

Insights on medical tourism: markets as networks and the role of strong ties

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Received: 1 February 2014 / Accepted: 11 April 2014 / Published online: 23 May 2014
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Abstract Despite a huge amount of speculation and expectation surrounding medical tourism, hard empirical evidence is only now beginning to emerge. This paper widens the focus of discussion by contrasting two country experiences (UK and Korea) which on the surface illustrate the diversity of medical tourism and little else. However, considered more comparatively, the accounts contribute toward wider, albeit tentative, theoretical understandings, and insights. The paper is drawn from two broad programs of empirical study conducted over three years in UK and Korea, respectively. The article is structured in three parts: first, a brief overview of policy, legislative, and accreditation frameworks that exist to govern medical tourist flows. Second, we present evidence around flows, demographics, treatment, and medical tourism for Korea and UK (both for supply and demand). Third, we examine conceptual and theoretical implications of this evidence. We argue that viewing medical tourism as a global market is problematic; some medical tourist markets are best viewed as networks with long-term exchange relationships; some specific areas of activity do function more strongly as price-related; decision making around medical tourism frequently involves a range of information and social networks (economic action as embedded social structure); and medical tourism is a function of globalization.

Keywords Medical tourism · Medical travel · Globalization · UK · Korea · Comparative analysis · Networks

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Introduction

Emerging forms of medical tourism

Over recent decades, the global growth in the flow of patients and health professionals as well as medical technology, capital funding, and regulatory regimes across national borders is leading to new patterns of consumption and production of health-care services. A significant new element of a growing trade in health care has involved the movement of patients across borders for medical treatment; a phenomenon commonly termed “medical tourism” (Connell 2013). Medical tourism occurs when consumers choose to travel across international borders with the intention of receiving some form of medical treatment which is booked and paid for. The type of treatment spans the full range of medical services but most commonly takes the form of dental care, cosmetic surgery, elective surgery, or fertility treatment. While such travel by elites from less-developed countries to developed countries has existed for decades, there has been a shift toward patients from richer, more developed nations traveling to less-developed countries to access health services, largely driven by the low-cost treatments available in these countries and helped by cheaper flights and information available on the Internet (Lunt et al. 2011). There are also strong intra-regional flows. Medical tourism differs from cross-border health care—for example, within the European Union, where patients may obtain treatment in a different country (within a regulatory framework, or according to an agreement between states)—in that it is almost entirely unregulated and occurs primarily in the private sector (Carrera & Lunt 2010).

Despite much speculation and expectation around medical tourism, hard empirical evidence has been relatively scarce. Discussion tends to be focused on marketing and market growth, without being critical of assumptions, and conceptual and theoretical resources have remained underdeveloped. Fortunately this gap is beginning to be addressed, and scholarship has encompassed discussion of North American (Crooks et al. 2010; Johnson & Garman 2010), Asian (NaRanong & NaRanong 2011; Pocock & Phua 2011), and European contexts (Legido-Quigley et al. 2011; Miyagi et al. 2012; Hanefeld et al. 2013).

These nationally focused and regionally situated debates notwithstanding, wider questions still remain, including: does a global industry exist, how large are the flows, what is the nature of medical tourism, and what are the patterns of activity and how should we best understand them? The nature of markets and their governance, the motivations of patients, and the malleability of medical tourist markets are key considerations (Lunt et al. 2013). This paper attempts to widen the focus of discussion for medical tourism research by contrasting the experiences of two nations (UK and Republic of Korea) that on the surface illustrate the diversity of medical tourism and little else. However, considered more comparatively, the accounts contribute to wider, albeit tentative, theoretical agenda. The countries were selected for comparative work on medical tourism, because both have a focus on inbound medical tourism, and both have a growing body of empirical evidence on the subject. The latter provides a rare opportunity for comparative empirical research on medical tourism given the systematic data collection. This comparative analysis provides important evidence regarding developments in medical tourism and allows a five-fold conjecture to be outlined for further scrutiny within the field.

Destination countries

Some places may be simultaneously acting as countries of origin and destination in a so-called medical marketplace (see Johnson et al. 2012, for a discussion of this topic as it concerns the

United States). Taking the UK experience, a number of Western, Central, and Eastern European providers have targeted potential medical travelers from the UK. For example, in Poland, a popular destination for dental and cosmetic tourists, medical tourism is facilitated through private companies, and many of the clinics used are state owned. Hungary has also sought to harness the opportunities presented by its entry into the European Union to develop a medical tourism industry. The UK falls within this group and itself also provides services to overseas elites, foreign governments, and multinational companies. Thus, private facilities such as those on Harley Street in London and those within the public National Health Service (NHS) specialist hospitals have longstanding reputations in the international provision of health care (including providing treatments for patients from Greece, Cyprus, the Middle East, and Africa).

Within Korea, the emphasis is primarily on the inbound flow of medical tourists and is in line with a range of developments elsewhere (Thailand, India, Singapore, Malaysia, and Turkey,) (Mudur 2004; Chee 2007; Whittaker 2008; Reisman 2010), where national government agencies and policy initiatives have sought to stimulate and promote medical tourism. Both Korea and the UK, despite their differences, see economic development potential in the emergent field of health trade. Both have sought to promote their comparative advantage as medical travel destinations at large international trade fairs, sometimes via advertising within the foreign press, and with official support for activities as part of their economic development and tourism policy. Since 2009, the Korean government has allowed hospitals and clinics to fully market health services to foreign patients, and the Korea Health Industry Development Institute plays a major role in national coordination and marketing. Measures to support international activities of NHS Hospital Trusts and organizations include NHS Global (2010–2012), and the launch in 2012 of the HealthCare UK scheme, promoting wider health interests. Attempts to attract international patients must be placed in the wider context of both countries offering a suite of expertise and services—consultancy, training, and education—around health provider development and delivery.

Motivations

Factors determining patients' decision to travel relate to cost, perceived quality, familiarity, waiting lists or delays in treatment, or the lack of availability of certain treatments in the country of origin (see Crooks et al. 2010; Lunt & Carrera 2010 for reviews); the importance of these factors may vary according to the treatment for which a patient travels and the patient's country of origin. Patients traveling for cosmetic surgery, for example, may enjoy the anonymity of a destination far from their country of origin, whereas migrants may prefer to travel to their country of birth to feel more comfortable with language or type of care provided (Lee et al. 2010). Glinos et al. (2010) develop a typology for patient motivation across all funding routes: availability, affordability, familiarity, perceived quality of care; cross-referenced with whether a patient has funding.

Tourism or not?

Medical tourist destinations differ in how much they openly promote the cultural, heritage, and recreational opportunities of their location. It is likely that for some treatments, the vacation and convalescence functions will be more marginal; for others, it could be a more significant component of consumer decision making. The reputation of particular destinations as highly customer-focused service providers is also a prevalent focus of advertising. An emphasis on marketing services as high technology and high quality is common,

as is identifying clinicians that have overseas experience (training, employment, registration). Countries seeking to develop medical travel earnings have the options of growing their own health service (public and private) or inviting partnerships with large multinational players. Securing accreditation from international programs such as Joint Commission International may be part of the development of services and an attempt to badge quality (Shaw et al. 2010). Achieving partnerships with foreign hospitals and universities (e.g., Asian countries' relations with the American private sector), can fulfill a similar role. As will be discussed below, all these considerations are potentially important in order to better understand the medical tourism market.

Methods and approach

The paper draws on two broad programs of empirical study conducted during 2010–2013 in the UK and Korea, respectively. The empirical programs sought to describe, explain, and understand the size, motivation, impact, and challenges of medical tourism within the respective countries. Clearly, comparing the UK and Korea highlights many differences in context, the structure of health-care provision, the regulatory framework, state, and regional support for medical tourism development, and the support and involvement of professional bodies within medical tourism. It also identifies commonalities across the different contexts. This paper examines three types of flow, arguing that taken together the sum of their understanding is far greater than the parts:

- Patient flows into Korea
- Patient flows into the UK
- Patient flows out of the UK

The UK and Korean programs of research integrated policy analysis, desk work, economic analysis, and treatment case studies. They utilized qualitative and quantitative data collection and were both underpinned by a systematic overview of the previously published literature on medical tourism, and legal and policy reviews (see Table 7). The datasets are not, however, identical and the data (while having significant depth) are used to help sketch the broad shape of medical tourism processes, flows, and structures in the respective countries and then to propose tentative conceptual and theoretical hunches. Here we concur with Mangan (1999) that “[b]y its very nature, cross-national research typically extracts greater methodological compromises than a single-country focus.” While each country offers a standalone case study, arguably the parceling of findings into national silos if taken to extremes risks side-lining broader conceptual and theoretical insights for medical tourism. To resist the slide from the “empirical” to *empiricism*, this paper is situated within the terrain of Merton's (1949) mid-range theorizing. The paper draws on the broad body of empirical data from across these two national experiences to contribute to a broader theoretical understanding of key elements within medical tourism around market development and market understanding.

The article is structured in three parts:

- First, a brief overview of policy, legislative, and accreditation frameworks that exist to govern medical tourist flows;
- Second, the evidence around flows, demographics, treatment, and medical tourism for Korea and the UK (for both supply and demand), and an examination of the drivers that encourage patients to travel for medical care;
- Third, a look at potential conceptual and theoretical implications of this evidence.

Policy, system, and regulation

Outbound travelers from the UK make a two-step decision when becoming medical tourists. First, they opt to be treated outside the publicly funded NHS system; second, they choose to be treated overseas (typically in mainland Europe and Asia) rather than within the UK private sector. The legal ramifications of seeking treatment abroad are complex. When attempting to sue for medical malpractice abroad, there are decisions about whom the patient should sue (clinic, surgeon, or facilitator), along with the particular jurisdiction where any legal case would be heard and the laws and legislation that would be used (Vick 2012). It is clear that safeguards for health care provided within the UK (e.g., General Medical Council registration) have little relevance if treatment is received out of the national jurisdiction. Where complications occur, and there are emergency circumstances, necessary treatment is provided by the NHS, irrespective of where treatment was initially carried out.

In terms of patient travel into the UK, large and well-known NHS facilities have a long tradition of treating international patients as private patients, defined as booked and planned admission for which there is a reasonable expectation of reimbursement (pre-paid or through a “letter of guarantee” from an embassy or insurer). These private services are offered to international patients within both integrated and standalone facilities. Income earned is retained to benefit patients within the public system (Health and Social Care Act 2012). Integrated facilities involve shared operating theaters and treatments when the need arises to co-locate activities for reasons of intensive care and specialist support (for example, shared theaters but private wards). For some treatments, there are dedicated facilities with private operating theater space and ward facilities. Types of treatment center on complex tertiary procedures (including pediatrics and heart surgery) and also include maternity services and ophthalmic surgery. Private clinics and hospitals will also seek to attract international patients, and all health-care facilities are regulated by the Care Quality Commission, whose findings are publicly available. UK hospitals and facilities (whether private or public) have eschewed external quality assessment in the form of accreditation bodies. The proposed publication of surgical outcome data linked to individual surgeons may, however, provide an element of benchmarking for NHS and private sector facilities.¹

Korea has since 1977 had a national health insurance system, and because the government controls the fee schedule, health expenditure as a share of gross domestic product is kept relatively low—6.9 % in 2009 (Jeong & Shin 2012). Even though the public sector finances over half of health expenditure, more than 90 % of medical institutions are private, and 90 % of all beds belong to private institutions (Jeong 2011). Hence medical institutions in the private sector face encouragement to actively increase their revenues by developing new medical techniques and increasing service volumes.

Faced with global economic recession and an aging population, the Korean government sought to find ways to boost the economy. Inspired by the purported success of leading countries in medical tourism (including Singapore, Thailand, and India), the Korean government decided to enter the medical tourism market, announcing in 2009 that medical tourism would be a new growth engine for economic development. Subsequently, the government changed medical law to allow advertisement to attract foreign patients. A medical visa was also adopted (Yu & Ko 2012; Kim et al. 2013).

The actual development and delivery of medical tourism policy are undertaken by public organizations, including the Korea Health Industry Development Institute (KHIDI)

¹ <http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx>

and the Korea Tourism Organization. KHIDI, under the Ministry of Health and Welfare, has two purposes: to improve the national health industry by providing comprehensive and professional support programs and to strengthen the competitiveness of the national health industry. Its department of international cooperation has five teams actively involved in promoting medical tourism (see also Kim et al. 2013).

Many Korean medical institutions and leading hospitals and clinics have supported the venture. In particular, they sought to increase revenue by treating foreign patients, charging premiums far above domestic insurance rates. Participating providers hoped that treating foreign patients would bolster their domestic reputation for medical excellence, and there were anticipated benefits from improving service quality, because many medical institutions in Korea are accredited by Joint Commission International.

A sharp difference with the UK is that under Korean law, any medical institutions that intend to treat foreign patients are required to be registered by the Ministry of Health and Welfare. (Interestingly, not all UK hospitals treating international patients know precise numbers and so cannot easily distinguish between domestic and international private patients.) Within Korea, the percentage of registered medical institutions increased from 2.6 to 3.6 % between 2009 and 2011. Nearly 98 % of tertiary hospitals are registered (Table 1).

Assessing evidence on the UK and Korea

Obtaining an accurate measure of the size of the medical tourism market has proven especially difficult. Many of the numbers that have been discussed and subsequently absorbed into both the gray and academic literature studies have been generated by the medical tourism industry itself and usually represent estimates based upon questionable growth models. In particular much has been made of a Deloitte report which suggested that 750,000 Americans traveled for medical treatment in 2007 and that this would rise to between three and five million by 2010, resulting in a global market of upward of 30 million tourists. This report has met with both skepticism and criticism within the academic literature (Connell 2013; Lunt et al. 2013). The serious problem when searching for reliable data is that most of the data sources are stakeholders with a vested interest (see also Connell 2011). While there are methodological issues with, and acknowledged within, the International Passenger Survey (IPS), it represents a credible source of unbiased information for the UK. The following section examines its headlines.

Medical travel to and from the UK

The IPS is conducted by the office for national statistics (ONS). As part of a series of questions, it asks travelers at UK ports to classify their purpose of travel, with one code set aside for “medical reasons.”

As Fig. 1 shows, the number of people traveling from the UK and into the UK for medical reasons increased over the period 2000–2010. The increase in those traveling from the UK is, however, much more drastic than the increase in those traveling to the UK. From a level of 8,500 in 2000, the number of people traveling from the UK for medical reasons surpassed 63,000 in 2010. Over these 11 years, the majority of people from the UK who traveled for medical reasons visited Northern, Southern, and Western Europe, with key destinations being France and Belgium. Similarly, this region was the source of the greatest number of people traveling into the UK for treatment, with the Republic of Ireland, Spain, and France being chief sources of medical tourists to the UK.

Table 1 Percentage of registered institution by type in Korea (2009–2011)

| Type of institution | 2009 | 2010 | 2011 |
|-----------------------------------|-------------|-------------|-------------|
| Tertiary hospital | 77.3 (34) | 93.2 (41) | 97.7 (43) |
| General hospital | 27.1 (73) | 35.0 (96) | 39.6 (109) |
| Hospital | 7.8 (96) | 11.2 (147) | 13.9 (191) |
| Dental hospital/clinic | 1.9 (271) | 2.6 (392) | 2.9 (446) |
| Oriental medicine hospital/clinic | 1.2 (145) | 1.5 (185) | 1.8 (211) |
| Clinic | 3.1 (828) | 3.4 (946) | 3.9 (1,072) |
| Others | 0.8 (6) | 0.8 (7) | 0.9 (9) |
| Total | 2.6 (1,453) | 3.2 (1,814) | 3.6 (2,091) |

Unit: % (number). Tertiary hospital: over 100 beds and 20 specialties. General hospital: over 100 beds and 7 specialties. Hospital: over 30 beds. Others: Long-term hospitals. *Source* statistics on international patients in Korea, 2011 (KHIDI)

In many ways, inbound medical tourism reflects established trade and cultural links, and while the increasing availability of low-cost air travel has made such travel easier, it has not “put Britain on the map” as a medical tourist destination. In contrast, while some destinations of UK medical tourists have historical or cultural ties to the UK, the locations visited by UK medical travelers represent some “new” destinations within emerging medical tourism markets.

Existing and new markets

Table 2 provides an overview of both the destination of UK medical travelers and source countries of medical travelers to the UK from 2000 to 2010. Medical travel from the Middle East was steady over this time period, whereas travel to Central and Eastern Europe “took off” after 2005. Taking the UAE, for example, the circa 32,500 travelers to the UK over the 11-year period are spread relatively evenly across that period. In contrast, since 2005, Poland has shown the largest surge in popularity and by 2009 was the most visited destination for medical travelers from the UK, being the destination of just over 21 % of all UK medical travelers in 2010. Central and Eastern Europe as a destination accounted for just 5.8 % of all UK medical travelers in 2000, compared with 39.4 % in 2010. While this extreme upturn is largely driven by travelers to Poland, large increases were also experienced in Hungary and Lithuania over the period.

The numbers traveling to Poland may, of course, as with India and Pakistan, reflect that the UK is home to a large population of people with historic and familial ties to Poland, a population that burgeoned considerably during the second half of the last decade. While this is likely to be the case, the importance of both proximity and accessibility to Central and Eastern Europe and the emergence of a reputation for high-quality cosmetic care (whether this is accurate or not) are also undoubtedly factors. The UK research suggests that while cost is a key motivator for some UK medical tourists (e.g., cosmetic and dental), proximity is also a huge pull factor. Most UK medical tourists travel for treatment that they cannot, for any of a variety of reasons, access through the NHS. Interviews with UK medical tourists suggest that had treatment been accessible, both in terms of availability and cost; in the UK, they would not have considered traveling. The ability to conveniently and relatively cheaply reach destinations such as Belgium, France, and Spain, plus a cultural familiarity born out of a long association with British people holidaying in these countries has clearly played a role in influencing where UK medical travelers have visited.



Fig. 1 UK inbound and outbound medical tourists 2000–2010

On the supply side, medical tourism “businesses” in Central and Eastern Europe, particularly countries such as Poland, Hungary, and the Czech Republic, are very much engaged in the kind of marketing of medical tourism that has been discussed at length in the literature. A key driver in the medical tourism phenomenon is the technological platform provided by the Internet for consumers to access health-care information and advertising from anywhere in the world (Lunt et al. 2010; Horsfall et al. 2013). Equally, the Internet offers providers vital new avenues for marketing to reach into nondomestic markets. Commercialization is at the heart of the growth in medical tourism, and in some part, this may be due to the availability of web-based resources to provide consumers with information, advertisements, and market destinations, and to connect consumers with an array of health-care providers and brokers. Here patients are treated as customers and, by and large, the treatments, while potentially life changing, do not involve life-threatening conditions, with cosmetic and dental work being key procedures offered in the region to UK medical travelers.

NHS provision

The marketing of largely cosmetic treatment to UK customers stands in stark contrast to the nature of much medical travel from the Middle East into the UK. Here existing relationships are incredibly important, with much of this medical travel being facilitated through embassy or consular channels. While some do undoubtedly travel to the UK for cosmetic surgery, many come in search of more complex procedures. Perhaps unsurprisingly, the largest numbers of inbound medical tourists were to the large hospitals which are internationally known for their

Table 2 Destinations of UK medical travelers and source countries of medical travelers to the UK 2000–2010

| Region | Number of UK travelers to the region (2000–2010) | Key destination country in region | Number of travelers to the UK from region (2000–2010) | Key source countries in region |
|--|--|-----------------------------------|---|------------------------------------|
| Northern, Western, and Southern Europe | 125,500 | France (43,000) | 234,700 | Ireland (39,000) |
| Central and Eastern Europe | 83,000 | Poland (41,000) | 18,700 | Czech Republic (2,700) |
| Africa | 4,400 | South Africa (2,200) | 45,500 | Nigeria (24,800) |
| Southern Asia | 38,700 | India (26,500) | 9,500 | Pakistan (8,000) |
| East Asia | 11,500 | Thailand (4,200) | 11,600 | Thailand (2,500) Hong Kong (2,500) |
| Middle East | 7,500 | Egypt (1,600) Lebanon (1,600) | 108,000 | UAE (32,500) |
| North America | 12,000 | USA (12,000) | 17,700 | USA (11,100) |
| Central and South America | 4,200 | Colombia (2,000) | 2,500 | Brazil (500) |
| Other | 3,100 | Australia (1500) | 12,500 | Trinidad and Tobago (2,500) |

Source Office for National Statistics, International Passenger Survey (2000–2010)

specialism; foremost among these is Great Ormond Street Hospital for Sick Children, which reported income of over £20 million from 656 patients (Hanefeld et al. 2013). To some providers, especially the large hospitals in London, medical tourism marks a significant proportion of private patient income, while for others, it contributes a very small percentage of funding. Despite the variations in the number of patients visiting various hospitals and in the income per patient, the number of medical tourists was comparatively smaller than the percentage of income generated by them (7 % of patients generating close to 25 % of private income). This indicates that spending by private non-UK residents per procedure was much higher than spending by private UK residents, suggesting, as noted above, that non-UK residents traveling to the UK for medical treatment seek expensive high-end specialist procedures.

Cultural considerations

As with the UK and the Middle East, medical travel between the UK and India or the UK and Pakistan is also likely to be driven by cultural factors, but here familial ties or diaspora connections are crucial rather than trade and diplomatic relationships. India proved to be a popular and increasingly visited destination during the time period studied, which might reflect that the UK has a large population with historic ties to India, and that travel to this region has become much more accessible in recent years. It may even be that those traveling retain Indian citizenship. While it is not possible to ascertain the citizenship or place of birth of IPS respondents, it is likely that many of those who have traveled from Spain, France, and Ireland to the UK are indeed expatriates.

Service use by foreign patients in Korea

The number of medical tourists traveling to Korea has steadily increased during recent years. In 2009, reportedly 60,201 medical tourists visited Korea; by 2011, this number had increased to 122,297. As Table 3 shows, in 2009, the U.S. was ranked first with regard to the number of inbound medical tourists, followed by Japan and China. In the period 2009–2011, the U.S. held a 30 % market share of all medical tourists in Korea, though approximately one quarter of these were military personnel, and a substantial number is thought to be Korean expatriates (see also, Lee et al. 2010). China and Japan were the next largest sources of travelers. During this period, both countries saw a substantial increase in the number of people leaving their shores for treatment in Korea.

The pace of change is marked. As Table 3 shows, the average annual growth rate of medical tourists visiting Korea depicts a rapidly emerging market. It is evident that Russia exhibits the highest growth rate (134.4 %) among the top five nations, followed by China (101.7 %) and Mongolia (96 %).

Table 4 shows the sociodemographic characteristics of medical tourists by nationality. In the case of Japanese and Chinese patients, over 70 % of medical travelers are females. However, among U.S. and Russian patients, the number of male and female patients is almost equal. In the case of Japanese and Russian patients, the largest percentages are in the age group 30–49. The largest percentages of U.S. and Chinese patients are in the age group 20–39.

Patients travel to Korea for a variety of treatments depending on country of origin. Examining the percentage of medical tourists by nationality for each specialty, in seven out of ten, the U.S. is first ranked for the number of patients. Japan is first ranked in dermatology and Oriental medicine—in this category, Japanese patients occupy 78 % of the

Table 3 Source country of medical tourists to Korea (2009–2011)

| Nation | 2009 | 2010 | 2011 | Average growth rate (%) |
|----------|-----------------|-----------------|-----------------|-------------------------|
| USA | 13,976 (32.6 %) | 21,338 (32.4 %) | 27,529 (27.1 %) | 40.3 |
| Japan | 12,997 (30.3 %) | 11,035 (16.8 %) | 22,491 (22.1 %) | 31.5 |
| China | 4,725 (11.0 %) | 12,789 (19.4 %) | 19,222 (18.9 %) | 101.7 |
| Russia | 1,758 (4.1 %) | 5,098 (7.7 %) | 9,651 (9.5 %) | 134.3 |
| Mongolia | 850 (2.0 %) | 1,860 (2.8 %) | 3,266 (3.2 %) | 96.0 |

Source statistics on international patients in Korea, 2011 (KHIDI)

Table 4 Most frequently observed sociodemographic characteristics of medical tourists to Korea by nationality (2011)

| Nation | Age | Sex |
|--------|----------------|-----------------|
| USA | 20–39 (42.3 %) | Male (50.8 %) |
| Japan | 30–49 (44.6 %) | Female (77.6 %) |
| China | 20–39 (43.5 %) | Female (70.8 %) |
| Russia | 30–49 (46.0 %) | Female (53.7 %) |

Source statistics on international patients in Korea, 2011 (KHIDI)

Table 5 Nationality of medical tourists to Korea broken down by major department (2011)

| Department | Rank | | |
|-------------------------|----------------|----------------|----------------|
| | 1 | 2 | 3 |
| Internal medicine | USA | Russia | China |
| | 6,155 (34.7 %) | 3,065 (17.3 %) | 2,669 (15.1 %) |
| Health examination | USA | Japan | Russia |
| | 4,683 (28.4 %) | 4,186 (25.4 %) | 3,454 (21.0 %) |
| Dermatology | Japan | China | USA |
| | 4,074 (34.6 %) | 2,664 (22.6 %) | 2,209 (18.8 %) |
| Family practice | USA | Japan | Russia |
| | 3,260 (27.7 %) | 2,246 (19.1 %) | 942 (8.0 %) |
| Plastic surgery | China | Japan | USA |
| | 5,875 (58.7 %) | 1,570 (15.7 %) | 923 (9.2 %) |
| Oriental medicine | Japan | USA | Russia |
| | 6,940 (78.1 %) | 567 (6.4 %) | 412 (4.6 %) |
| Obstetrics & gynecology | USA | Russia | China |
| | 2,418 (36.2 %) | 1,046 (15.6 %) | 959 (14.3 %) |
| Orthopedics | USA | Russia | China |
| | 1,885 (33.3 %) | 952 (16.8 %) | 915 (16.2 %) |
| Ophthalmology | USA | China | Russia |
| | 1,309 (32.9 %) | 852 (21.4 %) | 416 (10.5 %) |
| Dentistry | USA | China | Russia |
| | 1,482 (34.9 %) | 557 (13.1 %) | 497 (11.7 %) |

Source statistics on international patients in Korea, 2011 (KHIDI)

Table 6 Most frequently used services by medical tourists in Korea by nationality (2011)

| Rank | Country | | | |
|------|-------------------------------|----------------------------|-------------------------------|-------------------------------|
| | USA | Japan | China | Russia |
| I | Internal medicine (16.3 %) | Oriental medicine (28.7 %) | Plastic surgery (26.9 %) | Health exam (20.8 %) |
| II | Health exam (12.4 %) | Health exam (17.3 %) | Dermatology (12.2 %) | Internal medicine (18.5 %) |
| III | Family practice (8.6 %) | Dermatology (16.9 %) | Internal medicine (12.2 %) | Obstetrics/gynecology (6.3 %) |
| IV | Obstetrics/gynecology (6.4 %) | Family practice (9.3 %) | Health exam (6.2 %) | Orthopedics (5.7 %) |
| V | Dermatology (5.8 %) | Plastic surgery (6.5 %) | Obstetrics/gynecology (4.4 %) | Family practice (5.7 %) |

Source statistics on international patients in Korea, 2011 (KHIDI)

patient pool. China is first ranked in plastic surgery, where Chinese patients make up nearly 59 % of the market share Tables 5, 6, and 7.

Medical services used by foreign patients

U.S. patients mostly use primary care services from internal medicine, health examination, and family practice. There is a similar utilization pattern for Russian patients. However, questionnaire data suggest different motivations for these two groups, with U.S. patients drawn to Korea for lower-priced treatments, while Russians seek higher-quality service than is available at home.

Even though Japanese and Chinese patients are concentrated in beauty-related specialties, they exhibit different preferences. Japanese patients prefer less-invasive procedures, while Chinese patients prefer invasive procedures such as plastic surgery. This reflects the cultural difference in beliefs around the body between the two countries. Since the Japanese have a strong belief that the body should be inherited and intact, they may avoid invasive procedures (see, for example, Ashikari 2005).

The average payment across a three-year period steadily increased. In 2009, the average payment was US\$838, rising to US\$1,329 in 2011. The average payment by type of service shows a different pattern of change. The inpatient payment during the same period increased only slightly, from US\$5,847 to US\$5,905. However, in the case of outpatient services, the average payment increased from US\$481 to US\$892. The average payment for health examination dropped from US\$771 to US\$663 between 2010 and 2011. This latter change stems from keen competition in this sector and illustrates the potential for there to be some treatments where competition is focused on price.

In summary, there has been an increase in outbound medical travel from the UK. Travelers from the UK are not a homogenous group, with a large proportion traveling to “tried and tested” locations in Western Europe, a large and growing proportion traveling to Central and Eastern European countries, and a smaller, yet still substantial group traveling to more far-flung locations such as Asia. It is likely that the motivation for and type of treatment sought by those who travel to these destinations vary, with distance, cost, and cultural or familial ties playing some role in shaping both the decision to travel and the selection of destination. A great majority of international patient treatment and payment

Table 7 Summary of data

| | |
|---|--|
| Primary data collection: UK | |
| Interviews | Description |
| Patients (treatment groups, $n = 46$; Diaspora patients $n = 31$) | Interviews with treatment groups: cosmetic, dental, bariatric, dental, cultural. Focused on decision making and experiences |
| Hospital providers ($n = 23$) | Managers within hospitals |
| Professional associations ($n = 16$) | Representatives of professional associations |
| Commercial ($n = 18$) | Individuals working within the private sector of medical tourism |
| Overseas providers ($n = 23$) | To examine country strategies and marketing |
| Desk work | |
| Review of web sites | 100 sites reviewed. Guideline search |
| Review of quality and safety accreditation | 150 sites reviewed |
| Secondary data collection | |
| International passenger survey | 2000–2011 |
| Systematic review | Review of medical tourism literature |
| Primary data collection: Korea | |
| Survey | |
| Japanese tourists ($n = 127$) | Questionnaire: focused on intention to use medical services and reasons, preferred services, attitudes toward medical competence of both Korea and Japan |
| Hospitals/clinics ($n = 99$) | Questionnaire: human resources; physical resources; management systems; structural characteristics of organizations treating medical tourists |
| Desk work | |
| Review of web sites | 58 Websites of joint commission international-accredited hospitals in Korea, Singapore, Thailand, and India |
| Secondary data collection | Contents, user interface, design, interactivity |
| KHIDI data | Official data 2010–2011 |
| Systematic review | Review of medical tourism literature |

pathways into the UK were via embassies and national institutional links, with letters of guarantee providing reimbursement assurance to the medical facilities for what may be very expensive programs of treatment. Hospitals offered various forms of patient liaison but typically not hotel-type concierge services. Relationships, primarily clinical ones, were paramount in maintaining flows of international patients, with established practices of education, training, consultancy, and linkages helping to facilitate referrals.

Concerning Korea, there has been a steady increase in the number of medical tourists during recent years (to 122,297 in 2011). Most of the patients came from neighboring countries, including China, Japan, and Russia, and the services most utilized by foreign patients were primary care services (e.g., health exam, internal medicine), beauty-related services (e.g., dermatology, plastic surgery), and non-Western treatments (e.g., Oriental medicine).

Discussion

We argue that although the experiences of the UK and Korea are very different, they both contribute to a wider understanding of medical tourism. Considering the evidence above, we developed five tentative hunches concerning medical travel conceptualization and theorization.

- 1) Viewing medical tourism as a global market is problematic; Korea and the UK provide support for significant regional drivers and explanations that relate to cultural and historical ties.
- 2) Some medical tourism markets are best viewed as networks with long-term exchange relationships between what are interdependent interests, particularly when treatments are more complex and expensive.
- 3) However, some specific areas of activity may function more strongly as price-related and with a clearer consumer role (for example, cosmetic treatments and dental for UK outbound patients, and diagnostic treatment within Korea).
- 4) Despite the emphasis on the Internet as underpinning the expansion of medical tourism, decision making around medical tourism frequently involves a range of information and social networks. Thus economic action should be seen as embedded within social structure (with, for example, the Internet playing a relatively small role in the case of complex treatments of international patients in the UK).
- 5) Medical tourism is a function of globalization. Studying the changing patterns of patient travel shows how quickly they reflect changing realities within countries. This is evident from the greatly increased numbers of Russians and Mongolians traveling to Korea, and from the number of UK patients who choose to be treated in Poland. Such volatility in some parts of the market may encourage investment caution.

We will now discuss in more detail these tentative hunches. First, the prevailing narrative of medical tourism is one of open, global, and competitive markets. The limited research to date suggests a regional dimension to such medical travel. Japanese companies send their employees to Thailand (Connell 2006) or to countries in the Persian (Arabian) Gulf (Alsharif et al. 2010; Siddiqi et al. 2010). Medical tourists in Tunisia tend to be from neighboring countries (Lautier 2008). Thailand, Singapore, and Malaysia are regional hubs in Southeast Asia (Pocock & Phua 2011). Looking more closely at medical treatments for both the UK and Korea supports this view; typically the flows are bilateral and relations are distinctly regional, with specific patterns mapping onto geopolitical dimensions (including

colonial history and existing trade patterns). For example, those accessing medical treatments in Hungary tend to be from Western Europe, and some countries exploit longstanding historical ties; for example, between the UK and Cyprus. The colonial connection between the UK and India appears to have encouraged a medical market between the two countries (Smith et al. 2011). Considering UK inbound flows, cultural preferences may favor specific London hospitals, for example, Middle East nationals opt for particular London localities for treatment; similarly, a strong connection was identified between some parts of London and Greek and Cypriot populations. The Korean diaspora and that nation's close cultural and geographical proximity to China and Japan explain a great deal of Korean inbound activity (see also Lee et al. 2010; Lee et al. 2012). For Korea, there has been relatively limited success in attracting wider patient flows from Western industrialized countries or the Middle East, despite high-quality training, advanced technology, and JCI-accredited institutions. While factors listed here provide some explanation, further research is needed to understand, for example, why there are not more Russians traveling to the UK for treatment despite a growing Russian diaspora in the country. Research also suggests that countries are known for specific areas of medicine: Singapore for high-end procedures (Lee et al. 2010), Eastern Europe for dental tourism (Piazolo & Zanca 2011), and Spain for fertility treatment (Hudson et al. 2011). While this may seem relatively uncontroversial (it is, for example, how tourism develops), such a reality is not acknowledged by those encouraging the development of medical tourism and those who emphasize the development of global opportunities.

Second, the promotion of medical tourism market opportunities has rested on what Granovetter (1985) would term an "under-socialized" view of relations. Thus, neglecting to see buyer/seller relationships in a particular market as sometimes longer-term relationships of interdependent interests (rather than as resulting from straightforward decisions about price and quality) has stymied government strategies and not led to projected patient flows. Distinct referral and patient management pathways exist for the UK's international patients, while organizational reputation includes a broad perception of "the NHS" as trustworthy and the reputation of individual hospitals as world leaders. Further, relationships, primarily clinical ones, are paramount in maintaining flows of international patients, including training links, where referring doctors in other countries have trained in the UK or spent time alongside receiving consultants. While these relationships may be continuously fostered (e.g., NHS hospitals may offer clinical training to non-UK consultants and staff exchange and educational programs), they are premised on there being an existing connection. These professional networks are where clinicians draw on knowledge networks and characteristics of strong ties (e.g., shared education and training) for referral.

Third, illustrating the diversity of medical tourism and the range of treatments (including cosmetic), there may conversely be some markets that are more competitive and volatile, and where price is a more significant factor. In the UK study, cost played a particularly strong role among cosmetic tourists and the dental tourists who had no cultural or familial ties to their destination. United Kingdom patients traveling abroad for cosmetic treatment and inbound travelers to Korea for such treatment are likely to be self-payers (rather than institutionally supported). These individuals place a greater emphasis on price in their decision making process, while the role of remaking and reinvesting in the body entails particular theoretical perspectives around consumer culture that demarcate such cosmetic journeys (Bell et al. 2011; Holliday et al. 2013).

Fourth, medical treatment includes selecting country, clinic, and clinician, and arranging travel insurance or specialist insurance, financing, travel, accommodation, and aftercare. However, once again, avoiding an under-socialized view is important, because UK evidence

suggests that treatment activities incorporate ongoing networks of social relations (Granovetter & Swedberg 1992; Swedberg 1997).

A range of intermediaries—known as brokers or facilitators—may seek to reduce some of the uncertainty in arranging services and phases of treatment, tailoring packages to individual requirements: flights, treatment, hotel, and recuperation (Reddy & Qadeer 2010) and specializing in particular target markets, procedures, or destination countries. As well as e-mail and telephone communication, they may undertake chaperoning and translation functions during travel and treatment phases. However, even though there were 324 medical tourism facilitators in Korea in 2011, they occupied only 6.6 % (8,098 cases) of the market share (KHIDI 2013). Medical tourism facilitators in Korea have not played, as yet, a major role in the medical tourism market; (Jin 2011) on medical tourists from Japan suggests major sources of information were the media and informal groups (see also Lee et al. 2012).

Trust is established in diverse ways and affects a nation's plans to develop its medical tourism market. In complex markets such as health care, informal information transmitted through social networks about quality, trust, reputation, and status is significant. It is interesting that some travel from the U.S. to Korea for lower-cost treatments, while those from Russia travel for higher-quality treatments.

Such network dynamics (Smith & Christakis 2008, p. 406) include *demand-side networks*, involving patients selecting a provider/country because of advice, relationships, and social influence from a wider cultural or treatment-based group. For example, diaspora Koreans who choose their treatment destination according to informal recommendations from friends, who may emphasize cost, familiarity, and the high standard of care of Korean health-care services to first- or second-generation populations within the United States, Australia, and New Zealand (Lee et al. 2010). Treatment-focused networks include online discussion forums and self-help groups cohering around treatments/conditions (such as fertility and cosmetic).

In demand-side networks, the promotion of destination image plays an important role. Factors shaping the Korean cosmetic treatment image, for example, are culture and information technology. The emerging popularity of Hallyu as a cultural wave led to the number of foreign tourists to Korea reaching ten million in 2012. For some Asian countries, Korea is seen as a place of entertainment and beauty with a particular style and surgical technique, and images and understandings are shared among those looking for beauty-related services.

Fifth, studying the changing patterns of patient travel shows they may quickly reflect changing realities within countries. Thus, while history and culture explain much, there are locations visited by UK medical tourists and Asian/Eastern European medical travel into Korea that represent new destinations and source countries with emerging medical tourist markets. There is, however, potentially greater volatility within these markets, and it will be important to understand the implications of such outbound flows for medical services that are paid for by the patient. Of particular interest is whether Korea can continue to tap the growing wealth of the emerging middle class and elites from Mongolia and Russia. Here the ongoing work of the Simon Fraser University Medical Travel Research Group on outbound travel from Mongolia (see SFU Medical Tourism Research Group 2012) may help clarify whether mobility influences domestic provision, thus dampening demand, or whether such outbound flow (e.g., to Korea) is institutionalized and supported by training and consultancy linkages. Similarly, with regard to Russia, will outbound travel patterns to Korea endure (and, if so, for which treatments), or will Russian medical travelers increasingly turn toward Europe (Furmanov et al. 2012)?

Conclusion

The field of medical tourism is beginning to assemble detailed empirical evidence of flows and implications. Comparative research such as that detailed in this article will allow such empirical social science evidence to make a broader contribution toward understanding processes and drivers surrounding medical travel developments. It also highlights where gaps of knowledge still exist; for example, diaspora ties did not seem to consistently explain preference for travel.

The importance of historical and cultural linkages for some treatments challenges the view of open and global markets, and this may be an obstacle for countries attempting to break into new markets. While advertising, trade fairs, and direct-to-consumer activities may deliver some business for health providers (for example, cosmetic and dental), social ties and networks play a crucial, and too frequently unacknowledged, role. This insight is particularly useful when considering the types of treatment and patient that clinical providers and national strategies seek to target.

Globally, many government agencies continue unabashed, pursuing an identical high-end, wealthy, and complex patient market, primarily from the Middle East, North America, and Western Europe, and preferably one that is funded by insurance and public health system financing. Emerging markets may be more mundane (e.g., dental) or see wellness treatments displacing high-tech medical intervention, but may be valuable nonetheless.

Breaking into new markets is a challenge—as critical and historical views of health care will attest. Hospital reputation is based on many factors, not solely the quality of clinical services. But the evidence also illustrates that countries can sometimes expand and establish their medical tourism market, targeting particular treatments, settings, and niches. Thus, in surveying the wide panorama that constitutes medical tourism, there is no contradiction in suggesting that medical tourism is both localized and globalized that social networks frequently shape individual decisions and that particular markets are a function of culture, history, and sometimes, price.

Acknowledgments British Academy International Partnerships and Mobility Scheme 2012. This article was supported under the British Academy International Partnership and Mobility Scheme-IPM 2012, with an award for “*East Asian and European insights on global medical travel*” (2012–2013).HS&DR Funding Acknowledgement. This project discussed in this article was funded by the National Institute for Health Research Health Services and Delivery Research Programme (project number 09/2001/21).Department of Health Disclaimer. The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health.

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