# Interviewing elites. Perspectives from medical tourism sector in India and in Thailand

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In *Fieldwork in Tourism: Methods, Issues and Reflections*, Edited by Michael Hall, Routledge1. Introduction

From culture, to cookery, to eco - tourism, the holiday experience is becoming more and more diverse. Since the Asian financial crisis of 1997, medical tourism has increasingly contributed to this trend, particularly in Thailand and India. The main motivation of our project is to engage a research study on medical tourism which has been almost exclusively approached from the point of view of the media today. Medical tourism has been indeed widely commented by the press, which presents the 'sea, sun, sand and surgery' (Connell, 2005) phenomenon as 'the' answer for patients living in developed countries and having to deal with long consultation waiting lists, and high medical costs. Until now, few articles are putting medical tourism in perspective and therefore we wanted to go a little further than the headline story that the media and the medical tourism stakeholders keep selling. Through a comparison between India and Thailand, our objective was to better assess medical tourism, its development, its impacts. Medical tourism takes place in different parts of the world today and emphasises well the globalization in the field of health care. In this context, we thought that the mirroring effect between the two countries would be very effective to deepen our understanding of the phenomenon, and to bring out the main elements constituting this trend.

During our research project we had to conduct many interviews with medical professionals, marketing and operation managers of corporate hospitals, and key members of different ministers or professional organisations in India and Thailand. Following Herod (1999: 313) in his effort to define foreign elite, we can identify our interviewees as "foreign nationals who hold positions of power within organizations such as corporations, governments". In India and Thailand, the corporate hospitals, the professional organisations (e.g. the Confederation of Indian Industry) and the ministry of health and the ministry of tourism are instrumental in the growth of medical tourism. There is a growing literature about the specificity of elite interview (e.g. Sabot, 1999; Desmond, 2004; Herod, 1999; Smith, 2006; Welch et al, 2002). Though not exclusive, interviewing elites raises various methodological issues like the access to the informers, the unbalanced power relations during the interview, the reliability of information. Herod (1999) even considers that conducting research on foreign elites bring very specific issues of cultural positionality that do not exist in the case of study on non-foreign elites.

The objective of this article is to address the methodological issues we faced as French PhD students interviewing foreign elite. How did we interact with the main actors of medical tourism both in India and Thailand? How did we deal with interviewees who are mastering the art of communication and marketing? What strategies were adopted to get the right information during the interview?

In the following section of this paper, we will discuss the preparation of our field work and remind how it is essential before interviewing elite's members. Then, we will present the different strategies we used to access our interviewees. In a third section, we will document

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the process of interviewing and the related power-relation issue. In conclusion, we would like to discuss the interest of cross-border field works.

## 2. Preparing the fieldwork

*Approaching a global phenomenon: medical tourism*

In order for the comparison to become both useful and effective, we needed to choose some methods which could be applied in Thailand and India. With a common framework taking place in two different contexts, we would thus be able to discern similarities and differences in the way medical tourism has emerged in Thailand as well as in India. The first phase of our research relied heavily on secondary quantitative and qualitative sources. It involved the collection of many figures, articles, public speeches and interviews on medical tourism in the research reviews, the news magazines, the daily press and the professional magazines from both countries. We extended this work to the international and western media. These different sources of information gave us a broad perspective on a topic which was not that familiar to us.

We quickly found out that if we talk about medical tourism generally, it takes different forms through the context. For example, India receives among 'its medical tourists' nearly only Non-Resident Indians (NRI) living abroad who travel for medical treatment to their 'homeland' during their holidays. In Thailand, there is no typical medical tourist but a mix of nationalities among the patients and later the interviewees there were cautious in separating medical tourists from foreign patients. The private hospitals in India, have more difficulties in drawing such distinction. The medical tourist and the expatriate can be counted as foreigner patients, while the NRI coming for a health check-up can be counted as a local patient. As already mentioned by Connell (2005), measuring and assessing the exact number of patients involved in medical tourism is rather tricky. How differentiate a patient coming especially for care in Thailand or India from an expatriate or from a tourist using local health infrastructure further following an illness? And then among medical tourists, how differentiate those who have no quality hospital in their countries from those who are looking for cheaper treatments? The problem of the definition of 'a medical tourist' and the dissimilarities between Thai and Indian systems of counting brought us to be careful with the figures that we used and called into question the appellation of 'medical tourism' itself. The further we advanced, our look became more and more sceptical to this stock phrase as 'medical tourist' expression refers today to a reality which can not be precisely measured.

We also collected and analysed in a more detailed manner, the communication of the corporate hospitals involved in medical tourism. We collected brochures and visited their websites on various occasions. The concept of the brochures and the websites is similar for both countries: they are a well thought out mix of reassuring pictures, texts, patients' testimonials and international certifications. The ultimate purpose is to seduce the potential medical tourist into going to this particular facility in the same way as a classic tourist would choose this or that resort from a holiday brochure. This information gave us an idea of the manner the patients are perceived and medical tourism is heralded. All this documentation and the information previously collected in the media was analysed in order to outline the discourses produced by the various stakeholders of medical tourism and to identify the key arguments pro or against medical tourism, their variation from one country to another. We then realised that discourses on medical tourism, particularly in mass media, are coming from a limited number of sources and are controlled by certain groups, organisations.

*In defence of medical tourism*

In an enlightening paper about the development of biotechnology in Ireland, Desmond wrote (2004: 267): "During this early period the industry was embroiled in a society-wide discourse regarding its general safety and appropriateness. To counter these accusations, the sector actively attempted to discursively re-construct this image around claims of sound

science and the national economic interest." In a similar manner, medical tourism's stakeholders are producing discourses and ready-to-think ideas to justify and reassess their activity. This group of actors can be identified as elite as they have a great control over medical tourism, from its creation to the discourses pertaining the sector. In India, most of them are affiliated to the Healthcare branch of the Confederation of Indian Industry (CII). In Thailand they are affiliated to The Private Hospital Association (PHA). These lobbies are instrumental in the implementation of medical tourism and in the interactions with the public authorities and political sphere. In 2002 the release by the CII of a joint report with the audit agency McKinsey on the future of Indian healthcare ("Indian Healthcare: the road ahead"), gave them the opportunity to market the idea that medical tourism was paving the way for a profitable future for the all nation. The information on Indian healthcare being often fragmented and out-dated, this report has been praised as a thorough attempt to fill such gap. This report has been heavily over-quoted and is now at the base of many articles or figures on medical tourism in Indian and international media. It is on the evidence of this report that Indian central government gave more support to medical tourism and began to work with the corporate hospitals to frame and market medical tourism. In its National Health Policy 2002 (NHP-2002) paper (GOI, 2002) the government stated that: "To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sectors, NHP-2002 strongly encourages the providing of such health services on a payment basis to service seekers from overseas".

Interestingly, the arguments supporting medical tourism used in India and Thailand were slightly different. We noticed that Indian communication is well focused on the benefits of medical tourism for the whole nation as a mean to justify this trend in their country and also to prevent criticism of the phenomenon. As one brochure of the Indraprastha Apollo Hospital of Delhi claims after the hospital received the Joint Commission International accreditation, they are: "Carrying the Indian Flame High". This nationalist aspect does not appear at all in Thailand. Thai communication lays more stress on the medical hub, gentleness of Thai people, the leisure infrastructure and the good time you can get after your treatment. The Thai Authority of Tourism is creating confusion, mixing medical tourism and wellness tourism (spa, traditional Thai massage) in its communication campaigns, and thus concealing the medical procedures that made the reputation of Thailand at the international level (plastic surgery, sex change).

*Who? What? How? Preparing the interview*

After assimilating all these different information, it was time for us to prepare for interviews. We first identified three different types of interviewees: the hospital managers, the medical staff and the public authorities. We were interested in tracing the history of medical tourism, the diffusion of this concept and the network of actors involved in the birth of medical tourism. The most important thing for us was to collect their views on medical tourism, on the future of medical tourism, on the impact on local healthcare systems, on their marketing strategies, on the links between private and public players, on the architectural design and on the way the hospital as a place is envisioned. Like in any elite or organisation, the official voice, heavily reproduced in the media, may be undermined by some clashing voices from the inside. We were then very much interested by collecting the views of the medical staff.

We used a semi-structured questionnaire and designed a list of all the issues we wanted to discuss. Doing so, our objective was to create a confident climate based on a discussion more than simply ask direct questions from a ten pages questionnaire. It was the best way to adapt to the, sometimes, limited time that the interviewees could give to us. It was also a way to stay close to the interviewees' vision of medical tourism. The issues were structured according to their importance for us. We did not ask too much detailed information on the hospital or the quality of the offer (i.e. medical equipment, staff) when the time was limited as it was available in the brochures and the annual reports that the corporate hospitals publish for their shareholders. Doing so, we have been able to extract the main elements constituting

the medical tourism trend globally but also to underline differences in the way of broaching the phenomenon.

## 3. Accessing the elite

As seen previously, hospitals, ministries, professional organisations are highly visible and promote explicitly the medical tourism. It was of great interest as we could analyse at a pre-interview stage the discourses they produced and their agenda. Through selected examples, we will present the different ways we accessed the elite constituted by the managers, the medical practioners and the ministries' representatives.

*Thai fieldwork*

We conducted a fieldwork in Bangkok over a period of two weeks in June 2006. Bangkok is the common gateway for international tourists to South-East Asia. And, as the representatives of the main private hospitals based in the city used to repeat, Bangkok is now 'the health care hub' for South-East Asia: this is where all the biggest health care facilities, the best standards, the best skilled and trained staff of the country are concentrated. We conducted interviews in the hospital sector and in the public authorities.

We interviewed a doctor working in the International Patient building of the Bangkok Hospital (BH). Audrey previously met him for her own PhD research and arranged a meeting with him at the Bangkok Hospital. At the end of the interview we asked him how we could access and interview somebody from the marketing department. He called the marketing department and managed to arrange an appointment for us. Half an hour later, to our own surprise and without any prior appointment, we were having a long and in-depth interview with the head of the marketing department.

Audrey contacted through email the head of the marketing division of the Bumrungrad Hospital on various occasion but never get any reply from his side. Once we were together in Bangkok, we just decided to go the hospital, and try to get an appointment with this person. We briefly introduced ourselves and our project at the reception office of the hospital and asked if it was possible for us to meet somebody from the marketing department. An employee asked us to wait and went for enquiry. She came back to us saying it was not possible for us to meet somebody from the marketing as they were all in a meeting. We insisted, saying that we were ready to wait or to come back later. We reminded her that Audrey tried to contact the head of marketing division on many occasions without receiving any reply. We told her that Bertrand was coming directly from India. We also pointed out that we already had an interview with their concurrent from the Bangkok Hospital. The employee went again with all this new information to check from the marketing division. Surprisingly, she came back to us, cheerful, saying the head of the marketing was ready to meet us at the end of the meeting.

*Indian fieldwork*

The interviews in Delhi, conducted by Bertrand only, were slightly different. The choice of Delhi was well justified other than practical advantages. With its international airport, a mushrooming corporate hospital sector (Apollo, Max, Fortis), the rather good level of infrastructure (compared to the rest of India), Delhi is a hot spot for medical tourism in the country.

In the case of this research on medical tourism he mostly interviewed contacts he had already met on previous occasions for his own PhD research. Since 2004, Bertrand is conducting a PhD research on the corporate hospitals in India. When he started, some Indian scholars were pessimistic on his chances to get information and interviews with the marketing and operation managers from the corporate hospitals of Delhi. Apparently, an M.Phil student from the Jawaharlal Nehru University had tried to work with Apollo Hospitals for six months, till she realised it was not possible, due to their lack of cooperation. He faced

the same kind of difficulties during his first fieldwork. It took a long time to get an appointment in hospitals or at the Confederation of India Industry. Some people simply did not want to bother with a junior student in geography ("Why are you studying the hospital sector? Geographers should study relief and landscape" as one person said to him once on the phone) coming from an unknown university and struggling while speaking English. He shared then these difficulties with one of the heads of the Economic Mission of the French Embassy, who kindly prepared a letter of introduction for him, requesting the interviewees to be kind enough to cooperate as Bertrand was supposedly preparing a report on the corporate hospitals for the Economic Mission. Thanks to this letter and this faked identity, people were suddenly keener on taking some of their precious time to answer to his questions. It gave more credibility to his study. With this experience in mind, he is now emphasizing his affiliation not to his research centre in India which is a division of the French Embassy, nor his remote French university, but simply to the French Embassy in India, to gain an easier access to any new contact he wants to meet.

*Is accessing the elite so difficult?*

With regards to these experiences, it seems difficult to assess which method is better than another. From being introduced by an insider to the use of a letter of introduction, there are various possibilities to access the interviewees. We can thus consider two important issues out of our own limited experiences.

As Desmond state (2004), the question of time to access elite is extremely important. Medical tourism is actually a booming sector and the managers are ready to open their doors to herald the story of their success. As the marketing manager of the Bumrungrad Hospital told us, we were not the first students to visit him. His hospital is actually receiving a great interest from the media (e.g. CBS 60 minutes). We have been able to access sometimes very easily some top managers, because we are now at a deciding moment for medical tourism. It is no more a marginal phenomenon, be it by the number of patients involved or by the potential impact on the local healthcare sector. The use of marketing and branding is indeed a double edge sword. Bumrungrad Hospital or Apollo Hospitals position their brand at the international level in order to attract more international patients. It also positions them as potential target for public campaigns against medical tourism. There is an urgent need for the actors of this sector to legitimate their activity in face of the local and international public opinion. In an international activity like medical tourism, researchers, even juniors, can also be used to herald the medical tourism success and to disseminate the information abroad. Audrey was in contact last year with a TV journalist preparing reportage on medical tourism in Thailand. In 2005, Bertrand has been interviewed for a French travel magazine (Match du Monde) on medical tourism in India. It is somehow flattering for the managers to receive some interest from abroad.

Another important issue, was our positionality. We sometimes manipulated our identity to gain an easier access to the interviewees. For example we never insisted too much on the fact we were both geographers, in order to avoid the confusion and the reservation that goes with the typical question on "why geographers are studying medical tourism?". In the case of Bertrand we can see how his status improved drastically, in the eye of its potential interviewees, thanks to the French Embassy's label. The researcher's position is not only defined by what he is (e.g. a white, French, female researcher in geography) but also by what he represents in the eyes of the interviewees. This position evolves with the time and there is space for revealing more of your identity later. Befriend with your contacts can become beneficial on the long term. The interview is a defining moment in the evolution of your identity.

## 4. The moment of the interview

*Foreigners, junior researchers… the different faces of the interviewers*

Being a foreigner was certainly of great help to conduct our interviews. A foreigner is probably perceived as being less threatening than the local researcher by any elite. At the local level medical tourism raises some controversy, on the increasing inequality in term of access to healthcare. A foreign researcher is not here to stay. Because he did such a long way, coming from abroad, the foreign researcher is often welcome by the interviewees with lot of curiosity. “How long have you been in Thailand?” “Do you like Indian food?” “My daughter is going to study in France.” This empathy helped on many occasions to engage the interview in a positive and warm atmosphere. We faced also on certain occasions, particularly with Western managers, a rather cold welcome, probably because there was a sense of disappointment at the view of two junior scholars. We could feel from start that the interview would require a lot of patience and humility from our side because our interviewee was making us understand that he was busy and that he was doing us a favour by receiving us.

One clear advantage of being a foreigner and a junior scholar is that you are allowed to ask stupid questions. You are not aware of the local situation or all the details. You can genuinely ask challenging questions or pointing some contradictions in the discourse but without too much damage because at the end “I did not know”. Our experience was rather similar to what Sabot describes (Sabot, 1999) when write about the foreign researcher: “S/he is also able to circumnavigate cultural taboos whereas the local researcher is tied by his/her own culture. In effect, the reception given to foreign researchers becomes a sort of public relations exercise at an international level; thus the foreigner researcher is allowed to ask almost anything.”

*Who is controlling the interview?*

During an interview the power balance between the interviewee and the interviewers is evolving. This issue is very much important while interviewing an elite group. Elites have a strong consciousness of their importance (Richards, 1996). In our case we were interviewing marketing directors, operation managers who are trained for this type of exercise. During our interviews in both countries, the message delivered was that medical tourism is positive for the country, its economy and its healthcare system. Whoever is doubtful of this positive impact, is “an outsider who has misconceptions on what is really medical tourism” as one of the interviewees explained to us. It was important for the managers of the corporate hospitals we interviewed to deliver the proper message, to emphasize certain points, and to legitimise their opinion. As the marketing director of Bumrungrad Hospital put it “Regarding Medical Tourism, I am THE source.” It gives them more power over the interviewer who always has to be extremely careful if he wants some rewarding information. We had our own agenda for the interview, but so had our interviewees.

In face of such specialists, it was sometimes difficult for us to keep control over the interview. Some interviews were somehow turning into a Public Relation operation. Probably because we were junior researchers, some of them took even a paternalistic attitude, trying to advice us on what we should write and think or what part of their report is “particularly important to understand our activity” and that all the information we needed “is in the report”. Because we prepared our interviews well before, studying the marketing discourses, we were able during the interview to segregate original information from communication material. If we remained extremely humble during every interview, we also tried to make our interviewees understand that we were not that new in the field of healthcare.

Being together during our fieldwork in Bangkok was indeed of great help to gain more information from our interviewees. If one forgot to ask a question, the other can carry on the interview. Facing the same answer, we could have different interpretation and thus push in

the interview in different directions. During this fieldwork, Audrey was familiar to the Thai healthcare system and affiliated to a Thai university, while Bertrand coming straight from India was a complete alien to the local context. We had different level of foreignness to the situation. We experienced what Herod (1999) describes as different degrees of "outsiderness". The interviews were ultimately very rich. Doing her PhD between Laos and Thailand, Audrey was very much aware of the local context. Coming from India, without any prior knowledge about the local trends, Bertrand was asking very naïve questions. This strange combination was probably confusing for the interviewees and thus helped us at regaining more control over the interview.

*Of decentring and reciprocity*

Because we felt our position during the interview was fragile, we tried to broad the perspective of the interview. Instead of addressing certain sensitive issues too directly, we used such formula as "some people are saying that…" "We read on your website that… can you tell us more" or "The X hospital is doing that. What about you in Y hospital?" That way we gain not only information on certain sensitive issues (or we perceived as sensitive) but also on their perception of their concurrent or the medical tourism. While in Bangkok, the general atmosphere at least in the talk was more of "the medical tourism cake is big enough to be shared" or "their hospital is very different from ours. They are working their ways, we are working ours", in Delhi we could feel a strong sense of concurrence from every side: "We will always remain first because we invented everything in the field of hospital care in India. They are just followers and had previously nothing to do with this sector. They are just considering health as a business"; or "In this hospital, they are talking too much about medical tourism. What about the Indian patients? They are my real concern."

An interesting aspect from our fieldwork in Bangkok, was the use of India as decentring point. "In India, they are doing this…" Or "it is the same in India". It was again a way to avoid frontal and brutal questions on the use and misuse of marketing, for example. By relating some information collected previously in India or about the Indian experience, we have been able to build a confident exchange. Bertrand explained to some of our interviewees, what was the situation of the Indian hospital sector. The interview became then more like of an exchange of information. The reciprocity of information, the exchange of opinion, was of great help to build confidence among the interviewees. As the interviews were going on, the interviewees in Thailand were becoming franker, even sometimes very straightforward. The charitable activity being merely cosmetic, and a tool for communication, has been clearly explained to us. It was the same frankness regarding the surprising lack of cooperation between private players and the public authorities in Thailand. Similarly in India, interviewees were very keen on learning something about European or French healthcare. They were very curious about the French or other European health systems and were asking rather precise questions on the insurance systems, the public-private partnership or the potential for India to attract medical tourists. It was not rare that an interview that was supposed to last only 15 minutes at start lasted finally more than an hour.

## 5. Conclusion

We broach medical tourism from different points of view: main private actors in the hospitals and some important public actors in both countries. As it is a first step in the running of this study, we tried to focus the approach on the way the medical tourism phenomenon was setting up in the both countries, the political aspects of the trend, the levels of implications of different actors. But during this first stage, we didn't have the chance and the time to examine the point of view of the medical tourists themselves; how do they perceive the treatment and the global experience in these 'Five Star Hospitals'? What about their satisfaction? Of course, some comments of these patients are available in media, hospitals' websites or brochures but they are embedded in the discourse built on medical tourism as the 'perfect answer' today in the field of health care. It will be very necessary to

interview the medical tourists in order to balance the discourse from the main actors and to get a less polished vision of medical tourism.

In the face of such recent and over commented phenomenon, like medical tourism the use of comparison allowed us to go beyond the description of the trend and put into perspective the phenomenon. The comparison between India and Thailand sheds light for example on the misconceptions of the "Thai model" as it is perceived and explained by the Indian medical tourism stakeholders. Thailand is seen as the country ahead of the rest regarding the various aspect of medical tourism (marketing strategy, infrastructure, management of the medical staff). In India, during the professional summits on medical tourism or in the interviews given to the media, Thailand is praised as the model to follow and to beat. What is particularly stressed is the strong joint action between public authorities and private actors to market medical tourism abroad and to develop this activity (e.g. http://www.expresshealthcaremgmt.com/20050215/interview01.shtml). The interviews in Thailand have qualified this vision as idealistic. The managers met at the Bangkok Hospital (BH) and at the Bumrungrad Hospital have both stressed that the connections with Thai public authorities were very recent and still very weak. They both agreed that on this point Thailand was lagging behind Singapore and even India. Indian stakeholders of medical tourism seem to use Thailand as an idealistic model to pressure Indian public authorities to get more support. During the 2004 Health Summit organised by the Confederation of Indian Industry, the managers of the main corporate hospitals were requesting the central government to create a medical visa, like in Thailand. At the next Health Summit in 2005, the same managers were proud to announce that the medical visa has been launched couple of months ago. It seems also that always referring to the successful medical tourism in Thailand is a good mean to convince the public opinion, justify the development of this trend in India and prevent possible criticism. Comparison, and the necessary multi-sited fieldwork we conducted, gave us some interesting information on medical tourism. It also showed us on the way how a global phenomenon imbed in local societies and how certain elites are manipulating facts and discourses in their own interest.

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