

# Services Marketing and Medical Tourism: The Impact on Private Health Services in Bangkok

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## Abstract

This is a research paper that is concentrated on assessing service marketing developments and medical tourism and its impacts on the of private hospital provision in Bangkok, in terms of rationale, application and engagement.

An interpretive methodology was utilised in order to help understand the senior marketing management perceptions underpinning hospital services marketing developments directed towards medical tourism. The scope for this research were private hospital on-site senior marketing teams. The population of interest was made up of 14 senior marketers located at multiple-site main health services offices.

The research outcomes consisted of three (3) Main Themes - Health Services Marketing Management, Health Services Unit Internal Management and Services Marketing Developments; ten (10) sub-themes; with 244 discussion targets.

The paper addresses a number of raised issues and establishes outcomes and implications for managing medical tourism within the private hospital sector in Bangkok.

Very little research has been conducted in this area in Bangkok and the paper addresses health service issues/reactions to Medical Tourism as being unclear, tentative and requiring more effective and robust services marketing developments.

**Keywords:** Service Marketing, Medical Tourism, Private Hospitals, Bangkok

## 1. Introduction

The drive and level of international services marketing within private health services appears to be broadly supported in terms of value (Turner, 2007; Keckley & Underwood, 2008); improved marketing communication (Karuppan, 2009); social media marketing mechanisms (James, 2015); product and service quality (Zeithaml, Berry & Parasuraman, 1996; Clark & Clark, 2007; Murti, Deshpande & Srivastava, 2013); cost effectiveness (Rashdi, 2011; Hanefeld et al., 2013); reputation (Bhangale, 2011); and quality of facilities available (Li, Huang & Yang, 2011). Further, in order to provide an appropriate level of trust from prospective patients living in another country, the service marketing elements of branding equity (Bello & Holbrook, 1995); client satisfaction (Newsome & Wright, 1999; Gill & White, 2009); patient participation in decision-making (Fraenkel, 2013); and service development through the service chain, appears to be mandatory (James, 2005). Consequently, leaving one element unmanaged often results in failure for the whole service marketing chain (Voorhees, et al., 2017).

Private health services offer medical services appropriate to specific areas of expertise within a variety of disciplines – especially where this is associated with high-technology and consequent high cost. These service units have an operating business goal of making a profit (Raju & Lonial, 2002) that provides the fiscal drive to function and operate (James, 2012) with added value (Hareide et al., 2016; Fraser, Encinosa & Glied, 2008). Thus, private health services in Bangkok are now focusing on gaining additional revenue stream created through foreign patients. This is now moving more towards developing cross-border services that are likely to become more significant to the health services unit internal profit-generation ethos (Lin & Lin, 2010) through additional marginal revenue and profits because of oversupply (Crane, et al., 2011) and inter-hospital competition (Mascia, Vincenzo & Cicchetti, 2012). However, private health services tend to make a higher commitment to expending more on services marketing (Cutler & Morton, 2013) than government counterparts and can afford to target more effectively through clearly defined patient service marketing channels (Young & Erdem, 1996; James 2015).

In relation to profit requirements private health services appear to utilise additional elements of the marketing mix in order to establish and develop focused marketing related communications (James, 2015). This has led to changes in private health service provision, directed to additional management/marketing goals and internal processes in order to achieve this (Joynt, Orav & Jha, 2014). Consequently, many health providers attempt to pursue a systematic service marketing strategy (Speziale, 2015) that offers medical facilities to well-off patients (James, 2012) especially those with medical insurance. However, this should be contrasted with the notion that most insurance companies do not cover cross-border medical interventions (TravelInsurance.com, 2017) and therefore the use of accident insurance as an indicator of medical tourism transactions is perhaps widely inaccurate and imperceptive. However, it is an anathema to consider those individuals using accident insurance for inclusion in cross-border medical treatment as the accident insurance is in case of an accident, not as part of a planned medical intervention.

As hospitals are in a service sector, people, process and physical evidence are the additional factors associated with services through an extended marketing mix (Goi, 2009) by considering marketing practices (Thomas, 2005). Patients need to be informed and induced to engage through more focused hospital services marketing (Rivers & Glover, 2008), as patients require very personalised medical solutions. Medical professionals cannot operationalise unless the whole team including nurses, administrators, professional technician's and those comprised within the supply chain work towards more effective medical services provision (Sinha, 2017; Gordon, Feldman & Leonard, 2014). Inevitably, service marketing rests on all these incongruent individuals working together – and in the case of medical tourism – often at great distances. The engaged services marketing processes needed to work together so that the patient can safely, securely and comfortably move from home-hospital-home without risk or further injury and creates a need to consistently manage the service marketing strategy (Devers, Brewster & Casalino, 2003). Matching process requirements with patient requirements appears to be a very difficult issue to attain through the marketing services chain (McFadden, Stock, & Gowen, 2006). Further, services marketing developments in private health services tend to be motivated and constrained by government strategies and the regulators as a means to enhance service delivery (Al-Damen, 2017). This appears to be diametrically opposite the singular profit-oriented developments of private health provision (James, 2012).

Services marketing essentials that appear to be important in cross-border movement of patients (Horowitz & Rosensweig, 2007) appears to be the perception of the standard of practicing medical quality (Lagiewsky & Myers, 2008), responsiveness (Kanibir & Nart, 2012; Sheaff, 2002), whilst being cost effective (Lynch & Schalet, 1999; de Arellano, 2007). Changes in the service marketing prescription reflect different patient perceptions of heterogeneity (Grönroos, 1999), inseparability (Taner & Antony, 2006) and perishability (James, 2005) and appear to adjust client satisfaction and perceptions of service quality (Zeithaml, Berry & Parasuraman, 1996; Cronin, Brady & Hult, 2000). Services marketing mechanisms including digital communications and appear to have profound effects today on medical services provision (James, 2015) as patients demand more personal approaches (Choi et al., 2004) and delivery of international level capability who can afford to make appropriate choices regarding their medical needs (Fischer, Pelka & Riedl, 2015).

### *1.1 Medical Tourism services marketing in Bangkok*

Medical tourism (including health tourism (Borman, 2004) and wellness tourism (Pyke et al., 2016) is not a new medical professional undertaking, which has been conducted in private hospitals in Bangkok on an ad-hoc basis (James, 2012). However, the term 'medical tourism' is still in flux (Kelley, 2013), undeveloped (Horowitz, Rosensweig & Jones, 2007) and conditional (Carrera & Bridges, 2006), which raises confusion regarding its interpretation and use (García-Altés, 2005; Kangas, 2010; Sobo, 2009). Further, it is fairly difficult to understand the true numbers involved in medical tourism (Connell, 2006) and in Thailand where conflicting published figures such as 920,000 hospital visits by expatriates (Bangkok Post, 2018) or another source estimated 320,000 (Bangkok Post, 2017) does little to help build appropriate meaning associated with medical tourism for Thailand's medical policy developers (Bochaton & Lefebvre, 2008).

Consequently, there is a need to be more precise with the terms used for patient's crossing-borders (Turner, 2010; Masoud et al., 2013). For the purposes of this research, medical tourism is the intentional, prearranged single purpose, non-emergency medical undertaking (Johnson, et al., 2010) and experience of medical procedures and interventions across borders (Footman, et al., 2014).

Having raised these issues (Arksey & O'Malley, 2005), this creates the context for the research question, *In what ways do strategic services marketing developments impact health service providers in relation to medical tourism in Bangkok?*

## **2. Methodology**

Assessing perceptions of services marketing developments relating to medical tourism creates a need to utilise a qualitative inquiry to help differentiate more effectively between the various issues within the research scope (Walsh, White & Young, 2008). This research focuses on all senior-level marketing managers of private hospitals in Bangkok in terms of their opinions raised from their managerial experiences, as authoritative 'knowledge agents' (Benn et al., 2008; Sbaraini et al., 2011). This provides material observations (Sutton & Austin, 2015) and adequately focused on the research concerns (Cassell & Symon, 2004) regarding current services marketing practices in relation to medical tourism.

The research employed a semi-structured interview design process from a subjective knowledge perspective (Kvale, 1996) and reinforced by using an inductive/theory building approach (Glaser & Strauss, 1967). This methodology was devised for constructing appropriate contextual data (Qu & Dumay, 2011).

A closed population of fourteen (14), all contained within the research scope (Ritchie & Lewis, 2003; Fink, 2000), were made up of all senior-level marketing managers who had on-going direct services marketing experiences. Respondents were chosen randomly through employing the approach of a population of interest (Carman, 1990) thus ensuring empirical adequacy (Spanos, 1990). A pilot study was carried out with three (3) randomly chosen respondents from the population and excluded from the main interview process (Maxwell, 2013) that endorsed changes to language and the logic of questions to respondents (Kim, 2011) and streamlined the question arrangements (James & James, 2011). Eleven (11) respondents were interviewed, which were conducted in English and took approximately one hour each (Ward, et al., 2015; Sbaraini et al., 2011), audio-recorded with permission (Duranti, 2007) and interviewed using an identical set of prepared open questions (Gray & Wilcox, 1995; James, 2014; Kvale, 1996). These questions were, supplemented using speculative probing questions (Balshem, 1991; Punch, 2014; Meurer, et al., 2007). Each interview was transcribed verbatim - applying the qualitative software package NVivo 11 (Bailey, 2008) was returned to each respondent for comment, correction, addition or deletion and return (Harris & Brown, 2010; Irvine, Drew & Sainsbury, 2012).

The complete raw interview data sets (Harwood & Garry, 2003) was analysed and manually examined to create appropriate codes (Dey, 2005) and themes out of the thematic analysis (Glaser, 1992; Walsh, White & Young, 2008; Charmaz, 2006) using NVivo 11. No portion of

any expressed dialogue was left uncoded (Rubin & Rubin, 2005; James & James, 2011). Validity was increased using triangulation processes where appropriate (Onwuegbuzie & Leech, 2007). Further, methodological coherence (Altheide & Johnson, 1998) was preserved by relating the main research question to the data outcomes (Stenbacka, 2001). The expressed narrative that developed was based on substituting ‘credibility’ (Johnson, 1997) and ‘dependability’ (Lincoln & Guba, 1985) for ‘reliability’ (Strauss & Corbin, 1990).

This research outcome uses authentic observations reflecting the narrative experience level of services marketing leaders underpinned by robust rigour (Seale & Silverman, 1997) and the impact of their practices (Lambsdorff, 1998), designed to help build an analysis in the ‘interests of the public good’.

### **3. Results**

The research outcomes for this analysis is shown in Table 1 below and consists of three (3) main themes – Health Services Marketing Management, Health Services Unit Internal Management, and Services Marketing Developments; and ten (10) sub-themes with 244 discussion records. The respondent’s voice is exposed through ad-verbatim conversations, where the reporting format is derived from Gonzalez (2008) and also Daniels, et al. (2007).

Table 1. Outcomes - Research question, themes and discussion targets

<b>Research Question</b>			
<i>In what ways do medical tourism influence the strategic services marketing developments of private hospitals in Bangkok?</i>			
<b>Main-Themes</b>	<b>Sub-Themes</b>	<b>Respondent Citations</b>	<b>Discussion Targets</b>
<u>Health Services Marketing Management</u>	Client Orientation	5	29
	Marketing Materials	9	25
	Communication Developments	1	22
		<b>Total</b>	<b>76</b>
<u>Health Services Unit Internal Management</u>	Language Provision	7	19
	Doctor/Nurse Training	3	23
	Medical Tourism Statistics	11	26
	Privacy/Administrative Arrangements	8	21
		<b>Total</b>	<b>89</b>
<u>Services Marketing Developments</u>	Services Marketing Orientation	2	32
	Communications Channels	6	19
	Technology Changes	10	28
		<b>Total</b>	<b>79</b>

### 3.1 Main Theme – Health Services Marketing Management

In terms of Client Orientation this is typified by one respondent (5) who indicated that, ... *We don't connect directly to the foreign customer. We only see them when they arrive here. It takes time to understand their issues. Sometimes though customers contact our doctors. There has been a better communications when this happens...*

In terms of Marketing Materials this is typified by one respondent (9) who indicated that, ... *We are learning to use social media in their language that helps us when we are contacted by overseas customers, and they make the informed choice. Which is better for them, their physicians and us...*

In terms of Communication Developments this is typified by one respondent (1) who indicated that, ... *Web pages are not new to us, but staff do not really look at it at all, as we follow instructions. I do not know what is being stated, as it changes too often as I am too busy to look at it...*

### 3.2 Main Theme – Health Services Unit Internal Management

In terms of Language Provision this is typified by one respondent (7) who indicated that, ... *Patients can contact in a number of ways through our website. But contact is limited to e-mails and telephones. But our language capability is rather limited as little training is provided and it is too difficult...*

In terms of Doctor/Nurse Training this is typified by one respondent (3) who indicated that, ... *Some doctors have some English language. But many do not. It is still a problem. We try our best to have a translator available in all patient discussions. Sometimes that's not possible...*

In terms of Medical Tourism Statistics this is typified by one respondent (11) who indicated that, ... *It is difficult to know whether a foreign patient is living here or not. It's not our business. We only help with their medical needs, not where they come from. However, for foreigners we only take cash and this is a considerable problem...*

In terms of Privacy/Administrative Arrangements this is typified by one respondent (8) who indicated that, ... *Of course, our major responsibility is to protect medical data and keep it safe. However, one of the major issues is to verify such data, and that can be a problem especially for overseas customers...*

### 3.3 Main Theme – Services Marketing Developments

In terms of Services Marketing Orientation this is typified by one respondent (6) who indicated that, ... *I think the doctors and management need to get together to ensure we respond properly to changing international market conditions. We need them to direct us to economies that have many patients who will come here...*

In terms of Communications Channels this is typified by one respondent (2) who indicated that, ... *In so doing we can easily help them as they travel to us, because we can call on other professionals in the travel chain and make sure they are getting the best medical help prior to getting to us. It's not our responsibility though...*

In terms of Technology Changes this is typified by one respondent (10) who indicated that, ... *It is correct that we do not have really good understanding of marketing technologies or technologies to help with the patient. We have to get better and invest more...*

## 4. Discussion - Research Consideration and Implications

The discussion focuses on the Main-theme elements where the explanations presented are considered “internally coherent” (Coombs, 2017), whilst maintaining respondent “confidentiality” (Kaiser, 2009). The outline discussion of the research implications for this study is shown in Table 1 above, configured as representing a robust induction from the data by using a persistent taxonomy approach (Westhues et al., 2008) and emerging from the narrative as below: discussion

#### *4.1 Health Services Marketing Management*

In services marketing, client aspirations are very important. In this situation, underpinned by knowing the client through health records and personal discussions (Comandé, 2009). However, this is mostly done only when they arrive at the hospital, reflecting an underdeveloped services marketing chain. Social media developments may help bridge this service-chain component (James, 2015) enhancing the doctor-patient relationship through refined and targeted services (Cheek & Chandra, 2002) and may provide further opportunities for supplementary revenue and profitability (Han & Hyun, 2015; Jiang & Rosenbloom, 2005). Additionally, through a more effective client orientation starting at the beginning of the process, doctors/patients will be able to assess the data corresponding to a patient's health condition, as this engagement will generate greater trust and reliance of the foreign doctor's capability and motivation (Yoon, Cho & Sugaran, 2011).

It would appear from the data, that service support materials are often not in an appropriate language or packaged specifically for different overseas patients (Dooley, Jones & Iverson, 2014). It is perhaps difficult to understand why this remains an issue. This may influence the level of overseas patient retention which is reportedly as low as 5% (Han & Hyun, 2015).

The data indicated that some private hospitals utilise face-to-face discussions, but these were reported as being rare. Thus, the development of mobile technologies and online technologies (Dimitrov, 2016) have introduced opportunities for change to the business operations of health marketing services environments (James, 2015). Further, most hospitals implement such new technologies only within their core medical diagnostic arena. The data indicated that the patient contact was mostly through a website or by telephone and that a lack of language skills has made the call difficult and led in some cases to the relationship being terminated - even before it starts. This is an example of a supply-side impediment (Bahadori, et al., 2017) that needs to be addressed.

#### *4.2 Health Services Unit Internal Management*

From the data, a major issue that was raised was the level of communication capability between the patient, doctor and other staff of the hospital, as patients do not appear to be able to easily discuss with staff such issues as present medical strategy, meals, administration and also insurance. This also applies to signatures for data access and also primary permissions forms - especially as the only recognised legal language is Thai. Consequently, appropriate language provision is a difficult requirement to fulfil (Holmqvist, 2011), as there are latent costs and raised on-going legal problems associated with specialist communication and the loss of meaning within a service encounter through lack of suitable co-creation (Vargo & Lusch, 2004). Limited language skills appear to interfere with normal hospital processes, thus reducing the value of the discussion and mutual understanding (Marcella & Davies, 2004) leading to the possibility of creating unnecessary and significant health risks. Further, the doctor's understanding of what medical tourism patients require may be limited to the specialisation of their professional activity. However, the data suggests that dealing with different cultures poses a considerable challenge to ensure the adopted level and focus of services marketing, matches the patient's service needs and experiences (Holmqvist, 2011;



Carman, 2000). In this respect, there appears to be a need to provide more language and culture courses for all health service personnel, as this is seen as very important to better understand foreign patients (Jacobs et al., 2004; Chauvot, 2011). The data further suggests that some specialist health centres also offer basic language in Arabic and even Korean – but these are not widespread.

Reliance on foreign clients - at 9% in 2006, 14% in 2010 and estimated at 22% today (Noree, Hanefeld & Smith, 2016) will affect the bottom-line. This expansion is seen as critical to the growth of health service development in Bangkok.

From the data, upon arrival at the hospital, all patients have to explain the reason for their visit to first-line administrators (non-medical staff) that is conducted in the “open” for anyone to listen to the conversation. Privacy is not a premium consideration. However, a simple administrative code or QR Code (Uzun & Bilgin, 2016) and social media tracking systems should easily alert the first-line administrators of a medical tourism patient and then conduct the necessary administrative arrangements. Consequently, the data indicates that many patients were waiting for administrators to find out where the patient should go, which does not provide the necessary confidence that the efficacy of the arrangements for service quality provision were adequate (Owusu-Frimpong, Nwankwo & Dason, 2010). However, this underpins the raised services marketing issues, as not one of the health service providers operate a certified services marketing system - for example within TEMOS (Ratner, 2012).

#### *4.3 Services Marketing Developments*

From the data, health services management appear reluctant to help patients move seamlessly from home-hospital-home and to provide medical supervision for patients whilst travelling. However, cross-border collaboration is likely to be hospital-to-hospital based (Glinos, 2011) rather than just through doctors only. This indicates building proper communications patterns and data management that will add pressures to on-going services marketing delivery.

Further, the evidence clearly indicates that in many instances, the cross-border destination doctor often has had no connection to the patient’s home/origin doctor (Lunt, Hardey & Mannion, 2010) which fails the “continuance” duty of care required by doctors - irrespective of borders. This does not therefore provide adequate “due diligence” regarding potential patient history. Therefore, this is a material failure of the communication-chain on behalf of the patient (Yoon, Cho & Suguaran, 2011). The communication channel has therefore broken down and is a barrier to effective patient engagement (Rokni, Avci & Park, 2017).

The data indicates clearly that no doctor used supported/structured transcriptions of medical discussions - as case summaries do not appear to have been translated very well or not at all - resulting in medical clarification failure (Fry et al., 2017). The data presented indicates that doctor’s lacked genuine ability to provide anything more than just short-hand field notes that were inadequate and potentially irresponsible (Phillippi & Lauderdale, 2017; Ranney, et al., 2015).

The data indicated that in-house tracking of patients was conducted by some service providers through bar-codes entered into the service providers internal system. For example, the use of a

QR Code tag system and a smartphone (including 2D information codes) (Uzun & Bilgin, 2016). This helped develop a normalised internal patient tracking process from first-meet - and also ensure triangulation of ID sources to corroborate a patient's ID as well as medicine concerns, attempts at language conciliation and food requirements. However, such systems were not considered normalised.

## 5. Conclusions

The refocus of health services management towards overseas clients may add more supplemental value to the present medical services financial-stream. Confusion persists over whom is deemed a medical tourist, as private health services in Bangkok are not able to identify conclusively medical tourists except those in their own concentrated/limited supply chain. This misrepresents actual perceptions of medical provision/delivery to cross-border patients that are far below their presently stated numbers. Further, there does not appear to be an effective oversight of those entities engaged in medical tourism (Smith, Lunt & Hanefeld, 2012) and this can create barriers to building trust and appropriate encouragement of service channels through ineffective financial arrangements (Nagarajan, 2004). Thus, the effectiveness of strategic service marketing orientation is brought into question and it also negatively affects the credibility of their present medical service engagement, their developed brand and makes the efficacy of their marketing strategy for “medical tourists” ineffective.

For “medical tourism” patients, underpinning effective services marketing provision, there is a need to reassess the official languages used, in order to ensure the majority of staff fulfil the language/cultural requirements. With continual training and the building of connections to hospitals overseas, creating more effective communications directly between actors in the service chain may help to quickly resolve medical issues raised through the medical tourism process. The ultimate goal would be to seamlessly provide appropriate cross-border medical services that offer patients value for money and a quicker means to resolve their medical problems.

Changes to the present services marketing provision - that have structural and managerial impacts - need to be carried out using a rigorous approach in order to ensure appropriate medical outcomes. Managing patient relationships across borders requires more in-depth understanding of patient needs in order to help foreign patients understand their contractual obligations, as well providing a more effective services marketing ethic. Consequently, “medical tourists” requires better research to explore attributes and impacts on health marketing services provision.

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