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IMPACT OF HOME COUNTRY TERRORISM ON MEDICAL TOURISM IN INDIA JANUARY 2020

Stuti Jha

Assistant Professor of Economics Political Science and Economics Department Rowan University Glassboro, New Jersey, USA.
Email: jha@rowan.edu

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ABSTRACT

This paper examines the relationship between home country terrorism and medical tourism as many such countries are faced with failing health care systems because of the increased threat and incidences of terrorism. The results of this analysis show that there is a direct and significant effect of terrorism in a country on the number of medical tourists from that country. Using instrumental variable approach, I find that a country ranked high on the terrorism index is likely to send 28.95 per cent more patients to India for medical treatment than a country ranked lower on the same index. I also find that distance plays a crucial role in determining medical trade volumes between such countries and popular medical tourism destinations such as India. The analysis demonstrates that the top nations sending medical tourists to India are developing and/or war-ravaged countries. This is one of the first studies to look at the socio-political climate in a home country as a factor influencing trade in health services, in particular, medical tourism.

Contribution/ Originality: This study is one of very few studies which have investigated the link between socio-political climates in a home country, notably terrorism, as a factor influencing the outflow of medical tourists from that country.

1. INTRODUCTION

The movement of patients from one country to another to seek medical care is termed medical tourism. India is gradually becoming a top medical tourism destination for patients around the world (Mishra & Shailesh, 2012). The boom in this sector can be attributed to certain advantages India has over many other countries, especially when compared to other Asian nations. In recent years, patients from countries in South Asia and the Middle East have accounted for a large proportion of the medical visas issued by India. Factors common to many of these countries are political instability and social unrest. In general, many of these countries have been hit hard by terrorism, both domestic and international. In this paper, I examine the impact of terrorism in the home country on the number of medical tourists bound for India.

The nature of medical tourism has transformed in the last few decades. In recent years, some of the developing countries have become top destinations for patients, thus giving rise to South-South trade (Crush & Chikanda, 2015). Researchers have therefore have focused on the factors affecting South-South trade in health services. This

paper is one more step in understanding these trade relations and the importance of internal security and availability of health services in determining the movement of patients across borders to access healthcare services.

According to industry estimates, the medical tourism industry in India was valued at $3 billion in 2015, and it is expected to grow to $9 billion by the year 2020 (FICCI Medical Value Travel Report, 2018). The Indian government and the healthcare industry have invested heavily in promoting Indian health care abroad to attract more medical tourists. It is also important, however, to look at the characteristics of the patients that choose India for medical care. There are many qualitative articles and industry reports that discuss the Indian medical tourism sector, but many do not perform a detailed econometric analysis of the data.

The Ministry of Tourism of the Government of India recently released its 2017 annual report, which contains a country-wise break up of total foreign tourist arrivals in India based on the purpose of their visit. To conduct my analysis, I combine the ministry's data with the data on the terrorism index published by Institute for Economics and Peace (IEP).

I use a two stage least squares estimation to study the impact of terrorism on medical tourism in India. The instrument I use for the main variable of interest (terrorism) is the degree of democracy in the countries of origin of medical tourists. Many of these countries are likely to present common characteristics, and I use data from the democracy index, published by the Economist Intelligence Unit (EIU), as a control measure. My results show a positive effect of terrorism in a country on the number of tourists that country sends to India for medical care. That is, a country ranked high on the terrorism index is likely to send higher number of patients to India for medical care.

This paper makes three major contributions. The first contribution is the research question itself; no other paper has tried to estimate the effect of regional terrorism on the outflow of medical tourists. The second contribution of this paper is the instrumental variable used for controlling endogeneity in the data. To the best of my knowledge, the degree of democracy in a country has not been used previously as an instrument to measure the level of terrorism in a country. This is a unique approach that has implications for other areas of research, such as conflict resolution and development. The third contribution of this paper is the use of data on tourist visas, published by the government of India, for an advanced econometric analysis. The paper combines data from many different sources to create a unique dataset that can be used to answer other questions regarding tourism in general in India.

2. LITERATURE REVIEW

Medical tourism is not a new phenomenon, but only recently have many emerging economies and developing countries become preferred medical tourist destinations. Traditionally, most of the medical tourism was based on south-north migration. That is, people from poor, developing countries seeking treatment in developed countries. Developed countries still dominate providing high tech, complicated medical procedures or patients all over the world. Gunter et al. (2010) show that the USA is the top destination of cell therapy and other advanced biomedical research. For the purpose of this study we focus on south-south migration.

The reasons for people moving across border to get treatment varies by country of origin and destination country. Smith and Forgione (2007) develop a decision model for medical tourism destination based on country characteristics. They use a two-stage model to determine the factors that influence patient's choice of destination as well as specific service provider there. They show that country characteristics like distance from their country, per capita income, and trade relations between the two countries effect the patients' choice of destination country. However, patients may choose a health service provider based on cost of care, its international accreditation certificates like the Joint Commission International (JCI), and the quality of its staff.

The increased inflow of patients to the developing nations has shifted the focus of healthcare researchers on the quality of care provided by these countries. Turner (2010) brought attention to the lack of regulatory framework

protecting patients' rights which has a negative effect on the quality of care patients receive in these developing countries. As a result, having an international accreditation like the JCI works as an indicator of quality for the international patients. Woodhead (2013) shows the link between international accreditation and medical tourism in developing countries.

Connell (2013) argues that despite the hype, most medical tourists visit from nearby countries, which is to say that distance is a major factor in determining the destination country. He also demonstrates that most medical tourists in certain developing countries comprise primarily of the diaspora. This certainly seems to be the case for India. A large Indian diaspora lives in major European countries, Australia, and the United States. The data is not available for Indians who live abroad and travel to India for medical treatment, but some studies have shown a similar pattern of travel among the Indian diaspora. Dangor, Hoogendoorn, and Moolla (2015) show that most Indian South Africans traveling to India state medical treatment as one of the top reasons for their journeys.

Crush and Chikanda (2015) show that South-South migration is a more important contributing factor to tourist flow between countries than North-South migration, as projected by the media and industries in destination countries. This implies that most medical tourists traveling to developing countries such as South Africa and India tend to come from other developing countries. Their choice of destination might be influenced by factors such as proximity, low cost of care, and, in some cases, recommendations from government-run programmes in their home nations. This is an important discovery, considering that South Africa and India are somewhat similar in terms of economic size and the state of their healthcare system.

Vitthal, Subhash, Sharma, and Ramachandran (2015) discuss the advantages of India as a medical tourism destination. The positives discussed include access to low-cost healthcare and the virtual lack of waiting time for receiving medical treatment, including complex procedures such as open heart surgeries and transplants. The availability of highly qualified medical professionals is another reason for India's attractiveness for foreign patients. However, if we consider the population of India, the population of medical professionals does not seem very large. According to the World Health Organization, there are about 0.8 physicians per 1000 people in India[1].

Advertising and other promotional campaigns have also played an important role in promoting India's medical tourism industry. Hospitals all over the country promote their services to foreign patients by highlighting their interpreter services and featuring patient testimonials on their websites (Moghavvemi et al., 2017). The Government of India in its Government of India (2002) recognised the potential of India as an attractive medical tourism destination (Medhekar, 2014). Mukherjee and Das (2016) develop a consumer based marketing index to show the adaptation of innovative business model in attracting medical tourists to specific city or region.

There is a growing literature on medical diplomacy among developing countries to take advantage of mutually beneficial trade in health services. Whittaker (2015) studied the case of patients from the Gulf Cooperation Council who were sent to Thailand for their healthcare needs as the members countries of GCC don't have the trained professional staff and infrastructure to care for their sick patients who need advance care. Pérez-López (2017) shows the conscious effort of the Cuban government to improve its relations with other developing countries in the region.

3. MEDICAL TOURISM IN INDIA

As I observed previously, India holds many distinct advantages over several other countries, including its Asian neighbours, which make it a preferred medical tourism destination. First, almost all healthcare professionals in India speak English. Next, the low cost of health care in India when compared to regional competitors such as Singapore makes it a particularly attractive destination for health tourists. Further, cultural and historic ties with other countries in the region make it easier for citizens of these nations to travel to India for treatment. Another

[1] World Health Organization's Global Health Workforce Statistics, OECD.

major factor is the successful campaign to promote the Indian healthcare sector, which has been led by Indian hospitals and other Indian missions in these countries.

Mukherjee and Das (2016) develop a consumer based marketing index to show the adaptation of innovative business model in attracting medical tourists to specific city or region It is therefore unsurprising that India has become a focal point for patients from its South Asian neighbours and the Middle East. The largest number of medical tourists in India come Bangladesh, Afghanistan, the Maldives, and Iraq. Interestingly, India does not frequently issue visas to the citizens of these nations, excepting for people from Bangladesh. Medical visas constitute a large proportion of the total visas issued to the citizens of these countries, making up 71%, 63%, and 42% of the total visas issued to the Maldives, Iraq, and Afghanistan respectively.

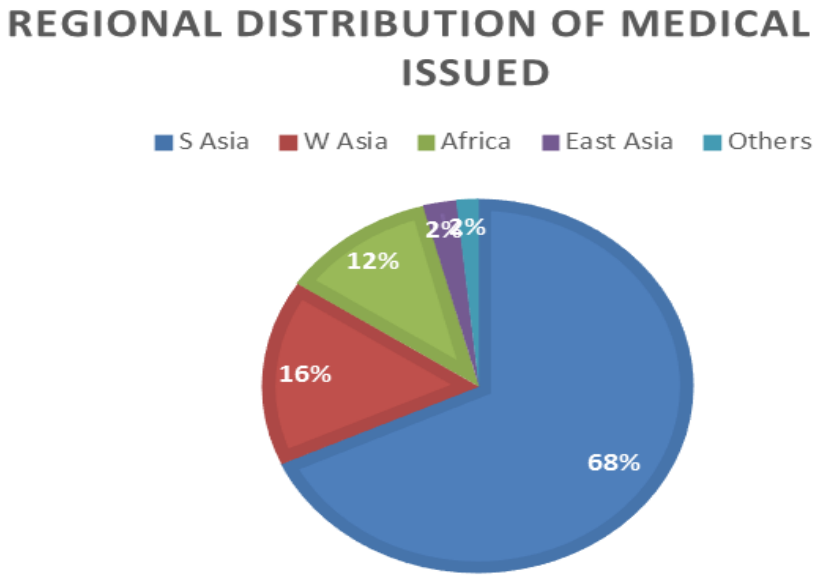

Figure-1. Pie chart of regional distribution of medical visas issued by India in 2017.
Source: Government of India (2017) Government of India, Ministry of Tourism, Market Research Division.

Table-1. Country with highest number of Medical Tourist visas to India (2017).

Country	Number of Visas 2017	Percentage of Medical Visa	Number Medical Visa 2017
Bangladesh	1380409	13.14	181385.7426
Afghanistan	123330	42.57	52501.581
Maldives	67457	71.58	48285.7206
Iraq	48227	63.04	30402.3008
Oman	105705	20.61	21785.8005
Kenya	44783	21.84	9780.6072
Nigeria	17964	44.34	7965.2376
Yemen	19383	40.34	7819.1022
Pakistan	104720	6.35	6649.72
Tanzania	23026	22.55	5192.363
Sudan	17093	22.25	3803.1925
Sri Lanka	297418	1.25	3717.725
Saudi Arabia	61605	4.35	2679.8175
Myanmar	51376	3.2	1644.032
Nepal	161097	0.9	1449.873
Mauritius	34280	3.42	1172.376
Bahrain	17382	5.3	921.246
United Kingdom	941883	0.08	753.5064
USA	1296939	0.05	648.4695

Source: Government of India (2017) government of India, ministry of tourism, market research division.

The pie chart above represents the regional distribution of medical visas issued by India in 2017. Sixty-eight per cent of the 423,279 visas were issued to natives of South Asian countries, while the second largest group of visa recipient was from West Asia. Many visas were also issued to nationals of African countries, including citizens of Nigeria, Kenya, and Sudan.

Table 1 provides deeper insight into the characteristics of these travellers; it lists the 20 countries that were issued the largest number of medical visas. The data reveals certain trends: many of the countries are Islamic nations; most of these countries have been ravaged by terrorism or civil war; most of these countries are economically poor, though some countries like Saudi Arabia and the UAE are relatively rich and stable in comparison.

Another observable trend is that some of these nations have a large Indian diaspora. India does not issue dual citizenships, but it does offer certain status to Indian origin people who are citizens of other countries. The most common status it confers is the 'Overseas Citizenship of India' card, which allows people of Indian origin who are citizens of other countries to live and work in India indefinitely. Importantly, people who qualify for such statuses do not require separate medical visas to seek treatment in India. Considering such variables, the actual number of patients from these countries traveling to India for treatment might be far higher than the number of medical visas issued by the Indian government.

There are two major reasons that drive most patients to travel abroad for medical treatment. The first is economics: the cost of healthcare in their home country is prohibitively high, which makes India a viable alternative. The second is the situation in their home countries: weak health care systems and other institutions might force patients, particularly the more affluent ones, to travel abroad for better medical treatment. Patients from countries ravaged by terrorism fall under this second category.

Table 2 above shows the terrorism index and democracy index scores of various countries. An observable trend is that of the 20 countries with the largest number of medical tourists to India, most of them are ranked high in the Global Terrorism Index issued in 2017. The instability and strife faced by these countries, coupled with the outreach and marketing efforts of Indian consulates and Indian hospitals, have led to an increase in the number of people seeking medical care in India over the past decade.

Table-2. Countries list with corresponding terrorism index and democracy index scores.

Country	Terrorism Index	Democracy Index
Iraq	10	4.09
Afghanistan	9.441	2.55
Nigeria	9.009	4.44
Pakistan	8.4	4.26
Yemen	7.877	2.07
Egypt	7.17	1.3
Philippines	7.126	6.71
Ukraine	6.557	5.69
Sudan	6.453	2.15
Bangladesh	6.181	5.43
Kenya	6.169	5.11
France	5.964	7.8
Saudi Arabia	5.808	1.93
China	5.543	1.39
USA	5.429	7.98
Russia	5.329	3.17
United Kingdom	5.102	8.53
Myanmar	4.956	3.83
Germany	4.917	8.61

Source: Terrorism Index data: Index (2017): Measuring the impact of terrorism, Sydney, November 2017. Available from: http://visionofhumanity.org/reports (accessed 23/07/2018). Democracy Index: The Economist Intelligence Unit, Democracy Index 2017.

It is therefore unsurprising that a large percentage of travellers from Iraq, Yemen, and Nigeria – nations that have been devastated by war and terrorist activities over the last 20 years have sought medical visas to India. Another common theme emerges from Table 2. Most of these countries are poor and have underdeveloped healthcare systems, and most of these counties fare poorly on the democracy index.

In addition to the problems that drive overseas patients to India, medical practice in India presents further challenges they must contend with. Notably, India does not have a law protecting patients' rights despite repeated calls from consumer rights groups. Doctors enjoy a god-like stature in Indian society, and they lack accountability. A famous case that highlights this lack of accountability is the story of Eman Ahmed Abd El Aty, an Egyptian woman who sought surgery in India to combat her obesity. She lost her life following complications that developed after her surgery. Besides being a PR disaster for the Indian healthcare industry, Eman Ahmed's case also shed light on the glaring lack of accountability that doctors and hospitals in India enjoy.

The problems faced by medical tourists in India are further complicated by the importance of its private sector. The overstretched public sector healthcare in India relies on private sector to meet the needs of the enormous population. The complete lack of regulation over medical practices is therefore a major concern. In many of their home countries, medical tourists to India must already contend with a similar lack of regulation. There is also no international law that protects the interests of these patients. This lack of protection further exacerbates the problems faced by patients who are already vulnerable to conditions in their home countries.

4. DATA DESCRIPTION

The data on medical tourism in India is reported by the Ministry of Tourism, and I use the data published in the annual report released by the Ministry for the year 2017. The report classifies different categories of visas issued by India, and it further presents a country-wise break up of all visa categories. These categories include business visas, travel visas, family visas, and medical visas. The Government of India started issuing medical visas to foreigners in 2003. Since then, millions of foreign patients have visited India to seek medical treatment.

For empirical analysis, I use other data sources. I discuss each of these sources and the variables constructed from them below.

4.1. Construction of Main Variables

Country of citizenship: The medical visa issued to individual patients is classified based on their country of citizenship, and this variable lists all those countries. Since only certain countries have medical tourists traveling to India, I restrict my analysis to the top 40 tourists-sending countries.

Number of medical visas: This variable contains information on the number of medical visas issued to patients from each country listed in the data.

Distance between India and the trading partner: This variable notes the distance between India and its trading partners. The specific distance is based on the geographic centre of each country and the centre of India. For example, although Bangladesh borders India, their centres are 1222 km apart. This data is sourced from DistanceFromTo, an online resource that calculates distances between various points in the world.

Terrorism index: The Institute for Economics and Peace publishes the Global Terrorism Index (http://visionofhumanity.org/reports (accessed 23/07/2018)), which scores the countries based on the number of terrorist acts it has faced and other related factors. This score helps them rank the countries around the world to construct an index.

Democracy index: This index is published by the EIU. Countries are scored on sixty different indicators, such as civil liberties and the fairness of elections. A higher score on this index implies that the nation follows democratic principles in its political and social structure, while a low score indicates that it is either an incomplete democracy or under an authoritarian regime.

Economic Variables: Medical care is a type of trade in health services, so it is important to consider some of the basic economic variables that determine trade between the two countries. Some of these economic variables include total trade between India and the trading partner (both exports and imports) and GDP per capita. The data is sourced from the World Bank national accounts data, and OECD National Accounts data files.

Some of the countries ranked high on the terrorism index are Afghanistan, Yemen, and Nigeria. These countries experienced numerous terrorist attacks in 2017. The ranking of these countries on the democracy index is also low; in fact, Yemen and Afghanistan are two of the least democratic countries in the world. It is conceivable that such countries lack strong political commitment and the institutional framework to control acts of terrorism on their soil.

5. EMPIRICAL MODEL

I use an instrumental variable to address the endogeneity in the regression. The first stage of the regression is given below:

$$Ter_i = \alpha_0 + \alpha_1 Dem_i + GDP_i + \mu_{idem}$$

Here Ter_i is the dummy variable for terrorism. Dem_i is the dummy variable for degree of democracy in a country based on the democracy index. GDP_i is the per capita GDP of the country, and μ_{idem} is the error term from the first stage.

Dem_i is the instrumental variable for terrorism in a country. It is safe to assume that countries with more democratic institutions will have stronger capacities to tackle domestic and international terrorism. Conversely, countries with more autocratic governments will contended greater civil unrest and thus may witness more domestic terrorism.

$$Y_i = \beta_0 + \beta_1 \widehat{Ter}_i + \beta_2 X_i + \beta_3 Dis_i + \mu_{iter}$$

Here Y_i is the variable medical tourists from country i as a percentage of total tourists from country i. $\widehat{Ter}_i$ is the predicted value of the variable terrorism index derived from the first stage of regression above. X_i is the vector of other economic variables of the home country, such as GDP per capita, volume of trade with India, and so on. Dis_i is the distance of country i from the centre of India. μ_{iter} is the error term in the regression. Our main coefficient of interest is β_1, which shows the effect of terrorism on the medical tourists a country sends to India. It is reasonable to assume that countries that rank high on the democracy index are more likely to be rich and developed. To control for this, I have used the GDP per capita of these countries. The results also show a negative relationship between the likelihood of sending medical tourists and the distance between India and the home countries of medical tourists.

6. RESULTS AND DISCUSSION

Table 3 gives the OLS regression results using a dummy variable for terrorism index as the main independent variable. The coefficient on the terrorism dummy is positive and both economically and statistically significant. The proportion of medical tourists from a country goes up by 16.5 per cent if it ranks high on the terrorism index.

However, it does not address the endogeneity issue arising from common characteristics shared by countries affected by terrorism. Column 2 of Table 3 uses the dummy variable for the democracy index as the instrument. Here, it can be observed that if a country ranks high on the terrorism index (6 or above), it is more likely to send medical tourists to India. The regression shows that a higher rank on the terrorism index leads to an increased proportion of medical tourists by 28.95 per cent. The first stage controls for economic variables like GDP per capita, while the second stage controls for trade and distance variables.

Table-3. The table shows the ordinary least squares regression and the instrumental variable regression. The main variable of interest is the dummy variable for the terrorism index. The instrumental variable is the dummy variable for democracy index.

	(1)	(2)
Variables	**Percentage of Medical Visas Issued**	
Terrorism Dummy	16.52**	28.95***
	(7.406)	(8.868)
Distance	-0.00163	-0.00120
	(0.00104)	(0.000875)
Exports to India	-0.00634	0.0198
	(0.0789)	(0.0570)
Imports from India	-0.0836	-0.102
	(0.0928)	(0.0985)
Constant	13.65*	8.194*
	(7.902)	(4.925)
Observations	40	40
R-squared	0.264	0.175

Note: Robust standard errors in parentheses.
*** p<0.01, ** p<0.05, * p<0.1.

Similarly, Table 4 gives the results from the regression with the terrorism index (absolute value) as the main independent variable. Column 1 of Table 4 shows the OLS regression results from the analysis. We can see that the coefficient on the variable terrorism index is positive, indicating a direct relationship between terrorism and medical tourism. In column 2 of Table 4, I use the democracy index as an instrument, and the terrorism index is the main independent variable. The coefficient on the terrorism index is 3.86, which means that if a country ranks one point higher on the terrorism index, the medical tourists as a percentage of total tourists go up by 3.86 per cent. The first stage of the regression also controls for the size of the economy, by using the variable GDP per capita.

Table-4. The table shows the ordinary least squares regression and the instrumental variable regression. The main variable of interest is the terrorism index, which gives the ranking of a nation on the terrorism index. The instrumental variable is the corresponding values of democracy index.

	(1)	(2)
VARIABLES	**Percentage of Medical Visas Issued**	
Terrorism Index	1.696	3.865***
	(1.716)	(1.346)
Distance	-0.00187	-0.00145
	(0.00111)	(0.000907)
Exports to India	-0.00963	0.0306
	(0.106)	(0.0995)
Imports from India	-0.0886	-0.127
	(0.135)	(0.122)
Constant	11.97	0.534
	(12.97)	(6.780)
Observations	40	40
R-squared	0.167	0.066

Note: Robust standard errors in parentheses.
*** p<0.01, ** p<0.05, * p<0.1.

Overall, the regressions in both Tables 3 and 4 support the hypothesis that there is a direct link between terrorism and movement of patients across the borders. The results show the indirect cost of terrorism in the

region. The destruction of local healthcare systems that forces patients to travel great distances to get basic treatment. However, the silver lining for these patients is the access to quality healthcare at affordable prices in other developing countries like India and Thailand.

7. CONCLUSION

In this paper, I have demonstrated the effect of terrorism in a country on the cross-border movement of patients. Medical tourism is a growing sector in the global health care system, and it is important to understand the numerous factors affecting medical tourism across countries to address the health care crises in various regions. Many countries, especially in Asia, are faced with failing health care systems because of the increased threat and incidences of terrorism. Patients from these countries are often left with no other alternative but to travel to a different country to seek medical treatment.

This is one of the first studies to look at the socio-political climate in a home country as a factor influencing trade in health services. I use an instrumental variable to estimate the causation effect of terrorism index on the movement of medical tourists across borders. I use the democracy index as an instrument to predict terrorism intensity in a country. The correlation between the terrorism index and the democracy index is shown to be negative; that is, countries with high degree of democracy also experience higher intensity acts of terrorism. This is a second contribution of the paper, as other studies have not used these two variables together. The third contribution of this paper is the use of econometric techniques to estimate the flow of medical tourists into India. Most studies on medical tourism in India are based on a small sample of patients visiting the country, which may not give a clear picture of the real circumstances behind the heavy volume of these tourists.

The results show that there is a direct and significant effect of terrorism on the number of medical tourists from a country. In particular, a country ranked high on the terrorism index is likely to send 28.95 per cent more patients abroad for medical treatment than other countries. I also find that distance plays a crucial role in determining medical trade volumes between such countries and popular medical tourism destinations such as India.

This is a preliminary study to establish the causal effect of terrorism on medical tourism. Given that most countries have only recently started keeping record of movement of patients across borders, there is significant research potential in this area of study.

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