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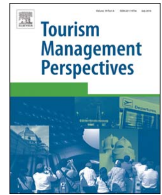

Sand, surgery and stakeholders: A multi-stakeholder involvement model of domestic medical tourism for Australia's Sunshine Coast

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ABSTRACT

This paper explores the developments of domestic medical tourism for Australia's Sunshine Coast. Most studies have characterised medical tourism to be an outbound phenomenon, where affluent tourists select mostly developing destinations for elective surgeries due to cost, quality or faster access to treatments. However, studies concerned with domestic medical tourism remain highly implicit. Employing a case study perspective of the Sunshine Coast, Australia, this research explored the potential for domestic medical tourism to be conceived. This research found that while most stakeholders considered the region to be well-suited for medical tourism, three issues presented some barriers to its development. The three issues were residents' access to hospital facilities, lack of cooperation and hostile attitudes between practitioners. This research shows the contested battlegrounds of domestic medical tourism initiatives, and how the development of a multi-stakeholder involvement model of medical tourism can bring desired outcomes to fruition.

1. Introduction

The understanding of domestic medical tourism remains an under-researched area. While Hudson and Li (2012) had investigated domestic medical tourism from within an American perspective, they asserted that there needs to be further studies of this phenomena elsewhere. The paucity of research related to domestic medical tourism may be attributed to the widely accepted notion that medical tourists are primarily travelling across international borders (Connell, 2013; Reddy, York & Brannon, 2010; Smith, Alvarez & Chanda, 2011). However, a broad definition of medical tourism reflects the primary purpose of travel for elective surgery (Wang, 2012; Wongkit & McKercher, 2013). As such, the value of incorporating both domestic and international medical tourism trends will provide rich insights to a fast evolving and lucrative tourism sector. Additionally, there may be wide variations in terms of quality and types of medical services across different regions within a country, as articulated by Gan and Frederick (2011). While official medical tourism statistics may not exist, Youngman (2015) estimated that there are 6 million international medical tourists, and another 4 million domestic medical tourists globally as at 2015. However, Australia is a relatively small player in this market, with the majority of medical tourism practiced in Asia-Pacific, Central Europe and South America (Ganguly and Ebrahim, 2017; Junio, Kim & Lee, 2017; Sandberg, 2017). Nonetheless, some media reports have emerged to show that more than 10,000 inbound medical tourists visited Australia in 2013 (West, 2014). These visitors were estimated to have contributed almost A$26 million to the nation on the back of direct and indirect economic initiatives (Medew, 2014). The literature reveals that data is somewhat available from an international mobility perspective, though domestic medical tourism remains under-reported. Such a gap in knowledge justifies the need for this research to be undertaken to better conceptualise the development of domestic medical tourism.

2. Literature review

To help frame this research, the review of the literature will examine the typology of medical tourists, motivations for medical tourism, destinations chosen and the concerns with these developments. Synthesising the literature will provide an overall state of medical tourism scholarly work, and highlight the existing gaps surrounding domestic medical tourism. The literature reviewed show that much of the knowledge is embedded from a demand-side perspective, which triggers the need to encapsulate the supply-side considerations from other stakeholders involved in domestic tourism practices. Each of these points will be separately analysed.

2.1. Typology of medical tourists

Some scholars have initiated discussions surrounding a typology of medical tourists (e.g. Connell, 2006; Esiyok, Cakar & Kurtulmusoglu,

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Table 1
Medical tourist types.

Author	Year	Context	Method	Sample size	Sample characteristics
Alsharif, Labonte and Lu	2010	Medical tourists to India, China, Jordan and the United Arab Emirates	Surveys	406 (India) 100 (China) 212 (Jordan) 52 (UAE)	● Most medical tourists to India and China were from the USA ● Middle Eastern medical tourists were visiting mainly Jordan or the UAE
Ye, Qiu and Yuen	2011	Chinese medical tourists to Hong Kong	Face to face interviews	9	● 8 visited to give birth, 1 for fertilization techniques ● 7 from Guangzhou, 2 from Beijing ● 7 stayed in private hospitals with the remaining 2 in public hospitals
Johnston, Crooks and Snyder	2012	Canadians going abroad for medical tourism	Phone interviews	32	● Just under half (15) visited India for medical tourism ● Almost half travelled for orthopaedic surgery ● Average age 53 ● 19 female, 13 male
Yu & Ko	2012	Chinese, Japanese and Korean medical tourists in Korea	Surveys	677	● Slightly more than half were female ● Most of the respondents were Korean citizens ● Almost equal spread across age groups ● Half of the sample possessed at least an undergraduate degree ● Most earned between US$25,000–74,999 annually ● More than half were on their first trip to the destination
Wongkit and McKercher	2013	Foreign medical tourists to Thailand	Surveys	345	● Most tourists decided equally on travelling for vacation and medical purposes ● 60% of medical tourism decisions were determined prior to departure ● Destination attributes were the key driver of medical tourism decisions
Yeoh et al.	2013	Foreign medical tourists to Malaysia	Surveys	441	● Around 95% of these tourists were from Indonesia or Singapore ● 56% female ● 76% aged between 31 and 60 ● 60% repeat medical tourists ● 65% have also visited Singapore for treatments

2017; Khan, Chelliah, Haron & Ahmed, 2017). While it is acknowledged that there are varying definitions of medical tourism, this research subscribes to a broader interpretation of a medical tourist as someone who travels to a destination (either domestic or international) outside their usual environment to undertake elective surgical treatment (Hudson & Li, 2012). Elective surgical treatment relates to non-emergency medical services rendered to patients (Carrera & Bridges, 2006). These include cosmetic surgery and in vitro fertilization (IVF) (Turner, 2007). For instance, Yu and Ko (2012) found that medical tourists were mostly women, with an almost equal age distribution across age groups, with tertiary qualifications and above average incomes. These demographic indicators were likewise corroborated in other studies (An, 2014; Gan & Frederick, 2013; Wongkit & McKercher, 2013; Yeoh, Othman & Ahmad, 2013). Nonetheless, the range of medical treatments could range from less complicated surgeries such as Botox, to more complex operations such as hip transplants. A plausible explanation as to why women appear to be more likely to undertake medical tourism is attributed to peer influence, where families and friends can have a strong effect as to social and relational norms of what is accepted as beauty personified (Viladrich & Baron-Faust, 2014). Table 1 provides a list of academic studies in chronological order that have documented various medical tourist types.

There are some commonalities observed within the six articles presented in Table 1. First, the context of medical tourism is largely confined to the Asia region. Apart from Yu and Ko (2012), the remaining five articles characterise medical tourism to be predominantly an international phenomenon. Third, these studies were exclusively dedicated to the perspectives of uncovering medical tourist decision-making and their associated experiences. There remains a knowledge gap of other stakeholders' perception of, and attitudes towards medical tourism developments. Even less is known as to how domestic medical tourism should be conceptualised.

2.2. Motivations for medical tourism

Three main themes emerge from tourism literature explaining motivations for medical tourism. These are cost (Moghavvemi et al., 2017; Mutalib et al., 2017), quality (John & Larke, 2016; Wu, Li & Li, 2016) and faster access to health and medical facilities (Abubakar & Ilkan, 2016; Fetscherin & Stephano, 2016). Each of these will be separately discussed.

Cost is arguably the most important motivation to undertaken medical tourism. Some studies have alluded to significant cost savings when medical tourists travel to less developing countries for medical tourism (Essier & Casken, 2013; Lunt, Mannion & Exworthy, 2013). Hence, the affordability of desired treatments outside of one's place of residence is a strong push factor in creating motivations for visiting medical tourism destinations.

Quality of healthcare is another antecedent that motivates medical tourists to action. In this paper, quality transcends all aspects of the medical tourism experience. These include service quality (hospitableness of staff involved in the whole experience), as well as technical quality attributes in terms of the surgery and procedural experience (Chuang, Liu, Lu & Lee, 2014; Debata, Patnaik, Mahapatra & Sree, 2015; Han & Hyun, 2015). These attributes of medical tourism matter because of the heightened perceived risks especially when the medical treatments involve unfamiliar environments. For this reason, there is a strong reliance on word-of-mouth as a credible source of information to influence the intangible, and high-involvement nature of medical tourism decisions (Connell, 2013; Lu, Wu & Chen, 2016; Yeoh et al., 2013). Nonetheless, providers of medical tourism have attempted to streamline the medical tourism experience by integrating the health and tourism sectors to provide some form of consistency where possible when dealing with medical tourists (Wernz, Wernz & Phusavat, 2014). Other leading practitioners seek international accreditation standards as a testament of quality (Woodhead, 2013). These efforts are aimed at reducing decision dissonance, and for providers to take a more

proactive stance rather than knee-jerk reactions to service failures (Woo & Schwartz, 2014).

The third motivator for undertaking medical tourism is related to faster access to medical and health facilities. Access is a key consideration for potential and current medical tourists, especially when it involves long waiting times in one's place of residence (Turner, 2010). Access is also a key consideration when the type and complexity of the medical treatment required is not available within one's usual local environment (Vijaya, 2010).

A discussion of these motivators further amplifies that such considerations can likewise be instrumental in charting medical tourism trajectories domestically, especially when quality and access to medical and health facilities are likely to vary in countries where residents are dispersed along an urban-rural divide (Ormond, 2011). A scoping study conducted by Deloitte Australia (2011) on medical tourism suggested that the country is perceived as a high quality medical destination. This perception has led to the mobility of patients investigating the best possible destination to seek medical treatment, such as in the case of cancer (Bergin, Emery, Bollard & White, 2017).

2.3. Destinations chosen

Medical tourism regions are often segmented by continental flows of medical tourist traffic. The USA is by far the largest outbound market for medical tourism, with Mexico having the most number of inbound tourists (Johnson, 2014a,b; Tore, 2016). However, the Asia-Pacific region is estimated to be the fastest growing region with countries such as Thailand, Singapore, Malaysia and India competing for the lucrative market share (Fisher & Sood, 2014). The benefits, therefore, for inbound destinations is twofold. One, public and private investments can be generated on the back of delivering high quality healthcare (Yu & Ko, 2012). Two, the increased quality and quantity of offerings can develop skillsets that benefit both patients, professionals and residents (Johnston, Crooks, Snyder & Whitmore, 2015). Collectively, a well-developed medical tourism blueprint enables destinations to reap the rewards of a strong brand, and one where the market is generally less price-sensitive to economic forces (Das & Mukherjee, 2016; Guiry & Vequist IV, 2015).

2.4. Ethical dilemmas

While medical tourism appears to be beneficial to both tourists and providers, scholars have raised serious ethical dilemmas about its rapid developments. One prominent dilemma evident in literature questions whether medical tourism should exist. For many nations, health and medical treatments are a highly sought after commodity, with public and private health sectors aiming to get the balance of demand and supply in equilibrium (Meghani, 2013). Facilitating the flow of medical tourism internationally thereby exposes the market to the notion of bidding for resources, and can become a divisive tool in separating those who can afford from those that do not have the financial means of required treatments (Lee, Wright, O'Connor & Wombacher, 2014). After all, medical facilities such as hospital beds and operating wards are limited in capacity, and so one such resource taken up by a medical tourist renders another individual the loss of such an opportunity.

The second dilemma raised by some scholars is the morality associated with medical tourism practices. This is because medical tourism postulates that any part of the human body can be (re)purchased at the right price. For instance, Cohen (2013) expressed this moral dilemma involving transactions of human organs within medical tourism. Likewise, reproductive tourism practices have mushroomed across national boundaries, with no universal guidelines as to the ethical rights of legal parents, the birth or surrogate mother or even the child (Gunputh & Choong, 2015; Inhorn, Shrivastav & Patrizio, 2012). The 2014 case of baby *Gammy* is one such unfortunate incident. Delivered by a Thai surrogate mother, Gammy was born with Down syndrome and initially forsaken by her legal parents who took her other healthy twin brother to Australia, leaving her behind in Thailand (Scherman, Misca, Rotabi & Selman, 2016). This incident generated significant media attention to the point where distinguished government officials had to intervene and draft policies to prevent further exploitation of a highly grey area operating within medical tourism frontiers (Cohen, 2015). Gammy's plight is an example of the vulnerability of individuals caught up in a medical tourism environment that is fast evolving and lacking in clear boundaries.

Given these dilemmas, some Australian stakeholders have developed new initiatives to tap into the potential of medical tourism. For instance, insurance provider NIB launched a travel option for its clients to purchase to mitigate the risks of medical tourism (Parnell, 2013). While this product has proven to be popular among its clientele, the Australian Medical Association have criticised NIB for profiteering from turning healthcare into an export commodity (Kwek, 2013). As the number of individuals participating in medical tourism has increased in the last five years, medico-legal and insurance issues and challenges regarding follow-up of patients are also burgeoning (Leggat, 2015). In this vein, there is clearly some disagreement as to the stance with outbound medical tourism in Australia, where some medical and health practitioners have launched advertisements that warn against the risks of overseas treatments (Hawkes, 2016).

Despite the unabated growth in medical providers internationally, the concerns of undertaking surgeries in an unfamiliar, foreign environment have not diminished (Wongkit & McKercher, 2016). On the contrary, Hong (2016) claimed that lawsuits concerning medical tourism have spiralled, which has led to several governments initiating policies to regulate a highly unmoderated operating environment. One such high-profile case involved a prominent surgeon who had allegedly charged more than US$15 million for a breast cancer victim who was from a royal family (Glanfield, 2016). However, efforts towards greater transparency to mitigate the risks associated with medical tourism across borders are only slowly emerging (Garman, Johnson, Lynch & Satjapot, 2016).

2.5. Frameworks of medical tourism

Tourism literature has revealed some frameworks to conceptualise medical tourism. These scholars have provided a useful approach to provide some insights as to the developments of medical tourism. Some scholars (see Runnels & Carrera, 2012; Smith & Forgione, 2007) have adopted a demand-driven perspective of medical tourists. Adopting such perspectives from a demand-driven phenomenon are justified, given that some studies postulate that medical tourism is very much dedicated to the private healthcare system (Sengupta, 2011; Ulas & Anadol, 2016). However, as discussed earlier, medical tourism is also characterised by the service providers. For this reason, other scholars (e.g. Heung, Kucuksta & Song, 2010; Hudson & Li, 2012) integrate the supplier perspective into their medical tourism models. While both models appear similar, the advantage of the Hudson and Li (2012) model is the explicit role of intermediaries acting as agents between the tourist and the medical providers. This illustrates the reciprocal value of such "middlemen" for both tourists and providers. For medical tourists, middlemen provide a one-stop shop approach to know about what is involved in medical tourism practices (Connell, 2013). Service providers, likewise benefit by focusing on the treatments or surgeries while leaving the administrative matters (such as visas and travel arrangements) to the intermediaries (Lunt et al. 2013).

Another angle that has scoped the framework for medical tourism has been undertaken from a perspective of the consumer journey (Lunt et al., 2013). This body of work has conceptualised medical tourism into a pre-, in-situ, and post-operative experience related to any consumer. The prior literature has largely been focused on the pre- and in-situ experience of medical tourists, while the post- experience has received minimal attention. Even though the post-operative timeframe is

crucial to assess a participant's speed of recovery, scholars who have identified this key facet of the consumer journey have merely described the activities in a superficial manner, such as the existence of a vacation package that incorporates accommodation, dining and attractions (Gan & Fredrick, 2011; Yu & Ko, 2012). Collectively, these frameworks have introduced the stakeholders, and decisions involved in the service-domain of medical tourism.

2.6. Knowledge gaps

While the extant literature has shown much in terms of medical tourism, some knowledge gaps remain. For instance, literature has shown some instances where medical tourism has flourished in a few destinations, though very little is known about how destinations can develop to become medical tourism destinations. Using the case of Egypt, Helmy and Travers (2009) argued that successful medical tourism practices are founded on support from governments, identification of key medical strengths and consistency of marketing campaigns. For Hong Kong, Heung, Kucuksta and Song (2011) instead highlight the need for financial backing, cooperation and training as essential ingredients to create a medical tourism destination. Another aspect that has been under researched is the role of the public sector in medical tourism. While medical tourism is characterised as a private sector commodity, the role of the government and public health practitioners has almost gone unnoticed within existing literature (Hall, 2011; Hanefeld, Smith, Horsfall & Lunt, 2014; Hazarika, 2010). A third gap in knowledge relates to the attitudes of residents in relation to the medical tourism developments within a country. How do residents view medical tourists? What types of medical treatments should be encouraged? And which others are not welcome? These questions remain unanswered in many parts of the world (Lunt & Carrera, 2010). These knowledge gaps have provided the justification to conduct this research to explore public-private partnerships from different stakeholder perspectives concerning domestic medical tourism developments for Australia's Sunshine Coast.

The aim of this research, therefore, is to apply the Multi-Stakeholder Involvement Model proposed by Waligo, Clarke and Hawkins (2013) to elucidate how destinations can develop and manage their medical tourism trajectories. Although the authors have used the model in a sustainable tourism perspective, the central tenets of stakeholder involvement are consistent with the practices observed across other sectors such as community-based tourism and ecotourism (Garrod, 2003; Okazaki, 2008). Therefore, this research applies the value of the MSIM to extend the current body of literature surrounding medical tourism. The essence of the Waligo et al. (2013) model was to illustrate how stakeholders with their diverse vested interests could be integrated to derive desired outcomes. Despites its advantages, Hatipoglu, Alvarez and Ertuna (2016) critiqued the MSIM for remaining implicit to guide various scenarios in terms of stakeholder nomenclature and timelines. This criticism notwithstanding, the MSIM is of value to steer how stakeholders could be involved in the inception of a medical tourism region as in the case of the Sunshine Coast. Outcomes arising from this research can then inform current and future domestic medical tourism theory and practices, of which very little is known (Goodarzi & Taghvaei, 2014).

To assist with addressing the research objective, the following questions are proposed:

- How do potential medical tourism destinations engage with different stakeholder groups?
- In what ways do medical tourism align with destination development goals and objectives?
- What are the facilitators or barriers to the development of medical tourism?

3. Study area

The Sunshine Coast is a popular domestic tourism destination region within Australia (Pike & Mason, 2011). Comprising of a hinterland and more than 100 km of sandy beaches, the Sunshine Coast region has a large proportion of its visitors from within Queensland, as it is an accessible one-hour drive from the state capital, Brisbane (Sharma & Dyer, 2009). Tourism is the main industry sector for the Sunshine Coast, and the region is visited by its primary target markets such as families and Visiting Friends and Relatives (VFR) tourists (Backer, 2012). A commonly held destination image of the Sunshine Coast is that of rest and relaxation (Gursoy, Chi & Dyer, 2010).

While tourism has brought significant benefits to the Sunshine Coast region, the growth of tourism developments has brought about negative impacts such as traffic congestion and crime (Sharma, Dyer, Carter & Gursoy, 2008). These incidents, on the back of tourism developments, have resulted in resident preferences for alternative tourism products and services (Sharma & Gursoy, 2015). In line with the growing population of the region, the Sunshine Coast Council has identified key sectors where it will dedicate more funding and development. One such avenue is that of health and medical facilities concerning the completion of the Sunshine Coast Public University Hospital by 2017 (Sawyer, 2015). Given that the region has already a pool of private hospitals and other allied healthcare providers, the new public hospital will provide further potential for the dovetailing of the health and tourism sectors, such as medical tourism initiatives (Fielding 2015; Moffat, 2016). Not only is the health precinct a blended environment of teaching, research and practice, but it also boasts of state-of-the-art facilities in the areas of emergency departments, operating theatres and 3D medical imaging (Hall, 2016). Such developments augur well for the region in being heralded as the future of medical practices, which has attracted some interest from Asian healthcare investors (Norris, 2016). In fact, several tourism operators have already taken steps to cater to the health and medical patients while the public hospital is undergoing construction. For instance, the Best Western Kawana Hotel opened as of November 2015 located within walking distance of the new hospital precinct (Chamberlin, 2015). Other businesses that are already in operation include vehicle shuttle transport services for patients and their families (Johnson, 2014a,b).

Overall, this section has illustrated the complementarity of medical tourism to the Sunshine Coast. It must be noted that the Sunshine Coast is not synonymous with domestic medical tourism, despite the region being recognised as a star performer in terms of domestic visitor growth (Sunshine Coast Council, 2017). Nonetheless, medical tourism is an appropriate fit to the rest and relaxation type experiences evident within the region, along with other rehabilitative facilities. Moreover, domestic medical tourism is argued to stimulate economic injection in terms of medical investment and job creation (Carabello, 2013). Additionally, the launch of a new Sunshine Coast Food Trail in October 2016 further enhances the links between health and wellness for the region (Taylor, 2016). However, there remains no knowledge as to how the different stakeholders view medical tourism on the Sunshine Coast. Hence, while there is the obvious potential of domestic medical tourism to the region, there is very little at present to guide how, what, and why such a sector should be developed on the Sunshine Coast. The purpose of this timely research is to address this knowledge gap to inform theory and practice associated with domestic medical tourism in an Australian context.

4. Justification for a domestic medical tourism perspective

This section will discuss the justifications for the research to adopt a domestic tourism perspective. First, as earlier discussed, cost and quality are key determinants for medical tourism demand. In this regard, while Australia is perceived to have high quality healthcare, Deloitte Australia (2011) found that medical tourism is not as price-

Table 2
Examples of domestic medical treatment arrangements in Australia.

State/territory	Domestic medical treatment example	Website
Australian capital territory	Interstate patient travel assistance scheme	http://health.act.gov.au/public-information/consumers/interstate-patient-travel
New south wales	Isolated patients travel and accommodation scheme	http://www.enable.health.nsw.gov.au/home/iptaas
Northern territory	Patient assistance travel scheme	http://www.health.nt.gov.au/Hospitals/Patient_Assistance_Travel_Scheme/
Queensland	Patient travel subsidy scheme	https://www.health.qld.gov.au/ptss/
South Australia	Patient assistance transport scheme	http://www.countryhealthsa.sa.gov.au/LinkClick.aspx?fileticket=jRzR71%2Fd%2BvE%3D&tabid=678
Tasmania	Patient travel assistance scheme	http://www.dhhs.tas.gov.au/hospital/ptas
Victoria	Patient transport assistance scheme	https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/vptas-how-to-apply
Western Australia	Patient assisted travel scheme	http://healthywa.wa.gov.au/Articles/N_R/Patient-Assisted-Travel-Scheme-PATS

competitive vis-à-vis other destinations such as Thailand, Singapore or Malaysia. This indicates that there is likely to be some demand, though somewhat small, from affluent international medical tourists to Australia. According to Medhekar (2013), the demand for medical tourism in Australia stems from access to high quality healthcare that may be unavailable in proximate countries such as Papua New Guinea and New Caledonia.

Second, Australia is the 6th largest country by land size, which means that not all health and medical facilities may be available within the different states and territories. For this reason, almost all the various states and territories have some form of agreement related to intrastate or interstate medical treatment where necessary. Table 2 highlights some of the existing schemes facilitating domestic medical treatments.

These examples show that there is at least some financial and logistical support available for medical tourists who seek to obtain access to intra- and interstate destinations for medical treatments that may not be available in their home regions. These governmental initiatives, on the back of a heavily subsidised medical system called *Medicare*, helps defray potential costs and risks associated with international medical tourism. Despite the imperfections of the Medicare system, some authors have contended that the public and private healthcare frameworks in Australia have provided an inclusive approach for all Australian residents to ensure that medical treatments are available where the need arises (Duckett, 2005; Harley et al., 2011; Kay, 2007). At present, Medicare and private insurance policies cover the costs of most common treatments, though there are certain financial limits in which a patient can claim for their respective surgeries. Medical tourism, in contrast, is not covered in domestic environments, unless the surgeries have been specified as an add-on option to pre-purchased insurance schemes, and where the patient has served his or her waiting periods (Medical Tourism Magazine, 2013). While such a flow of patients has occurred over the past decades, little remains known as to how various stakeholder groups conceive the notion of medical tourism in any given destination (Jackson & Barber, 2015). Furthermore, the costs and benefits of medical tourism are largely confined to the discussion of economic motives (Burns, 2015). Voices from a social standpoint or stakeholder interest, particularly in a domestic setting, are under-represented (John & Chelat, 2013). Collectively, these considerations lend the justification for the research to adopt a domestic tourism perspective.

5. Methodology

This research employed a case study approach to obtain insights that aid in the conceptualisation of a multi-stakeholder involvement model (MSIM) of domestic medical tourism. Broadly, a case study is essentially a unit of analysis (Stake, 1978). As such, a case may be selected from the lens of investigating individuals, communities, organisations or a destination region (Baxter & Jack, 2008). However, Flyvbjerg (2006) cautioned against using case studies to generalise findings. Instead, the merit of the case study method is its ability to elucidate further insights about a phenomenon (Gerring, 2004), which can then be applied towards constructing theoretical frameworks (Eisenhardt, 1989). Adopting such perspectives to the methodology is in line with the researcher's frame of interpretivism, which seeks to make meaning from an emic perspective (Arghode, 2012; Levy, 2006). In this context, interpretivism helps to better locate and relate to participants' perceptions and attitudes towards domestic medical tourism developments.

Several studies have employed the case study method in analysing medical tourism (e.g. Heung et al., 2011; Wongkit & McKercher, 2013). In Heung et al. (2011), the authors sought to articulate the barriers of developing medical tourism in Hong Kong. For Wongkit and McKercher (2013), their study sought to provide a typology of medical tourists for Thailand. While these studies provided some useful principles as to the use of case studies, they remained exclusively dedicated to the private sector developments on medical tourism.

This research adds three important facets that remain under-researched in existing literature. First, the region of interest, the Sunshine Coast is an area where medical and health sectors have only very recently been added as new pillars of the economy. Second, the research provides insights from both public and private sectors in conceiving medical tourism. Third, the research includes resident responses to medical tourism, a stakeholder group that has often been omitted, as observed by other scholars (Meghani, 2010). The case study involved conducting face-to-face interviews with a range of stakeholders who may be likely to be associated with the medical tourism scene on the Sunshine Coast. Fig. 1 illustrates the different stakeholder groups and the number of interviews (in parentheses) conducted within each group.

From Fig. 1, seven different stakeholder groups were involved in the research. The intent in consulting a diverse group of stakeholders lends a more nuanced understanding of their appreciation of the subject, and whether the intentions for further developments of medical tourism for the Sunshine Coast were mutual. The inclusion of two participants from the now defunct Gold Coast Medical Tourism Association (GCMTA) was intentional. In brief, the GCMTA existed as a collective group of operators involving local government councils, private hospitals, healthcare practitioners and tourism organisations to have a platform and develop medical tourism in the Gold Coast region. The term practitioners in this context refers to health or medical professional staff who are registered with their respective accrediting associations, and are directly responsible for the delivery of medical tourism practices. This definition is consistent with the label employed within the work of Heung et al. (2010). The GCMTA lasted for three years between 2011 and 2013, though different organisations continue to operate independently from the association. An online check on some of these organisations show that they are active in the South-East Queensland space, which comprises the Sunshine Coast, Brisbane and the Gold Coast regions. As such, the decision was made to include the GCMTA as a stakeholder group to provide a retrospective view of medical tourism,

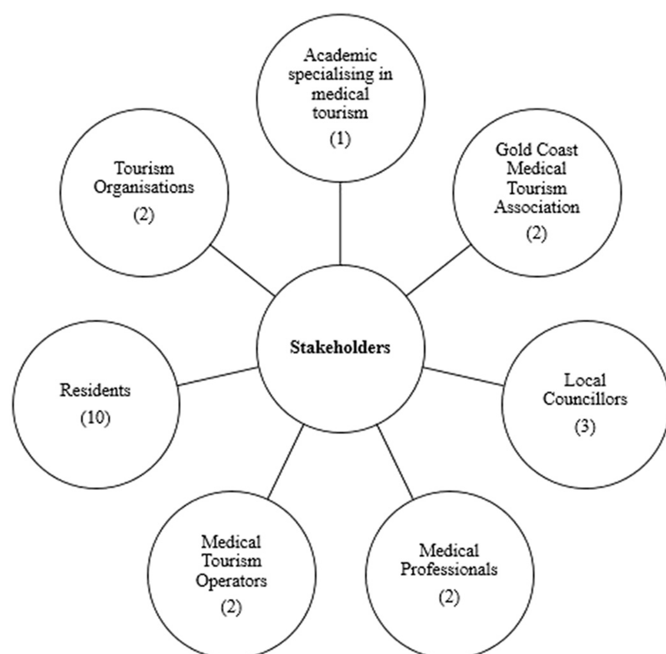

Fig. 1. Stakeholders and interviews conducted for this research.

and its likely implications for the Sunshine Coast in the future.

Approval was first sought from the university ethics committee to undertake the research. Once approval was gained, details of the medical tourism project were disseminated via flyers and emails to the different stakeholder groups. Further phone calls were made a few weeks after the materials were disseminated and to follow up as to participant interest in the project. Residents were made aware of the project through posters placed at public locations such as shopping centre notice boards and libraries, subject to the consent of the relevant management. In this vein, residents are determined by a geographical boundary of individuals living within the confines of the Sunshine Coast Council.

Participants who had expressed their interest in the project were then provided with a detailed information sheet and a consent form to be completed prior to the conduct of interviews. A sample of the interview questions is provided in Appendix 0. These questions were derived from the extant models conceptualising medical tourism by extrapolating pertinent issues such as barriers to entry (Heung et al., 2011), accessibility (Yu & Ko, 2012), ethics (Chuang et al., 2014) and strategic destination fit to the needs of the potential tourist (Guiry & Vequist IV, 2015). The interviews were conducted over a nine-month period between January and September 2015. This timeframe was carefully selected as it occurred during the main construction phase of the Sunshine Coast Hospital, so that the research topic was something that potential participants could relate to given that health and medical issues received widespread media attention in the local region. All interview data were transcribed verbatim and the next section will discuss and analyse the data. Each participant was assigned a pseudonym to de-identify the data. Further details of the sample are provided in Table 3.

6. Results

The results section has been divided to assist with discussing the data in a progressive manner to help address the research aims and objectives. First, participant awareness of medical tourism is discussed. Next, the role of domestic medical tourism as a desirable form of tourism development for the Sunshine Coast is explored. Subsequently, the challenges of developing domestic medical tourism practices for the Sunshine Coast are examined. Following this, recommendations as to how domestic medical tourism can be developed are provided.

6.1. *Participant awareness of medical tourism*

More than half (16 of the 22) participants had some awareness of the term medical tourism. The six participants who had not heard of medical tourism came entirely from the resident pool of participants. One such participant mentioned that she had not heard of the term prior to seeing the flyer, and subsequently proceeded to find out more about the concept: "*No I had never heard of this term. I initially thought it might be something of a package deal with tourism and cosmetic surgery… then I googled it.*" (Winnie). Another resident though, interpreted the term to be related to the study of medical practices. Brian commented: "*It suggests overseas students visiting Australia and studying medicine.*" These differences of opinions suggest that for residents on the Sunshine Coast, medical tourism may be a novel concept given that the existing literature related to tourism in the region have mostly painted a destination image of the hinterland and the beach. Moreover, several other participants alluded to the dominant perspectives that medical tourism referred to the notion of going offshore to seek surgical procedures. This was evidence within several quotes:

> "*To me, the term means medical treatment in overseas countries.*"
>
> (Dave)

> "*Yes, I have heard of the term. My understanding is that it refers to people who travel overseas for various medical procedures.*"
>
> (Steve)

> "*It means that people travel overseas for medical treatment because the costs are less than in Australia.*"
>
> (Jenny)

> "*The term suggests medical and dental services offered cheaper offshore from Australia.*"
>
> (Claire)

These various quotes reflect the heavily skewed perspective of medical tourism towards an international orientation, and perhaps disassociated how such experiences could be envisaged within a domestic market. In addition, various media channels (e.g. newspapers, television) channelled market attention to the opening of the hospital precinct, with hardly any mention of potential medical tourism opportunities (Tatham, 2016). There appeared to be an introspective view of what the hospital could deliver to a region experiencing population growth, rather than an outward perspective as to how medical tourism could be a part of the landscape. Nonetheless, the medical tourism concept was shared with each participant to ensure that their interpretation of the topic was consistent with what is defined as domestic medical tourism.

When domestic tourism was defined, other participants considered how such developments could generate wider economic and social benefits to the region. Job creation, was particularly highlighted as the positive net gains deriving from domestic medical tourism. Reflecting such sentiments, Geoff, a local resident explains: "*I think it could be a great thing, provided it offered highly specialised job opportunities to the locals.*"

6.2. *Domestic medical tourism as a desirable form of tourism development*

All seven stakeholder groups expressed overall agreement that domestic medical tourism was an appropriate fit to the Sunshine Coast. This was highly conspicuous within the three interviews conducted with local councillors involved in the development of the region. One such councillor, Thomas, indicated that medical tourism could be easily integrated into the local scene, given the different types of allied health and medical facilities existing on the Sunshine Coast. He added: "*The*

Table 3
Interviewee characteristics and coded themes.

Interviewee	Role	Gender	Age group	Domestic medical tourism scope	Source market	Destination appeal	Accessibility	Quality of treatments	Availability of treatments	Cost	Tourism attractions	Job creation
Jeremy	Academic	Male	51–60	✓	✓	✓	✓	✓	✓			
Donna	GCMTA representative	Female	61–70	✓	✓	✓	✓	✓	✓	✓		
Paul	GCMTA representative	Male	51–60	✓		✓	✓	✓	✓			
Thomas	Local councillor	Male	51–60	✓	✓	✓	✓	✓	✓			
Roland	Local councillor	Male	51–60	✓	✓	✓	✓	✓	✓			
Patrick	Local councillor	Male	41–50	✓	✓	✓	✓	✓				
Grace	Medical professional	Female	41–50	✓	✓		✓	✓	✓			
Rose	Medical professional	Female	31–40		✓		✓	✓	✓			
Joan	Medical tourism operator	Female	31–40	✓	✓	✓	✓	✓	✓	✓		
Colleen	Medical tourism operator	Female	51–60	✓	✓	✓	✓	✓	✓	✓	✓	
Winnie	Resident	Female	41–50	✓		✓			✓	✓		
Brian	Resident	Male	61–70	✓		✓			✓			
Dave	Resident	Male	51–60	✓			✓	✓	✓			
Steve	Resident	Male	31–40	✓	✓	✓			✓			
Jenny	Resident	Female	21–30		✓	✓		✓	✓	✓		
Claire	Resident	Female	31–40	✓			✓	✓	✓			
Geoff	Resident	Male	71–80		✓				✓	✓	✓	✓
Simone	Resident	Female	51–60	✓			✓	✓	✓	✓		✓
Vicky	Resident	Female	41–50		✓	✓	✓				✓	✓
Katherine	Resident	Female	61–70				✓	✓	✓	✓		
Ronnie	Owner at a tourism organisation	Male	51–60		✓		✓	✓	✓		✓	✓
Samantha	Manager at a tourism organisation	Female	31–40			✓	✓	✓	✓			✓

Sunshine Coast is synonymous with sport…medical tourism will be a useful addition to help with rehabilitative services before, during and after competitions." Thomas' views on medical tourism is likewise echoed by Roland, another councillor: "*The Sunshine Coast is already known as a rest and relax destination…what better place is there to have surgery and recuperate in peace?*"

While other stakeholders hold positive attitudes of medical tourism for the Sunshine Coast, some raise other considerations essential for the development of any initiatives. For instance, the range of tourism attractions will likely be another consideration for potential domestic medical tourists. Joan, a medical tourism operator, enquired as to the different types of attractions available on the Sunshine Coast: "*What attractions are available on the Sunshine Coast? As the patients travel with family or friends, they may want to explore the area, so it can't be just only Australia Zoo and the beach…*" Her views reiterate the propositions from existing literature that have argued for a diverse range of relevant and appropriate tourism activities to heighten the value proposition of selecting one medical tourism destination over another (Lee, Han & Lockyer, 2012; Wang, 2012; Wongkit & McKercher, 2013).

Ronnie, who manages a shuttle service for patients and their caregivers attending health and medical appointments within the Sunshine Coast region welcomes medical tourism developments. He stated: "*I am inundated with calls for more services and medical tourism can certainly provide the catalyst for me to hire more staff and coaches to make this business viable.*" The benefits of medical tourism in terms of economic and social contributions are also highlighted by Simone, a resident: "*Yes, they (medical tourists) have money to spend and will use hotel beds and create further employment, such as medical people. This also helps stimulate jobs, especially in areas such as youth unemployment.*" This comment lends a timely perspective of tourism as a pillar for the Sunshine Coast, and potentially as a tool to alleviate issues with youth unemployment. As Curtis, Gibbon and Katsikitis (2016) note, youth unemployment rates for regions such as the Sunshine Coast are twice that of the metropolitan cities, such as Brisbane. Given the current issues of stagnating tourism demand and unemployment, several Sunshine Coast public enterprises have articulated that medical tourism is considered a highly desirable sector driving tourism demand for the Sunshine Coast (Council of Mayors, 2016; Ramsay Health Care, 2013; RDA Sunshine Coast, 2013).

Drawing on her experiences in dealing with medical tourists on the Gold Coast, Donna from the GCMTA also emphasised the desirability of medical tourists as a target market: "*Medical tourists are very well-behaved. They also spend more, stay longer and will interact with the locals. Definitely much better than Schoolies! (Shakes her head)*" Her interesting perspective mirrors the positive attributes of medical tourists, an area that is somewhat synonymous with existing literature (Cormany & Baloglu, 2011; Mainil, Platenkamp & Meulemans, 2011). As earlier discussed, medical tourists tend to be more educated and affluent, and thereby have been postulated to be well-received by different medical tourism destinations. Donna compared medical tourists to the Gold Coast's annual hosting of Schoolies week, which are a short-term, high volume tourist engagement involving students completing their high school. This annual ritual, often brings thousands of students to the Gold Coast and has been known to foster anti-social and other forms of deviant behaviour, often perpetuated on the back of alcohol or drug-induced violence (Deery & Jago, 2010; Lawton & Weaver, 2015). Prompted by Donna's experience, this alternative form of tourism may be more conducive for the Sunshine Coast in positioning itself as a medical tourism destination. It is also very clear that the Sunshine Coast does not see itself as a mirror image of the Gold Coast, and have approached tourism developments meticulously and consciously to avoid becoming overrun by tourists (Weaver, 2011). For this reason, the niche

markets offered by domestic medical tourism potential are considered favourable in delivering high yield, and yet authentic experiences showcasing the best of the Sunshine Coast.

6.3. Challenges of developing domestic medical tourism

While the findings thus far have amplified the potential for domestic medical tourism to be introduced within the Sunshine Coast, there are nonetheless some challenges that confront any development. Emerging from the data were three challenges - Access to hospital facilities, lack of cooperation and hostile attitudes between practitioners. Each of these will be separately discussed.

6.3.1. Access to hospital and medical facilities

Extant literature has posited that medical tourism is primarily dedicated to the private sector where fee-paying tourists consume related experiences in private health establishments. By introducing domestic medical tourism to the Sunshine Coast, some participants were unsure if access to hospital facilities would be feasible. This was a point raised by concerned residents, as to whether medical tourists will have a displacement effect on their access to the medical facilities, as Vicky indicated: "*The medical tourists would bring extra funding to the area but it should not be at the expense in either cash or facilities for locals.*" Medical tourism can be developed, but Winnie espouses that it should occur after locals have been given preferential health access and treatments: "*No, we should not develop medical tourism until the people who live here have the care they need. Else you will be viewed as greedy and self-serving and not contributing to the community to which exists…It would need to complement the coast, not burden it.*"

Evidently, the hospital and medical facilities associated with relevant treatments are a perishable commodity and encounter capacity issues. As alluded to by the comments, there needs to be a clear plan as to how medical tourism can complement the hospital as a strategic tool for the development of the region, rather than merely viewed as the commodification of healthcare. At present, the healthcare system in Australia is facing severe pressure from a combination of increasing population size and lack of resources. This has led to the stripping of potential medical tourism facilities in capital cities such as Brisbane (Miles, 2015) and Melbourne (Medew, 2015). Access to healthcare in Australia is a very contested space, and certainly one that domestic medical tourism will need to grapple with. Such sentiments are best reflected in Winnie's comments: "*It (Medical tourism) would increase the gap between those who have and those who have not. For my family, it would provide strain on current infrastructure including services and utilities increasing the general price of living on the coast.*" Such concerns are not unfounded, as healthcare is one of the most critical and essential services that residents and other stakeholders do not want medical tourism to expose them to further pressures and jeopardise their entitled access to related infrastructure. For the Sunshine Coast to operate domestic medical tourism in an inclusive fashion, there needs to be an explicit demarcation of what locals and tourists may be entitled to.

6.3.2. Lack of cooperation

There is a perceived lack of cooperation in conceptualising any possible domestic medical tourism endeavours. Colleen, a medical tourism operator, voiced her challenges in trying to get different stakeholder groups to collaborate and put the medical tourism products and services within the GCMTA: "*Trust me, I've tried negotiating with hotels, transport, hospitals, clinic et cetera on developing the medical tourism scene on the Gold Coast. They all verbally agreed, but any subsequent actions have been piecemeal and sporadic. I've literally given up and taken my business overseas. At least, my international counterparts have been far more cooperative.*" The lack of cooperation is perhaps the reason as to why the GCMTA disbanded, as Donna explains: "*We had so many meetings and eventually most people were running their own show because they were unwilling to collaborate, despite the good intentions of the association.*" Likewise, Paul, another member of the GCMTA, ascertained: "*We had a database, maps, advertisements and strong support for the GCMTA to work, however, all this fell apart because the medical tourism practitioners held their cards close to their chest and protected their market share at all cost.*"

While there were obvious benefits shared among the practitioners, cost comparisons by potential and existing medical tourists also led to the demise of the GCMTA. Colleen explained that:

> "*Whilst medical tourism providers generate quotes based on the required surgical treatments, tourists would often cold call or obtain other quotes and compare prices. This shopping around behaviour alerted the various service providers who were showing signs of reluctance to divulge their prices.*"

From extant literature, cooperation is a necessary trait for medical tourism to flourish, regardless of domestic or international operations (Heung et al., 2010; Hopkins, Labonte, Runnels & Packer, 2010; Yu & Ko, 2012). Those members of the GCMTA interviewed for this project alluded to the crucial role of policymakers and operators to share information and leverage on existing networks. Price comparisons began to erode the potential of the GCMTA and resulted in a distrust among members. Such high levels of service integration suggest that a fragmented approach to medical tourism is unsustainable (Abd Manaf, Hussin, Kassim, Alavi & Dahari, 2015). Hence, rather than adopting a chaos theory approach characterised by the current developments on the Gold Coast, stakeholders within the Sunshine Coast should explore ways to harness cooperative outcomes to realise the potentials of domestic medical tourism for the region. This will be further presented within the discussion section.

6.3.3. Hostile attitudes between practitioners

There is a culture of hostility existing between medical practitioners. Joan shared an example of a case: "*When discussing patient details with potential practitioners, I also raised the differences between treatments by various providers. However, I was admonished for wanting to entertain such thoughts…cosmetic surgeons and plastic surgeons in particular questioned each other's professional skills.*" This view was likewise supported by Colleen: "*Sometimes the treatment may require transfer of patients between hospitals. One of my clients was asked by a staff as to why she wanted to be transferred to a second or third grade hospital!*"

These hostile attitudes do not merely just exist within the medical fraternity, but can also be found in the wider tourism community. For instance, Samantha from a tourism organisation highlighted that the consultation process involving tourism operators will likely be a time and resource consuming process due to the hostilities existing between some members. She added: "*While building medical tourism is a good thing for the Coast, some members will see us taking sides and giving preferential treatment to those in the health and food sectors and end up not supporting this because they have seemingly nothing to gain.*" For this reason, any distrust that may exist between tourism operators will likely create barriers to the development of domestic medical tourism, despite the overall inherent benefits to the Sunshine Coast region.

7. Discussion and contributions

Overall, this research sought to investigate how domestic medical tourism may be developed from an exploratory investigation of the Sunshine Coast. Positioning the Sunshine Coast from a domestic tourism perspective is warranted given the lack of price-competitiveness vis-à-vis other medical tourism destinations around the world. The research contributes to a more nuanced understanding as to how destinations can become medical tourism destinations by considering a range of key issues that needs further clarification, consultation and collaboration. The strength of this research is to add two perspectives to extant medical tourism literature. These are a public-sector involvement, and a wider range of stakeholder insights from among others,

Table 4
Summary of findings.

Issue	Outcome
Awareness	Some stakeholder groups, particularly residents, do not know what medical tourism means
Fit	Medical tourism viewed as an appropriate fit to the Sunshine Coast region
Access	Medical tourism can raise perceptions as a threat to residents' access to medical and hospital facilities
Lack of cooperation	Further collaboration and integration needed within stakeholder network to develop medical tourism for the Sunshine Coast
Hostile attitudes among medical professionals	Animosity exists between medical professionals because of previous experiences and negative stereotypes

residents, local councillors and intermediaries. The outcomes of the results show that while domestic medical tourism has a strong potential to further complement the Sunshine Coast region and its future development plans, the differences in terms of healthcare access, lack of cooperation and hostile attitudes will need to be carefully treaded and managed to derive favourable outcomes. Nonetheless, a summary of what the research has illuminated is presented in Table 4.

These findings then provide some key insights to help conceptualise a MSIM of domestic medical tourism. In particular, the research explores how the combination of public and private sector development should be conceptualised and operationalised through the lens of the MSIM to address knowledge gaps as instigated by other scholars (Kim, Lee & Jung, 2013; Skountridaki, 2017). This research thereby contributes to this gap by showing how regions initiating medical tourism developments can undertake and utilise such the MSIM for their respective practices globally. Derived from the gaps in the literature and the findings has led to the conceptualisation of the MSIM for domestic medical tourism as depicted in Fig. 2.

The approach taken to conceptualise the MSIM differs from existing models of medical tourism by amplifying the roles the roles of the public sector and other stakeholders impacted by medical tourism developments. This research then adds to the current scope of medical tourism literature by articulating how to manage relevant stakeholders and integrate their needs and capacities to formulate a more inclusive medical tourism regional framework. Strategies to manage stakeholders across the different stages of the MSIM were informed through the work of other scholars. For instance, the use of regular updates and meetings for stakeholders can help provide timely information related to the hospital developments, and any potential medical tourism policies or plans (Connell, 2013). Likewise, facilitation of medical tourism should be streamlined in terms of the administrative processes to reduce red-tape and unnecessary bureaucracy in fostering tourism flow in an efficient and effective manner (Lee & Fernando, 2015). Finally, health and tourism practitioners should explore further collaboration potential so that medical tourism can be of synergistic outcomes in terms of tourism regional development (Ormond & Sulianti, 2017). In other words, the development of a medical tourism precinct should be concurrently dedicated to both the medical, and the tourism aspects of the service experience. Whilst there is a need to clearly document the quality of healthcare available, there is also a justified need to ensure that the integration of other ancillary services such as transport, food, accommodation and tourist attractions are provided to new and

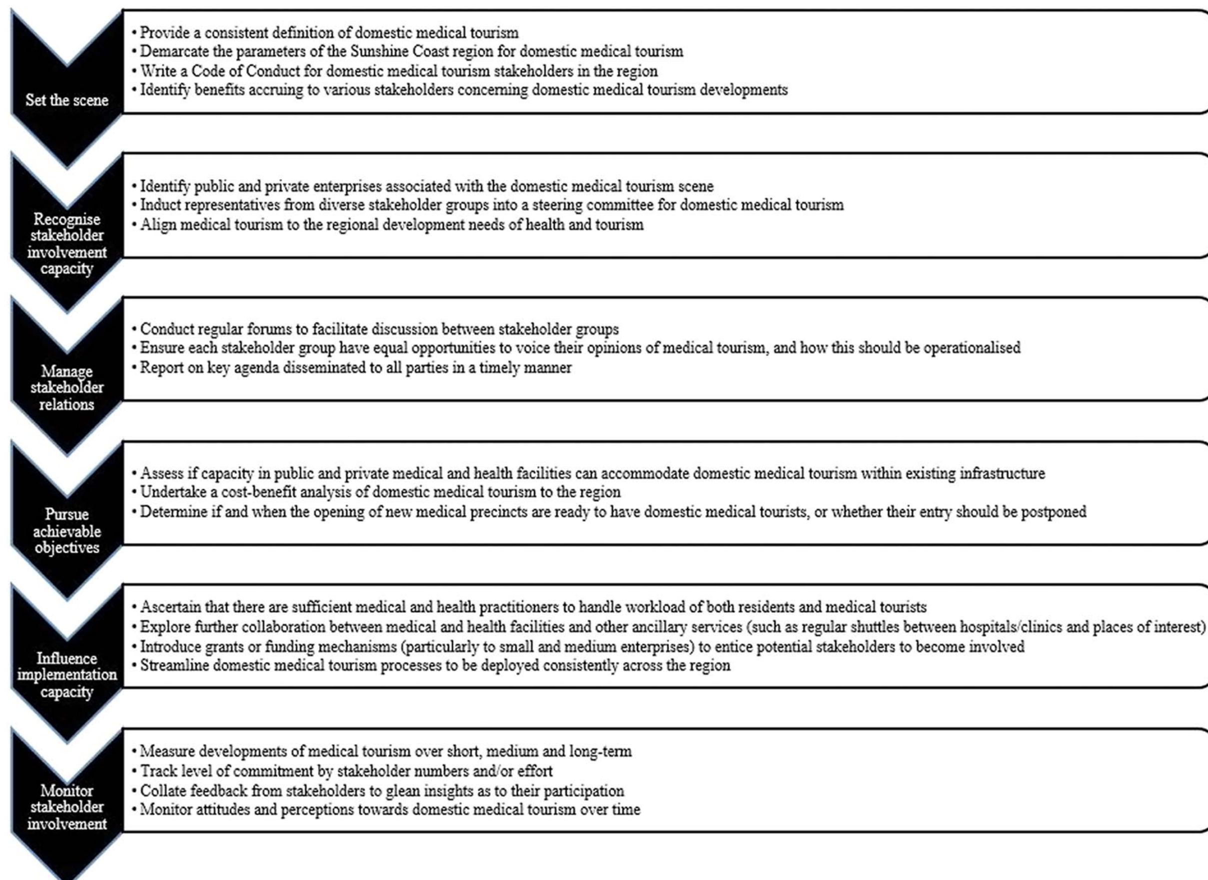

Fig. 2. MSIM for domestic medical tourism.

existing medical tourists (Connell, 2016). Collectively, these strategies can help mitigate some of the challenges previously discussed.

8. Conclusion, limitations and future research

In conclusion, medical tourism is experiencing significant growth in many parts of the world, and appears to be an appropriate fit should some regions such as the Sunshine Coast decide to pursue this market as a growth strategy. However, as this research has shown, the medical tourism perspective should adopt a more inclusive nature to facilitate developments from both a domestic and international perspective. Yet, amidst the potential for domestic medical tourism, it is essential for all stakeholders to be involved in the planning and development of the medical tourism sector for the region. More importantly, this is a conversation that needs to take place when the new Sunshine Coast Hospital is being built, rather than when it becomes more challenging to introduce after the hospital opens in 2017. The MSIM proposed in this research lends a nuanced perspective as to how to integrate stakeholders into a domestic tourism development perspective, an area that has received very little attention.

As with any research, some limitations exist with the nature of this investigation. First, the findings are gleaned from a small sample of stakeholders. More data is required to ensure the generalisability of this research. Second, the context is limited to a single tourism destination in Australia. Research on other destinations may provide similar or different outcomes concerning domestic medical tourism developments. Finally, the research draws from the perspectives of stakeholders within one point in time. Subsequent studies may want to conduct a longitudinal investigation to explore whether attitudes to domestic medical tourism change over time.

These limitations notwithstanding, the research has provided a useful base for further research on medical tourism. By focusing on a stakeholder perspective, the research can guide other studies seeking to explore the feasibility of medical tourism development for other tourism destinations. Likewise, cross-comparative case studies may be developed to ascertain the unique factors that may lead to successful implementation of medical tourism for various regions. Additionally, future studies could investigate the blurring of geographical boundaries when medical tourism entails patients who enter contractual obligations with physicians from their host country, but undertake surgeries overseas (Leggat, 2016). Studies may also seek to compare if there are different perceptions between a larger sample of residents that could distinguish support intentions between those with some awareness of medical tourism, and those without. Overall, the research has contributed empirical evidence to help steer medical tourism developments from a domestic perspective, and provided a timely and necessary response to Hudson and Li's (2012) foundational work on domestic medical tourism.

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Appendix A. Sample interview questions

1. Have you heard of medical tourism? From what sources?
2. What do you understand by medical tourism?
3. Do you consider the Sunshine Coast to be suited for medical tourism? Why or why not?
4. If we were to launch medical tourism on the Sunshine Coast, should the focus be on domestic or international tourists? Why?
5. Are medical tourists considered a desirable type of tourists?
6. What factors, in your opinion, will be instrumental in the development of medical tourism on the Sunshine Coast?
7. What are some potential barriers to the development of medical tourism on the Sunshine Coast?
8. How could we overcome such barriers?
9. As someone who works or lives on the Sunshine Coast, are you in favour of having medical tourism at the new hospital precinct in Kawana Waters? Why or why not?
10. Do you perceive medical tourists as a threat to residents accessing medical treatment?
11. At this point, do you have any further comments to add?

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