INTERNATIONAL JOURNAL OF HEALTH MANAGEMENT AND TOURISM

Volume: 5 Issue: 3 Year: 2020 E-ISSN: 2458-9608

IJHMT

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International Journal of Health Management and Tourism (IJHMT)

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Kavaklıdere, ANKARA, TURKEY

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Abstracting and indexing: Google Scholar, Scientific Indexing Services (SIS), Infobase Index, Researchbib Academic Resource Index, Arastirmax Scientific Publication Index, Internationla Institute of Organized Research (I2OR), Directory of Research Journal Indexing (DRJI), Root Indexing – Journal Abstracting and Indexing Service, ASOS İndeks, Bielefeld academic Search Engine (BASE), SOBIAD, Scilit, Türkiye Atıf Dizini

Volume 5, Issue 3, **ISSN: 2458-9608 (Online)**

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https://dergipark.org.tr/tr/pub/ijhmt Doi Number: 10.31201/ijhmt.634092

Int Journal Of Health Manag. And Tourism 2020, 5(3), 181-207

IJHMT Editorial

International Journal Of Health Management And Tourism

MEDICAL TOURISM IN INDIA: POSSIBILITIES and PROBLEMS OF ALTERNATIVE MEDICAL TREATMENT

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Received: 16.10.2019
Accepted: 10.11.2020
Review Article

Abstract: This study aims to explore the problems and potential of medical tourism in India. India has become one of the destination countries for medical tourists from around the world. However, due to issues at both the policy and operational levels, India, like many other such countries, faces several problems in the development of its medical tourism industry. Indian medical tourism can be divided into four categories: surgical treatment, cosmetic surgery, alternative medical treatment, and wellness treatment. In this study, the authors focus on alternative medical treatment and wellness tourism and explore the possibilities and problems.

Results of the current study show that India's medical tourism industry has potential, as international tourists can visit India at a relatively low cost, there is an easy visa process. India offers world-class and standardized medical services, services for alternative medical treatment, and more. Nonetheless, to realize this potential, the medical tourism industry in India must address with a variety of problems, including the absence of standardized herbal drugs and medicines as well as authentic raw materials, lagging processing technologies, the need for improved infrastructure, and lack of sufficient training for non-medical staff in cross-cultural sensitivity and language skills.

Keywords: *alternative medicine, AYUSH, health tourism, India, medical tourism*

Introduction

Medical tourism has become popular in recent years in countries such as Singapore, Indonesia, Malaysia, the Philippines, Thailand, UK, USA, Japan, Korea, and India (Turner, 2007; Connell, 2006). Notably, the demand for Indian medical tourism is significantly higher than in many of these other countries (Mishra & Shailesh, 2012), and the number of people crossing national borders seeking medical care in India is increasing year by year (Ministry of AYUSH, 2019). High medical treatment costs in the home country, dissatisfaction with long waiting times, a low-cost carrier, development of almost all medical technologies and improvements in services are considered to be among the factors explaining this growth (Turner, 2007). In recent years India is a place for "First World Health Care at Third World prices" (Turner, 2007). However, despite recent trends and a government focus on medical tourism in India, there are still relatively few medical tourists coming from other parts of the world.

Competition in the healthcare industry is intense everywhere in the world. Historically, wealthy patients from developing countries have often visited developed countries for top quality medical care (Herrick, 2007). Today, many poor patients from developed countries travel for medical reasons to areas once characterized as "third world." These patients are looking for high-quality medical care at affordable prices (Herrick, 2007). For this reason, India is becoming a medical hub.

Medical tourism in India can be divided into four categories: surgical treatment tourism, cosmetic surgery tourism, alternative medical tourism, and wellness treatment tourism. In this study, we focus on alternative treatment and wellness tourism. These categories have received particular attention and support from the Indian government (Ministry of AYUSH, 2015; IANS, 2017). Alternative treatment is composed of Ayurveda, Unani, Yoga, Naturopathy, Siddha, and Homeopathy (collectively referred to as AYUSH), details of which are presented in the literature review section). In general, wellness tourism focuses on the activities of human life and serves those who seek to balance the mental, emotional, physical, professional, intellectual, and spiritual aspects of their existence.

In recent years, global interest in traditional medicine has increased (Dawn & Pal, 2011; Kunwar, 2019) and Ayurveda is recognized as traditional Indian medicine (Patwardhan et.al., 2005). The modern epidemiological transition has allowed the growth of the conventional system of medicine

across the world (Gupta et.al., 2015) and traveling across borders to receive high-tech health care is increasing (Dawn & Pal, 2011). Wellness tourism and alternative medical treatment is a part of the traditional medicinal treatment was originated and famous in India. Today, Yoga and Ayurveda are synonymous with Indian medicine. In this stand, exploring potential and obstacles for alternative treatment and wellness tourism in India is necessary, which helps to increase the Indian alternative treatment market in the national and international society.

Mishra & Shailesh (2012) studied alternative medical treatment and explored that traveling abroad, patients not only save a considerable amount of money but also receive world-class service. Gupta et.al. (2015) presented that the Indian healthcare system is well-known for providing quality medical services at an affordable cost. Kunwar (2019) discussed the communication barriers in wellness tourism, and alternative treatments and Bookman (2007) discussed fundamental economic and legal issues in medical tourism. Some other scholars focused on specific topics of alternative treatments. For instance, Ayurveda (Patwardhan et.al., 2005), Yoga (Fontanarosa & Lundberg, 1998; Bhavanani, 2012; Kumar & Bharadwaj, 2016), Unani (Linde et.al., 1997), Siddha (Zysk, 2008) were studied individually.

However, to the best of the authors' knowledge, no previous scholars focused on to explore the potential and obstacles of alternative treatment and wellness tourism in India. Therefore, this paper aims to examine India as a competitive destination for alternative tourism based on potential exploration. It also clarifies the problems and obstacles of alternative medical treatments in India. Based on the results, the authors present the policy implications for the Indian alternative treatment.

1. Literature Review

Medical tourism is becoming an increasingly accessible health care opportunity for patients all over the world; it involves primarily and predominantly biomedical procedures, combined with travel and tourism (Dawn & Pal, 2011). The term "medical tourism" refers to traveling across borders to receive high-tech health care; it was created by travel agencies and mass media to designate the rapidly growing phenomenon of such travel (Dawn & Pal, 2011). It is also called medical travel, health tourism, or global healthcare is the practice of traveling abroad to receive healthcare services. Medical tourism consists of tourism for surgical treatment, cosmetic surgery, complementary alternative medicine (CAM), and wellness treatment (Dawn & Pal, 2011). In this

study, the focus is on alternative medical treatment, and wellness tourism, two areas emphasized by the Indian government. Further, the majority of wellness tourism originated in India. Today, Yoga and Ayurveda are synonymous with Indian medicine.

Seeking medical care in another country is motivated by a variety of factors, including long waiting lists for surgery and other specific treatments in the home country, the high cost of selective therapies at home, and significant reductions in travel barriers that allow more convenient and less costly international travel. Typically, by traveling abroad, patients not only save a considerable amount of money but also receive world-class service (Mishra & Shailesh, 2012). This has a great appeal to many people (Carrera & Bridges, 2006). The modern-day epidemiological transition has allowed the growth of the traditional system of medicine across the world (Gupta et.al., 2015; Meštrović, 2014). In this context, India has the potential to be one of the primary health tourism destinations not only for Asian visitors but also for tourists from elsewhere in the world.

The Indian healthcare system is well-known for providing quality medical services at an affordable cost. Health tourism packages provide a "basket of services" by merging traditional medicines with the existing allopathic system to attract patients across borders (Gupta et.al., 2015). Reflecting on the increased popularity of health tourism, generally, the health tourism industry in India has been growing by 25%-30% annually (Mishra & Shailesh, 2012). Private sector corporate houses dominate medical tourism in India; 80% of the hospitals are managed by private sector companies who are ultimately invigorating and transforming India into a global medical tourism destination (Mishra & Shailesh, 2012).

To better understand the concept of medical tourism, it is important to recognize the interrelationship between medical tourism and hospitality in hospitals. Stakeholders in the system need to be aware of the significance of cross-cultural behavior and intercultural communication between host and patient (Kunwar, 2019).

Bookman (2007) conducted research on medical tourism in developing countries and revealed the relationship between medical services and tourism. In this 2007 study, medical tourism is defined as a tour conducted for health purposes. The market is described in terms of its foundation, challenges, opportunities related to sector development, and the health care fairness problem (Bookman, 2007). In the course of the presentation, the author describes the fundamental economic and legal issues surrounding medical tourism (Bookman, 2007).

CAM encompasses modern or rejuvenated ancient practices that are claimed to have preventive or curative medical effects. These practices are not generally recognized in medical science and are typically not based on evidence or sound scientific hypotheses. CAM includes various therapies such as homeopathy, massage-based therapy, naturopathy, diet therapy, and other similar practices (Shakeel et.al., 2011). Generally speaking, medical therapies that are not included in modern scientific guidelines or not recommended by significant scientific associations are classified as CAM (Ray et.al., 2018).

In recent years, global interest in traditional medicine has increased. Patwardhan et.al. (2005) recognize Ayurveda as traditional Indian medicine (TIM) but claim that traditional Chinese medicine (TCM) is still considered the world's oldest medical system. However, Renckens (2009) argues that Ayurveda, the science of life and recognizes differences and seeks balance to keep the body healthy. Efforts are currently underway to monitor and regulate herbal and traditional medicine. Although China has succeeded in promoting treatment with more research and science-based approaches, Ayurveda still lacks a broad scientific research and evidence base (Patwardhan et.al., 2005). In this context, the present study deals with the introduction of AYUSH and explores the importance of CAM, such as AYUSH. The elements of AYUSH are described below.

The Hindu holy book Veda (Ayurveda) provides detailed information regarding medicinal herbs used to treat various human diseases. The Vedas include four core books of spirituality, which consider the topics of health, astrology, spiritual business, government, military, poetry, spiritual life and behavior (Shakeel et.al., 2011). The books are known as the four Vedas, i.e. Rik, Sama, Yajur, and Atharva. A part of alternative treatment Yoga is included under Rik Veda (Fontanarosa & Lundberg, 1998) which means Yoga is not only one of the oldest treatments but also a part of religious performance in the Hindu religion.

Yoga is the art of excellent living. Yoga practices help to achieve an individual's higher aims in life. It involves a lifestyle that regulates one's thought, character, and behavior, and is reflected in one's attitude, personality and designs of life. Human consciousness and yogic science are an attempt to understand the mystery of consciousness in relation to Yoga (Kumar & Bharadwaj, 2016). New medical improvements and developments integrate several traditional healing techniques, including Yoga, to provide a basis for promoting healing, health, and longevity. This is a holistic approach to Yoga that faces current health care challenges (Bhavanani, 2012). For

instance, Yoga therapy has been used as a stress reliever in other kinds of health care and additionally helps to address infertility treatment(Jasani & Heller, 2016).

Unani medicine is another ancient method for the treatment of disease. The Unani system of medicine originated in Greece (Shakeel et.al., 2011) and is generally believed to be based on the ideas of Aesculapius. According to Linde et.al (1997), Hippocrates (460-377 BC), the Greek philosopher/ physician, formulated the theoretical framework of Unani medicine. Hippocrates is said to be a descendent of Aesculapius and regarded as the father of Unani medicine. Galen (131-210 AD) further developed the system of Unani medicine. Unani, which deals with the preventive and promotive aspects of human beings and treats health complications caused by ecological and environmental factors, teaches us to maintain health and treat disease by rebalancing unbalanced humor (Linde et.al., 1997).

The Siddha slogan is "Prevention is better than cure." The history of Siddha, along with its principles of diagnosis and treatment, can be compared to that of north India's Ayurvedic medical tradition (Zysk, 2008). A skilled Siddha doctor uses various methods, including an examination of the patient's pulse, urine, tongue, and eyes, to determine any imbalance and to diagnose its essential nature (Bhamra, 2016). Siddha treatment to remedy an imbalance involves the use of plant-based and metal - and mineral-based medicines. The Siddha system of medicine prescribes a healthy way of living.

Homeopathy was introduced to India in the early 19th century. In 1973, the Indian government accepted homeopathy as one of the country's major medical systems. The Central Council of Homeopathy (CCH) was established to regulate education and practice (Ghosh, 2010). There are several reasons that homeopathy is ignored in a number of other countries. According to the Japanese Physicians Society for Homeopathy, the current status of homeopathy in Japan is far from prominent; due to the legal framework, there are no regulations relevant to homeopathic treatment.

The increasing incidence of complex, multi-factorial chronic diseases and multi-morbidity indicates the need for better therapy and treatment (Song et.al., 2016). In medical practice, the use of traditional and complementary alternative medicine (TCAM) is an important part of medical care. An increasing number of patients worldwide rely on TCAM prevention or palliative care (Song et.al., 2016). Given these factors, it will be necessary to place significant emphasis on

medical research and development that will facilitate the promotion and certification of alternative medicine in India.

1.1. Alternative Medical Treatment And Medical Tourism In India

Alternative medicine methods, mainly AYUSH (Ayurveda, Unani, Yoga, Naturopathic, Siddha, and Homeopathy), are rapidly gaining popularity in India. Reflecting this increased interest, the Indian government created the Ministry of AYUSH in 2014, in part to promote medical tourism in the country. To implement appropriate strategies, the government has continued to increase the budget of the AYUSH ministry every year; in 2018 the total budget increased by more than 13% as compared to the previous year [Press Trust of India-PTI, 2018]. The ministry has invested a significant proportion of its money in research and education in order to produce a qualified workforce to work in the medical industry (Ministry of AYUSH, 2019). A central committee has also been established to create the necessary infrastructure and implement a strong regulatory framework.

There is an increasing awareness of alternative medical systems around the world, and the demand for alternative medical treatments is growing rapidly. According to Research and Markets, AYUSH is a $10 billion market that is expected to grow into a $15 billion market by 2020 (Research & Markets, 2017). Various startups are working to expand this market, with projects dealing with the repackaging of drugs and formulas for Ayurveda and Homeopathy, and offering preventive and holistic treatments. Patients who have failed allopathy drugs or have suffered from their side effects are recommended for these alternative medical treatments.

Despite advances, however, Indian alternative treatment and wellness tourism is not free from challenges, including composite product development, standardization of products in the international market, product promotion, to name a few. It is in this context that the present study aims to explore the potential and problems of alternative treatment and wellness tourism in India.

The authors first review the literature and present an overview of AYUSH, then generalize this information based on an Indian perspective. Next, the potential and problems of the alternative medicine and wellness industry in India are assessed. Finally, based on study results, the implications of alternative medical treatment, and wellness treatment in India are discussed.

Complementary Alternative Medicine (CAM) is known by various names. Different types of practices in different ethnic communities are given different labels according to the community and country. For example, in China, the term traditional Chinese medicine (TCM) is used (Song et.al., 2016); in India, it is traditional Indian medicine (TIM) (Patwardhan et.al., 2005). The composite term "traditional, complementary, and alternative medicine" (TCAM) is sometimes applied (Song et.al., 2016). In the US, the terms alternative and complementary medicine are frequently used; in Europe, it is most often complementary medicine (Fisher & Ward, 1994). In this study, our use of alternative medical treatment is based on the Indian AYUSH.

2. Types of Medical Tourism in India

Medical tourism can be broadly divided into health tourism and wellness tourism. We further divide these two broad categories into four subcategories: surgical treatment tourism, cosmetic surgery tourism, alternative medical tourism, and wellness treatment tourism. To provide a better understanding of the Indian situation, Figure 1 shows for each of the four medical tourism types the corresponding medical services available in India. Market segment sizes are based on company sales; the competition category refers to competitor countries that are doing the same type of business with other countries; the strength category refers to the relative strength of each medical service in India.

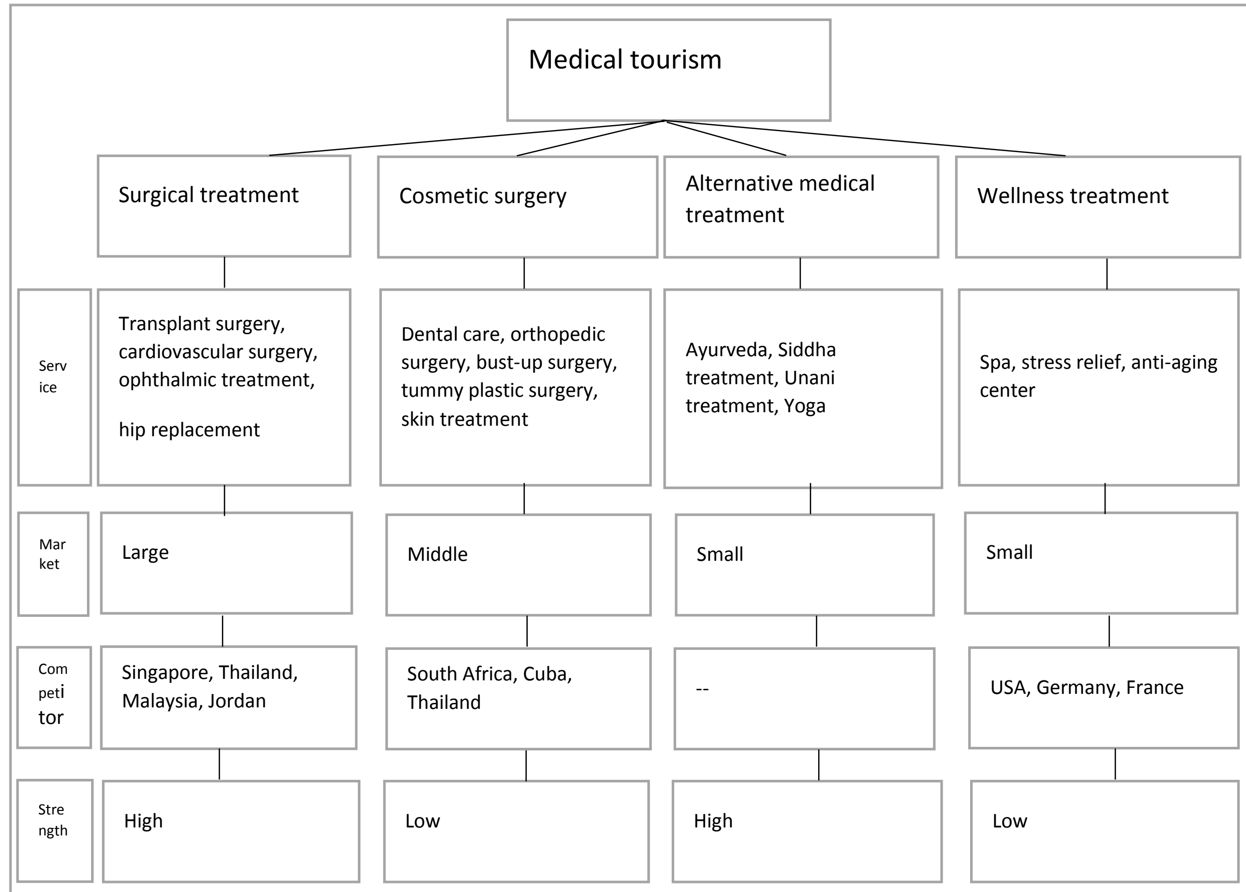

Figure 1. Structure an division of medical tourism in India

Source: (Dawn & Pal, 2011). Modified some by the authors

Surgical medical treatment includes life-threatening surgery, for which the market is vast; this is the strength of medical tourism in India. It is challenging to examine the medical tourism market sales by category. However, Indian hospitals have the largest share (71%) of India's healthcare industry (Biswas et.al., 2017). The leading companies are Apollo Hospitals Enterprise Ltd., Aravind Eye Hospitals, CARE Hospitals, Fortis Healthcare Ltd, Max Hospitals, Manipal Group of Hospitals, and Narayana Health (Dawn & Pal, 2011). Competing countries for surgical medical services include Singapore, Jordan, Thailand, United States, Japan, Malaysia, Costa Rica, South Korea, Mexico, and Turkey. In these countries, treatment costs are relatively higher than in India, which is a strength of Indian medical tourism (Dawn & Pal, 2011).

Cosmetic surgery is medical care that is not directly related to the preservation of human life. The market is considered to be at the middle level. In this category, some surgeries are performed according to a person's preferences, while others are performed to correct the shape of the patient's teeth or face. Although the history of cosmetic surgery is not particularly old in India, it has become quite important and popular over the past 20 years (Global Wellness Institute, 2018). The first hospital to perform plastic surgery called the Department of Plastic Surgery in India was established at the government medical college in Nagpur in 1958. Mumbai, Delhi, Kolkata, Chennai, Bangalore, Pune, and Chandigarh are the primary sites for cosmetic surgery within India. Competing countries for these services include South Africa, Cuba, Thailand, South Korea, Japan, the United States, Brazil, and Mexico. Due to technological advancements in these countries, India is losing its market share in cosmetic surgery.

Indian alternative medical services consist of unique treatment methods available only in India. Ayurveda, Siddha, Unani, and Yoga are examples of these alternative methods. In addition to these, patients can also receive treatments in India that are not unique to India. Ayurveda offers not only preventive medicine but also an advanced life philosophy. It prescribes appropriate diets and identifies those that may not be suitable depending on the physical condition of the individual. In recent years, Ayurvedic drugs have attracted attention because the drugs contain herbs, minerals, and biologics (formed with proteins such as oil). In India, the market for herbs used in Ayurvedic treatment is expected to increase to $ 6.1 billion in 2019 (Ali & Yadav, 2015). Major companies in the Indian herbal market include Himalaya Drug, Emami, Aswini, Ayur, Dabur, and Cholayil Pharma, which have patented herbs and Ayurvedic products in India and abroad.

Wellness tourism involves activities and treatments to improve and balance all the major areas of human life. Wellness addresses the physical, mental, emotional, professional, intellectual and spiritual aspects of one's way of living. The main motivation for wellness tourism is to engage in preventive and active lifestyle enhancement activities, which would include healthy eating, fitness, relaxation, luxury living and healing treatments (World Tourism Organization, 2019). Wellness tourism typically involves such elements as spa treatments, stress relief, anti-aging centers, meditation, acupressure treatments, and acupuncture treatments. According to a report issued by the Global Wellness Institute (2017), the most significant factors in wellness tourism are beauty and anti-aging, healthy living, nutrition, weight loss, wellness lifestyle, the real estate industry, mineral springs, and the hot springs industry. The leading countries in wellness tourism include the United States, Germany, France, China, and Japan. Between 2013 and 2015, the number of wellness tourism trips to India increased by 18% (Global Wellness Institute, 2016), and the revenue from wellness tourism has grown 7.8% over the past five years (Global Wellness Institute, 2018). However, India is still developing its medical tourism sector.
The AYUSH Ministry was established in November 2014 to ensure the optimal development and dissemination of alternative medicine (AYUSH) systems. Its predecessor, the Department of Indian System of Medicine and Homeopathy (ISM&H) had been created in 1995 and renamed AYUSH in 2003. The intention of creating the ministry was to focus on improving education and expanding research in Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy (Ministry of AYUSH, 2019).

2.1. Introduction of Alternative Medical Treatments of AYUSH

As noted, AYUSH is the acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy. Each is described below:

Ayurveda - Ayurveda offers a complete system for preventive medicine and healthcare. It has proven effective for many years in India. Ayurveda is based on natural herbs that give an individual advantage. The science of Ayurveda is based on knowledge of the human way of life. If every individual knows his or her way of life, they are able to understand what a good diet and lifestyle for them is. The five elements, such as ether, air, fire, water, and earth, constitute the most important basic concepts of Ayurveda. They are expressed in three Dashas (biological organizations) known as Vata, Pitta, and Kapha (Dawn & Pal, 2011). These biological organizations are used by individuals to fully understand all aspects of body function and establish the harmonious balance necessary for a healthy life.

Yoga and Naturopathy - The Sanskrit word "yoke" means Yoga. Yoga is a discipline to improve or develop inherent power in a balanced way. It provides a means to achieve complete self-fulfillment. Yoga can also be defined as the means of linking individual spirits with the universal spirit of God. Further, Yoga is the suppression of mental changes (AYUSH, 2018). It is a tool for self-evolution and enlightenment through physical and spiritual well-being. Several types of Yoga pose vital massage organs to keep them in perfect order. Yoga harmonizes the inside of the body, purifies and detoxifies it, and boosts the immune system.

Naturopathy holds the belief that the human body has unique self-building and self-healing powers. It does not seek out the exact cause of a disease and its specific treatment, but rather it examines and addresses the totality of factors responsible for these conditions, such as unnatural habits of life, thinking, sleeping, working, and environmental factors that can interfere with the normal functioning of the body.

Unani - The Unani Medical System holds that the human body is made up of four essential elements, i.e. earth, air, water, and fire, and that these elements have different temperaments cold, hot, wet and dry. When these elements collaborate and interact, a new compound having a new character comes into existence, i.e., hot-wet, hot-dry, cold-wet, and cold-dry. The Unani treatment system depends on observation and physical tests. A person's illness should be regarded as the product of that person's creation and material. The Unani system believes in the promotion of health, prevention of diseases and cure.

Unani medicine includes a variety of practices. Unani therapy consists of venesection, cupping, the promotion of diaphoresis and diuresis, Turkish baths, massage, cauterization, purging, exercise, leeching, and more. Unani diet therapy prescribes specific diets or regulates the quality and quantity of food. Unani pharmacotherapy uses natural, mostly herbal medicines (having animal or mineral origins). A combination or single medications in their raw form is preferred for compound formulations. Unani physiotherapy uses particular techniques of exercise to help balance the homeostasis of the body (World Health Organization, 2010).

Siddha - The Siddha system defines disease as a condition in which the normal equilibrium of the five elements is lost, leading to different types of discomfort and pain. The Siddha treatment method is based on the clinical judgment of the doctor after observing the patient and checking pulse, diagnosis, and medical history. According to Siddha, particular foods can improve physical and mental performance or even decrease the risk of disease. The concept of this ancient Indian system is "Food is Medicine and Medicine is Food." Specific food recipes/grains are prescribed, along with medicines for every illness (Sivaraman & Rajalakshmi, 2005).

Homeopathy - Today, homeopathy is a rapidly growing system being practiced in many parts of the world. In India, it is widely recognized for the safety of its pills and the gentleness of its cure. According to one study, approximately 10% of the Indian population depends on homeopathy for their health care needs. It is considered the second most popular system of medicine in India (Ministry of AYUSH, 2019). Homeopathic treatments have numerous components and three main agents: (1) the patient with his/her condition and personal characteristics; (2) drugs and their composition and manufacturing processes; and (3) doctors and the various treatment methods and health concepts (Poitevin, 1999).

All of these alternative medical treatment systems attract national and international patients and generate medical tourism in India.

2.2. Wellness Tourism

Wellness tourism is another important component of medical tourism in India. It includes spas, stress relief, anti-aging centers, meditation treatments, acupressure treatments, acupuncture treatments, herbal therapy, aromatherapy, batch flower therapy, chromotherapy, hydrotherapy, oil massage therapy, magnetic therapy, mud therapy, and a focus on balanced nutrition. Especially in

recent years, many people have sought a healthier lifestyle and have integrated health into their travel and vacation patterns. The current wellness tourism market contains primary and secondary wellness tourists. For prime wellness of tourists, the only purpose of their trip and reason for their destination choice is wellness treatment. The secondary wellness travelers participate in a wellness experience to rejuvenate or de-stress during their trip or visit, but wellness treatment is not their primary motivation for travel [Federation of Indian Chambers of Commerce & Industry -FICCI, 2018]. There are a number of destinations in India that are famous for wellness tourism for both domestic and international tourists. India had been featured as one of the top destinations for wellness tourists, with many of the best hotels for wellness treatments. Moreover, India offers access to international standard medical services and healthcare at a relatively low cost. Most of India's wellness service providers are from famous hotels and resorts; tourists check advertisements and search homepages to select their preferred providers.

The annual Indian wellness industry growth rate is 18.6 %, while the global wellness industry is expanding at a rate of 15%. Around the world, China, Brazil, the United States, India, and Indonesia represent the largest growth markets (Manideep et.al., 2018).

2.3. Reason for the Growth of Medical Tourism in India

India is known as the fastest-growing medical destination in the world. In India, travelers have access to treatments and procedures that may not be available in their home country or are unaffordable there. In some cases, there are legal restrictions on certain types of treatments or medicines. There are essentially eight major reasons that make India an ideal medical tourism destination:

I. The cost of treatment is relatively low compared to countries like the US and UK.

II. Obtaining medical visas for medical purposes is much easier than in other countries.

III. World-class medical services with the latest medical devices and technologies are available.

IV. Reasonable airfares and hotels are offered through travel agencies.

V. Surgery involves little (almost no) waiting time.

VI. After completing treatment, hospitals can provide services for alternative medical treatment on request (Ayurveda, Yoga, Unani, Siddha, Homeopathy, and others).

VII. Qualified and skilled doctors and medical staff who communicate in English are commonly available, which makes it more comfortable for foreign tourists to communicate with their doctors and supporting staff.

VIII. In addition to receiving treatment, medical tourists also have the opportunity to visit some of the most attractive tourist destinations in the world, including the Taj Mahal, one of the world's Seven Wonders.

3. Possibilities and Problems of Alternative Medical Treatment

3.1. Possibilities of Alternative Medical Treatment

In recent years, advanced computerization and the proliferation of the mass media have facilitated an increase in the number of patients seeking alternative medical treatments (Suzuki, 2004). Alternative medicine is becoming a medical trend worldwide. The range of alternative medicine is broad and includes new treatments not covered by health insurance as well as traditional medicine and folk remedies from various countries and regions across the world. In terms of population percentage, surprisingly few people are convinced of the benefits of modern Western medicine; indeed, the World Health Organization (WHO) classifies 65-80% of its global health care operations as "traditional medicine" (Suzuki, 2004).

There are multiple explanations for the growing popularity of alternative medical treatment. Such treatments and therapies help the patient feel better, concentrate on relaxation, and reduce stress allowing patients with serious diseases such as cancer to better cope with their condition. There is substantial evidence that certain complementary therapies can help manage or eliminate some of the symptoms of cancer and reduce the serious side effects of strong medications. For example, acupuncture can help relieve the pain and sickness caused by some chemotherapy drugs. It also can help to reduce soreness in the mouth after treatment for head and neck cancer.

Furthermore, for some patients, the comfort and satisfaction that comes from the touch, talk and time that a complementary therapist commonly offers is a meaningful benefit. The best therapist can play a helpful role during cancer treatment and recovery. For example, skilled and thoughtful aromatherapy can make a patient feel compassionate, which may help the patient's recovery. Some

patients use complementary therapies as a way to feel positive and hopeful, a feeling that may be difficult for a doctor to provide but one that alternative medical treatments may be able to foster.

The rate of CAM use among the elderly is substantial, ranging from 35% to 60% of the elderly population according to various studies, and is higher than in other age groups (Astin, 1998). According to a 2013 European Environment Agency report, the world's elderly (60 years and older) population has increased to approximately 841 million, comprising more than 60% of the total population (European Environment Agency, 2013). By 2050, most of these elderly (nearly 8 in 10) are expected to be living in less developed countries (Crimmins, 2004).

Ayurveda, the most popular alternative system practiced by Indians, is currently the most commonly used treatment method for elderly patients; homeopathy is another popular Indian treatment system (Sharma et.al., 2017). According to the 2007 National Health Interview Survey (NHIS), mind-body therapies, including Yoga, were the most favored (CAM) practices for children with behavioral, emotional or mental health problems. The 2012 NHIS reports that the use of Yoga and yoga therapy in children had increased from 2.5% to 3.2% since 2007 (Rosen et.al., 2015).

These facts reveal the potential of Indian alternative tourism and its market are expected to more than double by 2020. The revival of traditional and alternative medicine such as AYUSH has helped to boost India's medical tourism market in comparison to the markets in most Western nations (IANS, 2017).

3.2. Problems of Alternative Medical Treatment

The Indian herbal drug and medicine industry needs to ensure the procurement of standardized, authentic raw material free from toxic contaminants. Improved processing technologies and conducting all operations under the government of India is also needed to assure compliance and the maintenance of in-process quality control in the manufacture of herbal products; evidence of the therapeutic efficacy, safety, and shelf life of these products is also critical. Such approaches remain essential in the global promotion of Ayurveda, which requires comprehensive scientific research and an evidence-based approach (Patwardhan et.al., 2005).

Some alternative medical systems and treatments are simple and healthy, and the therapist can apply the methods with the assurance of no harm and no serious side effects. However, this is not

always the case. Delaying surgery, radiation, chemotherapy, or other traditional treatment by using an alternative therapy can allow cancer to worsen and spread to other parts of the body. Some complementary and alternative therapies and medicine have been reported to cause serious problems, even death. Special vitamins and minerals can increase the risk of cancer or other illnesses when used excessively. Some companies don't follow the Food and Drug Administration (FDA) rules regarding claims and labeling supplements properly. In some cases, harmful contaminants can be included in dietary supplements because of the way they are manufactured or handled.

Indian doctors and the clinical infrastructure in India are considered excellent. However, the general infrastructure does not necessarily meet the needs of medical tourists. For medical tourism, there needs to be trained non-medical staff who are well-versed in cross-cultural sensitivity and have strong language skills. Moreover, while the cost of medical treatment is generally acceptable, other costs (especially boarding and lodging) can be excessive.

3.3. Role of the Indian Government in Alternative Medical Treatment

The government of India has expressed support and encouragement for alternative medical treatment. A separate department (ISM&H), now known as the Ministry as AYUSH, was established to promote indigenous systems. The Indian government has involved itself in setting specific education priorities, raw material availability development, drug standardization, research and development, information, communication, and healthcare in general. The Central Council of Indian Medicine oversees teaching and training institutes (Patwardhan, 2007). Some traditional medical products are being added to the government's family welfare programs under a World Bank project. These medicines are for common diseases such as anemia, uterine and abdominal complications, edema during pregnancy, postpartum problems such as pain and difficulties with lactation, nutritional deficiencies and childhood diarrhea (Kumar, 2000).

The government of India education policy and human resource development sets the standards for education in AYUSH systems. The ministry works in tandem with two statutory regulatory bodies the Central Council of Homoeopathy (CCH) and the Central Council of Indian Medicine (CCIM) and permits the start-up of colleges recommended by these councils. At present, there are 401 Ayurveda, 11 Siddha and 53 Unani colleges affiliated with 59 universities throughout the country. Of these colleges, Post-Graduate Education in different specialties is offered in 140 Ayurveda

colleges, 12 Unani Colleges, and 3 Siddha colleges (Ministry of AYUSH, 2019).

The government of India has also established new drug testing laboratories for TIM and is upgrading existing laboratories to provide documented, high-quality evidence to licensing authorities for the safety and quality of herbal medicines. The Council for Scientific and Industrial Research (CSIR) has launched a research program under New Millennium India in 2002. Ayurveda identified three types of diseases under the scheme of the Technology Leadership Initiative program, including arthritis, diabetes, and hepatic disorders, which afflict large numbers of the Indian population (Patwardhan et.al., 2005).

The Central Council for Research in Ayurvedic Sciences (CCRAS) is an independent body under the Ministry of AYUSH and is the apex body for coordinating, undertaking, formulating, developing and promoting research along scientific lines in Ayurveda. The core activities of the council consist of clinical research, drug research (medicinal plant research, drug standardization, and quality control, and pharmacology research) and literature research.

The annual budget of the AYUSH ministry is substantial, with an estimated total budget of Rs.1626.37 crores for the year 2018-19 and a revised estimate of Rs.1692.77 crores. Expenditures through March 2019 were Rs.1606.96 crores. The Government of India established the Traditional Knowledge Digital Library (TKDL) in 2001, which led to the Traditional Knowledge Resource Classification (TKRC) system (Ganguli, 2004). Such activities are very useful for the research and development of alternative medical treatment in India. Under Intra Mural Research (IMR), At present, there are 401 Ayurveda, 11 Siddha and 53 Unani colleges affiliated with 59 universities throughout the country. Of these colleges, Post-Graduate Education in different specialties is offered in 140 Ayurveda colleges, 12 Unani Colleges, and 3 Siddha colleges (Ministry of AYUSH, 2019). These projects are making a highly significant contribution to the AYUSH field.

Conclusion

This study deals with the overview of Indian medical tourism, with a particular focus on alternative medical treatment, and wellness tourism. Specifically, this study explored the potentials and obstacles of alternative medical treatment and wellness tourism in India. The major findings are summarized below.

The Indian government's continuing emphasis on alternative medical treatment and wellness

tourism, the authors focused on these two types of medical tourism, i.e. alternative medical treatment and wellness tourism. The Indian government is investing a significant amount of budget in those industries. Thus, India is becoming one of the competent destinations for alternative treatments and wellness tourism. We believe this article will be useful for people seeking medical tourism (mainly alternative treatment) around the world, and for patients who are not cured by allopathic treatment. The patients/tourists not only from the South Asian countries but also from around the world can be benefitted in several ways such as reasonable treatment cost, easy visa process, English is used in the hospitals, no waiting time, and alternative treatment facilities.

As India is recognized as a medical tourism hub, those people who are not cured of allopathic treatment and faced side effects from allopathic medicines can be cured of alternative medicine. However, alternative medical treatment does not only have positive impacts, but also it has some negative aspects too. For example, delaying surgery, radiation, chemotherapy, or other traditional treatment by using an alternative therapy can allow cancer to worsen and spread to other parts of the body. Therefore, the proper decision should be made at the right time.

Based on the study, results, India appears to have the potential for its medical tourism industry. However, the Indian medical tourism industry also faces a number of problems. The herbal drug and medicine industry needs to ensure the use of standardized, authentic raw materials, improve processing technologies, upgrade infrastructure, increase training for non-medical staff regarding cross-cultural sensitivity and language skills, and address the issue of overpriced lodging and boarding. These problems need to be carefully reviewed and resolved as they can severely impede the growth of India's medical tourism industry. Alternative medical treatment and wellness treatments are gradually becoming more scientifically based, and the clinical efficacy of traditional medicines is being determined.

This study is based on secondary data, and it deals mostly with the historical description of the alternative treatment and wellness tourism in India. Thus, future research should be conducted by using primary data and explore the obstacles from the supply and demand side of alternative medical treatment and wellness tourism in India. Moreover, the research related to logistics should also be conducted.

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Int Journal Of Health Manag. And Tourism 2020, 5(3), 208-233

IJHMT Editorial

International Journal Of Health Management And Tourism

MEDICAL TOURISM POTENTIALS OF TAMALE TEACHING HOSPITAL IN GHANA

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Received: 21.05.2020
Accepted: 20.10.2020
Research Article

Abstract: This study primarily focused on "medical tourists", that is, patients who were referred or travelled from other districts/regions of Ghana and/or other countries to receive medical treatments at the Tamale Teaching Hospital (TTH). A total of 120 patients who were referred from other health facilities came seeking healthcare from 10 surveyed departments. These medical tourists were contacted over a one month period through structured questionnaire. Information was also sourced pertaining to the most visited departments and units in the hospital and the human resource capacity of the facility. Data relevant to this study about TTH were collated from management through in-depth interview (IDIs) schedules. The study revealed some departments in the facility with complements of qualified staff were heavily patronized. The main traffic to the facility came from the Upper East and Upper West Regions including other districts within the northern region. The facility had also hosted patients from other countries such as Togo and Burkina Faso on the continental front and the USA, UK and Cuba on the foreign arena. The paper recommends the need to keep an up-to-date record of both foreign and local patients who patronized the facility to foster monitoring of the medical tourism potentials of the hospital.

Keywords: *Tamale Teaching Hospital, Medical Tourism, Healthcare, Patients, Referrals*

Introduction

Health tourism as explained by Carrera and Bridges (2006) is the organized travel outside one's local environment for the maintenance, enhancement or restoration of an individual's well-being in mind and body. They maintain that some scholars have considered health and medical tourism as a combined phenomenon but with different emphasis. A subset of health tourism is medical tourism, which is the organized travel outside one's natural healthcare jurisdiction for the enhancement or restoration of the individual's health through medical intervention.

In Africa, medical tourism is becoming 'big business" for some countries namely South Africa, Egypt and Tunisia. South Africa for instance has emerged as the first country to offer medical and dental care and for long has had a good reputation for hosting some of the best doctors and hospitals in the world. In fact, the first human heart transplant was performed in Cape Town, South Africa in 1967 (Brink & Hassoulas, 2009). Wealthy middle Easterners, Americans and Europeans also "flock" to Cairo's Smart Private Hospital to access cosmetic surgery and dental work done at reasonably affordable cost. The prices for plastic surgeries in Egypt are 60-70% lower than similar surgeries and treatments in the USA or UK (According to Reuters, 2017). Another country making a name particularly in the field of plastic surgery is Tunisia. Its proximity to Europe makes it attractive to Indians and Thais (the current giants in the field of medical tourism). Clinics in Tunisia are also offering packages which combine beach vacations with a little rhinoplasty…a plastic surgery procedure for correcting and reconstructing the nose (Cohen, 2012).

In West Africa, Ghana and Nigeria have sought to improve medical centres to boost affordable healthcare delivery services to their citizenry and also attract medical tourists. As part of efforts to develop medical tourism in Cross River state (Nigeria), the state government and a consortium of Colorado (USA) based hospital development experts led by OMMA Healthcare, have agreed to build a world-class state-of-the-art hospital in Calabar (International Medical Travel Journal [IMTJ], 2017). In Ghana, Dr. Felix Anyaa of Holy Trinity Medical Center (HTMC) in Accra wants the government to consider health tourism since Ghana has expertise in heart and spinal surgery. For instance, while it may cost over $100,000 in the USA for cardio surgery, it costs just about $10,000 in Ghana to have a similar surgery (IMTJ, 2017).

Ghana as a proposed medical tourism destination can boast of health facilities rendering quality services and packages to their patients. Mention can be made of the Korle-Bu Teaching Hospital

(touted to be the best health facility in the country and a main referral facility for patients with severe medical conditions from far and near). The 37 Military Hospital, the Police Hospital and the Ridge Hospital all in Accra also serve as major referral points for patients within the country. Worth mentioning is also the Komfo Anokye Teaching Hospital (KATH) in Kumasi which serves as a major referral Centre for communities in the northern and middle belts of Ghana.

Medical tourism can also be viewed from the research perspective since facilities could also attract visiting researchers. The Nuguchi Memorial Institute is an example of a research institution contributing enormously to the development of medical research tourism in Ghana. It was established in 1979 as a gift from the Japanese government in memory of Dr. Hideyo Nuguchi, who succumbed to yellow fever in Ghana while researching into the origins of the disease in 1928. The institute is a semi-autonomous research institute affiliated to the University of Ghana and has a clear mandate, part of which includes lending support to the Ministry of Health/Ghana Health Service in the control of diseases, especially in the area of laboratory support for outbreak investigations in the various parts of the country. The government of Ghana’s attempt to build a Teaching Hospital for the University of Ghana will also in the long run boost medical tourism pursuits of the country (Carscious, 2013).

The Navrongo Health Research Centre is also a research facility that contributes to the development of medical tourism and research potentials of the country. Not only does this hospital have one of the largest pediatric wards in the country with the greatest number of deliveries each year (1000-2000 per year), but it is particularly unique due to its decision to maintain a pediatric research centre that focuses largely on pediatric vaccination. The concept of vaccination of babies against the six childhood killer diseases and the use of treated mosquito bed nets, which is now patronized nationwide, was “engineered” by the research efforts of this centre as reported by Gundona Sylvester in 1999 (Adu, 2014).

The Tamale Teaching Hospital (TTH), the third teaching hospital in the country, serves as a major referral hospital for the three regions of the northern and parts of the Bono-East, and Ahafo Regions of Ghana including portions of the newly created Oti Region (Addy, 1999). The hospital serves as the teaching hospital for the University for Development Studies in northern Ghana and offers undergraduate and graduate programmes in Medicine, Nursing and Nutrition. It is in the

light of this that it becomes imperative to assess both the domestic and foreign medical tourism potentials of the hospital.

The crucial issues of medical tourism are dynamic and layered, due to the multifaceted direction of development of the medical tourism industry. According to Connell (2013), the quality and availability of affordable care by healthcare providers and stakeholders are key influences on medical tourism in emerging medical tourism destinations, alongside economic and cultural factors. Another way of looking at medical tourism potentials include whether medical personnel come from elsewhere (within or outside Ghana) to offer services to patients suffering from particular ailments for specific periods of time, making use of the hospital's facilities or bringing in their own equipment to augment what the hospital has. Similarly, do we also have medical personnel in TTH going as organized groups to work in some hospitals within Ghana and abroad for a period and returning to base? In this wise, one wonders whether TTH has what it takes to qualify as a medical tourism destination/facility both domestically and internationally taking into consideration quality delivery, cost of access and doctor/patient ratios including medic-patient cordial relationship related issues. It is on the basis of the above that this research becomes relevant.

A major problem often associated with healthcare delivery in the northern part of Ghana is that many health experts either fail or refuse to take up postings to this part of the country. Indeed, it is on record that Accra and Kumasi alone have about 71% concentration of all public service medical doctors (GHS Annual Report, as cited in Dondomeso-Soglo, 2012). When given the chance to choose where they wanted to work after graduation from medical school in 2018, no doctor unfortunately chose to work in the northern region of Ghana where the doctor to patient ratio is one doctor to 51,000 patients (Kaminta, 2018). Indeed, the Director General of the Ghana Health Service (Dr. Anthony Nsiah-Asare) is on record to have lamented that, doctors who have been trained with the tax payers money in the country and who are supposed to be non-discriminatory in their service to the nation turn round to refuse posting to the five regions of northern Ghana and this impacts negatively on the medical tourism prospects of the country in general (Ghalley & Twumasi, 2019). It has therefore become imperative undertaking this research in an effort to unearth whether TTH has the requisite personnel to "man" the facility under the given circumstance. Are the various departments and medical units adequately resourced? Which is, do

they have experts and experienced clinicians/physicians to help deliver on its core mandate? (Runckel, 2007). This is what the study seeks to uncover.

Service quality and patient care are very important in attracting medical tourism but we have reached a point where some health personnel in some hospitals treat patients with some level of "disdain" and this leads to "mixed experiences" with regard to patient welfare (Wible, 2014). Do patients really receive what they expect from the TTH when they come on admission or when visiting for out-patient service? These are the main issues this study seeks to delve into. Thus, the main objective of the study is to assess the potentials of TTH as a medical tourism destination facility in Ghana in both the domestic and international arena while specifically seeking to; assess the human resource capacity of the hospital; analyze the main traffic of in-patients and to explore if patients' expectations are met when they come on admission in the facility.

Background Literature on Medical Tourism

Travel Motivations in Medical Tourism

While motivations are heterogeneous and differ across treatments, what is common to all treatment choices is the expectation of effective and safe treatment. Expenses for medical treatments or travel are among the most important factors in choosing a medical tourism destination (Caballero-Danell & Mugomba, 2007; Smith & Forgione, 2007; Heung et. al., 2010, 2011; Crozier & Baylis, 2010; Ye et al., 2011). However, health and wellness tourism, which includes all spa related services, detoxification diets, special exercise regimes such as yoga and massage and other relaxation techniques are less likely to be part of public health services and are thus sought after in private facilities (Bookman & Bookman, 2007).

In the Treatment Abroad (2012) research, in which 1,045 respondents took part, close to 55% of respondents were from the UK. For all patients in the survey from all countries, Hungary was the leading destination (12% of respondents) followed by Belgium (11%). Poland, Turkey, Spain, the Czech Republic and India were the destinations for around 7% of patients each. About 42% of the UK patients in the study went abroad for cosmetic surgery, 32% for dental treatment, 9% for obesity surgery, and 4% for both infertility treatment and orthopedic surgery. South Africa is already somewhat competitive in medical tourism and it is a fast developing industry as many patients from nations such as Britain, United States of America, Western Europe, the Middle East

and even citizens of sister African countries are seeking treatment for a wider range of ailments in South African hospitals. When it comes to cosmetic surgery for instance, an American citizen could enjoy huge savings by seeking treatment in South Africa where a facelift that normally costs about $25,000 in the USA, costs only about $2,000 in excellent facilities in South Africa (Crush et. al., 2012; Crush et. al., 2013; Crush & Chikanda, 2015).

Human Resource Capabilities of Medical Tourism Institutions

The number of doctors, especially specialists, clinical expertise, number of nurses, highly trained staff and other health professionals are some of the factors to take into consideration when looking at human resource capacity of the industry. Singapore strives to enhance the quality of its medical services by requesting that medical staff obtain tour guide certificates and by establishing service centres that are designated for foreign patients, discounting medical expenses, assigning a portion of the national hospital to attracting foreign patients and providing tax reductions to hospitals that attract foreign patients (Bookman & Bookman, 2007). India holds an advantage over its competitors by providing short waiting times for operations, medical staff who can communicate in English, low taxes on hospitals and including low property and rent rates by government to the medics who operate these medical tourism facilities (Kim et. al., 2013).

Singapore, with hospitals accredited by the Joint Commission Institute (JCI) attracts medical tourists from developed counties such as the United States and Malaysia (Kim et. al., 2013). The city offers complex neurosurgical procedures and highly advanced medical treatments such as liver and heart transplant with qualified medical experts (Tata, 2007). Medical tourism is an integral part of Thailand’s tourism and healthcare industries. As a medical tourism destination, it offers the JCI-accredited hospitals and U.S. certified physicians. Modern healthcare facilities, qualified medical experts, and low prices are the chief characteristics of the Malaysian medical tourism market that attract foreigners and locals alike (Connell, 2006). Hong Kong has modern facilities and several of its private hospitals have been accredited by the U.K-based Trent Accreditation Association.

However, in the East African bloc, the lack of skilled resources as reflected by the low health worker density of 0.84 per 1000 people in Rwanda and 1.3 per 1000 people in Kenya, coupled with inadequate infrastructure, the need for capital investment, and high construction costs hamper the availability of specialist care and high-end technologies in both countries. A greater level of

investment into infrastructure and the latest technologies, alongside the ability to attract skilled healthcare personnel, will be vital for market success, says PR Newswire Association LLC (2017). In this wise, both Kenya and Rwanda are focusing tremendously on the development of these areas and are relying on external funding to boost the development of their healthcare sectors as the East African bloc now boasts of advancements in technology and more specialist doctors. South Africa as at 2011 boasted of state of state of the art facilities and highly skilled medical practitioners. By close of the same year, it had approximately 247 private hospitals 30,334 beds and 12,751 medical practitioners and specialists affiliated to these facilities and there were potentials of improvements with the advancement of the years (Nicolaides & Zigiriadis, 2011).

Patient Expectations in Medical Tourism Facilities and Destinations

Patient satisfaction is an important dimension of healthcare treatment. Relatively little is known about the experience and satisfaction of medical tourists. The greatest influence on the decision making process of the medical tourist is the issue of quality service (Lunt & Carrera, 2010). It is ethical to ensure that patients are as well cared for as possible and to this end, patients should receive appropriate advice and input at all stages of the caring process. Patient follow-up by providers is rare; a study of 20 patients presented at a German university hospital after overseas refractive surgery concluded that there was insufficient management of complications and a lack of post-operative care (Terzi et. al., 2008).

There may also be issues of confidentiality related to the clients of companies who act as facilitators of medical tourism. The staff of medical tourism facilitators' offices may be party to clinical information on patients and this private and sensitive information would need to be dealt with very carefully since there is potential for them to sell the information to other medical service companies. In the UK, signed informed consent prior to an elective procedure is considered best practice and a standard requirement ensuring that patients are fully informed as to the benefits and adverse effects of a procedure or treatment they are being advised to undergo. They also have the opportunity to ask questions and seek answers. This may not be available every time in the medical tourism setting and it is possible that medical tourists may come to regret this if there are failings in professional or clinical practice (Jeevan et. al., 2011).

Methodology

Study Site

The study facility is located in the Tamale Metropolis, which is the administrative capital of Northern Region. The hospital, established in 1974 has had no major renovations until 2009 when new superstructure were added to give it a major facelift. The catchment area of the facility is quite vast, while the town is equally fast growing in business and commerce thus putting it in the spotlight in Ghana. It is in the light of this that it becomes imperative assessing the medical tourism potentials, hence taking a cursory look at both domestic and foreign medical tourism pursuits to the hospital. The mission of the hospital is to be a centre of excellence for quality tertiary health care, medical education and research.

In 2005, the Northern Regional Coordinating Council partnered the Ministry of health/Ghana Health Service to upgrade the hospital to the status of a teaching hospital. In 2012, the hospital had a donation of GH₵335,000.00 for the construction of an Ultra-Modern Neonatal Care Unit (NICU) from Mobile Telecommunication Network (MTN). The unit serves forty neonates and their mothers with office spaces as well as student's learning areas. Additionally, the hospital had also secured a dedicated power cable from the national electricity provider to supply the facility with uninterrupted power (Ministry of Health, 2018). The hospital may not have reached the apex of its development yet but suffice it to mention that it is charting a path that may not be long though, to become one of the best medical centres not only in Ghana but in Africa. The 341 bed capacity hospital provides specialist services in the following areas: Obstetrics and Gyneacology (O&G), surgery, Orthopaedics and Trauma, Internal Medicine, Child Health, Pathology, Ear, Nose and Throat (ENT), Endoscopy, Neurosurgery, Anesthesia and Intensive Care Unit (ICU), Psychiatry, Dentistry, Eye Unit and also runs ambulance services that respond to emergencies (Carscious, 2013).

The healthcare industry has grown significantly in the Tamale Metropolis with other new centres emerging and clinics built around notably Urology and Modern surgical centres. In this regard, there are a number of private and public hospitals, clinics and pharmacies in the metropolis contributing to good health delivery and well-being of patients from within and without the metropolis aiding in quality health service (see Table 1) but in instances when the situation required serious medical attention, the TTH becomes the main referral centre.

Table 1: Health Institutions within Tamale Metropolis

Public Hospitals	Private Hospitals	Some Leading Pharmacies
Tamale West Hospital	Kabsad Scientific Hospital	Charmalt Pharmacy
Tamale Central Hospital	Alive Legacy Mediherb Clinic	Peekay Gombila Pharmacy
Tania Specialist Hospital	St. Lucy Polyclinic	Ethical Pharmacy
Vittin Ridge Clinic	New Life Clinic	Dokuloku Pharmacy
Kadara Clinic	Spinal Clinic Limited	Multipharvum Pharmacy
Seventh Day Adventist Hospital	Habana Medical Services Limited	Mauplus Pharmaceutical Limited
Choggu Health Centre	Bilepela Health Centre	Abdul Razak Issifu Chemical Shop
Nyohini Health Care	Fuo Community Hospital	Opac Pharmacy
Kamina Barracks Hospital	Golden Health Diagnostic Imaging	

Furthermore, health care delivery can be achieved by the services done by other health related facilities. Cases in point include Laboratory and Ultrasonography facilities (Lanset Diagnostic Laboratories, Bil Laboratory, Polderman Laboratory and Good Start ultrasonography) and Maternity homes which include the God First Maternity Home (Jisonayili) Suglo Maternity Home, Fulera Maternity Home, Deahas Maternity Home and the As-Salam Maternity Home. Herbal medicine used in the maintenance of health as well as in the prevention, diagnosis and improvement including treatment of people in the area is very prevalent and practiced in the metropolis.

The metropolis can also boast of an International Airport serving Tamale and the capital city (Accra) and Jeddah (Saudi Arabia) during hajj. The airport helps in the improvement of health care delivery notably transporting patients with medical emergency cases outside Tamale for health delivery and treatment at the nation's premier teaching hospital at Korle-Bu and other cognate health facilities in Accra.

Sampling, Data Collection and Analysis

Collection of data relevant to this study were collated from management/staff and medical tourists (patients on referral from other hospitals in the country) who patronized the facility at the time of study and also from the staff of the Ghana Tourism Authority (GTA) in Tamale. The study primarily focused on medical tourists, who travelled from other regions of Ghana and/or other countries to receive various treatments at the TTH. All departments with referral cases were considered and respondents were visited after a letter of introduction was given to the ward in-

charge. In cases where a department did not have patients who could respond, that department was skipped. This was to ensure that all patients in each department had a chance of selection. The target sample selected in this study were all patients willing to respond even in their recuperative stages, hence the accidental sampling method was employed (ie researchers met them by dint of the fact that they were sick and came from other regions at that material time to be in the facility for medical treatment) Some medical tourists declined, explaining that they wanted to rest and so were excluded from data the collection process. Data were generally collected within the hospital facility during the entire period. In all, 120 patients (respondents) were reached in 10 wards over a one month period. It has been established that sample sizes of between 30 and 500 at 5% confidence level are sufficient for researchers to do data analysis (Altunışık et. al., 2004 as cited in Delice, 2010). The slow pace of data collection was in some cases due to difficulty in speeches/responses by patients who were often not audible and as such researchers often asked them to try and repeat their speeches.

Structured questionnaires were administered to patients (respondents) who could write their responses on their own. In instances where the respondents considered themselves frail and therefore found writing to be problematic, the researchers read out the questions and scribbled their responses in order not to stress them up. A few patients gave their responses through interpreters as they did not understand English. The study also undertook In-depth Interview (IDI) schedules with three senior management officials of the hospital and one official of the Ghana Tourism Authority. In this regard, qualitative data were thus collated through (IDI) schedules with the hospital administrators and the GTA official. Quantitative data sourced from questionnaires were analyzed employing SPSS (version 16) and these were put in frequencies and presented in tables, graphs and pie charts. The qualitative data were organized into themes and sub-themes and presented verbatim as responses from the transcribed IDIs. These were mainly also collated through notetaking in addition to recording their voices with permission sought from the respondents. The sub-themes for analysis of qualitative data included; where referrals came from, category of expatriates who patronized TTH, patient (respondents') satisfaction levels, relevance of the National Health Insurance Scheme in Ghana's health delivery, qualification of staff working in TTH, and hosting of medical teams who travel from the advance countries to perform surgeries for patients.

On issues of validity which is defined as the extent to which a concept is accurately measured in a quantitative study also comes into play in medical tourism related studies. Since tourism is a transient activity, and since patients have different ailments and come into contact with different medical staff at different times of the year, there is the likelihood of differences in results that may be obtained for reasons that may be linked to human (employee) behaviour and also facility deterioration. Reliability, which is referred to as the accuracy of an instrument delves into the extent to which a research instrument consistently has the same results if it is used in the same situation on repeated occasions (Heale & Twycross, 2015) and in this scenario, it is expected that this research if repeated consistently will give similar results.

Presentation of Results

Demographic Characteristics of Patients

Out of the 120 respondents contacted in the hospital, 46 were male and 74 were female. Table 2 shows the various age distribution and their corresponding percentages. From the data collated (age groups 20-30 through to 51-60), it was observed that majority of the respondents (about 83%) were in the working class. Almost all patients who visited the facility did so purposely because of the availability of professionally trained personnel and all were referred from other hospitals analyzed as follows: 21 from the Upper West Region, 20 from the Upper East Region, 12 from other districts within the northern region, 3 from Bono-East area with 7 from the Oti Region area.

Table 2: Demographic Characteristics of Patients

	Sex			
	Male		Female	
Age	Frequency	Percent (%)	Frequency	Percent (%)
20-30 years	18	52.9	16	47.1
31-40 years	10	26.3	14	73.7
41-50 years	8	40.0	12	60.0
51-60 years	4	50.0	4	50.0
Above 60 years	6	30.0	14	70.0
Total	46	38.3	74	61.7

Source: Field Survey, 2017

Table 3 shows the occupations patients were engaged in when on admission to the TTH at the time of study. Petty traders were the majority on admission (about 32%) followed by teachers (15%).

Others as captured in the study constituted electricians, civil servants, seamstress/housewives and a few officials of the community policing force. In all, close to 82% were in the working class. The same table depicts that most patients went on admission for an average period of between 1 and 4 days at the TTH which constituted 73%, while close to 12% stayed for a period between 5days and one week while. Others (8%) who were in need of serious medical attention and observation for a longer session came on admission for 14 days or more.

Table 3: Occupation of Patients/length of stay at the at the hospital

Occupation	Frequency	Percent
Businessman	4	3.3
Carpenter	4	3.3
Farmer	12	10.0
Health Personnel	12	10.0
Pensioner	4	3.3
Student	8	6.7
Teacher	18	15.0
Petty Trader	38	31.7
Others	10	8.3
Not Employed	10	8.3
Total	120	100.0
Length of Stay	**Frequency**	**Percent**
Less than a day	8	6.7
1-4 days	88	73.3
5days to 1 week	14	11.7
2 weeks and above	10	8.3
Total	120	100.0

Source: Field Survey, 2017

It was observed that patients got to know of the facility largely through their friends and relatives (about 42% attested) (see Figure 1) who gave good commendations about the facility implying that word-of-mouth publicity was in favour of the facility and this was a source of motivation for patients to visit the hospital. Invariably 30% of referral cases were also noted in the study and these category of respondents were also of relevance to this research probably portraying the fact that other hospitals within the northern environs were aware of the TTH being a giant in healthcare service delivery. Others as captured in the study referred to patients mainly brought in as a result some emergencies like accidents (cars, motorbikes and victims of violence) mostly from neighbouring districts.

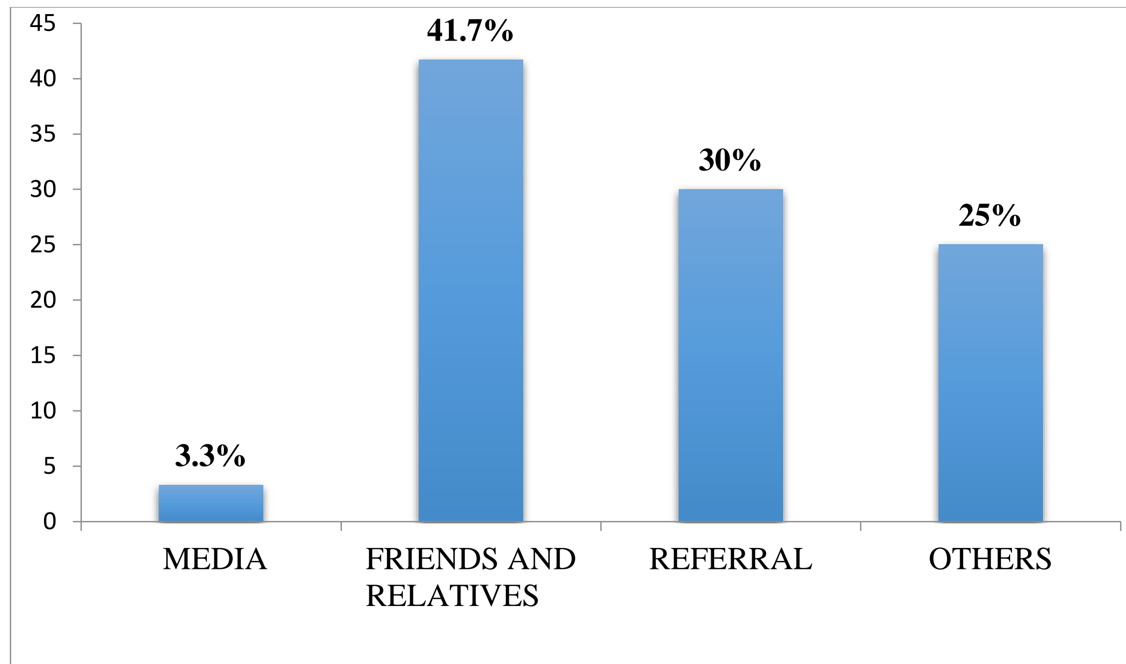

Figure 1: Patients' source of information about TTH N=120
Source: Field Survey, 2017

Most frequented Departments by Patients in TTH

Figure 2 shows the units/departments with the highest number of patients contacted during the period of study namely, the male medical and the prenatal wards with 15% of patients contacted. Closely followed by the general surgical ward (8.3%) where the patients on admission were mainly referral cases from other hospitals in different districts or regions outside the metropolis. Another revelation from the findings in this study was the fact that the facility was heavily patronized when medics from other countries visited to render services to patients. A respondent indicated the following:

I was referred here because there was information that a neurosurgeon had come in from South Africa to meet and treat patients. I have met him and he has attended to me a couple of times. He is a fantastic doctor and he cares for his patients with passion (From a 67 year old patient from Wechiau in the Wa West District).

During the study however, no foreigners were met on admission but in an IDI with authorities of the hospital, the ensuing revelation came to light:

We have hosted some of the expatriate community in this hospital before. Those who work with internationally related NGOs in this part of the region. There are instances the foreigners from Europe have come to this part of Ghana, gotten involved in accidents, and brought on admission here, got treated and discharged to go home or their embassies later arranged for them to be flown home. We have the personnel who can cater for any person of any race or country herein (From a 53 year old administrator at TTH)

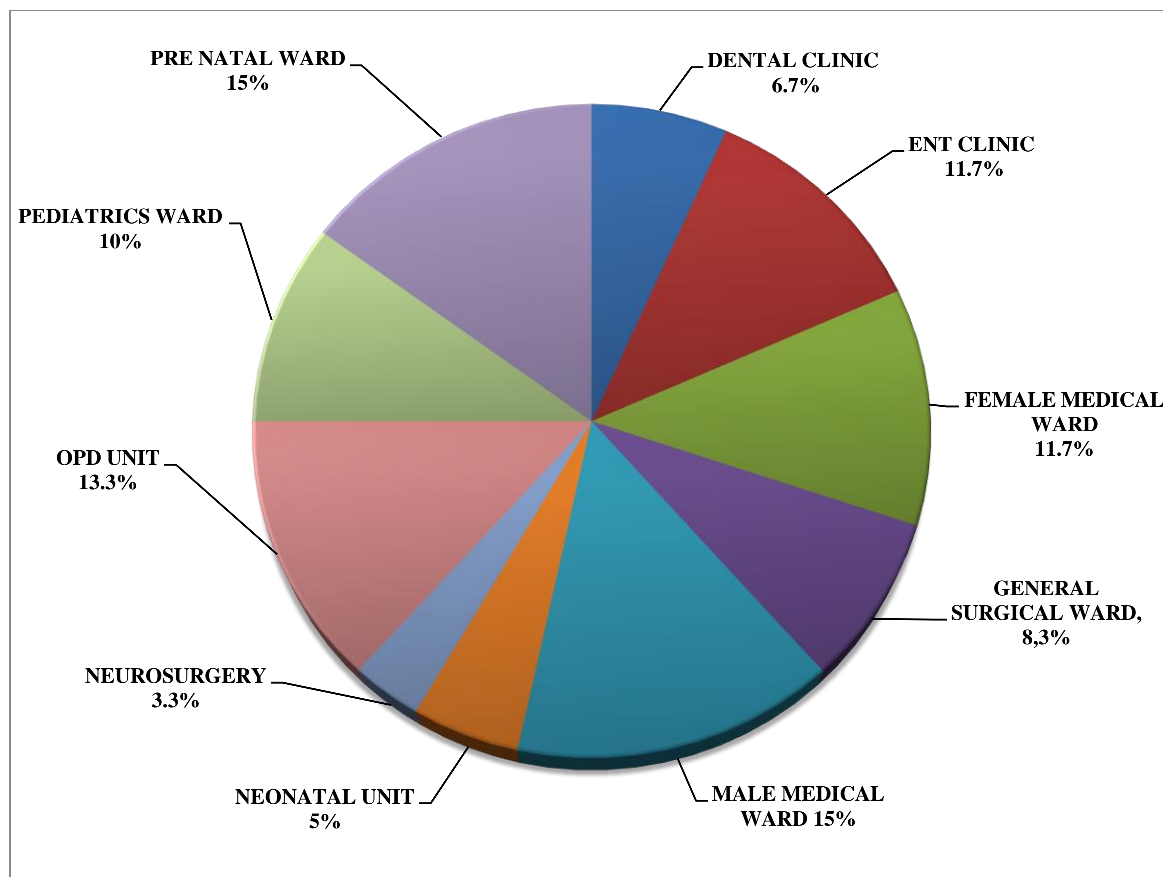

Figure 2: Most visited medical units/departments at the time of study N=120
Source: Field Survey, 2017

Clinical and non-clinical staff strength of TTH

With regard to staff strength of the departments and units of the hospital, it came to the fore in this study that the TTH had an employee strength of 2,103 with clinical staff totaling (1,323) while the non-clinical staff were (780). Table 4 indicates the category of clinical staff of the hospital who responded to the health needs of out-patients and those on admission. The enormous clinical staff list, probably the biggest staffing of a single health facility in northern Ghana may be the reason why the TTH is a major referral facility in the northern jurisdiction.

Table 4: Number of Clinical Staff in TTH

CLINICAL STAFF	NUMBER
General Doctors	275
Pharmacists	22
Pharmacy Technicians	19
Pathologists	2
Pediatricians	7
Laboratory technicians (Diploma)	12
Biomedical Scientists (Lab Technician with a degree)	43
Community Health Nurses	19
Midwives	122
Enrolled Nurses	76
General/Professional Nurses	688
Anesthetists	38
Total	1323

Source: TTH, 2017

Patient Expectations

One important factor taken into consideration by many a patient was how satisfied they were upon their arrival for medical services at the facility. Majority of patients' expectations were met (76%) when they got admitted to the TTH for treatment. Table 5 shows a cross-tabulation of patients' age range as against their expectations being met whilst on admission at the TTH. The results indicate that patients of age range 60+ were in the majority who were satisfied with the services rendered by the hospital followed closely by the 51 to 60 year cohort. When asked to explain the reasons for their satisfaction, an elderly patient explained as follows:

> I *am an elderly man and I think that most of those who come to care for me are mostly of my sons and daughter age ranges. They see me as a father. Nurses who come around to administer medication call be daddy. They are very humble and I appreciate their concern* (From a 71 year old patient from Garu District in the Upper East Region).

Table 5: Age range and patient expectations

Age Range	Frequency	Percentage
15-30	10	8.1
31-40	18	15.0
41-50	20	16.6
51-60	32	27.0
60+	40	33.3
Total	120	100.0

Source: Field survey, 2017

Reasons cited by those within the age range of 31 to 40 adduce to the fact that the TTH being an accredited national health insurance scheme subscriber was a factor accounting for their satisfaction with services rendered as it helped to reduce some level of the cost incurred on treatments. In explaining a point further on the relevance of the NHIS, a patient who was referred from Nadowli District Hospital explained as follows:

> *My relations had to hire an ambulance to bring us here at the cost of GHc 900.00. I have been here for 5 days now and had it not been for NHIS that catered for some of my drugs, it would have been tough for me to access healthcare here* (From a 71 year old medical tourist who came in from Nadowli District).

DISCUSSION

Demographic Characteristics of Patients

The study showed the occupation of respondents to which it was observed majority of the patients were in the working class (82%) with the exception of students, retirees and those not employed. The average length of stay in the facility is 5days to one week while motivations cited for their visit to TTH included; quality of service provision, availability of modern technology and equipment at the health facility. Other reasons also cited were availability of professional personnel (cited mostly by elderly patients). Patients were also happy that the facility subscribes to the NHIS. The NHIS system since its inception through the efforts of the government of Ghana, (as indicated by respondents) has helped in curtailing some percentage of the cost of treatment for some medical conditions and this has helped most underprivileged and financially handicapped patients including their families to resort to only accredited medical centres including the TTH. Key among those who cited the relevance of the NHIS as key in selection of the facility were referred patients to the TTH from other health centres outside the metropolis or other

administrative regions and districts. Such patients had already incurred huge transportation bills employing the services of ambulances to travel in.

Departments or Units frequently visited by Patients

The about 400 bed capacity facility is manned by both clinical and non-clinical workers spanning an array of departments with their sub-units for the smooth administration and progress. The departments include General Administration, Human Resource, Finance, Public Relations, Medical Social Works, Policy Planning, Transport, Security, Catering, Biomedical Engineering, Estate and Maintenance, General Surgery, Central Supply Department, Accidents and Emergency, Ear, Nose and Throat (ENT), Obstetrics and Gyneacology (O&G), Orthopedics and Trauma, Internal Medicine, Child Health, Pathology, Endoscopy, Neurosurgery, Anesthesia and Intensive Care Unit (ICU). Mention was also made of Psychiatry, Laboratory and Out-Patient Department (OPD) among others. The subunits include the Male and Female Wards, Pre-natal and Anti-natal Clinics, Neonatal unit, Eye clinic and Diet Therapy unit.

With regard to the choice of the TTH by patients, the study revealed reasons for their choice of the facility notably; presence of ultra-modern technology and equipment, cost, bed capacity, the reputation the facility, and availability of professional personnel. This seems to agree with Alsharif et al., (2010), whose study in India, China, Jordan and the United Arab Emirates indicated the most important reasons for patients travelling to hospitals in these countries for treatment to be cost affordability plus physician and facility reputation.

Human Resource Capacity of TTH

Human resources are often seen as one of the most important assets of tourism and hospitality organizations. The facility has total staff strength of 2,103 which comprises 1,323 (62.9%) clinical workers and 780 (37.1%) non-clinical staff. In an IDI with authorities regarding qualification of staff who work in TTH, the following revelation was relayed:

> The minimum qualification of staff is a tertiary programme specifically a degree at the unit managerial level and a postgraduate for the Heads of Departments. The number of trained doctors in some instances includes medical consultants, the large pool of specialists, staff with clinical expertise, all categories of senior staff nurses are highly trained and this makes the skilled manpower base one of the best in this

> part of the country. Our staff here can even compete with some of the premier health institutions in the southern sector. I guess these are some of the factors some of the district hospitals are aware of and often make referrals to the TTH, that is, the well-endowed human resource capacity of this facility (From a 47 year old Administrator at TTH).

Awareness levels about the stock of trained professionals in an institution gives an added advantage when patients are to choose a particular destination or facility for Medicare as expressed by the respondent. This response seems to resonate that of Unti (2009) who noted in the literature that availability of evidence about the quality of a particular surgeon or clinical team in a medical facility would encourage more people to pursue medical tourism.

Patients' source of information and traffic to TTH

Another factor of keen interest was how patients got to know about the facility and where they came from. It was observed that close to 42.0% of respondents came to the facility based on recommendation from friends and relatives while about 30% were referral cases from other health centres which mostly were complicated cases that were usually beyond their professional reach or the facility lacked the equipment and special technology which were present in the TTH or within the metropolis. Media coverage accordingly also accounted for 3.3% of the source of awareness with 25% which constituted others mainly emergency cases such as accidents (motor or violence related). The medical tourism industry is fueled and driven by patients who felt disenfranchised by the healthcare system in their place of residence or home and this informed patients to shop outside their home organized medical system to find services that were affordable elsewhere. The main traffic to TTH came from the Upper East Region (20 patients) and from the Upper West Region (21 patients), the northern region and its surrounding districts recorded 12 patients travelling to the facility with only 7 patients from the southern part of the Oti Region who came on admission, it was noticed that the main traffic to the hospital were mostly from the northern part of Ghana. At the time of study, people from the southern half of Ghana did not seem to visit the hospital regularly and this could be due to the presence of other competitive, modern and state of the art hospitals which they could resort to such as Komfo Anokye Teaching Hospital and the Korle-Bu Teaching Hospital in Kumasi and Accra respectively. Records from the TTH revealed

that the number of referral cases from other administrative regions and nearby districts over a one year period from May 2016 to April 2017 stood at 1,750 patients.

In an interview schedule with another administrator of the hospital, his response was as follows:

> The facility has had visits from foreign patients who are nationals of the USA, UK, Russia and Cuba and other nearby African countries who come to the region for volunteering and other purposes but no substantial records were teased out as foreign or domestic patients. We have treated and discharged several foreign personnel but the truth of the matter is that records are not kept the way you want it. Maybe your research is an eye opener and we will begin to look at the possibility of such. Let me also state that some of these patients did not come purposely for healthcare but they found themselves in the facility as a result of falling sick while doing their day-to-day work activities in the region (From a 53 year old administrator at the TTH)

This finding in IDI which indicates some expatriates coming on admission to TTH upon their visit to the region and falling ill seems to contradict that of Glinos et. al. (2006) who identified five drivers behind the increases in demand for medical services overseas: familiarity, availability, cost of access, quality and bioethical legislation (international travel for abortion services, fertility treatment, and euthanasia service). In another interview schedule, an administrator reiterated the following as medical tourism:

> The hospital once a while hosts some medical teams abroad who come to use the TTH facility to do surgeries and attend to patients for free. When coming they at times bring in their own medication and sometimes some equipment to help them execute the assignments they come to do. These appropriately could be termed medical tourists while within these environs. Medics from our facility also travel as a team and base themselves in some hospitals outside the region to deliver healthcare. Such gestures in my view amount to engagement in medical tourism (From a 55 year old administrator at the TTH).

A case in point with regard to motivation to visit this facility is an advert on social media that went viral about a team of medical tourists who visited TTH in December 2019. The team originally intended to stay a week but ended up doing two weeks due to the overwhelming number of patients who registered for consultation:

> "Doctors from the Czech Republic will visit the TTH from 8th to 14th December 2019 to conduct gynecological surgeries, fibroids, fistulas, cervical cancer, breast cancers and tumors, ovarian cancers, uterine and vaginal prolapses. Booking is ongoing at the TTH Antenatal Clinic. Regards to all"

Some medical Staff of the TTH have also gotten involved in organized medical tourism exploits in close collaboration with the Ghana Tourism Authority, Tamale Regional Office. According to an official of the GTA:

> Staff of the TTH through collaboration with the GTA have received medical tourists from Burkina Faso and Togo numbering about 200 in 2018 and many of them come with conditions ranging from diabetes, stroke and urology related problems. I can assure you that one Burkinabe who comes on admission for treatment in TTH and the money he leaves in the local economy is worth the value of about 10 of our local patients on admission. This we have been able to do in collaboration with the tourism boards in their respective countries (From a 47 year old administrator at TTH).

Patient Expectations in TTH

Patient expectation is one of the important factors taken into consideration when going for treatment and it is the desire of every patient to be satisfied before and after healthcare delivery. It was observed from the study that majority of the patients (close to 76%) were satisfied with the services rendered. The reasons for the satisfaction included; the facility was NHIS accredited and thus helped to somehow reduce the cost of treatment. Mention was also made of the medical units equipped with facilities which met modern standards. A facelift had been given the hospital and so it was good to be within such a modern edifice while others also indicated doctors, nurses and other medical personnel came in regularly on rounds and were usually very humble towards them. To patients, such professionalism was refreshing and aided healing. These reasons given by these patients seem to be in tandem with the viewpoints of Lunt and Carrera (2010) who posited that the greatest influence on the decision making process of the medical tourist is the issue of quality service offered at the facility or destination. A fair bit (24%) however expressed dissatisfaction and reasons cited were; despite the availability of NHIS, some patients had to procure some basic drugs from private pharmacies at their own expense. Congestion in the wards notably prenatal with associated poor sanitation issues in the washrooms and bathhouses were noted as appalling.

Conclusion

It came to the fore in this study that the main traffic to the TTH came from the other four regions of northern Ghana including other municipalities and districts of the northern region. Other foreign nationals from Togo, Burkina Faso and diplomats from UK, USA and Cuba have been catered for here. Patients got to know of the hospital mostly from friends and relations and also through referrals by other health facilities. The TTH has a total of 1,323 clinical staff who catered for the health needs of patients while medical teams from advanced countries have come to stay and work in the TTH for periods ranging between 1 and 2 weeks and performed free surgeries and provided health treatments to locales. It was also revealed that over the past one year before the study was conducted, a total of 1,706 referral cases came from other districts and regions to the TTH showing the traffic volume that emanates from other parts of the country. Majority of the patients (especially elderly ones) were satisfied with services rendered therein, reasons cited being medical staff were friendly and professional in caring for them while others cited that the hospital now has ultra-modern equipment. Furthermore, the facility's subscription to the NHIS helped subsidized the cost of treatments, hence the reason many also chose to seek medical services in the facility. There is therefore great potential of the TTH in the field of medical tourism but the following recommendations could improve its competency in that regard.

Recommendations

Good record keeping measures as in decoupling patients' records by virtue of country of origin, the region where the patient comes from in Ghana and furthermore a database of all foreign/ local patients must be kept by the facility and this will help monitor if the facility is making inroads in the area of medical tourism. Running periodic surveys on the satisfaction levels of patients could help in taking pragmatic measures to improve upon their services to patients so as to boost the image of the hospital and bring about positive word of mouth publicity. The TTH administration liaising appropriately with the GTA could result in better showcasing of the facility during tourism fairs organized at the sub-regional shows in neighbouring African countries to boost medical tourism of the hospital. It will be good for the Ministry of health and the Ghana Health Service should begin exploiting the medical tourism potentials of all teaching hospitals in Ghana. This is possible especially taking "a census" of the number of medical consultants and senior doctors and their areas of specialist training and marketing these in brochures in embassies of Ghana abroad.

Acknowledgements

First of all, we wish to thank administration of the TTH for granting us the opportunity to conduct this study and even availing useful information to aid the analysis. Secondly, the authors wish to also express their sincere gratitude to Prof. Dr. Dr. Juventus B. Ziem of the UDS Medical School for painstakingly reading through this paper and offering constructive criticisms using his “medical eyes and lenses”. To all of you, we deeply appreciate your gestures, sirs.

Conflict of Interest

The authors wish to state categorically that this study was undertaken for a purely academic perspective and that there are no financial gains sourced from any industrial establishments for the conduction of the study and the rights of patients and other respondents were well protected in terms of the ethic of confidentiality.

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TTH/R&D/SR/17/75
07/06/2017

TO WHOM IT MAY CONCERN

CERTIFICATE OF AUTHORIZATION TO CONDUCT RESEARCH IN TAMALE TEACHING HOSPITAL

I hereby introduce to you **Ms. Florence Esi Dooso,** currently a final year student from the Department of Ecotourism and Environmental Management of the University for Development studies. Who have been duly authorized to conduct a study on **"Medical Tourism potential in Tamale Teaching Hospital".**

Please accord her the necessary assistance to be able to complete her study. If in doubt, kindly contact the Research Unit at the second floor of the administration block or on Telephone 0209281020. In addition, kindly report any misconduct of the Researcher to the Research Unit for necessary action.

Please note that this approval is given for a period of three months, beginning from 7st of June, 2017 to 31st of August, 2017.

Thank You.

ALHASSAN MOHAMMED SHAMUDEEN
(HEAD, RESEARCH & DEVELOPMENT)

https://dergipark.org.tr/tr/pub/ijhmt Doi Number: 10.31201/ijhmt.753202

Int Journal Of Health Manag. And Tourism 2020, 5(3), 234-250

JHMT **Editorial**

International Journal Of Health Management And Tourism

TURKISH AESTHETIC SURGEONS' WEBSITES AS ONLINE INFORMATION SOURCES FOR MEDICAL TOURISM

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Received: 15.06.2020
Accepted: 31.10.2020
Research Article

Abstract: In recent years, the increasing importance of medical tourism in Turkey cannot be ignored. Existence of websites that fulfil various quality criteria concerning its features is important for providing the right information to people looking for aesthetic interventions and aesthetic surgeons. The aim of this study is to reveal the current situation of Turkish aesthetic surgeon's websites in terms of both HONcode (Health on the Net Code of Conduct) and TSPRAS' principles (Turkish Society of Plastic-Reconstructive and Aesthetic Surgeons' Ethical Rules for Websites). In this study, Turkish aesthetic surgeons' websites were evaluated and scored according to the HONcode and selected TSPRAS' principles concerning eleven basic features of the website. There were 749 surgeons who were members of the TSPRAS. Of these, 341 (45.7%) had their own accessible, professional websites. 190 websites confirm to at least all of the 5 selected TSPRAS' principles. Various studies have been conducted for the purpose of examining websites and their role in medical tourism. Based on those, it can be considered that increasing the number and quality of TSPRAS' registered surgeons' websites will give a fresh momentum to aesthetic health tourism. This will

be beneficial in terms of patient safety and national economy, and will increase the competition with other countries to achieve higher levels of quality in medical tourism.

Keywords: *Aesthetics, Internet, Medical tourism, Online health information, Turkey*

Introduction

Beauty and aesthetics are as old as human history. It is known that people resort to many different methods because of their desire to look beautiful and to satisfy their aesthetic sense (Ricketson, 1962). For this purpose, in addition to the use of various products, alternative treatment methods, natural or synthetic sourced human products and surgical procedures can be used (Azak-Sungur et.al, 2018; Heller et.al, 2006; Rowe and Baker, 2009).

The professionals in this field are aesthetic surgeons. Surgeons who perform appropriate interventions for their patients by making intensive efforts in accordance with medical requirements in the light of scientific methods also make important contributions to public health. According to Ricketson (1962), ‘‘Cosmetic surgery is defined as any surgical procedure in which the primary goal is beautification or improvement of appearance above and beyond what might be considered average or normal” (Ricketson, 1962). To sum up, ‘‘cosmetic plastic surgery’’ can be defined as a “specialized surgery that focuses on improved appearance for its own sake” (Atiyeh et.al, 2008). It is necessary to be aware of the procedures those are not carried out in accordance with professional and ethical rules will lead to important health problems and to avert this, reliable professionals should be consulted (Klein et.al, 2017).

At the same time, it is known that since the first ages of history, people went from the places where they are located to other sites with the aim to meet their requirements relating with health (Rodrigues et.al, 2017). These kinds of travels with the purpose of getting quality health services are being realized more widely in our present time due to emerging technologies and advanced opportunities in health and travel.

In the light of the above facts, medical tourism is a type of travelling activity that involves a wide range of medical services both domestic and across international borders (Heung et.al, 2010; Hudson and Li, 2012). Medical tourism has become a subject matter that is being demanded more and being given importance by various countries in recent years. Medical tourism, with sub-areas such as thermal health tourism, geriatric tourism, and tourism for the disabled people, is gaining

priority in the Turkish Health System. Notably, Turkey is one of the top 5 countries in the world in terms of having patients from various countries (Ministry of Health, 2019).

Across the world, it is seen specific sub-areas are parts of medical tourism with various purposes, ranging from operations to various cosmetic interventions (Falk and Prinsen, 2016). Similar to developing countries such as India, Brazil, Philippines, Malaysia, Thailand, Turkey is among the countries that are preferred for medical tourism (Falk and Prinsen, 2016; Dinçer et. al, 2016; Khan et.al, 2016). Eye surgeries, tooth surgeries, in vitro fertilization, aesthetic and plastic operations, and cardiovascular diseases comprise the general medical tourism services (Erdoğan and Yılmaz, 2012; Ozsari and Karatana, 2013). Turkey has a relative advantage compared to other countries such as Germany, Czech Republic, and Serbia due to lower price levels, talented health professionals, healthcare being provided with high standards, and reliable information sources, especially regarding aesthetic surgeries (Klein et.al, 2017).

It is well known that people want to get information relating to health benefits and risks from the Internet, mainly because it provides easy access with privacy being safeguarded, and due to the reasons such as fast and flexible accessibility and numerous options being provided (Winker et.al, 2000; Wong et.al, 2010). In this regard, Internet has a significant importance concerning medical tourism as well. People, who want to get healthcare services from places outside their own country, can reach to many different sources through the Internet and they can make their preferences accordingly (Klein et.al, 2017; Rodrigues et.al, 2017; Falk and Prinsen, 2016; Öksüz and Altıntaş, 2017). For this reason, it is required that the information provided on websites is reliable and meets some certain standards (Yegenoglu et.al, 2012).

The criteria concerning health-related websites should comply with some regulations established by various institutions. As being one of them, since 1996, the Health on the Net Foundation (HON), ensures that the health-related information on the Internet should comply with certain rules as per 8 principles that are specified in the HONcode (HON Foundation, 2019). This foundation is accrediting websites that meet the HONcode (Boyer et.al, 2016; Boyer et.al, 1998; Gaudinat et.al, 2007). Obviously, websites that meet certain quality standards are perceived by the users as trustworthy and reliable.

Furthermore, institutions related with certain disease groups or doctor communities develop specific regulations regarding the rules that must be complied with on the websites that provide

information concerning their fields (Siegel et.al, 2015). In this context, "Ethical Rules for Websites" exist as prepared by the Turkish Society of Plastic-Reconstructive and Aesthetic Surgeons (TSPRAS) for their privately working member surgeons (TSPRAS, 2019).

Since the beginning of the 2000s, various studies have been conducted about the aesthetics and plastic surgery-related information and websites on the Internet. In some of these, the content of the information was investigated. On the other hand, it is seen that there were some studies about the features of the websites. In 2002, Jejurikar et. al. found that 34% of the information about breast augmentation on the Internet were false or incomplete (Jejurikar et. al., 2002). In another study related to breast augmentation, it was found that only 25% of the websites examined were eligible for the Ensuring Quality Information for Patients evaluation (Palma et. al., 2016). In the study conducted by Wong et al. on aesthetic surgery, the appropriateness of the advertisements related to aesthetic surgery on the websites were analyzed according to the ASAPS / American Society of Aesthetic Plastic Surgeons (ASPS) and American Medical Association Codes of Ethics codes. As a result of this study, it was found that compliance with these codes is high (Wong et. al., 2010). Also, Gutierrez and Johnson emphasized the importance of following ethical rules in the Internet and social media use by plastic surgeons (Gutierrez and Johnson, 2018).

Besides, in a study conducted on the effects of information about aesthetic surgery that patients accessed over the Internet, it was determined that 95% of patients collected information from the internet before meeting with the physician (Montemurro et. al., 2015). Similarly, Janik et al.stated that social media is a frequently used for information gathering about aesthetic surgery (Janik et. al., 2019). In another study, it was determined that Internet searches on plastic surgery increased in December-January and June-July (Ward et. al., 2018).

In a study regarding the internet and social media usage of plastic surgeons in Canada, it was found that 42% of surgeons who are members of the Royal College of Physicians and Surgeons of Canada have a website and 85% have a social media profile (McEvenue et. al., 2016). In addition, it has been determined that the posts about plastic surgery on social media are made by plastic surgeons, 83% on Instagram, 18% on Facebook and 13% on Youtube (Naftali et. al., 2018). Besides this, in a study that examined the websites of plastic surgeons in Turkey, it has been demonstrated that the quality of the information related to orthognathic surgery was low (Baybek and Tuncer, 2017).

It is understood from the studies in the literature that the patients use the Internet for gathering information about aesthetic surgery and that the quality of this information is extremely important. In this context, the accessible websites of the TSPRAS' members are important information sources for aesthetic surgery and can have an important role in medical tourism in Turkey. The aim of this study is to reveal the current situation of these websites in terms of both their quality, measured by the HONcode and TSPRAS' principles.

1. Materials and methods

In this study, Turkish aesthetic surgeons' websites were evaluated according to the HONcode and selected TSPRAS' principles. All 8 principles[a] covered by HONcode were included in the study. Out of the 16 TSPRAS' principles, only 5 were selected[b] because of their online accessibility. Eleven basic features (gender, city, foreign language, biography, photo of the surgeon, other visual materials (photographs, videos, clarification drawing, etc), advertisements, interactive communication (an online tool for easy messaging), mail address, e-mail address, and telephone number) were identified to evaluate against the selected principles. A form containing the selected features of the HONcode and TSPRAS' principles was prepared by the researchers and consistently applied. The compliance to the criteria was scored as 1 point for compliance and 0 point for noncompliance. Maximum total scores were therefore 8 for the HONcode and 5 for the TSPRAS.

To assess the aesthetic surgeons' websites, the members of the TSPRAS were identified, afterwards investigated and a database was created according to the availability of the websites (Figure 1). Then, the websites were evaluated via a specifically developed form. The websites were accessed during the first half of 2017.

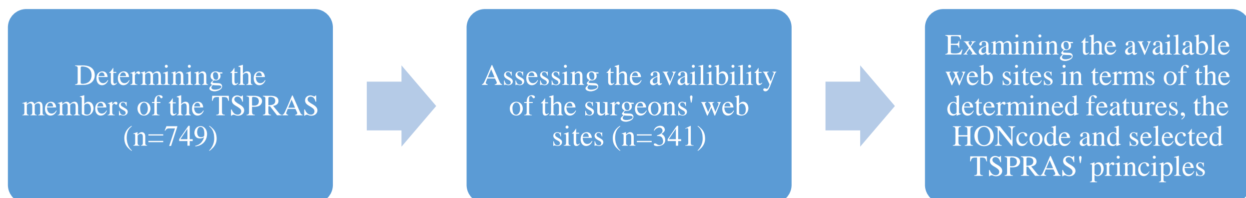

Figure1. Flow chart of the study

Also, the patient ratings for the surgeons were gathered as an indicator of patient satisfaction and the mean scores were calculated. However, a comparison to find a relation between the ratings and compliance to the principles couldn't be made due to the differences in the numbers of the patients who graded the surgeons online.

Since not all of the TSPRAS' principles were evaluated, statistical analysis was not performed to examine the difference between the determined variables in terms of compliance to these principles. Yet, statistical analyses on HONcode scores were undertaken. IBM SPSS version 22 was used for descriptive statistical analyses, two sample independent t-test and one-way analysis of variance (ANOVA) tests. ANOVA was used to examine if there were any significant differences between the compliance with different principles, or not. Tukey post hoc test was performed to find which groups are different in terms of compliance with the HONcode. The level of significance was set a priori at $p<0.05$.

2. Results

There were 749 surgeons who were members of the TSPRAS. Of these, 341 (46%) had their own accessible, professional websites.

As seen in Table 1, most of the surgeons are male (88%) and more than half of the clinics are located in Istanbul (51%). Only 24% (83) of them has their websites in English or in other foreign languages. On the other hand, 96% (326) of them provide their telephone number as a contact information on their websites.

Table 1. Basic features of the websites (N=341)

Features		n	%
Gender of the surgeon	Female	41	12.0
	Male	300	88.0
City (where the clinic is located)	Ankara	49	14.4
	Istanbul	175	51.3
	Izmir	28	8.2
	Other cities*	61	17.9
	NA	28	8.2
Website in foreign language	Available	80	23.5
	NA	261	76.5
Biography of the surgeon	Available	321	94.1
	NA	20	5.9
Picture of the surgeon	Available	310	90,9
	NA	31	9.1
Other visual materials on the website	Available	321	94.1
	NA	20	5.9
Advertisements on the website	Available	13	3.8
	NA	328	96.2
Interactive communication tool	Available	252	73.9
	NA	89	26.1
Mail address	Available	313	91.8
	NA	28	8.2
E-Mail address	Available	292	85.6
	NA	49	14.4
Telephone number	Available	326	95.6
	NA	15	4.4

* Adana, Afyonkarahisar, Antalya, Batman, Bursa, Canakkale, Denizli, Diyarbakir, Gaziantep, Hatay, Isparta, Kayseri, Kocaeli, Konya, Malatya, Manisa, Mersin, Sakarya, Samsun, Sanliurfa, Zonguldak
NA: not available

The number of the websites, which are conforming to the HONcode, are shown in Table 2. None of the websites meets all of the HONcode principles. Of these 341 websites, 132 (38.7%) contain a warning stating that "Information should support, not replace, the doctor-patient relationship". Solely, 5 (1.5%) of the websites provide references to the content (Table 2).

Table 2. Identified websites and their adherence to the HONcode (N=341)

HONcode	n	%
Authoritative "*Indicate the qualifications of the authors*"	304	89.2
Complementarity "*Information should support, not replace, the doctor-patient relationship*"	132	38.7
Privacy "*Respect the privacy and confidentiality of personal data submitted to the site by the visitor*"	5	1.5
Attribution "*Cite the source(s) of published information, date medical and health pages*"	5	1.5
Justifiability "*Site must back up claims relating to benefits and performance*"	2	0.6
Transparency "*Accessible presentation, accurate e-mail contact*"	134	39.3
Financial disclosure "*Identify funding sources*"	0	0.0
Advertising policy "*Clearly distinguish advertising from editorial content*"	9	2.6

190 websites confirm all of the 5 selected TSPRAS' principles. Also, none of the websites contain price information. The numbers of the websites, which are conforming to the selected TSPRAS' principles, are shown in Table 3.

Table 3. Websites conforming to the selected TSPRAS' principles (N=341)

Criteria	n	%
Any kind of information should not be aimed at gaining, directing, praising a physician, bringing to the forefront or defeating other physicians.	12	3.5
At the bottom of each web page the warning should be placed "*The content of this page is for informational purposes only. Please consult your physician for diagnosis or treatment*."	132	38.7
There should be no pre- or post-operative mentioning of information which may reveal the identity of any patient.	327	95.9
Information on the website should be scientific and should not encourage the patient to have an operation. There should be no doubtful expressions such as that surgery is painless and taintless.	338	99.1
Treatment costs should not be included on the website.	341	100.0

The results of the t-tests for the HONcode are presented in Table 4. Surgeons' gender has no statistically significant effect on the compliance with the HONcode. On the other hand, statistically significant differences are found for the compliance with the HONcode and availability of visual elements, interactive communication tool, mail addresses, e-mail addresses, and telephone number

Table 4. HONcode scores of the websites according to various variables

	Mean±SD	**Median**	**Min-Max**	**P value***
Gender				
Male	2.7±0.9	3	0-5	0.866
Female	2.7±1.0	3	0-4	
Foreign language				
Available	2.8±0.8	3	1-5	0.214
NA	2.7±1.0	3	0-5	
Biography				
Available	2.7±0.8	3	0-5	0.088
NA	2.2±1.4	2	0-5	
Other visual elements				
Available	2.8±0.8	3	0-5	<0.001
NA	1.5±1.2	1	0-3	
Interactive communication tool				
Available	2.8±0.8	3	0-5	<0.001
NA	2.3±1.0	2	0-4	
Mail addresses				
Available	2.7±0.9	3	0-5	0.091
NA	2.3±1.2	2	0-4	
E-mail addresses				
Available	2.7±0.9	3	0-5	
NA	2.4±0.9	2	0-4	0.019
Telephone number				
Available	2.7±0.8	3	0-5	0.064
NA	2.0±1.4	2	0-4	

*Independent samples t-test (The mean difference is significant at the 0.05 level)

SD: Standard Deviation; Min-Max: Minimum-Maximum; NA: Not available

According to the ANOVA and Tukey tests results, statistically significant differences were found between the groups in terms of compliance with HONcode principles (p<0.001). Mean values of websites that meet 3 principles and 4 principles are higher than websites that meet 5 principles.

Moreover, patients graded 298 surgeons on satisfaction and it was found that this sample got the mean score of 4,71±0.03 (Mean±SD) out of 5.

3. Discussion

In the age of information technologies, online health information is increasing rapidly (Sbaffi and Rowley, 2017). In recent decades the world is becoming smaller because of globalization and instant access to information via the Internet. Thus people, who want to get health services from locations outside their own country, can reach easily too many different sources through the Internet and make their preferences accordingly, while having privacy safeguarded (Klein et.al, 2017; Rodrigues et.al, 2017; Falk and Prinsen, 2016; Öksüz and Altıntaş, 2017). This has a significant importance regarding medical tourism (Lunt et.al, 2016), inclusive for Turkey. In this context, it is considered that increasing the number and quality of TSPRAS' registered surgeons' websites (45.7%) will give an impetus to aesthetic health tourism in Turkey, where medical tourism is supported as a government policy (Fetschrein and Stephano, 2016).

There are many studies conducted examining the websites, which have a significant role in medical tourism. These studies observe various features of the websites. One of them is the availability of information in foreign languages. In this respect, Moghavvemi et al. found that Malaysian healthcare facilities' websites provide a higher level (90%) of information in foreign languages than India and Thailand (Moghavvemi et.al, 2017). In the present study, it is found that only 23.5% of the websites gave information in foreign language and when compared to the previous studies this percent seems to be very low. Obviously, this ratio should be increased further in order to provide more widespread services in international healthcare markets, enhancing medical tourism in Turkey.

In this study, it was detected that 91% of the websites had the physicians' pictures online. In the study conducted by Frederick and Gan, it was found that only 62% of the investigated websites

had picture of the healthcare professional (Frederick and Gan, 2015). It has been shown that the CV and photograph of the physician is also preferred by users for various cultural reasons (Mason and Wright, 2011). In particular, the visitors of the website can feel more confidential when they see the picture of the surgeon besides reading his/her CV.

In addition, it is known that the presence of other visual materials is an effective marketing technique for the Internet (Frederick and Gan, 2015). In this study, the availability ratio of other visual materials is 94%.

Furthermore, e-mail and social media are potential tools for physician-patient communication (Lee et.al, 2016). Also, to have interactive communication tools on the websites is important to communicate instantly (Frederick and Gan, 2015). While healthcare facilities in India, Thailand and Malaysia, potentially outstanding countries in terms of medical tourism, have interactive communication tools in 18%, 14% and 0% of cases, respectively (Moghavvemi et.al, 2017) this ratio was 74% in the present study, much higher than in those other countries.

Another remarkable factor in the study is the lack of price information on any site. This situation, may vary though according to the legislation of the countries. As a matter of fact, a study conducted in Malaysia, India and Thailand indicates that this information is found on their websites (Moghavvemi et.al, 2017). However, according to TSPRAS' principles, price information of any operation shouldn't be available on the websites of the physicians in Turkey (TSPRAS, 2019).

Furthermore, it is stated that online ratings of physicians by patients are another important and widespread practice in decision making (Samora et.al, 2016; Trehan and Daluiski, 2016). There are some studies available about the relation of these ratings and website quality (Ford et.al, 2013; Graves et.al, 2012). The mean score of the surgeons' score is 4.71 out of 5 in this study, which seems relatively high.

As indicated before medical tourism is supported as a Turkish government policy and promoted by Turkish brands (like Turkish Airlines), as well as recognized worldwide (Fetschrein and Stephano, 2016). It should be noted that in the age of information technologies, online health information seeking is increasing rapidly (Sbaffi and Rowley, 2017). Compliance with both HONcode and local TSPRAS principles will increase the trust and credibility of the websites and will help these websites to become primary information source for medical tourism. This will be

beneficial for increasing medical tourism activities in Turkey as well as in terms of enhancing patient safety and the national economy. Also, it will increase the competition with other countries to achieve higher levels of quality in medical tourism in general.

Acknowledgment

The authors are thankful to Assist. Prof. Miray Arslan (Pharm, PhD) for her valuable comments and contributions.

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[a] ***Selected HONcode Principles*** *(HON Foundation, 2019)*

Aim: *The HONcode certification is an ethical standard aimed at offering quality health information. It demonstrates the intent of a website to publish transparent information. The transparency of the website will improve the usefulness and objectivity of the information and the publishment of correct data.*

1. Authoritative: *Any medical or health advice provided and hosted on this site will only be given by medically trained and qualified professionals unless a clear statement is made that a piece of advice offered is from a non-medically qualified individual or organisation.*

2. Complementarity: *The information provided on this site is designed to support, not replace, the relationship that exists between a patient/site visitor and his/her existing physician.*

3. Privacy: *Confidentiality of data relating to individual patients and visitors to a medical/health Web site, including their identity, is respected by this Web site. The Web site owners undertake to honour or exceed the legal requirements of medical/health information privacy that apply in the country and state where the Web site and mirror sites are located.*

4. Attribution: *Where appropriate, information contained on this site will be supported by clear references to source data and, where possible, have specific HTML links to that data. The date when a clinical page was last modified will be clearly displayed (e.g. at the bottom of the page).*

5. Justifiability: *Any claims relating to the benefits/performance of a specific treatment, commercial product or service will be supported by appropriate, balanced evidence in the manner outlined above in Principle 4.*

6. Transparency: *The designers of this Web site will seek to provide information in the clearest possible manner and provide contact addresses for visitors that seek further information or support. The Webmaster will display his/her E-mail address clearly throughout the Web site.*

7. Financial disclosure: *Support for this Web site will be clearly identified, including the identities of commercial and non-commercial organisations that have contributed funding, services or material for the site.*

8. Advertising policy: *If advertising is a source of funding it will be clearly stated. A brief description of the advertising policy adopted by the Web site owners will be displayed on the site. Advertising and other promotional material will be presented to viewers in a manner and context that facilitates differentiation between it and the original material created by the institution operating the site.*

[b] **Selected TSPRAS' Principles** (TSPRAS, 2019)

Aim: It is to establish standards for plastic surgery websites in order to prevent unethical practices and unfair competition at the same time to inform the public, and to transform these standards into a legal framework in cooperation with TSPRAS and Turkish Medical Association.

3. Any kind of information should not be aimed at gaining, directing, praising a physician, bringing to the forefront or defeating other physicians.

4. At the bottom of each web page the warning should be placed "The content of this page is for informational purposes only. Please consult your physician for diagnosis or treatment."

6. There should be no pre- or post-operative mentioning of information which may reveal the identity of any patient.

7. Information on the website should be scientific and should not encourage the patient to have an operation. There should be no doubtful expressions such as that surgery is painless and taintless.

10. Treatment costs should not be included on the website.

https://dergipark.org.tr/tr/pub/ijhmt Doi Number: 10.31201/ijhmt.733173

Int Journal Of Health Manag. And Tourism 2020, 5(3), 251-263

JHMT Editorial

International Journal Of Health Management And Tourism

HOW MEDICAL DESTINATION AFFECTS THE HEALTH TOURISTS' WELL-BEING?

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Received: 06.05.2020
Accepted: 31.10.2020
Research Article

Abstract: Customer satisfaction has significant influence on medical tourism. The aim of this study is to determine the opinions of heath tourists' buying health services from Turkish hospitals. The study was carried out on 69 foreign patients referred to hospitals in Trabzon and Ordu provinces. A revised well-being questionnaire aimed to measure the reflections of well-being indicators on health tourists. The Cronbach's alpha was calculated as 95. The validity of the scale was tested by factor analysis, and collected under the single factor account for 55% of the variance and are suitable. Participants' feelings of security, respect and courtesy were high and their level of satisfaction with explaining themselves and receiving services in exchange for payment was the lowest level. Patients differ in their level of satisfaction according to their country.

Keywords: *Medical Tourism, Foreign Patient, Health Tourist, Patient Satisfaction*

Introduction

As reported by WHO (World Health Organization); "Health is a state of complete physical, mental and social well-being. It is not merely the absence of disease or infirmity." We may add this definition the emotional well-being though. With emphasis on health in recent years tourists tend to be more sensitive in destination choices. On the other side health is an area of very sensitive and open to abuse. At this point tourist experience has a prominent importance for retention. The number of studies on well-being have been increasing in tourism literature. When the well-being of the tourists is high, they are more likely to visit the destination again. Psychological factors have been believed that they have a strong attraction effect. People share their happiness with other people as advice (Vada, Prentice and Hsioao, 2019). This contributes to destination brand value and increases destination loyalty (Hwang and Lee, 2019). The aim of the study is to examine tourists' experiences after staying a hospital. What they have expected more or less and what they have experienced according to well-being / wellness concept is the main objective of the study. To understand well-being in general a well-being module improved by from Scottish Government (2012) is shown below:

Table 1. Well-being Module

Be safe	shielded from misuse, disregard or mischief
Be healthy	encountering the best expectations of physical and emotional wellness, and upheld to make solid, safe decisions
Be achieving	accepting help and direction in their vacation – boosting their abilities, certainty and confidence
Be nourished	having a sustaining and invigorating spot to live and invest energy
Be active	having chances to partake in a wide scope of exercises – helping them to assemble a satisfying and upbeat future
Be respected	to be given a voice and associated with the choices that influence their prosperity
Be responsible	playing a functioning job inside their days off and networks
Be included	finding support and direction to defeat social, instructive, physical and financial disparities; acknowledged as full individuals from the networks in which they live and learn

These eight well-being indicators are used to reach high health level through achieving best well-being and wellness status.

In the light of these information, the aims of the study are,

- what is well-being and how can be measured?
- to be identified Turkey in the opinion of foreign patients' satisfaction of various hospital departments they receive health services in the field of medical tourism,
- to contribute to the foreign patient satisfaction literature
- to contribute human well-being literature

1. Literature

As tourists experience, some may have temporary difficulties, some may live with difficulties that divert them on their excursion and some may encounter progressively complex issues. Milman (1998) mentioned travel experience and physical well-being relationship. Gilbert and Abdullah (2004) explained the holidaytaking and sense of well-being. They found that the activity of holidaytaking changed the sense of well-being of those participating in it. Some authors focused on the physical dimensions of the well-being and tourism mostly. This is exemplified in the work undertaken by Mannell and Iso-Ahola (1987). And some focused on ecosystem and well-being. But we just wouldn't say who might need some extra help at some point if things haven't been going so well. And that's why it's so important that organisations should be aiming to get it right for every tourist. Every tourist has the right to feel safe. To be showed honour and to have holiday in a loving place. Also having right to spend quality time in a healthy environment. As the tourists only have the one go at being a happy tourist. However this study aims to show the dimensions of well- being in wellness type hotels for tourists and other parts. We may say; wellness is simultaneous presence of physical (health) and psychological (well-being) life satisfaction. When human harmonise health and well-being he or she would reach superior health and well-being (wellness). Health is state of more of a medical treatment. Encountering the best expectations of physical and psychological well-being, and thus to make healthy, safe choices (**Figure 1**).

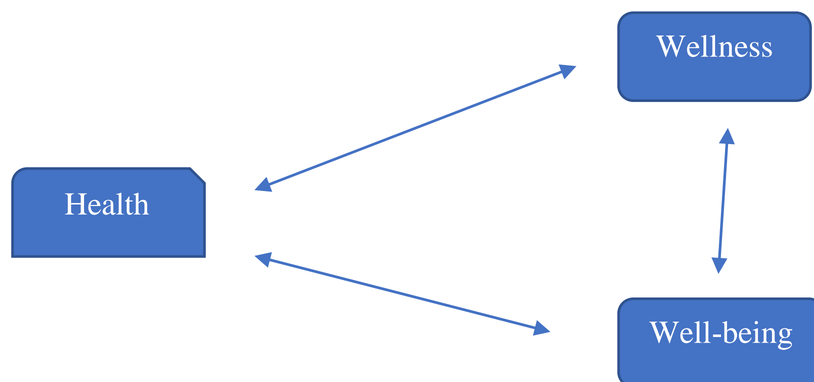

Figure 1. Relationships between Concepts

The eight dimensions of wellness adapted from Swarbrick (2006) understandable as follows:

Physical well-being – support of body in great condition through sustenance, physical movement, maintaining a strategic distance from unsafe propensities and making educated, capable choices about somebody's wellbeing.

Intellectual well-being – having a psyche open to new thoughts and ideas, to look for new encounters and difficulties to invigorate self-improvement and add to society.

Emotional and psychological well-being – getting feelings and realizing how to adapt to issues that emerge in regular day to day existence and how to suffer pressure. This fuses mental wellbeing, giving positive thinking about existence, oneself and what's to come.

Social well-being – associating with others and being able to live in the public eye easily and obligingly.

Spiritual well-being – a procedure of consistently looking for importance and reason throughout everyday life and in the improvement of an individual conviction framework.

Occupational well-being – the degree to which individual can communicate individual qualities while picking up happiness and improvement from paid or unpaid work. It is the capacity to utilize aptitudes and gifts and the harmony among occupation and different responsibilities.

Environmental well-being – the capacity to perceive individual's own duty regarding the nature of the air, water and land encompassing him; and the capacity to acknowledge and have a constructive outcome on the nature of his condition.

Financial well-being – relationship with cash and aptitudes in overseeing assets, just as individual's capacity to settle on great buyer decisions and search out fitting budgetary chances.

Travis (1972) explained popularity of the word “wellness” as; used by many people and organizations, especially since the sharp rise in healthcare costs, diabetes and obesity during the past decade. Maslow's concept of self-actualization, and the high-level wellness model proposed by Halbert Dunn (1961). He explained wellness as; “an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable, within the

environment where he is functioning**.**" Very first well accepted wellness concept defined by Hettler (1984) as "an active process through which people become aware of, and make choices toward a more successful existence". Sweeny and Witmer (2000) expanded this definition as; "a way of life oriented toward optimal health and wellbeing, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community." Hetler (1976) developed six dimensions wellness model. These are occupational, physical, social, intellectual, spiritual and emotional dimensions. Afterwards environmental and financial dimensions have added to this model. By balancing these eight dimensions and actively seeking to improve them, it is believed individuals could improve their overall well-being. Second model is Indivisible self by Sweeny and Myers (2001). Third one is Travis' (1972) iceberg model.

Ryan and Deci (2001) defines well-being as "a complex construct that concerns optimal experience and functioning." Well-being has been including two approaches. These are hedonic and eudaimonic, subjective and psychological approaches and scientists have been trying to flourish well-being theory. Well-being is a topic of positive psychology and has some elements. These are positive emotion, engagement, meaning, accomplishment, and positive relationships. None of them define well-being but contribute to it and can be measured through self-report (subjectively) and objectively. Generally happiness has been used for defining the well-being. According to Seligman (2011) happiness has been overused and meaningless. Thus it must dissolve into more workable terms. Original goal of happiness is increase life satisfaction.

Researches concerning subjective well-being (SWB) conducted within hedonic tradition. It has three distinct components. Life satisfaction, positive affect and (absence of) negative affect. Life satisfaction refers to global cognitive evaluation of life (Kahnemann, Diener and Schwalz, 1999). Hedonics are basic building blocks of subjective well-being. On the other hand Psychological well-being (PWB) argues that SWB has little theoretical background. It has been striving for perfection that represents the realization of one's true potential. Draws on mental health, clinical and life span development theories. Ryff (1989) suggested 6 ideals: autonomy, personal growth, self acceptance, purpose in life, environmental mastery and positive relationships with others.

2. Method

The data were collected through a seven-point Likert scale. The questionnaire adapted from Lee, Han and Lockyer study (2012). The questions are written in Arabic, English and Turkish. The data in the study consisted of two sections which consisted of a questionnaire about demographic characteristics of foreign patients and their satisfaction with hospital services. The population of the study consists of foreign patients who applied to health institutions operating in Trabzon-Ordu province of the Black Sea region. The data collection process, which started in February 2017, was terminated in May 2017. In this process, a total of 69 valid questionnaires were obtained. The data obtained from the study were evaluated by using quantitative analysis techniques. In this respect, quantitative data were analyzed by using SPSS 16.0 program, frequency analysis, factor analysis, T-test (nonsense) and Anova analysis.

We have analyzed the answers according to indicators. The wellbeing Indicators are used to record observations, events and concerns and as an aid in putting together a tourist's plan. The indicators classified into eight categories as mentioned above. The post-consumption evaluations of satisfaction has been examined.

2.1 Findings

In the factor analysis conducted to validate the Wellbeing scale, sample adequacy was achieved. It was seen that the expressions in the scale were collected under one factor and explained 55% of the variance. The reliability of the scale was measured by Cronbach Alpha coefficient and 95 was found to be reliable. Validity and reliability analysis results are shown in Table 2.

Table 2. Validity and reliability findings of wellbeing scale

Reliability and Validity			
Kaiser-Meyer-Olkin Measure of Sampling			,871
AdequacyBartlett's Test of Sphericity	Significant	Sig.	,000
Explained Total Variance	55,929	Cronbach Alpha Total	0,956
Health Tourist Hospital Hotel Services Well-Being Model How satisfied are you with this hospital hotel?		**Factor Loading**	**Exp. Variance**
Booking process		,495	55,929
Physical environment		,531	
Facilities		,565	
Understanding your needs		,532	
Your standard of living		,323	
Your health condition		,438	
Receiving support and guidance		,656	
Your personal relationships with the hospital hotel staff		,587	
Feeling safe and confident		,636	
Your social interactions		,505	
Your spiritual or religious side		,519	
Participation in hospital hotel activities		,666	
Recreational activities		,614	
Food and beverage (nutrition)		,531	
Being affiliated		,671	
Being respected (intimacy)		,622	
Being self actualized (personal potential)		,534	
Self transcendence (personal contribution to life)		,573	
Booking process		,627	

Table 3 shows the demographic variables and home country of the foreign patients participating in the study.

Table 3. Demographic findings

Demographic Data			
Variables	**Category**	**Frequency (N)**	**Percentage %**
Gender	Female	38	55,1
	Male	31	44,9
Age	18-24	34	49,3
	25-34	8	11,6
	35-44	15	21,7
	45-54	7	10,1
	55 and more	5	7,2
Occupation	Self-employed	10	14,5
	Civil servant	8	11,5
	Worker	11	16,0
	Retired	2	2,9
	Student	37	53,6
	Unemployed	1	1,4
Holiday with	Yourself	35	50,7
	Company	4	5,8
	Family	30	43,5
Holiday duration	1-10	15	21,7
	11-20	13	18,8
	21 and more	41	59,4
Education	Uneducated	5	7,2
	High school and <	9	13,0
	2yrs college	9	13,0
	University	42	60,9
	University +	4	5,8
Frequency of visit	Once	11	16,0
	2-3 times	22	31,9
	4-5 times	24	34,7
	6 and more	12	17,3
Home Country	Holland	3	4,3
	Saudi Arabia	9	13,1
	Germany	4	5,8
	Switzerland	2	2,9
	Russia	2	2,9
	Azerbaijan	5	7,2
	Georgia	7	10,1
	Northern Cyprius	9	13,1
	Pakistan	10	14,5
	Ukraine	2	2,9
	Bulgaria	3	4,3
	Slovenia	3	4,3
	Afganistan	6	8,7
	Egypt	4	5,8

According to Table 3, 55% of the women participating in the research, 49% of the 18-24 age group, 53% of students, 50% of their spending on vacation, 50% of their families and 43% of their families are covered and the university educated rate is 63%. Foreign patients are from the Middle East, Asian countries, The Balkans and European countries. Patients from Pakistan, Saudi Arabia, Northern Cyprus and Georgia come to the fore.
The mean values of the well-being level of the foreign patients participating in the study according to the statements they received from the health services are shown in Table 4.

Table 4. The level of well-being of foreign patients from health care services

Expressions	**Mean**	**Standart Dev.**
Booking process	3,21	,893
Physical environment	3,27	,770
Facilities	3,40	,869
Understanding your needs	3,12	,963
Your standard of living	3,37	,864
Your health condition	3,35	,764
Receiving support and guidance	3,29	,977
Your personal relationships with the hospital hotel staff	3,42	,936
Feeling safe and confident	**3,69**	,875
Your social interactions	3,33	,985
Your spiritual or religious side	**3,52**	,828
Participation in hospital hotel activities	**3,50**	,980
Recreational activities	3,44	,873
Food and beverage (nutrition)	3,33	,879
Being affiliated	3,31	,940
Being respected (intimacy)	**3,58**	,871
Being self actualized (personal potential)	3,21	,871
Self transcendence (personal contribution to life)	3,25	,764
Value for money	3,10	,975

According to Table 4; The average level of well-being of foreign patients from health care services is 3.35 points. The lowest score was 3,10 and the highest score was 3.69, and all statements were scored in this range. Considering that the scale is between 1-7, it can be said that the level of well-being of foreign patients is moderate. Foreign patients stated that they felt themselves safe with a maximum of 3.69 points, that they were respected with 3.58 points that they felt themselves mentally and religiously with 3.52 points, and that they found the hotel's hotel services well with 3.50 points. The lowest rated scores of foreign patients were; Their understanding of themselves with 3,12 points, appointment procedures with 3.21 points and expressing their personal potential were expressed.

In the analysis of whether there is a difference between demographic characteristics and well-being of foreign patients, it was found that there was a significant difference in terms of occupation, holiday style and holiday time variables. There was no difference in terms of other variables. These findings are shown in Table 5, Table 6 and Table 7.

Table 5. Profession of foreign patients

	Occupation	N	Mean	SD	F	P
Overall Satisfaction	Self-employed	10	4,0702	,89680	3,064	,018
	Civil servant	8	3,7719	,66644		
	Worker	11	3,6776	,36076		
	Retired	2	3,8947	.		
	Student	37	3,1433	,62015		
	Unemployed	1	4,2632	.		
	Total	69	3,3512	,66400		

According to Table 5; It was found that self-employed people have a higher level of well-being which the health services they receive.

Table 6. Vacation type (accompany) of foreign patients

	Holiday with	N	Mean	SD	F	P
Overall Satisfaction	Yourself	35	3,6316	,41442	3,613	,034
	Company	4	2,8026	,71053		
	Family	30	3,2561	,72307		
	Total	69	3,3512	,66400		

According to Table 6; It was seen that the wellness of the foreign patients who were on holiday through their companies was lower than the health services they received.

Table 7. Vacation period of foreign patients

	Duration	N	Mean	SD	F	P
Overall Satisfaction	1-10 days	15	3,6140	,54063	7,457	,001
	11-20 days	13	3,8316	,59328		
	21 days over	41	3,0860	,61183		
	Total	69	3,3512	,66400		

According to Table 7; The well-being of foreign patients who had holiday for more than 21 days was lower than the health services they received.

Conclusion

While the effects of destination on health tourists' well-being have been frequently discussed and studies are limited. We have predicted destination choices whether or not would affect tourist well-being. Tourists' mental health and well-being contribute to their learning and achievement and have a positive effect on retention. Chen, Fu and Lehto (2016) founded direct constructive outcome of fulfillment with movement on travelers' SWB.

According to the study; health tourists who were self-employed, self-traveled and have 11-20 days period of stay could be evaluated higher well-being status. Filep and Deery (2010) indicated that positive emotions, engagement and meaning are the main three elements of tourist's well-being. Compare to our scale expressions, it includes each of the three elements.

According to the findings of the research, it was found that foreign patients had a moderate level of satisfaction with the health services they received and felt better in terms of trust and religious values; It was found that they feel relatively worse in terms of understanding, appointment processes and being able to show themselves. It has clearly seen that occupations, holiday style and holiday periods are effective in evaluating health services. Also there is a higher gap between level of well-being and value for money.

If we look from the viewpoint of managerial implications, in order to reach a certain point in health tourism; especially public and private sector health institutions and tourism companies need to cooperate more closely with social security institutions in other countries. The quality of health care facilities should be improved to attract health tourists. In addition to health services offerings, other tourism facilities of a country should be designed within a package system.

Customer satisfaction has essential sides for health tourism industry. The most important sides affecting the preferences and demand of those participating in health tourism are as follows:

Affordability of the service,

Accessibility of the service,

Matching the service to the needs,

Quality of care,

Destination attractions as a component of tourism,

Privacy

Other benefits closely affect the preferences of health tourism participants.

Every health tourist has the right to expect appropriate support from organisations to allow them to develop as fully as possible across each of the well-being indicators. It can be discerned from the study that health services in general need to improve service quality, better organization of appointments, booking procedures, and the need to improve the number of foreign language-speaking health workers and foreign language levels in order to understand tourists and express themselves. The limitation of the study is number of the attendance. Sample is less generalisable. However the topic and implications could be valuable. There is a huge need for understanding the tourist's well-being (Nawijin and Filep, 2016). For further researches it has to be design longitudinal studies to understand causes and effects of health tourists' well-being.

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Int Journal Of Health Manag. And Tourism 2020, 5(3), 264-290

IJHMT Editorial

International Journal Of Health Management And Tourism

HEALTH TOURISM AND CONCEPT COMPLEXITY OF HEALTH TOURISM IN TURKEY

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Received: 17.07.2020
Accepted: 06.11.2020
Research Article

Abstract: Health tourism that has recently been discussed much is a service-based sector included in the strategy documents of the 10th Development Plan of the Turkish Republic and the Ministries and attached importance by the state. There has been no sufficient scientific evaluation on this area of investment concerning important institutions and organizations such as the Ministry of Culture and Tourism, Ministry of Health, Ministry of Energy and Natural Resources, Department of Finance and Turkish Industry and Business Association. Furthermore, various meanings are attributed to terms in official documents regarding scientific studies in the related Turkish literature and thus, there is no consensus on the terms used. This study aims to identify health tourism by compiling basic data about health tourism, summarize perception of health tourism in the literature and regulations of Turkey, clarify the terms that are widely used and produce information for managers at different levels.

Keywords: *Health tourism in Turkey, medical tourism, health tourism terms.*

Introduction

Human being has been in mobility on earth due to several reasons since his existence. One of the most important activities within this mobility is tourism activities. As defined by the United Nations World Tourism Organization, “tourism refers to visitors’ activities and the visitor refers to those who visit a place with the intention of a vacation, business or a different objective except for finding a job and stay for a while not exceeding a year period” (United Nation, 2010:10). Although this definition was made to collect statistically correct data, no definite term is used by all states and the definitions are not exactly the same as approved by the provinces in America sample. In shortest definition, tourism, which originates in France is recreation, entertainment, seeing and identifying a place (tdk.gov.tr, 2019).

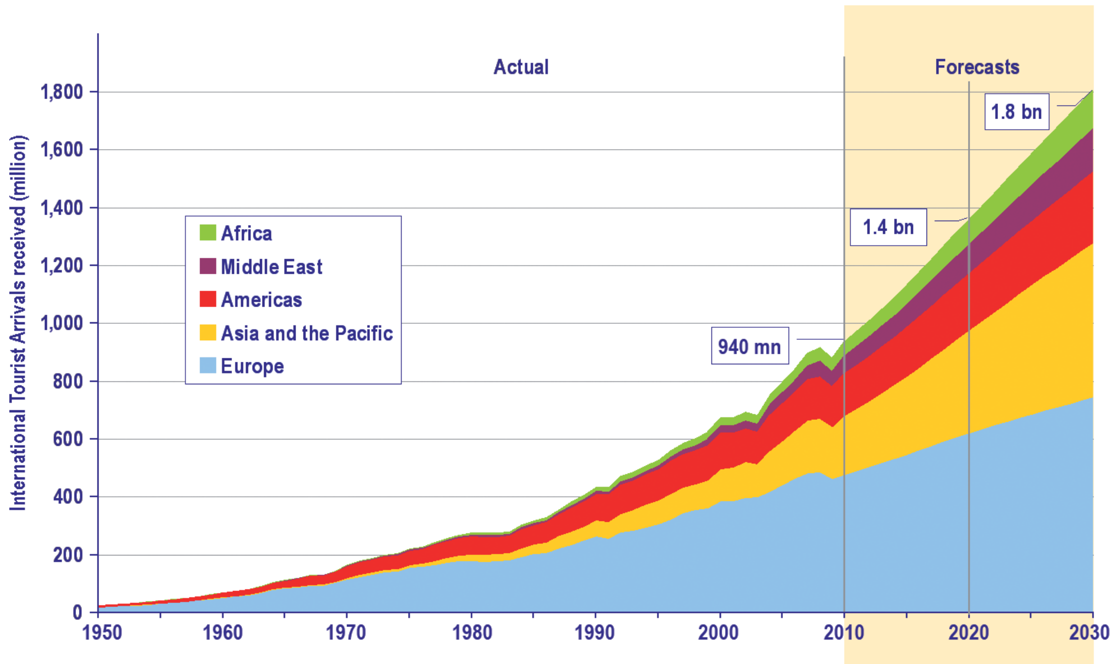
Tourism activities intended for seeing new areas, gaining new experience, making profits or getting healthier have reached to peak by organizing business life and creating spare time, thanks to increase in income levels as well as advanced transportation and communication technologies of the 20th century unlike in the past. According to the data from the United Nations World Tourism Organization, the number of tourists was 25 million in 1950 while it reached 671 million in the first half of the year 2019. This number is 30 million more than the previous year and the second half of the year 2019 is expected to complete at an increase of 3-4% compared to the previous year. A similar case was in 2014 and 2015; the number of international tourists was 1.138.000.000 and this increased 3% in 2015 (www.media.unwto.org,2019). Based on the number of international tourists, on average, almost one out of six people in the world travels internationally once a year as of the year 2018.

Another reality for tourism is that individuals set off to serve themselves in tourism activities. Personally beneficial outcomes such as relaxation, entertainment, recreation and raciness, and keeping healthy that are expected results of tourism are attached importance. Even culture tourism which offers relaxation through a delightful learning process is an example to providing personal benefits (Connell, 2006:1093). Providing these benefits is related to income level. For instance, strong dollar allowed America to settle to the second rank in overseas traveling as of 2019, while China with an excessive numbers of millionaires of dollars ranked first. On the other side, Middle

East countries among other regions visited, ranked first with an increase of 8% compared to the same period of the previous year. On this basis, we can say that tourism activities are related to income status of societies. Considering these facts, tourism activities are predominantly organized between the states that have equal economic power or ranging from developed countries to developing countries. The graphic including the estimations for the year 2030 prepared by the World Tourism Organization better shows the past, present and future expectations of the global and immense worldwide mobility of human.

This enormous mobility resulted in sharing a total of 6% export revenue of approximately 1.4 trillion dollars in 2013 in the global scale by the states of the world (unwto, 2014:2). Another important anticipation is that the shared income in the global scale as of the year 2020 will walk up to 2 trillion dollars. In this way, tourism which is also accepted as a source of hot money for developing countries is attached importance. In fact, 9% of the world's total product is related directly or indirectly to the effect of tourism (unwto, 2014:2).

In an old report, while Turkey was expected to have a share of 6.7% regarding its share in the number of international tourists, its income share was expected to realize at 5.7% (unwt, 2014:8). This makes health tourism which has the potential to make higher revenue receipt from tourists be more attractive in Turkey. This is because there will be more hot money flow into Turkey which already has tourism potential through surgical operations that can be performed in a short while. In this context, there is mobility in tourism sector as well as alternative tourism elements.



Graphic 1. World Tourism Organization 2030 Tourism: Current trend and forecast 1950-2030 (UNWTO,2014:14)

Getting higher shares from the revenue requires better responding to tourist expectations, a good introduction of the country, introducing and marketing the current tourism potentials to foreign markets. Especially the understanding of holiday started to change in Turkey with the change of tourist expectations in Turkey as of the 1990s. Becoming more evident, new expectations of tourists are "being far from the triangle of sea, sand and sun, a good room in the facilities that are not exaggerated and in touch with nature, good service, an intact and clean environment foremost among them and an efficient holiday" (Yalçındağ, 1994:44).

The Ministry of Culture and Tourism in Turkey supports alternative tourism activities within the Law 2634 for the encouragement of tourism. Turkey started its comprehensive incentive policies in tourism with the Law 2634 dated 16.3.1982 published in the Official Gazette numbered 17635. These incentives were land allocation for tourism investments, employing foreigners, communication facilities, differential treatment to exporters and tourism credits. Incentives such as VAT exception, investment allowance, full customs exemption and tax reduction for personnel of tourism were and are still provided (Sağlık Turizmi Derneği ve Türkiye Sağlık Vakfı, 2010:10).

Based on the data of tourism, there has been a global increase in tourism revenue since 1950 and health sector is another one that has been witnessed to have a global increase in demand. According to the 2010 data of the World Health Organization, health expenses were 6.5 trillion dollars in global scale and these were 948 dollars per capita (who.int, 2015). This was 4380 dollars per capita in the countries of Organization for Economic Co-operation and Development (OECD countries). These data are sufficient to see the size of the sector; however, an amount over 100 billion dollars which is spent for health globally is spent for manpower training. For execution of services for fight against AIDS, malaria, tuberculosis and vaccination only at least 4.2 million health care personnel are needed (who.int, 2015).

The idea of applying a general health insurance was adopted in many countries. This makes countries search for a health care financing model in which access to a comprehensive, more equal and efficient health service for the public. However, existence and maintenance of these systems financially bring along high premium payments. On the other side, access demand of those with higher income status to better health services contributes to the development of the private insurance and health care services. Besides the demand of insurance against possible health issues that can be encountered in countries visited in today's world where human mobility has increased, compulsory health insurance imposed by the visited countries have caused health services to be globally commercialized and required.

Health Tourism

Since the existence of human being, health tourism has existed in a way to provide people with therapy in an area away from the settlement, benefiting rehabilitation services, keeping fit through natural resources and benefiting similar facilities.

Nonetheless, today, it is an industry where tourism and health sectors meet and there is a kind of exportation that yields revenue to countries and creates new areas of employment. The main hypothesis asserted regarding the generation of health tourism in today's understanding is to respond to health service demands by developing countries due to patients' long waiting periods in developed countries and high costs of health services. Even though this idea is partly right, it is much lacking. These reasons are more appropriate for medical tourism which is a subbranch of

health tourism. The followings are deemed among the reasons of existence of health tourism in the report prepared by the Health Foundation of Turkey:

- Getting rid of long waiting periods for patients

- Getting more quality services in a shorter while

- Reaching high health technologies

- Decreasing health service costs

- Unwillingness of chronic patients and old people or persons with disabilities for participating other settings and getting treatment

- Willingness of drug and other types of addicts for being in a different or more appropriate settings

- Desire for traveling and making cultural visits as well as getting treatment

- Desire for holding on to life and desire to live (Sağlık Turizmi Derneği ve Türkiye Sağlık Vakfı, 2010:12).

There are other arriere-pensee apart from these factors within health tourism. Health tourism is benefited when a country, based on its laws, does not allow people to sex change or illegal organ transplantation which is totally illegal and unethical.

Development of hospital tourism that has an important place in health tourism and medical tourism which is defined with concepts such as medical tourism increases investments. Advanced technology can be utilized in the third step health services using budgets allocated for basic health services for the citizens of developing countries in order that medical tourism can progress (De Arellano, 2007:193).

- General Status of Health Tourism in Turkey:

Health tourism appeared as the subject of health tourism and tourist health taking part under the protective and basic health services in strategic plan of the Ministry of Health including the period of 2010-2014. Moreover, giving support to thermal tourism and medical tourism within the scope

of this plan was considered one of the strategies of making Turkey a center of attraction in delivery of health care. As a strategic aim, without being spoken out, health tourism was mentioned under the heading "providing necessary health services in a safe and quality way" (Sağlık Bakanlığı, 2010:13). Within the framework of the Tourism Strategy of Turkey 2023 prepared by the Ministry of Culture and Tourism, the health tourism and thermal tourism were included under the title of "Tourism Diversification and Strategies" and added in the "Activity Plan for Tourism Strategy of Turkey 2007-2013" among the targets.

While these developments are observed in strategic plans, other positive developments also came around regarding financial feasibility of the business. Government agencies (ministries) carrying out studies on the "Health Tourism" in August 4, 2010 by the Prime Ministry Undersecretariat of Foreign Trade General Directorate of Export brought together the NGOs and sector representatives and the parties and reported they would support "Health Tourism" and work for its presentation abroad. The representatives of the Ministry of Health were mentioned in the Ministry of Health Activity Report 2010 (Sağlık Bakanlığı, 2010:30).

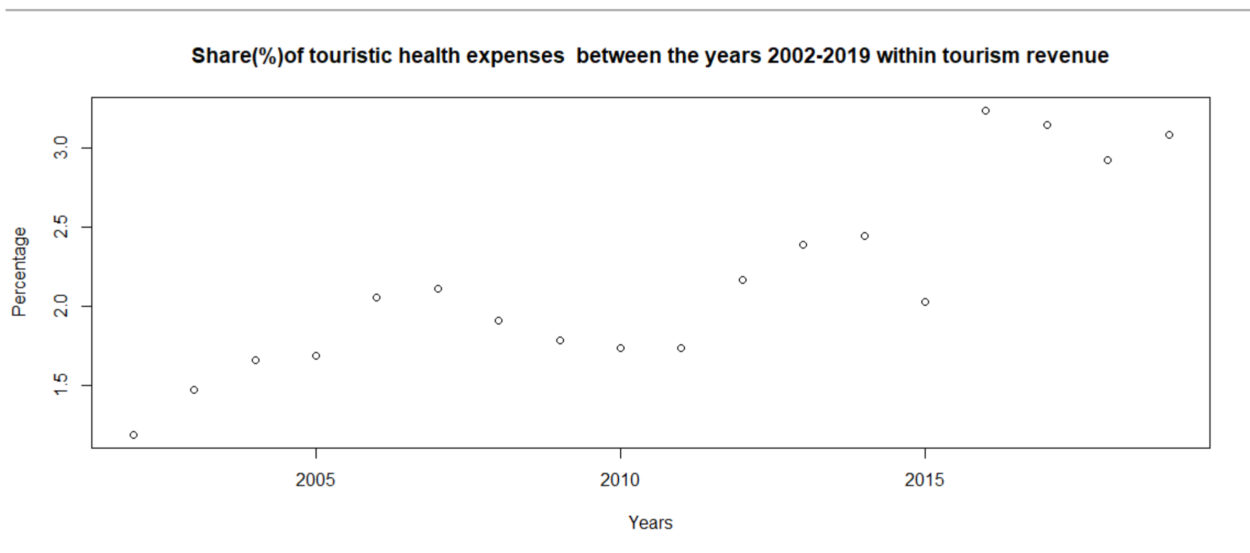
The "Health Tourism Development Program" action plan included in the primary conversion programs of the 10th Development Plan (2014-2018) comprises the "Development of Institutional and Legal Infrastructure of Health Tourism". The Health Tourism Coordinating Council was established with the circular published in the Official Gazette on February 7, 2015 by the Prime Ministry for developing this organizational structure. According to the circular, the council consists of representatives at general manager level from the Ministries of Family and Social Policies, Labor and Social Security, Foreign Affairs, Economy, Development, Culture and Tourism and Health besides Turkish Cooperation and Coordination Agency, Turkish Union of Chambers and Exchange Commodities, Foreign Economic Relations Board and Higher Education Council. Some of these ministries have been removed and some have been associated.

One of the main objectives through all these reorganizations with strategic documents is to increase national income and live in welfare using the potential that Turkey holds. In this regard, considering tourism revenue, the size of health revenue in it, share of tourism revenue in the Turkish export and the current account deficit amounts will let us see the general picture as a whole.

Table 1. Tourism and Export Revenue of the Republic of Turkey between the years 2002-2018 (tuik.gov.tr, 2019)

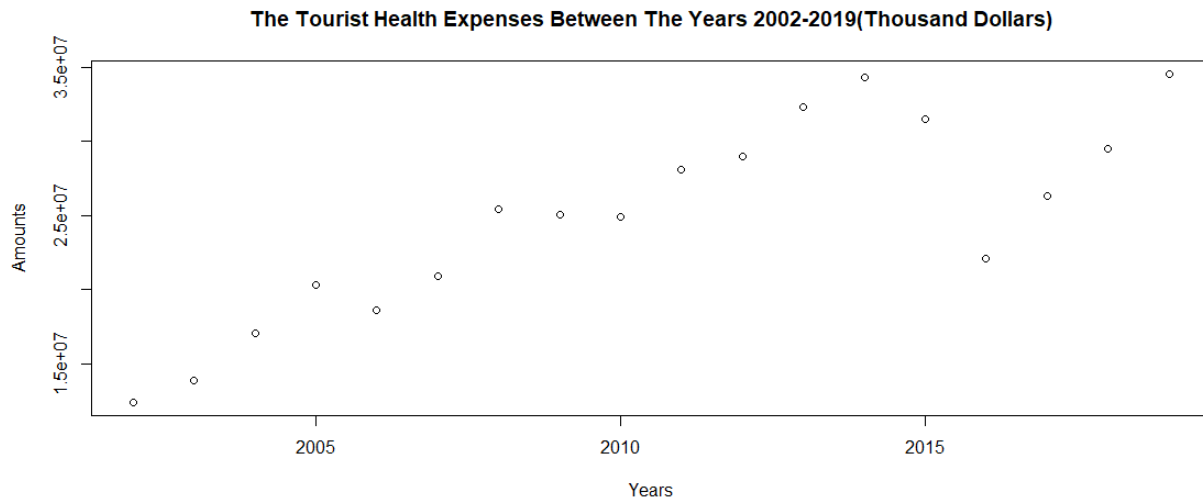
Years	TotalTourism Revenue	Export Revenue	Ratio of Tourism Income to Export Income (%)	Current Account Deficit
2002	12420519	36 059 089	34.4	15 494 708
2003	13854868	47 252 836	29.3	22 086856
2004	17076609	63 167 153	27	34 372613
2005	20322110	73 476 408	27.7	43 297743
2006	18593950	85 534 676	21.7	54 041498
2007	20942500	107 271 750	19.5	62 790965
2008	25415067	132 027 196	19.2	69 936378
2009	25064481	102 142 613	24.5	38 785809
2010	24930996	113 883 219	21.9	71 661113
2011	28115693	134 906 869	20.8	105 934 807
2012	29007003	152 461 737	19.2	84 083 404
2013	32308991	151 802 637	21.3	99858613
2014	32310424	157 642 154	21.8	84566959
2015	31464777	143 838 871	21.9	63395487
2016	22107440	142 529 584	15.5	56088651
2017	26283656	156 992 940	16.7	76806711
2018	29512926	167 920 613	17.6	55126481

A tourism based economy brings along economic risks and vulnerabilities in an area like Turkey where there is uncertainty and global intrigues. From this point of view, it is a positive progress that while tourism revenues are increasing they are relatively low to export revenues. The graphic including the health expense made by the tourists, its share in tourism and the progress that share within years provides summarized information about the health tourism.



Graphic 2. Share (%) of touristic health expenses between the years 2002-2019 within tourism revenue (Source: tuik.gov.tr, 2020)

Health expenses made by the tourists in Turkey provides information about the course of health tourism. Health expenses made by the tourists are as follows.



Graphic 3. The tourist health expenses between the years 2002-2019

Graphic 2 and 3 shows that there is an increase in tourism revenue in general, but the increase in health tourism revenue shows parallelism with tourism in fact. While tourism revenue constitutes the data, the increase in health expenses of tourists only shows that health tourism has moved forward. Compared to other sectors in revenue items, tourism is successful when health revenues are relatively evaluated, however, Turkey falls behind the targets at health tourism. Although its share in tourism revenue increased from 1.19% in 2002 to 3.08% in 2019, the desired rate is higher.

The International Patient Support Unit established in July 2011 within the scope of the Health Tourism Coordinator of the Ministry of Health in Turkey renders service for the calls in foreign languages made through the Ministry of Health Communication Center lines 112 and 184, and interpretation service is provided through teleconference for foreign patient practices to both public and private sectors. 444 47 28 is the direct communication number. When it was first established, a total of 847 calls were answered in English, German, Russian and Arabic languages. The number of calls incoming in a ten months period by November 2014 was 50152 and the service continued in six languages by adding French and Persian (saglikturizmi.gov.tr: 2015).

According to the data of the year 2017, the total number of physicians is 149997 in Turkey and the number of physicians is 186 per 100000 persons. The number of dentists is 27889. Considering that the total number of physicians is 149997, the number of specialist physicians in Turkey

(80951) should be regarded since the breakthroughs of the country in health tourism requires specialist physicians such as cardiovascular surgeon for cardiovascular operations that are intended for presentation to the tourists. The number of physician assistants is 24397 (Sağlık Bakanlığı, 2018:215-218). Thus, the number of specialist physicians in Turkey can be expected to be 100.000 by 2020. Differences in regional distribution of sickbeds have considerably reduced compared to previous years, they still continue, though (Sağlık Bakanlığı, 2018:113-120). Although the total number of hospitals in Turkey is 1518 in 2017 and the bed capacity is 225863, the number of qualified beds is 127347 and 32147 of them belong to private hospitals (Sağlık Bakanlığı, 2018:114). Private sector is important in health tourism in Turkey. This sector has an significant sources for health tourism with the number of employed specialist physicians and the number of qualified beds.

The Ministry of Health provides support to health tourism and the Department of Finance apply facilitative measures. However, the lack of encouragement for scientific reporting of the sector according to the records of the Ministry of Economy shows that the case has not been approached as it should be in terms of scientific consultancy. Health tourism is included in the supports for activities for the inflow of foreign currency in the service sectors supported by the Ministry of Economy including road support for patients, search engine support, organization support, overseas unit support (ekonomi.gov.tr, 2015). Tax reduction is provided for businesses offering services to foreigners not settled in Turkey in accordance with the Department of Finance Corporation Tax Law General Communiqué published in the Official Gazette in December 31, 2012. The statements are as follows: “It was judged that 50% of the profits obtained exclusively from the activities of the companies operating in education and health care services and providing services to non-resident people in Turkey can be deducted from the income statement of the institution being subject to the permission and supervision of the related ministry regarding service business operating in architecture, engineering, design, software, medical reporting, accounting record keeping, call center and data storage services provided in Turkey and benefited exclusively abroad for those non-residents of Turkey but have legal business and headquarters abroad, to be applied as of 15/6/2012 with clause (ğ) added to the 10th article of the Corporate Tax Law No. 6322. It is possible that enterprises dealing with health tourism benefit from the reduction on condition that they are accredited by the Ministry of Health.” (resmigazete.gov.tr, 2015).

No matter how much Turkey mentions that it has neighborhood with Europe, Middle East and Central Asia, there has been an improvement in many neighbor countries' medical tourism which has an important place in health tourism. The year 2013 was declared as the year of health tourism by Hungary (Connell 2006:1095). The Minister of Health of Iran evaluates it in terms of costs and mentions that a cardiovascular operation costs 40.000 USD in England, 18.000 USD in Turkey and 10.000 USD in Iran and after the treatment, patients can easily go on a tour of the country (Persian journal, 2004).

There are around 1500 geothermal resources in Turkey that locates in the seismic belt between 20 and 110 centigrade. The information shared by the Ministry of Health for thermal tourism in Turkey which is rich in terms of thermal tourism is as follows: "There are around 190 thermal springs in 46 provinces of Turkey. The number of beds of 12 facilities having tourism investment license is 2347 and the number of beds of 30 facilities having tourism operation license is 8567 from the Ministry of Culture and Tourism. There are 156 facilities with approximately 16.000 beds certified by the local government." It is expected to expand to 200.000 bed capacity in the medium term and to welcome 15 million of thermal tourists in the long-term targets in Turkey (saglikturizmi.gov.tr, 2015). Considering that the stay duration is 21 days for average cures and the resources are used with full employment, reaching at least 50.000 bed capacity is a long-term target.

- Risks for Health Tourism:

The risks that exist in the nature of tourism in general sense will be a risk factor for health tourism too. One of those risks is hard tourism. It is known that a tourist carries his/her expectations and hopes in his/her country, so causes changes in the new environment; thus, this phenomenon is known as "hard tourism" (Yalçındağ, 1994: 43). There are different demands by requests and affecting satisfaction for the claimants of health services including that cooks learn their food cultures, the health care personnel speak their languages, and care for certain practices regarding their religious beliefs. That collective tourism generally appeals to developed country markets allows factors gain importance in favor of the countries.

On the other hand, tourism is fragile in the face of unwanted events. It was anticipated that SARS

epidemic emerging in the Far East caused shrinkage in the gross domestic products of many countries and a global financial loss of 40 billion USD in total (Lee et al., 2004:103). If the security of a country becomes questionable due to terrorist attacks, epidemics, chemical, biological, radioactive and nuclear incidents that a country may face, all of its investments may become futile. The distribution of health personnel in a country is expected to be in accord with health needs.

However, employment of more health personnel is necessary to meet demands in cities having international airport as part of medical tourism and in cities having much hot water supply as part of thermal and mineral springs that are one of the main components of health tourism. The main subject here is to answer the question whether the trained manpower of health should primarily be used for health needs of the citizens of the country in question or employing abroad demand-oriented employment. This fact should be considered in detail for those making high level plans. As incorrect planning could trigger unrest in a country, it could also make foreigners get unsatisfied from the services provided.

2. Materials and Methods

Population of the study consisted of legal documents of Turkish bureaucracy, official reports and publications in Turkish literature. Examination of the terms regarding health tourism mentioned in those resources were supposed to be sufficient for this descriptive study. The terms of health tourism and the meanings ascribed to the terms were used as a method.

3. Findings

3.1. Conceptual Perception of Health Tourism in the Official Gazette in Turkey

According to the publications of the Official Gazette of the Republic of Turkey, the concept of “Health Tourism” in “Tourism Foundations and Qualifications Regulations” dated August 21, 1979 (resmigazete.gov.tr: 2015). The description related to the health tourism facilities also takes place in Official Gazette named “Tourism Foundations and Qualifications Regulations” dated January 16, 1980. Based on this description, health tourism facilities are the units where one or more types of practice are performed together under the supervision of a physician for treatment and protect human health in the form of massage and physical education by thermal spring,

drinking water, sea water, mud and similar substances or by respiratory tract or with electrical and other mechanical equipment (resmigazete.gov.tr: 2015).

The memorandum of understanding signed with Kuwait in September 25, 1985 and published in the Official Gazette dated November 29, 1985 has become the first memorandum to declare that Turkish side was ready to establish health tourism facilities with the participation of Kuwait and ready for common international initiatives in health tourism (resmigazete.gov.tr: 2015). The thought of collaborating in this area for the second time was published in the Official Gazette dated August 29, 1987 with the Turkey-Iraq Mixed Economic and Technical Cooperation Committee Memorandum of Understanding of the 7th Term Meeting held between 13-16 April 1987. Considering memorandum of understanding regarding these collaborations, health tourism is deemed as a sub element of tourism by some people, which may have importance. However, this seems to have health area and international relations dimensions. Furthermore, the headings in the memorandum of understanding published in the Official Gazette dated December 19, 1988 for the collaboration with Kuwait were specified as tourism and health tourism.

According to the Official Gazette records, certain budget was allocated as “Health Tourism Center Reorganization Project” in the budget for the Ministry of Tourism in the Budget Act for the first time in 1991. Including health tourism in the plans and targets of the government program announced in 30.06.1991 in the Turkish Grand National Assembly by A. Mesut Yılmaz, the Prime Minister at the time published in July 6, 1991 showed that health tourism focused on health components and started to be perceived in this way. Furthermore, health tourism was sometimes mentioned under the heading of tourism and sometimes under the heading of health tourism at that time and thereafter.

All these publications reveal that the Republic of Turkey is aware of health tourism, but health tourism in those days was predominantly perceived as an activity of tourism. The first sample regarding the change of perception was seen in the “Second Term Memorandum of Understanding of the working group formed within the scope of Intergovernmental Mixed Economic Commission between Turkey and Norway” (resmigazete.gov.tr: 2016). At this date, for the first time, health tourism was mentioned under the heading of health instead of tourism in a text on international collaboration. This perspective will manifest itself with encouragement declaration of common

projects in health tourism in the 5th article of the “Collaboration Agreement in Health and Medicine between Israel government and the Republic of Turkey” in April 24, 1995, presentation of health tourism under the heading of health and medical field in the “Collaboration Agreement in Health and Medicine between the Republic of Turkey and the Republic of Uzbekistan” published in the Official Gazette dated January 10, 1998 and its enunciation with health and medical field in the 4th article of the same agreement (resmigazete.gov.tr: 2016). All these evidences prove that health tourism, rather than being a branch of tourism, is considered as a field close to health and medicine.

It will be fair to say that tourist health was included in the plans mentioning the development of tourism health and health tourism centers together in the 2000 program published in the Official Gazette on November 21, 1999.

One of the improvements that can be deemed as a milestone is the meeting note of the agreement signed in Simferol on September 18, 2005 published in the Official Gazette dated December 27, 2005. Another is the statement “developing health tourism by using the potential of health tourism facility in Crimea” in accordance with the provisions of agreement of friendship and cooperation signed in May 4, 1992 and Cultural Cooperation Agreement signed in November 27, 1996 between Turkey and Ukraine. And it is the development of health tourism of Turkey in Crimea in accordance with the agreement signed with Crimean Autonomous Republic (Ukraine) in 2005. With this agreement, Turkey was mentioned to develop health tourism of another region aside from its own land for the first time. Currently, Crimea is located within Russia Federation and Turkey and Russia are in good relationship of tourism (resmigazete.gov.tr: 2019).

Making regulations for the development of health tourism practices and establishing coordination with the institutions were declared as the duties of the General Directorate of Health Services within the scope of “Legislative Decree on the Organization and Functions of the Ministry of Health and its Affiliates” dated November 2, 2011.

According to the definition of health tourism made within the scope of the “Regulation on the Qualifications of Tourism Investments and Enterprises” dated 21.11.1991, health tourism is to provide service under the eye of qualified personnel in order to protect and rehabilitate with

treatment the environment and human health with natural resources (resmi gazete, 2015). In this regard, the activities to be made with only nature and environment were included in health tourism. According to the "Directive on Health Services to be provided within the scope of health tourism and tourist health" to be put into effect with the approval of the Minister dated 23.07.2013 and numbered 25541, health tourism means to travel from settled country to another for any reason to regain and improve health (saglik.gov.tr: 2018).

3.2. Concept Complexity of Health Tourism in the Literature

The United Nations Statistics Commission published the "International Suggestions for Tourism Statistics in 2008". This publication was prepared with the revision and adaptation of the International Suggestions for Tourism Statistics prepared in 1993 and published in 1994 in regard to the 53rd period of the United Nations Statistical Commission of the year 2004. Description of visitor was made in the 13th page of that publication and the visitors over 24 hours were defined as tourists (unstats.un.org, 2010:13). This definition is considered in both academic circles and the meetings of non-governmental organizations in Turkey and the necessity of staying more than 24 hours in another country is considered as a condition for health tourism. However, the opinion that this will not be a correct understanding in health tourism comprising health practices, was underlined in the Processes and Intermediary Institutions Research Report in Health Tourism published by the Ministry of Health (saglikturizmi.gov.tr:2012). Although this was published in 2012, the erroneous understanding was repeated under the scope of the "Medical Tourism Evaluation Report" reminded to some lecturers of Hacettepe University Department of Health Administration in 2013 and published in 2014. One of them is health tourism which can be defined as "traveling from the settled area to another place and stay at least for 24 hours there and benefit from health and tourism facilities in order to keep and improve health and treat diseases" (Kaya et al., 2014:18, Saglik.gov.tr). It is an incorrect application to bring a 24-hour of stay in the description of tourist and attempt to define health tourism by using the word health based on the definition of tourist, which contradicts with health tourism facts. This definition does not apply today as we have daily treatments and medical practices.

In another resource, health tourism is defined as “health tourism, in other words medical tourism or health travel is a recent phenomenon” (Aslanova, 2013:131). We do not approve health tourism to be called as medical tourism or health travel. Although medical tourism is reported as a component of health tourism in many reports, interchangeability leads to concept complexity and to complexity on what basis the statistics will be gathered. Nevertheless, publications by the United Nations indicated some minor differences even between travel and tourism.

Starting from the Official Gazette and legislation documents of ministries, there seems to be a complexity in the usage of concepts in scientific texts about health tourism. For example, the tourism heading within the scope of the 1992 Investment Program published in the Official Gazette dated April 7, 1992 contained the subheading of “Infrastructure Arrangements of Thermal and Health Tourism Centers”. In fact, thermal tourism which is a component of health tourism was indicated separately. This is not a single sample and the approach in many texts was in this way.

The “Health Tourism Development Program” action plan included in the primary conversion programs of the 10th Development Plan (2014-2018) envisages the “Development of Institutional and Legal Infrastructure of Health Tourism”. The Health Tourism Coordination Board was established with the circular of the Prime Minister for that purpose (resmigazete.gov.tr: 2015). To achieve success in this, the concept complexity about health tourism should be solved immediately. Because it seems impossible to do legal arrangements for a specific field where there is concept complexity. Furthermore, concept complexity is not specific to Turkey but it is a global problem. Health tourism and medical tourism are interchangeably used in many articles published abroad. For instance, health tourism or medical tourism was used as an expression in an article published in a Public Health journal in Iran and expressions were made on the basis of interchangeable use of these terms (Sultana et al., 2014:867). While treatments made in the hospital by Jallad were evaluated under medical tourism, the phenomenon carried out through mineral resources and mentioned as thermal treatment in the Turkish literature was treated as therapeutic tourism (Jallad, 2000:11-12).

The book “Thermal Spring and Health Tourism Planning in Turkey” of İsmet Ülker, to our knowledge, was the first publication that brought health tourism to the agenda. However, starting from this publication, there are many definitions of health tourism and many terms are attributed

different meanings as pointed out. This publication provides first description of cure and defined tourism. After the "cure" (pursuing treatment goal also) was defined as benefiting thermal spring, sea water and climate by obeying certain rules, health tourism was defined as "people changing place within a certain period of time for cure need infrastructure-superstructure facilities that will meet their needs for accommodation nutrition, curing, recreation and entertainment. This phenomenon which becomes functional within the supply and demand rule of the economy today makes a tourism type called as Health Tourism" (Ülker, 1988).

This definition shows mainly thermal tourism view because the suggested period for the cures in thermal springs is a 21-day period. Nevertheless, we live in an era in which discharging a patient after one day through daily treatments has become possible. In some publications this view is mentioned today. A study points that when it comes to health tourism, the first thing that comes to mind is thermal tourism. (Aydın, 2012:92).

Health tourism is mentioned in the 10th Development Plan and strategy documents and determination of headings as "health tourism and thermal tourism" shows the complexity of concepts. These two fields overlap when patients who want to get treatment from thermal water desire to regain their health (Topuz, 2012:20). How the data were collected regarding more than one fields is not clear.

What is controversial in the health tourism definition is that the statement "for any reason" is included even though the reasons for travel are explained and health-protective activities are not included in the definition within the scope of "Directive on Health Services to be provided within the scope of Health Tourism and Tourist Health" put into effect with the approval of the Minister dated 23.07.2013 and numbered 25541". Although the directive is a subcomponent of health tourism, tourist health is indicated separately. Definition of tourist health was "procurement of health services by tourists who are temporarily in Turkey for any reason in case of any emergency or sudden diseases". This definition focused on unplanned activities and emergency in particular. However, a health care demand that appeared during vacation was ignored even though it was not planned and did not require emergency.

The data included in Turkey's medical tourism report which was published by the Ministry of Health and reminded to Hacettepe University most recently were evaluated. However, the issue was left ambiguous and so, the report became controversial skipping on what basis the distinction of health tourism and medical tourist is made and what method is used to classify patients. Contradiction between the data revealed is another topic of discussion.

Since thermal tourism is a kind of tourism performed with underground hot water sources, it will be fair to call it thermal or mineral tourism In the terms used in our literature as Spa & Wellness, the term SPA is defined as health coming from water and Wellness is defined as feeling better and refreshed. Therefore, these seem to have close meanings to health concept expressed by thermal spring and mineral spring. Due to this closeness, the terms thermal tourism and SPA&Wellness are used in the documents of the Ministry of Health. The bath applications are those found in thermal springs too. Nonetheless, it will not be true to denominate every medical practice under a separate tourism branch. Surely, data about the details should be collected in determination of the demands for each practice. However, what is more accurate for seeing the picture as a whole is to show the practices that resemble in general within a component. For example, mud bath shows closeness to thermal spring and mineral spring in terms of its formation with mineral rich waters. Not accepting such a practice pointing that it has only therapeutic purpose will lead to collect incorrect data for thermal tourism statistically and cause failure in planning future of the sector.

One of the descriptions made for medical tourism is collaboration with tourism industry so as to provide "cost-effective" special medical care to patients who need further medical interventions that require surgery or special expertise in general. As medical tourism emerged for foreign markets in particular, restraining compulsory patient transfers or patient mobility in the country into this context will lead to difficulties for making strategic plans. The most suitable description for medical tourism is to have contact with health services in line with the need for getting health services developing without any plan by benefiting access to third step or advanced medical practices and/or rehabilitation services by planning and going to another country. At that point, it is necessary to examine the term "international patient" and "tourist health" under medical tourism.

3.3. Advanced Age and Disabled Tourism

These two types of health tourism are handled together in some resources and separately in others. Especially, rehabilitation services that are oriented to providing old people or persons with disabilities with more effective lives is underlined, and this term is very comprehensible in Turkish. However, it will be right to include a third step medical treatment practice in medical tourism in terms of content. Because making a direct classification for age regardless of the application's content will make data collection difficult in making strategic plans. While some publications of the Ministry of Health use the nomenclature of "aged tourism", the term is used as "advanced age tourism" under the Health Tourism Development Program included in the 10th Development Plan. Rather than calling people aged, denominating them as advanced age will be more acceptable. Although the term handicapped which is used to describe disabled people in Turkey has no arriere-pensee, there is tendency for the term disabled. Similarly, the use of advanced age tourism instead of aged tourism is acceptable.

4. Results and Suggestions

First of all, the targets of catching over 40 million tourists in 2013, getting about 50 billion USD in tourism income and spending 1000 USD per person that were among ultimate goals under the scope of "Turkey's Tourism Strategy and Action Plan 2007-2013" did not happen. Although the Ministry of Health stressed that 9-10 billion dollars of health tourism income can be obtained in 2017-2018 as a result of the increase in patient bed capacity in public-private partnerships in the "Health Tourism Report" study of the Association of Turkish Travel Agencies, even one billion dollar could not be obtained (tursab.org.tr, 2018). In this case, strategic planning in health tourism, which has the highest amounts in expenses per capita gains importance in reaching the targets.

Since health tourism that is attributed importance in tourism and health strategies develops as a solution to meet the needs regarding health emerging in societies due to several reasons in addition to facilities like transportation and communication, etc. obtained through technology that human being has improved, is not merely a tourism or a health activity.

Among principle benefits targeted by the countries having provided their services in health tourism are realizing money flow to the country by doing a kind of service export within the borders, creating new areas of employment, minimizing social problems that may occur after unemployment by preventing unemployment, attracting foreign investors to the country, establishing good and strong relations between countries by constructing dependence between social security systems.

Turkey has become able to compete with leading countries on health tourism. Its primary markets are European countries, Middle East countries and Central Asian Turkish Republics. It has opponents among technologically developed countries such as England, Germany, Israel and other opponents like Jordan, Iran in its region and Hungary and Romania in Europe. The third-generation Turkish citizens living in Europe is important in terms of manpower to be employed in activities for these health tourism market regions. This youth wants to be adopted by Turkey. It will be useful to employ them in health tourism initiatives that Turkish investments will make in Europe or in Turkey.

That Turkey’s ratio of tourism revenues to current deficit has reached to a considerable amount and specifying targets and objectives in strategic (formative) plans by giving importance to health tourism in development plans show high importance of this sector for the Republic of Turkey. However, it should be considered that these sectors are very fragile, including tourism. An economic crisis that may be faced in the country in case of any outbreak will lead to security violation bomb attacks and the consequences will be too harsh to be compensated. Thus, besides public order works of the law enforcement officers, disease information should be followed updated, surveillance information regarding instant health condition in the country should be obtained, any pandemic should be foreseen in the first days and precautions should be taken, ministries should be organized to work in coordination and have a public health perspective in order that essential preventive health measures can be implemented to prevent recurrence for later processes.

While answering calls from 112 and 184, the Chinese language Mandarin dialect (main dialect of the continent) should be included in the service delivery. People's Republic of China that ranked 7th in 2000 in the order of participating in tourism activities most and yielding income worldwide

ranked first as of 2014. It became the country whose citizens went to other countries as tourists most as of 2018. In this sense, employment of Chinese-speaking translators in the sector and learning of Chinese by the health personnel should be considered in order to establish good communication with patients.

First of all, as suggested in the book, written by İsmet Ülker and published by the Ministry of Culture and Tourism in 1988 and whose preliminary studies dates back to 1968 for its preparation, the "Nature Conservancy Health Tourism Council" that will include Ministries of Finance, Health, Culture and Tourism, Energy and Natural Resources, and Development should be established at the national level. This council has not been established although it has been 30 years since this suggestion was made in 1988 and 50 years since the preparation of the book. The foundations of this constitution should be laid immediately. Founding Health Tourism Coordinating Council is an important step to establish the institutional structure for coordination between institutions. However, leaving the Chairmanship of the Board to the Under secretariat of the Ministry of Health shows that the Republic of Turkey has a medical tourism based understanding for health tourism. The presence of a bureaucrat from the Prime Ministry at the head of the board will be more appropriate for coordination.

Tourism (thermal tourism) for thermal spring and mineral spring, an important branch of health services should be used by taking precautions and incentive encouragement to serve rehabilitation of Turkish society's health level, but not focus only on overseas marketing. It should be remembered that there are 26 resources that are called youth elixir having radioactive feature.

Health services should aim at reducing dependency on technology in the long-term and dependency to some states technologically should be determined and the necessary precautions should be taken in the short-term. Although 10.000 beds were targeted for advanced age tourism only in the 10th Development Plan, Turkey should move forward in terms of qualified beds. In particular, health interventions made to every tourist incoming to Turkey should be monitored and should not be sacrificed to wrong medical applications (malpractices). With this monitoring at national level, the first step will be taken for determination of performance levels of the hospitals too. Obtaining successful results will both increase domestic competition and set forth evidence that can be used in international promotion of Turkey.

The most appropriate term as a top division comprising all phenomena for international patients and the medical tourism, thermal spring and mineral spring tourism, and advanced age and disabled tourism that are three main tourism groups.

A description that can be suggested for health tourism is that while individuals do health-based activities like going to another country to engage in activities to protect and improve their health with nature, environmental factors and/or tools, electronic devices or conducting these activities under the supervision and/or care of experts or benefiting health services such as treatment and rehabilitation, they can also do other tourism activities such as nutrition, accommodation and entertainment. We can say that this description comprises all elements of the process of health tourism in scientific publications and official documents regarding health tourism in the related literature. Thus, defining traveling for health purposes only as health tourism is prevented. Traveling to another country is a part of the process. It is also a part of the process experienced only during travel; it will not be pertinent to be used for all.

The most appropriate descriptions for service called today as thermal tourism, SPA & Wellness can be thermal spring, mineral spring and water based health tourism. Although some enterprises provide services for thermal tourism only, making service diversity with the increasing importance of marketing makes necessary monitoring practices together. Collecting data by collecting data at top level and separating into special subbranches will facilitate monitoring the sector as a whole. Although the term thermal is of foreign origin and points the word heat, such a definition will be too comprehensive as thermal spring and mineral spring are included in this.

Such concepts as advanced age, tertiary care, vulnerable tourism are suggested about health tourism components for aged people and disabled individuals. In this sense, the Aged and Disabled Tourism which is approved by the Ministry of Health seems appropriate and to be accepted, yet the definition “health tourism” will be more appropriate for advanced age and disabled people.

The term health tourism is regarded a tool for performing transactions in the countries where there is less audit for attaining their goals or health services that people cannot access in their own country due to legal barriers. In this regard, the top managements should determine possible

actions including illegal organ transplantations and abortions and rigorous studies should be carried out to identify deficits of the regulations.

Regarding having a seat among leading and successful states in health tourism, it is necessary that our physicians and other health care professionals motivate health care personnel to learn a second foreign language besides English to develop their communication skills starting from the faculty of medicine and faculty of health sciences; the schools should also be supported in this sense. The necessary technology and equipment for facilitating monitoring of advanced medical practices by universities should be obtained, the essential methods learned abroad should be taught and medical schools, university hospitals, education and research hospitals should be supported to have the appropriate equipment and educational opportunities.

The key to success in health tourism is successful medical practices. In case that our health manpower remains insufficient to meet incoming demands, the ministries should do the necessary regulations, determine the standards for employing foreigners and encourage foreign physicians who are really good and skilled, exceeding certain standards and have made their name in the sector to work in our country until we become able to meet the demands with our own physicians.

Support of the local community for all plans to be made on the subject should be taken. Ensuring high satisfaction in health tourism with plans that local community does not accept is not possible and a negative picture will be seen in the promotion of the country. Thus, perception for health tourism should be measured and expectations and concerns of the sectors should be determined. One of the best examples for this subject is plateau tourism; while this is realized the use of the plateau by the public should not be affected. In this sense, non-governmental organizations and enterprises should not ignore communicating each other.

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Int Journal Of Health Manag. And Tourism 2020, 5(3), 291-314

JHMT Editorial

International Journal Of Health Management And Tourism

EXPECTATIONS OF PATIENTS FROM HEALTH SERVICES WITHIN THE SCOPE OF HEALTH TOURISM: CASE OF BAKIRKÖY DISTRICT IN ISTANBUL

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Received: 18.08.2020
Accepted: 20.10.2020
Research Article

Abstract: In recent years, with the increasing demand in the world market, the health tourism sector has made a rapid development and has become a competitive international industry. Countries have made it a priority to be able to get enough shares from the market by following these developments closely, determining the needs and expectations of the industry, and meeting the demands by meeting international quality standards. Our country for medical tourism treatments in order from medical tourists in Turkey until they get through what channels to healthcare organizations, causing them to prefer Area, healthcare institutions provide their health care services rendered and foreign patients in addition to Turkey 'has been taken of the average satisfaction level of health services whether it differs according to demographic variables is to identify.

Questionnaire method was used to collect the research data. ANOVA and Pearson Correlation Analysis were used to analyze the data. As a result of the research, it was determined that the general adequacy perceptions of medical tourists for the treatment services they received within the scope of health tourism and the general satisfaction levels of the medical tourism services showed a significant difference according to the monthly total income, insurance status and nationality. As a result of the research, It has been identified that, there is no significant relationship between the general satisfaction level of medical tourists

from medical tourism services and regional competence, but there is a positive relationship between the general competency perception of treatment services, perception of accommodation facilities, perception of health services competence, perception of safety competence and perception of additional service competence.

Keywords: *Health Tourism, Medical Tourism, Medical Tourist Expectation And Satisfaction*

Introduction

Health tourism is a sector that includes the common basic features of the health and tourism sectors such as “service, quality, hygiene, environment, work environment and health (Jensen, 2003: 1), enabling people to travel between the continents for both health and tourism purposes (Aydın , 2012,91) as well as the most important alternative tourism branch and a special type of tourism. In another definition, the concept of health tourism is defined as an economic activity realized by connecting health and tourism activities consisting of two different sectors (Aktepe, 2012,170-188). The concept and classification of health tourism is to differ from country to country. According to the most common classification, Health tourism, 1. Thermal Tourism SPA-Wellness, 2. Advanced Age and Disabled Tourism 3. Medical Tourism,

Medical tourism due to many reasons such as the increase in alternative prices in treatment costs, rapid developments in information technology, ease of transportation, financial problems in private health insurances, increase in elderly population and chronic conditions (Altes, 2005: 262-266), competitive environment based on patient satisfaction; has increased rapidly worldwide. Increase in the number of medical tourists in Turkey compared to previous years, indicates that this country is a strong destination in medical tourism. (Tontuş, 2018.336)

The most important factor for the country to become a demanded region in the health tourism market in recent years is the services and practices performed by private health institutions and private enterprises compared to the free healthcare services. Examples of these are closely following the industry, R&D and investments made as a result of the work and analysis, including international patient services departments within the business, experienced physicians, trained personnel, building infrastructure-superstructure, facility machinery and device inventory to international quality and standards. , customer (patient) focused investment and service understanding and financial competition. In addition, measuring the expectation perception in order to meet the preferences and needs of the customer (patient) appears as the basic building block of satisfaction (Amzat, 2014: 21-23). In health tourism, satisfaction is important both before

and after travel. In this study, it is aimed to reveal the importance of medical tourism, which constitutes the most added value of the health tourism sector, for healthcare providers and to make some suggestions for its development. In addition, with this study, in order to support future research and all businesses within the sector, infrastructure, superstructure, building, technological equipment, machinery and equipment, personnel, physician, food and beverage services, etc. are provided. To support them to provide quality service in their fields of activity.

1. Health Tourism Concept And Its Varieties

We can define the concept of health tourism as travels for the purpose of treatment (Göçmen 2008: 42). The combination of health and tourism concepts causes different perspectives and increases the variety in definitions. When we examine the literature, it is seen that some of the definitions of health tourism are general and some are more specific and precise (Mossialos, Dixon, 2002: 22-24). If we define health tourism by thinking as foreign and domestic tourists (Jensen, 2003: 25), we can express it as follows. According to the foreign tourist; To take advantage of facilities that are not in the country within a period of at least 24 hours or overnight to another country in order to receive health services outside of its own country; While health and tourism express different meanings on their own, when they come together, they concern both of these two concepts closely; however, we can say that it is a whole of activities that are independent from them and have specific features and we can see that a wide range of health tourism ranges from time to time, to healthcare practices and rehabilitation services (Bektaş, Şimşek, 2016: 179-180). Medical intervention is inevitable. and tourism travel, which is predominantly for the purpose of protecting health, and a place where the treatment process continues, can be felt in a better environment where it can feel the health of the soul and body (Yıldırım, 1997: 79).

- Thermal and SPA Wellness Tourism: Comes with Water It means "goodness / health" (Özsari and Karatana, 2013: 139). The concept of thermal tourism is “physiotherapy and rehabilitation within the scope of the supervision of experienced physicians and a certain program, in order to benefit from protecting and improving human health together with the thermal waters naturally occurring in the form of minerals, together with the effect of environmental and climatic elements in the region where the source is located. for cure practices with

supportive activities such as exercise is the tourism movement" (Buldukoğlu, 2014,6).

- Elderly and Disabled Tourism; All applications made by certified personnel and nursing homes working in geriatric treatment centers to provide care and rehabilitation of elderly and disabled health tourists constitute advanced age and disability tourism (Tengilimoğlu, Özdemir, 2013: ss.136-137).
- Medical Tourism; According to Van Sliepen, medical tourism defines it as the process of being treated by traveling for the purpose of regaining health, provided that the remaining leisure time has been done after meeting all its needs, provided that it is out of the region where it is located (Harahsheh, 2002: 23-24).

2. Medical Tourism Concept

Medical tourism is not a name equivalent to health tourism (Karababa, 2017,67-68), however it is one of the sub-divisions of health tourism (Lund, Carrera, 2010: 470). If we separate the difference between them with a thin line, the most important factor that creates awareness of medical tourism is that it includes medical intervention (Frederick, 2013: 194). In addition, it is emphasized that medical tourism, which is generally used as a concept used in the medical treatment process, should make a clear distinction between health tourism and medical tourism. Medical tourism, which has achieved a rapid trend worldwide, has emerged with the rapid increase in overseas travel in order to improve the health of people with treatment or surgical intervention (Labonte, Runnels 2013).

Due to high treatment costs and financial problems that individuals face in their own countries, enduring long waiting times for treatment or operation and correlated similar obstacles have increased the demand for these travels' day by day. In the medical treatment process, the physician is at the forefront and secondary and tertiary health institutions and organizations are mainly used for the operations to be performed. Generally, the services provided are radiotherapy, oncology, cardiovascular surgery, dialysis, eye, teeth, plastic and aesthetic surgery, orthopedic surgery, IVF, hair transplantation, etc. It includes surgical operations and medical treatments (Aydın, Şeker, 2011). The highest level of policy with the professional approach of fully equipped hospitals, related government institutions and intermediary institutions that have quality and accreditation

certificates, to respond to customer needs and expectations, It also makes it compulsory for them to produce (Şahin & Tuzlukaya, 2017). Before choosing about alternative places to be treated, medical tourists go to their own research or to refer to the references of people who have benefited from the same service or treatment. If we look at the issues that affect the destination preference most; price factor, cultural proximity of that region, distance medical specialization service, the international accreditation of the hospital or health tourism authorization certificate, the experience of the branch doctors, the element of tourism, privacy, etc. We can count the titles; (Khafizova, 2011, 2, Akdu, 2014: 11).

According to the researches, when the destinations preferred in the first place within the scope of medical tourism are examined; India, Thailand, Singapore, United States, Mexico, Brazil, Malaysia, Costa Rica, South Korea, Taiwan, the Philippines and Turkey stands out (Connel, 2006: 5; Bookman, 2007). Joint Commission International (JCI) stands out among the leading accredited reference organizations of medical tourism. Since 2000, seventy percent of health investments to be made by the private sector is a great advantage to Turkey (Woodman, 2009). For this reason, it is the country with the highest number of JCI accredited health facilities in the world after Thailand (SAİK, 2011). Combining the high-quality standards, cost, physician experiences, economic conditions, political climate and health policy advantages provided by the letter of credit. Medical tourists from Azerbaijan, Iraq, Germany, Georgia, Libya, Afghanistan, Turkmenistan, Uzbekistan, Russia and Syria come to our country intensely from our nearby geography (Ministry of Health, 2012, p.67).

3. Customer Expectation And Satisfaction In Medical Tourism

The main goal of the improvement processes carried out with the understanding of quality in the service sector is based on a management approach to meet customer needs and reasonable expectations. As a result of this understanding reflected in the processes, the quality of service and customer satisfaction are increased, however, it facilitates better service and sustainable competitive power among competitors (Pouring, Shining, Raining,2017: 305) private hospitals in the climate of Turkey, to ensure competitive market correctly interpret the patient and continuity have noticed the importance of accreditation in order to prove itself in the industry and has accelerated since 2005 to work on this issue (TÜSİAD, 2006) as a result of .B medical tourism in Turkey last In the years, more action was taken by private hospitals than public hospitals. Private

hospitals, which aim to keep the quality standards at very high levels, have established "International Patient Center" units within their bodies in order to follow the sector closely throughout the world, to carry out representative studies in appropriate destinations, to provide rapid return to patients and to increase the satisfaction rates, and to conduct research on the demands and expectations of female patients. .

4. Method

4.1 Purpose and Model of the Research

This research is designed as a descriptive and relational scanning model. In the study of health tourism it is planned in the framework of descriptive and relational model to assess the overall adequacy perceptions and overall satisfaction of determining whether, how and whether the significance of differentiation based on demographic information for treatment services they receive medical tourists coming to Turkey.

4.2 Sample and Limitations of the Study

The data of this research are limited to medical tourists who apply to treatment centers in Bakırköy district of Istanbul. Research is limited to medical tourists between the ages of 21-65 who participate from various countries including Libya, Iraq, Germany, Azerbaijan, Russia and the Netherlands.The concepts measured in the research are limited to the questionnaire applied in data collection.

The concepts measured in the research are limited to the questionnaire applied in data collection. The research was conducted with 500 people who applied to the private institution in Bakırköy district within the scope of health tourism, and it was applied to 447 people with international status who applied to the private health institution. Before the questionnaire application, the people were informed about the subject of the study; it has been announced that the data to be collected will be used for its intended purpose and will not be adversely affected. It is important and valuable in terms of the reliability of the study that the questionnaire is filled out by only one person. The workload of the institutions, the fact that some foreign nationals do not want to participate in the study, the random filling of the questionnaire, and the patients did not fully understanding the questions constitute the limitations of the study.

4.3 Research Hypotheses

H1: There is a significant relationship between the general competence perceptions and general satisfaction of medical tourists regarding the treatment services they receive within the scope of health tourism.

H2: There are differences according to demographic variables in the perceptions of general adequacy of medical tourists regarding the treatment services they receive within the scope of health tourism.

H3: There is a difference according to demographic variables in the perception of general satisfaction of medical tourists from the treatment services they receive within the scope of health tourism.

4.4 Data Collection and Collection Tools

The questionnaire used in the study was collected by applying face-to-face with medical tourists who applied to the treatment centers in Istanbul city center and its districts within the scope of health tourism in 2018-2019. The data in the study were obtained by using survey method. The survey form consists of two parts.

In the first section of the questionnaire, there are questions about determining the demographic characteristics of the participants, the reasons for choosing the region and multiple-choice questions regarding the channel of arrival to the center. In the second part, there are questions consisting of a total of 15 expressions, which are arranged according to the 5-point Likert scale (1-strongly disagree, 2-disagree, 3-indecisive, 4-agree, 5-strongly agree) to be used in the overall evaluation of the region where the service is received. In the preparation of survey questions, Parasuraman et al. (1988), Zeithaml et al (190), Bebko (2000), Olorunniwo et al. (2008), Değermen (2006) and Odabaşı (2004), Zengingöl et al. (2012) and Kaşhvd. (2012) have been prepared to contribute to the sector and surveys of the studies have been used. It was determined that the total variance rate explained by the scale was 61.9%, that is, sufficient.

4.5 Data Analysis

Reliability analysis was carried out to determine whether the scales used in the data analysis phase showed sufficient internal consistency in the sample of this study. When the general internal

consistency coefficient of the scale is analyzed at α = .86, it is seen that the scales are highly reliable (α> .80). When the skewness and kurtosis statistics are examined, the values of all variables are between -1 and +1 (Demir et al, 2016: 133). Therefore, according to aforementioned data, It was determined that they show normal distribution. At this point, it was decided to use parametric analysis techniques to analyze the data. In the research, the data were analyzed by using ANOVA and Pearson Correlation Analysis. In the research, p = .05 was accepted for the level of significance.

5. Findings

In this section, the characteristics of the people forming the sample are determined as a result of statistical studies and frequency and percentages are included in the related tables.

Table 1. Findings Related to Demographic Information

Gender	**n**	**%**
Woman	110	24.6
Male	337	75.4
Age		
21-30	185	41.4
31-40	163	36.5
41-50	99	1.22
Education Status		
Primary education	63	14.1
High school	143	32.0
University	241	53.9
Total Monthly Income		
$ 500 and below	68	15.2
$ 501-999	42	9.4
$ 1000-1499	162	36.2
$ 1500-1999	66	14.8
$ 2000 and Over	109	4.24
Insurance Status		
State Insurance	140	3.31
Special insurance	212	47.4
Other	95	21.3
Total	447	100.0

According to Table 1, 24.6% (110 people) of 447 medical tourists who make up the sample are women and 75.4% (337 people) are men. 41.4% (n = 185) of the participants are 21-30 years old, 36.5% (n = 163) 31-40 years old and 22.1% (n = 99) are 41-50 years old. 14.1% (n = 63) of the participants are primary school, 32.0% (n = 143) are high school and 53.9% (n = 241) are university graduates. 15.2% of the participants (n = 68) under $ 500 and below 9.4% (n = 42) $ 501-999, 36.2% (n = 162) 1000-1499 $, 14.8% (n = 66) $ 1500-1999 and

24.4% (n = 109) have a total monthly income of $ 2000 and above. 31.3% (n = 140) of the people financed their treatment by making use of state insurance, 47.4% (n = 212) of private insurance and 21.3% (n = 95) of the other using facilities.

In this section, the problem of the research is “What are the general perceptions and general satisfaction of medical tourists regarding the treatment services they receive within the scope of health tourism? In order to answer the question, statistical information about the answers given to the scale items, which are prepared to get the opinions of medical tourists, is given.

Table 2. Averages of Response Given to the Scale of General Competency Perception for the Treatment Services and the General Satisfaction Question from the Medical Tourism Services

Cover	Mean
General Competence for Treatment Services	3.4
Adequacy of Accommodation Facilities	3.3
The quality of service in the accommodation facilities in this region is sufficient.	2.4
General cleaning of accommodation facilities in this region is sufficient.	4.0
In this region, food and beverage service in accommodation facilities or restaurants are suitable for our taste buds.	3.8
Food and beverage service variety is sufficient at the accommodation facilities and restaurants in the region.	3.1
Health Services Adequacy	3.7
The attitude and behavior of the staff in the accommodation facilities or health institutions are good in this region.	3.9
Education and experience levels of physicians or service providers are sufficient.	3.2
Infrastructures and equipment of the hospitals or facilities in the region are of high quality.	4.0
Safety Adequacy	3.0
There is an overall positive atmosphere in this region.	3.3
There is no security problem in the region.	2.7

Teble 2. (Continue)

Regional Qualification	3.8
Shopping opportunities are sufficient in this region.	3.4
It is easy to reach the area by air / land / sea.	3.9
Health institutions or accommodation facilities in the region provide a price advantage.	4.0
Additional Service Capability	2.9
The number of well-educated foreign language staff is sufficient.	2.7
The local people's attitudes and behavior towards tourists are positive.	3.1
Health institutions and accommodation enterprises in the region and intermediary institutions between tourists provide adequate service offers.	2.9
General Satisfaction from Medical Tourism Services	2.9

According to the information in Table 2, when the averages of the answers given by the medical tourists to the relevant scale items are examined; “General cleaning of accommodation facilities in this region is sufficient.” (x = 4.0), "The infrastructure and equipment of the hospitals or facilities in the region are of high quality." (x = 4.0) and “Health institutions or accommodation facilities in the region provide price advantage.” to the highest average; “The quality of service in accommodation facilities in this region is sufficient.” (n = x = 2.4) se has the lowest.

When the averages regarding the general and sub-dimensions of the Perception of General Sufficiency for Treatment Services Scale are evaluated, the general perceptions of the general proficiency of the medical tourists for the treatment services they receive within the scope of health tourism are medium (x = 3.4); accommodation facilities their perception of proficiency is moderate (x = 3.3); health services competence perceptions are at a level (x = 3.7); the perceptions of safety competence are moderate (x = 3.0); it is determined that regional competency perceptions are at a high level (x = 3.8) and additional service competency perceptions are at a medium level (x = 2.9).

When the averages for the General Satisfaction Question from the Medical Tourism Services are evaluated the medical tourists get it was determined that the general satisfaction level of the medical tourism services is at a medium level (x=2.9).

According to Table 2, 26.4% (n = 118) of the 400 medical tourists forming the sample were Libya, 23.5% (n = 105) Iraq, 18.6% (n = 83) Germany, 15.2% (n = 68) Azerbaijan is a citizen of 8.1% (n = 36) Russia and 8.3% (n = 37) is a Dutch citizen.

Table 3. Findings Related to Health Tourism Preferences

nationality	**n**	**%**
Libya	118	26.4
Iraq	105	23.5
Germany	83	18.6
Azerbaijan	68	15.2
Russia	36	8.1
Netherlands	37	3.8
Reason for Choosing the Region		
Relevant Ministry or Consulate health protocol	226	50.6
Geographical proximity	109	4.24
Treatment costs are cheaper	61	6.13
Trust in Turkish doctors and medical staff	51	11.4
Arrival Center to Treatment Center		
Private health agency	139	31.1
Related Ministry or Consulate	114	25.5
Internet	68	15.2
Close advice	49	11.0
Private insurance company	43	9.6
Newspaper, magazine, television ads	34	7.6
Total	447	100.0

50.6% of the people (n = 226) related ministry or consular health protocol, 24.4% (n = 109) geographic proximity, 13.6% (n = 61) cheaper treatment costs, 11.4% (n = 51) stated that they chose to be treated in Turkey because of confidence in the Turkish doctors and medical staff.31.1% (n = 139) private health agency, 25.5% (n = 114) ministry or consulate, 15.2% (n = 68) internet, 11.0% (n = 49) close advice, 9.6% (n = 43) of the private insurance company, and 7.6% (n = 34) of the newspapers, magazines, television advertisements stated that he was aware of the treatment

center.In this section, firstly, statistical information about the findings applied to test the H1 hypothesis of the research is given. Table 3 lists the Pearson's Correlation Analysis results.

Table 4. Investigation of the Relationship between the Perception of General Sufficiency for Treatment Services and the Level of General Satisfaction from Medical Tourism Services

one.	**2nd.**	**3.**	**4.**	**5.**	**6.**	
1. General Competence for Treatment Services	one					
2. Adequacy of Accommodation Facilities	.87 **	one				
3. Health Services Adequacy	.79 **	.61 **	one			
4. Safety Adequacy	.80 **	.70 **	.70 **	one		
5. Regional Qualification	.62 **	.55 **	.44 **	.30 **	one	
6. Additional Service Adequacy	.74 **	.49**	.40 **	.45 **	.25 **	one
7. General Satisfaction from Medical Tourism Services	.65 **	.54 **	.42 **	.50 **	.03	.80 **

When the information in Table 4 is examined, there is no significant relationship between the general satisfaction level of medical tourists from medical tourism services and regional competence (p> .05), but the general perception of competence for treatment services (r (445) = .65, p <.001), perception of accommodation facilities adequacy (r (445) = .54, p <.001), perception of health services adequacy (r (445) =. 42, p.001), perception of safety adequacy (r (445) = .50 , p <.001) and additional service competence perception (r(445)=.65,p<.001)

It has been determined that there is a positive significant relationship between.

In this section, statistical information about the findings applied for the second study to test the H2 hypothesis is given.

Table 5. Investigation of the Differentiation of the Perception of General Sufficiency for Treatment Services by Monthly Total Income

Total Monthly Income	n	Cover	ss	sd	F	p	Difference	
General for Treatment Services Qualifications	$ 999 and Under	110	3.73	.77	3443	15 461	.000	1> 2,3,4
$ 1000-1499	162	3:31	.67					
$ 1500-1999	66	3:12	.67					
$ 2000 and Over	109	3:19	.68					

When the findings given in Table 5 are analyzed, it is determined that the perception of general adequacy (F (3.443) = 15.461, p <.001) for the treatment services of medical tourists shows a statistically significant difference compared to the monthly total income. According to the Post Hoc tests applied to determine which group the meaningful difference originated from, positive perceptions of medical proficiency of medical tourists with a total monthly income of $ 999 and below, compared to medical tourists with a monthly total income of $ 1000-1499, $ 1500-1999 and $ 2000 and above. It was determined to be higher in direction.

Table 6. Investigation of the Differentiation of General Competence Perception for Treatment Services According to Insurance Status

Insurance Status	n	Cover	ss	sd	F	p	Difference	
For Therapeutic Services General Qualification	State Insurance	140	3.99	.62	2444	124 728	.000	1> 2> 3
Special insurance	212	3.15	.67					
Other	95	2.87	.25					

When the findings given in Table 6 are analyzed, it is determined that the perception of general adequacy (F (2.444) = 124.728, p <.001) for the treatment services of medical tourists shows a statistically significant difference according to the insurance status. According to the Post Hoc tests applied to determine which group the meaningful difference originated from, compared to medical tourists benefiting from private insurance and financing the treatment of medical tourists

with other means, compared to medical tourists benefiting from private insurance and financing the treatment with other means. It was determined to be higher in the direction.

Table 7. Examining the Differentiation of the Perception of General Competence for Treatment Services by Nationality

nationality	n	Cover	ss	sd	F	p	Difference	
For Therapeutic Services General Qualification	Libya	118	2.95	.27	5441	17 504	.000	2> 3,4,5,6> 1
Iraq	105	3.77	.65					
Germany	83	3:28	.87					
Azerbaijan	68	3:47	.76					
Russia	36	3:47	.83					
Netherlands	37	3:32	.81					

When the findings given in Table 7 are analyzed, it was determined that the perception of general adequacy (F (5.441) = 17.504, p <.001) for the treatment services of medical tourists showed a statistically significant difference compared to the nationality. According to Post Hoc tests to determine which group the meaningful difference originated from, the medical proficiency perceptions of medical tourists coming from Iraq for treatment services compared to medical tourists coming from Libya, Germany, Azerbaijan, Russia and the Netherlands, compared to medical tourists from Germany, Azerbaijan, Russia and the Netherlands. It has been determined that it is higher than medical tourists coming from Libya.In this section, statistical information about the findings applied to test the H3 hypothesis is given.

Table 8. Examination of the Differentiation of Medical Satisfaction Services from the Total Monthly Income

Total Monthly Income	n	Cover	ss	sd	F	p	Difference	
General From Medical Tourism Services Satisfaction	$ 999 and Under	110	3.90	1:30	3443	19.039	.000	1> 2,3,4
$ 1000-1499	162	2.65	1.62					
$ 1500-1999	66	2:35	1:54					
$ 2000 and Over	109	2.78	1:59					

When the findings given in Table 8 are analyzed, it was determined that the level of general satisfaction (F (3.443) = 19.039, p <.001) of medical tourists from medical tourism services showed a statistically significant difference compared to the monthly total income. According to the Post Hoc tests applied to determine which group the meaningful difference originated from, the monthly total income of the general satisfaction levels from the medical tourism services received by medical tourists with a monthly total income of $ 999 and $ 1000-1499, $ 1500-1999 and It has been determined to be positively higher than medical tourists with $ 2000 or more.

Table 9. Investigation of Differentiation of Medical Tourism Services According to Insurance Status

Insurance Status	**n**	**Cover**	**ss**	**sd**	**F**	**p**	**Difference**	
From Medical Tourism Services General Satisfaction	State Insurance	140	4:24	.93	2444	92 980	.000	1> 2> 3
Special insurance	212	2:36	1:56					
Other	95	2:29	1:44					

When the findings given in Table 9 are examined, it was determined that the level of general satisfaction (F (2.444) = 92.980, p <.001) of medical tourists from medical tourism services showed a statistically significant difference according to the insurance status. According to Post Hoc tests applied to determine which group the meaningful difference originated from, medical tourists benefiting from private insurance and financing the treatment of medical tourists benefiting from private insurance with other opportunities compared to the medical tourists benefiting from private insurance and financing treatment with other means. It has been determined that it is higher than the medical tourists.

Table 10. Examination of the Differentiation of Medical Satisfaction Services from National Tourism by Nationality

nationality	N	Cover	ss	sd	F	p	Difference	
From Medical Tourism Services General Satisfaction	Libya	118	1:12	.40	5441	111 828	.000	2,3,4,5,6> 1
Iraq	105	4:09	.87					
Germany	83	4:13	.73					
Azerbaijan	68	2.88	1.65					
Russia	36	3:19	1:56					
Netherlands	37	2.62	1.72					

When the findings given in Table 10 are examined, it was determined that the level of general satisfaction (F (5.441) = 111.828, p <.001) of medical tourists from medical tourism services showed a statistically significant difference compared to the nationality.

According to the Post Hoc tests applied to determine which group the meaningful difference originated from, medical tourists from Iraq, Germany, Azerbaijan, Russia and the Netherlands received positive satisfaction from the medical tourism services they received within the scope of health tourism compared to medical tourists from Libya.

Discussion

Research has revealed that health tourism has reached a serious market size. At the same time, this study revealed that health tourism market has the potential to take share in Turkey. Turkey's biggest advantage at this point, the appropriateness of the price that is cost advantage. The infrastructure of hospitals (private institutions and university hospitals), language facilities of the staff and physician quality are sufficient in the triple of cost, quality and time. In this context, there is a statistically significant difference between transfer / accommodation / language problems and transportation option in the waiting area sub-dimension. There is a statistically significant difference between the “wage group” and “none” option in the overall Patient Satisfaction Scale.

In order to attract health tourists, a good health tourism target image should be created by offering standard and satisfactory services to medical tourism customers. The satisfaction of health tourists depends on the expectations and perceptions of the services offered by medical tourism providers. Medical tourism providers often offer service packages, including tourism services and healthcare services.

Organizations involved in the medical tourism process; healthcare providers, travel agencies, tour guides, hotels and holiday villages are important. Among the health services; it allows the relevant medical professional to be consulted prior to arrival, with the assistance of email, telephone and videoconferencing if required, flight arrangements and extension / visa. However, when necessary; Airport pick-up by ambulance, under normal conditions; includes hotel accommodation, medical appointments specialists, clinical tests, scheduling of all medical appointments, coordination of the admissions process, cost estimates for expected treatment. Finally, additional services such as special diet arrangements, local travel, foreign exchange, insurance services, financial services, travel advice for local conditions, ticketing, spa, shopping, yoga and beauty care are provided to patients.

Conclusion And Recommendations

As a result of the research, there is no significant relationship between the general satisfaction level of medical tourists from medical tourism services and regional competence; It has been determined that there is a positive meaningful relationship between general competence for healthcare services, health care competence, perception of safety competence and perception of additional service competence. When the correlation coefficients are analyzed, the quality expectations regarding the cafeteria services, cleaning services and the physical structure of the institution do not affect the satisfaction of the medical tourists for the treatment services they receive within the scope of health tourism, but respectively; It has been determined that the meeting of the quality expectations regarding the advisory service, the attitude of the business management in the second place, the trust in the personnel of the institution in the third place, the pricing policies of the enterprises in the fourth place and the floor services in the fifth place. In the study, the perceptions of general adequacy, accommodation facilities adequacy, safety adequacy and additional service adequacy for medical services received by medical tourists within the scope of health tourism were moderate; it has been determined that health services competence and regional competency

perceptions are at a good level.As a result of the research, in terms of H1, there is no significant relationship between the general satisfaction level of medical tourists from medical tourism services and regional competence, but there is a positive difference between the perceptions of general competence, accommodation facilities, health services competence, safety competence and additional service competence. turned out to be a relationship. When the correlation coefficients of H1 are analyzed, the perception towards regional competence does not affect the satisfaction of medical tourists for the treatment services they receive within the scope of health tourism, but the sufficiency of additional services respectively, the sufficiency of accommodation facilities in the second place, the safety competence in the third place and the health service competence in the fourth place. It seems that the share of meeting their expectations towards them has a share.

When the findings of H2 are examined, it is determined that the general adequacy perceptions of medical tourists with a total monthly income of $ 999 and below are higher than the medical tourists with a total monthly income of $ 1000-1499, $ 1500-1999 and over 2000 and above. From this point of view, it has been determined that the expectations of medical tourists, who have low income, for the treatment services they receive within the scope of health tourism are higher than the medical tourists with higher income.

Another finding for H2 is the treatment of medical tourists who received from state insurance.

The perceptions of general competence for their services are higher than those of medical tourists who benefit from private insurance and finance their treatment with other means, compared to medical tourists financing their treatment with other opportunities, and that medical tourists benefit from state insurance within the scope of health tourism. their expectations for treatment services are higher than those of medical tourists benefiting from private insurance and financing their treatment with other opportunities.

It was determined that they perceive that they are met. In addition, compared to medical tourists coming from Libya, Germany, Azerbaijan, Russia and the Netherlands, medical tourists coming from Iraq, Azerbaijan, Russia and the Netherlands have positive positive perceptions of medical tourists from Iraq, compared to medical tourists from Libya. It was determined to be higher.

Considering the findings of H3, medical tourists who have a total monthly income of $ 999 and below are in the positive direction compared to medical tourists with a monthly total income of $ 1000-1499, $ 1500-1999 and $ 2000 and above, the level of general satisfaction of the medical tourism services received by the medical tourists benefiting from the state insurance, It was determined that medical tourists benefiting from private insurance benefited from insurance and financing their treatment with other opportunities were higher than medical tourists financing their treatment with other opportunities. In the other finding, it has been determined that the medical satisfaction of medical tourists from Iraq, Germany, Azerbaijan, Russia and the Netherlands, in terms of health tourism, is higher than the medical tourists from Libya.

When we look at the findings related to demographic features, 75.4% of the patients coming under the scope of medical tourism for treatment purposes consist of male patients; It is seen that there are 41.4% of the age range of 21-30 young people, the level of education is 53.9% university graduate or studying, middle income and 47.4% come under private insurance. In the findings related to the preferences, the country that sent the most medical tourists was Libya with 26.4% and 50.6% of the leading reasons for the preference of the patients were ministerial guidance or official.

it appears to be a protocol. The biggest share in the arrival channels to our country was determined as the work of agencies with 31.1%. When the average of response given by medical tourists to the relevant scale items is examined; answers with the highest average “General cleaning of accommodation facilities in this region is sufficient.” (x = 4.0), "The infrastructure and equipment of the hospitals or facilities in the region are of high quality." (x = 4.0) and “Health institutions or accommodation facilities in the region provide price advantage”. The item with the lowest rate is "Service quality in accommodation facilities in this region is sufficient." substance (x = 2.4) was observed. When the averages of the General Adequacy Perception Scale for Treatment Services and its sub-dimensions are evaluated, medical tourists receive treatment within the scope of health tourism.

general competency perceptions about services are moderate (x = 3.4); the perception of adequacy in accommodation facilities is moderate (x = 3.3); high perceptions of health care competence (x = 3.7); perceptions of safety competence are moderate (x = 3.0); it is determined that regional competency perceptions are at a high level (x = 3.8) and additional service competency perceptions

are at a medium level (x = 2.9). When the averages for the General Satisfaction Question from the Medical Tourism Services were evaluated, it was determined that the general satisfaction level of the medical tourism services received by the medical tourists within the scope of health tourism was medium level (x = 2.9).

In line with the information obtained as a result of the analysis of the data of this research limited by private hospitals, the current state of medical tourism has improved and improved, the scope of the researches to be carried out in this field will be expanded, and the sufficiency and satisfaction of patients who will come within the scope of medical tourists for private and public health providers. The items presented below can be recommended to enable them to analyze their expectations well in order to keep their perceptions high.

The increase in satisfaction with the treatment services is directly proportional to the increase in the adequacy ratio of the service received. Great attention should be paid to this measure in marketing studies. All private and public health providers should care about R&D studies to understand the expectations of patients and determine a strategy accordingly. This issue can be taken into consideration in the selection of the market due to the high level of competence perceptions and satisfaction of the medical tourists with middle income range. For example, Asian, African and Turkic Republics can be advantageous in this sense. Extra options such as visa and price eligibility can be offered to the people living here. Turkey has become an important destination of choice in the medical tourism market and sector basis in order to stand as a rival in the face of other countries, medical tourism service offering with all other stakeholders (food and beverages, transportation, accommodation, travel agencies, insurance companies, etc.) To raise the competence of quality and It is inevitable for them to act jointly within a certain standard. In addition, steps should be taken in this direction by producing a country policy of our own in medical tourism. In this policy, instead of marketing patients with individual agencies, protocol-based systemic processes should be established through the relevant ministry or another institution of foreign countries with the step taken by the government. In this way, solving financial problems and directing patient potential from a single center will make things easier.

The competent institutions of the state should try to keep the buildings, infrastructures, machinery and technological equipment of the private and public hospitals or facilities in the region in a certain standard and develop a control mechanism within it. It is necessary to encourage all

healthcare providers to have a Health Tourism Authorization Certificate, JCI or other quality accreditations that will make them preferable for the development of medical tourism."International Patient Center" units should be established within the businesses to provide communication with foreign patients and the number of linguistic staff. The safety of the region visited for treatment is important. For this purpose, promotion and advertisement activities should be supported by the state, and the safe image of the region should always be prioritized in order to avoid a negative impact.It is necessary to accelerate the opening of representatives of other private and public health providers in other countries by expanding the scope of the current “foreign unit support” incentive package (support amount increase). Keeping the statistical data of public or private enterprises that continue their work in the field of medical tourism regularly and in detail, be shared for use. Medical tourism industry is among the economies that show a rapid growth on a global scale. There is a shortage of qualified and up-to-date working. Therefore, it contains different opinions about the clarity and consistency of the information obtained.

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Int Journal Of Health Manag. And Tourism 2020, 5(3), 315-335

JHMT Editorial

International Journal Of Health Management And Tourism

A BIBLIOMETRIC ANALYSIS OF THE 100 TOP-CITED PUBLICATIONS IN HEALTH TOURISM

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Received: 03.09.2020
Accepted: 13.10.2020
Research Article

Abstract:

Objectives: The purposes of this study are: a) to review evidence-based and cumulative information health tourism literature by bibliometric analysis; b) to identifies the current 100 top-cited articles in health tourism ranging from 1970 to 2020 and indexed in Web of Science (WoS).

Method: Retrospective analysis was used bibliometric information from database of WoS. The obtained data analyzed by using VOSviewer through software package. Statistical analysis were performed using SPSS software version 23.0 (SPSS Inc., Chicago, IL).

Results: The citation count of the most-cited articles varied from 27 to 361 WoS (1970 – 2020). The most productive year was 2010 and the most productive country is USA. 65 different journals were detected and the most frequent article was Tourism Management. Total citation time was positively associated with age of article ($p<0.001$). Citation time in 2017 was positively associated with average citation per year ($p<0.001$). Citation time in 2017 was negatively associated with age of article ($p<0.001$).

Conclusion: This study shows that the trends of health and medical tourism research fields and also the main papers, authors, journals, institutions and countries within the most cited top 100 articles in this area.

Keywords: *Tourism, Health tourism, medical tourism, top 100 articles, bibliometric analysis*

Highlights:

- To discover topic-linked innovation evaluation paths in health tourism area
- Revealing patterns in the evaluation of science product into health tourism field.
- Summarizing the top cited top 100 publication relationship between health tourism and scientific production

Introduction

Tourism is one of the economic sectors that have been constantly expanding and diversifying, including travelers with different motivations over the past 50 years (Sánchez et al., 2017: 9). Health and medical tourism have an important interest in this sector and the value of health and medical tourism is becoming increasingly important in the world (Horowitz et al.,2007: 33). All over the world, the number of people moved abroad to seek medical treatment as international health tourists have been increased dramatically in recent years. It could be part of a growing global trend (Morgan, 2010: 12). International medical tourists preference such treatments (e.g., in vitro fertilization or stem cell treatments) abroad that are approved by their health authorities at home (United Nations World Tourism Organization, 2018) and travel all over the world for treatment.

Depending on the source estimates of the value of the medical tourism market differ greatly. According to Reportlinker, the global medical tourism sector was valued at $53,768 million in 2017 and is estimated to reach $143,461 million by 2025. This is also a rising trend that has attracted interest in the scientific community (Correa et al., 2018: 201; Chew and Darmasaputra, 2015: 119).

Scientific publications have undergone an evolution process in recent years. Publications are the primary output of scientific research and the most widely-used method of releasing scientific discoveries to other researchers. In the academic area, scientific papers are the best way of sharing and distributing new knowledge (Fan and Frcophth, 2008: 56; Cant and Cooper, 2019: 2). The universities are key institutions in scientific paper production and this function plays an important role in the acceleration of progress in every country (Soosarei et al., 2018: 34). Scientific papers show up developments in different disciplines using different techniques and methodologies (Fontana et al., 2019: 1773). To measure the scientific output of researchers is an important task for the scientific community. Nowadays, almost every research assessment decision accepting research projects, contracting researchers, awarding scientific prices, concede a grant, and so on depends to a great extent upon the scientific merits of the involved researchers (Alonso et al., 2009: 273). Increasingly, evaluation studies of scientific performance conducted during the last years focus on the identification of research of the highest quality, top research, or scientific excellence. This shift in focus has lead to the development of new bibliometric methodologies and indicators (Van Leeuwen, 2003: 257). The scientific bibliometric analysis utilizes citation data and is an important scientific tool for evaluation of the research performance of authors, institutions, and journals (Gogos et al., 2019: 2; Ahmad et al., 2019: 3). Citation analysis is the most commonly used bibliometric assessment method. This analysis indicates the relationship between the cited study with the studies published afterward. This approach assumes that the cited publications have an influence on other authors (Onat, 2011: 158; Sims and Franzco, 2003: 15). This analysis is important in terms of the use of quantitative parameters in the assesment of scientific publication performance (Wallin, 2005: 263). It also provides researchers with substantial evidence of the research area. In this context, the purpose of this study are a) to review evidence-based and cumulative information medical tourism literature by bibliometric analysis; b) identifies the current 100 top-cited articles in health tourism ranging from 1970 to 2020.

Method

Literature Searching

The WoS database was used to find publications. Web of Science is a web technology owned by Thomson Reuters and it has conducted bibliographic databases, citations, and references of scientific publications in any discipline of knowledge; scientific, technological, humanistic, and

sociological since 1945. It occurs of more than 12,000 live journals, 23 million patents, 148,000 congress proceedings, more than 40 million, and 760 million sources of cited references (Sánchez, 2017: 12).

Bibliometric Analysis

In this study, medical tourism literature investigated with a bibliometric analysis by executing a citation analysis to top 100 cited papers at the WoS. A retrospective analysis was used bibliometric information from the database of WoS. The obtained data analyzed by using VOSviewer through a software package. The following keywords were search: "medical tourism" and "health tourism" in the topic section; "aesthetic", "plastic"," transplantation"," dental", "transplant tourism", "transplant tourist", "medical", "health", "cross border", "medical tourist", "health tourist", "wellness tourism", "wellness tourism", "stem cell", "medical travel" from 1970 to January 2020. Then publications were ranked by the number of citations using the option 'Times cited-highest to lowest' listed on the WoS, the abstracts were checked according to relevance and were exported using Microsoft Excel 2016.

The most cited top 100 articles were classified into and analyzed as title, authors, number of authors, journals, publication year, total citations WoS. The articles were also mapped with a co-citation network to understand what outstanding articles are. The obtained data were analyzed by using VOSviewer through software packages on 16th January 2020 (VOSviewer, 2020).

Statistical Analysis

Statisticalanalyses were performed using SPSS software version 23.0 (SPSS Inc., Chicago, IL). The statistical significance of the correlations among citation times in 2017, the average per year, total citation times, age of the article. The variables were determined by Spearman test $P<0.05$ was considered to be statistically significant.

Limitations

This study has several limitations. In this study only used and searched WoS database and the other sources as Pub Med, Scopus, etc. may be missed, our findings may be affected by the interpretation of the results. This is a basic limitation of the study. Besides, the fact that only mentioned keywords were used in obtaining scientific publications related to medical tourism can be considered as another limitation of the study. Despite these limitations, it is assumed that this study reflects the

100 most cited studies in the field of health tourism and the software reflects the best results during the analysis.

Results

A total of 1316 articles were found in WoS using the search terms and the most cited top 100 publications were reviewed the most cited first 120 paper and selected 100 paper according to title and abstract by two authors (Fig 1).

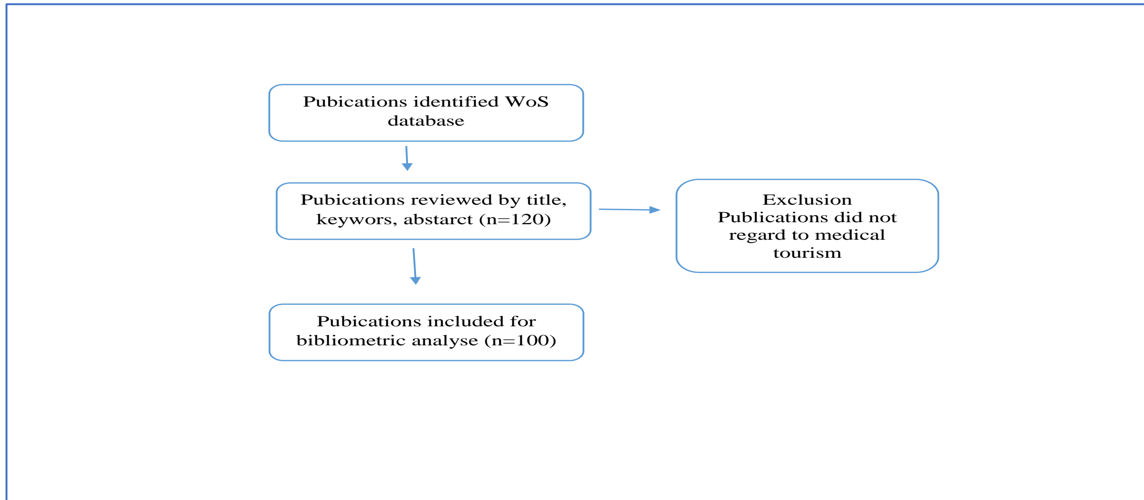

Figure 1. Flow Chart

As our findings these publications were written English which included 77 articles, 11 editorial material, 10 reviews, 2 proceedings paper, 1 book, and 1 news item. While the top paper has been cited 361 times, the number of citations the least was 27 and the average number of these citations was 6,16 (616,39/100). The two oldest cited papers were by Bezruchka and Bishop & Lithch and were published in 2000 (Bezruha, 2000; Bishop and Litch, 2000). Nearly 12 % of publications had more than 100 citations and the most cited paper was published by J. Connell from the University of Sydney in 2006 in the Tourism Management Journal (IF: 6.012) (Connell, 2006).

Table 1 has shown that the most cited top – 100 publications. The top-ranked author was John Connell who published two the most cited articles in Tourism Management Journal in 2006 and 2013. The most cited top 10 publications have a total of 1764 cited compose of 28 % (1764/6178) and published between 2006 – 2010. According to total citation time 2017 was the most cited year (866 citations).

Table 1. Top 100 list most – cited articles in Health and Medical Tourism

Rank	WoS Citation	Author	Title	Year
1	361	Connell, John	Medical tourism: Sea, sun, sand and . . . surgery	2006
2	190	Bookman, Milica Z. Bookman, Karla R.	Medical Tourism in Developing Countries	2007
3	183	Connell, John	Contemporary medical tourism: Conceptualisation, culture and commodification	2013
4	183	Crooks, Valorie A, Kingsbury, Paul, Snyder, Jeremy; Johnston, Rory	What is known about the patient's experience of medical tourism? A scoping review	2010
5	173	Shenfield et al.	Cross border reproductive care in six European countries	2010
6	143	Lunt, Neil; Carrera, Percivil	Medical tourism: Assessing the evidence on treatment abroad	2010
7	138	Budiani-Saberi, D. A. Delmonico, F. L.	Organ trafficking and transplant tourism: A commentary on the global realities	2008
8	138	Ramirez de Arellano, Annette B.	“atients without borders: The emergence of medical tourism	2007
9	128	Han, Heesup; Hyun, Sunghyup Sean	Customer retention in the medical tourism industry: Impact of quality, satisfaction, trust, and price reasonableness	2015
10	127	Hopkins, Laura; Labonte, Ronald; Runnels, Vivien; Packer, Corinne	Medical tourism today: What is the state of existing knowledge?	2010

11	118	Pocock, Nicola S.; Phua, Kai Hong	Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia	2011
12	112	Johnston, Rory; Crooks, Valorie A.; Snyder, Jeremy; Kingsbury, Paul	What is known about the effects of medical tourism in destination and departure countries? A scoping review	2010
13	98	Canales, Muna T.; Kasiske, Bertram L.; Rosenberg, Mark E.	Transplant tourism: Outcomes of United States residents who undergo kidney transplantation overseas	2006
14	96	Yu, Ji Yun; Ko, Tae Gyou	A cross-cultural study of perceptions of medical tourism among Chinese, Japanese and Korean tourists in Korea	2012
15	91	Glinos, Irene A.; Baeten, Rita; Helble, Matthias; Maarse, Hans	A typology of cross-border patient mobility	2010
16	90	Lindvall, Olle; Hyun, Insoo	Medical Innovation Versus Stem Cell Tourism	2009
17	88	Heung, Vincent C. S.; Kucukusta, Deniz; Song, Haiyan	Medical tourism development in Hong Kong: An assessment of the barriers	2011
18	88	Crooks et al.	Promoting medical tourism to India: Messages, images, and the marketing of international patient travel	2011
19	82	Heung, Vincent C. S.; Kucukusta, Deniz; Song, Haiyan	A Conceptual Model Of Medıcal Tourısm: Implıcatıons For Future Research	2010
20	82	Ryan, Kirsten A.; Sanders, Amanda N.; Wang, Dong D.; Levine, Aaron D.	Tracking the rise of stem cell tourism	2010
21	79	Garcia-Altes, A	The development of health tourism services	2005
22	76	Chen, Chun-Chu; Petrick, James F.	Health and Wellness Benefits of Travel Experiences: A Literature Review	2013
23	75	[Anonymous]	The Declaration of Istanbul on organ trafficking and transplant tourism	2008
24	74	Murdoch, Charles E.; Scott, Christopher Thomas	Stem Cell Tourism and the Power of Hope	2010
25	69	York, Diane	Medical tourism: The trend toward outsourcing medical procedures to foreign countries	2008

26	68	Burkett, Levi	Medical tourism - Concerns, benefits, and the American legal perspective	2007
27	65	Cormany, Dan; Baloglu, Seyhmus	Medical travel facilitator websites: An exploratory study of web page contents and services offered to the prospective medical tourist	2011
28	64	NaRanong, Anchana; NaRanong, Viroj	The effects of medical tourism: Thailand's experience	2011
29	63	Horton, Sarah; Cole, Stephanie	Medical returns: Seeking health care in Mexico	2011
30	62	Chen, Kaung-Hwa; Liu, Hsiou-Hsiang; Chang, Feng-Hsiang	Essential customer service factors and the segmentation of older visitors within wellness tourism based on hot springs hotels	2013
31	62	Lautier, Marc	Export of health services from developing countries: The case of Tunisia	2008
32	59	Hanefeld, J.; Lunt, N.; Smith, R.; Horsfall, D.	Why do medical tourists travel to where they do? The role of networks in determining medical travel	2015
33	58	Penney, Kali; Snyder, Jeremy; Crooks, Valorie A.; Johnston, Rory	Risk communication and informed consent in the medical tourism industry: A thematic content analysis of canadian broker websites	2011
34	58	Song, Priscilla	Biotech Pilgrims and the Transnational Quest for Stem Cell Cures	2010
35	55	Ogbogu, Ubaka; Rachul, Christen; Caulfield, Timothy	Reassessing direct-to-consumer portrayals of unproven stem cell therapies: is it getting better?	2013
36	52	Hanefeld, Johanna; Horsfall, Daniel; Lunt, Neil; Smith, Richard	Medical Tourism: A Cost or Benefit to the NHS?	2013
37	51	Fetscherin, Marc; Stephano, Renee-Marie	The medical tourism index: Scale development and validation	2016
38	51	Turner, Leigh G.	Quality in health care and globalization of health services: accreditation and regulatory oversight of medical tourism companies	2011
39	51	Zarzeczny, Amy; Caulfield, Timothy	Stem Cell Tourism and Doctors' Duties to MinorsA View From Canada	2010
40	51	Turner, Leigh	Medical tourism - Family medicine and international health-related travel - Commentary	2007

41	51	Jones, C. A.; Keith, L. G.	Medical tourism and reproductive outsourcing: The dawning of a new paradigm for healthcare	2006
42	49	Ferraretti et al.	Cross-border reproductive care: a phenomenon expressing the controversial aspects of reproductive technologies	2010
43	48	Turner, Leigh	Medıcal Tourısm And The Global Marketplace In Health Servıces: Us Patıents, Internatıonal Hospıtals, And The Search For Affordable Health Care	2010
44	47	Lee, Misung; Han, Heesup; Lockyer, Tim	Medıcal Tourısm-Attractıng Japanese Tourısts For Medıcal Tourısm Experıence	2012
45	47	Smith, Richard; Alvarez, Melisa Martinez; Chanda, Rupa	Medical tourism: A review of the literature and analysis of a role for bi-lateral trade	2011
46	47	Petrosoniak, Andrew; McCarthy, Anne; Varpio, Lara	International health electives: thematic results of student and professional interviews	2010
47	46	Abubakar, Abubakar Mohammed; Ilkan, Mustafa	Impact of online WOM on destination trust and intention to travel: A medical tourism perspective	2016
48	46	Petersen, Alan; Seear, Kate; Munsie, Megan	Therapeutic journeys: the hopeful travails of stem cell tourists	2014
49	46	Reddy, Sumanth G.; York, Valerie K.; Brannon, Laura A.	Travel for Treatment: Students' Perspective on Medical Tourism	2010
50	46	Reed, Christie M.	Medical Tourism	2008
51	46	Chinai, Rupa; Goswami, Rahul	Medical visas mark growth of Indian medical tourism	2007
52	45	Crush, Jonathan; Chikanda, Abel	South-South medical tourism and the quest for health in Southern Africa	2015
53	45	Chen, Lin H.; Wilson, Mary E.	The Globalization of Healthcare: Implications of Medical Tourism for the Infectious Disease Clinician	2013
54	45	Adler et al.	Introduction of OXA-48-producing Enterobacteriaceae to Israeli hospitals by medical tourism	2011
55	45	Snyder et al.	The 'patient's physician one-step removed': the evolving roles of medical tourism facilitators	2011
56	44	White et al.	The global diffusion of organ transplantation: trends, drivers and policy implications	2014

57	44	Alleman et al.	Medical Tourism Services Available to Residents of the United States	2011
58	43	Sobo, Elisa J.	Medical Travel: What It Means, Why It Matters	2009
59	42	Helble, Matthias	The movement of patients across borders: challenges and opportunities for public health	2011
60	41	Rizvi et al.	A kidney transplantation model in a low-resource country: an experience from Pakistan	2013
61	40	Chuang, Thomas C.; Liu, John S.; Lu, Louis Y. Y.; Lee, Yachi	The main paths of medical tourism: From transplantation to beautification	2014
62	40	Cohen, Cynthia B.; Cohen, Peter J.	International Stem Cell Tourism and the Need for Effective Regulation Part I: Stem Cell Tourism in Russia and India: Clinical Research, Innovative Treatment, or Unproven Hype?	2010
63	40	Turner, L.	Cross-border dental care: 'dental tourism' and patient mobility	2008
64	40	Bies, William; Zacharia, Lefteris	Medical tourism: Outsourcing surgery	2007
65	39	Hanefeld, Johanna; Smith, Richard; Horsfall, Daniel; Lunt, Neil	What Do We Know About Medical Tourism? A Review of the Literature With Discussion of Its Implications for the UK National Health Service as an Example of a Public Health Care System	2014
66	39	Shetty, Priya	Medical tourism booms in India, but at what cost?	2010
67	38	Bochaton, Audrey	Cross-border mobility and social networks: Laotians seeking medical treatment along the Thai border	2015
68	38	Birch, Daniel W.; Vu, Lan; Karmali, Shahzeer; Stoklossa, Carlene Johnson; Sharma, Arya M.	Medical tourism in bariatric surgery	2010
69	38	Barclay, Eliza	Stem-cell experts raise concerns about medical tourism	2009
70	38	Bezruchka, S	Medical tourism as medical harm to the Third World: Why? For whom?	2000
71	37	Mason, Alicia; Wright, Kevin B.	Framing Medical Tourism: An Examination of Appeal, Risk, Convalescence, Accreditation, and Interactivity in Medical Tourism Web Sites	2011

72	35	Lee, Hwee Khei; Fernando, Yudi	The antecedents and outcomes of the medical tourism supply chain	2015
73	35	Crooks et al.	Ethical and legal implications of the risks of medical tourism for patients: a qualitative study of Canadian health and safety representatives' perspectives	2013
74	35	Moghimehfar, Farhad; Nasr-Esfahani, Mohammad Hossein	Decisive factors in medical tourism destination choice: A case study of Isfahan, Iran and fertility treatments	2011
75	35	Hazarika, Indrajit	Medical tourism: its potential impact on the health workforce and health systems in India	2010
76	34	Cohen, I. Glenn	Transplant Tourism: The Ethics and Regulation of International Markets for Organs	2013
77	34	Chen, Y. Y. Brandon; Flood, Colleen M.	Medical Tourism's Impact on Health Care Equity and Access in Low- and Middle-Income Countries: Making the Case for Regulation	2013
78	33	Wang, Hsiu-Yuan	Value as a medical tourism driver	2012
79	33	Palattiyil, George; Blyth, Eric; Sidhva, Dina; Balakrishnan, Geeta	Globalization and cross-border reproductive services: Ethical implications of surrogacy in India for social work	2010
80	32	Runnels, Vivien; Carrera, P. M.	Why do patients engage in medical tourism?	2012
81	32	Lee, Chew Ging	Health care and tourism: Evidence from Singapore	2010
82	32	Cohen, I. Glenn	Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument	2010
83	31	Ormond, Meghann; Sothern, Matthew	You, too, can be an international medical traveler: Reading medical travel guidebooks	2012
84	31	Connell, John	A new inequality? Privatisation, urban bias, migration and medical tourism	2011
85	31	Whittaker, Andrea	Cross-border assisted reproduction care in Asia: implications for access, equity and regulations	2011
86	31	Bishop, RA; Litch, JA	Medical tourism can do harm	2000
87	30	Bell, David; Holliday, Ruth; Ormond, Meghann; Mainil, Tomas	Transnational healthcare, cross-border perspectives Introduction	2015
88	30	Crozier, G. K. D.; Baylis, Francoise	The ethical physician encounters international medical travel	2010

89	29	Connolly, Ruairi; O'Brien, Timothy; Flaherty, Gerard	Stem cell tourism - A web-based analysis of clinical services available to international travellers	2014
90	29	Gunter et al.	Cell therapy medical tourism: Time for action	2010
91	28	Schnabel et al.	Multistate US Outbreak of Rapidly Growing Mycobacterial Infections Associated with Medical Tourism to the Dominican Republic, 2013-2014	2016
92	28	Beladi, Hamid; Chao, Chi-Chur; Ee, Mong Shan; Hollas, Daniel	Medical tourism and health worker migration in developing countries	2015
93	28	Einsiedel, Edna F.; Adamson, Hannah	Stem Cell Tourısm And Future Stem Cell Tourısts: Polıcy And Ethıcal Implıcatıons	2012
94	28	Carrera, Percivil; Lunt, Neil	A European Perspectıve On Medıcal Tourısm: The Need For A Knowledge Base	2010
95	27	Viladrich, Anahi; Baron-Faust, Rita	Medical tourism in tango paradise: The internet branding of cosmetic surgery in Argentina	2014
96	27	Heung, Vincent C. S.; Kucukusta, Deniz	Wellness Tourism in China: Resources, Development and Marketing	2013
97	27	Lunt, Neil T.; Mannion, Russell; Exworthy, Mark	A Framework for Exploring the Policy Implications of UK Medical Tourism and International Patient Flows	2013
98	27	Wilson, Ara	Foreign Bodies and National Scales: Medical Tourism in Thailand	2011
99	27	Johnson, Tricia J.; Garman, Andrew N.	Impact of medical travel on imports and exports of medical services	2010
100	27	Lee, Chew Ging; Hung, Woan Ting	Tourism, Health and Income in Singapore	2010

This study discovered that the associations between average citation per year, citation time 2017, total citations time, and age of the article with bivariate correlation analysis. According to the result total citation time was positively associated with the age of the article ($r=0.957$, $p<0.001$). Citation time in 2017 was positively associated with average citation per year ($r=0.814$, $p<0.001$). However, there was no significant relationship between total citation time 2017 and citation time 2017 ($r=0.268$, $p=0.007$); total citation time and average citation per year ($r=0.156$,$p=0.122$); age of article and average citation per year ($r=-0.231$, $p=0.021$). In addition citation time in 2017 was negatively associated with the age of article ($r=-0.309$, $p<0.001$).

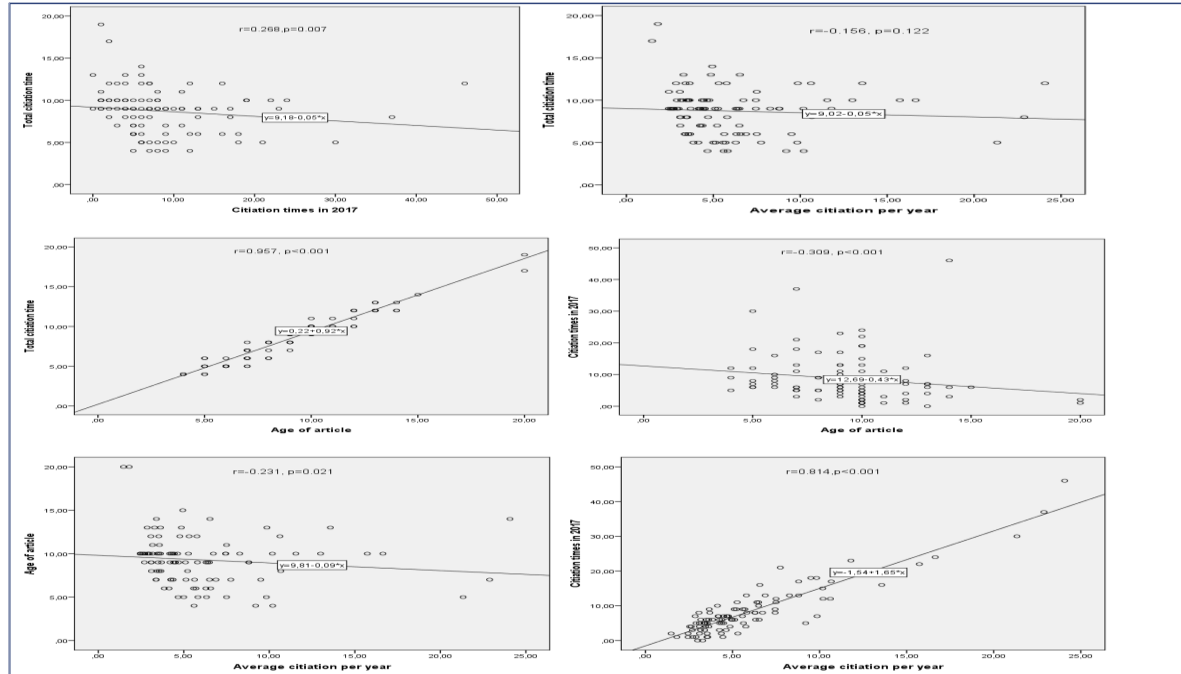

Figure 2. The relationship between average citation per year, citation time 2017, total citation time and age of the article

Journals

The total 65 different journals were detected which include indexes follows: BKCI-S, BKCI SSH, SCI-EXPANDED, ESCI, A&HCI, SSCI, CPCI-SSH, CPCI-S. Figure 3 has shown that the most frequent journals which include Tourism Management was the journal with greatest number of articles (11) in the top 100, followed by Social Science and Medicine (7), Bulletin of the World Health Services (4), International Journal of Health Services (3) and International Journal of Tourism Research (3).

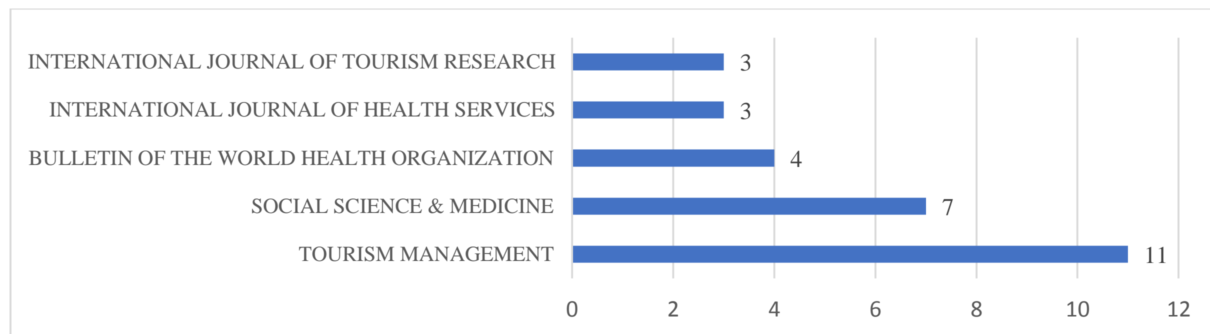

Figure 3. The Most Frequent Journals

The Publication Year

The publications included in the present study were between 2000 and 2018, there are no studies from 2001 to 2004. More than 10 published studies were found that in 2010, 2011 and 2013, the most productive year was in 2010 (Fig 4).

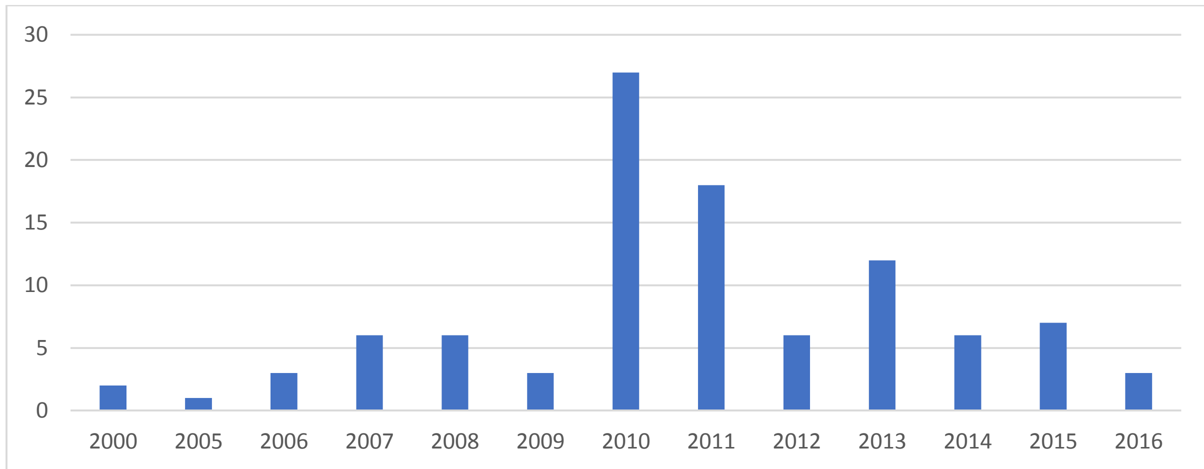

Figure 4: The Publication Year of the most cited publications

The Active Authors

Within 237 authors, the greatest number of articles were published by Crooks V. (n=6), Snyder J. (n=6), Johnstone R. (n=5), Turner Leigh G. (n=5), Lunt N. (n=5), Smith R. (n=4) and Kingsbury P. (n= 4). In addition Connel J. published 3 article as single author and has the greatest number of citation within the most cited top 100 articles (total 575 cite). Figure 5 has shown that the network visualization map. The colors indicate the clusters and the thickness of the lines indicates the strength of the relationship.

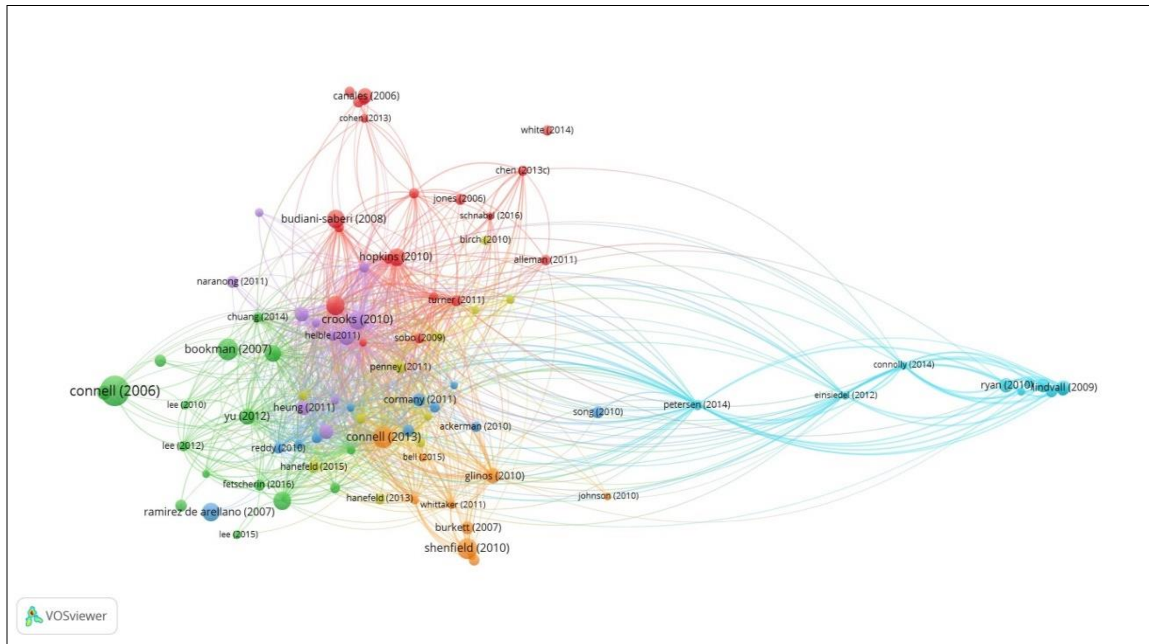

Figure 5: The Active Authors network visualization map

The Countries

The most 100 cited papers were published by institutions from 10 different countries. 36 articles were from America (USA), 18 articles were from North America (Canada), 1 article was from South America (Brazil), 9 articles from Oceania (Australia and New Zealand), 17 articles were from Asia and 18 articles were from Europa. More than half of the articles were published in the America continent (Fig 6).

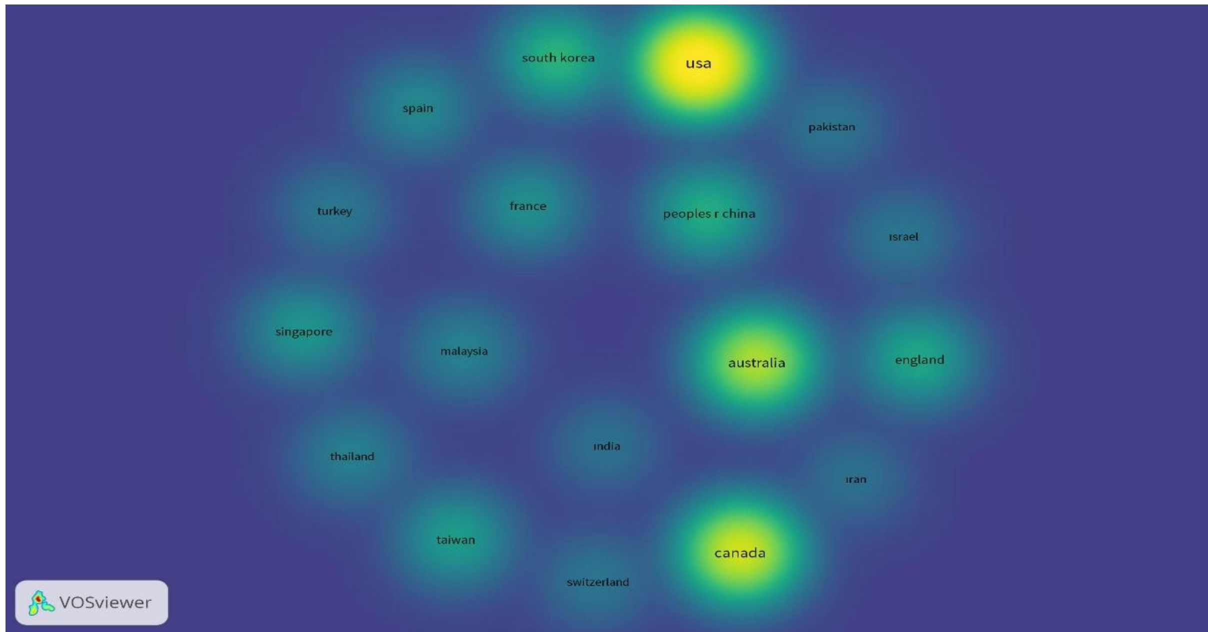

Figure 6: The Country of the most cited publications

Keyword Analysis

This analysis was used through keywords co – occurance and the purpose of this analysis was to conceptualize that the tendency and currently state of the main research topics in health and medical tourism. Figure 5 shows that the papers keywords were revealed down of the abstract. There were 222 different keyword in the most cited top 100 articles in this study. “Medical tourism” was occured 43 and total link strength was 57. “Globalization”(9), “stem cell tourism”(6), “health tourism”(6) and “ethics” (4) were another keywords. According to keywords visualization “tourism”, “study” and “care” bigger than other keywords, it means that they have been aboved most commonly.

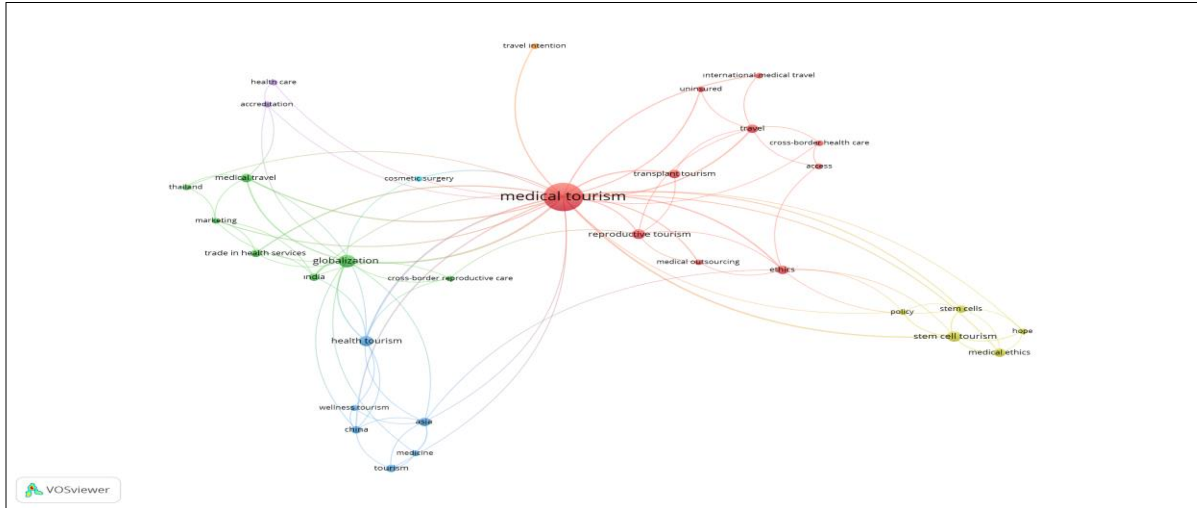

Figure 7. The keywords analysis network visualization map

Discussion

Bibliometric analysiss are useful to the evaluation of authors, journals, institutions, and countries in the academic field (Ramos et al., 2019: 369). The purposes of this study are a) to review evidence-based and cumulative information health tourism literature by bibliometric analysiss; b) identify the current 100 top-cited articles in medical tourism ranging from 1970 to 2020 and indexed in WoS.

Given how important research on Health and Medical Tourism field is in scientific areas, it is necessary to prove the most cited top 100 articles in this area and draw a picture of the output process. This study will also help researchers in the health and medical tourism field.

In the literature, tourism researches, analysis of journals, the tendency of health tourism researches, analysis of citations in publications were analyzed by bibliometric methods. Our study is consistent with these studies (Temizkan et al., 2015; Benckendorff and Zehrer, 2008; De la Hoz et al., 2018; Hall, 2011; Yuan et al., 2015; Canik et al., 2019).

According to publication years of the most cited top 100 articles, all of the articles were published between 2000 – 2016 and the most productive year was 2010. Almost 75% amount of those articles were published in 2010 and after years. The reason for such an increase may be Health Tourism being an emerging sector due to some internal problems in different countries in the last ten years (Toprak et al., 2014: 44). There were only five most frequent journals which include Tourism

Management Social Science and Medicine, Bulletin of the World Health Services, International Journal of Health Services and International Journal of Tourism Research. Nearly one – fourth of these articles were published in those five journals. Also a total of 65 different journals were detected in our study. This result shows that the health and medical tourism area was very large and varied as the tourism area. In their bibliometric analysis, Garrigos-Simon et al. (2019) have concluded that the Tourism Management journal is one of the biggest in the tourism literature.

The most 100 cited papers were published by institutions from 10 different countries. 36 articles were from America (USA), 18 articles were from North America (Canada), 1 article was from South America (Brazil), 9 articles from Oceania (Australia and New Zeland), 17 articles were from Asia and 18 articles were from Europa. More than half of the articles were published in the American continent. However, it is a remarkable finding that there is no publication from the African continent within the most cited top 100 articles in medical tourism. This is also confirmed that some bibliometric studies. For instance, a bibliometric study has shown that the total number of publications of the Journal of Cardiothoracic and Vascular Anesthesia from Africa has unvaried from 1990 to 2011 (Pagel and Hudetz, 2013).

Conclusion

Generally, medical tourism and related fields have been covered by the research area which including contributions from various authors, institutions, and countries. Within the most cited top 100 articles globalization and stem cell tourism seem to be trending topics in the field. We also have seen that health tourism is a very large area due to different journals. Bibliometric analysiss are a useful tool for researchers and they could implement it for their studies.

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Int Journal Of Health Manag. And Tourism 2020, 5(3), 336-347

JHMT Editorial

International Journal Of Health Management And Tourism

THE EFFECTS OF INFORMATION SECURITY TRAINING ON EMPLOYEES: A STUDY FROM A PRIVATE HOSPITAL

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Received: 08.09.2020
Accepted: 31.10.2020
Research Article

Abstract:

Aim: Human error is known as the biggest threat to information security in healthcare organizations. Training on the information security is important to the mission of establishing sustainable information security. The aim of the study was to evaluate the effect of a training program for information security in a private hospital.

Materials and Methods: In this cross-sectional study, 66 medical unit employees (M/F: 53/13, mean age: 30,27±11,12 years) and 34 administrative unit employees (M/F: 11/23, mean age: 31,5±10,84 years) using

the Hospital Information Management System (HIMS) were included. Data were collected by a questionnaire regarding the validated Information Security Scale before and after the training program.

Results: Scores of Security Policy, Security Applications, Access and Authorization subgroups were significantly improved by the training program in both medical and administrative staff ($p<0.05$). However, these scores in pre-test and post-test were found to be similar in both groups ($p>0.05$). In addition, there was no positive effect of HIMS training on scores of these subgroups ($p>0.05$).

Conclusion: Well-designed training programs are necessary for improving information security culture in hospitals. Since ensuring the appropriate protection of organizational assets, it is essential to design an effective training program regarding information security and privacy in the perspective of health managers.

Keywords: *Information security, Privacy, Information security training, Private hospital*

Introduction

Information and communication technologies (ICTs) are increasingly used in healthcare. The use of ICTs in healthcare services contributes positively to service delivery by increasing service quality and patient safety, ensuring the efficiency of financial and administrative activities, storing data easily and having access to the system for many users (Delgado et.al, 2016). Although they offer numerous benefits, risks of security and privacy are copying or sharing of username/password and patient information or visible patient information on device screens. Data security breaches are growing concerns (Arain et.al, 2019).

Information security and technology use are two essential components in the provision of healthcare services (Mumcu et.al, 2014; Wilkowska et.al, 2012). Moreover, users have important roles to contribute institutions' information security performance as well as security awareness and cautious behavior (Schattner et.al, 2007; Stanton et.al, 2005). Accessibility, integrity and confidentiality of electronic medical records are important issues for providing healthcare services (Kruse et.al, 2017). It should also be kept in mind that negative situations such as attacks on medical records, changing records or blocking access to records are significant risks for all stakeholders involved in service delivery (Desjardin et.al, 2020).

Since the healthcare environment involves several stakeholders, namely the patient, the healthcare provider, researchers, and third-party payers, unauthorized access or any failure of the information security are critical points for the perspective of health management. Security breaches are threats that they also result in both direct and indirect costs. The data security is ensured by the application of technical controls, well-designed operational plans, policies and awareness and training (Box

and Pottas, 2013; Ahlan et.al, 2015). Since it is important for organizations to create a security-conscious culture, each organization has its own information security culture. Culture has influenced by the formation of many security measures, such as national security policy, information ethics, security training, and privacy issues (Gebrasilase and Ferede, 2011). Organizations should make continual efforts to ensure that the content of policy is effectively communicated to the employees (Ghazvini and Shukur, 2016). Therefore, the factors that play a significant role in shaping perceived security should be enhanced (Peikari et.al, 2018).

Training programs for information security are required by all organizations because they need to protect their valuable assets. The employees play an enormous role in information security. As many organizations are envisaging new threats and challenges in information security, the training programs should be flexible and adjustable to meet the current and future challenges. A sustainable training program would have been established to meet the future need. The training program will also accord the users to realize the knowledge of sensitive and personal data, knowledge of the organization security goals, security policies and the skills needed towards information security management (Olusegun and Ithnin, 2013).

Since training programs are effective approaches to reduce the risks in electronic health systems (Olusegun and Ithnin, 2013), the organizations can develop several training modules that target employees who need to be aware of their requirements for compliance based on legislative policies and acts (Arain et.al, 2019; Tsohou et.al, 2008). Employees have different levels of computer skills, thus they require to be trained differently. It is also observed that most of the trained employees do not attempt to apply the learned skills in the work environment. Moreover, many training programs do not measure users' performance before and after the training, and therefore, it is not possible to evaluate the training's outcome. Additionally, several employees are not motivated to contribute on the awareness-training program (Ghazvini and Shukur, 2016). Finally, human error is considered as the biggest threat to information security effectiveness owing to lack of employees' attention (Ghazvini and Shukur, 2016). Therefore, many organizations establish the awareness programs to ensure that their employees are informed about security risks, thereby protecting themselves and their profitability (Gebrasilase and Ferede, 2011).

Security policy is about making users aware of the value and importance of information and security procedures. Therefore, these programs are important approaches towards training users to prevent security incidents (Tsohou et.al, 2008).

The aim of this study was to evaluate the effect of an information security-training program for Hospital Information Management System (HIMS) in a private hospital.

Materials and Methods

The study was carried out in a private hospital that had a total of 403 employees. The number of HIMS users was 313 in the hospital. Among them, 100 users participated in the study. Pre-tests were applied before information security training. Then, the training was performed. A week later, post-tests were carried out.

The data were collected by a structured questionnaire regarding the Information Security Scale validated by Kılıç Aksu et.al (2015). In addition, employees were asked whether training for HIMS was received or not. The health manager in the hospital chose three sub-group scores of the scale regarding "Security Policy", "Access and Authorization" and "Security Applications". The questionnaire was scored with a five-point Likert Scale (1: strongly disagree, 2: disagree, 3: neutral, 4: agree, 5: strongly agree). Low scores indicated good information security status. The study was performed according to the principles of the Declaration of Helsinki and was approved by the Ethical Committee of Marmara University Health Institute (15.04.2019-108).

Statistical analysis. Data were analyzed by using SPSS 26.0 statistic program (IBM, USA). The differences between Pre-test scores and Post-test scores were compared by Paired T test. Scores of different groups were analyzed by Unpaired T test. In the study, p value less than 0.05 was accepted as statistically significant.

Results

Table 1. The Profile of the Study Group

		Medical Unit Employees		Administrative Unit Employees		Total	
		n	%	n	%	n	%
Gender	Female	13	19,70	11	32,30	24	24,00
	Male	53	80,30	23	67,70	76	76,00
Age	20-30	43	65,20	21	61,80	64	64,00
	31-40	11	16,70	10	29,40	21	21,00
	41-50	5	7,60	1	2,90	6	6,00
	>50	7	10,60	2	5,90	9	9,00
Graduation	High School	25	37,88	16	47,05	41	41,00
	University	41	62,12	18	52,95	59	59,00
Working period in the hospital	0-1 years	39	59,10	12	35,30	51	51,00
	1-2 years	20	30,30	17	50,00	37	37,00
	> 2 years	7	10,60	5	14,70	12	12,00

In the study, the profile of the study group was seen in Table 1. When the working experience in the hospital was evaluated, 88% of employees were working in this hospital for less than 2 years (Table 1). When subgroup scores of the scale were examined in medical employees and

administrative employees, pre-test scores of them were found to be similar in the study (p>0.05) (Table 2 and Table 3).

Table 2. Comparison of Pre-Test and Post-Test Scores of Information Security Scale of Medical Unit Employees

		n	Mean	SD	p
Security Policy	Pre-test	66	20,34	7,52	**0.000**
	Post-test		14,56	3,19	
Access and Authorization	Pre-test	66	13,39	4,59	**0.000**
	Post-test		10,71	1,87	
Security Applications	Pre-test	66	8,9	3,15	**0.000**
	Post-test		6,22	1,58	

Table 3. Comparison of Pre-Test and Post-Test Scores of Information Security Scale of Administrative Unit Employees

		n	Mean	SD	p
Security Policy	Pre-test	34	20,05	7,02	**0.000**
	Post-test		14,88	2,69	
Access and Authorization	Pre-test	34	12,29	3,88	0.07
	Post-test		10,94	1,89	
Security Applications	Pre-test	34	8,35	3,23	**0.001**
	Post-test		6,11	1,64	

In medical employees, all subgroup scores were significantly decreased by the training compared to pre-test scores ($p<0.05$) (Table 2). When the pre-test and post-test scores of the employees working in the administrative unit were compared; decrease in scores were found in the sub-groups of “Security Policy” and “Security Applications” after information security training ($p=0.000$, $p=0.001$ respectively). Yet, no significant difference was found in the “Access and Authorization” subgroups ($p=0.07$) (Table 3).

The effectiveness of HIMS training on information security was also evaluated in the study. There were no significant differences observed in subgroups scores of employees whether HIMS training was received or not ($p>0.05$) (Table 4).

Table 4. Pre-Test and Post-Test Scores of Information Security Scale in Employees According to Education Status for HIMS

			n	Mean	SD	p
Pre-test	**Security Policy**	Education (+)	67	19,46	7,41	0.068
		Education (-)	33	22,30	6,87	
	Access and Authorization	Education (+)	67	12,67	4,61	0.259
		Education (-)	33	13,72	3,81	
	Security Applications	Education (+)	67	8,55	3,24	0.458
		Education (-)	33	9,06	3,04	
Post-test	**Security Policy**	Education (+)	67	14,32	2,95	0.108
		Education (-)	33	15,36	3,09	
	Access and Authorization	Education (+)	67	10,73	1,96	0.643
		Education (-)	33	10,90	1,70	
	Security Applications	Education (+)	67	6,17	1,63	0.923
		Education (-)	33	6,21	1,55	

Discussion

Information security and privacy are important for medical unit employees in terms of protecting patient information, while administrative unit employees have responsibilities for the protection of institutional information (Sevimli et.al, 2019). The importance of information security training is emphasized in order to prevent user-related problems (Kılıç Aksu et.al, 2015). Employees of an organization are still the most variable, unpredictable and the most uncontrollable factor in the information security. They may consider themselves secure by using passwords for accessing computers or any data. But in fact, it does not hold truth because some of them might choose predictable passwords or might share it. All these could happen because employees are not aware of the importance of information security, or they may not have a clear understanding of the risk. Information security is a critical and complex task, it is not just using usernames and passwords as security measures (Tschakert and Ngamsuriyaroj, 2019; Hepp et.al, 2018). The most important factor in effective information security is to make all employees aware of their responsibilities and their roles in information security. Security awareness teaches them how to protect the organization's valuable information and how to take responsibility for preventing security breaches. The aim of information security awareness is to make positive changes in the behavior of the employees (Tschakert and Ngamsuriyaroj, 2019). Therefore, the aim of the study was to evaluate the effect of a training program for information security in a private hospital.

In the study, scores of "Security Policy", "Access and Authorization" and "Security Applications" subgroups in the Information Security Scale were decreased by the training in the medical unit employees. However, similar trend was seen in administrative unit employees, except "Access and Authorization" subgroup. Since Access and Authorization of the scale is critical component for administrative unit employees, these results were predicted.

Information security training should be an integral part of healthcare employees' continuing education to prevent potential breaches and protect patient information. The evaluation of the training program ensures that employees are aware of available resources and understand how to prevent ICTs security breaches. Employees' lack of awareness related to organizational ICTs policy and compliance requirements could potentially create more risk for security breaches (Arain et.al, 2019). Therefore, information security training is an important instrument to improve and

influence the knowledge, attitude, and behavior, for information security in the employees. Human error can be minimized through the training programs. The significance of information security is the best defined as the level of user comprehension of information security awareness. In every organization, employees have varying knowledge of information security awareness. These kinds of errors can be corrected through training programs with an intention to promote behaviors of individuals toward organizational policy. Training programs in organizations can help to improve employees' awareness toward the security of E-health systems and help them to adhere to appropriate behaviors that do not compromise the security of the system (Ghazvini and Shukur, 2016). Based on these facts, the information security awareness programs have positive influences on the employees' knowledge, attitude, and behavior in real life. It is strongly recommended to have management support, in order to promote the employees into massive participation (Tschakert and Ngamsuriyaroj, 2019; Hepp et.al, 2018). Therefore, employees' training is the greatest non-technical tool to protect information security in organizations (Fernández-Alemán et.al, 2015). Good training and efficient policies to deal with security threats are good sources of preventing security breaches in health organizations (Fernández-Alemán et.al, 2015; Veiga and Martins, 2015). Training can increase staff knowledge and awareness about the threats and consequences of a security breach, leading to the prevention of such incidents. Likewise, employees' training and monitoring can influence the security culture in organizations. Employee monitoring is used by organizations to ensure that their employees adhere to their rules and regulations. Accordingly, employee monitoring reduces the likelihood of an employee-related security breach by increasing their perception of certainty and severity of punishments and the potential consequences for such behaviors (Peikari et.al, 2018).

In the study, no significant difference was found in the pre-test and post-test subgroup scores of those who received HIMS training and those who did not. The use of HIMS has ensured the achievement of many purposes such as creating a cost advantage, saving time by efficiently using time, producing quality service, and protecting and improving health. In particular, it has enabled the service provision to the patient at the right time (Mumcu et.al, 2014). In this respect, HIMS training is of great importance. However, according to the results of the study, it is thought that HIMS training is not sufficient in terms of providing information security and privacy. This results could be predicted since the outlines of information security training are different from HIMS

training. It is thought that ensuring information security is possible by creating an institutional culture on this subject, increasing the awareness of the employees through information security and privacy training at regular intervals. According to the results, training is of great importance in ensuring information security and privacy.

This study showed the importance of information security training as well as lack of performance of HIMS training on information security. The main limitation of the study was that data were collected from a single hospital.

Conclusion

Employees must be trained on how to handle information carefully according to the guidelines and to become aware of the possible consequences of their actions. Security training and awareness programs are even more critical to any comprehensive information security policy. It is essential to increase the effectiveness of information security training programs by encouraging employees to make an effort in transferring the learned skills to their daily job activities. Employees who interact with HIMS must be educated about the risks and hazards associated with information security. As a result, the security policy should be aligned with the readiness of the user's state of perception and emotion, as well as the user's environment.

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Int Journal Of Health Manag. And Tourism 2020, 5(3), 348-362

JHMT Editorial

International Journal Of Health Management And Tourism

HEALTH TOURISM CONCEPT AND TRANSCULTURAL NURSING ACCORDING TO THE MEANING WORLDS OF NURSES

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Received: 01.09.2020
Accepted: 31.10.2020
Research Article

Abstract: Purpose: This study aims to describe health tourism and transcultural nursing concept from the viewpoint of nurses and to find out how they interpret them. Method: As a mixed study, it was conducted at 6 private hospital with the participation of sixteen nurses. Data were collected with demographic information form, intercultural sensitivity scale and semi-structured interview form. Result: The mean of cultural sensitivity scale score of nurses was 81.39 ± 4.84. Cultural sensitivity levels of nurses were not correlated with gender, marital status, age, education level, professional title and transcultural nursing training background. Only one nurse had transcultural nursing training. Lack of foreign language and cultural knowledge are problems for nurses while caring to foreign patients. Conclusion: Nurses mostly face language and communication difficulties while caring to foreign patients. Also, they need to get information and training about different cultures. Even if nurses play an indispensable and key role in health tourism, they cannot represent themselves sufficiently. Implications for Practice: The professional and personal development of nurses should increase by trainings on ethics, intercultural nursing and geography, especially foreign language. For easy and error free communication between nurse and patient, foreign language education must be integrated nursing education program.

Keywords: *Health tourism, transcultural nursing, nurse's experience, interpretation*

Introduction

Every year many people have to change their places due to some economic, politic and social reasons. (Tanrıverdi, 2017; Temel, 2012). In recent years one reason was added to these. People start to travel from home country to another to regain or to protect their health. (Çalışkan, 2009). Travels for this purpose revealed the concept of health tourism. (Soysal, 2017).

Described as a traveling from home country to another for health protection and promotion, health tourism includes treatment of diseases and rehabilitation services. According to Health Ministry of Turkey a person should stay at least 24 hours at other country and utilizes health and tourism opportunities of that place for being considered as a health tourist (Aydın, Constantinides, Mike, Yılmaz, Genç & Lanyi, 2012).

Health tourism, which has a rising value among tourism types, (Heung, Kucukusta & Song, 2011; Soysal, 2017) is a multicultural sector for both healthcare providers and patients. Sometimes nursing requires to give nursing care and treatment to the persons with different cultures at multicultural environments. (Tanrıverdi, 2017; Temel, 2012). Cultural diversity is an important approach that affects the quality of care (Temel, 2012).

Within the scope of health tourism, nurses should have some cultural knowledge and skills in order to provide appropriate and sufficient care (Amiri and Heydari, 2017) to persons who want to receive health services from another country (Soysal, 2017). Firstly, nurses should have cultural knowledge about their culture and also awareness about different cultures for giving care sensitively to foreign patients (Mubita-Ngoma and Mayimbo, 2017).

The scarcity of research related to health tourism and nursing in the literature and the lack of clarity between concepts (Ben-Natan, Ben-Sefer, and Eh-renfeld, 2010; Çevirme, Kaynak and Uğurlu, 2014) raised the question of how nurses interpret these concepts Nurses have great importance in health sector and the meaning of concepts for persons effect their private and professional lives. Because of that reason we think that this study contribute to nursing care and its quality.

Aims

The aim of the study was to describe health tourism and transcultural nursing from point of view of nurses and to find out how they interpret these concepts.

The main research question was "What are the health tourism and transcultural nursing according to nurses?

The sub-research questions were as follows:

Research Question 1: What are the health tourism and transcultural nursing?

Research Question 2: How do nurses experience health tourism and transcultural nursing concepts?

1. Method

In this study mixed research method was used. Quantitative data were collected with demographic information form and intercultural sensitivity scale; for collecting qualitative data, on the other hand, semi-structured interview form was used. According to "Regulation Concerning International Health Tourism and Tourist Health" dated 13.07.2018 from Turkish Health Ministry, if any healthcare facility wants to operate within the scope of international health tourism, it must have an international health tourism authorization certificate. Participants were recruited from six private hospitals, having international health tourism authorization certificate, located in Kayseri Province in Turkey.

1.1. Participants

Selected by using a purposive sampling method, participants consist of 16 nurses who are working at private hospital. They attended voluntarily.

The inclusion and exclusion criteria were

a) Private hospital which has international health tourism authorization certificate

b) Nurses who had at least undergraduate education

c) Nurses who had over 2 years of experience providing nursing care to foreign patient

d) Participant is excluded if he/she wants to leave from study at any stage.

1.2. Measurements

Questions on demographic information form and semi-structured interview form were developed from a review of the literature by researchers. Demographic information form consist of gender, age, marital status, professional time and title, education level, transcultural nursing training

background and nursing care experience to foreign patients. Semi-structured interview form aims to figure out nurses' experiences acquired over time related to foreign patients (see Table 2). Developed by Chen and Starosta (2000), intercultural sensitivity scale, 5-point Likert-type having 24 items that examined the nurses' intercultural sensitivity levels The average duration of the interviews was 15 minutes. Each interview was audio recorded. After that, researchers listened and transcribed the records into text word-by-word.

1.3. Ethical Considerations

The Ethical Committee of Erciyes University Social and Human Sciences approved this study. Private hospitals gave written permission. Also, it was obtained informed consent form and tape recording approving from participants.

2. Results

Sixteen nurses entered into the study. Participants consist of twelve female and four male nurses. One out of every four had Bachelor's degree. All of them were working in private hospitals. Their working experiences were between 2 to 36 years (Mean= 13.13±12.19). They had 2-8 years nursing care experience to foreign patients. Only one nurse had transcultural nursing training (see Table 1). The mean of cultural sensitivity scale score of nurses was 81.39 ± 4.84 and below the average. Spearman's Rho (two tailed) was used to assess the association between the cultural sensitivity scale score of nurses and socio-demographic characteristics of nurses. Findings indicated that cultural sensitivity scale score of nurses were not correlated with gender, marital status, age, education level, professional title and transcultural nursing training background.

According to qualitative part of the study, results that have participants' thought and experiences were surveyed three main themes. These themes were; health tourism, transcultural nursing and experiences of participants. Themes and related questions are shown in Table 2.

Table 1. Demographic Characteristics of the

Participants (N=16).

Variables	n	%
Gender		
Female	12	75
Male	4	25
Age, years		
20-24	2	12
25-29	5	31.3
30-34	3	18.8
35-39	1	6.3
40 and above	5	31.3
Education level		
Associate degree	3	18.8
Bachelor's	12	75
Master's or above	1	6.3
Marital Status		
Married	11	68.8
Single	5	31.3
Professional title		
Manager	4	25
Unit supervisor	6	37.5
Clinic nurse	6	37.5
Transcultural nursing training		
Have	1	6.3
Have not	15	93.8

Table 2. Interview Questions

THEMES	QUESTIONS
Health Tourism	What is the first thing coming to your mind about health tourism? What do you think about health tourism? What are the roles and responsibilities of nurses on health tourism? What is the place and importance of nurses on health tourism?
Transcultural nursing	What is the first thing coming to your mind about transcultural nursing? What do you think about transcultural nursing?
Experiences	What have you experienced while providing nursing care to foreign patient? What are the difficulties of providing nursing care to foreign patient How have you overcome these difficulties? How would be easier to provide nursing care to foreign patient?

First theme is related to health tourism concept and resolved by four questions.

First thing coming to nurses' mind about health tourism. Some of the participants' answers to this questions are like that;

"Interaction… a concept that is intertwined with health and tourism (P.16)"

"It is the process of foreign patients getting health care in our country (P.1)".

Another participant from holistic point of view stated that "It is the fact that people move to a different country in where have higher treatment center, medical center for regaining their physical, mental and spiritual health and receive treatment (P.8)".

According to participant 6, "health tourism represent different language and people from different cultures." Participant 7 interprets as "an income and advertising channel for Turkey".

Participants' thought about health tourism. Participant 3 from a perspective on research and development described this concept like that "To investigate the health structure and functioning of different countries." According to some participants, "it is an individual freedom to choose of health facility, doctor and country" (P.5) and "to be able to provide health services fairly" (P.9), "To be able to do our best so that people can achieve better quality living conditions" (P.7). "The effect of technological developments on health." (P.10)

Health tourism consists of health and tourism concepts, so it could be evaluated as a service that provides health and tourism services together (P.11). This is a reason that creates health tourism. People go to other countries for getting health related services.

"You can be sufficient in terms of medical devices and equipment, due to the lack of staff like nurses and doctors or lack of experiences of medical staffs. People can think to get medical supports from another place" (P.4)

Some participants laid stress on nursing care about the roles and responsibilities of nurses on health tourism. Even if nursing care is one of the main roles of nurses, participants mentioned that nurses' roles cannot be limited just nursing care and it is crucial to improve nurses' professional and personal development for increasing quality in nursing care (P.2, P.4, P.10, and P.15).

Some participants referred to the relationship of trust, which is important in establishing the therapeutic relationship between patient and nurse as a nursing role and responsibility at health tourism (P.11, P.8).

"Doctor prescribes medication, tells the treatment, but I am the one who will provide care and service. In order to be able to provide the correct service, I need to understand the patient" (P.14).

Thoughts of nurses about what the importance and place of nurses on health tourism were significant. As a member of health team, nurses "At the key point… a bridge between doctor and patient" (P.1).

Some participants criticized nurse's place on health tourism like that "In fact, medical treatment services are the same as those offered by the physician in other countries. So there is a method. I think that nurse is very effective on health tourism. If we can reveal our talent in terms of care and communication, if it is possible of course, I think nursing care will affect the medical treatment… nursing care services will be very effective on health tourism" (P.15),

"Nurses are of secondary importance in health tourism" (P.13) and

"Foreign patient come to Turkey for doctor or health facility's reputation. Doctors just give orders about what should be done. On the other hand, nurses are responsible for more jobs and patient satisfaction depends on nurses" (P.7).

The second theme of this research is related to transcultural nursing. Some participants evaluated this concept as a nursing service given to persons from all over the World. One participant emphasized that whole and complete nursing care should be given to patients regardless of the differences of religion, language, and race, social and cultural status (P.1).

According to participant 16, “transcultural nursing is acceptance, understanding and respect.”

A few participants mentioned that nursing is the same regardless of time, condition and country, it is the culture of the individual that makes care different.

“Nursing is same at all times and conditions. Because basic care needs of a person are always the same. It does not matter what the person’s culture is. Every person has same basic needs like, food, water, love, safety. These needs are unchangeable. Except culture. While given nursing care, nurses should pay attention moral side of the culture.” (P.7)

“…maybe cultural expectation can change otherwise nursing care are the same everywhere” (P.1).

Third theme of the research is experiences of nurses while providing nursing care to foreign patient in health tourism. A few participants said that foreign patients had higher expectations. This is probably the result of the differences between home country and host country health system.

According to participant 7, “This can be related to difference of privacy feelings of patients. Their expectations are different. In order to meet those expectations, it is necessary to know their sensitivity and what their privacy is. If we know what they like or not, our approaches will change.”

All of the participants gave the same answer directly or indirectly about what the difficulties of providing nursing care to foreign patient are and emphasized the importance of knowing a foreign language. They stated that their biggest challenge while providing nursing care to foreign patient was language problem. Knowing a foreign language is necessary to understand patients, to increase nursing care quality and to improve personal and professional growth.

“If we have difficulty in health tourism, this will be language problem. Except that, I think there is no problem.” (P.9)

“Knowing a foreign language will be easier for both the patient and professional groups.” (P.3)

Another problem was while providing nursing care to foreign patients was consent form. Consent forms should be prepared patient’s language.

Participant 5 stated that some female patients requested female nurses for religious sensitivities.

“I often come across Syrian female patients. They want a female nurse for taking nursing care.”

The participants developed some solutions individually for the language problem, the biggest difficulty while providing nursing care to foreign patients. These solutions involved “using various translation programs in internet” (P.1), “interpreter” (P.2), “gesticulation” (P.8) and “pictures” (P.10). A few health facilities hired interpreters. But, sometimes communication through interpreter has a risk and can increase misunderstanding between patient and nurse. As a nurse and also an interpreter, participant 11 declared her opinions about this risk like that:

“The biggest problem is torn between. Firstly, the treatment is told to me, after that I tell the treatment to the patients. If I had understood correctly, I had to ask 3-4 times at that moment. Since I am a nurse also, I can get it wrong, I can say that is wrong or cannot be done that way and I can explain the treatment such as what I know. For that reason, knowing foreign language is important and it would be easy if we speak the patient’s language.”

The last question related to easier way to provide nursing care to foreign patient consists of lack of staffs, importance of nursing education, language education and other training subject like ethic, geography.

“In our country, all nurse no matter having degree high school or bachelor can provide same health services even if they are different between in terms of educational level. Nurses working in health tourism should know different languages, should be trained in a more detailed related to foreign patients’ needs.” (P.1)

“Apart from language, ethic and geographical trainings….for understanding patients can be given geography trainings.” (P.16)

Participant 15 believe that “language is not important for nursing care. Good communication can solve whole difficulties. Nurses must know basic nursing care implements and bring the nursing care forward.

Another participant highlighted the shortage of staff and said "If our number of staff was a little more, it may be easier to care for the foreign patient" (K.2).

3. Discussion

The results of this study, aiming to describe health tourism and transcultural nursing from point of view of nurses and to find out how they interpret these concepts, were discussed three main themes which are health tourism, transcultural nursing and experiences of nurses.

As a first theme, health tourism was emphasized like these: interaction, getting to know different cultures and different persons, an advertising opportunity of Turkey. Also nurses mentioned health tourism components like an individual freedom to choose of health facility, doctor and country, to provide health services in a fair way and an economic income channel. It is well-known that health tourism has high economic income and this feature makes it attractive globally (Heug et al., 2011; Smith & Puczko, 2014).

Participants considered that nurses have an important place in health tourism; indispensable; and as a bridge between the patient and the doctor. However, they criticized that nurses have not been taken into consideration sufficiently and have been stayed in the background. They also mentioned the importance of nursing care, communication skill, therapeutic and reassuring relationship in health tourism as nursing roles and responsibilities.

Emphasizing the importance of personal and professional development in order to increase the quality of care, it has been stated that the quality of nursing care will increase healthcare demand not only for institutional but also across the country and make outstanding contributions to health tourism.

The findings related to transcultural nursing concept as a second theme showed that nurses need to get information and training about different cultures. For gaining cultural awareness, nurses should know knowledge about cultural differences and cultural values. According to Foronda (2008), cultural awareness includes not only respect, understanding, taking into account other people's concerns, caring, and careful thinking, care needs and also making treatment appropriate to the individual's needs.

In this study, the cultural sensitivity levels of the participants were below average. These findings were similar to some studies (Bulduk et al., 2011; Bulduk et al., 2017). Besides, findings show that participants did not have transcultural nursing education except one of them and transcultural nursing education should be included in nursing education program. Transcultural nursing

knowledge is as important as foreign language for nurses in order to take an effective and strong place in health tourism. It is thought that the quality of nursing care will be one of the required and sought qualifications for patients' selection process of the health facility and country in where they want to get medical treatment. Because of this, not only just nursing education but also its components are crucial.

In the study, it was determined that additional subjects like transcultural nursing, not just English also a few foreign language, ethic and geography could be added to basic nursing education and by that way nurses could be more familiar with different cultures. As a significant component of nursing care, transcultural nursing training will move nursing profession and nursing care quality forward in health tourism.

Nurses give care that is appropriate to the cultural, social and ethnic characteristics of the individual and that are different from each other. Nursing education give some information and opportunity to student on being comfort and sensitive to differences and complexity while they are practicing culturally competence care to person having different needs of care (Powell et al., 2008) and it must also give. In Turkey, it is expected that nurses must do same care at the same facility even if they have different educational levels. This can lead to problems, especially while caring for a foreign patient.

Sub-title of the third theme of this study is nurses' experiences is difficulties. Nurses mostly have problem on communication and cultural differences while caring to foreign patients. Knowledge, skill, positive attitude and awareness are some components of communication and important especially while interact culturally different people.

Results show that participants mostly face language and communication difficulties while caring to foreign patients. They created and used new alternative communication ways like pictures, internet translator, and body language for overcoming that difficulties. Aside from using internet, other methods are the basic communications ways. These lifesaving tools in hard situations are helpful for starting and maintaining diagnostic and therapeutic relationship between nurse and patient. True and accurate communication will reduce feel of inadequacy, stress and ambiguity and can create a mutual trust environment. Similarly, Boi (2000) stated that non-verbal communication ways help to overcome the communication difficulties between patients, patients' relative and medical staffs.

Findings show that communication is being through interpreter in some facilities, but risky and can increase misunderstanding during translation. Hence the study of Al-Amer et al. (2016), an interpreter must transmit the meaning of the spoken language in a complete and systematic way, beyond just transmitting the message.

All participants mentioned that knowing a foreign language is crucial in health tourism. Similarly, previous studies remarked that nurses had language problem while caring for different language speaking patients (Boi, 2000; Nielsen, 2009; Ngai et al., 2016; Ian et al., 2016). Language and cultural problems based on both nurse and patient can restrain nurses from practicing accurate and effective nursing care (Almutairi et al., 2015). Similarlly, Maeno et al. (2011) showed that Japanese nurses coul have difficulties because of the language and cultural differences while caring to foreign patients. A study showed that one of the dissatisfaction with the American health system of patients was language barrier with 7.9% (De Gagne et al., 2015). Amiri and Heydari (2017) found that giving nursing care to foreign patient could be challenging due to the language and cultural differences. Also, this situation sometimes causes nurses hopeless, fear and anxiety, and can lead them to avoid the patient. According to Hull (2016), language is the voice of culture and at the same time culture creates language. Not speaking same language can be lead to chaos, stress and disappointment among people.

In conclusion, language education must be integrated nursing education program. If it happened, nurses and foreign patients' communication could be easy and error free. According to Heung et al. (2011), language problems can be an obstacle for foreign patients. In order to overcome this problems and to provide health services at international standards within the scope of health tourism medical staff with foreign language knowledge needs to be recruited. Also, knowing more than one language not just English will increase nurses' job opportunity international level.

4. Limitations of the study

This study had sample limitation because of that only was conducted at private hospitals which has international health tourism authorization certificate. Besides, since this study includes qualitative research method and answers of nurses had theirs point of views that cannot be generalized.

5. Conclusion and Implications

Through the mixed research methods, this study shows that nurses should improve their foreign language and transcultural nursing knowledge. Health tourism and providing nursing care to foreign patients both can be challenging for nurses and also offer them some opportunities. Getting to know different cultures and learning different languages can be motivating for the personal and professional development of nurses. The quality of nursing care will increase patient satisfaction and healthcare demand not only for institutional but also across the country. Thus it will reveal the difference of Turkey in health tourism across the world. It is thought that nurses who speak foreign languages and have cultural competence will make outstanding contributions to health tourism. In order to thrust nursing profession forward in health tourism, the professional and personal development of nurses should increase by trainings on ethics, intercultural nursing and geography, especially foreign language.

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