

All in or À la carte: Preferences of Medical Tourists towards Value Co-Creation

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Abstract

Medical Tourism

Patients Beyond Borders (2014) defines a medical tourist as anyone who travels across international borders for the purpose of receiving nonemergency medical care. It has been estimated that the market size in USD ranges from 38.5 to 55 billion based upon eleven million cross-border patients worldwide spending an average of 3,500 – to 5,000 USD per visit. Further, *Patients Beyond Borders* suggests that the top Medical tourism destinations are Costa Rica, India, Israel, Malaysia, Mexico, South Korea, Taiwan, Thailand, Turkey and the United States.

Crooks et al (2010) identified four themes associated with the increased growth of medical tourism. These are:

- (1) *Decision-making factors* including the reputation of the foreign hospital to provide quality care as well as positive word of mouth (Alsharif et al, 2010; Peters et al, 2011)
- (2) *Motivations* including the availability of procedures in foreign destinations, the ease of booking the procedures, and the potential cost savings (Gan et al, 2011)
- (3) *Risks* to health, travel associated risks and pre and post-operative risks (Jonas et al, 2011)
- (4) *First-hand accounts* including positive and negative aspects, sensationalized issues, and reports of post-recovery life

Value Co-creation

The co-creation of value is a term used to connote mutual value creation by the actors involved emphasizing a business relationship where both parties, often the customer, contribute to the value that is created (Ramaswamy, 2011)

In traditional health-care service delivery, the role of the patient is passive, i.e., the receiver of care. (McKoll-Kennedy et al, 2012) More recently, research

indicates that patients are playing a more interactive role. Elg et al (2012) suggest that “caregivers, together with patients can draw upon the knowledge that patients experience in healthcare service development.” Merz et al (2013) argue that service providers “need to aim at co-creating dynamic, social, and interactive service ecosystems together with their customers such that their customers have the highest value-in-use and value-in-context perceptions.” In other words, patient input is becoming an increasingly critical ingredient to the successful delivery of value-added healthcare services.

The purpose of this research is to determine how consumer perceptions of two scenarios, one traditionally consumer passive and the other value co-creative, impact consumer perceptions of a trip abroad for medical services.

Methodology

A survey instrument was developed to identify consumer preferences towards the co-creation of value in medical tourism options. Respondents were initially asked whether they would consider seeking medical treatment overseas for a serious, but non-life-threatening medical condition, such as hip or knee replacement or gastric bypass. Only those that responded positively to this first question were retained for further analysis. The data gathering process is ongoing; to date, the usable responses gathered is 147. Respondents were asked questions about what factors would cause them to consider medical tourism. Respondents were then presented with a hypothetical scenario in which they were faced with knee replacement surgery and were considering receiving treatment abroad.

Two treatment options were presented: one in which all of the medical procedures, room and board, and related services and amenities were combined into an “all-inclusive” treatment package. The second option allowed respondents to pick and choose among different services, amenities and accommodations in a “à la carte” treatment package. After reading a description of both packages, respondents indicated their likelihood of choosing each package. A list of possible medical tourism destinations was presented to gauge likelihood of considering different locations for treatment.

The sample consisted of 43.5% males and 54.5% females. Seventy-five percent of respondents were between the ages of 40-60. The majority were well educated with over 70% having a college or post-college graduate degree.

Results

The data were subjected to two-step cluster analysis in SPSS. The clustering base was predicated on responses to the questions, “How likely are you to select the all-inclusive /à la carte package”. Responses were measured on a 5-point Likert scale

(1=very unlikely to choose/5=very likely to choose). Cluster analysis yielded a 4 cluster solution with good separation between the groups based on clustering variables. Cluster 1 (n=46; 31.3%), labelled “À la cartes”, consisted of respondents who were highly likely to choose the a la carte treatment package in which they could select their own services and amenities. Cluster 2 (n=27; 18.4%) consisted of respondents who were unlikely to choose either treatment package, and were labelled “Disinclined” towards both options. Cluster 3 (n=32; 21.8%), labelled “Favorably Indecisives”, contained respondents who were favorably disposed to both treatment packages, but did not show a strong preference for one package over the other. Cluster 4 (n=42; 28.6%) demonstrated a strong preference for the all-inclusive package, and were labelled as “All-inclusives”.

Following classification of respondents, characteristics of each cluster were described based on data not included in the cluster procedure. Clusters were further compared using one-way ANOVA, and post-hoc tests were conducted using Duncan’s procedure for between group differences.

There were no significant demographic differences between the clusters on variables of age, gender, marital status, education, or income. There were no significant differences between the groups based on general risk tolerance/aversion, frequency of healthcare visits, or extent of international travel. However, ANOVA results indicate some between group differences in their motivations for considering medical tourism.

All groups were equally motivated to engage in medical tourism by cost incentives.

The “Favorably Indecisive” group (cluster 3) indicated a greater lack of trust in the U.S. healthcare system than the other groups. This group was also more motivated towards medical tourism to patronize the most highly regarded specialists for treatment and to obtain unapproved treatments than were the other groups. The “Favorably Indecisive” group was also more motivated by the opportunity to combine medical treatment with travel than were the other three groups.

The “Disinclined” (cluster 2) were significantly less motivated than were the other groups by short waiting periods, availability of unapproved treatment options, insurance coverage, and combining healthcare with travel.

The all-inclusive group and the “Favorably Indecisive” group were both more motivated by privacy concerns than were the ‘disinclined” and the “à la carte” groups.

The three groups (clusters 1,3,4) who were positively disposed towards one or both of the treatment packages were all more motivated to consider medical tourism if such treatment were covered by insurance.

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