care from spa and wellness tourism to medical care, but with an awareness of treatment diversities and their different emphases involved (Hall, 1992; Bristow et al., 2011; Lunt & Carrera, 2010).

Goeldner (1989 in Hall, 1992: 151) lists five components of health tourism by identifying elements of demand, whereby medical care is one of the categories. The below illustration demonstrates the five components on a continuum that indicates the decreasing demand towards special forms of health tourism. It means that 'sun and fun activities' is the most leisure-related category where travelers are less concerned about illnesses, but may travel to a seaside resort with a belief that salty sea air has a positive influence on their health. From the second to the fourth component the interest and demand tightens and specifies actual health-related activities, and thus narrows the market. Towards the fifth component it becomes very

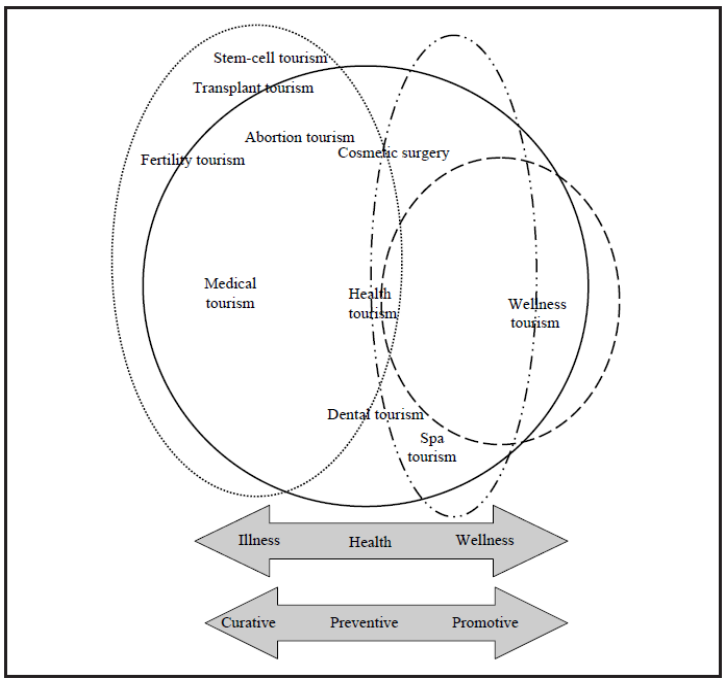
specific. Medical treatment is the smallest aspect where particular needs and purposes play a significant role. However, due to the variety of medical treatments, this component can then also be further divided into more explicit parts, so called micro niches (NB: the graph does not show all types of medical tourism niches). As the graph also illustrates, the demand within this category also varies. For example, dentistry tourism is more popular than the less practiced suicide tourism (see the figure below).



Model 5 Own creation of a model illustrating the continuum of health-related tourism forms and types. Based on Goeldner (1989), Hall (2003) and Connell (2006)

Hall (2011) also shows a representation of medical, spa, and wellness tourism in the overall context of health tourism. The figure demonstrates the relation of two continuums: the one from wellness to illness and the other with health approaches from promotive through preventive to curative. It shows that wellness is more of a promotive concept (exceptions may occur) as it is seen advertised by many hotels offering professional know-how and individual care to target guests. Therefore, wellness and spa tourism are more trendy words that attract customers. On the other hand, these types of health tourism overlap and may also attract consumers who seek to prevent their health problems (e.g. thermal water visits). Hall puts dental tourism and cosmetic surgery on the border of illness and health, indicating that participants may either prevent or cure their look or teeth. It also suggests that these forms of medical tourism are sought on a

larger scale and thus they may be seen less risky than, for instance, heart or transplant surgery. When risks come to play a role, demand seems to decrease as consumers are more cautious with their choices. Illnesses are the other end of the continuum which are sought to be cured. Hall lists stem-cell, transplant, fertility, and abortion tourism in his model highlighting the risks and dangers of these procedures. His perspective also confirms the narrow and specific market of medical tourism.



Model 6 Interrelatedness of health and medical tourism domains (adapted from Hall, 2011:8)

Moreover, Smith and Puczko (2009) also distinguish between wellness and medical tourism as two main types of health tourism. Although they tend to use the terminology of 'health tourism' and focus more on the wellness side of it, their figure (see App.2) illustrates the spectrum of medical tourism starting with medical wellness, medical-therapeutic, and medical-surgical. The latter with dentistry, cosmetic surgery, and surgeries is the focus of this paper.

The above argumentations and models suggest that medical tourism is a part of health tourism, but it should be treated and researched as a separate area of study as the *"one involving specific medical interventions"* (Connell, 2006: 1094) where an illness is elected to be treated in a different cultural setting than the home environment, to which risks, trust issues, and consequences are attached. Our investigation is therefore aimed at understanding trust and distrust in taking medical interventions abroad. Thus the next subchapter draws attention to the concept of medical tourism by deep elaboration on its definitions and reasons.

DEFINING MEDICAL TOURISM AND REASONS OF ITS EMERGENCE

Tourism is connected with travel, relaxation, pleasure, exploration, or learning in different contexts. However, tourists may also travel for beneficial outcomes (Connell, 2006). This aspect is perceived when a tourist travels to achieve better health while on holiday. This beneficial outcome can be seen personally, as health-wise or financial, due to medical tourism in most cases being seen as cost-oriented. Many authors (e.g. Yu & Ko, 2012; Connell, 2006; Gill & Singh, 2011) indicate that price matters and often influences the choice of destination, yet travelling for medical treatment to a foreign country in order to benefit from the host country's lower medical costs is what makes medical tourism a *"new and distinct niche in the tourism industry"* (ibid: 1093).

Medical tourism is a "*contested term*" (Hall, 2011: 7), however its appearance is undoubted. Heung et al. (2010) claim it is among the fastest growing sectors within the health tourism industry. Researchers such as Kulkarni (2008: 2) recognize that *"more and more people are travelling abroad as an affordable, enjoyable, and safe alternative to having treatment in their home countries"*. Connell's (2006: 1094) definition on medical tourism also supports this travel trend by arguing that

> medical tourism as a niche has emerged from the rapid growth of what has become an industry, where people travel often long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense.

His definition points out the types of medical tourism and the advantage for consumers to combine medical care with holidays. Smith and Puczko (2009: 7) also demonstrate the same three types of medical tourism and point out the types of health tourism facilities involved when traveling for medical treatment abroad, namely hospitals and clinics (places of treatment) along with hotels and resorts (places of recovery and possible recreation after the treatment; see App.2). However, Connell does not specify that these medical services abroad are sought in order to obtain lower cost procedures, which is among the important aspects of contemporary medical tourists (Smith 2006:1 in Tompkins, 2010).

Besides the mentioned high cost of medical care in source countries, other aspects such as avoidance of long waiting lists, lack of medical insurance, and improvements of technology and standards of care in many developing countries determine the emergence and growth of medical tourism (Bookman & Bookman, 2007: 51; Vequist et al., 2012; Ch.1). Further determinant of medical tourism can be the opportunity of keeping anonymity and privacy (Connell, 2006). This may be especially important to

medical travelers who intend to do a sex change or plastic surgeries in countries such as Thailand or Malaysia.

Some authors recognize cross-border as well as incidental medical tourists as participants of medical tourism (Bookman & Bookman, 2007: 46). We, on the contrary, agree with the definition by Crooks et al. (2010: 2) because they limit actual medical tourists to patients who (bold added)

> **intentionally** leave their country of residence outside of established cross-border care arrangements in pursuit of **non-emergency medical interventions** (namely surgeries) abroad that are commonly paid for out-of-pocket. It typically includes **staying abroad for at least part of the recovery period**, whereby such post-discharge time can be spent at tourist resorts that cater to international patients.

The central point of this definition is that medical tourists should seek medical care intentionally and be open for having an elective procedure in a foreign country by one's own choice. This limits the scope of medical travelers as in this way patients being sent to a foreign hospital due to the unavailability of certain procedures home are not considered medical tourists in this narrow sense. Moreover, this definition excludes incidental medical treatments abroad that happen to occur while on vacation. For instance, people going to Thailand for three weeks as backpackers, whose primary purpose is to visit Thailand, may happen to be treated in a Thai hospital after an accident, but it is an emergency situation, not a choice. Furthermore, the definition also excludes immigrants, who are seeking medical care while working or studying abroad. Cross-border tourists are also not considered to be medical tourists as they do not stay overnight at the destination.

Based on the elaborations above, we may conclude our own definition on medical tourism that gives the groundwork to our thesis. We summarize and describe medical tourism to be a practice of patients intentionally traveling to a non-residential foreign country for more than a day-trip to participate in elective medical interventions, such as dental, cosmetic, or surgical treatments in order to gain beneficial outcomes in the nature of either economic, personal, or health advantages.

To quote Bookman and Bookman (2007: 1), who define medical tourism from a business perspective, *"the aim of improving one's health, medical tourism is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism"*. Even though the former requires rational decision-making, the latter involves imagination and exoticism. It means that tourism – on the contrary to medicine - involves more of a pleasure decision-making when one can fulfill his or her needs for something extraordinary and unique, such as sunbathing on an exotic beach and can act less rationally. Therefore, medicine and tourism stand in a controversial position towards each other, however they claim that both legs are important for successful medical tourism in order to be able to walk (ibid: 21) because

they supply momentum to each other. Once a medical tourist is at a destination he/she or the accompanying partners may want to fulfill their needs for vacation, but it can work oppositely as well. A tourist may get familiar with a destination and thus place his/her trust in engaging in a medical intervention abroad at a later point. And since there are different factors influencing the choice for a medical treatment abroad, it is also recognized that both sectors are growing on their own as being service industries that face high income elasticity of demand (ibid). This refers to the fact that the wealthier the consumers, the bigger the demand for these services. For instance, higher incomes are likely to be spent on vacations or plastic surgeries (see also Ch.1). Thus, when these services are merged, they appear to have a greater potential.

The rise of medical tourism is also a consequence of changed attitude towards health and leading a healthy lifestyle as people are generally more conscious about their health in the early 21st century (Ritter, 2005; Bookman & Bookman, 2007). Eurostat research (2011: 159) also emphasizes the importance of health for Europeans who *"expect to be protected against illnesses and disease – at home, in the workplace and when travelling."* On the contrary, when this expectation is not fulfilled in a home country (due to e.g. long waiting period, unaffordable or even unavailable elective procedures), health is to be sought abroad. Especially, the ageing of the post war baby-boomers - who are often affluent - affects the increased demand towards such treatments (ibid: 1094). Today's sophisticated travelers value the service quality to price as a critical element (Bookman & Bookman, 2007) and because they are more aware of the world, they can make choices to find alternatives for quality medical treatments abroad (at lower costs).

Furthermore, Bookman and Bookman (2007: 27) state that the globalized environment is the enabler of medical tourism. In the absence of globalization, international accreditation of hospitals, international education provided for doctors, and the spreading of technology improvements would not be available, as everything would be mostly localized, which means produced and consumed in the same place. In addition, Connell (2006) and Vequist et al. (2012) recognize the affordable international air travel – an example of globalization - as a generator of growing medical tourism, because the easy and relatively low-fare access to those services determines destination choice. He also lists favorable exchange rates as an additional reason for choosing a particular destination. Both examples affect the overall costs that medical tourists may end up paying.

Despite the benefits of medical tourism for patients, destinations, or hospitals, there are various disadvantages shadowing the reputation of medical tourism. Even though medical tourism is a tool to stop brain drain - the migration of doctors and nurses wanting to work abroad to make more money - by providing higher earnings at private hospitals treating foreign patients, the locals (poor) continue to be disadvantaged. These ethical issues of providing quality health care for rich foreigners yet not treating the

locals still need better balanced regulations (cited in Crooks et al, 2010). For instance, in India there is a big controversy over local poverty with low access to treatments and high standards in hospitals.

Furthermore, participating in medical tourism is more risky as the consequences of failed surgeries or post-operation troubles are difficult to balance with cost savings, both personally as well as legally. The issues of legal rights of travelers in foreign countries may not be the same as back home and thus protection of individual rights is questionable (Vequist et al., 2012). The post-operational risks are mentioned against medical tourism where follow-up care may in most cases happen in the home country of the patient and therefore responsibilities are questioned. Additionally, Hall and James (2011) identify the issues of bio-security as medical travelers expose themselves to new microbiologic fauna and flora when having their treatment in a foreign country or even to unhygienic hospital conditions. They see tourism as a contributor of spreading pandemics and epidemics, yet with medical tourism this issue is at a higher level. Therefore, international regulations are needed to prevent biological invasion and protect human health.

In the face of these risks, the question of trust towards traveling for a treatment is more relevant to explore. The next section will highlight forms and types of medical tourism in order to show the diversity of the industry. The classifications then also differentiate the participants of medical tourism.

CATEGORIZATION OF MEDICAL TOURISM

Medical tourism is a complex concept that has a range of divisions according to the various perspectives. The principal division by Cohen (2010: 11-12) distinguishes three kinds of medical tourism based on legal and ethical considerations:

1- Medical tourism for services that are illegal in both the patient's home and destination countries.
2- Medical tourism for services that are illegal in the patient's home country but legal in the destination country.
3- Medical tourism for services legal in both the home and destination countries.

This categorization supports the reasons for the emerging niche and potential risks when participating in medical tourism. The first kind of medical tourism is probably the worst case scenario, which is undergone on the so called black markets of organ sale. The focus of this project is not to discuss ethical questions of such purchases, yet it is important to mention the dark sides of medical tourism. The second category of the patient traveling abroad for undertaking medical procedures which are illegal in their home country is a very

likely form of medical tourism. Here we may list suicide tourism (a practice of seeking artificial death) in e.g. Switzerland where euthanasia is permissible (Connell, 2006: 1097), and some cases of reproductive or abortion tourism where patients undertake such treatments abroad due to the unavailability of such procedures at home. Medical tourists falling into the third category form the contemporary trend towards medical tourism as they obtain legal treatments abroad that are also available at their source countries, but different factors influence their decision for participating. Those push or pull factors are listed above (e.g. high costs of medical care in the home country).

Another categorization is based on the fact that medical tourism has several micro-niches categorized according to the type of medical care (see also Ch.1). Kulkarni (2008: 1) also confirms it by stating that *"medical tourism is a universal term that encompasses several specialty markets"*. The list is long, starting with the above-mentioned suicide, to reproductive tourism to cosmetic surgery involving liposuction, breast enhancement/reduction, and sex change. Iran, for instance, is famous for its open heart surgeries (Connell, 2006). Dental tourism also compromises a big market and can probably be listed as a less risky procedure to take abroad.

Destinations usually specify themselves for particular treatments. In Europe, dental tourist destinations are the Eastern European countries, such as Hungary, Poland, Czech Republic, Estonia, and Lithuania, utilizing their lower costs potential (Tourism-Review, 2009). For instance, based on the British source market, patients pay just 30% of the price in Poland than what they would pay in the United Kingdom (Tourism-Review, 2012). These destinations are easily accessible for Westerners due to its relatively close distance and the affordability of air travel (low-cost airlines). However, Western patients also travel long-haul for medical healing. Available statistics on Dutch medical tourists suggest that nearby Europe is the main medical tourist destination for them, countries such as Germany, Belgium, and Turkey. In addition, it advocates Malaysia with 60%, the Philippines with 53%, and Jordan with 50% of cost saving (Hospitalscout.com, n/a). The top five medical tourism destinations in 2010 were Panama (targeting Americans), Brazil (popular for cosmetic surgeries), Malaysia (with cosmetic, cardiac, and dental services), Costa Rica, and India (Tourism-Review, 2010).

The list of medical tourism destinations is long, yet the aim of our thesis is to understand how trust and distrust are generated towards the phenomenon. As mentioned in methodology, theory forms the basic arguments of the concepts, which are then converged with our findings. Moving on, the next chapter focuses on notions of trust and distrust in order to ground our understanding of these concepts in medical tourism.

TRUST AND DISTRUST IN MEDICAL TOURISM

This chapter outlines theories on trust and distrust. Besides discussing the concepts and the general theory of trust, the focus is set on trust in medical professions and services. The chapter therefore also includes conceptual and theoretical models that illustrate trust and distrust in such fields, which are then used in analysis. Lastly, trust is discussed in relation to marketing to show its importance.

THEORY OF TRUST

Trust is seen as an essential element for building and developing human relationships, and thus as a fundamental component in forming healthy societies (Hill & O'Hara, 2005). Researchers from different disciplines connected to trust failed in defining one common definition of trust. Although, most 'trust experts' agree that:

> trust is a state of mind that enables its possessor to be willing to make himself vulnerable to another – that is, to rely on another despite a positive risk that the other will act in a way that can harm the truster (bold added; Hill & O'Hara, 2005).

Trust being seen as a state of mind indicates that the human beings are able to control it and shape it according to their beliefs. Moreover, if it is a state of mind then not only internal but also external facilitators can influence it. The definition above implies that trust is associated with a 'positive risk' of being harmed, which indicates that there is never a 100% certainty towards the other. O'Neill (2002) also argues that trust has to be placed without guarantees. Guarantees or proofs, such as the knowledge that two plus two equals four, are not based on trust, yet there is no guarantee that each individual will trust one another in an everyday situation. Hence, trust *"is constantly observed, is hard earned and easily dissipated"* (O'Neill, 2002: 6) making it a valuable social capital. We humans actively place our trust in others around us, starting with our family, social environment, teachers, politicians, medics, hospitals, and so on. By trusting others, humans risk disappointment or betrayal, but in spite of past disappointments or limited evidence of reliability, humans may still need to continue placing their trust in those individuals (ibid). For instance, experiencing a disappointment in a local doctor, one will still need to trust other doctors in order to be cured. Theoretically, debates continue whether trust should be perceived as a (1) prediction on someone's

behavior, (2) confidence in someone's decisions, actions and desires, or maybe as (3) qualities and norms of another to behave in a loyal and honest way.

Researchers divide trust into interpersonal trust and social trust. Interpersonal trust refers to relationships between individuals built through repeated interactions, whereby social trust is understood as personal attitudes towards collective entities or social organizations (Hall et al., 2002). Since the main goal of this paper is to research the aspects that generate trust and loss of trust towards the idea of traveling abroad for medical treatment, we take into consideration interpersonal trust as well as social trust. We will not make a clear distinction between those two areas, for the reason that they seem to interweave and influence each other in this particular case.

Trust in medical professions is defined as *"a set of beliefs or expectations that a physician will behave in a certain way"* (Anderson & Dedrick, 1990 in Pearson & Raeke, 2000: 509) or *"reassuring feeling of confidence or reliance in the physician and the physician's intent"* (Caterinicchio, 1979 in Pearson, Raeke, 2000: 509). It indicates that generally patients expect a satisfactory outcome from the relationship with their physician, in which money, time, and feelings are invested. Studies also show that when it comes to the most important dimensions of physician's behavior, on which patients base their trust towards them, seven qualities play a role: competence, compassion, privacy, confidentiality, reliability, dependability, and communication (Mechanic & Schlesinger 1996; Emanuel &Dubler, 1995; Gray, 1997; Anderson & Dedrick, 1990, Thom & Campbell, 1997, Caterinicchi, 1979 in Pearson & Raeke, 2000).

In our paper, we analyze trust as a major feature of creating positive or negative perceptions towards the idea of traveling abroad for a medical treatment. We seek for deep generators of trust and distrust in medical patients. The research should also help us understand why some features are more important than others in creating trust in this particular relationship (patient – medical tourism). Moreover, we acknowledge the fact that trust/ distrust are changeable features and therefore external generators can influence the level of trust/ distrust in every kind of relation.

FUKUYAMA'S THEORY ON TRUST

The American scientist, economist and author Francis Fukuyama focuses on analyzing societies' non-kin relations, defined as voluntary associations. Fukuyama explains that the higher the amount of non-kin relationships (which are based on trust) in societies is, the larger the economic development of the

country (Fukuyama, 1995). In other words, the author suggests that trust in society plays a very important role in relation to national and economic expansion. He divides societies into two groups – low trust societies (such as China, Korea, Italy, France) and high trust societies (USA, Japan and Germany). Low trust societies are characterized as more family-oriented, where labor is often divided among family members and an *"ever-widening circle of kin"* (Fukuyama, 1995: 63). The author emphasizes that in this group of countries, there is a very strong tendency to trust only in related people and distrust those who are outside their family and affinity group. One of the biggest difficulties those societies are facing, is to make a transition from a family business to professional management. Fukuyama sees this aspect as a possible threat, since *"[..] a single family, no matter how large, capable, or well educated, can only have so many competent sons, daughters, spouses, and siblings to oversee the different parts of a rapidly ramifying enterprise"* (Ibid: 64). In order to develop and grow bigger, enterprises must delegate some responsibilities to people not related to the family. Trust towards strangers has to be gradually built up and socially accepted. Moreover, in organizations where family relations mingle with economic rationality, behaviors such as nepotism and cronyism may take place, which is regarded as rather negative occurrences for any organization (ibid).

On the contrary to low trust societies, high trust societies developed the habit of cooperating and building their relationships in non-kinship ways. Those nations are more likely to be guided by economic rationality than by loyalty. They are also more capable of building large-scale corporations since they have less fear in trusting non-family members and people not associated with their circle of acquaintances. Fukuyama notices that in modern economic life, it is very difficult to be a part of a society without a minimal level of informal trust:

> Now trust has a very important pragmatic value, if nothing else. Trust is an important lubricant of a social system. It is extremely efficient; it saves a lot of trouble to have a fair degree of reliance on other people's word. Unfortunately this is not a commodity which can be bought very easily. If you have to buy it, you already have some doubts about what you've bought (Kenneth J. Arrow, 1974 in Fukuyama, 1995: 151).

The study of Francis Fukuyama indicates that in general different countries have a significant level of trust, which is developed during the process of social interactions. Even though in his studies he mostly analyses those variables in relation to economical development of a nation, it also has an impact on individuals and their view on personal matters, as well as influencing their choices and decisions. Since the study of Francis Fukuyama is from 1995, it is important to mention aspects such as globalization as a factor that influence the development of societies. Globalization assimilates countries and gives possibly a new perspective on social trust. Low trust societies may become more aware of the existence of trustworthy groups others than the family and friends due to more open markets and international exchange. On the other side, the

development of globalization all over the world may decrease the level of trust between people and groups because there will be a higher possibility of misunderstanding and miscommunication caused by the growth of diversity on the market. Trust in societies is an important perspective for our research since in order to research and analyze our data we must acknowledge the level of general trust in the examined societies.

A CONCEPTUAL MODEL OF TRUST IN THE MEDICAL PROFESSION

Trust is seen as a critical aspect, especially when discussing the situation of a patient in relation to his/ her physician. Moreover, trust is often a decisive factor when choosing to seek for healthcare, reveal personal information, submit for treatment, and follow physicians' advice and prescriptions (Hall et al., 2002). The 'Conceptual Model of Trust in the Medical Profession' was introduced by four American researchers (ibid). The model is based on theoretical and empirical work on general, social, and institutional trust of different areas. The authors present five overlapping domains in relation to general physician trust: (1) fidelity – being concerned and caring about patient's wellbeing; (2) competence – being well-trained and qualified for performed tasks as well as being responsible for taken actions and decisions when it comes to patient's health; (3) honesty – telling the truth and keeping clear and open dialogue about a patient's health; (4) confidentiality – using patient's personal information only for proper and adequate purposes; (5) global trust – an aspect of trust which combines elements from separate dimensions (Hall et al., 2002: 1422).

The model hypothesizes connections between general trust towards physicians and other structures. It presents a significant relation between general trust in physicians and trust towards a specific physician. The authors indicate that factors such as previous experiences with one's own doctors and a greater general trust increase the reliance towards the physician they meet for the first time. Furthermore, this reliance is enhanced also through the symbolic and archetypal projection of a doctor, as well as by an image created and conveyed by media (such as social media) which also influences the perception on medical issues (Mechanic, 1998 and Griffin, 1998 in ibid). Nevertheless, in the early stage of the relationship, a patient bases his assumptions on 'general system features', which are understood as the common characteristics distinguished for the chosen kind of treatment. Basically those features could be seen as patient's habits related to the process of a chosen treatment. For example a patient from Holland who decides to go to Poland to treat his teeth will use his previous experiences from Dutch dentists as a reference point to his current treatment.

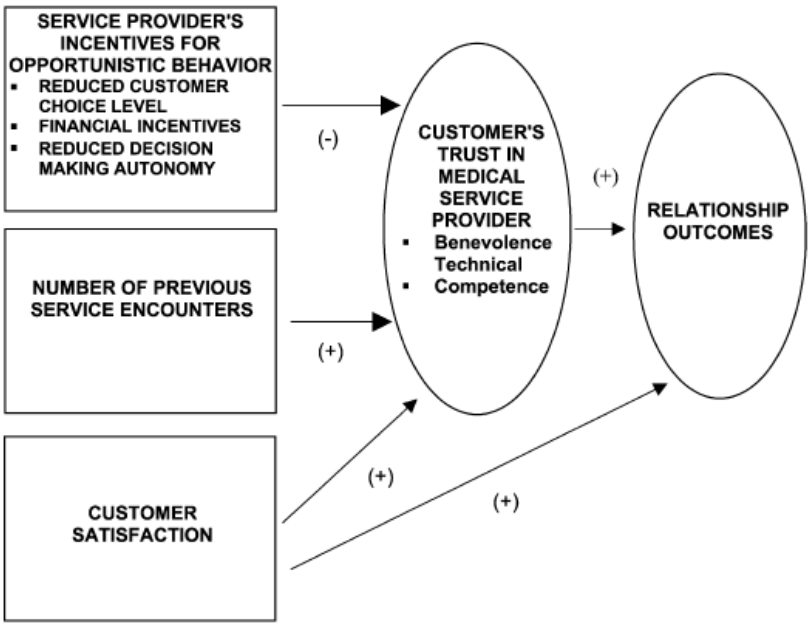
The researchers indicate that there is also a significant relationship between general trust and a patient's attitudes and behaviors. Strong positive associations of that relationship are: satisfaction with care, desire to follow doctor's recommendations, and prior discrepancy with the physician; whereas strong negative associations are: previous disagreement with a physician, seeking for second opinions, and changing physicians. However, the authors distinguish general trust and satisfaction, because as they explain *"satisfaction is an evaluation of previous experiences, whereas trust is primarily future-oriented"* (Hall et al., 2002: 1422). Trust is here seen as a certain belief/ hope that the coming process (future-oriented) will be successful, whereas satisfaction is a final emotional outcome of a procedure performed in the past. Therefore in our project, we focus on trust – not satisfaction, because our main goal is to understand the process of generating certain emotions before the final result is known.

Subsequently, the authors' research shows no relationship between trust and a range of demographic characteristics (such as ethnicity or race), other than age. Consequently, we consider age as an important factor when choosing our research group, since it is the only demographic characteristic that may influence the perception on a relationship where trust is involved. Therefore, all our respondents are above 30 years of age, as this indicates personal independence and the ability of making one's own decisions in all aspects of life. In order to search for features that generate a patient's trust towards medical treatment abroad, we take into consideration a patient's medical background as an important element that influences an image of doctors and medical facilities in a patient's mind and therefore may affect his/ her future choices related to this area.

THEORETICAL MODEL OF TRUST IN A MEDICAL SERVICE

Even though there has been a wide recognition of trust in other fields, such as studies on customer behavior, where trust is seen as a key ingredient in successful relationship (Dwyer et al.,1987; Gundlach & Murphy, 1993; Morgan & Hunt, 1994 from Leisen & Heman, 2004), some researchers suggest that very little attention has been given to trust in the medical industry, especially in the context of patient – physician relationships (Leisen & Heman, 2004). In their study, Leisen and Heman focus on different aspects of trust in the 'patient – medical service' relationship. The study is based on the responses of employees from a service organization concerning their primary care physician (PCP). The research concentrates on analyzing the bond which is being created between those two parties (patient - doctor) and the patient satisfaction. Factors such as trust, awareness, satisfaction, and length of patient-physician relationship are taken into

account. This study gives us an important insight to the topic, as it analyzes different aspects which influence customers' trust in medical service providers as well as the final relationship outcome. In order to illustrate their research, a model of antecedents and consequences of trust in a medical service is presented:



Model 7 Antecedents and consequences of trust in a medical service (Leisen & Hyman, 2004: 991)

In this model, the authors identify three generic antecedents of trust: customer satisfaction, accomplished interactions, and incentives for opportunistic behavior. The model indicates that those three antecedents take place in a patient's past and therefore influence his or her level of trust towards the medical service provider. Concomitantly, the level of trust combined with benevolence and competences of the medical provider leads to the final outcome of the relationship formed between a patient and a medical service. Further in their paper, the authors state that patients' trust towards physicians is vital for a successful medical care, because it:

> (1) encourages patients to reveal stigmatizing information about health-related behavior; (2) makes patient accept prescribed changes in risky behavior, (3) encourages patients to share their thoughts and feelings so that mental disorders many be diagnosed, and (4) makes patient accept treatment" (Mechanic & Schlesinger, 1996 from Leisen & Hyman, 2004: 991).

The relationship between patients and physicians evolves and develops through the following stages: awareness, exploration, expansion, commitment, and dissolution (Dwyer et al., 1987 in Leisen& Hyman, 2004). Usually a relationship between a patient and a physician begins with *"history taking and diagnosis followed by treatment and follow-up visits"* (ibid: 993). However, in the case of medical tourism, the

relationship begins with contacting the medical provider via phone or email, and exchanging information, which results in decision-making. Therefore, in our paper we use this model as a base for understanding the process of trust formation between cooperative parties. In the analysis part, the model is developed and reconstructed according to the needs of our study.

Gray (1997 in ibid) argues that in order to gain patients' trust, the physician must put patients' interests above self interest. This indicates that a doctor should be empathic towards his patient and listen to his/her problems rather than just give advice or prescriptions. Thom and Campbell (1997 in ibid: 994) recognize nine different elements that generated trust in the patient–physician process model:

> (1) evaluates problems thoroughly; (2) understand patients' individual experiences, (3) expresses caring, (4) provides appropriate and effective treatment, (5) communicates clearly and completely, (6) builds partnership and shares power, (7) shows honesty and respect for patients, (8) predisposing factors, and (9) structural and staffing factors.

The above model emphasizes the importance of a close and individual relationship between a doctor and a patient. Understanding, caring, communication, partnership, and honesty are the base for a trustworthy affiliation between two cooperating parties. The above theory refers to a doctor-patient relationship among regular conditions (healthcare in a home country). However, we are searching for generators of trust when deciding on a treatment abroad, where the influence of additionally appearing factors (such as language or different culture) play a significant role.

Leisen and Hyman put forward in their work different hypothesis related to the above model (Model 1). The table below shows the researched hypothesis and the result of the study.

Summary assessment of research hypotheses

Factor and hypotheses	Expected sign
Relationship outcomes	
Hypothesis 1: The greater patients' trust in their physician, the more positive the patient–physician relationship outcomes.	positive
Hypothesis 6: The greater patients' satisfaction with their physician, the more positive the patient–physician relationship outcomes.	positive
Trust	
Awareness of incentives for opportunistic behavior by physicians	
Hypothesis 2: The greater patients' awareness of their physician's financial incentives to provide lower-cost care, the lower patients' trust in their physician.	negative
Hypothesis 3: The greater patients' awareness of utilization reviews by insurers, the lower patients' trust in their physician.	negative
Hypothesis 4: The wider patients' choice in selecting a physician, the greater patients' trust in their physician.	negative
Patient satisfaction	
Hypothesis 5: The greater patients' satisfaction with their physician, the greater patients' trust in their physician.	positive
Length of patient–physician relationship	
Hypothesis 7: The larger the number of service encounters with their physician, the greater patients' trust in their physician.	positive

Model 8 Summary assessment of research hypotheses (Leisen& Hyman, 2004: 997)

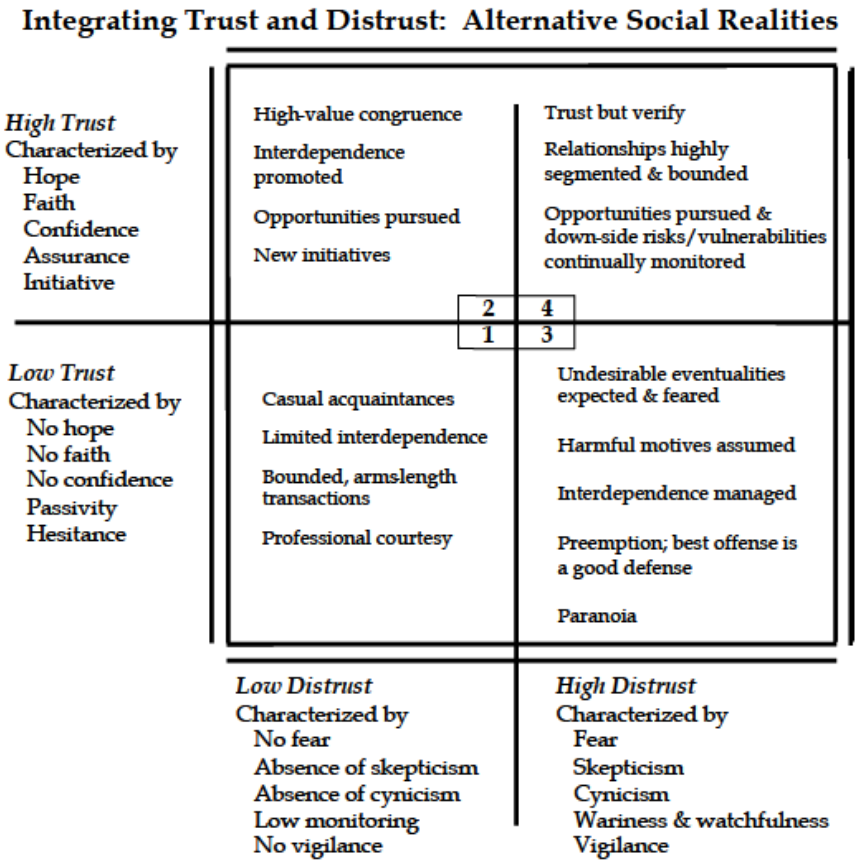
The above hypotheses refer to patient – physician relationships where trust and satisfaction play significant roles. Hypothesis numbers 1 and 6 show that trust and satisfaction have a positive influence on the patient – physician relationship. Interestingly, the awareness of doctor's financial incentives as well insurers' utilization reviews do not affect a patient's trust towards the physician. However, a wide range of physicians (which could be seen as a great possibility of selection) decreases the amount of trust towards physicians. Hypothesis number 5 indicates that satisfaction is closely correlated with patients' trust, whereas hypothesis number 7 shows that the number of interactions between patient and physician influences the amount of trust towards a doctor.

The authors of the above hypotheses and model indicates that building a relationship between a patient and a physician is a continuing process in which office visits play an essential role for building trust. If the medical providers expect patients' positive references and their returns in the future, they must work on building trustworthy and stable relationships (ibid: 998). In the analysis part, we will discuss whether direct interactions (office visits) are necessary in creating trust between a patient and his/her doctor.

TRUST AND DISTRUST

The main focus of the paper lies in researching what generates trust or lack of trust towards the idea of traveling abroad for a medical treatment. For that reason, this part of the theory discusses distrust and its characteristics. We use a model on trust and distrust which illustrates possible outputs of social relations characterized by low and high trust in correlation with low and high distrust. According to the 'Cognitive Theory of Trust', *"trust involves positive expectations about things hoped for and distrust involves positive expectations about things feared"* (Hill & O'Hara, 2005: 11). Distrust here is associated with fear and trust with hope. Some feelings of trust can soothe distrust and alternatively, certain feelings of distrust may influence trust. For example, family or friends' recommendation of a doctor from abroad may soothe the distrust created by the fact that the doctor himself does not speak English, however his assistant is fluent in English and is always next to the doctor. On the other hand, lack of English could be the main reason for creating distrust; however, experience and recommendations of friends and family could calm or even fully erase the emerging lack of trust. Therefore, it is often a case that in relationships those two feelings occur simultaneously between two or more parties (ibid). Apparently, trust is not as fragile as many scholars argue (Blair & Stout, 2004 in Hill & O'Hara, 2005: 14) and individuals are often capable of adjusting the level of trust by following their impressions about others. The authors mention that both trust and distrust play an important (often beneficial) role in relationships. They talk about 'optimal trust' as the most beneficial combination of trust and distrust.

In his studies Lewicki (1998 in Hill & O'Hara, 2005) discusses trust and distrust as significant aspects in creating a relationship between two or more people. A model of trust and distrust is presented (see below) as a base for understanding how humans generate trust in the process of meeting others.



Model 9 Integrating Trust and Distrust: Alternative Social Realities (Lewicki et al. 1998 in Hill & O'Hara, 2005: 12)

According to the above model, trust and distrust relationships are divided into four cells: high trust – low distrust; high trust – high distrust; low trust – low distrust, and low trust – high distrust. In the optimal situation, the beginning of a relation begins in cell 1. Here the parties are rather neutral in trusting/ distrusting one another since they have limited information and interdependence over each other. In this cell, parties have no reasons for generating strong opinions on whether or not trusting or distrusting the other party is suitable. Time and repeated interactions make the relation progress into one of the other cells. For instance, providing accessible, checkable, and adequate information over a particular medical tourist destination is a key tool for forming stable interaction and thus a trustworthy relationship. If the relation is rather positive during the process of getting to know each other, it is highly possible that it will move to high trust and low distrust environment (cell 2). In this cell, the parties show strong confidence in each other; they are also more eager to resolve arising obstacles and tensions while they occur (Lewicki et al. 1998 from Hill & O'Hara, 2005). Furthermore, subsequent indications of untrustworthiness or dishonesty are often diminished or denied.

If an outcome of a relationship is relatively negative (e.g. discouraging word-of-mouth information about a medical treatment from an acquaintance), then it is very possible that it will move towards cell 3, which is characterized by low trust and high distrust. In this case, the individuals become very suspicious about each other (or the medical destination/treatment), and they tend to monitor and highly control the actions of the other and protect themselves from possible misleading or deception. Conversations between parties in this cell are likely to be cautious, guarded, and disingenuous (Lewicki et al. 1998 from Hill & O'Hara, 2005). Relations move to cell 4 if the parties show high trust towards each other with regard to certain aspects, but also have reason to highly distrust one another in some matters. In this case, the individuals have both shared and separate goals. Trust, in relation to shared goals is reflexive, whereas in separate goals, suspicion and monitoring the other often occur. Hill & O'Hara point out that perhaps in many relations people start in cell number 2 or 3 instead of 1, which consequently leads them to an inaccurate update of the process. According to the authors, assessing the initial level of trustworthiness from cell number 1 or 4 is related to a more careful process of analysis towards existing information.

The same authors discuss trust in relation to health, where they state that the sicker the patients the more vulnerable they are and so they are more likely to trust their doctor. The type of trust established through the patient-physician relationship is often comparable to *"fraternal, family or love relationships"* (Hall, 2002 in Hill & O'Hara, 2005:37). Interestingly, not seriously ill patients also tend to build significantly high level of trust towards their physicians. Moreover, surveys incessantly show very strong general trust in doctors, which brings the authors to the conclusion that many patients are likely to 'overtrust' their doctors – *"this is to trust [...] beyond what a rational calculative assessment would warrant"* (ibid: 38). Some studies on patients' trust indicate that there is no significant difference between the high and low trust personalities in perceiving trust towards their physicians (it's similarly high). Even though the term 'overtrust' seems to have a negative connotation, it can generate benefits for a patient's health. Patients who overtrust their doctors happen to be more enthusiastic about their health since trust works on them as a 'powerful placebo' and may accelerate the process of recovery (ibid).

Trust and distrust as social realities influence the individual's way of approaching the social environment and other humans. In this case, potential medical travelers will also experience trust and distrust towards a medical travel. As indicated by the above theories of trust, many different aspects influence the level of confidence towards the idea of traveling abroad for a medical treatment. Most of those aspects refer to the internal beliefs and personal connection with the supplier side. However, the external factors such as marketing also seem to play an important role in creating trust between certain parties. Consequently, medical tourism suppliers have to market trust in order to target potential travelers. But can trust be actually marketed? And if yes, how to market trust in such a subtle area? Even though this paper

does not focus on marketing approaches in medical tourism, we include a small section on the issue of marketing trust within the medical area.

HOW TO MARKET TRUST?

Morgan and Hunt (1994: 22) discuss relationship marketing, which refers to *"all marketing activities directed toward establishing, developing, and maintaining successful relational exchanges"* in respect to relationship commitment and trust. They argue that in order to maintain successful relational exchange, those two aspects are crucial. This form of promoting a company is also described as *"marketing oriented toward strong, lasting relationships, with individual accounts*" (Morgan & Hunt, 1994: 21), which in the case of our research could represent the health care marketing area. The main goal of this form of marketing is to develop consumer trust over a period of time. Trust is here seen as *"a willingness to rely on an exchange partner in whom one has confidence"* (Moorman, Deshpande, and Zaltman, 1993 in ibid: 23), whereas relationship commitment is defined as *"an enduring desire to maintain a valued relationship"* (ibid). The Commitment – Trust Theory of Relationship Marketing presented by the authors (Morgan & Hunt, 1994) confirms that trust is a basic value in the customer – supplier relationship.

Plank et al. (1999) indicates that trust in marketing relations can refer to many different aspects, such as: company, salespersons, or a product itself (in Kim, Ferrin and Rao, 2008). In our study, we have a clear focus on trust generated towards the idea of traveling abroad for a medical treatment and the physician who performs the operation. We use the marketing related theory as additional and auxiliary material for understanding the significance of trust in marketing relationships.

The next chapter will introduce the decision-making processes in relation to medical tourists and trust in order to understand the influencing aspects of trust/ distrust during their decision-making processes.

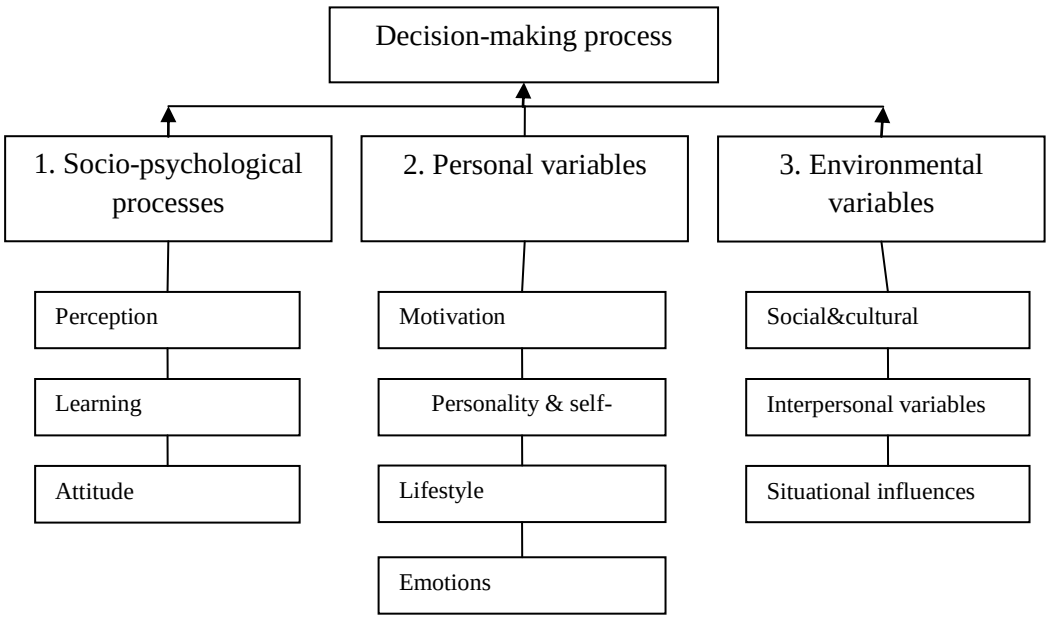
DECISION-MAKING IN RELATION TO MEDICAL TOURISTS AND TRUST

In this chapter, the focus will be given to the decision-making processes of medical tourists. Firstly, decision-making processes in tourism are discussed generally. It is followed by a narrowed focus on trust in medical tourists' decision-making processes. Thirdly, characteristics of medical tourists are introduced in order to understand the demand side of the medical tourism industry. Due to the fact that there is no comprehensive profile of medical tourists (Karuppan & Karuppan, 2011), their preferences, motivations, and needs are collected from previous studies on this matter in order to reflect the academic understandings.

DECISION-MAKING PROCESSES

In current economies, consumers (i.e. tourists) are confronted with several alternatives (e.g. in tourism new forms of holidaying, large number of travel agencies, hotels, restaurants to choose from) and often overwhelmed with information from many sources (e.g. family, advertisements/commercials; Decrop, 2006: 6). Therefore, several types of literature aim at figuring out what is the process of choosing among the alternatives when making a decision in order to understand the individuals and target them through the best possible way and in the best possible time. Although the focus of this paper is not oriented towards marketing, we find it important to elaborate on this topic to a certain degree in order to later analyze the influence of trust/distrust during the decision-making process.

Decrop (2006: 7-14) concludes major variables which describe consumers' decision-making processes. These variables influence the actual decision-making process of an individual. He divides them into three main groups and numerous subgroups. The illustration below sums up the main variables.



Model 10 The main variables describing decision-making processes (own creation based on Decrop, 2006: 7-14)

Firstly, socio-psychological processes are presented, which refer to perceived and learned information and to the individual's attitude. As Decrop (2006: 8) argues, perception is *"an absolute pre-requisite for processing information"*. At this moment, the brain has to make sense of external information through a selective and interpretive process of perception. In the case of medical tourism, potential travelers may perceive a developing destination, such as India, as a poor standard, or a dirty country (e.g. in Connell, 2006; Solomon, 2011), and this image can prevent them from traveling abroad for a medical treatment. However, the influence of marketing messages or social networks may cause changes and reinterpretations of the perception towards the destination. This leads to the second variable of learning where perceived information is absorbed in order to develop new knowledge, which is then stored in long-term memory and causes the birth of feelings and beliefs. To proceed with the example above, a potential medical tourist may come across new information that the required treatment is more affordable and at a higher quality in an Indian accredited hospital. It is then stored in the memory as an optional plan, which also influences the tourist's feelings about the country itself. Yet it depends on the tourist's attitude whether he will just believe India would be a good option, or evaluate it as a good option, or even take an action towards traveling there.

The second group of variables is called personal variables, as humans have their individual personalities, lifestyles, motivations and emotions that impact their decision-making process. It is not enough to have perceived and learned information if, for instance, the individual's lifestyle is not at the stage of taking an action towards traveling (e.g. in medical tourism terms he/she is not ill or has a job that does not support a treatment abroad). Motivation as a generic term refers to *"a process by which an individual will be*

driven to act or behave in a certain way" (Decrop, 2006: 9). Motives, needs, wants, and benefits describe motivation more specifically. Illustrating these terms, we go on with our example (to be noted it is a general example and not valid for all medical tourists). A potential medical tourist has a 'push factor' (i.e. a motive) of seeking a particular treatment abroad because he is not insured. His goal is then to find alternatives as he needs that treatment done and wants it to be at a lower cost with a benefit of quality care and possible vacation afterwards. These motivations depend on the personality and self-concept of the tourist, which influences his behavior. A less open-minded and less confident person is less likely to participate in a medical procedure abroad. In this thesis, a personal characteristic of trust-placing is being explored. Lifestyle also reflects the personality because the way an individual lives tells a lot about him/ her. Lastly, emotions play a fundamental role as they are seen as feelings towards a product or a service, which appear through experiences and changes. A study by Solomon (2011) examines the emotional structuring of medical tourism in India showing the importance of emotion that influences the decision-making process. The interviewed patients range their trips from betrayal to gratitude, expressing risks, costs, and cultural differences impacting their emotions and their decisions.

The third context of environmental variables affects what and how a tourist actually thinks, behaves, and learns. Mostly, individuals are unaware of the influences that they are impacted by, such as culture. As humans are born into a culture, even into a sub-culture, they learn to act according to the introduced values, norms, and ideas of a particular society, which also influences their traveling behavior. Social classes are then examples of subculture where education, prestige, occupation, and wealth determine the social belonging. In terms of medical tourism, interpersonal influences are important in order to generate trust towards treatments abroad and thus, supporting family and friends are relied on, yet they are not the decision-makers. Even if they travel along, they do not determine the final decision as it should be the medical travelers' choice, however it is often based on their advice and tips. Lastly, situational variables such as money, time, health, or marketing pressure may intervene as either inhibitors or facilitators of decision-making (Decrop, 2006: 14). In the case of medical tourism, the situational influence of cost-saving is seen as a facilitator, yet time may be seen as an inhibitor because not all individuals may have the opportunity to leave their job or family for the whole period of treatment and thus would rather stay home. The deeper description of characteristics of medical travelers is portrayed in the following section.

As indicated, the described variables have an impact on the overall decision-making process, but especially they initiate the process itself (e.g. push factors, situational variables). Decrop (1999: 126) argues that there is no universal decision-making process as it depends on individuals and circumstances. Therefore in our study, we will try to determine individual aspects which might have possible influence on the choice of whether to trust or distrust the concept of medical tourism. Although trust is not named

literally as a variable or an element in any decision-making process model, we see it as an important part of any decision. For instance, confidence or uncertainty refers to the notion of trust figuratively.

This section summarized the main terms and steps in the tourist decision-making process, which are then reflected on in the section describing the characteristics of medical tourists. However, medical tourists are more than tourists, having to trust their health in a foreign environment, which involves a detailed information search on medical suppliers rather than only on a destination (see Figure 3). Therefore, we will now move on to discuss trust in relation to decision-making in medical tourism in order to understand how and when trust or distrust come to play a role in making a decision of undertaking a medical procedure in a foreign country.

TRUST IN RELATION TO DECISION-MAKING IN MEDICAL TOURISM

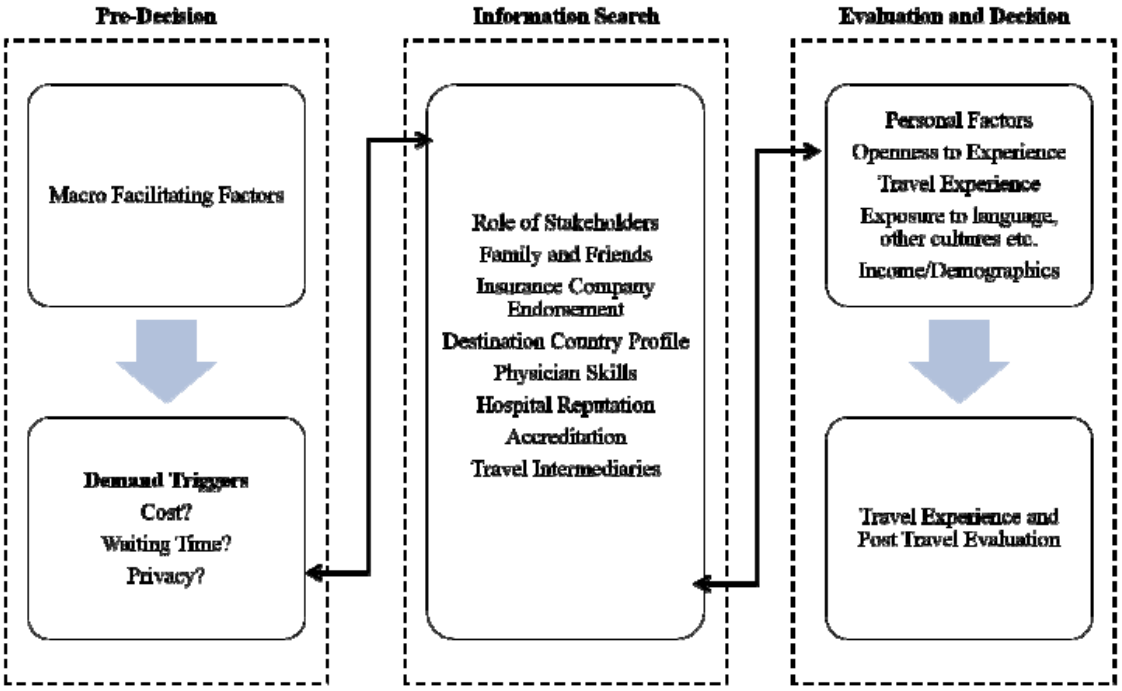
The quotation below states that a decision-making process is influenced by many people through their advice, opinions and feedbacks:

> [t]he real decision-making process involves a lot of people, and the whole structure is redolent with feedback. At every decisive moment, of which there will be great many within the total decision, we range ahead and back sideways. We gauge the effect of this sub-decision on everything we have tentatively decided already, and on the sub-decisions left to take. This is why I think the decision tree is an artifact, and of little use to us. You cannot isolate these nodes either in time or in logical connectivity, and anyone who has ever taken a complicated decision knows this. (Stafford Beer, Platform for Change, 1975:85 in Zeleny, 1982: 85).

Therefore, it is a process of learning about the subject and its possible outputs, reflecting and absorbing the learned information, and projecting it back on one's reality. In the area of medical tourism, this process is imaginably longer because it considers one's health and personal intervention in the body, therefore there are some risks that are thought over and consulted with others.

The process of deciding whether to go abroad for a medical treatment or choose the domestic medical care is seen as a very complex process where many different factors play an important and influential role. As a consequence of this complexity, many traveling patients decide to use the assistance of medical tourism travel agents who help them arrange their medical trip. These organizations serve as patient's representative, and provide them with help in pre- and post-operation procedures, the travel, health services, and the management care (Surgeryplanet, 2010).

The decision-making process in medical tourism is often emotional in nature, which affects the physical and mental well-being of the patients (Crouch & Louviere, 2001 in Altin et al. 2011). Altin et al (2011) emphasize the quality of service, perception of the stakeholders, and influence of family members as important aspects of the process. Below we use the figure which represents consumer's decision components involved in medical tourism.



Model 11 Decision components in medical tourism (Altin et al., 2011: 8)

In the pre-decision phase, the patient establishes his/ her need for the travel and considers the basic benefits (such as costs, waiting time, and privacy). Since our paper focuses on trust and distrust in the decision-making process, we see the middle phase of the above figure (information search) as well as the last phase (evaluation and decision) as the most adequate to use in order to find possible components that influence a medical patient's choice. The authors place particular emphasis on the role of:

(1) stakeholders, who are often involved and interconnected with consumer's choice;
(2) destination country profile, where economic, political, legal, socio-cultural, and technological status play a decisive role in any tourist activity, is predicated to become of even greater importance in the context of medical tourism;
(3) hospital/ treatment facility and reputation. It is stated that medical tourism travel agents have a great influence in creating consumer trust towards certain providers. Also the general reputation of an institution which provides medical services tends to affect consumer's choice.

(4) personal factors, such as *'openness to experience and prior experience to the culture and language'* as well as demographic variables such as age, income, and education have an impact on the decision making process to travel abroad for a medical treatment.
(Altin et al., 2011: 8)

The above figure and descriptions indicate possible directions to our findings, however it does not specify the influence of trust/ distrust in decision-making. We believe that trust and distrust also play a significant role in any decision-making process, yet when a medical treatment is to be decided upon, these aspects seem to be even more important – even if on an unconscious level- as they have an impact on the overall decision-making process. In the analysis part, we will investigate the relation between the mentioned decision components with the elements influencing trust and distrust in medical treatment abroad. Moreover, this model is to be altered according to our findings in order to conclude the decision-making processes of the interviewed medical travelers and understand where trust/distrust is generated. Now we continue with describing the characteristics of medical tourists based on literature materials.

CHARACTERISTICS OF MEDICAL TOURISTS

Most of the literature and measures on medical tourists are based on the U.S. market. Due to the lack of data, we will use research on the U.S. market and try to understand medical tourists according to those articles. We are aware that the U.S. medical market differs from the European, however the general representation of motives and understanding of the idea to travel abroad for a medical treatment is used here as a universal image of medical tourists.

Crooks et al. (2011: 726) summarize two motivations for undertaking medical procedures abroad. They distinguish (a) patients coming from privately funded health systems, such as in case of US patients wanting to obtain affordable treatments. In their study, Karuppan and Karuppan (2011) further categorize U.S. medical travelers according to testimonials into uninsured or underinsured individuals, cosmetic surgery patients, and individuals seeking easier access to restricted procedures (e.g. reproductive services). Secondly, Crooks at al. (ibid) name (b) patients having publicly funded health care in their source country, like in most of European countries, but searching for shorter waiting periods, or locally unavailable or illegal procedures abroad.

In their article, Karuppan and Karuppan (2011) also argue that besides people who need to save on medical costs, people with money may also travel to receive care abroad because they look for a greater value. Quality of care plays a significant role in the decision-making, especially in that it cannot be assessed and measured beforehand (this is also the aim of our paper- to understand how then trust is generated). Prospective medical travelers revealed that physicians' reliability and their ability to inspire trust and confidence matter in the first place, followed by the appearance of physical equipment at a hospital (Babakus & Mangold, 1992 in ibid).

In most cases, the reason for participating is the cost savings, yet the required cost differential of home and abroad prices depends on the risk of the procedure. That means that the more one saves on a risky procedure, the more likely he/she will consider undertaking those procedures abroad. On the other hand, there are obstacles to medical travel, such as culture shock, postoperative care, length of stay, and lack of legal recourse (Karuppan & Karuppan, 2011).

In addition, Crooks et al. (2011) recognize – based on their thematic content analysis on promotional materials – that though price/cost plays a significant role in influencing potential travelers' decision-making, it is not the only and most important element of the decision-making process. Glinos et al. (2006 cited in Lunt & Carrera, 2010) identify five drivers behind the demand for medical interventions abroad, namely: (1) familiarity, (2) availability, (3) cost, (4) quality, and (5) bioethical legislation.

This research also points out that majority of medical tourists do not have international travel experience as would be expected. However, this study has been restricted to the U.S. area only. From this point, possible vacations do not have a major impact on the likelihood to seek medical care abroad, as many patients are dissuaded from vacationing after serious procedures. Bookman and Bookman (2007: 2) also confirm that *"people want exotic vacations, but not exotic health care. They want first world treatment at third world prices"*. Therefore, medical care is chosen first and further paired with a holiday destination.

Huang et al. (2011) explore motivations and dilemmas in the decision-making process of medical tourists engaging in liver transplant in Taiwan. Their main conclusion is that those candidates are likely to approach family members, friends, or others with similar experiences. This need for support decreases the candidates' feelings of uncertainty. This example shows the importance of relatives and friends for medical tourists. Besides being caring, they may be the initiators or encouragers, as well as the accompanying partners. By traveling with the patient, they are also taking part in the medical travel, though definitions do not refer to them. Yet they are the ones to be engaged in tourist activities while the patient recovers in the hospital. Moreover, they generate tourism revenue by staying at a hotel and eating out.

ANALYSIS

This chapter contains the analysis of our research. Based on the theory gathered during the process of writing as well as on the conducted interviews and auxiliary material used for this project (e.g. App.10&11), we discuss and analyze the collected data. This part of the project is divided into three main sections: an analysis of medical tourism, an analysis of trust and distrust in relation to medical tourism and lastly, the analysis of the decision making process in relation to medical tourism. We decided to use this structure in order to create a clear correlation with the theory chapter and to show the interrelated character of those parts. However, at first we share our thoughts on the challenges related to the data collection in order to give the reader a better understanding of the undergone process when constructing this paper.

DIFFICULTIES WITH DATA COLLECTION

Medical tourism is a widely recognized phenomenon, which is becoming a more and more identifiable occurrence all over the world. However, during the process of creating this thesis, we experienced difficulties with finding theoretical material corresponding with our subject. Since our topic is directed to the thought of generating trust and distrust towards the idea of traveling abroad for a medical treatment, we looked for literature which combined our three theories. We found almost no article that combined those three areas, though many pieces of literature elaborated on the separate subjects. This assured us in the belief that this project will contribute to the study area of trust in medical tourism and gave us a strong motivation for researching the topic and seeking for all possible solutions.

Another big challenge appeared when searching for adequate samples of our interviewees. As we decided to focus on the Dutch and Danish market, we looked for people of these nations who had traveled abroad for a medical treatment. As described in the methodology part, those nations are seen as potentially interested in the idea of medical tourism. When discussing the subject of our thesis with Dutch people, all agreed that it is an increasing trend in the Dutch society, yet most of them had never participated in it themselves and do not know anybody who ever took a part in this kind of occurrence. Interestingly, during the search for our interviewees, a student of medicine indicated that medical treatment abroad is mostly interesting for lower educated people: "We don't really learn about this subject in college only that it might be lower educated people who go for these treatments" (App.10). Although the focus of our thesis is not directed into finding the common characteristics of medical tourists, we find this thought interesting and alluring for further investigation.

Moreover, some of the medical tourists contacted by us refused to participate in our study because they felt that it was too personal for them and subsequently too emotional to speak about their experience (reproduction tourism). We also had to reject one of our potential interviewees due to the fact that two days before the meeting a traumatic medical experience took place in her life (her daughter in law had a miscarriage). This aspect would probably overrule the interview and therefore the answers might have been invalid; but most importantly we found it unethical to conduct this interview. Furthermore, in order to find suitable interviewees we contacted three medical clinics in Holland, which organize this kind of treatment abroad. However, due to confidentiality of patients' information, they could not provide us with any personal data. Nevertheless, one of the managers of a dental clinic agreed on a short conversation about his company and trust related issues. Despite the arising challenges, we managed to find our interviewees through our family and friends.

In this section, we analyze how medical tourism is seen and experienced by the research sample. First, we explore the perceptions of medical tourism, followed by the types and reasons for which such trips were undertaken by the sample. Second, we sum up the aspects that may cause no or decreased interest in such tourism and may discourage participation. Third, we examine the sources of information that affect willingness to obtain a medical intervention abroad. And finally, the impacts of destination characteristics are elaborated on.

The label 'medical tourism' brings various ideas up in the respondents' minds. Most of the respondents relate the term with generating financial benefits, yet doctor's reputation is also emphasized as a pulling factor. The potential Dutch medical traveler sees medical tourism as a "little bit funny" practice due to being combined with tourism, but mentions budget, time and doctor's reputation as pulling factors:

> *"Well, when you say tourism, to me it's not negative. Because it's okay [to] go abroad, try to find out treatments or second diagnosis abroad might be very intelligent and very useful. But to me the idea of combining it with tourism is a little bit funny, I would say. I know it's... you could find reason because you want to see a doctor, because it's cheaper abroad – because I guess it's that. When people look for treatment abroad it's first of all it must be about budget, unless they know – again I come back to the same idea – unless they know about reputation, about a doctor they've known by friends or whatever. Then I guess you'd decide to well to find out and then the budget is less important. But if you don't know the doctors abroad, to me it's only the matter of budget and perhaps of time, but especially matter of budget."* *Interviewee # 2*

Although, the respondent above is not fully positive about the phenomenon, she connects medical tourism with financial matters. A rather negative perception of medical tourism is expressed by Interviewee nr.4 who connects the phenomenon with threatening the future of home welfare-society model:

> *"me as an individual, I would prefer the Danish not because it's closer or it's more safe or anything, but because of the Danish welfare society model that it's based on high taxes and free universal health care for people that pay taxes – or for I mean for all that live in Denmark. Just on my own, I think I would support that model because the last people without high income are treated and if people with money begin to go private or if they begin to go abroad at a pace and numbers that threaten the overall model of the welfare system, then I see a problem in a longer future."*
>
> *Interviewee # 4*

Interestingly, experienced medical travelers may also see the concept more as a negative idea, like the dental tourist to Poland, who does not support the idea of doing something only for cost benefits (App.7, p.41) in the face of his participation for this very reason (see more below p.57). He, furthermore, links medical tourism with avoidance of a waiting period, which is seen to him as a rather important and accepted aspect.

"If you look at other countries it is mostly about the costs and in Holland there are some kind of treatments where you have to wait very long. So if it is fairly important for me to do something in a short time then you have to go to another country, because in Holland it is rather difficult."

Interviewee # 6

It suggests that humans protect their health and find alternatives in cases where medical tourism provides an option. Even though the phenomenon might be widely practiced, the perceptions of it, in general, seem not to be positive. For instance, regardless of her good experience, the Dutch female medical traveler still considers medical tourism as only being neutral (App.8, p.50).

CATEGORISATION AND REASON FOR OBTAINING MEDICAL TREATMENTS ABROAD

As elaborated in the theoretical chapter (Ch.3), there are differences not just between the concepts of health tourism and medical tourism, but also within the concept of medical tourism itself. The latter combines various types of treatments and procedures that can be obtained by choice in a foreign country. During our search for actual medical travelers, we experienced the narrow market of medical tourists, which made it rather difficult to conduct interviews with participants (see p.54). These findings also support the academic literature that suggests the existence of diverse demand towards certain procedures that create micro-niches within the concept of medical tourism.

This paper examines so-called less severe procedures within medical tourism, because three of our interviewees engaged in dental treatments abroad: one in Poland (App.7), two of them in Thailand (App.3&5), and one participant of a knee surgery in Germany (App.8). According to Cohen's (2010; see p.32) division, these interviewees participated in medical services that are legal in both the home and destination countries. Our findings point out that people who participated in less invasive legal treatments abroad are more likely to share their experience compared to people who went through complicated and severe operations either of legal or illegal nature. Our participants did not experience a feeling of deep emotional stress, in contrast to patients who chose to participate in more complicated surgeries (such as bariatric surgery):

"[b]ecause it is a really emotional thing, a lot of people told me. It is a personal thing. Some people would go over there [to Belgium], have their surgery, have a bed rest for a day and then be up exploring the city, because it was Brugge and Antwerp – beautiful cities to visit. I had one lady on the far extreme side of that, who immediately after the surgery called me crying, saying that she made a mistake, and she can't believe that she did it to herself, she wished she could undo it. And

she wanted me to speak to the doctor to fix it again. She had emotionally and mentally a horrible time with it – not even physically." *Interviewee # 7*

In the theory, we discuss that dental tourism lies on the health continuum, which is rather preventive in nature and may therefore involve regular visits, as in the case of the two Danish interviewees, who treat their teeth in Thailand on a regular basis:

"Actually I go there [to Thailand] just to have my normal check-ups also.[...] I haven't used that [Danish dentist] for 10 years." *Interviewee # 1*

"My dentist is near the hotel in middle of Bangkok and they check me every time." *Interviewee # 3*

For these participants dental treatment in Thailand has become a routine. This medical routine is always combined with holidays and visiting friends and family. In their eyes, dental treatment is a part of the holiday package and not the only reason, certainly not the main reason for traveling there. As it is expressed below by the Danish dental travelers:

"And it's actually really funny as you say it now when I think about it. I go to Thailand to save 500kr [DKK] or maybe 1000kr. for the normal check-outs. If I have a hole, maybe 2000kr. every two times to save. But I use 14000kr for fun and going out. So it actually don't matter at all. I just got used to go there, so actually it's quite funny when I think about it." *Interviewee # 1*

"But I don't go only for this. When I'm here [Thailand] I check all the other things together. Of course it is nice to save some money, but it's not all. *Interviewee # 3*

Despite the Danish interviewees' replies, the Dutch dental traveler only travelled to Poland once to obtain primary cost benefits with a natural human curiosity:

"It was only the cost, and then to go to another country and see how it works there, so also some kind of adventure". *Interviewee # 5*

It can be then concluded that cost savings play an important role in decision-making, however with an individualistic perception of its implication. Except in the case of the Dutch dental traveler, cost benefits are not the primary aspects for engaging in dental treatments abroad, but are always mentioned as secondary reasons. The two male Danes emphasize the quality of the service and equipments, which impact their loyalty towards the Thai dental care over the Danish.

"Very impressed with the service, by the luxury and the quality and also the way... the place I was, was like a huge- huge dentist's clinic. [...]One hour later I went out and I paid like one tenth of the

price I would do at home. And it was a really good job. So I was like: wow, why the hell go to the dentists in Denmark. And since that time I just come there again and again and again."

Interviewee # 1

This quotation also supports the theory of medical tourism being a practice of seeking medical treatments at lower costs, but higher quality, where the respondents judge the benefits over the value of their money. This attitude is expressed in terms of destination comparison by Interviewee nr.4, who will aim to provide the fun part of such trip to his children in a future case:

"Obviously Western Ukraine doesn't have the same advertising and PR budgets as Disneyland Paris does, but if they provide enough information to trust, then this might be more interesting because you have - coming as a Dane - my money would take me a lot further in Western Ukraine than it would be in Paris." *Interviewee # 4*

In addition, Interviewee nr.3 adds that his reason for choosing Thailand is based not only on the price. With his eye surgery in Thailand the price mattered as low as three on a 10-pointed scale, whereas with the dentistry, he gave four, which is also below the middle way (App.5, p.22). In contrast, he tends to focus on the reputation and professionalism when choosing a medical treatment abroad:

"And they are more specialized here [meaning in Thailand]. So I feel they are more professional, because they... like this guy today, he is dentist and professional in only cleaning teeth and nothing else. Just today I was to three different dentists, because they have to check, and they have to make x-ray and they have to clean. This is 3 different doctors, because they specialized in everything and this is what I really like. You cannot be specialist in everything, so this one thing I really like."

Interviewee # 3

Furthermore, as a listed reason in the theory, the Dutch female respondents also argue that avoiding long waiting lists are usually the reasons in Holland to engage in treatments abroad, which in fact is also positively accepted by the Dutch dental travelers (see p.).

"Well, in Holland it's especially about waiting long time to have treatments. I know it's a little bit better than a couple of years ago, but it's very started there. I mean, for many surgeries people needed to wait such a long time that they planned to go abroad." *Interviewee # 2*

To give an example, Interviewee nr.6 engaged in medical tourism in order to shorten the waiting time that she faced in her home country. Her uncomfortable pain made her open to alternatives. She was covered by insurance, so costs did not matter to her and her aim was to escape the pain as early as possible and not to wait for an available appointment in Holland. On the other hand, the service in terms of medical care amused her and certainly made an unforgettable memory, which generates a comparison with the source country. This type of experience may affect patients' future decisions regarding medical treatments:

"I was really surprised about the way they communicated with me. I could not believe it existed, because I was used to the way of communication here in Holland. It was better quality. They really made contact with me and I felt connected. Not alone the doctors, but also the nurses. I also saw that especially the nurses, they acted for me very confidentially [meaning confident], because when they didn't know what to answer, they were very clear and said: well, at the moment I don't know it, but I will check it and I'll tell you. They always did." *Interviewee # 6*

All in all, it is apparent that various reasons and pulling aspects can determine whether one engages in medical travel or not. It also depends on the type of medical problem as well as one's own interest. Four of the five listed drivers by Glinos et al. (2006, see p.52) are identified in our research, namely the mentioned cost, quality, availability, and familiarity. For instance the Danish medical travelers see Thailand as their second home (familiarity; more on pp.62-63), which makes them return and then combine their medical needs (price and quality) with holidays and visiting friends and relatives (App.3&5). The Dutch dental tourist and the knee surgery patient are not personally connected to the medical destinations, so their medical practice in a foreign country is limited to one occasion (caused by cost and availability) that resulted in an experience that has an impact on their overall evaluation for potential future medical travels.

ASPECTS THAT (MAY) NEGATIVELY AFFECT PARTICIPATION

There are also threats and obstacles that would prevent medical travelers from engaging in treatments abroad. As cost mostly seems to be linked with medical tourism, it is the first aspect that is named by the participants:

"If it was more expensive than in Denmark, I would not go [to Thailand], to be honest"
Interviewee # 3

It supports Bookman and Bookman (2007) who state that medical tourists want first world treatments at third world prices (see p.52). Moreover Thailand, as a distant country from Denmark, impacts the travel expenses, so even if the participants highlight the importance of quality care, costs anyway matter to a certain level.

"Even if the operation is cheaper down there, the whole trip is not."
Interviewee # 1

Distance, on the other hand, may also limit the willingness of engaging in a medical procedure abroad. Distance is seen negatively in terms of being far from the supporting family and friends. This aspect is highlighted by the Interviewee nr.6, who had a hard time missing her husband during her knee surgery and rehabilitation process (App.8, p.50). It is not seen here as a decisive but rather as an influential characteristic that may discourage the patient in his/ her (future) choice. In addition, unfamiliar culture and unfamiliar health care systems with different rules may lead to frustration and a decrease in the level of trust towards medical tourism:

> *"It's like one thing desiring to be with people who are a little bit similar to your own culture. [...] If the culture is that different from your culture, I would be less trustful and that's because of the communication and reputation – everything I mentioned – it is related to culture. And although I like/ I love very different cultures from all over the world, let's say Southern America, I feel very much less comfortable in a hospital in Southern America then in my Western world."*
>
> *Interviewee # 2*

Another interesting aspect that could trigger lack of participation in medical tourism is related to destination ethics. One of our interviewees stated that it is 'funny' to consider going abroad for a medical treatment to less developed countries, such as China or India because it simply feels like a business and not a proper medical care. Therefore, she distinguishes between going to private and public hospitals as well as going for a medical treatment abroad to Western and non-Western worlds.

> *"[...] when there is a very big difference in a country in good hospitals – private hospitals or public hospitals, when there is a big difference, then it feels like business. And when you live in a country like Holland where the standard is very high and of course there are problems and there are mistakes, but in general the standards are very high, then I feel much more comfortable in my country or in a European country. That's why I make a difference between going abroad for treatments in Western world or non-western world."* *Interviewee # 2*

This may be taken into account by medical tourism destinations and intermediaries because health cannot be commoditized in the same way as, for example, a sunny beach. Business and inequality seem to impact the partaking of and thus the trust towards medical destinations. Likewise the dilemma expressed by Interviewee nr.4 concerning whether it is moral and right to use e.g. private hospitals in India where the poor of the Indian society has almost no access to a medical support:

> *"would feel hesitant about it because if it's something eager by access to because of your own wealth, but the people living in the place don't have access to it, I would feel less inclined to go"*
>
> *Interviewee #4*

In this sense, ethical considerations can also stop people from supporting and engaging in medical tourism. However, it seems to be more of a concern to potential medical travelers, which suggests further investigation within this subject.

Other obstacles listed by Karuppan and Karuppan (2011; see p.52), such as culture shock, postoperative care, and lack of legal recourse are not cited by our samples.

INFORMATION SOURCES

Friends and relatives act not just as pulling factors, but as influencing and information tools. Medical tourism literature lists word-of-mouth, the Internet, general practitioners, and intermediaries as information tools used by medical travelers. Our findings show the former two tools as having the most impact. The source of information appears to be a trustworthy person, whom the participants happen to know before (see also p.72).

> *"I asked my girlfriend that time. She was Thai and she lived there and she used the same. So I didn't go internet or anything."* *Interview # 1*

Besides acquaintances, the Internet is also used to find information as was the case with Interviewee nr.3, who engaged in a laser eye operation in Thailand because of the positive findings on a doctor's status:

> *"Actually on the Internet, I write a little bit about it [the eye problem] and they showed that he had made the machines. He had the sign of the machines in the United States. The same machines they also use in Denmark. And they write a lot about him and then I contacted him."*
> *Interviewee # 3*

The medical tourists also form their word-of-mouth recommendation, which may pull attention and interest among their family, friends, and acquaintances. For example, Interviewee nr.5 expresses the importance of influencing the hesitance in others by telling her own experiences:

> *"when I tell some of my colleagues that I do my teeth in Poland, they say: oh, why are you going there? And I tell them how is it going there and how they do that, they also say: can you make me an appointment and where is it; you can see that they are more interested. When I only would say: it is that and that clinic and I don't know how it goes there, I think nobody would go there"*
> *Interviewee # 5*

Moreover, Interviewee nr.1 argues for quality and price when spreading the word and takes friends with him to the clinic if they accompany him on a trip to Thailand (App.3, p.5). These arguments indicate the importance of word-of-mouth reach within medical tourism, which is also stated by the former employee:

> *"We have also put them [potential medical travelers] in touch with somebody who had the surgery before. In Ireland there is a really big word of mouth – it is better if you know somebody, that's how business goes there. So one lady that we got from Ireland, she would go to another patient's house and meet face to face, and that would do a world of good to them."* *Interviewee # 7*

Therefore, it is concluded that references in the form of relatives, friends or experienced medical travelers increase the likelihood of participating in medical tourism and are useful tools in marketing activities.

DESTINATION ATTRACTIVENESS: TOURIST OR PATIENT?

Our findings indicate that not all medical travelers utilize tourism facilities or participate in tourism activities during their stay at a medical tourism destination. The knee surgery patient was in a hospital and after that in a rehabilitation center (App.8), so she did not have a chance to approach the destination from a touristic point of view.

On the other hand, the dental tourists experience the destination's offerings as traditional tourists. The Danish dental travelers even use Bangkok as a hub and stopover destination to go further to other countries or travel forward to places within Thailand, and during their stop in Bangkok, they happen to check their teeth at a clinic (App.3&5). The Dutch dental traveler also visited several castles and some 'places around' (App.7, p.37), but he considers himself a patient because:

> *"I didn't know Poland. At first I am coming there for my teeth, to do that, and then it is nice to see some other countries and then go to Poland to look at the country."* *Interview # 5*

This shows that he had no previous interest in the destination itself and he acts as a patient who utilizes the acquired time and opportunity to see a new destination. This is in contrast to the Danes, who tend to travel to Thailand for other reasons than medical, but utilize the opportunities of having their teeth checked while at the destination. From this point of view, it is debatable how a destination image impacts the medical travelers.

First of all, the findings show that personal and cultural experiences with a certain medical destination positively impact the potential travelers. If a patient had visited the country before (he knows the culture, he understands the way of life), it makes it easier to consider and undertake a medical treatment in that country due to familiarity, which increases the level of trust towards medical professionals as well:

> *"Thailand is different because I lived there for a year also. I started traveling around as a backpacker and after there I found a work down there, couple of years after. I have lots of friends down there."* *Interviewee # 2*

Destination image and attractiveness are major concerns when people think about engaging in medical tourism. Some destinations may have a negative image in people's mind, while others again a positive and pulling nature:

> *"I don't go to South America or South Africa or that kind of countries, because I believe that it is not very healthy there, but for Europe, Western Europe- all the countries I think and for Eastern Europe- the places that somebody else recommends."* *Interviewee # 5*

This respondent emphasizes the need for recommendation when it comes to Eastern Europe. He tends not to trust those countries unless he has someone's experience or reference to rely on. Another interviewee also points at a familiar contact at a different medical destination than he used to go to, but price consideration and probable impact of destination attractiveness influenced his final decision:

> *"I was actually considering in Poland once. Hungary or Poland, whatever, but I was considering in Poland, I have a dentist contact in Poland, but then I thought: okay, Poland is only half the price in Denmark, the other one is one third and I have to make a new... I had some old holes that to remake, so I actually pay much trip to Asia and I rather go to Asia then to Poland or go to Budapest."* *Interview # 1*

Lastly, it is also stated that a participant evaluates many destinations worthy for trust, yet only in regards to their private hospitals.

> *"I think United States, but I have never been there. But I think they have also good hospitals there. But... I like to travelling but... I also think about a lot of other countries in Asia, Malaysia or private hospitals in China. In Asia, the treatment and as they are, I really like, so I will have no problem with going to hospitals there. Not in to Laos or places like this, but most of the other countries in Asia, but only in private hospitals. Yeah, because the other one is really really not good."* *Interview # 3*

Based on the argumentations in this chapter, it can be summarized that medical tourism is not an easily defined phenomenon because of the various aspects that influence the participants. Some are concerned about the price, destination image, and doctor reputation; others question the ethical rights and source of information. Behind these concerns, there is the question of trusting or distrusting e.g. a destination or a foreign doctor. The following section outlines the findings on trust and distrust of medical tourists.

ANALYSIS OF TRUST AND DISTRUST IN RELATION TO MEDICAL TOURISM

Based on our research group as well as gathered material, the Dutch and Danish societies belong to the group of high trust societies (Fukuyama, 1995). All the interviewees are actively involved with tourist activities as well as open for new experiences and in general very positive in their trust of others. In those two countries individual development plays a significant role. These countries represent a Western approach, which is seen as self-centered and focused on creating independent networks, the opposite of e.g. Italy where the approach is more family- and community-oriented. This analysis indicates that the Dutch and Danish societies represent a high level of general trust towards the surrounding world and everyday approach.

"I'm concerned about people who don't trust people and to me it's something that really doesn't make the world better, because it makes the world so much better when you have trust in people."
Interviewee # 2

"Most of the times I am very curious [about a person met for the first time], I always want to know who is he or she and what is going on in her or his life. [...] I trust people most of the time, 9 or 10 . Yes. I trust people. Sometimes my husband says that I should be less than 10 for instance, because I trust people and it is my problem sometimes." *Interviewee # 6*

TRUST IN MEDICAL TOURISM

When discussing trust in medical areas, it is recognized that trust is seen as a vital condition in a doctor – patient relationship. Without trust there is no successful treatment. As mentioned in the theory part (p.37), trust encourages patients to be more open about the problem and it makes patients accept the suggested treatment. Therefore, trust is seen as a 'powerful placebo', which allows the patient to believe in his/ her recovery and often accelerate the process of healing.

"Working on trust is the most important condition I think between a doctor and a patient. So it is also with being abroad. It is very important, because if it is not there it will be a problem with solving the problem with the health." *Interviewee # 6*

All our interviewees see trust as an important aspect of medical tourism. This is often related to the fact that medical treatment is always associated with certain risks. Therefore, the level of trust may vary depending on the seriousness of a treatment undertaken abroad.

"dentist is not bad, you can destroy teeth only, but if it goes something to your body and you don't trust the people who do it, then damn you're stupid to do it." *Interviewee # 1*

GENERATORS OF TRUST AND DISTRUST TOWARDS A MEDICAL TREATMENT ABROAD

One of the managers of a dental practice which receives medical patients from abroad suggested that the trust between a patient and a doctor should be based on the knowledge and experience of the doctor (App.11). Therefore, in order to comfort the patient, that clinic advises to begin with a consultation visit before proceeding with a full treatment. This approach is designed to ensure the patient of the reliability and confidence of the clinic. This open attitude and clearly provided information are very comforting for the patients and increase trust towards all involved parties. In this part of the project, we present our analysis on the generators of trust and distrust towards the idea of travel abroad for a medical treatment. For a better image of our findings, we created a model which represents the aspects that influence the perception of trust towards the idea of traveling abroad for a medical treatment:

Model 12 Main generators of trust and distrust in relation to medical tourism

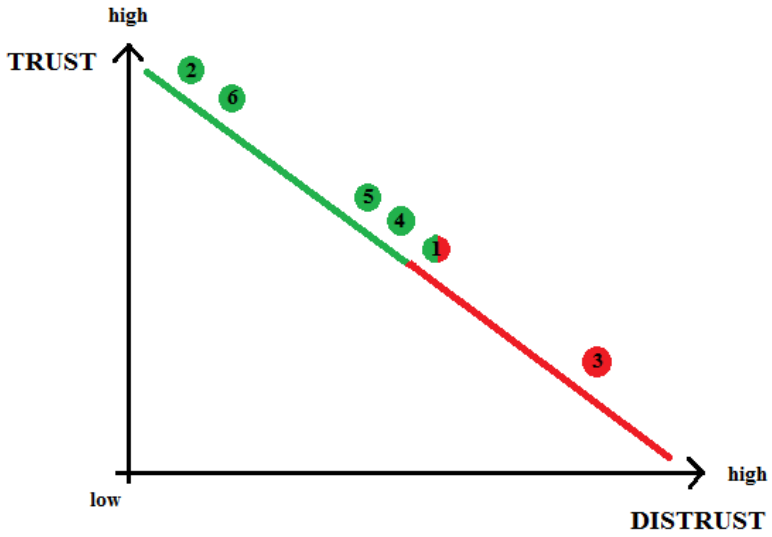
The above model is based on the model used in the theory part (p. 39) and it represents the decisive aspects that generate the level of patients' trust and distrust for the idea of medical tourism. Further in this section, all variables are discussed based on the conducted interviews and the theory gathered for this project.

GENERAL TRUST

General trust is seen here as the basis for all human interactions. By the term general trust we mean the perception of trust, which is developed during a person's life, towards the surrounding world and other people. Apparently, the level of general trust may evolve, change, and adjust to the present situation. However, the 'basic trust' built in the early childhood towards one's surrounding as well as towards one's caretakers shapes the foundation for the development of further perception in that aspect (Erik Erikson in Solomon & Flores, 2001). Our research indicates that general trust/ distrust is a feeling that people themselves choose to recognize or not. Therefore, it is an intrinsic feeling influenced by internal as well as external factors, which are not linked with rational thinking. As indicated already in the introduction part, trust and distrust seem to be subconscious concepts, which are constructed by internal emotions and intuition.

> *"I think people don't think about trust. [...] It's about the feeling and I think you can't give this interpretation. It's the end of feeling, because you trust or you don't trust people. But you don't have the same in yourself; you don't make the same reasoning. Most people choose or decide on different arguments."* *Interviewee # 3*

Based on the discussion in the theory part (p.42), trust is often associated with hope, whereas distrust is linked with fear. Based on the analyses of six conducted interviews, we place the participants on a continuum that best represents their trust or distrust towards medical professionals.



Model 13 Level of trust & distrust towards medical professionals represented by our interviewees

Our research indicates that distrust as well as trust in medical tourism is an effect of many correlating variables which develop in human perception from an early stage of life. Those variables consist of: general trust, previous medical experiences, communication, family and friends' recommendations, and doctors' attitude. The results of our analysis show that more than half of the interviewees represent high level of trust towards medical professionals. Interviewee nr.2 and nr.6 seem to have significantly higher levels of trust than the other respondents. We can therefore conclude that these two individuals may be prone to overtrusting doctors. However, as discussed in the theory part (p.44), despite the negative connotation, overtrust often generates benefits for a patient's health. The high trust is often a consequence of generally positive experiences with physicians as well as a high level of general trust towards the surrounding world. The gathered data indicates that those four individuals tend to trust their doctors (both within their country as well as abroad). All four interviewees mention that they base the feeling of trust on the education of medical professionals, since they believe that people who studied for certain profession deserve trust from the very beginning.

> *"When they [doctors] have an education in the small field, they know more about that field than I do and that creates a kind of trust I think."* *Interviewee # 5*

> *"At the beginning I trust you and I trust people and medicals, doctors or nurses are also people who have their profession [...]. I believe that you are good in the things you have learned or what is your profession."* *Interviewee # 6*

Interviewee nr.1 trusts medical professionals when the treatment is uncomplicated and rather safe (e.g. dentistry), however he is very cautious when the surgery is more complex and may have a serious impact on his life.

"[...] dentist is not bad, you can destroy teeth only, but if it goes something to your body and you don't trust the people who do it, then damn you're stupid to do it. I easily pay double the price if I trust somebody, but it's a money question again. But if there is something you have to do what is not necessary, like cosmetic. Then I would not do it if I don't trust a place." *Interviewee # 1*

This approach may be a consequence of his bad experiences with doctors in the past (App.3, p.7). However, the respondent emphasizes that he does trust medical professionals, so we placed him in the middle of the continuum.

Interviewee nr.3 seems to have the lowest level of general trust towards medical practitioners due to his traumatic experience from the past. On the scale from zero to ten (where zero is seen as the lowest level of trust and ten is seen as the highest level of trust), he selects two as the representation of his trust towards Danish doctors. However, he acknowledges that he trusts Thai doctors much more (App.5, p.23).

Previous general experiences with the doctor seem to have a strong influence on the general trust towards physicians (see more in the section below). Moreover, general trust in people is also seen here as a strong generator of trust towards medical practitioners from abroad. Oppositely, general lack of trust and suspicion towards individuals generates a feeling of distrust towards medical professionals from other countries.

PREVIOUS MEDICAL EXPERIENCES

In the theory part, we discuss the Conceptual Model of Trust in the Medical Profession (Hall et al., 2002; p.37). The model consists of five domains responsible for creating trust towards a physician: fidelity, competence, honesty, confidentiality, and global trust. Additionally a patient's medical background is mentioned as an aspect worthy of being researched. These features also appear in our study; however, we supplement them with additional variables. We devoted a lot of attention to the aspect of patient's medical backgrounds and we discovered that it has a significant influence on the decision-making process as well as trust and distrust perception towards the doctor.

Previous medical experience is an important aspect when analyzing trust and distrust in medical tourism. The research indicates that traumatic or negative experience with doctors from a patient's home country may decrease the level of trust towards the national healthcare and therefore it may stimulate patients to seek medical help abroad.

"[...] three years ago I got very sick. I was in Herlev hospital [Denmark], I lie down there for two weeks, they just give me morphine and they could not find out what was wrong. I had another doctor, a friend of mine's father, he tell them what it was. They don't want to listen. [...]. And this is incredible, really incredible. I was really nearly dying. [...] a Thailand doctor... I trust him a lot

more. [...] I had always said it was good system [the Danish health care system], but with my own experience it is not so good any more, to be honest. I have bad experience with hospitals in Denmark, very bad experience and I hope if I get sick, I hope I get sick in another place."

Interviewee # 4

Negative experiences with a doctor may generate a lack of trust towards him/ her or even towards the whole medical system in that country, whereas on the opposite site, a positive experience abroad may generate trust towards the idea of traveling out of the country for a medical treatment. It seems that trust based on this particular variable also depends on the kind of operation undertaken abroad. If the operation is complicated and emotionally difficult it may be received very negatively, despite great results. This is due to the process and again perception of the person that undergoes this treatment. The former employee of a medical company in Belgium emphasizes the emotional breakdown accompanying difficult operations:

"If you did it once, I don't think that you would do it again. Because it is a really emotional thing, a lot of people told me. It is a personal thing. [...]. I think that the surgeon put a lot of trust in people, but the whole process of doing it is hard. And hopefully you wouldn't have to do it more than once." *Interviewee # 7*

Patients who never experienced any negative or traumatic experiences in their home country but still decide to go abroad for a medical treatment are often motivated by external motives (mostly costs; pp.56-59). However, we can deduce that negative and traumatic experiences increase the possibility of searching for more trustworthy doctors abroad.

Some of our interviewees mentioned that they themselves have never had negative experiences (App.4&8), but they experienced those feelings through their close family or friends.

"Not for me personally, but I have some negative experiences with one of my father's doctors. [...] he made a very bad diagnosis and it was very sad for my mother, for my family."

Interviewee # 2

"Not my personal experiences, but sometimes is feels personal, when somebody is impolite to you and I am with you [...]." *Interviewee # 6*

This 'not personal' experience may influence future choices and the decision for traveling abroad for a medical treatment, but only if the experience was really strong and had affected the person on a deep, personal level. Experienced medical travelers may be open towards future medical treatments in a foreign country due to their evaluation of past experiences (for example the Danish dental tourists). Moreover, it can also make participants more open to medical procedures in a different field than the initial experience:

"[...] if one day I decide to get [a plastic surgery] then I would think about where to get it. I would investigate where it is good. It is not like I only want it in Denmark or I don't want be in Denmark." *Interviewee # 1*

PREVIOUS TRAVEL EXPERIENCE

Karuppan and Karuppan's (2011) research outlines that medical travelers do not necessary have previous travel experience before undertaking a medical travel (p.52). On the contrary, our interviewees suggest conflicting findings. All of the four medical tourists engaged in traveling quite frequently and are open to exploring and experiencing new cultures and countries:

> *"At least, the last two years I have traveled more than these 15 times a year outside Europe. [...]Five-six times abroad and five-six times around Europe a year"* *Interview#1*

> *"I travel in summer time, when it's summer time in Denmark one week to capital in Europe to show my wife [wife of Thai origin] Europe. And then in winter time we take 5 or 6 weeks holiday in Thailand, also distance to China, Malaysia, Laos, other countries around here. This is the way we travelling every year."* *Interview#3*

> *"I like to travel. I like to see how things work in other countries. We've been in China. But mostly European countries, in the East. I have seen rather a lot of foreign countries."* *Interview#5*

> *"I like traveling. I prefer traveling not in a group, but just together with my friend or alone. And I like traveling in a bus or in a train, not by car, just sitting around a little bit and talk with people. But I like traveling."* *Interview#6*

On the other hand, the former employee tells that she handled one or two participants that were not previously abroad (App.9, p.59). Despite this fact and the former research on the U.S. travel market (p.52), we conclude that previous travel experiences of the Dutch and Danish travelers influence their attitude towards obtaining medical procedures abroad. This makes them more open towards foreign nations and broadens their horizons. This may indicate that people with travel experience are more likely to see an alternative in a foreign medical treatment. In addition, deciding on a medical intervention abroad involves accepting unknown and maybe even unexpected experiences that may arise during the trip. As stated by Bookman and Bookman (2010), medical tourism stands on two legs (i.e. tourism and medicine; p.) and both legs are needed for a successful experience. From this point, we suggest that both legs require trust from the participant's side. This means that it is easier to rely on a medical travel if one of the components is trusted based on former evaluation of travel experiences. If a participant has a travel package full of experiences, he or she faces no unfamiliarity with traveling itself. Moreover, as it is not their first experience of traveling, the unknown medical experience is to be handled on its own, and not the overall travel experience combined with medical concerns.

COMMUNICATION

When deciding on a medical treatment abroad many possible obstacles and misunderstandings may appear. Therefore, communication is seen here as a crucial ingredient for creating a positive and trustworthy relationship. All of our interviewees mention this aspect as a base for a successful bond with a doctor. By the term communication we mean: language, mutual understanding, and a 'personal click' with the doctor.

From the patient side, communication is seen as a characteristic that makes a doctor trustworthy. It gives patients the feeling of safety and reliability.

> *"The way he [doctor] behaves and tell about the medicine and you can ask questions and everything... if they are trying to make you feel safe, then this is the way."* *Interviewee # 3*

> *"I like to talk and be open towards things, not to be like.. very clinic. [...] if you have a very clinic relationship with somebody, then maybe you are afraid of asking the questions."* *Interviewee # 1*

> *"When he or she [doctors] really listen to the patients and he or she must connect with the eyes, that is for me very important."* *Interviewee # 6*

Language is another aspect that is mentioned by the interviewees. Most clinics abroad are prepared to receive patients from overseas. Therefore, they solve this communication challenge by different approaches. In the Belgian clinic (App.9) the doctor is fluent in English and since most patients arrived from Great Britain or Ireland, there is no problem with communication between them. However, the nurses are not always able to speak (good) English and this leads sometimes to misunderstandings and can be seen as a problematic issue. Therefore, the doctor is trying to implement changes in the clinic by increasing the level of English among his staff (App.9). In Thailand, the strategy was different:

> *"They [the clinic] had like an accountant for every language: for French, for Chinese, for Japanese, for English and for German. So there are people who speak every language, I go to the English part, I get an appointment and I could go in 10 minutes later."* *Interviewee # 1*

None of the medical tourism participants experienced language problems while abroad. However, some see it as a potential challenge that could threaten the relationship and the final decision.

> *"I would probably not go to Russia to have it treated, even if they have a better waiting list because of the insecurity of language."* *Interviewee # 4*

However, generally the interviewees were rather impressed with the linguistic abilities of their doctors and all the medical personnel abroad, which is associated with professionalism.

"The doctors on private hospital they had worked about 5 or in the middle of 5 or 10 years in America or England, so they know... their language are perfect and they are very professional."
Interviewee # 3

Communication is the variable that plays a significant role not only during the process of the treatment, but it is often the aspect that creates the first impression over a particular medical organization. The Belgian company (introduced by the Interview nr.7) had no tangible office, which means that the issue of generating trust was based on communication alone. The direct contact with patients (through phone calls & emails) must be received by the patient positively in order to continue the process in a trustworthy atmosphere (App. 9). Based on this example, we can follow the discussion initiated in the theory part on whether office visits are necessary to create a trustworthy relationship with the patient. Since the Belgian company remained successful for many years, we can conclude that office visits are not necessary for generating trust. This challenge can be solved by effective communication. It is therefore not only about the content of the message sent to the patients, but it is mostly about the quality and the way of communication.

"I was really surprised about the way they communicated with me. I could not believe it existed, because I was used to the way of communication here in Holland. It was better quality. They really made contact with me and I felt connected. Not alone the doctors, but also the nurses."
Interviewee # 6

Additionally, the possibility of having direct contact with previous patients with the same or similar problem, their recommendation, and their personal story often increased the amount of trust for the particular surgery (p.61).

FAMILY & FRIENDS RECOMMENDATION

Support of family and friends in the process of deciding on going abroad for a medical treatment plays an important role. The acceptance from their closest environment gives the participants courage and strengthens their will to take part in medical tourism. All of our interviewees were either recommended to go abroad for a treatment or supported in the idea by their closest surroundings. One of our interviewee mentions that being away from home, family, and friends de-motivates her from participating in medical tourism. It is the lack of support and fear of being lonely abroad in a foreign culture without anybody to share the experience with that makes it so difficult to many patients.

"I mean if it is not really urgent, you can wait and you can find out a doctor in your country. And why go abroad and be without your family, alone all around...?" *Interviewee # 2*

The above quotation supports the idea of distrust being associated with fear (Ch.5). There is a clear indication that fear is the base for all generators of distrust in medical tourism. When discussing family and friends, it is the fear of lack of acceptance as well as a fear of 'losing' them for the period of the treatment.

> *"The only negative thing for me was that my husband could not meet me... I saw him 2 or 3 times because it was very far [...]"* *Interviewee # 6*

On the other side, family and friends are often the ones to recommend the treatment abroad and it is word-of-mouth that motivates others to decide to have a treatment in another country (p.61). Three out of four interviewees were recommended to go abroad by their relatives or friends. Based on the results of our interviews as well as on the model of decision components in medical tourism (p. 50), we conclude that the family and friends recommendation is the best way of 'advertising' the idea of traveling abroad for a medical treatment. A story of a successful experience increases the trust towards medical tourism and towards doctors and medical providers in another country.

> *"I got the information from my friend, who knew some people from Poland. Otherwise I don't think that I would come to Poland for teeth I think, because if you don't know somebody, it is rather difficult to go to Poland and then go somewhere to do something with your teeth."*
> *Interviewee # 5*

DOCTORS' ATTITUDE

Many sources mention that medical treatment abroad is an emotional experience (e.g. Solomon, 2011). As discussed earlier, the level of emotions depends on the seriousness and type of the undergone operation. The interview with the former employee of a Belgian company which provided medical services abroad indicates that each patient needs a personal approach, since it is very difficult to judge how intimate the surgery is for a specific individual. Therefore, the doctor's attitude and empathy can become a central matter of the arrangement. When discussing (with our interviewees) the characteristics that make doctors trustworthy, most of our respondents mention: listening to the patient, explaining the process, being open, creating a personal relation, having a friendly approach, possibility to contact the doctor after the operation, general interest and concern about the patient, human attitude, honesty, professional approach, and helping to decide on possible choices.

On the opposite side, among features that make a doctor untrustworthy are listed: insecurity of the doctor, 'robotic behavior', acting and doing things too quick, bad reputation, lack of concentration on the patient (e.g. writing things on his/ her computer during appointments), dishonesty.

Interviewee nr.4 mentions that a good and trustworthy doctor focuses not only on the physical sickness of a patient, but also on the mental well-being which makes the experience much more human and better for the patient. The attitude of a doctor or a medical company is very much integrated with the communication part. However, as emphasized by the former employee of the Belgian company, in order to create a trustworthy relationship with the patient, the attitude must be professional and honest.

Question: What in your opinion is important for creating a trustworthy relationship?

"Between the patient and the doctor, I think professionalism with a big slice of humanity [...]. If the patient feels right with the doctor, asks questions and doesn't feel stupid about it – especially with obesity surgeries it is really sensitive [...]. So it is really important if they feel comfortable with him or her in that sort of way. Because you have to trust this person when you are under anesthesia, you are really putting a lot into somebody's hands with that kind of surgery. And you are choosing to do it. Between the customer and the medical company, I think you just have to be as honest as possible, what people appreciate with me sometimes and I am not so sure if it helped my sales pitch, but I was always extremely honest with what could happen. If one patient came back and said: I've had these symptoms ever since and it is causing problems – and it did happen once in a while that the surgery would go wrong, I would mention it to other people who were asking, because their number one question was: what is the worst that could happen? What problems could happen? I would say that a previous patient had certain complications (like trouble with eating rice), so you have to understand that this can happen to you as well. And I think that was important. It helped the sales that I did get, but maybe it drove some sales off as well."

Interviewee # 7

Trust is an intangible aspect, which in relation to medical tourism becomes very fragile and easy to be damaged. Therefore, the attitude of a doctor plays a significant role in constructing and shaping this trust. An approach filled with the positive characteristics mentioned above, increases the level of trust, whereas attitude filled with negative characteristics increases the level of distrust towards a doctor and the idea of traveling abroad for a medical treatment. Additionally, trust towards a doctor is built up during the process of healing, therefore good diagnosis is also mentioned by our interviewees as an important aspect which increases the reliability and therefore strengthens the belief that it is a trustworthy doctor.

ANALYSIS OF DECISION-MAKING PROCESS IN RELATION TO MEDICAL TOURISM

In this section of analysis, we discuss the aspects that influence a patient's perception on medical tourism as well as the final choice whether to obtain a medical treatment abroad or in a home country. The analysis is based on the theoretical part, especially on the model of the decision-making process as well as on the conducted interviews.

A decision-making process is a deeply individual process influenced by many internal as well as external features. In today's world people are bombarded by enormous amounts of external stimulus from different directions (media, family, friends, billboards, etc.), therefore it is often very difficult to make independent decisions based on internal feelings.

The model used in the theory part (p.40) divides the variables that influence the decision-making process into three sections: socio-psychological process, personal variables, and environmental variables. The socio-psychological process consists of perception, learning, and attitude. In relation to medical tourism, perception is an internal way of seeing all the aspects connected to the idea of traveling abroad for a medical treatment.

> *"I think it is good [to travel abroad for a medical treatment]. It is not just home the good country, I don't think so. Of course other countries have good doctors, I really think so – in Germany and France, in England, in Africa, in Indonesia, I really think so."* *Interviewee # 6*

> *"I don't go to South America or South Africa or that kind of countries, because I believe that it is not very healthy there, but for Europe, Western Europe- all the countries I think and for Eastern Europe- the places that somebody else recommends."* *Interviewee # 5*

Influencing someone's perception on medical tourism is a difficult and rather long process because perception is connected to a person's prime beliefs. Changing someone's perception is therefore largely connected with gaining the other person's trust and proving that the new concept is more valuable to the patient.

The process of learning is another part that influences the socio-psychological variable of decision-making. Learning gives the patients the opportunity to gather more information about the medical destination and therefore creates an image of the place as well as of the concept of medical tourism. However, it is important that a medical patient (or a potential patient) is willing to learn about new things.

"And I'm trying to travel less as a tourist – although obviously I am one – but I am trying to travel in a way where I am learning understandings." *Interviewee # 4*

In connection to learning, we analyze attitude, because we see it as a correlated variable. A person's attitude influences the process of learning. If a person is open-minded and willing to see and understand how things work in different parts of the world, then the learning process is much easier to absorb. Furthermore, if someone is willing to learn, he or she is prepared to change and explore his/ her attitude. All of our interviewees have a very open attitude towards traveling and meeting new cultures, however when it comes to medical area, the attitudes are more cautious.

"I have seen hospitals also in Poland and that experience was not so positive, but for teeth I think it is no problem, but for [surgery] - because all the tools are rather old, it looks rather old, and then it's a negative side on the health care. It isn't said that the [medical] care is not good, but you see that they tools that they are working with are rather old. But the end effect is the same as in Holland. It doesn't care [matter] what they work with only it looks a little bit modern, but it won't say that the other tools don't work."

Interview # 5

The above interviewee declares that he learned about hospitals in Poland and the image he got was rather negative. However with his open attitude to experience, he still decided on having his teeth treated in Poland. When it comes to more serious treatments in a hospital, he is more cautious, but still does not question the ability of Polish doctors.

The second subdivision is called personal variables and it contains motivation, personality and self-concept, lifestyle, and emotions. These variables represent individual features of a person, and therefore they can be influenced by the external elements much easier than e.g. perception.

"If it gets too expensive to fly there or if I lose my job and I won't have money, so I would have to go here. Even if the operation is cheaper down there, the whole trip is not." *Interviewee # 1*

"[...] because some people booked the surgery and then said no, no, no, I don't trust anything. And then we would cancel. One guy didn't even show up even though he paid for everything himself, on the day he decided not to. Or sometimes they got there and they decided not to (participate)."

Interviewee # 7

The above quotations indicate that personal variables such as lack of money, job loss, increase in costs, or even 'last minute' emotional breakdown stops a person from going abroad for a medical treatment. Therefore, the decision process is based here on individual features which seem to be very fragile and susceptible to internal (emotions) as well as external (motivations such as costs) changes. This is very much linked to developing trust. During this part of the decision-making process, patients can be approached and lured by the medical companies from abroad that offer good quality for great price.

The last group of variables is called environmental variables and it is composed of social and cultural influences, interpersonal variables, and situational variables. In relation to medical tourism, those variables are connected with communication and family and friends recommendation. As discussed before (p.71) communication is a base for human interactions and for building trust. From the supplier side (medical organization), it is important to discover how a tourist thinks and behaves through a close interpersonal relationship.

> *"[To build trust] was a really hard part of the job actually, because we were approaching people through phone calls, emails, websites – there was no personal contact, there was no office that they could come to, and if things were to go wrong, that was their question – what if something will go wrong when I am back to England? And we had to answer that in a way to make people feel comfortable. And a lot of people kind of said: how do I know that you won't just take my money and run? So we had to explain that they could talk to the doctor and we also did patient referral – we had a list of people who had the same surgery and they agreed to be phone contact, and that worked really well, because some of the women would actually go and meet the other women and show them how they look now (it was the obesity surgery), explain the difficulty of going through it, so that was the biggest way we got people to trust."*
>
> *Interviewee # 7*

The example above shows that building trust in medical tourism is a long and a difficult process. People tend to be suspicious and they expect tangible proof of reliability of a medical company abroad. This suspicious is a consequence of how personal and at the same time unknown the whole concept of traveling abroad for a medical treatment can be (especially if it is done for the first time). The clearer the verification of a company (the more tangible proofs), the easier it is to convince potential medical tourists to trust that company. The recommendation of family and friends plays a significant role in the decision-making (p.72) and here we link it with the cultural influence. As all humans are brought up and raised in different cultural and social surroundings, those who are a part of our life influence our choices.

> *"My friend, my husband – he supported me, because he knew my problem and he knew about my pain, so he supported me. He also was very, very surprised that the treatment could start that quickly. My family reacted as well. They said: go."* *Interviewee # 6*

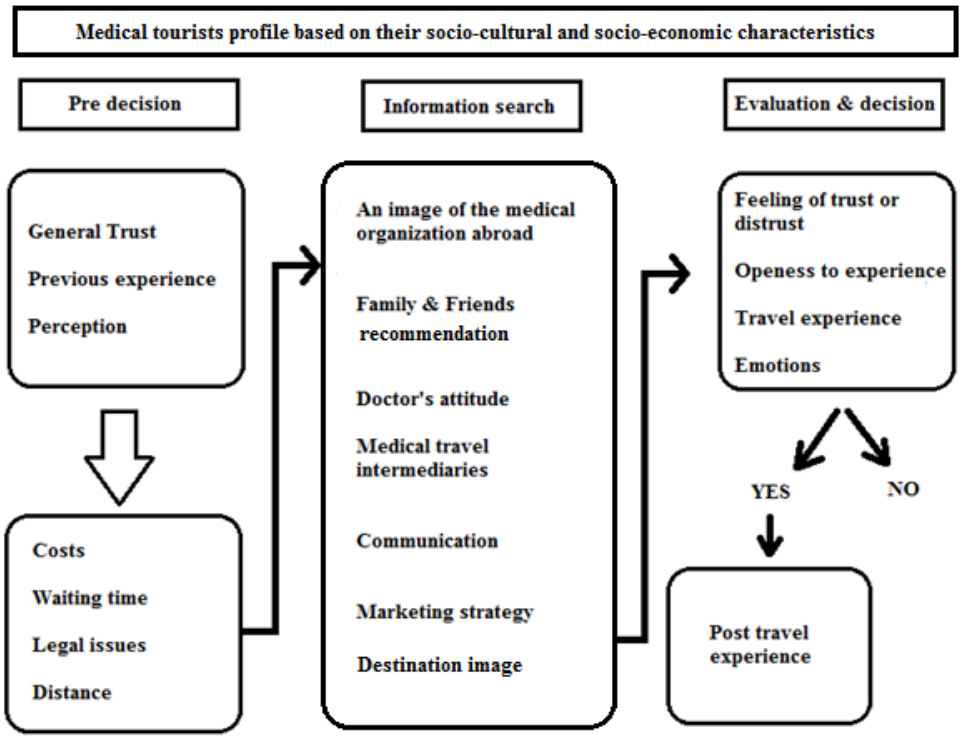
Therefore, we conclude that choosing to participate in a medical treatment abroad is never a fully independent decision, because due to its serious output it feels much safer to the patients to communicate about the idea with others. All the presented variables are included in the decision-making process in medical tourism, but we also recognize that they often initiate a process itself (e.g. worth of mouth). The first idea of traveling abroad for any kind of treatment arises from certain stimuli, which are partly included in this paper.

Based on the conducted interviews and the theory chapter, we agree with Decrop (1999), who argues that there is no universal process of decision-making, but the process is rather dependent on

individuals and arising circumstances. Especially when discussing medical tourism, where emotions and issues connected to trust and distrust play such a significant role. Therefore in this paper, we discuss mostly the personal aspects of decision-making. However, we base them on the general elements of generating trust and distrust in medical tourism (Model 10, p.47).

DECISION-MAKING PROCESS IN MEDICAL TOURISM

As stated above, the decision-making process is rather complicated and it is often influenced by other people through their advice, feedback and comments. When it comes to the decision-making process in medical tourism, it is a very complicated emotional process. Therefore, it is difficult to generalize the process even on our small sample. However, with the help of the theoretical model by Altin et al. (2011; Model11, p.50), we created our own model of the decision-making process in medical tourism:



Model 14 Decision-making process in medical tourism (own creation, based on Altin et al., 2011:8)

This model combines the medical tourist's decision-making process with decisive aspects of medical tourism. It is based on our theoretical research as well as on our sample group and it presents the progression of an idea to travel abroad for a medical treatment. This creation is improved by an implementation of all important aspects (based on our findings) that a potential medical tourist comes across during the decision-making process.

The above model divides the decision-making process into three main parts: pre decision, information search, and evaluation & decision. The first part shows the variables, which are responsible for creating the idea of traveling abroad for a medical treatment. Furthermore, practical motivators are taken into account. Those features may differ from one person to another (e.g. perceptions of distance - some people from Holland see Germany as a distant destination, whereas others see it as being attractively close). In the pre-decision phase, the potential patient starts to notice and consider potential benefits of medical tourism. If the benefits seem interesting, or valuable enough, he or she goes to another phase, namely information search. This phase consists of a more active approach, where the patient may look for information online, may talk to family members and friends who had participated in medical tourism themselves, or question his/her perception on a destination image based on new information gathered (Which medical destination is interesting? What do people say about it? What does the procedure look like?). At this stage, he or she contacts the medical organization or the doctor in order to gather more information about the process. Therefore, at this point communication and marketing strategy play an important role in either encouraging or discouraging the patient about his/ her decision. The last stage of the process depends on personal beliefs based on two previous stages. We argue that trust is here the main generator for the final decision. Lack of trust may radically decrease the chances of participating in a medical treatment abroad. Besides trust and distrust, variables such as openness, travel experience, and emotions shape the person's knowledge and the final choice is made. After participating in a medical treatment abroad, closing evaluation is made in a person's mind (Was the experience positive or negative? Did I feel comfortable? Can I trust this doctor again?) and post travel feelings are taken into account. The possible output is that a patient will continue participating in medical tourism (and spread a positive word about it) or will never want to do it again.

The model can be further improved by an additional analysis (e.g. quantitative research) on the individual sections of the model (pre-decision, information search, and evaluation and decision) as well as on the further analysis of negative output. By negative output, we mean the 'no' response in the final part of the process, which may be further investigated in order to explain how those aspects could be changed or improved upon in order to positively approach the future potential medical tourists.

CONCLUSION

The aim of this thesis lies in exploring and understanding the generators of trust, respectively distrust towards the idea of engaging in a medical intervention at a foreign country. As it is found, medical tourism is a growing phenomenon, which lacks deep academic research, especially within the area of trust and lack of trust in the decision-making processes of a medical traveler. When deciding on a medical surgery in a foreign country, the issue of trust and distrust is essential as medical treatment abroad requires full confidence in the respective doctor as well as the medical system of a chosen country. Hereby, this study was conducted in order to contribute and draw attention to this important interdisciplinary subject area.

This paper is made up of five chapters. In the introduction, we present the subject of medical tourism and its significance for the research. We discuss various economic, social, technological and demographic aspects in order to understand the complex nature of the growing medical tourism. Furthermore, we talk about medical tourism in relation to niche tourism and its distinction from other existing categories (e.g. health tourism or wellness tourism). Trust and distrust is then discussed as important socio-cultural variables that influence choices of medical tourists. Finally, a research question is presented, which is followed by six hypotheses that specify the research area. In the methodology chapter, we present the terminologies as well as our approach towards the research subject. Moreover, the sample group used for this project is introduced and the Dutch and Danish travel markets are described in relation to medical tourism. In the theory part, we present existing theories and models linked to medical tourism, trust and distrust as well as to the decision-making process, which we critically discuss in relation to our topic. Based on the models, the theories and our empirical data, we created our own figures, which are then used in the analysis part to present the results of our research. In this last chapter, we summarize the findings that were examined and analyzed in the previous chapters according to the purposed hypotheses and thus answer our problem formulation.

In this paper, medical tourism is defined as an intentional choice for an elective medical treatment in a foreign country in order to obtain beneficial outcome in forms of economic, health or personal advantages. Our empirical data indicate that medical tourism, despite of being worldwide practiced, is seen as a rather negative or neutral concept due to its cost-oriented nature. Attention is also drawn to the fact that by using foreign health care, the process of maintaining the Danish welfare system (high taxes, free universal health care access) is at risk, which discourages potential traveler to participate in a medical treatment abroad. On the other hand, cost saving, avoiding long waiting list and better quality care (including professionalism and the general attitude of doctors and assistance towards the patients) are listed as main motives of participating in medical tourism, both by our interviewees as well as by academic literature. However, it is also found that quality care itself is not able to attract contemporary medical tourists to another destination if the costs are high (note the definition used in this thesis). These two reasons seem to overlap and target medical tourists as being motivated by high quality health care at low (or at least the same level of) price. Moving on, discussions on purposed hypotheses are presented in order to understand the impact and role of trust, respectively distrust in medical tourism and conclude the generators of these notions towards the idea of traveling for a medical intervention to a foreign country.

***H1**: Trust and distrust play a significant role in the decision-making process of medical treatment abroad.*

Trust and distrust are natural internal feelings of humans that drive their behavior, choices and actions. Health is seen as the most important gift in human life, makes the concept even more important within the area of medicine. The significant role of trust and distrust, therefore, originates from a general human attitude towards doctors or any medical authority, which humans seek in order to help them staying healthy. This leads to the presumption that trusting a doctor or hospital in a foreign country requires, so to say, placing of double trust: once towards the destination and its culture, secondly placing trust in doctors at that foreign place. All of our interviewee agree and state that without trust they cannot imagine having a surgery or any kind of medical procedure abroad. However, the significance of these concepts may be on an unconscious level, but questioning about trust makes people think about their unconscious acts. As a result, we also adjusted a model by Altin et al. (2011) in order to emphasize and show the significance of these concepts in decision-making processes of medical tourists. We conclude that after the stages named pre-decision and information search, a medical traveler evaluates the gathered information and his/her existing knowledge on the topic based on his or her feeling of trust/distrust (even if this action is unconscious). When the information is perceived as trustworthy, the medical traveler is more likely to obtain a medical treatment abroad, whereas unreliable information will cause no interest in medical tourism (e.g. news about an unsuccessful operation, negative opinions of a clinic, etc.). In the following, we discuss the different aspects that generate trust or lack of trust towards a medical intervention abroad.

***H2:** The opinions and recommendations of family and friends influence the amount of trust and distrust generated towards the idea of medical tourism.*

Our findings suggest that family and friends are central influencers in decision-making and key generators of trust or distrust. Acquaintances or relatives are decision-influencers (App.3&5), who act as trustworthy pulling factors for a treatment abroad by providing their recommendations. Based on our interviews, these are mostly familiar faces from the destination of the treatment (e.g. the Thai girlfriend or a Polish friend). Further on, we conclude that medical tourists seem to value and search for trustworthy references from personally known as well as unknown individuals, who have experiences with the desired treatment.

Moreover, family members seem to behave as supporting columns in the decision-making process. This positive and encouraging attitude comforts the medical traveler in his/her decision (e.g. husband of the Dutch knee surgery patient).

H3: *Previous medical experiences influence the amount of trust and distrust towards the idea of traveling abroad for a medical treatment.*

Previous medical experiences are the base of the attitude towards medicals in general. Incidents from the past influence the choices of the future. Especially when it comes to fragile aspects of trust and distrust in relation to the emotional choices of going abroad for a medical treatment, medical background plays a significant role. Therefore, we conclude that negative experience with doctors or hospitals in a home country can become a motivator for seeking alternative possibilities abroad (as in the case of Interviewee nr.3). If the relation with medicals from abroad is positive and additionally another aspects support the positive image (e.g. lower costs, better quality, more personal approach), the patient is very likely to develop the idea of returning abroad for medical purposes. This also means that the trust level towards medical practitioners from abroad is higher than towards the doctors from the country of origin. If the previous medical experience is rather positive, then this variable does not play a significant role in the decision-making process, however, external factors such as costs, waiting time and legal issue may influence patients' choice. Consequently, a first positive medical treatment abroad (e.g. Interviewee nr.6) generates trust towards the idea of participating in medical tourism and may lead to deciding on further health-related interventions.

H4: *The fear concerning communication difficulties in a foreign country may cause lack of trust towards the idea of medical tourism.*

Communication is an essential variable in medical tourism because this is how a potential customer gains required information of trustworthy character. Consequently, it is not only about the content, but the affectivity and the way of communication, which should be comforting and reliable in order to persuade and convince patients sitting at another destination. It is due to having direct contact with medicals at a medical tourism destination in forms of mails, phone calls, till the participation actually occur. Therefore, a consumer is to place trust in advance to an inexperienced and unknown activity at a non-residential country. Communication difficulties are then also evaluated while obtaining a medical treatment. The way nurses, medical assistance and doctors communicate and treat the medical traveler adds to the overall experience and often to the quality of the medical care. Positive evaluation of such communication may terminate in return visits (e.g. Interviewee nr.1) or positively influence a future consideration of a medical treatment abroad (Interviewee nr.6). However, if a communication is discouraging or not convincing, either from the beginning or during the treatment process, negative word-of-month is likely to spread and the (future) participation is threatened.

Communication variables also involve linguistic concerns. For instance, a potential medical traveler stated that the Russian alphabet and the insecurity of the language would prevent him from engaging in a Russian medical procedure. This ensures the importance of mutual understanding (often in form of common language) between medical persons and the consumers that gives the patient the feeling of safety and trust.

H5: *People with previous travel experience are more likely to decide on having a medical treatment abroad.*

The interviews conducted with the four experienced medical travelers show that these participants have previous travel experiences, which broadened their horizon and openness towards experiencing new and often different cultures. Despite the literature (Karuppan & Karuppan, 2011) and the experiences of the former employee (App.9) that outline the fact that not all medical tourists have a previous travel experience before choosing to obtain a medical treatment abroad, we propose that previous travel experiences increase and positively influence the likelihood of engaging in a medical procedure abroad. It is due to the familiar process of traveling, which ensures the participants that they can rely on the tourism settings of medical tourism and 'only' face the unfamiliar medical experience in a foreign country. However, a deeper research within this field is needed to support the conclusion and ensure that medical tourists without travel experience are not urged to undertake a treatment abroad (as this falls out of our definition).

Furthermore, it is found out that the familiarity with a destination (due to previously undertaken trips) increases the level of trust towards that destination, and thus is more likely to be considered as an alternative to obtain cost benefits, higher quality care or shorter waiting period.

H6: *Destination is secondary to treatment and hospital/doctor reputation.*

As medical tourism is a concept that combines industries of tourism and medicine, the question of to what extent the tourism part plays a role in medical travel was also examined. The theoretical data claim that destinations have a secondary role in deciding where to obtain a medical treatment, as it is the treatment that pulls medical tourists to a destination. This was observed during the interviews with the Dutch medical tourists (i.e. Poland was chosen due to the cost saving opportunity of a dental treatment, and Germany due to the available knee surgery treatment). On the other hand, our empirical data also reveal that destination attractiveness and image impacts the decision-making processes of medical tourists. Negative images of African countries or Ukraine were mentioned as discouraging and untrustworthy, whereas destination Thailand was chosen first and then was followed by the utilization of dental treatments while at a

destination. However, in the Danish cases, familiarity with the destination also plays a trust-generating role. Besides familiarity, the reputation of a doctor or hospital is valued (e.g. in case of laser eye surgery by Interviewee nr.3). Doctors' reputation is seen as one of the primary generators of trust, which is important in marketing due to providing a competitive advantage for a destination. Destination characteristics itself are not able to pull medical tourists to a destination, yet familiarity or reputation may provide a positive or negative influence when choosing from destination alternatives (e.g. dental care can be obtained in Hungary or in Thailand). Moreover, distance of a certain destination is also mentioned by individuals who have a close relationship with their family or friends and have a need to be close to them once abroad for a medical treatment. This means the destination attractiveness may also depend on the distance of a medical tourism destination.

To sum up, the problem question of *'What generates trust and lack of trust towards the idea of medical treatments abroad?'* cannot be answered straightforwardly, but this study is believed to have contributed to a better understanding of some of the generators that influence the decision-making process of medical travelers. Being a complex research area, generators of trust and distrust are found in forms of previous medical and travel experiences, familiarity with a medical destination, impact of a destination image, family & friends recommendations or trustworthy references, reputation of a doctor/hospital, good communication and mutual language, and lastly, but not at least, general trust of an individual, who seek a medical treatment abroad. Our model on main generators of trust and distrust in relation to medical tourism (p.65) involves and illustrates these aspects and is believed to contribute to the academic knowledge within this interdisciplinary subject.

The conducted research on trust and distrust in medical tourism involves a significant impact from the studies on tourism, medicine and psychology. Therefore, we recognize an opportunity to develop and explore this subject not only from the tourist perspective, but also from the medical and psychological viewpoint. The phenomenon of medical tourism is growing every year and therefore more scientific research is needed in this area of study. Our thesis confirms an undeniable importance of the issue of trust and distrust in relation to medical tourism; either it is being a conscious or unconscious state of mind. Therefore, in the last part of our paper, we suggest a few important and unexplored areas of research within the subject of medical tourism for further investigation.

In order to develop the research on trust and distrust in medical tourism, it is vital to provide deeper qualitative data on this subject. By broader qualitative studies, a more general image of trust and distrust in medical tourism could be obtained and our findings and models could be supported. For a better understanding of intrinsic and extrinsic stimuli of going abroad for a medical tourism, it is important to study also other variables than trust and distrust (e.g. demographic characteristics of medical travelers). We have been triggered by the comment of a student of medicine (App.10), who suggested that it is more common for lower educated people to participate in a medical treatment abroad. Since our thesis is not oriented towards searching for common demographic, socio-cultural or socio-economic characteristics, we did not analyze the interviews from that point of view. However, it seems as an interesting subject for future research on medical tourism. How do demographic, socio-cultural and socio-economic aspects influence the choice of going abroad for a medical treatment? What are the common characteristics of medical tourists, if there are any? How does education level influence the decision-making process?

Moreover, the findings of our thesis indicate that choosing to participate in a medical treatment abroad is never a fully independent decision. This is due to its serious output, which often makes patients more doubtful and requires some communication about the idea with others. Therefore, for further investigation we suggest to research the degree of dependence between a medical tourist and the people whom surround them. To what extent are patients' decisions autonomous? What kind of influence does a family and friends have on a medical patient? And finally, what is the role of intuition in decision-making process in relation to medical tourism?

Furthermore, we find medical tourism a very gentle and emotional subject, where many ethical questions come to mind. These moral issues apply to different aspects of medical tourism: from more obvious, such as transplantation tourism or suicide tourism, to less controversial, e.g. reproductive tourism. However, we are aware that due to its very personal and taboo-ish character, it would be very difficult to find suitable respondents who will be willing to participate regarding the above issues. Another ethical matter was introduced to us during our research, when some respondents questioned the whole medical system of a country, where the surgeries are performed. In today's world, it is often recognized that the rich, Western societies travel to the Eastern, less developed societies to obtain a medical treatment, due to costs, quality and shorter waiting time. It is then ethically questionable, whether going overseas for a medical tourism is morally fair? Is it all right to use the luxurious, private hospitals in e.g. India when the poor group of Indian society has almost no access to medical support? Is it ethically correct to expect the first class quality in the

third world countries? We are aware that the answers to those questions are never black or white and there will be as many arguments to support some of the ideas as to contradict them. However, an academic research always creates a more valid and complex image on the subject, which leads to a better understanding and as a consequence enriches person's perception on the research area.

Finally, we suggest researching marketing of medical tourism, since it seems to be an unexplored area of study. Medical tourism is recognized as a developing phenomenon all over the world. Therefore, the marketing strategy for this group of tourists should be thoroughly investigated. Since this form of tourism is related to individual emotions and personal feelings, it should be approached from a certain perspective. In our paper, we discuss relationship marketing as one of the possible ways of promoting medical treatment abroad. However, there are many other approaches that should be studied and discussed in relation to enrich this area of study.

We believe that this thesis will contribute to the academic research on medical tourism and that the ideas for further investigation will inspire some students or academics for additional explorative research on this interesting subject. We hope that through this thesis we have created additional insights to the study area of trust and distrust during the decision-making process when choosing a medical treatment in a foreign country.

- THE END -

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