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# Regulatory Framework in Healthcare Delivery: A Study of the Kerala Medical Travel Industry

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***Abstract***

Kerala has become a major international destination for healthcare.People from the South Asian Association for Regional Co-operation (SAARC) countries, Middle-East countries and the developed world look up to Kerala in their search of cheaper quality healthcare. There are many multi-speciality hospitals and medicities with accreditations and trained and experienced doctors. It can be observed that, in the last few years, billions of rupees have been invested in the healthcare sector of Kerala. Hospitals position themselves as centres of international healthcare. However, there is a regulatory vacuum in healthcare delivery and it has direct repercussions when it comes to international healthcare delivery. The absence of a regulatory framework leads to many unethical practices. This will force international patients to switch to other international competitors. This article describes the various ethical and legal concerns of Kerala medical travel from the perspectives of hospitals and intermediaries. This article evaluates the regulatory environment of Kerala and puts forward suggestions to address the issues by the industry players including public sector undertakings.

***Keywords***

medical travel, health care delivery, regulation, ethical issues

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## Introduction

The earlier system of healthcare which was nationally bound and locally based has been changed to an international healthcare system where patients can go anywhere in the world to get appropriate treatment. The fast-growing trend of cross border travel looking for inexpensive and quality healthcare services while incorporating an extended holiday on discretion is termed medical travel or Medical Tourism (MT). Medical tourism is the catchphrase of the new globalised world which enhances the revenue portfolio of many direct and indirect sectors of the economy (RNCOS, 2011). More than 50 nations have identified MT as a national industry (Gahlinger, 2008; Rad et al., 2010). Kerala has been a hopeful destination for health seekers from abroad for decades and now witnesses a diverted trend of seeking curative care in the modern medical treatment system. It has become a good source of foreign exchange as well. It paved the way for a drastic development of the healthcare industry especially in catering to the needs of international patients. There are many corporate, super specialty and multi-speciality hospitals and medicities that have this international orientation. Qualitatively and quantitatively, healthcare facilities have been improved in Kerala over a decade (Destination Kerala, 2015). Currently Kerala has 22 hospitals accredited with the National Board of Accreditation for Hospitals (NABH) including public hospitals compared to 2005 when no accredited hospitals existed there (Destination Kerala, 2015). There are two Joint Commission International (JCI) accredited hospitals compared with no single hospital in 2005 (Destination Kerala, 2015). Kochi has become the hub of Kerala MT with its cultural, political and geographical advantages. Major cities like Calicut and Trivandrum are receiving a good number of patients from abroad. The high end technology, the talent pool and intellectual wealth of Kerala, its English speaking population, good connectivity, moderate climate and a wide variety of natural and cultural attractions have motivated many discerning patents to come to Kerala (Destination Kerala, 2015). The treatment cost in Kerala is 30-70 per cent less, including the expenses for air travel and accommodation, when compared to the cost in the international market (Destination Kerala, 2015). For example, a heart bypass

surgery costs USD 130,000 in the US but in Kerala it is USD 7,000 (Destination Kerala, 2015). Similarly, a knee replacement in the US costs around USD 40,000. Here it is 9,200 USD (Destination Kerala, 2015). Kerala is aiming to become the health tourism hub of India by 2020, by earning 15 per cent of the market share in the Indian medical travel industry from its current share of about seven per cent. To this end, hospitals and the Confederation of Indian Industries in collaboration with the state government have been conducting bi-annual International Kerala Health Tourism Conferences since 2005 (*Malayala Manorama*, 2015).

According to the Ministry of Tourism, as against an ordinary vacationer per capita expenditure of US$3,000 per visitor, the average medical traveller in India spends more than $7,000 per visit (Riesman, 2010). MT is identified as an opportunity and hence hospitals including general, dental and eye care specialties, spend huge amounts in healthcare and are adopting various promotional strategies to woo medical travellers. For this reason, there are chances for commercialization and malpractices. Above all, unlike other businesses, life is being handled in MT industry, which requires the utmost care as ignorance, negligence or malpractices will have serious repercussions. Being a knowledge specific industry, MT practice requires certain competencies. Sufficient knowledge within the medical care industry and know-how of marketing medical care and leisure are the prerequisites for operation within this niche market. Legal risks, medical risks and communication errors need to be addressed effectively.

MT has become a complex phenomenon by its very nature and there are chances of clinical errors and malpractices which will be aggravated in an unregulated environment. According to Riesman (2010), about 90,000 patients have died due to medical negligence. Yet there are several obstacles which make foreign patients reluctant to complain against the issues in another country. Sometimes it is the weak legislation, especially in developing nations, which keep them away from litigation. Steven (2010) called for responsiveness in the case of surgical negligence without meaningful legal recourse and using medical devices which are not on par with the US FDA (Food and Drug Administration) or equal standards for safety. Presently there are no dependable, complete sources for patients

to learn about the legal ways for malpractices committed in jurisdictions (Steven, 2010). In many countries, doctors try to deceive medical tourists by suggesting to them that they undertake a sequence of unwanted tests which are not related to the patient's illness (Riesman, 2010). The ethical issues include (1) falsified promotional claims; (2) provision of inadequate information (3) unreasonable claims of clinics; (4) excessive financial burden; (5) clinics which do not stick to international or national guidelines (stem cell-based treatments); and (6) inadequate patient informed consent, including concealing the side effects of treatments from the patients. Henderson (2004) suggests the necessity for firm controls on the promotional aspects, ensuring safeguards and accountability to protect patients, and the legal machinery to deal with malpractice and grievances procedures.

The healthcare providers in MT are suspected for commercialised services and inflated rates. 'Health' which is marketed through websites with 'tourism' and other sales promotion activities and are 'packaged' may create an image of suspicion. There is no uniformity in cost and quality across hospitals which are competing with each other. A wide gap exists in treatment costs between hospitals across the countries and across the world. For instance in India, a liver transplantation will cost more in Chennai than in Cochin (Destination Kerala, 2015). Again, there is an enormous difference in cost when treatment is offered to a foreign patient. Even though some might find the cost inflated, they will not question thisas the rates are still cheaper when compared to the expenses of the home nation. This finally makes the healthcare providers keep the rate high. Ability to pay determines access to care; the more customers are ready to pay, the more services they can purchase and in turn, limited economic resources buy limited care (Turner, 2011). MT often results in a way of widening the gap between the 'haves and have-not' (Tattara, 2010). In a study conducted among the vice presidents of hospitals in Bangkok, James (2012) found that costs are fluctuating even when the treatment is proceeding. While agreeing with the fact that individual cost of treatments will vary, there are hidden charges. "Add-ons" such as stays in luxury hotels and exclusive tourist resorts are determined by how much customers are prepared to

pay (Turner, 2011). Again, medical provision in Bangkok combined with the commercial operating notions of a five star hotel has led many first-world patients to select South East Asia as a medical-related destination (James, 2012). The demand for highly technologised medicine in a limited number of profitable specialities also creates distortions within the health care system. These include 'cherry picking', whereby corporate hospitals only provide the health services that are most profitable for their foreign patients (Chanda, 2002). Some doctors or owners may be motivated to favour services and treatments that are more profitable and may encourage the development of an inequitable two-tiered health system, where the elite, technologically sophisticated hospitals catering to wealthy foreign clients stand alongside poorly resourced public hospitals (Chanda, 2002). Pellegrino (1999) pointed out the dangers of the increasing commercialisation and commodification of health care as "physicians no longer look on patients as 'theirs' in the sense that they feel continuing responsibility for a given patient's welfare" (p. 253). In Israel, where MT is popular, waiting times of MTs are shorter than those of local people, especially in procedures like in vitro fertilisation (IVF) (Connell, 2011:205). Cohen (2008) observed that "each time a foreigner sees a Thai doctor at 'foreigner prices' he takes away an opportunity for a Thai person to see the same doctor at normal Thai fees. In other words, this programme, while presumably bringing foreign capital to our hospitals, is sucking medical care from our own people". This trend contrasts the Declaration of Alma Ata adopted at the International Conference on Primary Health Care in 1978 that has voiced the necessity for urgent action by the world community to guard and promote the health of all the people and make health available to individuals and families at a cost that they can afford. Since then the primary health care approach has been accepted by member nations of the World Health Organization as the key to attaining the goal of "Health for All" (Tattara, 2010).

Managerial actions and regulatory support are essential for any destination to survive and it helps the tourists to keep themselves away from psychological and performance risks. Competition in the MT industry has caused innovations and cost effectiveness and this has also put the stress

on them to get accreditation. Aregulatory environment is the best option for developing sustainable medical tourism of which regulation of the behaviour of medical tourism intermediaries, hospitals and referring physicians in the home country are vital (Cohen, 2012). Government could necessitate these institutions to adhere to certain guidelines in terms of the facilities to which they refer patients, along the lines discussed above, perhaps by way of a licensing regime (Cohen, 2012). Hall (2008) observed that government helps shape the economic framework for the tourism industry although international economic factors relating to exchange rates, interest rates and investor confidence are increasingly important. The government could also make it a criminal or civil offense for the intermediaries to enable certain kinds of circumvention tourism (Cohen, 2012). In the case of malpractices, the government has to impose liability against intermediaries for medical negligence and errors. These types of regulation would be very easy to implement as against intermediaries incorporated or with assets within the patient's home country (Cohen, 2012).

One major instrument to regulate any industry is policy development. Tourism policy is a road map of tourism development, which lists thepriorities and action plan showing the direction the tourism industry needs to grow (Thomas, 2012). According to Richter (1989), tourism policy development and implementation is a function of political and administrative action, rather than economics or business. Policy conceptualisation is a holistic function of interactions and a process in negotiationwith all the parties directly or indirectly impacted from tourism development (Thomas, 2012). Therefore, tourism policy decisions must be collective and holistic andshould be made with the involvement of government agencies, non-government organisations and businesses (Airey and Chong, 2010).

### *Objectives of this study*

1. To identify the unethical practices in international healthcare delivery of Kerala.
2. To identify the level of commercialisation of medical tourism services.

3. To analyse the level of regulation in the Kerala medical tourism industry with reference to modern medicine

### *Methodology*

This is a qualitative study based on a descriptive research design. There are many stakeholders in the medical tourism industry such as hospitals, medical tourism companies and freelancing agents. The respondents in the study include the managers or Public Relation Officers (PROs) of hospitals and MT intermediaries such as higher officials of medical tourism companies/travel agencies and freelancing agents who collaborate with healthcare delivery for international patients (medical tourists).This study was undertaken in Kerala during January-May 2015. Seventeen hospitals in Kochi catering to medical tourists and 17 MT intermediaries from all over Keralawere interviewed using a semi-structured questionnaire. Data was collected and analysed using the Consensual Quality Research (CQR) method which is ideal for conducting in-depth studies of the inner experiences of individuals (Hill et al., 2005). In CQR, multiple researchers are involved to systematically analyse the data to arrive at a consensus on the representativeness of the results across cases (Hill et al., 1997). The five essential components of CQR are: the use of semi-structured open-ended questions in data collection, the participation of more than one judge in the data analysis process to have diverse perspectives, consensus of the judges to keep away from the biases of the research team members in arriving at the meaning of the data, minimisation of the effects of groupthink in the primary team of judges by the assessment of an auditor, and the enumeration of the domains, core ideas, and cross analyses in the data analysis (Hill et al., 2005). Hill et al. (2005) mentioned about 17 studies from the 27 studies using CQR, which used only one auditor and four studies used two external auditors. However, Hill et al., (2005) stated that the involvement of one external auditor is sufficient at the cross-analysis stage. The sophistication level of the team members must be determined by the topic (Hill et al., 2005). Further, Hill et al. (1997: 558) noted that the "results and conclusions of the data analysis need to be logical, account for all the data, answer the research questions and make sense to the outside reader".

In this research, along with the researcher, the research team for the analysis of the data was comprised of one judge and an external auditor. The judge had her masters in social work and the external auditor had a doctorate in clinical counselling psychology from De La Salle University, the Philippines. It is important to note that the auditor had used CQR methodology before. Before the research team began the data analysis, the researcher gave a description of the study to the primary research team members. In addition, the researcher provided them with copies of the research questions and interview protocol.

Data analysis using CQR involves three central steps. Domains (i.e. topics used to group or cluster data) are used to segment interview data. Core ideas (i.e. summaries of the data that capture the essence of what was said in fewer words and with greater clarity) are used to abstract the interview data within domains. For characterising the frequency of occurrence of the categories while allowing better description of the data, as Hill et al. (2005) suggested, 'general' include all or all but one of the cases. Typical would include more than half of the cases up to the cut-off for general (given that half does not seem typical). A variant would include at least two cases up to the cut-off for typical. With samples larger than 15, Hill et al. (2005) recommended adding a new category of 'rare', which would include 2–3 cases, to allow more differentiation among categories. Finally, as before, findings emerging from single cases should be placed into a miscellaneous category and not reported in the data analysis. Hill et al.'s (2005) recommendation is to fully and richly describe at least the general and typical categories and provide at least one example (using the core ideas or quotes) to illustrate each category in the text. Unless important for some reason, variant or rare data can be left in a table so that the results section is not cluttered with too much information.

## Analysis

The study considered three aspects such as regulatory environment, legal and ethical issues related to medical tourism and cost difference of procedures. The results of the in-depth interview with the hospital authorities are shown in Table 1 and explained underneath.

Table 1: Regulatory environment (a)

| *Domain* | *Subcategory* | *f* | *Exemplar Responses* |
|---|---|---|---|
| Industry Regulation | No | G | "There is no regulation. Mostly it's like real estate!" |
| Legal and Ethical Issues | No | G | "So far we have never felt any legal/ ethical issues" |
| Cost Difference | 100-150% | T | "Normal x 2 is the average cost" |
| | 30 to 40% | R | "Patients from SAARC patients are charged like patients or 25% extra as they are poorer than us" |
| | 150-300% | R | For PET scan they charge, Rs. 60,000 instead of Rs. 20,000. Other hospitals charge Rs.40,000. |
| | No cost difference | R | We have published costs...no difference in costs |

Note: n=17 and hence category and subcategory are considered as general (G) if applied to 15-17 cases, typical (T) if applied to 9-14 cases, variant (V) if applied to 4-8 cases and rare if applied to 2-3 cases.

The respondents are of the general opinion that there is no regulation at all. The following comments validate the finding.

"We use implants which are metal free...cost about 10,000 for one tooth. Since there is no standardisation, some doctors give inferior implants and charge lower and thereby give an opportunity to compare both. Then they will bargain thinking that we are adding up" (Dental Doctor, Kochi).

"People from the Gulf are highly demanding and difficult to fix the cost for them as they bargain to the core. So will keep a cost which is little higher than the actual cost" (Manager, Health check-up and Dental Clinic, Kochi).

There is a variant observation of the absence of strict legislation and policies against crime from the part of MTs. The following experience validates the finding:

"One Canadian couple has taken away my articulator that costs around Rs. 25,000. Soon, I had informed the local police, airport authority and I personally met the City Police Commissioner...my people went behind

them and shown them to the police...no use...nothing happened. Finally as a last resort, I called them and told them that I would report to the police. Next day, when I was not here, they came and gave it here (clinic) after taking all the costly parts. Will it happen in any other country?" (Dental Doctor, Cochin).

Another category which emerged from the data is unethical and legal issues related to medical tourism. It is a general observation that there are no issues at all. The following statement will manifest the finding.

"We insist on M-Visa for surgical patients. Other than that, nothing is felt so far."(Senior Manager, Allopathy Hospital, Kochi).

Another category which emerged from the interview is cost difference. There is a remarkable difference in cost in treatment between the local people and foreigners which varies from 25-150 per cent. This finding is validated in the following statements:

"There should be a standardised cost for each treatment in each category. There can be different standards of treatment, but the cost also will be uniform across the country for each treatment category. Here there is a huge cost difference in treatment as much as 100 per cent or more" (Dental Doctor, Kochi).

"Accreditation, standard protocols (like in Thailand), standardised prices and treatment are essential for this industry to survive and sustain" (Senior Manager, Eye Care Clinic, Kochi).

But there are few dental clinics that have published a cost chart which is the same for all regardless of whether the patient is local or foreign. One of the interviewees (Dental Doctor, Kochi) shared his feelings:

"We have the same cost for treatment both for locals and foreigners. This authenticity of my clinic leads most of the walk-in patients to us. They share their experience with others and that's why most of my patients are referrals" (Senior Manager, Eye Care Hospital, Kochi).

### *Medical tourism intermediaries*

The study considered three aspects such as regulatory environment, legal and ethical issues related to medical tourism and cost difference of

procedures for the study. The results of the in-depth interview with the intermediaries are shown in Table 2 and explained underneath.

Table 2: Regulatory environment (b)

| *Domain* | *Subcategory* | *f* | *Exemplar Responses* |
|---|---|---|---|
| Industry Regulation | No | G | "There is no regulation...all are working for profit." |
| Legal and Ethical Issues | Yes | G | "Patients are not reaching the correct doctor...instead they were the agents who get more commission" |
| | Unwanted tests | T | "We feel bad of these tests for MTs, but are forced to do" |
| Cost Difference | More than 300% | V | Normal x 3 is the average cost, 300 per cent increase. |
| | 100-150% | T | A health check-up is charged Rs.12,500 which costs just Rs. 5,500. |
| | 30-40% | R | They take just above normal rate, i.e., 30-40% |

Notes: n=17 and hence category and subcategory are considered as general (g) if applied to 15-17 cases, typical (t) if applied to 9-14 cases, variant (v) if applied to 4-8 cases and rare if applied to2-3 cases.

The respondents are of the general opinion that there is no regulation at all. They all expressed the necessity of regulatory measures against malpractices and commercialisation of medical services. The following comments show the unregulated dimensions of the MT business in Kerala:

"There are hospitals that market treatment for non-curable diseases. In fact, for certain diseases, no medical treatment is available. It is so pathetic that some of them will become very complicated after arriving here. I had seen many deaths. The patients will realise that they are cheated after spending a lot of money here" (Medical Tourism Facilitator, Kozhikode).

"My patient aged 50 years was advised to do treadmill test (TMT) and the same day he was done the angiogram. The next day he was weak and in a couple of hours' time he died. It was due to the internal injury caused by the medical negligence while doing angiogram. He was very healthy. The

hospital was in a never mind attitude. We cannot work in this industry conscientiously" (Medical Tourism Facilitator Malappuram).

"Kerala is marketing where there are no treatment options. An official at the Oman embassy told me about this as 'we had many cases of death and complications related to this and we do not promote medical tourism in Kerala'" (Medical Tourism Facilitator, Kozhikode).

"One patient contacted us for a small child who is having some genetic problems. They had been even to the US. Somebody told them about Kerala and they contacted us. I spoke to a specialist and she had a perusal of medical records as well. The doctor is under the impression that there is no treatment. Still we asked them to come and undertake tests. Afterwards, we referred them to another hospital in Kochi where more facilities are available. Here the thing is that each time, each doctor tries out experimentation and they have to undertake same tests again and again" (Medical Tourism Facilitator, Kochi).

"When I took three Arab ladies to a doctor for orthopaedic problems the doctor prescribed same medicines to three of them and send us to the pharmacy. But I went to the medical shop and enquired about the medicine. One was for stomach upset and another was a vitamin syrup. Both the brands were very costly and a commission-based business of doctors!" (Medical Tourism Facilitator, Kochi).

"I know one Arab patient admitted in (hospital), Kozhikode. He is suffering from cancer in intestine which is in the advanced stage. He is there for the last five months and they have been telling it is curing. When I saw the tests and bills I really felt very bad. It is highly unethical" (Medical Tourism Facilitator, Malappuram).

"There is a case where the doctor advised not to have tablets for cholesterol after having a check-up using online ASCVD (Atherosclerotic Cardiovascular Disease) Risk Estimator" (Medical Tourism Facilitator, Thrissur).

"There are no regulatory measures to control the agents. One agent has taken one patient from Oman using his contacts. While he landed at Nedumbassery airport there was no agent, no vehicle, no translator. The

agent was not attending calls. He had taken 250 Rials in advance" (Medical Tourism Facilitator, Kothamangalam).

"I happen to hear the translation of an agent who wanted to translate about the pain which starts from head which then slowly spread to the whole body to the feet" like this. "I have a pain in my head and feet" (Medical Tourism Facilitator, Trivandrum).

A further category emerged from the interview is the cost difference. There is a lack of standardisation and regularisation of treatment costs. But there are few dental clinics that have published a cost chart which is the same for all regardless of local or foreign patients. However, there is a remarkable difference in costs in treatment between the local people and foreigners which varies from 100-150 per cent typically. This finding is evident in the following statement:

"Diagnosis is very costly. To test cancer, they will advise a Positron Emission Tomography (PET) scan which is available only in four hospitals. Doctors in Cochin prefer to give letter to a hospital where it costs Rs. 40,000 whereas in another hospital it is only Rs. 20,000. When I took them to the other hospital and submitted the report to the doctor he got angry" (Medical Tourism Facilitator, Thrissur).

"Check-up cost is very high for medical tourists like MRIs, scans etc., at least over 100 per cent" (Medical Tourism Facilitator, Trivandrum).

"The consultation fee for a foreign patient is Rs. 500 as against Rs. 150-200 for a domestic patient. But it can be justified by the excess time, effort and risk factor of a doctor. While a doctor sees a local patient in two minutes' time, a foreign patient will be checked up in detail sparing at least 10-20 minutes" (Medical Tourism Facilitator, Kozhikode).

However, it is a variant observation that there are hospitals that charge more than 300 per cent extra for the treatment when compared to for a local patient. The following remark manifests this:

"Charges are highly unethical, though the cost is still cheaper than in their country even after charging three-fold of the actual charges, it is real exploitation. It will affect the future business. Some patients know that it is cheating and some of them will bargain with the hospitals. Finally, it will result in bad reputation" (Medical Tourism Facilitator, Kozhikode).

It is observed that there are many allopathic hospitals that insist on unnecessary diagnostic tests. The following remarks clarify this.

"Firstly, they will take patients to a physician who will insist on some tests. Then they will send to specialists, sometimes more than one. Each specialist will insist on a number of tests. Sometimes, we don't feel its logic, but are not able to question. For a small disease, they will ask to do all tests and scans. Most of the hospitals are having tie-ups with labs outside. Finally, when seeing the bill it's shocking. It happens to even a local patient, but when it comes to foreigners, it's more" (Medical Tourism Facilitator, Malappuram).

The triangulated findings of medical tourism hospitals and intermediaries revealed that there is no regulation in the industry. According to UNWTO (2004), in addition to the direct economic measurements such as volume and income generated, all managerial actions are related to the economical sustainability such as the lack of non-enforcement of policies. To achieve greater sustainability in the tourism industry the primary instruments of actions include the enforcement of laws and regulations as well as voluntary standards and initiatives (Bohdanowicz et al., 2005). No policies and regulations related to the MT industry are planned and implemented in the Kerala medical tourism industry. This study confirms the findings of Cherukara and Manalel (2008) that the government of Kerala is not involved in the promotion of MT except for some financial funding for holding events like the Bi-Annual Kerala Health Tourism Conference. Hosting events dedicated to raising awareness about physicians and best business practices will help reduce the incidence of malpractice in the future and earn the trust of foreign patients (Bookman and Bookman, 2007). The findings show that general observation of medical tourism intermediaries (Table.2) is that there are a lot of unethical practices taking place with regard to cost and treatment. Many unwanted tests are insisted upon for foreign patients with the intention of making money. Further, there is no proper mechanism to complain and sue against medical negligence and treatment errors due to the absence of an effective international legislation related to medical tourism.Ben-Natan et al. (2009) argued that safety and appropriateness of treatment is a real problem of MT. There are several

obstacles which make foreign patients reluctant to complain against the issues in another country (Steven, 2010). Sometimes, it is the weak legislation especially in developing nations which keep them away from litigation and eventually making the situation a real muddle without suing or succeeding in suing (Steven, 2010). Presently there are no dependable, complete sources for patients to learn about legal ways out for malpractice committed in [foreign] jurisdictions (Steven, 2010). Hence Henderson (2004) suggests the necessity for firm controls on promotional aspects, ensuring safeguards and accountability to protect patients, and the legal machinery to deal with malpractice and grievances procedures.

Medical Tourism Facilitators (MTFs) observed that there is a big difference between the perceived treatment cost and the actual cost. A big difference in costs from hospital to hospital and from local patients to foreign patients is observed. The average costs charged for procedures is about 150-300 per cent higher than that of the actual costs charged from local patients. The major market of Kerala is the Middle East and the Maldives (Cherukara and Manalel, 2008). Here it should be noted that Arab countries are at different stages of their development, ranging from the industrialising to the underdeveloped (Branine, 2011). The majority of the Arab nations have experienced depressed economic conditions especially from the 1980s to about 2004 due to fluctuation in oil and gas prices and political instability (Branine, 2011). The UAE, Jordan and Bahrain have also been severely affected by the 'credit crunch' recession (Branine, 2011). The global recession for the last few years has affected them again. Thus the backward pricing strategy and overpricing of stakeholders may keep the present budget category MTs away from Kerala. All the stakeholders have to believe and act by a philosophy that profits and money are byproducts which will come automatically from the quality service delivery.

## Conclusion

The study throws light into the urgent need of managerial actions in the medical tourism industry in Kerala.Managerial actions in terms of regulatory support influence the MT destination choice (Smith

andForgione, 2008). The study reveals that there is a big difference in cost and a high degree of commercialisation in the industry. There are many unethical practices in terms of cost and treatment which is triggered by the absence of a regulatory framework. There is no significant effort made by the competent public authority to govern the industry with an effective policy framework, guidelines and legislation. It is high time to regulate the industry by preventing unauthorised entry of illegal investors to protect the interest of genuine stakeholders. In short, organised strategic synergy among all stakeholders aimed at improved quality embedded healthcare delivery with an overarching regulatory system is essential for the sustainability of medical tourism in Kerala.

## References

Airey, D., and Chong, K. (2010). "National policy-makers for tourism in China." *Annals of Tourism Research,* 37(2): 295-314.

Ben-Natan, M., Ben-Sefer, E., and Ehrenfeld, M. (2009). "Medical tourism: a new role for nursing?" *The Online Journal of Issues in Nursing (OJIN),* 14(3): 1-9.

Bohdanowicz, P., Simanic, B., and Martinac, I. (2005). "Environmental training and measures at Scandic hotels, Sweden." *Tourism Review International,* 9 (1): 7-19.

Bookman, M. Z., and Bookman, K. R. (2007). *Medical Tourism in Developing Countries.* New York, NY: Palgrave Macmillan.

Branine, M.(2011). *Managing Across Cultures-Concepts, Policies and Practices.*London; Sage Publications.

Chanda, R (2002). "Trade in health services." *Bulletin of the World Health Organization*, 80: 158–163.

Cherukara, J., and Manalel. J (2008). Medical tourism in Kerala: challenges and scope. Presented at the Conference on Tourism in India: Challenges Ahead.5-17 May, IIMK, Calicut. http://dspace.iimk.ac.in/bitstream/2259/579/1/369-379+Joseph+Cherukara.pdf Accessed on 20 January 2014.

Cohen, E. (2008). "Medical tourism in Thailand." *AU-GSB e-Journal.* http://gsbejournal.au.edu/e-Journal/Journal/Medical%20Tourism%20Dr%20Cohen.pdf. Accessed on 22 January 2014.

Cohen, I.G. (2012). "How to regulate medical tourism (and why it matters for bioethics)." *Developing World Bioethics*, 12 (1): 9–20.

Connell, J. (2011). "A new inequality? privatization, urban bias, migration and medical tourism." *Asia Paci?c Viewpoint,* 52(3): 260–271.

Destination Kerala (2015). "Promoting Kerala as a healthcare destination." *Destination Business Media,* 18 (6):14-17.

Gahlinger, P. (2008). *The Medical Tourism Travel Guide: Your Complete Reference to Top-quality, Low-cost Dental, Cosmetic, Medical Care & Surgery Overseas.* Forest Lake, MN: Sunrise River Press.

Hall, C.M. (2008). *Tourism Planning: Policies, Processes and Relationships*(2nd Edn). New York: Pearson/Prentice Hall.

Henderson, J. C. (2004). "Healthcare tourism in Southeast Asia." *Tourism Review International,* 7(3-4):111-121.

Hill, C. E., Thompson, B. J., and Williams, E. N. (1997). "A guide to conducting consensual qualitative research." *The Counseling Psychologist,* 25(4): 517–572.

Hill, C.E., Knox, S., Thompson, B.J., Williams, E.N., Hess, S.A., and Ladany, N. (2005). "Consensual qualitative research: an update." *Journal of Counseling Psychology,* 52(2): 196-205.

James, P. T. J. (2012). "The impact of medical tourism on Thai private hospital management: informing hospital policy." *Global Journal of Health Science,* 4 (1): 127-139.

*MalayalaManorama* (2015). 'Kerala health tourism 2015: Nalekochiyilthudakkam' (Mal.). October 29, p.13.

Pellegrino, E. D. (1999). "The commodi?cation of medical and health care: the moral consequences of a paradigm shift from a professional to a market ethic." *Journal of Medicine and Philosophy*, 24 (3): 243–266.

Rad, N.F., Som, A.P.M., and Zainuddin, Y. (2010). "Service quality and patients' satisfaction in medical tourism." *World Applied Sciences Journal,* 10(1): 24-30.

Richter, L. K. (1989). *The Politics of Tourism in Asia.* Honolulu, HI: University of Hawaii Press.

Riesman, D. (2010). *Health Tourism: Social Welfare through International Trade.* Cheltenham: Edward Elgar.

RNCOS (2011).Asian Medical Tourism Analysis (2008-2012).http://www.rncos.com/Market-Analysis-Reports/Asian-Medical-Tourism-Analysis-2008-2012-IM105.htm Accessed on 15 November 2012.

Smith, P., and Forgione, D. (2008). Global outsourcing of healthcare: a medical tourism decision model. http://business.utsa.edu/wps/acc/0033ACC-205-2008.pdf Accessed on 14 January 2013.

Steven, L. M. (2010). "Ethical issues threaten the future of the medical tourism sector?" *Medical Tourism Magazine*.http://www.medicaltourismmag.com/ethical-issues-threaten-the-future-of-themedical- tourism-sector/ Accessed on 6 January 2013.

Tattara, G. (2010). "Medical tourism and domestic population health." *Global Social Policy,* 10(3): 336-357.

Thomas, T.K. (2012). Evaluating the performance of index core components for destination benchmarking: the case of international tourism in Kerala. PhD Thesis, Indira Gandhi National Open University, Delhi.

Turner, L. (2010). "Quality in health care and globalization of health services: accreditation and regulatory oversight of medical tourism companies." *International Journal of Quality Health Care*. 23(1):1-7.

UNWTO (2004).*Indicators for Sustainable Tourism: A Guidebook*, Madrid: UNWTO.