
Can Inbound and Domestic Medical Tourism Improve Your Bottom Line? Identifying the Potential of a U.S. Tourism Market

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EXECUTIVE SUMMARY

In large part due to current economic conditions and the political uncertainties of healthcare reform legislation, hospitals need to identify new sources of revenue. Two potentially untapped sources are inbound (international) and domestic (within the United States) medical tourists. This case study uses data from a large, urban health-care system in the southeastern United States to quantify its potential market opportunities for medical tourism. The data were mined from electronic health records, and descriptive frequency analysis was used to provide a preliminary market assessment. This approach permits healthcare systems to move beyond anecdotal information and assess the relative market potential of their particular geographic area and the diagnostic services they offer for attracting inbound and domestic medical tourists. Implications for healthcare executives and guidance on how they can focus marketing efforts are discussed.

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INTRODUCTION

Medical tourism is generally considered to encompass "the act of traveling . . . to seek specialized or economical medical care, well-being, and recuperation of acceptable quality with the help of a support system" (Keckley & Underwood, 2008).

Medical tourism can vary in scope in terms of tourist services offered (e.g., medical treatment is sometimes packaged with complementary sightseeing tours and other vacation-oriented services [Konrad, 2009]) and according to type of medical procedure (e.g., from dental procedures to cosmetic surgery [York, 2008]). Traditionally, the medical tourism model has focused on residents who leave their country to pursue care at a destination that may provide less costly care and a vacation-like experience. In terms of the U.S. medical tourism model, this segment of the market is referred to as *outbound* medical tourism and presents the potential for lost revenue for domestic healthcare providers. *Inbound* medical tourism involves providing services to patients from other countries who travel to U.S. facilities for treatment (Keckley & Underwood, 2008). *Domestic* medical tourism involves providing services to patients from other states within the United States.

In 2008, more than \$5 billion was spent by the 400,000 non-U.S. residents who traveled to the United States for medical care, representing about 2% of hospital revenue. Most came from Europe, Canada, South America, and the Middle East (Keckley & Underwood, 2008). Typically, medical tourism does not encompass those patients who happen to fall ill while visiting another

locale; the term is reserved for those who seek out medical care in another state or country (NaRanong & NaRanong, 2011).

Medical tourism is a niche business (i.e., a small market segment) within the overall U.S. healthcare industry. The future growth of inbound and domestic medical tourism is not assured. Even with potential benefits for patients and healthcare organizations, possible impediments include opposition from medical associations, government travel restrictions, lack of patient information in the relevant markets, and inadequate marketing efforts. However, a global and national market for healthcare services is likely to continue as long as patients from other countries or other states seek care in a given facility and are able and willing to pay the cost directly, or indirectly through insurance. In addition, large U.S. employers, including Lowe's, Boeing, and Wal-Mart, are entering into partnerships with Cleveland Clinic, Mayo Clinic, and other prestigious health centers to offer their employees complex surgeries at reduced or no cost typically at out-of-state facilities (Cheung-Larivee, 2012; Terhune, 2012).

While prior research has examined the patient experience of Americans traveling abroad for care, a gap exists in the literature related to domestic medical tourism, especially studies based on methodology in how to assess current trends and tailor marketing to target consumers (Guiry & Vequist, 2011; Hudson & Li, 2012). One review of the medical tourism literature found little hard data on patient flows, revenues, benefits, costs for various stakeholders, and effective strategies to address such

challenges (Hopkins, Labonte, Runnels, & Packer, 2010). Most published information is anecdotal, derived from claims submitted by medical tourism brokers and from theoretical conjectures. Strategic marketing perspectives from the viewpoint of U.S. healthcare providers are almost entirely absent.

Another review concluded that research on medical tourism to date has been largely conceptual in nature, with major gaps in data analysis (Hudson & Li, 2012). Moreover, most research has focused on outbound medical tourism. In this article, we examine a case study of one large U.S. healthcare system as it begins to assess the market potential for both inbound and domestic medical tourism in an ongoing process to identify, assess, and market to their potential medical tourism target markets.

FUTURE POTENTIAL OF THE MEDICAL TOURISM MARKET

Many hospitals and health systems are looking overseas and to other states to attract new patients and sources of revenue (Van Dusen, 2008). Furthermore, medical facilities are exploring partnerships with hotels and other hospital-ity entities to promote entire medical tourism packages to interested patients (Hume & DeMicco, 2007).

To keep medical practice sustainable and innovative, external sources of patients and funds are vital. The Deloitte Center for Health Solutions (2008) calculates that outbound medical tourism represented \$15.9 billion in lost revenue for U.S. healthcare providers in 2007. It projects that the outbound medical tourist rate will grow from 750,000 patients in 2007 to

15.75 million in 2017. That estimate translates to a potential loss of revenue for U.S. providers of \$228.5 billion to \$599.5 billion in 2017 (Keckley & Underwood, 2008). However, providers have an opportunity to develop a medical tourism market that would attract patients outside the United States by partnering with tourism agents in both the patient's home country and the United States (the destination country) (Crooks, Turner, Snyder, Johnston, & Kingsbury, 2011). In so doing, medical tourism could shift from a revenue inhibitor (outbound) to a revenue enhancer (inbound/domestic).

U.S. healthcare facilities offer several potential competitive advantages relative to foreign competitors for both inbound and domestic tourists. These include positive word of mouth; services that are illegal or unavailable in other countries; numerous flights to major cities; assurance of high quality based on recommendations of employers or insurers; lowered risk of infections that are sometimes contracted in non-U.S. facilities; the availability of legal recourse in U.S. courts in the event of negative outcomes potentially caused by malpractice; and ease of communication during recovery.

Inbound Medical Tourism

Economic and population growth in some foreign countries has caused a demand for health services that these countries are not equipped to meet with their current policies and infrastructure (Thomas, 2010). An analysis of push and pull factors has shown that high costs and deteriorating healthcare systems in one's home country combined

with the innovation, efficiency, clinical quality, and service quality offered by many U.S. providers are major factors considered by inbound medical tourists. However, a lack of empirical research in the field makes it difficult to verify both the clinical outcomes for patients and the financial outcomes for providers (Veerasoontorn & Beise-Zee, 2010). Furthermore, if a patient's home country does not provide the service being sought or the patient does not consider local care to be comparable to that typically provided in the United States and other more developed nations, that individual may be more willing than other residents of that country to travel abroad for medical services (Keckley & Underwood, 2008).

Conversely, hospital resources, institutional environments, and geographic attractiveness to tourists are the most important considerations when considering how successful a hospital will be in attracting medical tourists (Al-Amin, Makarem, & Pradhan, 2011). A key driver of inbound medical tourism is the lengthy wait times for major surgeries in foreign countries with universal healthcare systems, such as Great Britain and Canada (Thomas, 2010; *The Economist*, 2008). In 2010, a considerable portion of patients in Canada, Sweden, Norway, and Australia reported waiting four months or more for elective surgery (OECD, 2011).

Domestic Medical Tourism

U.S. residents may engage in domestic medical tourism for a multitude of reasons. Some patients travel to seek care that is only available out-of-state,

while other patients travel in search of less expensive care or care that is perceived to be of higher quality. Although evidence of healthcare systems purposefully attracting domestic medical tourists is limited, examples do exist. Major healthcare systems, including Mayo Clinic, Johns Hopkins Health System, Baptist Health System, Adventist Health System, and Cleveland Clinic, have expanded their reputations across state lines and market to state, national, and international consumers.

In an attempt to reduce spiraling healthcare costs, some large employers, such as Wal-Mart, Lowe's, Boeing, and PepsiCo, are embracing domestic medical tourism whereby employees travel, usually across state lines, for surgeries at healthcare systems with which the company partners. These large employers have negotiated reduced rates for various procedures to decrease their healthcare costs and insurance premiums while ensuring that their employees receive high-quality care. Some insurance companies also contract with specialty clinics for competitive pricing and convenient scheduling (Glattner, 2012; Terhune, 2012).

Domestic medical tourism is expected to grow significantly in the United States as more employers and insurers offer financial incentives for employees to seek health services outside their home state. More than 40% of U.S. patients have indicated that they would be willing to travel outside of their immediate area if their physician recommended it or if they could achieve a 50% cost savings (Deloitte Center for Health Solutions, 2009).

Facilitators and Inhibitors of Inbound and Domestic Medical Tourism

Figure 1 illustrates the environmental factors facilitating or inhibiting inbound and domestic medical tourism. The first facilitator is the level of tourism in a given market. In the United States, large, internationally known cities naturally attract tourists from other countries or states.

Other facilitators are a metropolitan area with well-known groupings of healthcare facilities; an affiliation or a national brand; attractive weather; a collaborative medical tourism marketing plan among individual healthcare organizations, corporations, and states;

and the presence of local healthcare providers who sign contracts with out-of-state or out-of-country employers and insurers to provide specific services to employees or enrollees at a discounted price. Obviously, the potential growth of medical tourism is greater for those geographic locations that already attract significant numbers of out-of-state and out-of-country tourists.

For this case study, we used data from a large, urban healthcare system that is attempting to determine potential market opportunities for medical tourism. We analyzed demographic characteristics and diagnosis-related groups (DRGs) for the system’s inbound

FIGURE 1
Facilitators and Inhibitors of Inbound and Domestic Medical Tourism

Facilitators	Inhibitors
1. Large tourism industry (e.g., New York, NY; Boston, MA; Washington, DC; Orlando, FL; Los Angeles, CA; San Francisco, CA)	1. Little tourism to the area
2. Well-known clusters of health facilities (e.g., Medical City, Houston, TX)	2. Few or no well-known healthcare facilities in the area
3. Well-known individual health facilities (e.g., Mayo Clinic, Cleveland Clinic)	3. Few or no well-known healthcare facilities with national brand status
4. Attractive weather (e.g., Florida, California, South Carolina, Georgia)	4. Lack of attractive weather
5. A developed, focused, and discounted strategy by healthcare facilities, states, or corporations (e.g., Galichia Heart Hospital, Wichita, KS; oncology care programs throughout Oklahoma; partnership between Cleveland Clinic and Lowe’s)	5. Lack of leadership and strategic plans to attract inbound and domestic tourism
6. Local healthcare facilities willing to contract with out-of-state employers and insurers to provide specific services at a discounted price	6. Lack of out-of-state or out-of-country contracts

and domestic medical tourists. The article concludes with implications for other U.S. hospitals and healthcare systems examining their potential for inbound and domestic medical tourism.

DATA AND METHODS

Research Questions

We determined the following research questions for our study:

1. For this healthcare system, are any patterns evident in hospital admissions of international or out-of-state patients in terms of country of origin and DRG?
2. What countries of origin, states, and clinical services might present the largest market opportunity of international or out-of-state patients for the healthcare system?

Study Sample

The sample for this case study is derived from a large, urban, not-for-profit healthcare system in the southeastern United States. Data for 2010 were analyzed for all non-U.S. and out-of-state residents. This system consists of a full-service medical/surgical facility with an emergency department; a hospital for women and babies; a Level I trauma center (the only one in the local area); a cancer center; a nationally ranked children's hospital; and three smaller regional hospitals, which have a combined 1,780 beds and together annually serve 2 million U.S. and 2,000 international patients. The system employs more than 14,000 team members, including 2,200 physicians. The system also serves as one of the state's six major teaching facilities and offers

residencies in eight specialties: cancer care, emergency/trauma care, heart and vascular care, neurosciences, oncology/hematology, orthopedics and sports medicine, surgery, and women's services. It receives the highest patient ratings in the metropolitan area for the measures under study: overall hospital stay and intent to recommend.

Data Collection Methods and Variables

The system furnished the data for this case study using patient records from each of its hospitals. The system's IT staff mined the data from electronic health records (EHRs), and all data pertaining to each patient's admission and treatment at all of the system's facilities were included. Descriptive frequency analysis was used to evaluate the following data elements:

- Hospital admissions—by facility and for the system as a whole
- Country of origin—nationality (if not the United States) of the traveler
- State/province—state or province in which the patient resides
- Age—patient's age at time of admission
- Diagnosis—patient's primary diagnosis
- Payer—whether the payment to the hospital was out-of-pocket or through a third party; if payment was received through a third party, the name of the payer
- Charges and source of payment

Analysis

Descriptive tables were developed from the data to identify utilization patterns for inbound and domestic medical

tourists, which in turn can be used to develop future marketing plans to attract both types of patients.

RESULTS

Tables 1 through 3 provide a summary of 2010 patient admissions data that were mined from the system's EHR. Each table contains data from various hospitals in the system: a women's and children's hospital (CHILD); a 237-bed, full-service medical/surgical facility that also operates a busy emergency department (LARGE W/ ED); a Level I trauma center (TRAUMA); and a collaborative of three smaller regional hospitals (3 REGIONAL). It is important to note that LARGE W/ ED is located in close proximity to several major tourist attractions. The percentages represented were calculated on the basis of the category's ratio to the number of both out-of-state and out-of-country patients as a whole.

Table 1 displays the origin of out-of-country and out-of-state patients who received services at the facilities. Countries and states are listed in numerical order, from highest to lowest, based on their total number of patients. Only countries with greater than 10 patients are listed. Those with fewer than 10 patients are represented by ALL OTHERS. The United Kingdom represented the most inbound medical tourists (124, or 4% of all medical tourists). Canada and Brazil accounted for the second and third highest number and percentage, respectively, with a combined 3.2% of all medical tourists.

The states with the highest number of patients seen in the system were New York (282), Georgia (191), and

Pennsylvania (185). Patients from New York accounted for 9.2% of medical tourists. Of the 3,064 total patients, 420 were visitors from other countries (14% of all medical tourists) and 2,644 were from out of state (86% of all medical tourists) in 2010. Most patients (40.1%) were treated at the main downtown hospital facility (LARGE W/ ED). States with fewer than 50 patients are accounted for in ALL OTHERS.

Table 2 displays the gender and age of medical tourists who were treated. The out-of-country population was 50.7% female and 49.3% male, and the out-of-state population was 49.4% female and 50.6% male, representing a relatively even split. Patients aged 18–44 accounted for the highest percentage of out-of-country patients at 30.2%, while the majority of out-of-state patients were age 65 or older (35.5%).

Table 3 displays the DRGs captured from the case study system's medical tourists. Data are again displayed from highest utilization to lowest. All DRGs with fewer than 10 out-of-country patients are represented by ALL OTHER, as are all out-of-state DRGs with fewer than 50 patients. The top DRG categories for out-of-country visitors were Digestive System (19%), Circulatory System (14.5%), Respiratory System (12.4%), and Nervous System (11.4%). The top DRG categories for out-of-state patients included Circulatory System (17.2%), Digestive System (12.0%), Nervous System (10.4%), and Respiratory System (10.2%). The top four DRG categories were uniform for all medical tourists. For all inbound and domestic medical tourists combined, the most heavily utilized DRG categories were

Circulatory System (31.7%), Digestive System (31%), Respiratory System (23.1%), and Nervous System (21.8%).

Although not presented in a table, we also examined the sources of payment for all medical tourists. We found that the top three payment sources for

inbound medical tourists were managed care (43.6%), commercial insurers (29.5%), and self-pay (24.3%). By comparison, the top three payment sources for domestic medical tourists were managed care (30.9%), Medicare (39.0%), and self-pay (11.4%).

TABLE 1
Patients from Out of Country and Out of State (excluding the ED)

	Child	Large w/ED	Trauma	3 Regional	Total	%
Out of Country						
United Kingdom	28	77	11	8	124	4.05%
Canada	12	35	2	2	51	1.66%
Brazil	11	34	3	48	48	1.57%
Venezuela	4	13	2	19	19	0.62%
Ireland	5	9		2	16	0.52%
Mexico	3	9	1		13	0.42%
Germany		4	6		11	0.36%
All Others	30	66	27	15	138	4.50%
Total Out of Country	93	247	52	28	420	13.71%
U.S., Out of State						
New York	39	115	70	58	282	9.20%
Georgia	31	55	52	53	191	6.23%
Pennsylvania	20	58	39	68	185	6.04%
Texas	19	39	31	49	138	4.50%
Michigan	8	50	32	37	127	4.14%
Illinois	15	61	25	25	126	4.11%
New Jersey	17	58	20	28	123	4.01%
Ohio	13	45	31	29	118	3.85%
North Carolina	24	31	33	14	102	3.33%
California	19	40	20	24	102	3.36%
Virginia	21	29	25	25	100	3.26%
Massachusetts	6	39	27	24	96	3.13%
Indiana	9	35	13	25	82	2.68%
Puerto Rico	7	36	27	12	82	2.68%
Tennessee	6	23	19	24	72	2.35%
Maryland	7	33	15	7	62	2.02%
South Carolina	4	15	20	12	51	1.66%
Alabama	14	18	14	4	50	1.63%
All Others	78	202	146	128	554	18.08%
Total U.S., Out of State	357	982	659	646	2,644	86.29%
TOTAL	450	1,229	711	674	3,064	100%

TABLE 2
Gender and Age of Out-of-Country and Out-of-State Medical Tourists

Gender	Child		Large w/ED		Trauma		3 Regional		Total		%	
	F	M	F	M	F	M	F	M	F	M	F	M
Out of Country	48	45	130	117	21	31	14	14	213	207	50.7%	49.3%
U.S., Out of State	212	145	507	475	286	373	301	345	1,306	1,338	49.4%	50.6%
Gender Total	260	190	637	592	307	404	315	359	1,519	1,545	49.6%	50.4%
Age												
Out of Country												
Age 0-17	83			2				1		86		20.5%
Age 18-44	10			89		18		10		127		30.2%
Age 45-64				91		12		5		108		25.7%
Age 65+				65		22		12		99		23.6%
Total Out of Country	93			247		52		28		420		100.0%
U.S., Out of State												
Age 0-17	252			9		6		8		275		10.4%
Age 18-44	103			239		173		209		724		27.4%
Age 45-64	1			365		206		135		707		26.7%
Age 65+	1			369		274		294		938		35.5%
Total U.S., Out of State	357			982		659		646		2,644		100.0%
Age Total	450			1,229		711		674		3,064		

TABLE 3
DRGs for Patients From Out of Country and Out of State (excluding the ED)

	Child	Large w/ED	Trauma	3 Regional	Total	%
Out of Country						
Digestive System	22	50	4	4	80	19.00%
Circulatory System	1	45	10	5	61	14.50%
Respiratory System	16	32	3	1	52	12.40%
Nervous System	6	27	13	2	48	11.40%
Musculoskeletal System	7	20	4	1	32	7.60%
Hepatobiliary System	2	19	1		22	5.20%
Pregnancy, Child	10	6	6	1	17	4.00%
Kidney & Urinary		14		1	15	3.60%
Endocrine, Nutri	8	5		1	14	3.30%
Skin, Subcutaneous	4	6	3		13	3.10%
Infectious & Parasitic	2	9		1	12	2.90%
All Other	15	14	14	11	54	12.90%
Total Out of Country	93	247	52	28	420	100.00%
U.S., Out of State						
Circulatory System	2	214	152	88	456	17.20%
Digestive System	42	164	58	53	317	12.00%
Nervous System	36	102	98	39	275	10.40%
Respiratory System	32	120	59	58	269	10.20%
Musculoskeletal System	12	66	96	37	211	8.00%
Mental Diseases		11	5	127	143	5.40%
Hepatobiliary System	3	66	26	23	118	4.50%
Pregnancy, Child	99	10	2	8	119	4.50%
Kidney & Urinary	9	57	11	25	102	3.90%
Skin, Subcutaneous	4	31	29	29	93	3.50%
Infectious & Parasitic	7	37	9	25	78	3.26%
Endocrine, Nutri	14	31	13	17	75	2.80%
Inj, Pois, & Tox EF	19	15	20	16	70	2.60%
Ear, Nose, and Throat	10	20	23	5	58	2.20%
BLD & BLD Form O	11	15	7	17	50	1.90%
All Other	57	23	51	79	210	7.90%
Total U.S., Out of State	357	982	659	646	2,644	100.00%
Total	450	1,229	711	674	3,064	

DISCUSSION

This article presents a case study of how one large, urban healthcare system gathered relevant data for developing a medical tourism marketing plan. The goal was to identify geographic areas outside the state and the country likely to be attractive markets for medical tourists and to determine appropriate service categories likely to appeal to such patients. Our analysis shows that most domestic medical tourists, who represented 86% of all medical tourists, were from New York, Georgia, and Pennsylvania.

With respect to inbound medical tourists, who represented 14% of all medical tourists, the largest percentage came from the United Kingdom, followed by Canada and Brazil. The high percentage of UK patients could be due to the perceived wait times for health services and to National Health Service insurance limits. Canadians were also well represented due to the large number of so-called snowbirds who travel to the particular geographical area in winter. Brazil was overrepresented due to demographic affiliations, including immigrant relatives and ease of travel to the area considering the large number of flights to and from Latin America.

The highest patient DRG volumes from both out-of-state and out-of-country locations were Circulatory System, Digestive System, Respiratory System, and Nervous System. Together, these four categories represented about 57% of inbound medical tourists and 50% of domestic medical tourists. These might be interesting areas for clinics and strategic planning departments to explore for possible medical tourism marketing efforts in the future.

The system in this study has been trying to develop a marketing plan focused on categories of services currently in demand by domestic and inbound medical tourists representing the highest proportions of these patients. Targeted countries include the United Kingdom, Canada, and several Latin American countries and the states of New York, Georgia, and Pennsylvania. While this marketing plan has not been fully developed as of this writing, the administration is aware that multiple media channels, including social media (e.g., Twitter), may need to be used outside the United States.

The fact that the same four service categories accounted for half or more of the utilization for both inbound and domestic medical tourism should help to focus future marketing plans. The identified older demographic and consequent greater use of Medicare by out-of-state medical tourists may also differentiate this market from the younger demographic of out-of-country medical tourists. Marketing efforts aimed at seniors will probably be different than those aimed at a younger demographic.

Although this case study focused on patterns of existing inbound and domestic medical tourism, the development of marketing plans should not focus exclusively on foreign countries and states where the system already has demonstrated significant attraction for medical tourists. The system may also want to recognize other countries or states with significant tourism in the area as identified by the local convention and visitor's bureau (CVB). For example, the healthcare system used in this case study seems

to be attractive to residents of Mexico and Ireland. If the CVB also identified these nations as countries of origin for significant numbers of tourists, they may be potential target markets as well.

Finally, the system might wish to enhance both types of medical tourism in specialties that have not yet been fully utilized. It currently attracts mostly adult medical tourists despite having an outstanding children's hospital. Marketing pediatric services to both inbound and domestic medical tourists would increase the visibility of pediatric services and provide another avenue to grow the system's market share of medical tourists.

CONCLUSIONS AND PRACTICE IMPLICATIONS

Outbound medical tourism as a healthcare trend has occurred in the United States for many years. Healthcare executives should investigate opportunities to expand their addressable markets by considering the potential revenue enhancement from inbound and domestic medical tourism.

The discussion of a paradigm shift in the way U.S. healthcare providers view medical tourism is timely given the implementation of the Affordable Care Act (ACA). The ACA's reforms will affect hospitals and healthcare systems in numerous ways, such as the influx of patients who were formerly uninsured into the healthcare system. Many of these patients will now be covered by Medicare or Medicaid. Historically, these payers have reimbursed providers at lower-than-average rates, which raises the question of the relative desirability of newly identified potential domestic

medical tourists who are likely covered by Medicare or Medicaid. By comparison, inbound medical tourists are likely to be covered by commercial insurance or will self-pay. The emerging trend of large employers contracting with out-of-state facilities may prove financially beneficial enough to compensate for the increase in domestic government-insured medical tourists.

Regardless of the impact of the ACA's reforms on a medical tourism destination healthcare facility, as a result of expected decreases in reimbursement, hospitals and healthcare systems will likely find themselves operating with reduced profit margins and will need to create new ways to generate revenue or shift costs onto other payers. Implementing a medical tourism line of business in a healthcare system could be a viable way to increase revenues without shifting the cost burden to payers and patients in the local community. Such an initiative is more likely to be successful if the incremental costs are not prohibitive and the new contracts do not jeopardize existing contracts.

This article serves as a starting point for healthcare executives to begin investigating an opportunity to take advantage of medical tourism markets. Future research could identify ways to target patients from certain countries. For example, if an area reports high levels of tourism from a specific country but local hospital data do not show this population represented in their out-of-country patients, marketers could focus their efforts on attracting these individuals as potential medical tourists.

Of course, successful attempts to attract medical tourists are not based on

marketing alone. Future research might also focus on the barriers to medical tourism, including cultural differences; difficulties in transferring and translating medical records across countries; and expectations of third-party payers, embassies, and international companies. Healthcare executives must be able to address such difficulties if their marketing efforts have a chance of proving fruitful.

In addition to data mining from sources internal to the organization, we suggest looking to tourism data already collected in the state in which the healthcare system is located as well as international data (e.g., that collected by the World Health Organization [2010]). Census data could also be studied to identify the percentage of foreign-born residents living in a certain area (e.g., Canadians in northern border states, Latin Americans in Texas). They might be inclined to bring family members to the United States from their home countries for medical services, thus becoming another potential market for inbound medical tourism. Identifying this pattern can help market researchers adjust their strategies to target such populations.

Fried and Harris (2007) suggest steps that hospital leaders could take to enhance their inbound and domestic medical tourism. First, demonstrate that the quality of service is worth the extra cost. Second, reduce the cost and improve the efficiency of operations. Third, emphasize personal privacy and personalized care.

In addition, we suggest that marketing plans be developed in conjunction with tourist agencies, corporations,

other healthcare facilities, and states to market the competitive advantages of the facility and region to medical tourists and employers. In other words, U.S. hospitals should develop and market a niche brand that focuses on medical tourism markets. To do so, however, requires partnerships with intermediaries, such as medical brokerages, to bridge the gap between clients and providers.

Some evidence suggests that domestic medical tourism is becoming increasingly organized. For example, Healthplace America offers travel and healthcare benefits directly to health plans that provide discounts for surgeries performed in 35 U.S. locations. Another medical tourism company, Healthbase, works with healthcare providers in California, Florida, and other states to fill beds with out-of-state patients who visit to undergo discounted surgeries (Lubell, 2009). These developments are consistent with a prediction by Rhea (2009) that more U.S. hospitals will offer discounted bundled care for particular procedures to attract domestic tourists. Such bundling may be more relevant for domestic than for inbound medical tourists.

One limitation of our study is that internal patient privacy policies prevented the release of detailed data that would have allowed cross-tabulations of the data. A second limitation was our inability to completely differentiate medical tourists from those who happen to need medical care while on vacation.

Future Research

To accurately evaluate the potential of inbound and domestic medical tourism

markets, it is imperative that healthcare executives and researchers seek answers to the following questions if they are to identify and develop inbound and domestic medical tourism markets.

1. Why are medical tourists using services outside their own service area, and how can U.S. healthcare facilities leverage this attraction to enhance their market share?
2. What cultural, informational, financial, and other barriers impede domestic and inbound medical tourism in the United States?
3. What types of services are demanded by inbound and domestic medical tourism patients, and from which countries? Is a pattern evident?
4. What are the demographic characteristics of each DRG in general or classified by type of medical tourism and type of services available to medical tourists?
5. How do inbound and domestic medical tourism patients pay for their care?
6. How do, and should, healthcare systems handle bundled payments for services under the Affordable Care Act? That is, what are the implications of healthcare reform for domestic and inbound medical tourism?
7. Under what conditions are target consumers willing to travel outside their country or state to access medical tourism services?
8. What are the costs of marketing to medical tourists, both globally and domestically?

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PRACTITIONER APPLICATION

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There is little argument that the healthcare industry continues to change at a fast rate. In fact, many healthcare organizations have had to evolve—if not reinvent themselves—to keep up with industry changes or risk being left in the wake of their competitors. At present, I see no sign of slowed momentum with healthcare reform. This means that today's healthcare administrator must become comfortable navigating unfamiliar waters and be willing to look at new sources of revenue to overcome a landscape characterized by reduced reimbursement.

Fottler et al. present a market perspective that has received limited research attention. Yet, I suspect that many domestic hospitals realize the potential of attracting the

medical tourist segment and have, at one point or another, created strategic initiatives to support both inbound and domestic medical tourism.

As a practitioner, I have had the privilege of experiencing all forms of medical tourism described in this article, including helping to grow a successful international center for inbound medical patients in a world-class academic medical center, managing hospitals in foreign countries that provide less costly care for American patients unable or unwilling to pay for their domestic insurance copays, and overseeing a hospital in the southern United States that serves the snowbird population from Canada and the northern U.S. states. On the basis of my experience, I concur with Fottler et al.'s conclusion that these markets represent potentially significant revenue streams.

In this study, the authors looked at a comprehensive data set to determine the utilization of healthcare services for a large urban healthcare system. While it is true that geographical, environmental, and individual facility (e.g., brand, reputation) factors attract medical tourists to healthcare organizations, all administrators should study their hospital admissions to determine origination patterns. Understanding current patient demographics and reviewing information from local convention and visitors bureaus may help organizations discover an untapped market for their hospital.

In addition to the external marketing plan the authors describe, organizations should review internal programs to determine if changes are warranted in areas such as translation services that cover patient education. Nutritional needs and diets may also require review to ensure alignment with the patient's country of origin. Finally, hospital staff may require culture-specific training to understand patients' traditions and customs.

In summary, healthcare administrators should recognize the potential that inbound and domestic medical tourism offers. While understanding why medical tourists visit certain hospitals is important, knowing the key satisfiers that grow future volume is essential. Experience suggests that facilities that formalize strategies with specific goals and established resources for inbound and domestic medical tourism outperform those facilities with unorganized approaches for this market.