Loïck Menvielle, William Menvielle
and Nadine Tournois

Medical tourism: A decision model in a service context

Abstract

Even if its roots date back to Antiquity, medical tourism is a very recent concept and refers to patients taking advantage of medical services abroad and their rehabilitation in an environment different from that of their everyday lives. Several factors have led to this recent phenomenon: modern communication tools (Internet), high quality healthcare services in medical tourism destinations (highly-qualified physicians and modern facilities), low prices in order to attract tourist-patients (services must be substantially cheaper) and ease of travel (flights are ubiquitous, discounted and patients are taken in charge at their arrival). Consequently, the numbers speak for themselves. A report by Deloitte and Touche portrays North Americans looking abroad for medical treatment by specifying that "6 million Americans will receive treatment in a foreign country in 2010 and 10 million in 2012". It is in this context that we have decided to explore this field of research. The purpose of this article is, first, to present this concept which is still underestimated and, second, to analyze the factors which stimulate it, as well as a model which highlights the factors influencing a patient's decision to seek healthcare abroad. Even though this may be a risky endeavor for consumers, "medical tourism is in good health".

Keywords:
medical; health; tourism; risk; decisional process

Introduction

For a number of individuals, the term medical tourism seems to be an obscure and questionable neologism. Yet, history shows, as illustrated in Figure 1, that it is one of the most ancient forms of tourism (Smith & Kelly, 2006, p. 1). The ancient Egyptians understood the healing virtues of sea baths to relieve certain health problems. This idea of well-being and the possibility of treating diseases otherwise considered incurable prompted certain populations to emigrate towards the Roman Empire in order to benefit from these treatments. The quintessence of hydrotherapy and thalassotherapy, as well as more rudimentary forms such as the use of natural springs or thermal springs, were largely exploited until the Middle Ages. However, the use of water as a remedy (hydrotherapy) quickly declined as obscurantism prevented further exploitation.

Loïck Menvielle, Groupe EDHEC – Nice, France; E-mail: loick.menvielle@edhec.edu

William Menvielle, DBA, Université du Québec à Trois-Rivières,Département des Sciences de la Gestion, Canada:
E-mail: William.Menvielle@uqtr.ca

Nadine Tournois, Institut d'Administration des Entreprises, Nice, France;
E-mail: Nadine.tournois@unice.fr

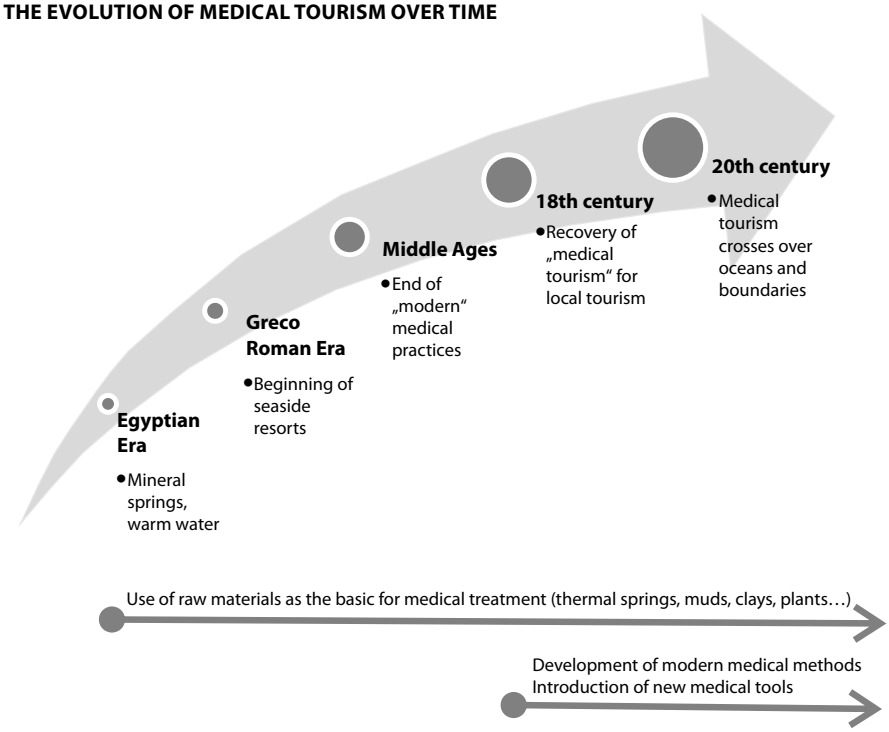
It was only in the 18th century that medical tourism was rediscovered. In Britain, medical tourism was reborn in Bath (Boyer, 1996), where wealthy Europeans travelled to benefit from the healing properties of water as well as to assert their social status. In France, Napoleon III instigated a new craze for the thermal benefits of water. At the beginning of the 20th century, the French Riviera, considered to have a favourable climate for healing, attracted large numbers of the wealthy (Proulx, 2005; Smith & Kelly, 2006). Over time, new trends have emerged from this type of tourism. The most significant changes in tourism occurred after World War II, a period where acceleration in social, political, economics and logistics translated into an increase in tourist activity, leisure and entertainment (Gartner & Lime, 2000; Durand & Jouvet, 2004), which has started now to fragment into a number of special niche markets, of which medical tourism has seen a significant expansion.

The medical tourism market is sizeable and growing. According to the Web Health Tourism website, in 2008, more than 1.2 million tourists sought treatment in Thailand, 500 000 in Singapore (with a projected one million for 2010). In Costa Rica, 150 000 foreign patients sought treatment in 2006, 300 000 in Malaysia and a half million in India in 2007. Some of the reasons tourists have given for seeking treatment in other countries include: the host country's advanced technology (40%), a better healthcare system (32%), shorter waiting time compared to similar surgery in their own country (15%), as well lower rates (9%) (Ehrbeck, Guevara, & Mango, 2008).

As seeking treatment in other countries is risky due to the cost of travel and healthcare, risk of contracting a nosocomial disease in countries where hygiene is different (Leblanc, 2010), the patient-tourist needs to find out as much information as possible in order to reduce or prevent such risks. Since information can now be retrieved using the Internet on a regular basis, patients also have access to other sources of information, such as others who have gone through a similar experience, family or physicians' advice, and even the medical facility's reputation.

It seems appropriate to question the factors that have influenced this growing demand for medical tourism: What is the role of medical services tour operators? Are they creating a market from medical tourism? Or, is this increase in demand a legitimate response to the high costs of local providers, or is it due to the deficient systems in their home countries? In the following paragraphs, we will look at the factors which determine which stakes derived from medical tourism while explaining the subtle differences found in its different forms. We will then review factors allowing the fruitful development of medical tourism before analyzing marketing strategies available to countries promoting this type of activity.

Figure 1
THE EVOLUTION OF MEDICAL TOURISM OVER TIME



Source: Menvielle & Menvielle (2010)

Purchasing behavior and perceived risk

Many variables contribute to conditions favouring the set-up of medical tourism. Presenting them will allow us to develop a preliminary model and better understand factors influencing consumer behaviour.

POLITICAL AND GEOPOLITICAL ENVIRONMENT

The political variable has an impact on the offer and the attractiveness of medical tourism. Certain countries have disengaged from their medical sector, thereby creating a new need. In the United States, for example, the medical sector has gone from public to private, generating significant out-of-pocket expenses for patients (Connell, 2006), especially for those with no medical insurance (Levasseur, 2008). We have seen, as a result, a two-speed medical system emerging, in which the upper class receives excellent care within the U.S., and where the middle and lower classes are unable to afford expensive healthcare in their home country. At the same time, the deregulation of transportation has opened up the market, allowing for inexpensive travel expenses.

Geopolitical dimensions can create major obstacles for medical tourism. Pizam and Mansfeld (1996) signal that peace and security is a pre-requisite in attracting tourists, while Toolis (2004) points out that the rise in terrorism contributed to altering the climate of confidence. The September 11, 2001 attacks have amplified this phenomenon of insecurity and, unfortunately, many countries which have opened their doors to medical tourism are located in zones where terrorists are potentially active. For Bi-

anchi (2006), recent attacks by Islamic organisations in Indonesia, North Africa and Jordan reveal there is no discernment in aggressions, which further increases tourists fear. Pforr (2006), citing Floyed, Myron, Gibson, Pennington-Gray and Thapa (2004), concludes that the increase in risk perception regarding a tourist destination is proportional to the attractiveness it displays.

These dimensions are difficult to control for the tourist-patient who must confront a stressful, moral dilemma: going to a potentially dangerous country for treatment, or delaying surgery and/or going to a different country. Either waiting for the security situation to improve or having to investigate the possibility surgery in another country means delay, which can have an adverse effect on the health of the patient.

ECONOMIC ENVIRONMENT

Secondly, we must consider the economic aspect as it also explains the growth of medical tourism. The attractive prices of medical care and favourable exchange rates push consumers to opt for medical care abroad (Connell, 2006). One of the essential reasons leading to this choice is found within the price variable as patient-tourists make a selection based on what is included in the price, considering such elements as the attractiveness of a destination and complementary services offered.

Walker (2006) explains that in India, for example, medical care is 80% cheaper than in the United States; in Thailand, prices are 70-75% less expensive. If we recall that American health insurance does not adequately cover the whole population the patient is forced to look for affordable options abroad. Table 1 compares the average hospitalization costs per patient per day for several types of common procedures, in the United States, India, Thailand and Singapore.

Table 1

PRICE RANGE FOR SURGICAL TREATMENTS IN SELECTED COUNTRIES (in US$)

Procedure	US Insurer's cost	US Retail price	India	Thailand	Singapore
Angioplasty	25,704 to 37,128	57,262 to 82,711	11,000	13,000	13,000
Heart Bypass	27,717 to 40,035	47,988 to 69,316	11,000	12,000	20,000
Hip replacement	18,281 to 26,407	43,780 to 63,238	9,000	12,000	12,000
Knee replacement	17,627 to 25,462	40,640 to 58,702	8,500	10,000	13,000
Masectomy	9,774 to 14,118	23,709 to 34,246	7,500	9,000	12,400

(1) Prices shown are in US$

Source: Walker (2006)

Let us now consider the reimbursement policies of insurance companies. American and British insurance companies cover only a portion of medical costs and certain types of medical care are not reimbursed by some medical insurance companies. For example, dental surgery, not reimbursed in the United Kingdom or Australia (Connell, 2006), presents significant out-of-pocket expenses for patients. Furthermore, the patient is unsure what part, if any, of additional treatments required, will be reimbursed by the insurance company upon his/her return. These financial questions can be a significant source of stress and can have a psychological impact on the patient.

From a financial point of view, it is also important to take into consideration the exchange rate and all indirect costs that must be paid for treatment abroad such as cost of obtaining a visa, interpreter services, and 'artificially' increased prices for foreigners who have higher incomes than the local population, and eventually gifts (bribes) to be offered to various authorities.

SOCIO-DEMOGRAPHICS AND CULTURAL ENVIRONMENT

The aging population in wealthy countries is contributing to the development of medical tourism. With over 220 million baby-boomers in the United-States, Canada, Europe, Australia and New-Zealand, medical tourism's prospects are favourable (Hutchison 2005; Bennet, King & Milner 2004). Based on their projections this aging population will increasingly need expensive medical treatments and care (Connell, 2006). In addition, this aging baby-boomer segment is fuelling demand for various cosmetic procedures. We must also take into consideration the lengthy waiting lists for certain surgical procedures in North America and the United Kingdom. Hutchinson (2005) underlined this point by comparing the delays for hip replacement surgery in London and Ottawa (one year or longer) with Bangkok or Bangalore (2-5 days).

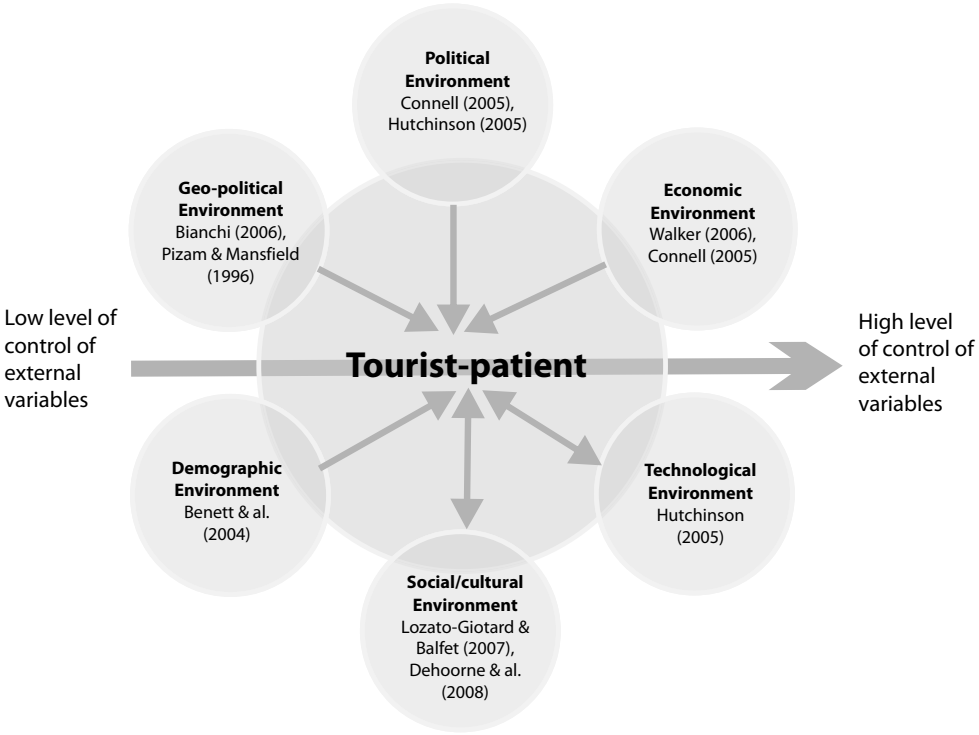
TECHNOLOGICAL ENVIRONMENT

We must also consider technological variables, which play a leading role in medical tourism. Highly trained physicians, combined with technological progress, modern medical equipment and qualified post-operative care make these countries very attractive for medical tourism. Air transportation has democratized travel for a number of tourists, allowing access to destinations around the world. However, these countries have to overcome the negative image often associated with developing countries. It is recognized that in Tunisia or South Africa, the level of hygiene found in clinics or hospitals receiving occidental patients and the medical care offered are comparable to that of western countries (Connell, 2006).

Hutchinson (2005) estimates that the level of technology respects medical standards and that the degree of hygiene is very strict. For example, the patient death rate for open-heart surgery is less than 0.8% in India; almost half of death rate in the United States. We must, however, put an asterisk next to those numbers. Hospitals accepting medical tourists choose patients whose death or complications-risks are minimal, and patients are screened before surgery. Those who are obese or have a history of diabetes, high blood pressure are usually considered ineligible for the treatment.

Figure 2 shows an assessment of our previous claims as well as the impact that the business-related variables have on a patient's purchasing process. In certain cases, these variables are unidirectional. This is the case with economical or geopolitical variables, where tourists have very little or no influence. In the case of socio-cultural or technological dimensions, the tourist can have greater influence. Such is the case with the cosmetic surgery where the patient can "shop" for the most technologically advanced clinic.

Figure 2
PRESSURE AND EXTERNAL VARIABLE CONTROLLABILITY LEVELS AFFECTING A TOURIST-PATIENT



Source : Menvielle & Menvielle (2010)

Modern medical tourism and implications for patient risk perception

As already discussed, medical tourism – even if the term is rather new – is a relatively ancient form of tourism. The fact that this type of tourism seems obscure to many is often due to the health-related terms to which it is associated. Although this type of tourism is often critiqued by western medical circles because it goes against their healthcare systems (Brun, Deau & Roffé, 2009), it constitutes, nevertheless, an axis of development for many emerging countries. It is also of interest to many actors involved in this phenomenon, be they doctors, journalists or researchers in diverse disciplines.

Garcia-Altes (2005) underlines that medical tourism is rather broad term, because it includes numerous fields of health care, including wellness. Therefore, it is important to distinguish these two broad categories - wellness tourism and vital medical tourism. Although a thin boundary separates the two terms, we must, in a marketing and strategic approach, make a clear distinction. For Mueller and Lanz Kauffmann (2001), Garcia-Altes (2005) or even Kušen (2002), wellness tourism is defined as scheduled and elective medical care dedicated to maintaining and preserving health and well-being (aesthetic surgery, spa and thalassotherapy). Mueller and Lanz Kauffmann's (2001) research on wellness tourism constitutes the basis of our reflection on elective medical tourism.

On the other hand, vital medical tourism is intended for patients needing / seeking life-saving procedures (Menvielle, 2010). By integrating wellness tourism with vital-care tourism, we are presenting and developing another market reality, as defined below:

- *Wellness tourism (including cosmetic surgery):* Ranges from spa, thalassotherapy, weight-loss programs, relaxation packages to cosmetic surgery.

  The latter, according to society today, is based on appearance and youth. The global-medias define our standards of beauty world-wide, influencing the population to a uniform concept of beauty. It is in this context that health clinics and medical providers have created a market and tailored their services in order to reach this population.

- *Spa treatments:* Wellness can sometimes be associated with sustainable tourism. Health centers and spas are primarily located in the mountains, on the coast, in the forest, or in isolated places to stay in contact with nature. The healthcare products used are generally eco-friendly.
- *Vital medical tourism* can be subdivided into :
  - *Rehabilitation tourism:* Offers general medical care as a temporary solution to certain problems. For example, treatments for certain addictions (nicotine, drugs, alcohol) are available. But, other treatments such as dialysis are worth mentioning. As surprising as it may sound, many centers in Tunisia build complexes dedicated to individuals in need of such treatments. Rehabilitation tourism can include treatment and care after surgical procedures.
  - *Surgical tourism:* Necessitates a complete medical infrastructure and highly-qualified personnel (physicians, surgeons, anaesthesiologists etc.). This form of tourism is by far the most well-known, and receives the most media attention, due to the wide range of surgical procedures it offers (dental surgery, cardiac surgery, anti-cancer treatments…). It generates exponential and substantial profits for clinics and hospitals treating occidental patients. Surgical tourism is the solution when waiting lists are too long at home or when local care is too expensive.

Those who use medical tourism services can be called tourist-patients, defined as a person seeking either a surgical intervention or wellness and preventive care. In addition, this person is willing to travel abroad in order to be treated. Certain destinations are chosen according to the country of residence. North Americans prefer Central or South America, while some prefer Asia; Europeans feel more 'reassured' in Central and Eastern European countries or in North Africa, while the English prefer their ancient colonies of India and Asia (Ehrbeck, Guevara & Mango, 2008; Menvielle, Menvielle & Tournois, 2010a). Moreover, a tourist-patient uses all infrastructures available to him/her: travel, lodging or services of a specialized travel agency authorized in certain countries only. Numerous variables, such as long waiting lists, expensive surgeries or unsuccessful procedures received in the past, explain why patients are looking for treatment solutions abroad (Bovier, 2008). Furthermore, certain insurance companies do not offer full coverage or cover certain procedures.

However, travelling for medical reasons and selecting the best options available is also risky for the patient-tourist. One of the main questions which arise is how to reduce risk perception in order to favorably stimulate buyers. This question, characterized by its intangibility, is imperative in the marketing of services and has seemingly been a major issue over the last few years, judging by the literature published on the topic (Bauer, 1960; Güseman, 1981; Flipo, 1984, 1988; Murray & Chlater, 1990; Laroche, Bergeron & Goutaland, 2001, 2003; Mallet, 2002). The negative influence created by risk perception is even more important in the medical sector because it can generate a form of repulsion.

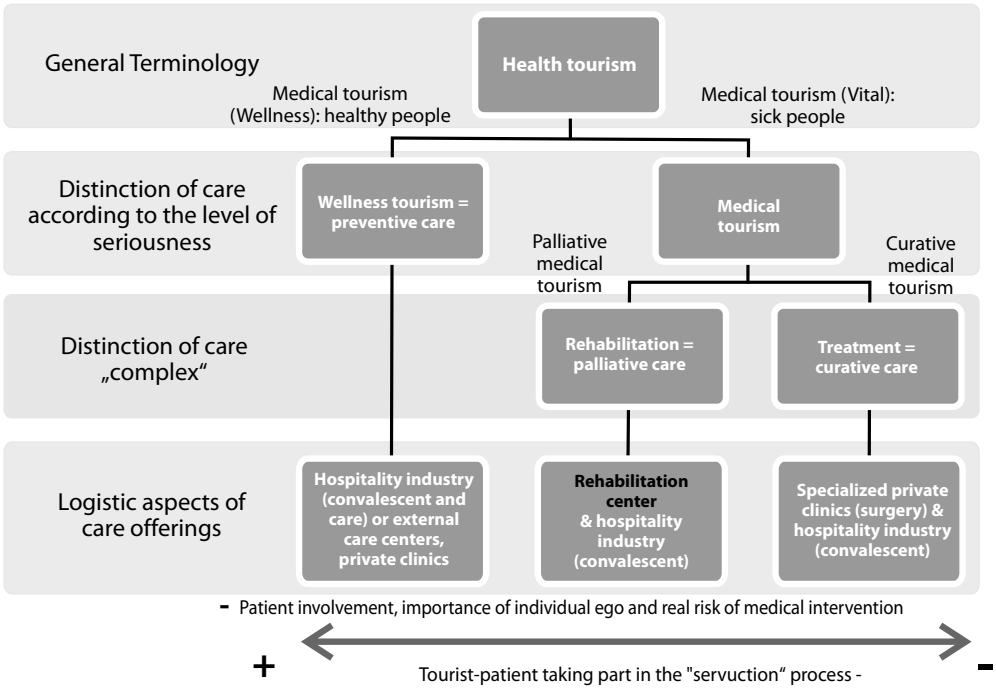
In medical tourism, the risk perception is proportional to the type of treatment sought. Therefore, the level of risk perception is much greater for a patient undergoing major surgery than for one receiving spa therapy. This analysis of risk remains purely theoretical, since, according to our first exploratory qualitative analyses (Menvielle, Menvielle & Tournois, 2010b), it seems that the notion of risk is also a function of the patient's pathological state and of his/her personal interpretation of risk. Jacoby and Kaplan (1972) suggest six variables which identify a consumer's risk perception, applied to healthcare offers sold on the Internet:

Functional risk: The difference between patient expectations and the services to be received and the price paid for these services.

- Financial risk: Additional costs to the client if the service received is deficient (new operations, longer post-operative care…).
- Physical risk: The impact of a service received on the consumers' health (reactions or allergies to certain medication, rejection after a graft).
- Wasted time risk: The amount of time spent researching information, offers, travel plans etc...
- Social risk: The service or product does not correspond with the consumer's personality (different perception of cosmetic surgeries in relation to the patient's cultural context).
- Psychological risk: General dissatisfaction following a misguided purchase.

The nature of medical tourism offers and the consumer's level of risk perception allow us to differentiate these forms of medical tourism. Figure 2 completes and synthesizes our thoughts based on Mueller and Lanz Kaufmann's (2001) work. Our contribution is to integrate and insert into this conceptual framework the vital medical tourism aspect which represents a fundamental and very profitable dimension of this new form of tourism. The analysis combines their main ideas with the level of patient involvement with regard to the medical offering. It also highlights level of risk perception and interaction with the global infrastructure.

Figure 3
A RANGE OF SERVICES OFFERED IN MEDICAL TOURISM



Source: Menvielle & Menvielle (2010)

Figure 3 analyzes three types of treatments offered to patients, either for preventive, palliative or curative needs. For each of these, we have introduced the notion of risk perception which can vary from one extreme to the other and from one individual to another. Therefore, a patient seeking hydrotherapy treatments will generally not show the same level of apprehension as a person requiring an angioplasty or a hip/knee replacement. The pace at which a disease progresses could also increase the patient's level of risk perception and apprehension.

Looking at Figure 3 we can easily understand that the patient-tourist is confronted with a similar range of issues whether he/she is considering travelling for major surgery or rehabilitation treatment. Risk perception is proportional to the type of treatment received. For example, in the case of major surgery, the patient goes through all the important steps to understand the service being offered to him/her and the risks associated with each step of the process. Therefore, the level of risk perception is higher for a patient undergoing major surgery than for the one receiving spa therapy.

However, when wellness treatment is sought, the patient-tourist is confronted with fewer and simpler issues, relating mostly to the geographical location (type of water, climate preference) and type of wellness programmes offered. The expertise of the practitioners working in these health centers is not taken much into account.

The greater the risk, the higher level of uncertainty and apprehension. Consequently, diverse marketing tools (spokesperson, promotional offers, detailed information but, more importantly, consumer testimonials and operation success-rates), must be used to encourage a favourable customer reaction and to reduce the gap between their perception of medical care and its realities. A consumer proactively searches for information (often via the Internet) to minimize his / her uncertainty.

The choice of service offered and tourist-patient purchasing behavior

In medical tourism there are two groups of services considered simultaneously by the potential patient-tourists. The first belong to the medical services offered and the second to the travel package (transport, accommodation). Since both are important, it is necessary for the patient to take the necessary amount of time to collect any and all information which could minimize his/her anxiety and allow him/her to choose the most appropriate facilities for the treatment. In many ways, patient-tourist purchasing behavior is similar to the purchase of any other services, while in some ways it also differs.

Traditionally, services are considered to be characterised by intangibility, heterogeneity, inseparability and perishability (I.H.I.P.).

However, Lovelock and Gümmesson (2007), remarked that I.H.I.P. cannot be completely applied to the services in medical tourism, especially with new technology and the evolution of services offered. In medical tourism, services may be tangible, in the sense that the service is going to have physical consequences for the consumer. For example, in cosmetic surgery, the results could have irreversible positive or negative physical as well as emotional repercussions on the patient. The consumer purchase of a service can be described in the following three steps:

- *Pre-transaction phase*, during which the consumer is conscious of a need for this service. He/she will do an in-depth search for information on the offerings. He/ she will seek a highly-qualified physician. For example, India boasts a number of reputed surgeons, trained in Europe, notably in the United Kingdom; Tunisia has 8,500 doctors whose diplomas are recognized in Europe (Saget, 2005; Labelle, Colombel & Perrien, 2003). According to Lovelock, Wirtz, Lapert and Munos (2004, p. 37), "New users tend to feel more uncertainty. The greater the perception of risk, the greater probability of being a victim of a bad provider."
- *Transaction phase,* considered as "the moment of truth" (Edvardsson, 1996; Edvardsson, Gustafsson, Johnson & Sandén, 2000; Grönross, 2000; Normann, 1984), is the step during which the consumer will evaluate the service provided. For Shostack (1985, p. 243), it is "the moment during which the consumer interacts directly with the service". The consumer can thus "experiment" with a variety of services which can be scrupulously analyzed during the post-transactional phase.
- *Post-transactional phase,* step during which the consumer analyzes the situation in which he/she has been confronted with regard to the information he/she had about the service before benefiting from it.

In addition to the traditional "4P's" of the marketing-mix, we find the "3P's" of services: physical dimensions, personal contact and the providing of the service. According to Shostack's molecular model (1985), health care is situated in the middle of the axis combining tangible and intangible aspects. Indeed, if medical expertise and competence are required and looked for in a physician, the care depends on the medical supplies and the hospital infrastructure. These two features are essential: the whole process includes taking care of the patient from beginning to end. We will discuss the impact and risk of these features in the following paragraphs.

The physical dimension is the first impression that a patient measures upon arriving at a clinic or hospital. As Lovelock et al. (2008, p. 27) reiterate "For lack of being able to inquire *ex ante* about the quality and the level of performance of the services rendered by a provider, a client will build his / her expectations and perceptions with the elements to which he / she has access". These elements include aesthetic appearance of buildings as well as equipment used in the hospital.

Before arriving at the clinic or hospital a patient may have doubts regarding the level of modernism of the equipment, buildings, etc. However, studies have shown that the equipment used by these facilities is up-to-date and often financed by developed countries. This is the case with Japan, who invests in Tunisia by providing ultramodern equipment and lasers, or partnerships between certain countries, such as: the Appolo Hospital in India and Johns Hopkins Medicine International (Nys, 2010a).

An analysis of medical destinations around the world coincides with countries where diseases such as malaria, hepatitis A or B, typhoid, influenza are still present. Hospitals must take great care to make sure that these infections do not affect their health services. This dimension must be taken seriously, since a good part of these physicians come from areas where these diseases are present (Knapp, 2007 in Smith & Forgione, 2007). Once again, minimizing these risks is an attraction factor for new, foreign patients.

The personnel is equally important. In certain countries, such as India, which is the top destination for medical tourism, the personnel and physicians speak English, of course, but also a half dozen other languages (German, French, Chinese, Japanese) in order to communicate well with patients. Patients are made at ease since they can communicate with their physician before a procedure.

The capability to speak a foreign language is also observed among certain physicians; thus, Nys (2010b) reminds us that at the Bumrundgrad International Hospital in Thailand, there are over 15 different languages spoken by 900 physicians. This helps to reassure the patients and avoid any miscommunication with potentially unfortunate consequences. Also, if certain physicians speak a foreign language, it is because they studied abroad. The United States and Britain are often the countries of choice to study medicine. Smith and Forgione (2007) brought forth the case of Bumrundgrad and reported that one-fifth of the physicians at this hospital studied in the United States.

Finally, numerous physicians benefit from extra training to become specialists in procedures such as heart bypass surgery, aortic replacements or similar (Marlowe & Sullivan, 2007). This extra training, which is recognized through diplomas or mentioned in their CV's, also gives patients the benefits of healthcare while at the same time reassuring them.

Service benefits are also considered by patient-tourist. Due to cracks in healthcare procedures in western countries (United States, Canada, Britain, France…), special agencies developed specific services for patients who were willing to travel and receive treatments while on holiday. These organizations offer complete packages, including travel, accommodations, airport transfers, healthcare and other related activities.

These all-inclusive packages allow the patient to take advantage of their stay with the least possible worry. We have even noted a specialization in these areas; certain providers specialize in dental tourism in Hungary, for example, others in plastic surgery (North Africa), while others concentrate on major surgery (Menvielle & Menvielle, 2010; Nys, 2010b). Travel agents use this hyper-specialization, which puts the patient at ease, to evaluate the "best" offer and sell the most profitable one to "consumers".

Medical providers try to reduce the perceived risk of their offerings by developing a strong brand image and a positive reputation. This contributes to a favorable consumer's judgment and helps establish trust relationships. Many factors come into play when measuring perceived risk: customer guarantees, publicity, follow-up after procedure. Consumers often put their trust on these factors (Gurviez, 1999).

In the medical field, these signs of credibility often mean certification or licensing. The Joint Commission International's (www.jointcommissioninternational.org) goals for accreditation include offering a quality and secure environment, in order to obtain patients' confidence and furthermore minimize the risks which may affect the patient.

Conclusion

Throughout this article, we have presented the main characteristics of various types of medical tourism. This form of tourism is a rapidly growing market. Elements such as operations costs in developed countries, long waiting lists and the non-reimbursement of certain medical costs favor its emergence and development. But, medical tourism generates a certain number of marketing questions.

Throughout the purchasing process, the patient-tourist must overcome numerous fears. The proposed model, emanating from our studies and from those of Smith and Forgione (2007) is the first step to understanding and clarifying these risks and their impact on the choice of the patient.

This article also revealed the shortcomings of researchers, more particularly, European researchers, interested in this subject. Since many clinics have web sites, it could be interesting to further research consumer's risk perception with relation to medical

tourism packages purchased online. As for clinics, it would be enriching to understand the communication strategy employed to market their services. Further research should be done on client relations once the package has been sold and the service has been consumed? Finally, additional study should be done on Rawls' question (1971) of a nations' ethical right to refuse or limit Primary Goods (access to healthcare) to its tax-paying citizens?

Whatever the case may be, as Levasseur (2008) has mentioned, "medical tourism is in good health".

References

Bauer, R.A. (1960). Consumer Behaviour as Risk Taking. In R.S. Hancock (Ed.), *Dynamic Marketing for a Changing World*, *Proceedings of the 43rd Conference of the American Marketing Association* (pp. 389-398).

Bennett, M., King, B. & Milner, L. (2004). The Health Resort Sector in Australia: A Positioning Study. *Journal of Vacation Marketing*, *10*(2), 122-137.

Bianchi, R. (2006). Tourism and the Globalisation of Fear: Analysing the Politics of Risk and (in) security in Global Travel. *Tourism and Hospitality Research*, *7*(1), 64-74.

Boyer, M. (1996). *L'invention du tourisme*. Paris: Gallimard.

Bovier, P.A. (2008). Explosion du tourisme médical : des voyageurs d'un nouveau type? *Revue médicale Suisse*, 157, 14 mai 2008. Retrieved June 5, 2008, from http://revue.medhyg.ch/article.php3?sid=33183.

Brun, N., Deau, X. & Roffé, J.-L. (2009). Tourisme médical : la médecine low cost? *Médecins*. Retrieved April 2, 2010 from http://bulletin.conseil-national. medecin.fr/article.php3?id_article=273.

Connell, J. (2006). Medical Tourism: Sea, Sun, Sand and … Surgery. *Tourism Management*, *27*(6), 1093-1100.

Durand, H. & Jouvet, F. (2004). Le temps du Tourisme triomphant. In J. Spindler, *Le Tourisme au XXIe siècle* (p. 463). Paris: l'Harmattan - Collection Tourismes et Sociétés.

Edvardsson, B. (1996). *Kvalitet Och Tjänsteutveckling*. Lund: Studentlitteratur.

Edvardsson, B., Gustafsson, A., Johnson, M.D. & Sandén, B. (2000). *New Service Development and Innovation in the New Economy*. Lund: Studentlitteratur.

Ehrbeck, T., Guevara, C. & Mango, P.D. (2008). Mapping the market for medical travel. *The McKinsey Quarterly, 11*.

Flipo, J.-P. (1984). *Le management des entreprises de services.* Paris: Les Éditions d'Organisation.

Flipo, J.-P. (1988). On the Intangibility of Services. *The Service Industries Journal*, *8*(3), 286-298.

Floyed, Myron F., Gibson, H., Pennington-Gray, L. & Thapa, B. (2004). The Effect of Risk Perceptions on Intentions to Travel in the Aftermath of September 11, 2001. *Journal of Travel and Tourism Marketing*, *15*(2/3), 19-38.

Garcia-Altes, A. (2005). The Development of Health Tourism Services. *Annals of Tourism Research*, *32*(1), 262-266.

Gartner, W.C. & Lime, D.W. (2000). *Trends in Outdoor Recreation, Leisure and Tourism*. Cambridge: CABI Publishing.

Grönroos, C. (2000). *Service Management and Marketing: A Customer Relationship Management Approach* (2nd ed.). Chichester: John Wiley & Sons.

Gurviez, P. (1999). La confiance comme variable explicative du comportement du consommateur : proposition et validation empirique d'un modèle de la relation à la marque intégrant la confiance. *Actes du 15ème congrès international de l'Association Française de Marketing* (pp. 301-327). Strasbourg.

Güseman, D.S. (1981). Risk Perception and Risk Reduction Strategies in Consumer Services. In J.A. Donnelly & W.R. George (Eds.), *Marketing of Services* (pp. 200-204). Chicago: American Marketing Association.

Hutchinson, B. (2005). Medical Tourism Growing Worldwide. *Messenger - University of Delaware Review*, *13*(4). Retrieved July 24, 2007, from http://www.udel.edu/PR/UDaily/2005/mar/tourism072505.html.

Kušen, E. (2002). Health tourism. *Tourism, 50*(2), 177-190.

Jacoby, J. & Kaplan, L. (1972). The Components of Perceived Risk. In M. Venkatesan (coord.), *Proceedings of the Third Annual Conference of the Association for Consumer Research* (pp. 287-291).

Labelle, M.J., Colombel, L. & Perrien, J. (2003). Le processus décisionnel du consommateur en matière de produits et services financiers. *Actes des 8ème journées de recherche en marketing de Bourgogne* (pp. 139-157). Dijon.

Laroche M., Bergeron J. & Goutaland C. (2001). A Three-dimensional Scale of the Intangibility. *Journal of Service Research*, *4*(1), 26-38.

Laroche, M., Bergeron, J. & Goutaland, C. (2003). How Intangibility Affects Perceived Risk: The Moderating Role of Knowledge and Involvement. *Journal of Services Marketing*, *17*(2), 122-140.

Leblanc, S. (2010). Les risques du tourisme médical. *La Presse*, 10 August. Retrieved August 12, 2010, from http://www.cyberpresse.ca/opinions/201008/16/01-4307056-les-risques-du-tourisme-medical.php

Levasseur, M. (2008). Tourisme médical: opportunités et controverses. *Réseau de veille en tourisme*, 12 September. Retrieved October 2, 2008, from http://veilletourisme.ca/2008/09/12/tourisme-medical-opportunites-et-controverses/?tagged.

Lovelock, C., Wirtz, J., Lapert, D. & Munos, A. (2008). *Marketing des services* (6th ed.). Paris: Pearson Éducation.

Lovelock, C. & Gummesson, E. (2007). Où va le marketing des services? À la recherche d'un nouveau paradigme et de nouvelles perspectives. In F. Salerno & H. Colas (coord.), *Marketing: analyses et perspectives*. Vuibert.

Mallet, S. (2002). *Vers une clarification des déterminants du risque perçu et de ses conséquences sur le processus de décision d'achat*. Paris: Academic thesis from Université de Paris - Panthéon Sorbonne.

Marlowe, J. & Sullivan, P. (2007). Medical Tourism: The Ultimate Outsourcing. *Human Resource Planning, 30*(2), 8-10.

Menvielle, L., Menvielle, W. & Tournois, N. (2010a). Panorama du tourisme médical, Une logique de flux migratoires. *Revue Espace*, 106, septembre.

Menvielle, L., Menvielle, W. & Tournois, N. (2010b). Tourisme médical et risque perçu: une étude exploratoire en contexte multiculturel. *Actes de l'IFSAM World Conference 8-10 July 2010*. Paris.

Menvielle, L. (2010c). Medical Tourism: Paradoxes of Globalisation and Ethical Issues. In N. Tournois & E. Milliot (Eds), *The Paradoxes of Globalisation* (pp. 145-166). Hampshire: Palgrave Macmillan.

Menvielle, L., & Menvielle, W. (2010). Le tourisme médical, une nouvelle façon de voyager. *Revue Téoros*, *29*(1).

Mueller, H. & Lanz Kaufmann, E. (2001). Wellness Tourism: Market Analysis of a Special Health Tourism Segment and Implications for the Hotel Industry. *Journal of Vacation Marketing*, *7*(1), 5-17.

Murray, K.B. & Chlater, J.L. (1990). The Impact of Services Versus Good on consumers' Assessment of Perceived Risk and Variability. *Academy of Marketing Science*, *18*(1), 51-66.

Normann, R. (1984). *Service Management: Strategy and Leadership in Service Businesses*. New York, NY: Wiley.

Pizam, A. & Mansfeld, Y. (1996). *Tourism, Crime and International Security Issues*. Chichester: John Wiley & Sons.

Pforr, C. (2006). Tourism in Post-Crisis is Tourism in Pre-Crisis: A Review of the Literature on Crisis Management in Tourism. Curtin University of Technology –School of Management. *Working Paper Series,* n. 1.

Proulx, L. (2005). Tourisme, santé et bien être. *Revue Téoros*, *24*(3), 5-11.

Rawls, J. (1971). *Theory of Justice*. Cambridge, Massachusetts: Belknap Press Of Harvard University Press

Saget, E. (2005). Des pays très hospitaliers. *L'Express*, October. Retrieved October 10, 2008, from www.lexpress.fr/reussir/dossier/sante2/dossier.asp?ida=434541.

Smith, P.C. & Forgione, D.A. (2007). Global Outsourcing of Healthcare: A Medical Tourism Decision Model. *Journal of Information Technology Care and Application Research*, *9*(3) 19-30.

Smith, M. & Kelly C. (2006). Wellness Tourism. *Tourism Recreation Research*, *31*(1), 1-4.

Shostack, G.L. (1985). Planning the Service Encounter. In J.A. Czepiel, M.R. Solomon & C.F. Surprenand, *The Service Encounter* (pp. 243-254). Lexington, MA: Lexington books.

Toolis, K. (2004). Rise of the Terrorist Professors. *New Statesman*, 14 June, 26–27.

Walker, T. (2006). Consumers go Abroad in Pursuit of Cost-effective Healthcare. *Managed Healthcare Executive*, *16*(7), 10.

Submitted: 03/23/2010
Accepted: 03/10/2011