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## Motives for Different Types of Medical Travelers: An Analysis of the Current State of Academic Research on the Topic

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MOTIVES FOR DIFFERENT TYPES OF MEDICAL TRAVELERS: AN ANALYSIS OF THE  
CURRENT STATE OF ACADEMIC RESEARCH ON THE TOPIC

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## ABSTRACT

### **Motives for different types of medical travelers: An analysis of the current state of academic research on the topic.**

By  
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The purpose of this research is to determine the current state of research undertaken to provide insight into the motivational characteristics of medical travelers, as reported by scholarly publications in the last five years. As a part of the study, an exploration is undertaken of the four basic schools of psychological thought, as each have different explanations for human motivation. These four schools – psychodynamic, behavioral, humanistic, and cognitive or pragmatic – are examined in the light of six categories of medical travelers. The categories are those traveling for life-saving surgeries, for treatments to improve quality of life, for elective procedures, as well as those seeking diagnostic assessment, alternative (non-Western) medical treatments, or those with a primary goal of improving wellness.

Study results showed applicability of the psychodynamic, behavioral and humanistic theories to the medical traveler, and demonstrated different motivational drivers for each of the six categories of travelers. However, the conclusions are based upon the assertions of academic authors, for it was discovered a dearth of research exists examining the medical traveler's motives. Therefore, results from this study are useful primarily to guide such research in the future, with the intention of discovering whether the assertions that have been made are accurate. Areas of minimal consideration are also identified as these too carry the assumption of non-applicability which needs to be proven or disproven.

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## CHAPTER 1

### INTRODUCTION

In 2002, Dr. Mary Maples of the University of Nevada, Reno, coined the term “silver tsunami” to describe the impending retirement of the baby boomer generation (Maples, 2007). This extended longevity holds ramifications for many areas of society, not the least of which is healthcare.

Although the arrival of this aging generation is a predictable phenomenon, it is difficult to judge its ultimate impact in advance. Between 2010 and 2030, the number of people on Medicare will increase from 46 million to 78 million. There is no reason to believe the current ratio of one quarter of Medicare recipients who suffer from serious health problems will change as Medicare enrollment grows (Kaiser Family Foundation, 2007). Adding to the anticipated strain on the US healthcare system from a growing population of seniors are rapidly rising costs for medical procedures for all in the United States and a steadily decreasing level of health insurance coverage (Kaiser Family Foundation, 2007).

Between 2000 and 2008, health insurance premiums grew three times as fast as wage increases, increasing 119% (Rowland, Hoffman, & McGinn-Shapiro, 2009). The global recession of 2008-2009 resulted in over half the working-age adults reporting that they have postponed, cut back, or skipped needed healthcare (Rowland et al., 2009). In 2004, the last reported year, 45 million non-elderly Americans suffered significant financial burdens (defined as more than 10% of their family’s income) because of healthcare costs. By 2009, 40% of low income wage earners, and 24% of middle income

workers reported that they have difficulty in paying their medical bills (Rowland et al., 2009).

While not all medical conditions require hospitalization, for those which do, the average hospital stay in the U.S. costs \$31,100 (Andrews, 2007), and major medical procedures such as heart valve replacement or organ transplants routinely top \$200,000 to \$500,000 (Grace, 2007; Forbes, 2007). These costs are on the rise, at the same time that the number of uninsured Americans continues to grow to past 47 million (Bacon, 2007). If one counts those who were without medical insurance for some part of a year, the number of uninsured grows by another 95 million (Gahlinger, 2008). Those without dental insurance surpass 120 million (Tatko-Peterson, 2006). In 2002, the per capita spending on healthcare costs averaged \$6,037, the highest in the world, and nearly double the average of most European countries (Organisation for Economic Cooperation and Development, 2007).

Cost and insurance coverage are not the only factors that intensify the effects of both the “silver tsunami” and the challenge to healthcare. Since the 1980’s, medical schools in the United States have been capping enrollment, thus resulting in a manmade shortage of physicians which the U.S. Department of Health and Human Service’s Health Resources and Services Administration predicts will continue to grow to between 55,000 and 191,000 by 2020 (Hidalgo, 2008). Even if costs were controlled and insurance coverage expanded, the accessibility of care will be delayed by availability of physicians and facilities.

As expenses soar, coverage drops, and caregiver numbers shrink in relation to the size of the population size. At the same time, this is the first generation to reach an older

age having lived its collective life under the expanded health expectations introduced by the World Health Organization in 1948 with the broad definition of health as “complete physical, mental, and social well-being” (Nahrstedt, 2004). Such a definition has influenced “physical, social, psychological, emotional, spiritual and environmental” approaches to wellness (Edlin & Golanty, 1988) as the simple “absence of disease or infirmity” (Anderson, 1987) is no longer viewed as sufficient. Expectations increasingly revolve around holistic care and maintenance of good health (Douglas, 2001); these expectations further tax the healthcare system.

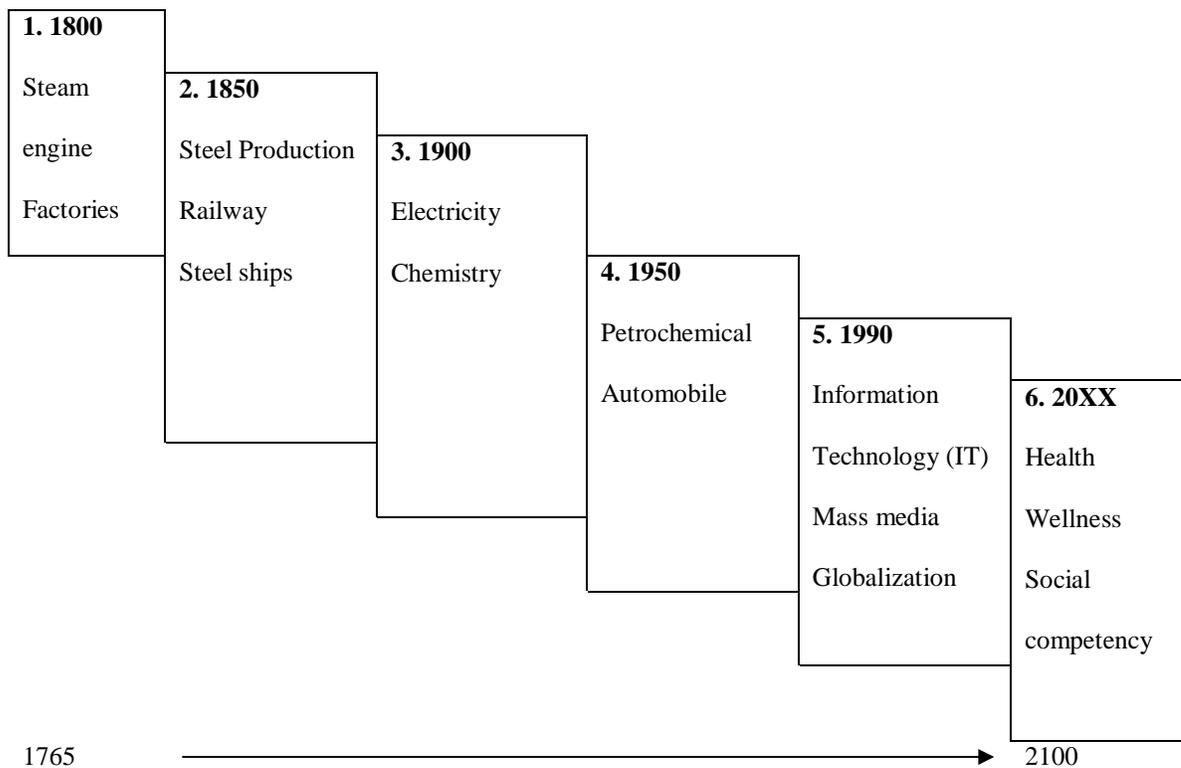


Figure 1: “Kondratieff cycles” are long-wave economic foci identifying primary driving forces which have or will dominate the world economy.

Nahrstedt, W. (2004). Wellness: A new perspective for leisure centers, health tourism, and spas in Europe on the global health market. In K. Weiermair & C. Mathies (Eds.), *The tourism and leisure industry: Shaping the future* (pp. 181-198). Binghamton, NY: Haworth Hospitality.

Indeed, healthcare is identified in the economic model of long wave influences as being a dominant factor for the foreseeable future, and medical tourism is an extension of the most recent dominant factors of globalization and growth of the field of information technology (Nahrstedt, 2004).

Together, these factors portend a tidal wave on its way of change in how Americans choose or seek medical treatment and health maintenance. As the allegorical flood waters start to trickle under the doorways of some aging or under-insured citizens, one response that is growing exponentially on an annual basis is that of “medical tourism” (Demicco & Cetron, 2006).

### **Definition of “Medical Tourism”**

Through use of the term in popular media, “medical tourism” has become a catch-all phrase describing the act of traveling to foreign countries for medical or dental procedures, at times combined with vacationing, touring or exploring the attractions of the destination country (George & Henthorne, 2009). Depending upon the source, spa and wellness services form a part of medical tourism (Erfurt-Cooper & Cooper, 2009). Henderson (2004) attempts to provide an umbrella phrase, “healthcare tourism,” to incorporate medical tourism, cosmetic surgery, and spas and alternative therapies (p. 113).

Health tourism, wellness tourism, curative tourism, medical tourism – all are used by different authors. As early as 1990, Bywater wrote, “Opinion is mixed on whether this sector represents medicine or tourism, and whether and to what extent the two can meet...” (p. 52).

Hall (1992) classified health tourism as any activity, away from home, which has health as the key motivator. This could include simply engaging in healthy activities, such as hiking or golf, sports tourism, or adventure travel. Alternatively, Kaspar (1996) defined health tourism as:

The sum of all the relationships and phenomena resulting from a change of location and residence by people in order to promote, stabilize, and, as appropriate, restore physical, mental and social well-being while using health services and for whom the place where they are staying is neither their principle nor permanent place of residence or work. (As translated by Mueller & Kaufman, 2001, 7)

This sweeping definition, which includes as a goal to “restore physical...well-being while using health services,” seems to include travel for surgical interventions along with activities included by Hall. German, Austrian and Swiss academics have utilized distinctions between health and wellness tourism (Smith & Puczko, 2009). Mueller and Kaufmann (2000) suggested wellness tourism was a subset of health tourism, and curative tourism is a subset of wellness tourism. Deutscher Wellness Verband (2008) advanced the terminology of medical wellness, while in several Asian

countries the concept of medical interventions often include spiritual aspects not generally a part of the western medical culture (Smith & Puczko, 2009).

Terminology is further confused where curative treatments are traditionally associated with spas, such as in France and Germany at which physicians and medical treatments may be a part of the service offerings (Cohen & Bodeker, 2009) and are covered by national health insurance plans (Bookman & Bookman, 2007). A partial furthering of this concept is growing in the United States through “medical spas,” or “wellness spas,” the fastest growing of all spa classifications (Beil, 2006; International Spa Association, 2004; Johanson, 2004; Mayes, 2004).

Adding to the jumble of terms, expatriates living in a foreign country may have their routine medical visits counted in the column of “medical tourists.” Additionally, the medical community has used the term “medical hotels” since at least 2000 (Leibrock, 2000), and hospitals have been adopting hospitality concepts, architecture and terminology (Carlson, Frieder, Hanley, Cama, & Kuehl, 1994). Another body of literature addresses health concerns as a part of travel, including travel medicine, the unplanned hospitalization of tourists, or the protection of travelers from disease (Page, 2009). All of these terms are mentioned from time to time in popular publications as “medical travel.”

The lengthy explanation of the current evolving state of terminology is to emphasize that this is an unsettled term, so definitional clarity is particularly important in this study. For purposes of this study, medical tourism is defined as individuals intentionally traveling to other countries, or other regions of their own country, in order to receive medical procedures or health treatments (Bookman & Bookman, 2007; Goodrich & Goodrich, 1987; Hudson & Li, 2012). It is worthy of note that while travel

within one's own country for treatments is being included in this study as medical tourism, very little of the current literature includes such travel. Since this is projected to be a growing area for medical travel (Hudson & Li, 2012) while the literature addressing it is sparse, what does exist on domestic medical tourism has also been included in this effort.

Such medical care may be divided into classifications based on the care sought (Cormany, 2008). Treatments range from lifestyle adjustments, to cosmetic and dental surgery, to life-saving organ transplants and heart valve replacement. A classification system for medical tourism travel will include three broad areas and six categories:

1. Intrusive medical procedures (three categories):
  - a. Elective surgery or procedures, initiated due to the wishes of the patient. These include cosmetic surgery, cosmetic dentistry, sex reassignment operations, or assistance with reproduction.
  - b. "Quality of life surgery," defined as medically-required or recommended surgery for conditions that are not immediately life-threatening, including dental work, bariatric surgery, or joint replacement.
  - c. "Life saving surgery" for those medically-required or recommended surgeries for life-threatening conditions, such as cardiovascular surgery, organ transplant, or oncology
2. Diagnostic procedures (one category, including, for example, stress tests, screenings, cat-scans, electrocardiograms and "executive physicals")

3. Lifestyle procedures (two categories):
  - a. Spa treatments and consultations on overcoming addictions, learning stress alleviation, or relaxation.
  - b. Non-surgical alternative therapies (such as acupuncture, Botox injections, Ayurveda, or herbal treatments for specific conditions)  
(Cormany, 2008)

This broad spectrum of medical tourism treatments was accepted and published by the Medical Tourism Association as encompassing the varied dimensions of medical travel. It illustrates that the medical tourism is not a monolithic group. Additionally, a seventh group which may fit into any of the above six categories has since been identified. These have been referred to as “circumvention tourists” (Stolley & Watson, 2012, p. 60). These are individuals who are traveling to obtain treatments not permitted at home, or for which treatment in another region comes with special legal benefits. Some examples of this are women from Ireland traveling for abortion, couples visiting India to solicit pregnancy surrogates, individuals traveling to Switzerland for euthanasia, or mainland Chinese traveling to Hong Kong for births to circumvent the one-child-per-family law and to give the child Hong Kong residency for the benefits it carries later in life. While not including this group for the present study because they prevent clearly defined and mutually exclusive groups to be identified, it must be noted that their exclusion will leave a small sliver of medical travelers unclassified and excluded from this study’s consideration.

Little has been empirically researched on the travel and tourism components of medical tourism, but face validity advocates that travelers in at least some of these categories cannot be clumped with leisure travelers for purposes of market segmentation, traveler satisfaction, economic benefit analysis, regional development patterns, and studies of destination appeal without research to demonstrate such an association is justified.

### **Research Purpose**

The purpose of this research is to start the exploration of what the research community has assigned as motivation factors of the medical traveler in choosing to travel for medical care, and in selecting a specific destination for the provision of such care. These represent both the “push” factors in electing to travel, and the “pull” factors of destination selection, as has commonly been identified in other tourism studies (examples include: Crompton, 1977; Dann, 1977; Gnoth, 1997; Mannell & Iso-Ahola, 1987; Mayo, 1973; Ross, 1991; Sirgy & Su, 2000; and Um & Crompton, 1990, 1991).

Since few motivational studies of the medical tourist have been undertaken (Laessar, 2011; Taleghani, Chirani, & Shaabani, 2011; Ye, Qui, & Yuen, 2011) are the only ones specifically focused on it, and two of these are concentrating on a particular destination), the majority of academic articles allude to motivational factors, or make assertions regarding it. A first phase of this study is to identify what those allusions are.

It is unknown whether push and pull factors would vary between the differing types of medical tourists or between those choosing one potential destination over another. Therefore, this study also seeks to offer a baseline from which further study may evolve by considering the topic of motivation in majority of the academic literature

produced in the last five years among the business and tourism and the social science academicians.

It is posited that those traveling for medical treatment may be different from either leisure or business travelers, so by investigating the six medical tourist categories as they are identified in literature, it may be possible to discover what motivational factors are currently being ascribed to these travelers. Note that the seventh wildcat category, that of Circumvention Tourism, is not included for two reasons. First, it is difficult to identify and isolate such tourists, for in many cases they have a clear purpose in wishing to have their intentions not publicized. Secondly, by the very fact that the travel is to avoid restrictions at home, the push factors in their decision have been identified. As for the pull factors of destination selection, these do not vary considerably from the pull motivations of other medical tourists; i.e., once the destinations which are capable of providing the service are identified, there is no obvious reason to believe the process of willowing down their final destination would take any different form than that of the other medical travelers. The sole exception to this is when a family seeks certain legal opportunities which result from the location of a child's birth, in which case, both push and pull factors are clearly identified.

Additionally, insight is sought into the assumptions that are applied when discussing medical traveler motivation. Psychology is not a monolithic discipline into which all researchers share the same philosophical assumptions. By viewing the manner in which medical tourist motivations are discussed, some insight may be gleaned as to which psychological schools of thought are currently being favored, and conversely,

which may warrant more consideration as an explanatory model for the motivations of medical travelers.

Finally, the last 30 years has hosted a variety of travel motivational studies and tentative theory development. These are compiled and analyzed so fledgling efforts at understanding the medical traveler's motivation may be overlaid with those of other tourist motivational schools of thought to discover if any of them seem to fit the medical traveler. These are explained and summarized in Chapter Two.

### **Research Questions**

Most certainly, the greatest potential result of this study is in raising a host of additional research topics needing exploration. Since an exploratory, content analysis approach is being used, none of the findings may be expected to be conclusive, but some preliminary grounds for future studies in a number of areas may emerge:

1. What is the current state of discovery on what motivates the medical traveler?
2. Does one or more schools of psychological thought dominate the consideration of the motivational explanations for medical tourists?
3. Are there delineated differences in motivation between the six types of medical travelers?
4. Upon what sort of research are the commonly held conclusions based?

### **Significance of Study**

As is the case with most medical tourism research at present, this is an exploratory study, aimed at identifying what has or has not been given academic research attention. Understanding of motivation has profound implications for this new industry. It affects marketing messages of destinations, hospitals and support facilities, it provides

insight to the medical and guest service providers, it helps to delineate to insurance companies and medical facilitators who may or may not be a good candidate for medical travel, and it provides understanding for the traveling patient and his/her family as to why such travel might be appropriate. Additionally, greater understanding of motivations may help adapt current tourism literature to include the potential vagaries of the medical traveler.

In many cases, the medical traveler is currently viewed as a monolithic group, but even on face validity this is subject to question. A young couple seeking assistance in reproductive issues certainly will have different hopes, fears, motives, and expectations than a retired individual needing heart valve replacement. It is hoped that this study will encourage the process of segmenting medical travelers into psychographic groups for which motivations may be wildly different.

However, like any great journey, this is but the first step. As an exploration of what has been studied, it is posited that areas or individual types of medical tourists who have been slighted by study up to this point are illuminated so study focus on their specific motivations and needs. There is no claim of finality in this study, no assertion of certainty, only an attempt to discover areas in greater need of research. A benefit of content analysis, as will be discussed in greater detail in Chapter 3, is that is an ideal methodology to support ongoing longitudinal study (Neuendorf, 2002), so these same research questions may again be examined in another five years with precisely the same study purpose.

## **Organization of Dissertation**

The first chapter of this dissertation was meant to introduce and review the topic of medical tourism from a non-legal, non-medical basis. The removal of law and medicine from the topic leaves the other important component of understanding the drives and motives of the medical traveler, and this has been explained. Chapter two provides a review of how studies regarding tourists have frequently been undertaken. From there, the drives and motivations in general identified in psychology are explored, and those which have been applied to tourists in general are detailed in the review of literature on the topic. Chapter three delineates the methodology and reasoning employed in the undertaking of this study, including an exploration of the strengths and weaknesses of both content analysis and correspondence analysis, the two research tools employed in this dissertation. Also included is an explanation of the elements of the study, with definitions of terms. The fourth chapter reports on the results of the study. Finally, chapter five provides a discussion of these results, an exploration of their meanings and limitations, and recommendations for future research.

## CHAPTER 2

### LITERATURE REVIEW

#### **Scope of Tourism Studies**

Tourism studies span a broad scope of topics, including destination development, economic impact, sociological impacts on destinations, comparison of travelers seeking a particular niche experience, environmental impact, planned growth, technological influences, development and management of visitor attractions, destination marketing, impact and influence of government in industry development and sustenance, as well as analysis of specific components of the industry, such as accommodations, food and beverage, and transportation (Cooper, Fletcher, Gilbert, Shephard, & Wanhill, 1999; Mason, 2008; Page, 2009; Ryan, 2003).

Each of these topics may be valid grounds for research into medical tourism, but they fail to provide insight into the medical traveler. Research efforts focused on the leisure traveler have typically focused on the individual's personal motivation to travel, the person's reasons (affective and cognitive) for selection of a specific destination, demographic summaries, and satisfaction measures associated with the resulting experience (Johnson & Thomas, 1993; Pearce, 2005; Ryan, 2002; Swarbrooke & Horner, 2007). Little has been empirically researched on the travel and tourism components of medical tourism, but face validity would advocate that these travelers should not be clumped with leisure travelers on any of these dimensions without research to demonstrate such an association is justified.

Demographic summaries of the medical tourist remain difficult to complete until standard definitions are accepted because numbers currently reported, whether

internationally or those of just one hospital facility, vary wildly depending upon the criterion applied (Stephano, 2010). Likewise, research on medical traveler post-trip satisfaction is currently of dubious conclusion for three reasons. What research on the topic that does exist has been done by individual hospital corporations who understandably consider such information proprietary. However, more problematically for medical research is that it is not at all clear upon what criteria traveler satisfaction may be based.

Kozak (2004) proposes that the leisure traveler's experience needs to be viewed holistically; in other words, the traveler's perception of the destination and his or her experience while there is primarily viewed as a single experiential entity, rather than fragmented and evaluated in a compartmentalized manner. Multiple components of the travel experience merge and impact an overall level of satisfaction in the traveler's memory. This series of experiences is recalled as a holistic travel impression, but lack of quality in even one of the experiences may result in a domino effect, in which overall satisfaction of the trip is diminished (Jafari, 1983). It would logically follow that a bad experience at the hospital or clinic therefore could dramatically affect the medical traveler's journey satisfaction. However, issues which contribute to a "bad experience" at a medical facility are far from a settled subject. Hospitals have traditionally been focused on monitoring clinical process and improving healthcare, but consumer satisfaction has not received as much attention (Bernard & Savitz, 2006). Customer satisfaction research was resisted by administrators with an antipathy toward business models that ran deep in the healthcare industry until well into the 1980s (Bashe & Hicks, 2000).

Measuring service satisfaction in a generic sense has been theoretically focused through the eyes of the customer since at least 1984 when Gronroos advanced the concept that service quality is a blend of perceived outcomes (technical aspects) and the process by which those services are delivered (functional aspects).

Based upon that theory, researchers have attempted to further refine a standard by which service quality might be evaluated. Parasuraman, Zeithaml, and Berry (1988) divided the functional aspects of Gronroos' (1984) theory into four dimensions, and included his technical aspects as "tangibles," resulting in a service scale of five dimensions, termed the "SERVQUAL" model.

The SERVQUAL model is a generic measurement of service satisfaction and has been a lightning rod for academic debate, both on its concept and its application, since it was first proposed (Lopez & Serrano, 2005). Additional researchers seeking to establish a generic model for all service industries have found differing number of relevant dimensions (for example: four dimensions of outcome, process, environment, and enabling by McDougall and Levesque (1994); three dimensions of service environment, service delivery, and outcome or technical quality by Rust and Oliver (1994); and three dimensions of interpersonal quality, outcome quality, and environment quality by Brady and Cronin (2001)). What each of these general service models share is that their models did not work well in all service encounters when empirically tested in a variety of settings (Dagger, Sweeney & Johnson, 2007). Studies targeting specific service sectors found differing dimensions to be of greater or lesser importance.

Various components of tourism, notably hotels in particular, have been studied on these five service dimensions using the SERVQUAL model of service evaluation with

varying results. While some researchers have found applicability of the SERVQUAL instrument to hotels (Akan, 1995; Home, 2005), others have found it to be a model with varying utility (Fick & Richie, 1991; Johns & Lee-Ross, 1997; Saleh & Ryan, 1991), and still others have tested various permutations of the SERVQUAL model with mixed results (LeBlanc, 1992; Lopez & Serrano, 2005).

In the health sector, there has been even more confused applicability. Dagger, et al (2007) proposed nine dimensions upon which healthcare is judged; other models have posited seven dimensions (Reidenbach & Sandifer-Smallwood, 1990), twelve factors (Licata, Mowen & Chakraborty, 1995), six dimensions (Headley & Miller, 1993), or nine factors (Carmen, 1990).

These findings suggest that consumer judgments of service quality are contingent upon the service being sought and the dimensions by which both hotels and hospitals are measured remain far from settled. Marrying that idea with the concept of a traveler developing a holistic impression of his or her trip, as advanced by Kozak (2004), it may be proposed that medical tourists are likely to have a more mixed set of criteria by which they will judge their travel experience than any other sort of traveler, perhaps rooted in the unsettled dimensions of medical care – but also affected by the equally unsettled dimensions of consumer satisfaction with the tourism and hospitality elements of the trip.

This leads to the third difficulty in studying medical tourism satisfaction. To have statistical rigor, it would be necessary to identify past medical travelers who had good medical experiences but poor travel and hospitality experiences, those whose medical and travel/hospitality experiences were both good, those which had what were perceived to be poor experiences in both sectors, and those whose medical experience failed to meet

expectations but whose hospitality and travel experiences were positive. There is no doubt that if sufficient numbers in each group could be identified, the results of the research would be enlightening, but practical difficulties of identifying sufficient numbers keeps this study in only conceptual terms.

However, the remaining area of individual tourist research, that of traveler motivation, does not suffer from such restrictions. While study structure will be detailed in Chapter 3, it is first advisable to review the current status of theory in traveler motivation research.

### **Motivation**

Motivation is a complex area of research, dealing with not only explaining human behavior but also attempting to understand it and its immediate genesis (Walmsley, 2004). In terms of tourism, travel motivation is “a response to felt needs and acquired values within temporal, spatial, social and economic parameters” (Gnoth, 1997, p. 283).

The more relatively simple task of explaining human behavior may more correctly be defined as a “motive” (Page & Connell, 2006) which, in tourism research, is the stated reason or purpose of the travel. This distinction is important, for the explicit motive for medical tourism is to seek some sort of medical or wellness procedure, but this alone does not provide an understanding of the motivation of the medical traveler to journey for such treatment, nor does it assist in an understanding of the process by which a particular destination is selected.

The definition for “motivation” differs depending upon the theoretical thread of psychology using the term. These general theoretical threads lead to differing approaches in both general psychology and the more specific study of tourism motivation. It is

therefore important to first understand the various psychological schools of thought as they pertain to “motivation.”

These threads, or schools of thought, developed as a tree, with its roots traced to Leipzig, Germany, and the founder of the discipline, Wilhelm Wundt, who established the first experimental laboratory for psychological studies in 1879 (Chaplin & Krawiec, 1974). This study focused on feeling and emotion, but the more action-oriented concept of motivation did not become a major avenue of inquiry until the 1920s (Ferguson, 2000).

Delineation of the consequent schools of thought generally include psychodynamic, behavioral, humanistic, and cognitive as major branches (Gilliland, James, & Bowman, 1989; Halbur & Vess Halbur, 2006; Petri, 1996), although variations are also abundant in how the philosophical divisions are defined (Atkinson & Birch, 1978; Chaplin & Krawiec, 1974; Hergenhahn & Olson, 1999). Pearce and Stringer (1991) describe psychological inquiry based upon biological and physiological processes, cognitive and mental processes, individual differences, inter-individual behavior, and cross-cultural behaviors. Schultz (1981) identified nine theoretical categories, but noted differing opinions in classification abound. As many as 34 other schools or sub-schools of thought have been named, so the divisions are not free of controversy or overlap.

Two points are important in this consideration of classifications. First, all developed as general ways to study psychology, of which motivation is only a part. In other words, these are not divisions in motivational theories; the concept and study of motivation fit more comfortably into some than into others. Secondly, rather than searching for the “correct” school of psychological thought, Schultz urges that each be used for the insight it provides.

The classifications provided by the four basic schools (psychodynamic, behavioral, humanistic, and cognitive, as noted above) each contribute an element to consumer psychology and more specifically, tourism motivational studies, so this is the classification system used for organizational purposes in this paper. Each of the four will be briefly described. Following that, more specific focus will be given to consumer motivation, with the greatest attention and specificity provided in reviewing models and concepts of tourist motivation.

### **Psychodynamic School of Psychology**

Advocates of psychodynamic positions include Sigmund Freud's (1920) psychoanalytic work, Carl Jung's (1923) analytical psychology, Alfred Adler's (1929) "individual" psychology, and transactional analysis, as developed by Eric Berne (Halbur, & Vess Halbur, 2006). Although each of these positions make distinctions about the origin of an individual's motivation (for instance, Freud stressed sexual and destructive urges), a unifying concept of the psychodynamic psychological theories is the importance of the unconscious in shaping emotions and creating motivations. Although this philosophical approach to psychological studies is one of the oldest, the neuroscience studies during 1990's "decade of the brain" (White, 2002) have reasserted the significant role played by the unconscious in consumer decision making (Zaltman, 2003). Zaltman cites as claiming that 95% of a person's thinking, including consumer decisions, resides in the unconscious mind. Additionally, such decisions are a simultaneous function of reason and emotion (Zaltman), so according to psychodynamic philosophy, understanding the traveler's unconscious is a key element in identifying travel motivations. As will be shown when specific traveler motivational theories are reviewed,

only a small portion of them incorporate the consideration of the unconscious in their postulations.

### **Behavioral School of Psychology**

Behavioral schools of thought, best exemplified by Skinner (1938) and Bandura (1969), approach human behavior from a different vantage. Motivation is of less importance than the subsequent behavior which is determined through socio-cultural factors – specifically through classical and operant conditioning and social learning theory. These principles are important to advertising. Some advertisements seek to merge the perception of a product with a selected emotion so that the product becomes associated with the desired emotional reaction. This is classical conditioning, wherein a conditioned reaction is developed in response to a stimulus (Middleton, Fyall, & Morgan, 2009). Alternatively, operant conditioning results in learning to assess rewards or punishments, the assessment of which steers one to a particular behavior. Within consumer psychology, this is illustrated by repeat purchases when a product's consumption results in a positive experience (Middleton, et al., 2009).

According to the social learning theory, these potential rewards or punishments may be learned vicariously through the observation of others' behavior. A relevant consumer concept advanced by the social learning theory is that one's behavior may be impacted by the observation of the consequences of others' behavior. This observation offers some potential explanation for the surge in a particular behavior within society and may have some application to the growth of a phenomenon such as one's willingness to travel for medical treatment. Also, the concept of assessing benefits or liabilities of one's

actions seems particularly relevant as a potential part of the thought process of the medical traveler.

### **Humanistic School of Psychology**

Humanistic theories represent those philosophical threads most often applied to tourism (Ryan, 2002). They developed from the work of Kurt Goldstein's (1939) Organismic psychology, Client-Centered psychology by Carl Rogers (1951), and an early effort in identifying and classifying motivations by Henry Murray (1938). As with psychodynamic theories, each of these have slightly different emphases, but the common thread present in all of them is the belief that "the fulfillment of needs is not the mere release of tension or the elimination of deficiencies, but the more positive goal of joy in achievement and the pleasures of exercising one's capabilities and abilities" (Goldman, 1939, p. 203). In contrast to the previous two schools of thought which emphasize past experiences, humanists have a focus on the here-and-now, and have contributed the concept of "self-actualization" that is present in many travel motivation models. The concept of self-actualization is may be defined as a "situation that exists when a person is acting in accordance with his or her full potential" (Hergenhahn & Olson, 1999,p. 19).

One of the first writers in the humanistic school was Murray (1938), who identified 14 physiological and 30 psychological needs. Murray posited that the strength of each of these needs varied independent of the other needs, so to understand the motivation of a person required measuring the strength of all their key needs. The comprehensive nature of Murray's list has kept it relevant for the travel motivation researcher, for it appears to be possible to identify factors that would influence a potential traveler to prefer or reject a particular destination (Witt & Wright, 1993). However, its

complexity also is a liability, proving to be more daunting to non-psychologists than Maslow's later hierarchical system (Ross, 1998). Murray is credited with first introducing the concepts of achievement, affiliation and power as motivational forces, laying the foundation for later work by Herzberg, Mausner, & Snyderman (1959).

Herzberg et al. (1959), who focused on employee motivation, is most relevant here for advancing the idea of "hygiene" factors (conditions that may de-motivate an individual if they are absent from a situation) but which do not serve as motivational factors themselves. These stand in contrast to "satisfaction" factors which exercise a compellingly positive influence in encouraging a particular action, such as making a purchase choice (Kotler, Bowen, & Makens, 2010). Understanding the concept of hygiene factors may be particularly helpful in the study of travel motivation, especially with regard to destination selection, as the absence of these factors suggests that the destination will not be considered by the potential traveler.

Yet another theorist in the humanistic category whose work is potentially useful to travel motivation analysis is Kurt Lewin (1935). While remaining focused on the individual's thinking in the here-and-now, Lewin posits that behavioral decisions are the result of resolving motivational conflict (Chaplin & Krawiec, 1974; Hawkins, Best, & Coney, 1992). Three types of conflict are possible. The Approach-Approach conflict forces a choice between two attractive alternatives. The more equal the attractiveness of the alternatives, the greater the conflict will be experienced by the decision maker. The second type of conflict is Approach-Avoidance, wherein the individual perceives both positive and negative consequences to making a specific decision. Finally, the last type of conflict is Avoidance-Avoidance, in which the person must decide between two

undesirable alternatives. This motivation conflict theory has applicability to many consumer purchase decisions (Hawkins et al., 1992), and holds some face validity as one manner in which medical tourism decisions may be explored.

Basing his work on the work of Lewin and Murray's work, Victor Vroom also did work on employee motivation, developing a theory of worker motivation (Vroom, 1964). His work introduces two premises, the first being that some outcomes may be attractive, and therefore motivational, for their own sake, while others were not attractive as ends onto themselves but held value as instruments by which to attain other outcomes; the second being that the force or motivation upon a person to act is directly associated with the expectancy that individual held that his or her action would result in the desired outcome (Witt & Wright, 1993). As will be discussed below, this premise has been applied to study of tourist motivation and holds a particular potential for application to medical tourism, in which the travel is by definition a means to an end, and expectancy of a desired outcome would be anticipated to be high.

It is in this school that Abraham Maslow (1943; 1954) and his work on the hierarchy of needs resides, which is one of the most frequently cited concepts upon which several travel motivation theorists have based their work and is the best-known overall work on motivation (Page & Connell, 2006). Maslow built upon the work of Goldstein (Chaplin & Krawiec, 1974). He initially suggested a five-tiered hierarchy of motivational needs, with physiological needs (such as thirst, hunger, rest, sex) being foundational. According to the theory, once those needs are at least partially met, the second tier of safety needs (such as freedom from physical or psychological threat) become motivating factors. Likewise, as those needs are satiated, the next tier is that of belonging and social

needs (such as friendships and giving and receiving love and affection) develop in importance. The fourth tier is that of esteem needs (such as self-confidence, self-esteem, reputation, prestige). These first four tiers are considered deficiency or deprivation motives, as they are triggered by the perception of their absence in adequate quantity to satisfy the individual's need (Hergenhahn & Olson, 1999; Petri, 1996). The final tier is that of self-actualization needs (such as the desire for fulfillment and becoming all one is capable of being). Unlike the other needs that are defined by a deficiency, these "growth needs" are defined by more passive "being" and are insatiable (Hergenhahn & Olson, 1999; Petri, 1996).

Since Maslow is frequently cited in tourist motivation literature (e.g., Cooper, et al., 1999; Kotler & Armstrong, 2010; Kotler, et al., 2010; Page & Connell, 2006; Pearce, 1982; Ryan, 2003; Ross, 1998; Witt & Wright, 1993) and forms a foundation for some specific travel motivation theories such as Pearce's (2005) travel career pattern approach, it may warrant some closer examination. There is attractiveness to the theory for purposes of studying medical travel, as physiological and safety needs would appear to be a part of such travel. There is also an intuitive appeal to the notion of a hierarchy of needs although this is somewhat diluted by Maslow's suggestion that more than one tier of need could be simultaneously influencing behavior (Witt & Wright, 1993). He asserted that if a need were being met "perhaps 85%" of the time, that need would cease to have much influence of behavior (Petri, 1996, p. 319).

Maslow's appeal may stem from the ease by which his hierarchy provides labels for understanding consumer patterns (Cooper et al., 1999), but this may be understanding through oversimplification (Rowen, 1998). Even in its fully examined form, Maslow's

theory is not without critics. It has been noted that his model was developed without clinical observation or experimentation (Cooper et al., 1999). The application of the label self-actualization seems particularly problematic, for it was developed solely by Maslow's examination of friends and observation of public and historic figures (Petri, 1996). From this has stemmed the charge of elitism, for there are economic, educational and social benefits that must be available to the individual on the path of self-actualization (Petri, 1996). Maslow believed less than 1% of the population was "self-actualized" (Goble, 1970), leading to the additional accusation that such growth may be more idiosyncratic than general.

The lower levels of Maslow's hierarchy were developed in a clinical setting. This, too, raises the generalizability of his theory, as Maslow himself stated:

My work on motivation came from the clinic, from a study of neurotic people. The carry-over of this theory to the industrial situation has some support from industrial studies, but I would certainly like to see a lot more studies of this kind before feeling finally convinced that this carry-over from the study of neurosis to the study of labor in factories is legitimate (Maslow, 1965, p. 55).

In later years, Maslow also suggested there were two more tiers to be included, that of the need for knowing and understanding, and that of esthetic need (Goble, 1970). Their proposed placement within the hierarchy was not clarified. Still, Maslow remains prominently mentioned in the literature of travel motivation.

## **Cognitive (Pragmatic) School of Psychology**

The final major school of thought in psychology is referred to alternatively as the pragmatic (Halbur & Vess Halbur, 2006) or the cognitive (Ross, 1998). (It should be noted that, especially in this final classification of psychological thought, considerable variation exists. Indeed, the term “cognitive,” though commonly used in the way described below, was also found to be used to represent “concepts of irrationality and unpredictability of behavior” (Cooper et al., 1999, p. 33). These same authors termed Maslow a behaviorist, further demonstrating the unsettled division of psychological thought.)

Two major contributors to this philosophical perspective are Albert Ellis (1962) and William Glasser (1965). Although primarily of use in therapeutic roles of psychology, the essence of this school is that thoughts are the root cause of emotions and behavior; therefore, to change feelings and actions, thoughts first must be modified (Halbur & Vess Halbur, 2006). This perspective may apply to highly-involving consumer purchases, in which it is common for the consumer to have “after sale discomfort” or “post-purchase dissonance” (Kotler & Armstrong, 2010, p. 152). This may be relieved through the provision of evidence to the consumer that the decision was indeed a sound one.

To briefly summarize and simplify, psychodynamic thought emphasizes the role the unconscious plays in motivation and decision-making; behavioral schools stress the elements of learning in shaping future actions; humanistic theories provide hypotheses to focus on the here-and-now in a variety of conceptual models; and pragmatic models add the element of reason and logic to the motivational process. Depending on the school of

thought, greater emphasis may be placed on antecedent conditions or anticipated outcomes as the focus of motivational study, but unifying all schools is the definition that motivations “are energizing forces that activate behavior and provide purpose and direction to that behavior” (Hawkins et al., 1992).

Some authors, such as marketing professors Kotler and Armstrong (2010), have stated that motivations are one of four psychological factors at work in buying decisions, the other three being perception, learning, and beliefs/attitudes. It is in these delineations that confusion of terms may arise, for behaviorists would include learning as a central part of motivation, while the pragmatic school would incorporate beliefs and attitudes into its umbrella of motivational forces. Still other authors include emotional states, habits or incentives as a part of motivation, while others draw distinctions between these conditions or dispositions (Chaplin & Krawiec, 1974). For purposes of the proposed study of motivations of medical tourists, it is suggested that a broad definition, including all of the above components, be used to better insure a complete picture of the traveler’s decision-making process is captured.

### **Tourism and Medical Tourism Motivation**

Before continuing, it is necessary to pause to define medical tourism. Just as Schultz (1981) recommended consideration of all schools of psychological thought, pragmatically using the ones best fitting the situation under study, in the consideration of the motivations of the medical traveler, there are elements of many travel motivation theories that may partially apply depending upon the type of medical tourism being examined.

Medical tourism has been described as when individuals needing or desiring medical or wellness procedures are seeking alternatives for medical treatment outside of their local borders (Bookman & Bookman, 2007; Goodrich, 1993). The term is most commonly used to indicate travel outside of one's country (Connell, 2006). This travel may be for one or more of six categories of medical or wellness procedures: 1) Those seeking life sustaining surgery (defined as surgery without which there are life-threatening consequences), 2) quality of life surgery (defined as pain-relieving or quality-of-life enhancing procedures such as hip resurfacing or bariatric procedures), 3) optional procedures (such as cosmetic surgery or reproductive services), 4) diagnostic procedures, 5) alternative treatments, or 6) wellness services (Cormany, 2008).

The focus of the motivation differences between these groups may be profound. Those medical tourists who are traveling for life saving or quality of life surgery may be the most distinctly different from the leisure traveler, so distinctions between the medical travel and the leisure traveler might be highlighted. The latter four groups afford greater opportunities to balance medical procedures with vacation activities, therefore presenting a blending of medical and recreational considerations in the decision to travel and in destination selection.

This may be illustrated by the work of Banner and Himmelfarb (1985). They propose that general motivation may be viewed on two continua. The first is whether the reward or outcome is an intrinsic or extrinsic one; that is, whether the activity in which the person is engaged is its own reward in terms of pleasure or value associated with the action itself, or whether the behavior is seen as a means to an independent end (such as earning more pay, pleasing others, achieving status). The second continuum is the degree

to which the activity is perceived as necessary (such as holding a job) or voluntary (elective in whether or not to participate).

Degree of Voluntarism		
Type of Reward	Compulsory	Voluntary
Intrinsic	Fun Work	Tourism
Extrinsic	Work	Obligatory Tourism

Table 1: Degrees of voluntarism

Ross, G.F. (1998). *The psychology of tourism* (2<sup>nd</sup> ed.). Melbourne, Australia: Hospitality Press

While the researchers were primarily studying work motivations, a key contribution they make is the concept that tourism, while always voluntary, may have intrinsic or extrinsic motivations, and extrinsic motivators will result in “obligatory tourism.” Banner and Himmelfarb (1985) use the example of visiting distant relatives, motivated by family expectations rather than personal desire, as one sort of obligatory tourism. Applying the concept to medical tourism, it is suggested here that the surgical medical tourist – the focus of this study – may be motivated primarily by extrinsic motivations of the surgical outcome rather than intrinsic rewards of travel. In other words, surgical medical tourists could be classified as “obligatory tourists” who voluntarily engage in travel activity as a means to an extrinsic end of better health.

The concept of “obligatory tourist” provides a response to critics who challenge the term “medical tourism” as not actually tourism for the primary focus is not recreation (although heard primarily at the first two Medical Tourism World Congresses (Medical Tourism Association, 2008, 2009) from some academics in casual conversation, some

moderate protest may also be seen in: Horowitz, Rosensweig, & Jones, 2007; Inhorn & Pasquale, 2009; Woodman, 2008).

### **Worker Motivational Theories and Their Application to Tourism Models**

Banner and Himmelfarb (1985) represent one of the attempts to apply motivational theory to worker motivation. Earlier such attempts to apply psychological theory in the area of worker motivation were some of the first efforts at applying motivational theory in pragmatic settings. These efforts are of relevance here for two reasons. First, these efforts had as a goal the understanding of non-neurotic, average behavior. This represented a growth from psychology as a basic science or clinical technique to that of applied science with day-to-day applicability. This use of psychology to understand the motivators of one sort of observable behavior then provides a model that may be applicable to understanding the psychological underpinnings of other behaviors and decisions, such as in leisure and tourism. Additionally, much of the study in tourism motivations arises from leisure studies, rather than pure tourism research (Mannell & Iso-Ahola, 1987). A frequent approach to leisure studies is to contrast such behavior to work activities; hence, some leisure and travel motivational theories attempt to build from work motivational theories (Ross, 1998).

One of the earliest works in worker motivation was by McClelland, Atkinson, Clark and Lowell (1953). Basing their work on Murray (1938) of the humanistic school, McClelland et al. (1953) found that the most prominent need from the standpoint of understanding workplace behavior was that of achievement. Simplifying a very complex work to isolate its utility to the current study, those with high achievement needs show a strong desire to assume personal responsibility in solving problems and are more willing

to assume calculated risks. This suggests there are differing levels of comfort in assuming risk, and according to McClelland et al. (1953), the perception of risk may be a motivator or a de-motivator.

This concept, with regard to risk-taking and tourists, was applied in Plog's (2004) theory of allocentric and psychocentric travelers. In it, Plog advanced the theory that travelers may be classified on a continuum, the one end of which represented the most risk-taking, adventurous travelers who prefer exotic locations and unstructured holidays with immersion in the local culture. These are similar to the "early adapters" in more general marketing terms (Hawkins et al., 1992). At the other end of the continuum are the psychocentric travelers, whose preferences include familiar destinations, structure available from tours, packages and group activities, and touristy areas. In his orthogonal scheme, the other dimension is that of traveler energy level, in which higher energy travelers prefer more activities. Plog (2004) proposed that destinations could be assessed on these same dimensions, and travelers would most prefer and tend to select destinations that best matched their personal dispositions. It may be that in the young and growing field of medical tourism, the traveler for surgery may resemble the allocentric leisure travelers.

Spector (1982) researched locus of control as a motivational factor for workers, stating that it may be one of the most prominent motivators when the locus was felt to be internal. If workers perceived that their actions were dictated to them without significant individual choice in the manner or method that a task was to be done, motivation was less. The concept of locus of control may be a factor that will present itself in comparing medical travelers to those who elect not to travel for surgical procedures; those who feel

empowered about their decision may show greater tendencies to either travel or look for non-travel alternatives. Alternatively, those who perceive the locus of control for obtaining medical attention as somewhat forced upon them by personal circumstances may be either more willing or more resistant to the concept of medical travel.

Combined with McClelland et al. (1953), who concludes that those more prone to assuming personal responsibility in solving problems are also more likely to be risk-takers, this raises the question of risk-perception as a factor in deciding to travel for medical treatment. Is there a different perception of the risk of medical travel in those with a sense of inner locus of control? Or, are loci of control and perceived risk separate but interactive variables? In such a case, would the sense of inner control and low risk advocate for a decision to travel for medical care, while a sense of high risk and outer locus of control tend to advocate for not being a medical tourist? In cases where the risk is not perceived as high, but the perceived locus of control is external, does the locus of control become the larger factor, and conversely, if the locus of control is internal but risk is viewed as high, does the sense of risk play a larger role in deciding whether to travel?

These are examples of the wide range of concepts that make the study of motivation difficult (French, Craig-Smith, & Collier, 1995). Fortunately, another worker motivation theorist, Victor Vroom (1964), provides a model for approaching these questions. In his Expectancy Theory, built upon the work of humanist Levin, Vroom advances the concept that motivation is determined by expectations and valences. Expectations are the probabilities one personally believes that a certain action will lead to a given outcome. Valence is the value one places on the importance of that outcome. The greater the sum of probabilities and the importance of those outcomes are, the more likely

a person will engage in a specific action. These are interactive concepts, so if the probability times the outcome importance is higher than the probability times the outcome of another action, the first action will be selected unless the probability and importance of doing nothing exceeds it. This is a deconstructive approach; it breaks motivation into component parts which is helpful for understanding, but it does rely on identifying all the component parts. This may not always be possible, as observed by Lawler (1973): “At this point it seems that the theory has become so complex that it has exceeded the measures that exist to test it” (p. 502).

Still, it affords insight not available with many other motivational theories. Using Crompton’s (1977) and Dann’s (1977) concepts that all travel decisions are the result of both push and pull factors, Vroom’s theory has been translated into travel motivation assessment by Witt and Wright (1993). Dann (1977) wrote that travel motivation research needs to incorporate both the reason a person elects to travel (the push factors), and the factors that cause the person to select a particular destination once the decision to travel has been made (the pull factors). Witt and Wright note that push factors for travel are assessed by individuals when the probability and desired outcome of decision to travel exceeds that of not traveling. Then, individual locations are assessed in a comparative way, comparing the probabilities of each to satisfy the desired outcome, and the importance of each outcome to the overall decision. This concept is attractive and useful for assessing conscious motivators for travel, but its heavy reliance on cognitive factors fails to recognize the unconscious factors that may also be operating.

In merging work situations with travel motivations, Kabanoff and O’Brien (1986) suggested that work environment created psychological needs that were consciously or

unconsciously taken into account in tourism motivations. Those who lacked certain desirable states at work, such as status, autonomy, or self-fulfillment, would pursue these states in their leisure activities. Further, those who experienced undesirable states at work, such as stress or physical fatigue would seek alleviation of them through their leisure pursuits. Although application of this theory to medical tourism is unclear, another component of the Kabanoff and O'Brien work seems to hold some investigative promise for such travelers. Building on their work, Mitchell, Dowling, Kabanoff and Larson (1988) posit that work habits become deeply engrained and become a part of one's approach to leisure. For instance, a person engaged in detailed work is likely to approach his or her vacations with a similar degree of planning, leaving little to chance. This may have little influence on pull factors, but may make a difference in one's conscious consideration of push factors. While the final decision and destination may not be altered, the length of time given to consideration of factors, the scope of information gathering done, the weighing of alternatives, and the concern for planning details may be affected, all of which may be factors influencing decisions in non-life threatening medical treatments.

Both leisure travel and medical treatment are a form of market consumption. There have been several studies of leisure travel motivation, albeit the varying theories are taking different approaches and emphasizing different elements of such motivational elements. Study of consumer motivation in medical procedures is less developed. This may be because the concept of marketing medical procedures is a relatively new one and is still resisted by some parts of the medical community (Bashe & Hicks, 2000). Emphasis has tended to be on cognitive aspects of service quality and patient care and

historically has attempted to sell services to all in need (Thomas, 2008). The primary motivational research in clinical settings tends to be on psychological impacts during recovery (Bashe & Hicks, 2000) and on understanding the cultural differences that may make clinical procedures more or less successful (Gropper, 1996).

The less medically-invasive spa industry has primarily relied upon tourism research (Erfurt-Cooper & Cooper, 2009). It has also frequently cited scientifically unproven “pop” psychology, much to the detriment of its own credibility (Smith & Puczko, 2009).

In terms of tourism research, Dann’s (1977) theory of push and pull elements informs many of the methods, but others have also been employed. In an early attempt to delineate these methods, Dann’s later writing (1981) asserted that there are seven approaches to the study of traveler motivation:

- 1) The motivation is to find something desired but lacking in everyday life.
- 2) Motivation as push and pull factors.
- 3) Motivation as a fantasy, or escape during which behavior may be engaged in that would not be sanctioned at home.
- 4) Motivation is studied as a classification of trip purpose.
- 5) Motivation as a typology. This may be approached as either a behavioral typology, or one made based upon psychographic or demographic information.
- 6) Motivation driven by the authenticity of the travel experience.

7) Motivation is self-defined, so the way a traveler views his or her situation provides greater insight into their motivations than simply observing their behavior.

These definitions continue to illustrate a difficulty in motivational studies and the potential differences between various types of medical tourists. Depending upon the approach (and similar to the four basic schools of psychological thought), one might approach such a study with one of these definitions of motivation that is incompatible with other studies using a different definition. These differing approaches accentuate or diminish basic psychological principles, such as the role of the unconscious, the individual circumstances, the involvement of perception, personality and emotions, or the use of logic and reason.

They also appear more or less applicable to differing medical travelers. For instance, the person traveling for cosmetic surgery may be engaged in behavior that would not be sanctioned at home in some cases (Dann's approach 3). However, that motivation of escape is less likely among major medical patients, so such an approach in the study of their motivation is less likely to be productive.

Looking more closely at a few of these approaches, proposing that motivation may be ascribed to a trip's purpose (Dann's point 5) does little more than classify it as a recreational, business, adventure, relaxation, or health-related undertaking. It provides statistical data as to the relative popularity of each travel purpose, but does little to explain the underlying reasons for that purpose nor does it contribute to an understanding of specific site selection. A liability of such classifications is pointed out by Ryan & Huyton (2002), as they describe the cultural tourist. They argue that the title "cultural

visitor” says little about the depth of interest of the traveler. One cultural traveler may be motivated to focus on learning an indigenous culture; another may wish to explore the culture while in the vicinity; yet another may want simple exposure for the edutainment value. All would be classified as cultural visitors, but little may be gleaned from a statistical clumping of such travelers. As an aside, it is posited that this may be the current case with composite numbers of medical tourists. Gross numbers of such travelers are estimated, but as of yet there is no refinement in understanding the continuum from wellness tourists to those traveling to remedy a life-threatening condition. Definitional difficulties also cripple the attempt at collecting solid data on the number of medical tourists, as is detailed in the medical tourism research section that follows this one.

Many travel motivation writings seek to establish a typology of travelers (Dann’s approach #5). One of the earliest was Cohen (1972), who divided travelers into one of four categories: the organized mass tourist (who typically purchases a travel package and is anxious to maintain a similar environmental bubble as it exists in the home setting), the individual mass tourist (who is similar, but desiring more scope for individual flexibility during the trip); the explorer (who self-organizes a trip, but desires comfortable accommodation and reliable transportation); and the drifter (who has no fixed itinerary and is spurred to become immersed in the local culture).

This early typology led to several others. In 1981, Mayo and Jarvis, building on the work of McIntosh (1977), advanced the concept that tourists travel for one of four reasons. They were seeking 1) physical rest, sports participation, and relaxation; 2) desire for knowledge of countries and cultures; 3) to meet new people, visit friends or

relatives, or escape family routine; or 4) desire for prestige and status. These same categories were suggested more recently by McIntosh, Goeldner and Richie (1995).

A very basic classification is offered by Burkart and Medlik (1981) and Gray (1970). According to them, all leisure travel is prompted by either wanderlust, the desire to exchange the known for the unknown, or sun lust, the desire to temporarily enjoy better amenities, especially better weather, than is available in the home setting.

At the other extreme, Gibson and Yiannakos (2002) suggest 14 tourist roles: sun lovers, action seekers, anthropologists, archaeologists, organized mass tourists, thrill seekers, explorers, jetsetters, seekers, independent mass tourists, high class tourists, drifters, escapists, and sports lovers. It appears Gibson and Yiannakos (2002) have incorporated several elements from previous typologies in constructing these roles. The traveler typologies offered in literature are numerous (e.g., Beard & Rogheb, 1983; Cooper, et al., 1999; Crompton, 1979; Lundberg, 1971; Mill & Morrison, 1985; Schmidhauser, 1989; Shoemaker, 1994). Most emphasize a person's role in traveling, with some giving attention to the psychological motivations that create that role. Less attention is given to destination selection motivators, albeit certain destination characteristics, such as warm weather, are suggested by some.

Krippendorf (1987) took a different approach. His position was that all travel is based as the result of getting away from something, rather than moving toward something. Looking at the travel motivation literature, he found eight main themes which he believed all supported his contention. He found travel to be an opportunity for recuperation and rejuvenation, compensation and social integration, seeking a chance for communication, freedom and self-determination, self-actualization, or happiness. He

also included the general concept of “escape” and the pursuit of mind-broadening activity. Perhaps his greater contribution, however, was his observation that, in asking travelers why they traveled, he found most the responses were reiterations of marketing messages in some form.

This would seem to raise the question of whether such classification systems are true indications of traveler motivation or whether instead they were self-justifications for travel having been provided for tourists in travel advertising. More important to the study of medical tourists, all typologies appear applicable predominantly to the leisure traveler. While some indicate through their headings some wellness aspects, such as rest and recuperation (Krippendorf, 1987), or physical rest (Mayo & Jarvis, 1981), deeper exploration into the usage of these terms reveal a meaning more closely associated with an absence of psychological stress or physical demand than a focus on specific medical issues. One major area of exploration for the proposed study is to determine which of the motivational factors present in leisure travel are also applicable for medical travel.

A helpful approach in such consideration is work by Sirgy and Su (2000). It considers the traveler self-concept and how that self-concept is congruent with the evocative image the traveler holds for a destination. Sirgy and Su identify four elements of self-concept – the actual and idealized self image, and the actual and idealized image one believes oneself to hold in society. This latter element permits an examination framework of negative attitudes toward medical tourism cited above as common in the experience (Marsek & Sharpe, 2009). The breadth of this approach allows, for example, consideration of mental images held of hospitals and doctors in the destination, which is an element that fails to fit into most leisure tourism models.

The Sirgy and Su (2000) model, however, makes one assumption for the leisure traveler from which the industry of medical tourism needs to step back and examine its applicability for the medical tourist. The claim is that the affective elements of self-concept and its congruity with a travel destination hold greater sway in the selection process than the functional (or cognitive, utilitarian) elements of the destination. This may or may not prove to be the case for medical tourists, especially those seeking needed surgery, as the very genesis of the trip appears to develop from utilitarian elements.

Sirgy and Su's (2000) work places greater balances of emphasis on both of Dann's (1977) push and pull factors. Understanding both the psychological motivations of the traveler and how the selected destination is expected to fulfill those needs provides a more complete picture of why a specific destination is selected. However, Um and Crompton (1990, 1991) argue that the information about various previously unvisited destinations is apt to be limited. This means the perceived image of the destination may have a greater factor in destination selection than objective reality. It also suggests that understanding the sources of the image is an important part of understanding travel motivation, especially when the desired outcome of the travel has long range health implications which represent greater importance than just a satisfying vacation experience.

Sirgy and Su's (2000) work is an example of Dann's (1977) approach #2 – the consideration of push and pull motivations in the travel decision. Gnoth (1997) has asserted that push factors are primarily emotional drives, while pull factors are predominantly cognitive in nature. This is not universally accepted. Others view the pull factor of a destination as multifaceted and consisting of cognitive, affective and

behavioral elements (Pike & Ryan, 2004; White, 2004). Apparently less controversial is Kozak's (2002) observation that push and pull factors will vary in different demographics.

Mannell and Iso-Ahola (1987) consider both push and pull factors to be determined by personal and interpersonal factors the traveler is either trying to extenuate or escape. Their work is frequently cited in travel motivation literature, but its applicability to medical tourists is not readily apparent.

There have been studies on destination image as a part of a traveler's motivation for its selection in leisure travel. Milman and Pizam (1995, as cited in Ross, 1998) reported that familiarity with a destination positively influenced eventual intentions to visit it. This may help to explain medical tourism destination selection for those who have previously visited a locale. However, for the visitor without previous experience, limited information may be a positive or negative factor. Crompton (1979), for instance, found limited information mixed with preconceived notions worked against the selection of México as a leisure tourism destination.

Travel motivation studies are frequently a classification misnomer for destination marketing attitudinal or satisfaction studies (Pearce & Stringer, 1991). While Kao, Patterson, Scott, and Li (2008) assert that satisfaction of a travel experience cannot be studied apart from motivational considerations, satisfaction is a different focus than taken in this proposed study, as the emphasis proposed is on the factors which prompt the decision to travel and in destination selection, not in consequent satisfaction. The conception of the destination prior to travel, however, is pertinent to this study.

This image, whether positive or negative, is a critical factor when choosing a leisure destination (Mayo, 1973; Ross, 1991). A destination image, and thereby its role in traveler selection, is made of two levels. The first is the information known to the prospective traveler from sources other than advertising or promotion. This includes news stories, history, magazines, and general word-of-mouth. The second is an induced image as a product of marketing (Gunn, 1972). The relative influence of each has been addressed in current research, but the degree of one over the other may be explored during the proposed research.

Another delineation of the components of destination image is provided by McKay and Fesenmaier (1997), who posit that image is composed of personal factors (such as familiarity with the culture) and objective factors (such as the physical features of the region). Rather than being viewed as an alternative to Gunn's (1972) model, this might be viewed as complementary, as it provides criteria by which to consider both the organic and induced images to which Gunn refers. It is suggested that the personal factors may be operative for the medical tourist, while the objective factors may morph into the traveler's assessment of the medical care offered in a particular location.

Yet another consideration is that of distance the destination is from home (Nicolau, 2008). This is a particularly intriguing consideration in assessing the medical tourist, for the two most frequented destinations of medical travelers seeking surgery are Thailand and India (Alsever, 2006; Bookman & Bookman, 2007; Tatko-Peterson, 2006). This seems to raise the question of distance as a primary factor.

Related to this, there is another factor that comes into play in destination selection; that of the pragmatic considerations of time available for travel, the

accessibility of the destination, and the anticipated total cost of the trip (Crompton, 1977; Um & Crompton, 1990, 1991). It is postulated that these factors may be at least as important for the medical tourist. Indeed, one of the most commonly cited popular beliefs about the medical traveler is that such activities are predicated often on cost savings compared to similar medical treatments at home (e.g., Gahlinger, 2008; Grace, 2007; Kaiser Family Foundation, 2007; Keckley & Underwood, 2008, 2009; Tatko-Peterson, 2006). These have implications in assessing both the push and pull factors of medical traveler motivations.

Dellaert, Ettema, & Lindh (1998) regard these pragmatic considerations as restraints on destination selection and add to the list that of the availability of traveling companions. Most medical travel is made in the company of a friend or relative (Woodman, 2008). Therefore, the companion's perception of the destination, as well as available travel time and additional costs are potential factors that need to be included in medical traveler destination selection.

All these models attempt to explain how a final decision is reached by the prospective traveler (Mansfield, 1992). Because the decision is complex, and in the case of the medical traveler, perhaps especially considered risky, the decision may be viewed as a high involvement activity (Hawkins et al., 1992). The eventual decision involves an assessment of the probabilities that will result from the alternatives under consideration (Mansfield, 1992; Mathieson & Wall, 1982). Sirakaya and Woodside (2005) propose that explanation of this decision making process by be explained in one of two broad concepts. The behavioral approaches advance the idea that tourists are motivated to first

collect information on a number of different alternatives and weigh these factors in reaching a final conclusion:

Behavioral models, in general, assume utilitarian decision-makers who can evaluate outside information to which they are exposed, search for additional information to make better decisions, create alternatives in their minds and make a final choice from those alternatives. The main purpose of behavioral models is to identify the decision stages decision makers pass through and illustrate this process by identifying the inside and outside factors influencing this process. (Sirakaya & Woodside, 2005, p. 824)

This is contrasted to the other major concept, that of choice-set, which Crompton (1991) describes as approaching tourism research as: “[A tourist] first develops an initial set of destinations, widely known as an awareness set, then eliminates some of those destinations to form a small late consideration or evoked set and finally selects a destination from the late consideration set” (pp. 421-422). This is frequently compared to a funnel-like process of decision making. This has been the preferred approach by travel researchers (Sirakaya & Woodside, 2005), for while being lighter in theory, are more apt to produce results applicable to destination marketing. Choice-set perspectives emphasize past knowledge of destinations as a heavy influence on final selection, but such an emphasis may or may not be applicable to the medical tourist, as familiarity with medical specialties in specific destinations is not likely. The behavioral approach is broader, incorporates psychological elements to a greater degree by placing a greater emphasis on alternatives, and tends to be more complex, which seem to be in keeping with the merger

of travel and medical considerations. In maintaining the widest possible scope upon which to proceed with exploratory research of medical tourism, the behavioral approach seems to be advocated, until it is demonstrated that the more limiting approach of choice-set models may apply to such travelers.

The predicted uniqueness of the medical tourism experience may also make the application of a final tourist motivation theory less applicable. Pearce & Caltabiano (1983) have proposed a “travel career ladder” in which a person’s past tourism experience contributes to future travel plans which serve a higher tier in Maslow’s (1943) hierarchy of needs. Thus, the more a person travels, the more motivations such as self-esteem and self-actualization play in encouraging future travel and destination selection. These motivations may manifest themselves in seeking more authenticity in travel destinations (defined as desiring genuine people and places (MacConnell, 1973)), and more interest in cultural and historical elements. Given the physical needs, which are the root of medical travel, it is not clear that this theory directly applies to the medical tourist; however, past travel experiences may create a greater willingness to travel to foreign cultures for such treatment.

### **Chapter Summary**

Clearly, there are a plethora of theories, emphases, and schools of psychological thought that may be applied to tourist motivations and destination selection. Traveler motivation for any purpose remains an unsettled area of investigation, informed by psychological theories of general motivation. As has been indicated, given the potentially unique aspects of the medical tourist in contrast to the leisure tourist, some theories intuitively seem more applicable to the medical traveler. However, until studied, these

remain intuitive hunches. Perhaps leisure considerations, such as climate or physical factors of a destination, play a greater role than anticipated, particularly if the journey is one made accompanied by several family members. Why medical travelers elect an international journey and choose one destination over others also capable to providing desired medical treatment, may fit one or more of the current leisure motivation theories or may provide evidence that a new theory applicable to only medical travelers needs to be developed.

## CHAPTER 3

### METHODOLOGY

#### **Conceptual Framework of a Qualitative Study**

In such a new and unexplored area as medical tourism, if the starting point is not qualitative research, there is nothing theoretically concrete upon which to base the selections of items to be included in quantitative survey instruments (Echtner & Brent-Richie, 1991). Quantitative studies are helpful in exploring already tested theories to find new depth or application to those theories. When those themes, patterns, or biases have yet to be clearly established, their application to new subjects carries with them the assumption that they apply to the new subject. A prudent first step is to strive to objectively explore what patterns or themes may be operative in the new subject area, and in this, qualitative research is particularly well suited (Leedy & Ormrod, 2005).

Since it is not known whether medical travelers share similar motivators to those of leisure tourists, an instrument informed on motivators of leisure travelers may be prejudiced in its item inclusion, or, as Zaltman (2003) reported, quantitative research becomes an instrument by which to reinforce existing conclusions - in this case that the leisure and medical travelers share similar motivations. Previous tourism research has demonstrated the potential for such circular logic by Krippendorf (1987) when he discovered in his research into travel motivation that what was most frequently cited by tourists were the same reasons provided to them in advertising for travel or encouragement in selection of a specific destination. To avoid this pitfall, a qualitative research approach has been utilized in this study.

Qualitative research involves studying a topic in its complexity and identifying hidden aspects that can then be explored piecemeal by quantitative efforts. In other words, qualitative study can help identify “what needs to be studied” (Leedy & Ormrod, 2005). A challenge with most qualitative research, however, is the potential for subjectivity to creep into the data (Bird, 1998; Klee, 1997, Neuendorf, 2002). Unlike quantitative research, a strength of the qualitative approach, which makes it particularly desirable for this effort, is that it is well suited for exploring little-known phenomena as freedom is granted for topics to arise as the process proceeds (Marshall, 1985a, 1987, as cited by Marshall & Rossman, 2006). Since qualitative studies approach research from a holistic perspective, and allow for inquiry into yet-unknown possible linkages between topics, results from qualitative studies may develop frameworks. Quantitative studies by their rigid nature, their pre-conceived hypotheses, or researcher-selected rigidity of inquiry, are poorly equipped to make such an initial assessment (Lincoln & Guba, 1985).

It is suggested here that research on medical tourism may have two current weaknesses: 1) In some cases, theories from outside the medical travel arena have been imposed which may or may not be appropriate, and 2) even when there has been caution in not imposing theories, the biases by researchers on what is assumed to be traveler motivation may still be evident.

There are currently many assumptions being made about the motivation of the medical traveler, from the construction of marketing plans to legislative policy formation, and from decisions in investment to the design of services assumed to be desired by these travelers. As Babbie (2010) instructs, content analysis is a valuable approach in

considering at once two key variables in a topic of interest; in this case, the medical traveler and the assumptions of motivations encouraging their behavior.

Indirect exploration is critical to making this a well-rounded study in two aspects. First, it is reported that 95% of thinking happens on the unconscious level (Zaltman, 2003). In other words, even with solid research methodology, assumptions about the topic may creep in. With so little direct research into medical traveler motivations, these assumptions may influence academic research. Without methodologies to probe this influential part of a researcher's thinking, the best research studies can be based upon these assumptions. Therefore, a key element of this study is to discover what motivational factors are being de facto assigned to the medical tourist by researchers, both to inquire whether such a bias does exist, and to identify motivational factors that to date may have been overlooked and worthy of future exploration.

Although this study is exploratory in nature, the research benefits from a theoretical framework upon which academic journal contents may be categorized and analyzed. Academic articles published between 2007 and April 2012 were assembled and categorized as focused on 1) business and tourism, 2) legal, policy, and economic, 3) medical and technical, or 4) social science. The legal, policy, economic, medical, and technical articles were then discarded as not pertaining to the topic of traveler motivation, but only after review to assure motivational intentions were not explored in relation to their larger foci. The remaining articles were then analyzed using key words that pertain to, or in some cases define, the theoretical framework in each of the four schools of psychological thought. Additionally, additional key words relevant to specific theories of leisure traveler motivation were classified under the applicable school of psychological

thought to broaden the terminology database and provide a way to assess if one or more of their leisure travel motivational theories seemed to be gaining preference in explaining the motivations of the medical traveler.

## **Research Design**

### **Content Analysis**

This study is approached using two accepted qualitative methods of research. The first is content analysis.

Content analysis seeks to discover a general but condensed meaning of the phenomenon under consideration via the use of inductive data (Elo & Kyngas, 2007). It assumes that “embedded in the text and objects that humans produce are larger ideas these groups have, whether shared or contested” (Hesse-Biber & Leavy, 2011, p. 227). Its basic process is that of dividing, defining, and tallying units of communication through the use of a classification system with the result of making scientific meaning from a collection of work (Clark-Carter, 1997; Holsti, 1969; Krippendorf, 1987; Lewis-Beck, Bryman, & Liao, 2004; Weber, 1990). Notably for this study, content analysis has found its greatest application in psychology, sociology, social sciences, medicine and health, and has achieved continued and broadening acceptance as demonstrated by its growth ninety-five fold in dissertations from 1958 to 1999 (Neuendorf, 2002). It is not unknown in the field of tourism research, either, as Finn, Elliott-White and Walton (2000) include several examples of its implementation in their book on tourism research methods.

Content analysis is “a detailed and systematic examination of the contents of a particular body of material for the purpose of identifying patterns, themes or biases” (Leedy & Ormrod, 2005, p. 142). It is fitting for this study to note that “it [content

analysis] might be used in an ex post facto study to determine how people in different academic disciplines interpret and understand new data differently” (Ormrod, Ormrod, Wagner & McCallin, 1988, p. 425). A key factor making it applicable to such a task is that it is “unobstructive and nonreactive” (Marshall & Rossman, 2006, p. 108). In other words, it does not disturb the context or setting from which the material is drawn, as may happen in interviews, surveys, and other techniques in which researcher bias may influence what is heard, or what is incorporated into a survey (Leedy & Ormrod, 2005).

A strength of content analysis is that it can amass material from a global nature (Koufogiannakis, Slater, & Crumley, 2004; Marshall & Rossman, 2006). As will be shown below, material was gathered from several countries and continents - an impossibility in all but the most generously funded research effort- using interview, survey, or experimental techniques. Without geographical limitations in the material analyzed, the findings may be more universally applicable.

Content analysis requires some clear definitions at the beginning of a study. Babbie (2010) explains that it is critical to identify the units of analysis to be used – in this case the individual academic articles produced in the last five years – and the units of analysis to be employed. There are two aspects to these units of analysis; first is clarity on what is being studied for content analysis is not to be used as a fishing expedition into a broad topic. That is not to suggest that concepts might not emerge during the course of the study that were unanticipated at its beginning (White & Marsh, 2006) but rather that a specific focus must be identified and maintained. In this case, the analysis is on the motivational traits identified in medical tourists by academic researchers to date.

### *Selection of Terms*

The unit of analysis also applies to a definition of what is being analyzed – words, themes, characters, sentences or paragraphs, or items (Holsti, 1969). The most commonly used unit is the word, which is also what will be utilized here. Neuendorf (2002) identifies eight possible types of analysis. Her definition of “discourse analysis” as a “technique [which] aims at typifying media representations” (p. 5) best describes the efforts represented here. A weakness Duncan (1996) identifies of this sort of analysis is that it is subject to various opinions as to how to judge and classify a text. One reader may render a different judgment from another, particularly in the interpretation of what assumptions may be made by the reading. This is particularly true when the researcher is seeking to determine the motivation of the speaker or author, referred to by Babbie (2010) as the latent context of the message. By focusing on the “manifest” content (Babbie, 2010, p. 338), or in other words the visible, surface content, much of these vagaries are avoided, thus giving greater reliability to the results. Fortunately, this study is about the manifest content, as no effort is made to determine the authors’ hidden intentions in their word selection.

Classification by word has the added advantage of removing much bias from the circumstance of having only one rater, as words more easily may be judged by their usage, providing “categories [that] reflect the purpose of the research, [are] exhaustive, mutually exclusive, independent, and ... derived from a single classification principle” (Holsti, 1969, p. 94-95).

An almost invariable element of content analysis is to determine the frequency in which a characteristic is found in the material being studied. This study has also utilized

this technique. First, key concepts and ideas were identified in each of the four psychological schools of thought, and these were translated into representative words. Then 48 academic articles on tourist motivation were grouped and a word search was run on the 1500 most common words shared by the articles. From these, words relevant to motivation were culled, and using dictionary definitions, they were assigned to a placement under one of the four schools of psychological thought. Finally, key motivational terms identified in the literature of medical tourism were analyzed for frequency, and those appearing to have relevance as an identification of motivation were added to the list. This is in keeping with the directives of Neuendorf (2005) that such word listings, or “dictionaries,” (p. 129) may emerge from the data. Adding the motivational terms identified in the medical tourism literature also prevents the bias of searching only for pre-determined terms from the leisure travel literature which, as discussed above, has not been proven to have relevance to the medical traveler.

The resulting list from the three sources became the master list upon which each medical tourism academic journal article was analyzed. Note that some words discovered in the initial perusal of the medical tourism literature, when examined on an individual word appearance basis, were found to have a different usage and therefore eliminated from the final tabulations. (An example of this is the word “need” which appeared 1793 times in the journal articles, but only 78 times was it used to describe a motivational factor.)

In total, 215 words associated with “push,” “pull,” or “hygiene factors” of motivation were identified and examined. Push and pull factors (Dann, 1977) refer to those elements that encourage a person to travel (the “push” elements), and those

characteristics that are then used in the selection of a particular destination (the “pull” items). “Hygiene factors,” (Herzberg, Mausner, & Snyderman, 1959) as explained in the literature review, are a part of the humanistic school of psychological thought, but have been isolated here due to the role that they purportedly play – elements that may discourage the motivation to travel if present or absent, but their presence or absence is not a motivator, per se, to encourage the travel. For instance, if one is fluent in a foreign language, that may eliminate the concerns of communication difficulties in a destination country; however, that proficiency itself is not a factor in the determination to travel. However, lack of proficiency may be a discouragement toward the consideration of travel for medical care.

### **Population Sample**

As previously noted, travel for medical care as currently being done is a relatively new phenomenon, with attention only recently being given to it. An example of its quickly rising popularity may be observed in that English language news sources made reference to “medical tourism” only eight times in 1992 and this had risen to only 40 mentions by 2000 (Eades, 2010). However, by 2007, the phenomenon’s annual reference rate had swelled to 2335 (Erfurt-Cooper & Cooper, 2009). In fact, the year 2007 seemed to be a pivotal year for the new industry, as the first edition of the most popular guidebook for prospective medical tourists – *Patients Beyond Borders* by Josef Woodman – was published (Woodman, 2007), the Medical Tourism Association was established ([medicaltourismassociation.com](http://medicaltourismassociation.com)), the International Medical Travel Journal completed its first full year of internet publishing ([IMTJ.com](http://IMTJ.com)) (note: despite the name suggesting to the contrary, this is a business publication rather than an academic effort),

the first mainstream publisher released *State of the Heart* - a book about an individual's journey to India for heart treatment (Grace, 2007), *Travel Weekly* ran its first article on medical tourism informing travel agents of its potential and growth (Baran, 2007), and film director Michael Moore releases the movie *Sicko* which highlights a medical journey to Cuba (Moore, 2007).

However, all of these were in the popular media. Academic publishing on the topic was very limited until 2010, but since 2007 was the year that first advanced on several fronts the concept of traveling for medicine to the public, the compilation of academic journal articles on medical tourism for use in this study was started in this year.

Articles were collected from database searches of terms "medical tourism," "medical tourist," "medical traveler," "health tourism," "health traveler," "health tourist," and "global healthcare." Libraries of the University of Nevada, Las Vegas, and Florida International University were supplemented by interlibrary loan support, and articles were also obtained from the Center for Medical Tourism Research at the University of the Incarnate Word in San Antonio, Texas ([www.uiw.edu/medicaltourism](http://www.uiw.edu/medicaltourism)), a research center for medical tourism at the University of York, England ([www.medicaltourismresearch.co.uk](http://www.medicaltourismresearch.co.uk)), the Simon Fraser University Medical Tourism Group in Burnaby, British Columbia, Canada ([www.sfu.ca/medicaltourism](http://www.sfu.ca/medicaltourism)), the Medical Tourism Research Center at the University of North Carolina, Pembroke ([www.uncp.edu/mtrc](http://www.uncp.edu/mtrc)), and the joint research effort between Westfield State University, Westfield Massachusetts, and Feng Chai University in Taichung, Taiwan ([www.westfield.ma.edu/medicaltourism](http://www.westfield.ma.edu/medicaltourism)).

Also utilized was the Centre International de Recherches et d'Etudes Touristiques, in Provence France (<http://www.ciret-tourism.com>), the International Medical Travel Journal in Berkhamsted, Hertfordshire, United Kingdom, ([www.imtj.com](http://www.imtj.com)), and the Medical Tourism Association based in West Palm Beach, Florida ([www.medicaltourismassociation.com](http://www.medicaltourismassociation.com)), and Globally Integrated Healthcare and Medical Tourism, of Denver, Colorado ([oneworldonehealthcare.ning.com](http://oneworldonehealthcare.ning.com)). Finally, documents were also secured from the European Medical Travel Congress ([www.emtc2012.com](http://www.emtc2012.com)) and Medical Korea Global Healthcare and Medical Tourism Congress ([www.medical-korea.org](http://www.medical-korea.org)). By using such a plethora of sources, and by eliminating from consideration articles clearly from popular media outlets, it is posited that few academic articles were missed. A few were not retrievable through any of these sources, but over 90% of those identified were eventually secured for this study.

From those secured, the result was 1586 documents, and each was categorized by its primary focus: 1) business and tourism, 2) economic, policy and legal, 3) medicine and technology, or 4) social science. The economic and legal category, as well as the medicine and technology category, were then eliminated due to having a focus that did not include travel motivation. The remaining 1037 documents were then assessed for their worthiness for classification as academic research. This left 216 articles, of which 112 were classified as business or tourism oriented and 104 classified as social science. These became the basis upon which the study was conducted.

The 215 terms associated with “motivation” were then located and examined in each article for whether the usage was related to motivation, and for those articles which an individual term was used in such a way, the article was credited with its use.

The breakdown of article publication dates are noted in Table 2

Classification	2007	2008	2009	2010	2011	2012 (through April)
Business and Tourism	12	9	10	34	39	8
Social Science	5	7	11	43	31	7

Table 2: Breakdown of publication dates.

By compiling such a large majority of the total population, issues of sampling error are greatly diminished. In truth, it is virtually impossible in most cases to have access to an entire population for a study, but this represents the closest possible assemblage of the entire population of academic articles by business, tourism, or social science academicians as may be possible to assemble. This rarity is only due to the very new nature of this topic for academic consideration.

Each of these articles was examined for the 215 words identified as potential motivational factors. Determination was made only of whether a key word was used associated with motivation. Total counts of word usage were not made per word per article as it was not necessary for the next step in the analysis, using correspondence analysis.

Examination of articles was done using NVIVO version 9, a program which, under its former name NUD\*IST, received recommendations from Neuendorf (2002) and Leedy & Ormrod (2005) as the most commonly used computer program for such study.

Articles were also assessed for the type of medical or health treatment being addressed, and these were classified by the six kinds of medical travel detailed in Chapter

One. Finally, articles were judged based upon the type of research of academic discovery used – so articles were identified as qualitative, quantitative, or descriptive. In 16 cases, the articles were deemed to be primarily an opinion piece. These have been included as well but categorized as opinion articles.

Assessment was also made on whether an article was focused on motivation from a perspective of primarily understanding patients or for purposes of enhancing marketing efforts, and determination was made of whether the medical travelers assessed were studied prior to travel, after travel, or whether their focus was on those choosing to not travel, or finally, whether the focus on the study was on the “speculative” medical traveler. These last two assessments were of greater inferential nature than the other categorizations, and as such may be considered of less reliability due to the increased reliance on rater opinion. With only one rater completing this study, it was sought to reduce the inclusion of rater opinion in the classifications, but in these last two categories it could not be avoided.

Each of the 215 motivational variables were associated with a psychological school of thought or purely “pull” variables and then laid out on a contingency table showing their presence or absence in the 216 articles under study. The articles were coded so that distinctions may be made by authors writing for business and tourism consumption and those writing from a social science perspective. Also, articles were coded by publication year to allow for examination of any longitudinal trends during the brief existence of this literature production.

Additionally, each article was assessed as to its mention of any of the 68 most common medical conditions have resulted in medical travel, as determined by a review of

conditions cited in the following eleven books written for prospective medical travelers and their service providers:

Gahlinger, P. (2008). *The Medical Tourism Travel Guide*.

Hancock, D. (2006). *The Complete Medical Tourist*.

Jagyasi, P. (2011). *Dr. Prem's Guidebook: Medical Tourism*.

Kumar, R. (2009). *Global Trends in Health and Medical Tourism*.

Marsek, P.W., & Sharpe, F. (2009). *The Complete Idiot's Guide to Medical Tourism*.

Singh, P.K. (2008). *Medical Tourism: Global Outlook and Indian Scenario*.

Stephano, R.M., & Cook, W. (2010a). *Developing an International Patient Center*.

Stephano, R.M., & Cook, W. (2010b). *The Medical Tourism Facilitator*.

Todd, M.K. (2012). *Handbook of Medical Tourism Program Development*.

Todd, M.K. (2012). *Medical Tourism Facilitator's Handbook*.

Woodman, J. (2008). *Patients Beyond Borders* (2<sup>nd</sup> ed.).

To assure no condition had been overlooked, a word frequency was also run on all articles under study, and those conditions appearing in the top 1500 most frequently used words were also integrated into the list. Each of these conditions was then assigned one of the six categories of the type of medical traveler represented (see operational definitions below).

Finally, the contingency table included the assessment of each article based upon the type of research it represented, whether the focus was on the individual or on

marketing messages, and whether the study was made on pre-travelers, post-travelers, non-travelers, or the speculative potential traveler.

### **Correspondence Analysis**

To analyze such a large amount of nominal data, a useful technique is correspondence analysis. It is a technique developed in France in the late 1960s and only recently has it gained much attention or application in the English speaking countries. Jean-Paul Benzercı perhaps summarized its strength best in the title of his seminal work introducing the technique to the English speaking world: *Statistical Analysis as a Tool to Make Patterns Emerge from Data* (Benzercı, 1969).

The method is especially advised in the case of this study, as it has three important characteristics. First, it is an inductive technique, providing a tool to search for underlying structure within a data set by “replacing the raw data with a more simple data matrix without losing essential information” (Clausen, 1998, p. 1). In this regard, it is much like traditional multivariate techniques such as factor analysis or discriminant analysis (Hair, Black, Babin, Anderson & Tatham, 2006). However, a limitation of those statistical methods that does not hinder correspondence analysis is that it applies when data are nominal without violating any statistical assumptions (Clausen, 1998). Therefore, it provides an “easy-to-interpret perceptual mapping tool that is appropriate for analyzing categorical data” (Javalgi, Whipple, McManamon & Edick, 1992, p. 35). Data analyzed by correspondence analysis is not subject to any restrictions, save that no negative numbers may be used. Categories do not need to be approximately equal in size, and as such, it is a preferred technique for exploratory studies (Hair et al., 2006).

Thirdly, correspondence analysis provides a way to see patterns, and judge “inertia” (which is similar to variance in principal components analysis) that is contributed by the principal axes. Additionally, the inertia associated with each dimension may be broken into proportions explained by the various points (Weber, 1990). These proportions measure the “quality” of the results obtained for a particular row or column (Hoffman & Franke, 1986). As detailed by Hoffman and Frank, such a quality number is “the relative contributions to inertia...the relevant squared correlations and the sum of these correlations across dimensions” (p. 168). While the interpretation is subjective, the higher the quality number (from 0 to 1), the higher assurance there is that the results are a good representation of that aspect of the data (Lee, et al., 2007) .

The most identifiable weakness of correspondence analysis is that it may be inordinately influenced by outliers (Clausen, 1998). To account for this, all initial correspondence analysis results were scrubbed to remove outliers. All correspondence analysis results provide a numerical set of coordinates that represent where, on the graphs it produces, that particular element resides. To assure consistency, all points which had either an x- or y-coordinate in excess of 0.75 in the initial run was considered an outlier and removed from further consideration.

On these charts, by using symmetric graphing, the same relative values are used in all axes thus permitting a comparison of rows and column values at the same time. The nearer a row or column item is to the intersection of the axes, the less relative difference it represents compared to other row or column items a greater distance from the intersection; the closer a column value is to a row value, the greater interrelatedness do the components share. While similar distances of one characteristic from two others may

be interpreted as a relatively similar degree of difference of that first characteristic to the others, this difference in distance is not an arithmetic one. Therefore, conclusions may not be suggested that a certain characteristic is, for instance, “twice” or “half” as likely as another due to plotting alone, but relationships may be posed by those in proximity to each other (Hair et al., 2006).

A particular benefit of correspondence analysis is the insight it can suggest by how items are grouped along an axis. By examining each axis, it may be possible to see certain themes which explain item orientation along one axis. The positioning of items on the graph will also highlight those items given most close attention by a certain set of authors and those which have received lesser attention.

### **Operational Definitions**

#### **Medical tourism terms**

The newness of academic attention to medical tourism is accompanied by new or specifically-utilized terminology. Please note that the terms “medical traveler” and “medical tourist” are used interchangeably as there is no clear delineation between the two. The following words or phrases are used in reporting the results of this study:

*Alternative treatment* is one of the six reasons for medical travel. It refers to traditional or non-western medical attention, such as Ayurveda, acupuncture, acupressure, herbal treatments, homeopathy, naturopathic, siddha, holistic, yoga, spiritual, or other traditional methods, sometimes referred to as complementary medicine, thought to bring healing (Cormany, 2008).

*Diagnostic treatment* is one of the six reasons for medical travel. It applies to both preventative and restorative examination, including executive physicals, exploration of

infertility or reproductive difficulties, or investigation of unknown reasons for a condition. This is not simply the preliminary check-up any individual might undergo prior to medical treatment, but rather the investigation of the cause of a known or unknown condition (Cormany, 2008).

*Elective treatment* is one of the six reasons for medical travel. Elective treatments pertain to medically unnecessary procedures undertaken because the patient desires them, such as cosmetic surgery, tattoo removal, hair restoration, or cosmetic dentistry. This usually refers to aesthetic improvements or body contouring, but may also include gender reassignment. Note that this does not include reconstructive surgery to correct or restore conditions created by injury (Cormany, 2008).

*Quality of life treatment* is one of the six reasons for medical travel. This includes procedures that are not life threatening in the near future, but for which corrective treatment will improve the individual's daily life quality. Examples of this include orthopedic treatments, LASIK or other eye treatment, non-cosmetic dental care, treatment of chronic conditions, and rehabilitation. Bariatric surgery is also placed in this category, for while obesity may be a long term threat to life, it is generally not a surgery that is undertaken because of an immediate danger to short-term existence (Cormany, 2008).

*Treatment for life-threatening conditions* is one of the six reasons for medical travel. Life-threatening refers to circumstances which, if not addressed, may shorten a person's life within a matter of months. Examples include cardiology, oncology, organ transplants, and conditions seeking stem cell treatment (Cormany, 2008).

*Wellness improvement* travel is one of the six reasons for medical travel. This term has the loosest definition, as it is alternatively referred to for specific treatments

such as treatments for addictions, hydrotherapy, stress relief, or for any wellness activity such as hiking, cycling, or other physical activity. In remaining true to the definition of medical tourism as traveling for medical treatments, the term of wellness traveler here is applied only to the former categories of wellness (Cormany, 2008).

### **Motivational terms**

*Traveler motivation* is the application of established theory to explain human behavior in the decision to travel and in the selection of a destination. Theories used to examine such behavior vary depending upon the psychological school of thought through which they have been developed. For purposes of this study, and by definition of “medical tourism,” it is posited that all medical travel by the surgical recipient is for the purpose of seeking medical treatment. Therefore, traveler motivation specifically refers to the choice to travel (frequently called “push” factors), and the reasons for selection of a specific destination (categorized as “pull” factors) (Crompton, 1979; Dann, 1977).

In remaining consistent with the essence of each school of psychological thought detailed in Chapter Two, specific terms associated with or affecting motivation have been classified into as either one of the four schools, as hygiene, or as pull factor. As is true of the psychological schools in general, there is some overlap in terms; the school with which the terms appear most closely associated are assigned the term, but this is subject to challenge and must be considered a potential weakness of the study. For instance, the term “stress” applies to all schools, but has its roots and greatest applicability in the psychodynamic school of thought. The terms identified with each school (shown below) are checked in the first stages of correspondence analysis for their fit with other terms; they have been reassigned and noted in the results section if this initial inquiry indicates

such reassignment may be warranted. The conclusions section shows final assignment of terms most closely associated with a specific school of thought, the terms most commonly found regarding motivation in the tourism literature and their assignments beneath a specific school, and finally, the terms that most frequently appeared in the medical tourism literature, also sub-assigned to a psychological school of thought.

*Behavioral school* is summarized by terms of behavior, social influence of others, reaction, rewards, and work style. A key element in this is one's social conditioning and responses to stimulus. Additional terms included under these five encompassing terms are shown on Table 3:

Defining terms:	Behavior	Social Influence	Reaction/ Response	Rewards	Work Style
Additional psychologically applicable terms:	Conditioning Punishments Stimulus	Experience of others Socio- cultural factors Social learning	Cause Emotions Effect	Liabilities Penalties	Job Satisfaction Employee attitudes
Terms commonly appearing in tourism literature:	Outcomes Consumer	Family Friends Comparison Observing	Obligatory Perspective	Satisfaction Prefer	Work experience Choices

Table 3: Terms related to behavioral psychology

*Humanistic School* of psychological thought has a focus on the here-and-now and the interaction of thinking and emotions. Key definitional phrases or words for this school include: joy in accomplishment, escape, locus of control, personal responsibility, risk taking, and problem solving. Additional terms included under these six encompassing terms included on Table 4.

Defining terms:	Joy in accomplishment	Locus of control	Personal responsibility	Problem solving	Risk taking	Escape
Additional psychologically applicable terms:	Achievement Pleasure Status Prestige	Empowered Self-esteem Control	Thoughts Self-actualization Capabilities	Adaptors Potential Probability	Safety	Freedom Spiritual Fantasy
Terms commonly appearing in tourism literature:	Recreation Affiliation Physical Rest Luxury	Approach – approach Approach-avoid Avoid-avoid Experience Energy level	Loyalty Seeking	Importance of outcome Push factors Structured - unstructured	Adventurous Reliability	Lifestyle Free Anonymity

Table 4: Terms related to humanistic psychology

Also represented in the Humanistic school are “hygiene factors,” a term coined by Herzberg, Mausner, and Snyderman (1959) to describe factors or conditions which if absent may be a de-motivational element in an individual, but their presence does not necessarily encourage or motivate a person to action. An example of this is the

possession of a passport, the absence of which may discourage travel, but its presence is not a cause for medical travel. Others include physiological needs and cost.

*Pragmatic School* of psychological thought is one that focuses on the conscious and logical control a person may exercise on his/her life. Key concepts/phrases for this school include dissonance, habits, logic, and perception. Additional terms included under these four encompassing terms shown on Table 5.

Defining terms:	Logic	Perception	Habits	Dissonance
Additional psychologically applicable terms:	Reasoning	Understanding		Therapy
	Purpose			
	Examine			
Terms commonly appearing in tourism literature:	Benefit	Expectations		
	Options			

Table 5: Terms related to pragmatic psychology

*Psychodynamic School* of psychological thought, the oldest of all, is concerned with emotions, unconscious factors, and dispositions. Additional terms included under these three encompassing terms are shown on Table 6.

Defining terms:	Disposition	Emotional states	Unconscious factors
Additional psychologically applicable terms:	Tendency	Insulation	Drives
	Temperament	Release	Desire
	Provocation	Excitement	Impetus
		Fear	
Terms commonly appearing in tourism literature:	Attitude	Power	Impulse
		Inspiration	

Table 6: Terms related to psychodynamic psychology

*Factors involved in the decision to travel for medical care.* Before a destination might be considered, the decision needs to be made to entertain the notion of traveling for medical care (“push factors” in tourism theory – Dann, 1977). All of the psychological schools of thought focus primarily on these push factors.

While much has been debated about deep-level needs which are served by leisure travel (see theoretical explanation in Chapter Two), it has generally been advanced that medical travelers wishing medical care elect to travel for one of the following reasons: cost savings, treatment availability not offered at home, opportunity to utilize a renown medical expert in a particular treatment, or to be closer to one’s original home and family (Medical Tourism Association, 2009). However, these are untested assumptions and do not explain why individuals with similar conditions, financial resources, and similar backgrounds may diverge in their choice of whether to travel and in destination selection.

There may be affective elements with the decision to travel, such as feeling opportunities at home are financially out of reach with resultant emotions that may be associated with such a condition; also of issue is that of what are the factors, emotional and cognitive, that cause the traveler to select a particular destination.

*Cognitive Factors* are the rational, logical reasons medical travel is undertaken. The chances that rational, cognitive factors may significantly influence the medical traveler are probably greater, due to the overwhelming consequence of the decision on one's health and life expectancy, than in the average consumer purchase. The need is unhidden and palpable, so it is hypothesized that awareness of the process of the decision making may be more recognizable by the traveler.

*Affective Factors* are the emotional or visceral factors that influence the decision to choose to travel and to select particular destination for medical treatment. Zaltman (2003) represents a growing school of marketing experts who believe affective and unconscious factors are most significant in a consumer's decision process. This therefore refers to the affective (if not unconscious) elements of the decision selection process.

*Non-medical considerations or support* include any services or facilities not under the operation or conducted by medically-trained personnel. This may be accommodations based upon a traveler's condition, such as transportation adaptation needed by limited-mobility individuals, accessible hotel facilities, or dietary modifications made by food service operations. This may also include those destination considerations not medically related, such as tourism opportunities, airline support and travel time, and hotel services.

*Terms related to nature of studies under examination*

*Qualitative studies* are endeavors where the data is not in numbers (Punch, 1998), the design is emergent, the data is focused on the meaning of words, the process is intuitive and the focus is on exploring new phenomena and developing theory (Henderson, 1990).

*Quantitative studies* are undertakings where the data is in numerical and non-nominal form (Punch, 1998), the design is pre-ordinate, the data is focused on measurement, the process is rational, and the focus is on confirming or refuting theory (Henderson, 1990). Note that, by this definition, correspondence analysis is a qualitative instrument, for its resulting numbers do not represent specific values, only a comparison of relative placements, and as such, hold no definable inherent values.

*Descriptive studies* are summaries and compilations of what are already elements of existing knowledge, without any process of data measurement involved. Much like a free standing literature review, these have been used to report and alert other academicians to the growing trend of medical tourism.

*Non-traveler studies* pertain to a focus on those who either needed or desired medical treatment and considered then decided against travel to receive their treatment. A key element in such studies is that a medical need or desire needed to already exist, so the consideration regarding travel is not speculative.

*Speculative studies* pertain to those who may be surveyed or interviewed about their attitudes toward medical travel if they had a condition warranting attention. Given the complexity of emotions and needs when medical attention is needed, it is posited here that speculative travelers may have less dependable responses to the concept of medical travel than those who have considered it under the weight of impending medical treatment.

*Pre-traveler studies* have a focus on those who have determined to travel for medical care but have not yet made the trip at the time of data collection. In contrast, *post-traveler studies* are gaining information from those who have decided to travel and

have completed that travel. Pre-traveler studies may have greater insight into the anticipation, excitement, fears, and other emotions which precede both the experience of travel and the lead-up to receiving medical treatment. It is conjured that post-traveler studies may provide greater reflective insight into the logic, thinking and expectations as a result of already completing the trip.

### **Chapter Summary**

From 1586 documents, 216 were determined to be addressing in an academically viable way the business, tourism, or social science interests in medical tourism (a listing of these is available in Appendix I). To these articles, key words were examined for their relevance in describing an aspect of motivation. Articles were evaluated as either containing or not containing each of 215 terms as used in describing a motivation for travel. From this, a contingency table was developed and an initial application of correspondence analysis served to identify outliers so they could be removed. This scrubbed table was then divided into six tables with each table representing one of the six types of medical travel previously discussed. Correspondence analysis was then run on each table as a whole and on only the key words associated with psychodynamic, behavioral, humanistic, or pragmatic psychological schools of thought. Additionally, each table was examined by correspondence analysis for the hygiene and pull factors associated with that particular reason for medical travel. Finally, each table was divided by articles from either the business and tourism perspective or the social science perspective, and each sub-section was again analyzed against the schools of psychological thought and the hygiene and pull factors. This provided both macro and

more specific identification of the motivational terms associated in the current literature with each of the six reasons for medical travel.

CHAPTER 4  
RESULTS AND ANALYSIS

**Motivation terms**

A word count was run on the 216 articles identified for inclusion in this study. From it, all words that suggested motivational applications or reasons for travel were identified and added to the appropriate school of psychological thought. The result was an additional 110 terms being categorized by psychological school and added to the list of terms being examined in each article. This means that over half of the searched terms came from the articles themselves. In this manner, the framework of the psychological schools served as the theoretical backbone for analysis, but the potential bias was overcome of using only terms from psychological or leisure travel texts and potentially missing other patterns provided in the articles.

The application of 215 search terms to 216 articles resulted in a potential of 46,440 key word matches. Of these, 2693 applications of key words, as used in motivational terms, were discovered in the articles. In some cases the key words did not appear in a motivational sense in any articles. In others, after the initial application of correspondence analysis it was determined to be an outlier, and therefore removed. The resultant 132 remaining terms were then included in the subsequent analyses. In this first run, the terms were dropped from consideration as identified in Appendix One.

It is important to note that the above list is not simply a differentiation of word counts. Correspondence analysis provides each term a pair of two coordinates, so in addition to their visual location of the figures created in analysis, a standardized level may be determined above which the term assumes the role of an outlier. The location of

each labeled point is determined based upon its relation to other points on the graph. Therefore, points grouped closely together have more in common with each other; however, the scale shown on the axes has no arithmetic meaning. The relativity is shown compared to other points in the variable, and also on the symmetric plot the relative position to the points of the other variable.

For this study, any term above .750 or below -.750 in either coordinate was labeled an outlier and removed. Again, these terms assume no ratio scale significance; they simply represent the term in relationship to all other terms included in the analysis. Because of this, when the analysis is done on smaller portions of this overall sample, some terms became outliers and were eliminated for that sub-domain only.

One notable observation with the first run of correspondence analysis on the newly scrubbed data was the clear distinction illustrated between the articles written by social scientists and those written by business or tourism academicians. Of less distinction, but still observable, is the grouping of life-saving, quality of life, elective, and diagnostic procedures relatively close together for each of the disciplines, as well as a more distant placement for wellness and alternative treatments, thus suggesting that these two types of treatments are viewed as having somewhat different motivators. For each of the academic disciplines, the interests and concerns of the individuals traveling for the four grouped conditions are most similar within that discipline, yet quite far removed from those of the other discipline. This difference suggests that each discipline is potentially missing information upon which the other is focused. To a greater or lesser extent, this dichotomy between the two disciplines was apparent in all analyses done.

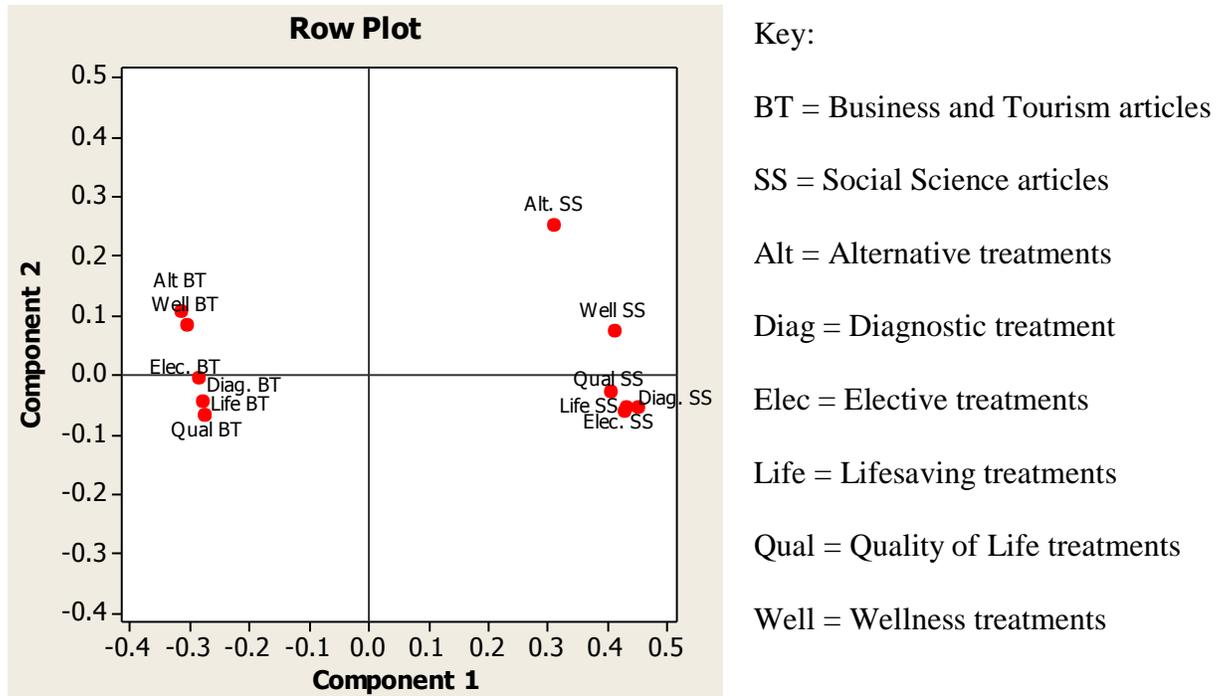


Figure 2: The correspondence analysis assessment of the defined types of medical travelers and treatments as related to the type of academic journal in which they were cited.

### Medical conditions

Sixty eight medical treatments were identified and each of the 216 articles was assessed for mention of them. Articles using a term in a medically-related manner were counted and then assigned categories when considering motivations assigned to a specific type of traveler. The categorical assignments for life-saving treatments included the following key words: cancer, cardiovascular, heart, hysterectomies, kidney, liver, mastectomies, oncology, organ, stem cells, and transplant. Quality of life procedures included: bariatric, chronic, continuity of care, dental, eye, gynecology, hip replacement, knee replacement, LASIK, orthopedics, reconstructive, rehabilitation, replacement, root canals, and spinal. It is clear that there may be some potential overlap of these two lists,

as stem cells, for instance, may also be used in quality of life treatments. The attempt was to place terms where they would receive the greatest appropriate use.

For elective procedures, the following words were searched: aesthetic, beauty, body contouring, breasts, cosmetic, elective surgery, enhance, face lift, implants, liposuction, outpatient, plastic, rhinoplasty, and sex reassignment. Diagnostic procedures included: baby, diagnosis, executive physicals, fertility, fertilization, in vitro, IVF, pregnancy, reproduction, and x-rays. These two categories point up the exploratory nature of this study, as the categorical assignments are correct but broad enough that each may contain vastly different motivations for the various treatments they contain. For instance, it is self-evident that a person getting an executive physical may have very different motives than a young couple seeking to become pregnant.

The final two categories are the two slightly removed from others on the above figure. Alternative treatment contained: acupuncture, alternative, Ayurveda, complementary medicine, holistic, and therapies. The wellness category was represented by: addiction, chronic, hydrotherapy, mud, and yoga. It is suggested here that wellness travel is developing its own body of literature, and as such, may be sufficiently different in focus from these other five categories as to eventually be no longer considered medical tourism. This is supported by the writings of Smith and Puczko (2009) who make the same assertion.

All of these terms, save body contouring, fertility, hip resurfacing, and hysterectomies, were found in one or more articles studied. The final number of articles included in each category is represented below.

Document Focus:	Alternative	Diagnostic	Elective	Life-saving	Quality of Life	Wellness
Business & Tourism Literature	58	59	89	61	69	52
Social Science Literature	41	63	50	74	76	54

Table 7: Types of treatments cited in two major academic research journal categories.

### Results of overall analysis

Key to drawing some direction from applying correspondence analysis to content analysis is the detection of patterns. In the analysis of all terms, the significance of certain terms may encourage business and tourism research to more greatly explore the application of certain tourism motivational models. Past experience and travel experience were heavily weighted phrases in the business and tourism literature, which suggests some applicability of Pearce's (2005) travel career pattern concept. Plog (2004) advances the concept of venturesomeness (p. 61) to explain the early adaption of travel trends by some individuals; key words such as excitement, adventurous, and innovator, although perhaps not intuitively associated to medical tourism, do show up as important words in the analysis. Plog has cultivated ground on the notion of traveler psychographics, and this may prove to be an adaptable and useful concept in further medical tourism research.

The further identification of consumer motivations, as shown in the analysis, will be reinforced momentarily during the analysis of the behavioral school of psychological thought from which most marketing and advertising psychology emerges. The business and tourism authors have emphasized loyalty, incentives, comparisons, and the experience of others as anticipated motivators of the medical traveler. Likewise, words of

satisfaction, assurance, and outcomes fall strongly to the business and tourism author's side of the divide, perhaps indicating that applications of some modification of the SERVQUAL (Parasuraman et al., 1988) model may be appropriate.

There is little doubt that the business and travel literature has been more inclusive of non-medical aspects of medical travel, as motivational appeal words such as recreation, relaxation, activity, attractions, shopping, site-seeing, and food all are more strongly favored by such authors. Many of these tend to be pull factors, and 26 of the 37 pull terms are more strongly associated with the business and travel articles. Oddly, two of the eleven words showing a stronger utilization by the social scientists are hotel and housing which are strongly ensconced on their list of more strongly utilized terms. The lack of apparent interest in medical tourism by larger hotel firms, as noted by the Medical Tourism Association (2010), adds emphasis to their absence as items of motivational appeal for medical tourists by the business and tourism researchers. Equally noteworthy was the low value placed by both the business and tourism and social scientists on destination, distance, or the possession of a passport in the list of all items

On the social science side, the key words have a less commercial ring, with an emphasis on anonymity, autonomy, prohibition (as in the case of escaping prohibitions for certain treatments in one's own country), desire, feelings, and trust. Just as tourism writers somewhat mysteriously seemed to overlook hotels, the social scientists are remarkably mute regarding family, relationships, or relatives. This would appear particularly odd since families are usually involved in medical decisions.

It is important to be remain mindful during the discussion of word utilization that these are the words selected for use by authors from these two backgrounds. These are

not terms that have been verified as important to the medical traveler; their use is as secondary information, and as such may reflect more about the mindsets of the authors than it answers for what motivates the medical tourist. As results will show, some patterns of word usage are forming by both academic disciplines and absent studies of medical travelers themselves; the repeated asserted use of these terms may lead to an inappropriate acceptance of them as validated findings regarding traveler motivations.

For each categorical analysis, an analysis of contingency is made identifying how much of the variation in word relationships may be accounted for through two or three dimensional graphing or hypothetical fourth and fifth (or more) dimensions (Hair, Black, Babin, Anderson, & Tatham, 2006). It is recommended that dimensions greater than .2 inertia be included in analysis, and a minimum of two axes is suggested in order to meet research objectives (Hair et al., 2006). The analysis just given of contingency for all terms from all articles has a cumulative explanatory value of 87.34% for a two axis interpretation, providing a criterion by which judgments on the validity of the correspondence relationships may be concluded.

### **Psychodynamic thought applied to medical travelers**

As discussed in Chapter Two, psychodynamic thought traces its roots to Freud (1920) and Jung (1923) and focuses primarily on the unconscious – drives, impulses, fears, needs, etc. While psychodynamic thought remains a significant influence on medical providers (Benedetti, 2011; Russell, 1999), the cloak of the unconscious has made it less appealing to businesspersons and marketers. In the last ten years some businesses and business researchers have been giving more attention to this psychological philosophy (see Carbone, 2004; Underhill, 2009; Zaltman, 2003), but it continues to

receive less attention by business than the behavioral and humanistic schools (Witt & Moutinho, 1995).

The articles by business and tourism academicians analyzed and included here have held psychodynamic terms in most of cases. This may be little more than a nod to psychographic segmentation which has grown in popularity due to the development of more available segmentation techniques (Kotler, Bowen, & Makens, 2010). The earlier articles by business and tourism researchers more centrally identified fear as a central motivational element, but with the exception of patients traveling for elective surgery, more recently these authors have held stress, need, and power as their stronger elements. Stress may be a more refined element of fear – a reasonable assertion in most psychological thought but an unproven assertion in this case. Need remains central in all versions of medical travel, including elective and wellness travel. Power may deserve further research as this may be power to take control of one's own situation, or it may be a sense of powerlessness in being able to receive treatment at home. It is suggested that the term power may be quite differently used by those seeking life-saving treatments and those seeking elective surgery.

Notable is that trust does not hold a more prominent position, for intuitively it would seem that trust is an important consideration in whether to travel for medical care. This may be trust in the care providers to which one is traveling, or lack of trust in local care providers. The element of excitement shows itself in a more central role for elective and alternative treatments, which may be an explanation of a result of having decided to pursue treatment, but it also oddly appears as a central term for live-saving surgery. In the latter case, this may be more closely tied to the concept of hope, an assertion that would

need further research. The assertion receives additional support in that feelings are central in all but the elective and alternative treatment travelers.

Except for these just noted differences, the application of psychodynamic thought does not change greatly between the six causes of travel. This is not a psychological school to which travel motivation researchers have given much attention, but a merger of such researchers with the much more popular application in medicine may yield some interesting insights.

Results from the articles by social scientists show greater variation between traveler types. All the search terms, save notably stress, are closely grouped in their description of the person traveling for quality-of-life treatment. In other treatment types, different emphases seem to be present for differing years of publication, with 2008 most centrally focused on alternative care, 2009 on quality-of-life care, 2010 incorporating all six types of care, and 2011 and 2012 with no discernible focus. This results in differences in central terms for the various conditions. Most central for life-saving procedures are the concepts of stress and need; for alternative treatments, key terms are need, trust, and power; fear, feelings, trust, and need are central to the traveler for diagnostic care. Elective and wellness travelers have no clearly discernible terms assigned to them.

Trust holds a prominent position in the social sciences collections except for the life-saving surgery traveler, where it is noticeably removed from the term clustering. In all cases, awareness and excitement are closely matched, thus leading to the speculation that the authors are linking an increase of a traveler's awareness of treatment options to an increase in his or her excitement.

## **Behavioral thought applied to medical travelers**

The psychological school of behavioral thought has been the philosophy most often utilized by marketers. At its most basic is the concept of stimulus and response, with the assertion that the motivations for behavior are driven through factors by which individuals are conditioned to act in a certain way. With this as a central premise, it may be conjectured that there would be greater variability in motivations assigned to travelers for different medical treatments, and this is demonstrated to be the case by the results of correspondence analysis

Business and travel literature started with considerable year to year differences in its view of the traveler for life-saving treatment. Central cited motivators for such travel are cause, assurance, follow, friends, and place. The first two may be self-explanatory, while follow and friends are both central to the school's concept of learning appropriate responses and coping behaviors from others. In this regard, it surprising that terms such as family, relationships, and relatives showed as outliers. The term place is used in the sense of identifying or feeling a oneness with a location and may point to an interpretation of individuals returning to locations of their birth for such serious treatment because of the inherent comfort they feel for it.

Business and tourism authors linked some of the same terms with quality-of-life treatment seekers, but most central to their terms was that of consume, used to describe the motivations of a consumer is selecting a product. Also a key term is that of satisfaction, which, when linked to consume, again points to marketing and customer service orientations. Traditions also entered a prime location very close to place, identifying not just the physical location preference, but also a comfort with the customs

and vagaries of the location. It may be worth noting that while friends remained a commonly shared term, experience of others was far removed from central consideration. This may suggest that the authors believe that, while recommendations of individuals familiar to the potential traveler are important, generic recommendations or stories of strangers play a lesser role. Emotions and advantage also were far away from center, which is curious since these are such key marketing motivational terms.

For the alternative treatment traveler, the most central term is that of comparison, which may refer to comparison of alternative treatments to standard western medical practices, or may be a comparison of alternative practices to each other. Additional motivational assignments included assurance, satisfaction, concern, preferences, and choices. The first three point to potential criteria by which a treatment is assessed and chosen, while the latter two may capture the spirit presented in alternative treatments; i.e., there are choices and options to be appreciated.

Authors for business and tourism grew more focused from 2007 to 2012, with articles showing greater consistency in identified terms each year.

With those traveling for elective surgery, the emphasis of friends gives ground to the centrality of consume, satisfaction, choices, comparison, and outcomes leading to the potential conclusion that this is viewed as a more traditional consumer purchase. Inexplicably the term tradition also holds central prominence, apparently in contrast to these other terms.

Diagnostic treatment travel is the most convoluted graphing, with nearly all previous terms stacked upon each other. This may be a reflection of this category's contrasting treatments, for intentions to receive an executive physical most certainly

would generate different factors than a couple desperate for fertility treatments. The latter introduces emotional elements probably absent in the former, which may serve to explain how consume, incentives, follow, assurance, comparison, emotions, outcomes, and traditions all occupy approximately the same placement. It is suggested that rather than providing insight into the attitudes and assumptions of the writers, in this particular case what may be indicated is the incompatibility of comparing such diverse treatments, and further research into the separate treatments contained in this category is warranted.

Finally, wellness travel returns to the theme of consumerism, with key words including consumer, comparison, observing, and place representing such travel motivation. Curiously, far removed from a central position are rewards, concern, experiences of others, and emotions, which could be guessed to be associated with wellness travel.

Social science academicians mirrored those of their business and tourism colleagues in identifying the same motivators for travelers of life-saving treatment, except they added share as a central term. This may be the first indicator recognizing the importance of accompaniment for such travel, as over 90% of such travelers are accompanied by a companion (Cormany, 2011). This raises the question of whether it is felt that such travelers would not choose to travel without such a companion.

The two groups of writers diverge when considering quality-of-life travelers. Shared is the concept of place, but rather than taking a more consumer orientation, the social science writers suggest cause, rewards, assurance, comparison, friends, believe, and culture are most central. Because many terms are relatively closely clustered by social science academicians in this category, perhaps as much may be gleaned from the

terms they deemed as of less significance. These included tradition, preference, emotions, reaction, and outcomes. Upon reflection, the one term that makes face value sense is reaction, for quality-of-life travelers are, by definition, traveling to correct an ongoing or chronic difficulty. Reaction may apply to life-saving travelers responding to the receipt of bad medical news, but quality-of-life travelers have no bell ringing moment. This may be one of the most significant differences between the two types of travelers.

The divergence of the business/tourism and social science divisions is complete in identifying motives for the elective treatment traveler. Social scientists suggest family, place, share, perspective, choice, and concern with no overlap from the business and travel authors' list. Words are evaluated regardless of their positive or negative usage; one possible explanation for these words is that such travel is an escape from family and their concerns, a conscious relocation in a place away from home for such treatments as plastic surgery. Medical centers in Beverly Hills, Miami, and Las Vegas frequently service those seeking such treatment away from home, but as with all possible explanations offered here, each is in need of research verification or refutation. Some elective procedures are not available in home countries, so the assignment of choice may be greater in this category of traveler than some others.

Little differentiation of terms was discovered among social science writing with regard to alternative care. Although nearly all terms were clustered centrally, the ones occupying the most central positions were behavior, cause, culture, and traditions. Recalling the premise of this school of psychological thought – that of stimulus and response via conditioning – a possible application of these terms would fit the circumstances of individuals returning to countries of origin for traditional treatments

culturally consistent with their upbringing. These terms have no overlap with those favored by the business and tourism authors who took a more consumerism approach to this type of travel.

Both categories of writers mentioned consume in relation to wellness travelers, and the social scientists also identified incentive, culture, and community. Such terms suggest research into the impact of cultural norms influencing this sort of travel.

### **Humanistic thought applied to medical travelers**

The humanistic school of psychological thought is the one upon which much of popular psychology is built, as well as many of the most popular tourism motivation research theories (Crompton, 1979; Dann, 1977; Gibson & Yiannakos, 2002; Gnoth, 1997; Krippendorf, 1987; Lundberg, 1971; Mannell & Iso-Ahola, 1987; Pearce, 2005; Plog 2004; Sirgy & Su, 2000). One of the most popular motivational theories, that of Maslow's (1943) hierarchy of needs, is representative of this school. Its primary focus, unlike the previous two, is on the here and now. Such a focus also makes it appealing to apply to medical tourism, for much of medical travel is in response to a "here and now" circumstance. When words were added to the word search list from the tourism motivation literature, the majority of them were introduced to this school's list.

In considering the travelers seeking life-saving procedures, the business and tourism journals seemed to emphasize two concepts. The first, and most central, was share, buttressed by together, place, and believe. All of these may contribute to the emotional comfort or psychological peace being sought as one proceeds with a critical surgery. The other concept is represented by advantage, which may refer to anticipated financial savings, opportunities for a particular treatment, or the expected gain by

securing the services of a particularly noted physician. It appears the writers are emphasizing both the affective and the logical sides of what may spur a person to make such a critical choice of travel for life-saving treatment.

A similar duality exists with the travelers for quality-of-life care. Of most central identified motivators are legal, safety, and reliability. Unlike the life-saving traveler, who may be willing to take a greater risk as his or her life is in jeopardy, this seems to suggest that quality-of-life travelers have less concern about surviving the treatment, but greater awareness of the risk that it could be potentially detrimental if something went wrong. Hence, one may be more conscious of weighing legal and procedural safeguards. On the other hand, the words prestige and relaxation suggest that the level of care expected extends beyond the procedure and medical travel has an additional non-medical component for these travelers. Prestige may also refer to the reputation of the health center or the credentials of the attending physician. The appearance of these words signals a clear differentiation from that of the life-saving traveler.

According to the assertions of the business and tourism academicians, a similar concern is shared by elective treatment individuals. Legal, risk, and to a lesser extent, reliability are also attributed motives to this group. However, accompanying these is a different second emphasis. Autonomy and freedom replace concepts of prestige and relaxation. This seems to bolster the hypothesis suggested by the social scientists when describing these same travelers in behavioral terminology.

According to the business and tourism writers, legal and risk continue to be common themes with the alternative treatment traveler,. However, their expectations may be different, as luxury, potential, and status hold central spots as their conjectured hopes.

Since many advertisements for elective surgery tied to vacation activities – such as Surgery and Safari offered by a South African firm (Woodman, 2008) – this may be a recognition of these raised expectations.

According to the business and travel academicians, the number one consideration for diagnostic travelers is relaxation. Since most diagnostic procedures may be perceived as carrying minimal danger, the concepts of legal, risk, and safety are replaced for these travelers by pleasurable motives, including luxury, prestige, and freedom. Like some alternative treatment travelers, the opportunity for pure vacation elements within the trip are greater, and this may mean that modified tourism motivation theories may be more applicable to such travelers.

When attention is turned to wellness travelers, the humanistic school terms most applicable are lifestyle, pleasure, recreation, status, and risk. The first four are intuitively applicable to wellness, but risk is subject to at least two possible interpretations. Since wellness travel may include physical activities, it may be reflecting a concern for mitigating risks in those activities. Conversely, some wellness travelers intentionally seek out some risk-taking activities, such as white water rafting, so in this case risk may be a positive element.

Social scientists have vacillated much more with regard to their assertion of prime motivators from the humanistic school perspective, with each year's publications showing a notably different focus for life-saving travel. In 2007, inexplicably the key words were recreation, fantasy, and pleasure – words generally not associated with someone needing a treatment in order to continue living. In 2008, legitimacy, escape, lifestyle, and understandably, legal were greater foci. These suggest writings that focused

on the entire concept of medical tourism, of which life-saving procedures were just one element. Perhaps this is a reflection of the very term medical tourism which implies an enjoyable element to the travel with the use of tourism in the name. From 2009 forward, the word selection and application of different forms of such travel seems to have caught up, as the composite picture for social scientists' view of motivators for life-saving travelers include legal and potential, but also anonymity, relaxation, and status. Without further research, it is perplexing at these key word selections and may be a factor of the first two years of examined research (2007-2008) skewing the composite results.

The year by year variation is not as extreme when considering quality-of-life travel. The most central motivational descriptions include legal, potential, anonymity, lifestyle, prestige, and restrictive. These again appear more applicable to the entire concept of medical travel than for specifically quality-of-life travelers, but to subscribe to such an interpretation would raise questions about the social scientists' selection of key words for the other psychological schools of thought, most of which have appeared as understandable.

The perplexity continues with both alternative- care, diagnostic, and elective surgery travelers, for it is here that social scientists identify risk, safety, and legal as most central factors to these travelers. Wellness travelers were most clearly associated with legal and anonymity. One partial explanation may be that, starting in 2009 and growing each year after that, several social scientists had chosen to focus on the ethics of medical tourism and that increasingly critical tone may be reflected in these results. However, the lack of obvious impact in their results for other schools of thought cannot then be explained.

### **Pragmatic thought applied to medical travelers**

The pragmatic school of psychological thought has concentrated primarily on therapies for the treatment of individuals, and not been widely used for research of social phenomena . If the psychodynamic school focuses on the unconscious and the hidden, the pragmatic school takes the opposite approach with a concentration on logic, reasoning, and individual will. It is the school with the greatest number of sub-categories within it, but all share this basic foundation. Its principles are rarely applied to marketing or commerce.

Given such a perspective, there is little in need of conjecture or speculation in its results. The business and tourism literature identifies for all six types of medical traveler with a common denominator of purpose. With the elective surgery travelers they add criteria, and for the alternative and diagnostic patients, they add intention. Finally, for diagnostic travelers, benefit is added to the shared foundation of purpose. The results from social scientists are equally slim, with life-saving, quality-of-life, diagnostic, and wellness travelers are sharing a common central theme of intention, while elective surgery travelers are identified by benefit and alternative care patients having no central term. It would appear that there is little the pragmatic school of psychological thought may offer to better understand the medical traveler, and the most productive future studies will be best advised to focus on the other three schools.

### **Hygiene factors applied to medical travelers**

The term “hygiene factor” was coined by Herzberg, Mausner, and Snyderman (1959) to describe conditions which will not motivate an individual, but their absence or presence may demotivate a person. In terms of medical travel, the reference is to a factor

that may trump push factors described by the various psychological schools and prevent a person from traveling for medical care. All six types of medical travelers have cost as a hygiene factor in the business and tourism literature, indicating that the presence of a price over a certain amount (determined individually by the decision maker) may prevent travel, even if the push factors are conducive toward a decision to travel.

For life-saving treatments, additional central hygiene factors include access, time, and uninsured. If the potential traveler does not have access to information regarding foreign treatments, or access to necessary support for planning such a trip, or access to the necessary medical center, the individual is predicted to not travel. Time may refer to the needed speed in which treatment may be secured. The term uninsured may have two applications. The traveler may not be able to travel if his or her insurance company refuses to assume payment for foreign treatments. Alternatively, an uninsured person may be prevented from staying at home for treatments due to cost.

Quality-of-care travelers share the same hygiene factors, according to business and tourism writers, but also have an additional factor of wait. These travelers have the liberty of determining how long they are willing to wait for available treatment. An acceptable wait period for treatment at home may negate consideration for foreign travel.

Seekers of alternative healthcare generally will not have such treatment covered by insurance, so the term uninsured is dropped for such potential travelers, but otherwise the key words for alternative health treatments remain the same as those for quality-of-care patients.

Elective and diagnostic travelers continue to share similar central words, but add income, money, language barriers, and policies. Policies may be a factor for some

elective procedures, as they may forbid desired treatment at home. If a destination shares those same policies, there would be no reason for travel, regardless of other motivating factors. Also, with elective procedures, the time spent outside of medical care is often longer, so lack of language skills to navigate within the city or country may be a factor that would negate an otherwise motivationally advisable trip.

Social science writers are more Spartan in their assignment of central hygiene factors, including cost for all six types of travelers. They add coverage and policies for life-saving treatments, access and wait for quality-of-life patients. The social science literature, similar to the business and tourism writers, identifies language barriers for alternative treatment and diagnostic travelers, and elective treatment seekers are identified by only access and cost.

### **Pull factors applied to medical travelers**

Pull factors are items, services, or characteristics which attract a traveler to a certain destination once the decision to travel has been made (Dann, 1977). By definition, they are only a factor in the latter stages of determining to travel, but because these are viewed as key items for marketing (Pike & Ryan, 2004), they receive considerable attention from business and tourism research. This becomes apparent in the key word review that follows, as social science articles uniformly have fewer central pull factors.

Since most medical tourists travel with at least partner or family member (Cormany, 2011), pull factors may be sensitive to the needs and desires of the partner. No attempt was made to determine whether a particular pull factor was for the benefit of the patient or the partner, but research to decipher this potentially would be very useful to fledgling medical tourism destination marketing operations. It would also help to provide

a valuable tool to interpret the central terms identified in this study, for at times items that would appear to be important, such as hospital accreditation, are not in the central cluster of terms, while other words, such as sports, are included.

With that potentially confounding factor in interpretation, the value of this section is made no less, for these are terms which business and tourism academicians believe to be important in the final destination selection regardless of whether the benefit is for the patient or his or her companions. Those traveling for life-saving treatments are coupled with the pull terms of appeal, attractions, available, climate, destination, distance, and promotions. The social scientists posit quite a different set of terms, including advertising, best, and brands, apparently believing that the message, rather than specific features, is the greater influence. Notable by their low centrality ranking are the terms accreditation, financing, and security, for all frequently appear in popular publications as key elements in destination selection. Accreditation in particular is a puzzlement, for this is a certification of the quality of the health care facilities, and since 2001 when the accreditation process started, 555 non-United States hospitals have undergone the expensive accreditation process (Joint Commission International, 2012) and is significant differentiator in destination selection.

The tonal difference is less stark with travelers for quality-of-life attention, as key words from the business and travel writers emerge as destination, distance, transportation, available, barriers, activity, spas, site seeing, best, and advertising. Perhaps the longer list is a recognition of the less urgent time frame upon which these travelers may select a destination, as contrasted to the immediate needs of those needing life-saving treatment. Two of the words may require clarification. Activity may be availability of activities for

visitors, but care must be used to assure that it is not also implying activity of the location which may deter visitors, such as the rioting in Bangkok which raised safety concerns and slowed travel to that region. The other term is barriers, usually used in medical tourism literature to refer to legal hurdles which must be navigated to enter a country for treatment.

Social scientists limited their central word cluster to advertising, best, climate, and transportation. Certain regions, such as India, have a reputation for difficult and dangerous ground transportation, so this last term may be a negative in destination selection. It may also refer to the distance from airport to hospital and accommodations.

One might speculate that pull factors could be of greater importance for travel involving diagnostic, elective, alternative care, or wellness, for each generally provides the traveler with less severe recovery circumstances and more recreational time. Among business and tourism writers, commonly appearing and central words include climate, destination, resort, retreat, spa, sports, and appeal. Again, although less surprising in this context, accreditation holds no central position, although affordable does. Only in elective medicine does the term security reach the central cluster, perhaps owing to the fact that much of this is cosmetic surgery and therefore involves a greater percentage of female travelers.

### **Summary**

This has been the first known effort to compare motivational terms across the various schools of psychological thought, and the first examination of current academic thought regarding medical tourism from two disciplines. While only exploratory in nature, differences have been shown between the disciplines in their assessment of the

same type of medical traveler. Additionally, a balance of term utilization has been found between three of the four schools of psychological thought, with only the pragmatic school providing little detail or differentiation. Results of the central terms for each academic disciplinary writing, each psychological school and each medical travel condition are summarized below.

Cause for Travel	Psychodynamic	Behavioral	Humanistic	Pragmatic
Life Saving	Fear	Cause	Share	Purpose
	Stress	Assurance	Together	
	Need	Follow	Place	
	Power	Friends	Believe	
Quality of Life		Place	Advantage	
	Fear	Consume	Legal	Purpose
	Stress	Satisfaction	Safety	
	Need	Cause	Reliability	
Power	Tradition	Prestige		
Elective		Place	Relaxation	
	Fear	Consume	Legal	Purpose
	Stress	Satisfaction	Risk	Criteria
	Need	Choices	Reliability	
	Power	Comparison	Autonomy	
	Excitement	Outcomes	Freedom	

Cause for Travel	Psychodynamic	Behavioral	Humanistic	Pragmatic
Alternative	Fear	Comparison	Legal	Purpose
	Stress	Assurance	Risk	Intention
	Need	Satisfaction	Luxury	
	Power	Concern	Potential	
	Excitement	Preferences	Status	
		Choices		
Diagnostic	Fear	Consume	Relaxation	Purpose
	Stress	Incentives	Luxury	Benefit
	Need	Follow	Prestige	
	Power	Assurance	Freedom	
			Comparison	
		Emotions		
		Outcomes		
		Traditions		
Wellness	Stress	Consume	Lifestyle	None
	Need	Observing	Pleasure	central
	Power	Comparison	Recreation	
		Place	Status	
			Risk	

Table 8: Motives attached to various types of medical travelers by writers in business and tourism.

Cause for Travel	Psychodynamic	Behavioral	Humanistic	Pragmatic
Life Saving	Stress	Cause	Recreation	Intention
	Need	Assurance	Fantasy	
		Follow	Pleasure	
		Friends	Legitimacy	
		Place	Escape	
		Share	Lifestyle	
		Legal		
Quality of Life	Stress	Place	Legal	Intention
		Cause	Potential	
		Rewards	Anonymity	
		Assurance	Lifestyle	
		Comparison	Prestige	
		Friends	Restrictive	
		Believe		
Culture				
Elective	None central	Family	Risk	Benefit
		Place	Safety	
		Share	Legal	
		Perspective		
		Choice		
		Concern		
Alternative	Need	Behavior	Risk	None
	Trust	Cause	Safety	central
	Power	Culture	Legal	
	Fear	Tradition		
Diagnostic	Feelings	Assurance	Risk	Intention
	Need	Behavior	Safety	
	Trust	Comparison	Legal	
		Obligatory		

Cause for Travel	Psychodynamic	Behavioral	Humanistic	Pragmatic
Wellness	None central	Consumer	Legal	Intention
		Incentive	Anonymity	
		Culture		
		Community		

Table 9: Motives attached to various types of medical travelers by writers in social science.

Hygiene and pull factors provided additional differentiation between the two academic disciplines. However, distinguishing differences between the various types of travelers was not strong. There was an apparent assumption by authors that the process of destination selection followed a similar course regardless of the condition for which the patient was traveling. The most notable observation from these factors was the inclusion of apparent pull factors of appeal to traveling companions – an assertion that has face validity but needs testing. This finding, if proven by further study to be true, has significant implications for destination marketers.

### **Contingency tables**

Correspondence analysis provides a percentage of the total variance in each model explained by the two axis table developed. In other words, this gives an indication of the degree to which centrality of key terms may be relied upon. Following the directives of Hair et al. (2006), the number of axes selected for consideration should only be those that have an inertia greater than .2, which fit each analysis. The following tables show the variance for all writings by business and tourism, and social science authors, then the variance for each sort of traveler by each group of authors.

Cause for Travel	Composite %
Composite	.87.34
Lifesaving	64.01
Quality of Life	61.88
Cause for Travel	Composite %
Elective	49.79
Diagnostic	59.85
Alternative	61.73
Wellness	59.30

Table 10: Variance by reason for travel, all authors.

	Psychodynamic %	Behavioral %	Humanistic %	Pragmatic %	Hygiene Factors %	Pull Factors %
Composite of all writers	79.32	83.93	88.8	78.91	77.28	93.56

Table 11: Variance by psychological school for all authors.

Cause of Travel	Psychodynamic %	Behavioral %	Humanistic %	Pragmatic %	Hygiene Factors %	Pull Factors %
Lifesaving	71.92	56.72	63.36	64.95	62.95	54.09
Quality of Life	52.42	56.24	65.98	65.11	64.58	58.27
Elective	70.79	60.49	61.52	74.35	69.36	55.68
Diagnostic	88.28	64.53	65.4	82.22	83.42	58.39
Alternative	74.45	63.23	60.81	73.88	72.03	56.5
Wellness	88.65	87.04	73.33	60.74	65.87	49.84

Table 12: Variance by psychological school and cause of travel by business and tourism authors.

Cause of Travel	Psychodynamic	Behavioral	Humanistic	Pragmatic	Hygiene	Pull
	%	%	%	%	Factors %	Factors %
Lifesaving	78.48	69.84	65.45	95.36	63.87	60.36
Quality of Life	64.35	72.26	65.49	68.33	56.55	65.99
Elective	82	65.81	54.66	90.36	64.33	55.68
Diagnostic	68.81	69.7	62.92	84.49	61.37	56.36
Alternative	80.09	74.89	76.28	100	71.21	70.47
Wellness	87.43	68.48	72.63	72.48	53.67	72.3

Table 13: Variance by psychological school and cause of travel by social science authors.

There is no consistently stronger showing between the business and tourism literature and the social science literature, but with the exception of two, which account for under 50% of the total explained variance, most are within reasonable limits. The two under 50% would have required considerations up to 10 dimensions, a situation that Hair et al. (2006) strongly recommends against attempting.

## CHAPTER 5

### DISCUSSION AND CONCLUSION

#### **Introduction**

The intent of this study has been to discover the current thought of academicians in explaining motivations of individuals choosing to travel for medical care. As a relatively new sub-industry of both medicine and tourism – the two largest industries in the world – an understanding of what impacts a potential medical traveler’s decision making process has ramifications for marketing of destinations and facilities, for providing medical facilitators a better understanding of client needs and expectations, for civic assessment of its potential to develop and maintain itself as a medical tourism destination, and ultimately for making the travel experience for those who choose it a more pleasant and successful one.

This effort was undertaken by assembling the majority of current academic literature on the topic. From this literature, a content analysis of words was made, and once identified and their context verified, these were included in a content analysis to determine word significance as defined by their centrality to the articles under study.

As has been stressed throughout, the terms which have been searched and classified are terms which have been assigned to medical travelers by academicians. With only three studies to date focused specifically on motivation, and two of them concentrated on specific populations or causes for travel, there is a dearth of verifiable information. Each article was assessed for its focus. Of the 216 articles, 112 were from the business or tourism perspective, and 104 were written for social sciences. However, 31% (28 articles) of the business and tourism articles were written to provide description

or opinion only and included no methodology or fresh research. This was even greater among the social science literature, where 52% (45 articles) contained no methodology or new research. It was discovered that 21% of the business and tourism literature was written with the purpose of exploring the consumer, with the rest taking a broader focus on marketing. Among the social science literature, 33% concerned itself primarily with understanding the traveler, with the remainder scattered among topics such as ethics, the meaning of medical tourism for feminism studies, or viewing it as a cultural artifact to be examined. Among the business and tourism writers, 19% appear to have actually spoken with medical travelers, with the rest relying on speculation or second hand material.

These numbers further weaken any conclusions that may be drawn from this study's data. If the motivational terms identified are already the author's interpretation of what he or she believes may motivate the traveler, and if this interpretation is based frequently upon information obtained from a secondary source or anecdotal observation, both its reliability and validity are suspect.

However, this is also believed to be an accurate representation of the current state of understanding and investigation into medical traveler motivations. Several efforts to study this topic have been thwarted by patient privacy laws or corporate proprietary rights (Connell, 2011), thus creating a challenge heretofore not faced by tourism researchers. Fledgling efforts by the Medical Tourism Association to create a database of information, similar to the Smith Travel Research reports for hotels, have been met with a lukewarm response from international healthcare corporations (Stephano, 2012), many of whom are new to serving international patients, working to establish international patient offices, obtaining accreditation, and developing a marketing plan. In such an

environment, it may be difficult in the short-term to obtain adequate patient contacts to conduct large scale studies. Additionally, survey techniques often employed by marketing researchers may be inadequate for obtaining understanding of some of these potential travelers. For example, can anyone respond to what they might do if faced with a life-threatening medical need or a debilitating condition? Answers to such hypothetical questions may not be representative of a person's thought process when such a circumstance is actually encountered.

However, Maple's (2007) 'silver tsunami' continues to approach, and understanding of medical travel is growing in importance by the year. This study has shown current academic opinions, as reflected in publications, and in the process has attempted to illuminate areas of confusion, assumptions that have been made, and the potential applicability of different psychological schools of thought in understanding motivational factors of travelers or those who choose not to travel for medical care.

Nothing may be claimed to have been proven with reliability or validity from the effort. However, results do suggest a few concepts. First, even with article overlap, the notion that there are different types of medical travelers with different needs and desires seems to be given some credence. The centrality of term grouping for life-saving, quality-of-life and elective surgeries provides a tentative starting point for further investigation. Some chaotic findings with regard to diagnostic travel may suggest that this area needs further definition, or perhaps separation into two or more sub categories. Alternative care travel appears less well defined too, and this may be because it is believed to be a smaller category than the others and therefore receiving less attention. Its deviation from traditional western healthcare does not make it a less worthy topic, but perhaps one that

fits uncomfortably among categories concerned with accreditation, insurance, and provision of modern facilities. There also may be less urgency in understanding those particular and few travelers than in the larger phenomenon of medical travel. As Smith and Puczko (2009) have suggested, wellness travel may be sufficiently different in focus to be viewed as its own industry, separate and apart from medical tourism.

Research may proceed on any of many fronts, but with regard to this study, it is hoped that three general concepts may emerge. This study has identified assumptions – perhaps not even conscious assumptions – which have been made by researchers of medical travelers up to this point. One approach is to explore empirically whether such assumptions are verifiable. Using the central key words from the various schools of psychological thought may inform the design of such inquiries. Whether done quantitatively or through qualitative interviews, seeking indications of whether the currently held motivational terms are accurately reflective of the medical traveler would broaden the foundation upon which future research might be done and advance understanding beyond speculation and anecdote.

The second approach is to explore the topics represented by the words not found to be central in current motivational thought for the medical traveler. Marketing decisions are currently being made based upon assumptions that are not supported by the findings here. For instance, the investment in accreditation is only tangentially supported by what is reported here. Assumptions that a region's perceived safety affects travelers to that region was only hinted at among elective surgery travelers, but it is commonly felt that this is a crucial destination criterion. Investigating the vagaries between what is revealed

here and what is currently being acted upon may eventually give direction to destinations and its investors.

The third approach, not isolated from the first two, is to consider the merger of psychological theories into a more uniform motivational understanding of the medical traveler. As was stated earlier, marketers often rely on principles from behavioral psychology; tourism research has a strong foundation in humanistic psychology, and medical approaches to psychology frequently come from the psychodynamic school. This study has shown results worth consideration for all but the pragmatic school, so a theorizing of cross-school models may be warranted for an activity that has a footing in so many different disciplines. For instance, is there an order to the application of motivational elements from each school? Are psychodynamic motivators initially present, giving way to patterns of behavior identified by the behavioral school, and the final decision incorporates the humanistic elements? If a pattern is found, is it consistent for most individuals, or are there indicators that may suggest the order and weight an individual would give to each in reaching a conclusion of whether or not to travel for healthcare? If there is a pattern, does it significantly differ from that of other decision making processes due to the centrality of one's desire to survive in a healthy, holistic manner? Healthcare has long held that motivators for its services are different than those for other products and services (Bashe & Hicks, 2000; Berkowitz, Pol, & Thomas, 1997; Thomas, 2008) and now both an opportunity and need to examine that assumption are presented.

Finally, perhaps this study may give rise to some cross disciplinary consideration. In most cases, tourism and business researchers and social scientists shared a bit of

common ground, but their key words, if taken as a directive for understanding the medical traveler, would reach quite different conclusions. Tourism and business applied the terms of business and marketing; social scientists employed the language of psychology and sociology. While not unexpected, it is suggested that each provides a partial picture to this complicated topic.

### **Study limitations**

More so than most studies, this has little generalizability or reliability. It is a snapshot of the current status of thought regarding motivations of the medical traveler. Additionally, terms usually avoided in academic research, such as should, many, or most have been required as the data has no quantitatively consistent meaning. The only measurement guide has been the relative centrality of words related to traveler conditions and psychological schools. Words such as weight or significance can only be used in the layman's vernacular, for they cannot represent typical statistical operations or conclusions. Therefore, key findings, primarily found in word centrality, must be taken as representative of only the articles under analysis, with no generalizability possible. It was for this reason that the most complete compilation of articles possible was undertaken.

The best that may be claimed by results is that this is a starting point from which investigation may be started with a set of words or criteria from which validation or replacement may start. However, it is a starting point as the first compilation of potential motivational terms assembled from literature, theory, and current articles. It is in providing this starting point that it is hoped a value to this effort may be found.

### **Revisiting the research questions**

This study intended to explore the current state of discovery on what motivates the medical traveler, review the four schools of psychological thought for applicability, consider whether there are delineated differences in motivation between the various types of medical travelers, and assess the sort of research that has been done to date in this new industry.

Exploration using the delineated methodology has been completed, providing answer to each of these questions in the most tentative terms due to the nature of the research design and the availability of data. It would be inaccurate to suggest any of these questions have received a reliable answer, but the assessment of each question was intended to provide indicators upon which more solidly empirical research might be constructed. A bibliography of the articles included in this study may be found in Appendix I listing those related to medical tourism, and in Appendix II for a list of the tourism motivational articles used to develop part of the motivational terminology baseline.

APPENDIX I

RESULTS OF CONTENT ANALYSIS WORD SEARCH, DIVIDED INTO  
PSYCHOLOGICAL SCHOOLS OF THOUGHT

Category	Psycho- dynamic thought	Behavioral thought	Humanistic thought	Pragmatic thought	Hygiene factors	Pull factors
Words not found to be used motivational terms	Insulation Provocation Temperament	Effect Liabilities Punishments	Ability Action Adopter	Availability Examine Expectations	Physical Physiological	Customs Language Location appeal
Words not found to be used in motivational terms	Unconscious	Social Influence Learning Work experience Work style	Affiliation Approach Avoidance Capabilities Challenges Circumstances Control Empowered Energy level Experience (personal) Focus Importance of outcomes Intention Joy in achievement Leisure	Negativity Options Plan Reasoning Standards Therapy Understanding		Policy Relatives Resources Settings Treatment Availability

Category	Psycho- dynamic thought	Behavioral thought	Humanistic thought	Pragmatic thought	Hygiene factors	Pull factors
Words not found to be used in motivational terms (continued)			Locus of Control Opportunity Personal responsibility Probability Physical rest Problem- solving Seek Self- actualization Self-esteem Single Spiritual Thoughts Unstructured			
Words determined to be outliers	Affect Emotional state Inspiration Release	Conditioning Family Obligatory Participants Relationships Socio-cultural Suggest Support	Free Sophistication		Hygiene factors Passport	Accommodation Accreditation Culture Destination Distance Night life Sports Wellness destinations

Category	Psycho- dynamic thought	Behavioral thought	Humanistic thought	Pragmatic thought	Hygiene factors	Pull factors
Words	Attitude	Advantage	Adventurous	Benefit	Access	Activity
remaining	Awareness	Assurance	Anonymity	Concern	Alone	Advertising
for	Characteristics	Behavior	Autonomy	Criteria	Cheap	Affordable
consideration	Disposition	Believe	Escape	Dissonance	Concierge	Airport
	Desire	Cause	Fantasy	Intention	services	Appeal
	Drives	Choices	Freedom	Logic	Cost	Attractions
	Excitement	Community	Innovators	Perception	Coverage	Attributes
	Fear	Comparison	Legal	Purpose	Income	Available
	Feelings	Concern	Legitimacy		Insurance	Barriers
	Impetus	Consume	Lifestyle			Best
	Need	Culture	Loyalty		“Language	Brands
	Power	Emotions	Luxury		barriers”	Climate
	Stress	Experience of	Pleasure		Money	Cultural
	Tendency	others	Potential		Policies	opportunities
	Trust	Follow	Prestige		Time	Economy
	Underlying	Friends	Push		Interpreters	Events
		Incentives	Recreation		Translators	Financing
		Observing	Relaxation		Uninsured	Food
		Outcomes	Reliability		Wait	Hotels
		Perspective	Restrictive			Housing
		Place	Risk			Nature
		Preference	Safety			“Past
		Reaction	Status			Experience”
		Rewards	Structured			“Perceived
		Satisfaction	“Travel			Quality”
		Share	Experience”			Pricing
		Stimulus				Promotions
		Together				Ranking

Category	Psycho- dynamic thought	Behavioral thought	Humanistic thought	Pragmatic thought	Hygiene factors	Pull factors
Words		Traditions				Ratings
remaining						Reputation
for						Resort
consideration						Retreat
(continued)						Savings
						Security
						Shopping
						Site-seeing
						Spas
						Timing
						Tours
						Transportation
						Visa

## APPENDIX 2

### ARTICLES INCLUDED IN THE ANALYSIS OF MEDICAL TRAVEL

- Ackerman, S.L. (2010). Plastic paradise transforming bodies and selves in Costa Rica's cosmetic surgery tourism industry. *Medical Anthropology: Cross-Cultural Studies in Health and Illness*. 29(4), 403-423.
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APPENDIX 3  
TOURISM MOTIVATION JOURNALS USED AS BASELINE  
FOR TRAVEL MOTIVATION TERMS

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