

CONSUMPTION OF DENTAL SERVICES: MEDICAL TOURISM IN CEE

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ABSTRACT The aim of this paper is to explain the growing phenomenon of the consumption of dental services beyond the place of the patient's permanent residence. The essence and the scope of the phenomenon are discussed and the main factors affecting its development are indicated. The elements of the service package offered by dental clinics are identified. A critical analysis is conducted of relevant literature items. The paper constitutes an introduction to further research that will take account of medical tourists' leisure activities, the dental tourism dysfunctions and the specificity of the medical tourism sub-segment in Central and Eastern Europe (CEE).

Introduction

Globalization is becoming a reason for still open debates on its significant social, cultural and economic impact. Undoubtedly, globalization reinforces the trend towards privatization, commercialization and competitiveness of health care institutions. Combined with the tendency for consumerism now observed in the post-modern society,

it improves mobility and creates an opportunity to receive treatment in parallel with the consumption of tourism services.

In the subject literature and in the industry itself, medical tourism is understood as “the process of travelling outside one’s local area of residence for the purpose of receiving medical services” (Global Buyers Report 2016–2017, 2017, p. 4). Connell (2013) additionally points out that the process includes the use of tourism packages. The consumption of medical services most often concerns the following areas: cosmetic and dental surgery, cardiac surgery, orthopaedic and bariatric surgery, in vitro fertilization and organ and tissue transplantation. Dental services definitely have the biggest share in this basic group of the medical tourism product, and interest in their consumption is still on the rise (Miyashita, Akaleephan, Asgari-Jirhandeh, Sungyuth, 2017).

As observed by Youngman (2014), in order to use dental services, inhabitants of North America travel to Mexico and Latin America (Argentina, Costa Rica, Peru), European patients – to CEE countries, Asians – within the continent (to India, Korea) and Australians – to South-East Asia (Malaysia, the Philippines, Singapore, Thailand). This phenomenon is referred to as ‘dental tourism’/‘dentourism’, ‘dental travel’ or ‘dental holiday’. The size of the market has not yet been fully identified. It is estimated that the participants in this category (sub-segment) of medical tourism constitute a third of the total number of medical tourists worldwide.

The aim of this paper is to explain the essence and scope of dental tourism by: (1) indicating the main factors affecting the development of the phenomenon, with respect to CEE countries; and (2) identifying the elements of the package of services available on the market. The work draws on a critical analysis of desk research results.

‘Dental tourism’

The American Dental Association (2009) defines dental tourism “as the act of travelling to another country for the purpose of obtaining dental treatment”. According to M. Jaapar, G. Musa, S. Moghawemi and R. Saub (2017) dental tourism is understood “as activities related to travel and to hosting a tourist who stays at least one night in the destination region for purposes which include maintaining, improving or restoring health through dental care intervention”. K. Dhama, B. Patthi, A. Singla, J. Kumar and M. Prasad (2016) add that “dental tourism means travelling abroad for economical dental treatment as the cost of treatment is high in one’s own country”. In the analysis of the cross-border provision of dental care services, some researchers perceive the phenomenon as the flow of mobile patients resulting from high costs and/or high co-payments for dental services in the patients’ country of origin and from the country’s legal regulations. Dental services have enjoyed the greatest popularity among tourists. They are well known in professional circles and receive extensive coverage in the media.

The dentourism concept is complex. The phenomenon gives rise to two types of travellers: (1) classic dental tourists – those who travel to a foreign country to access dental treatment being either the sole purpose of the visit or part of a holiday package; and (2) migrant tourists – those who return to their native country for a holiday or to visit relatives and then access dental treatment during their stay (Iqbal, Shah, Ashley, 2014; Chandu, 2015). Nonetheless, it is observed that dental tourists are most often national patients and those coming from neighbouring countries (Österle, Balázs, Delgado, 2009). Their convalescence period usually does not exceed a week. In the case of maxillofacial surgery services, they stay for 7–10 days. Dental tourists also include those who have been dissatisfied with dental care in their place of residence. For this reason, such great importance is attached to interpersonal communication with due consideration given to ethical issues. A. Conti, P. Delbon, L. Laffranchi and C. Paganelli (2014) point not only to communication as such, but also to the patient’s autonomy over the

practitioner's choice, his/her informed consent, security, as well as the possibility of continuity of care. With respect to the latter, D. Panteli, U. Augustin, J. Röttger, V. Struckmann, F. Verheyen, C. Wagner and R. Busse (2015) suggest that patients undergoing planned treatment were more satisfied with all aspects of care and reported that follow-up care had been required less frequently. This of course does not mean that the patient was denied such aid if needed. Considering the above, it may be assumed that dental tourism concerns both domestic and foreign travel of different nature (business, holidays, 'bleisure', VFR, shopping etc.) combined with the consumption of dental services.

It seems that the relatively low cost of dental care in some countries where the cost of living is lower is the main reason for seeking treatment beyond the permanent place of residence, disregarding potential complications, but making sure that appropriate quality of service is maintained (Dhama et al., 2016; Kesar, Mikulić, 2017; Romita, Perri, 2017). According to Patients Beyond Borders (Double-time dental, 2017), a patient could save as much as \$4,400, \$5,800 or \$6,400 travelling to get implant-supported dentures (upper and lower) to Costa Rica, South Korea or Singapore, respectively, compared to the same treatment purchased in the US. However, J. Köberlein and D. Klingenberger (2011) point to the fact that "the decision for or against foreign dentures and the extent of the willingness to pay depend on a range of criteria, of which price is only one and not the decisive factor". Beside the high cost of local care, L. Turner (2008) mentions other reasons for the development of dental tourism, such as delays in obtaining access to local dentists, competent care in many international clinics, inexpensive air travel and the Internet's capacity to link 'customers' to 'sellers' of health-related services. J. Connell (2013), on the other hand, views the development of dentourism as the consequence of the fact that many forms of dental surgery, especially cosmetic dental surgery services, are not covered by insurance in some countries, e.g. the UK and Australia. The findings of H. Rodrigues, A. Brochado, M. Troilo and A. Mohsin (2017) are valuable in this context. The authors claim that the decision whether to purchase such services is strictly related to other consumers' opinions and the direct associations triggered for them in connection with the phenomenon. These associations include the following words: *treatment*, *clinic*, *happy*, *recommend*, *service*, *confidence*, and *cost*. What is important, though, is that male patients referred more often to 'service' and 'cost', whereas for women 'treatment', 'recommend', and 'clinic' were more common. J. Hanefeld, N. Lunt, R. Smith and D. Horsfall (2015) prove that there are other important reasons behind the patient's decision to choose a specific treatment, provider and destination. While distance, costs, expertise and availability of treatment are all significant in this respect, the decision is largely affected by informal networks, including web forums, personal recommendations and support groups.

The synergy between dental and tourism services is treated not only as business (Kamath et al., 2015), but also as an important factor in the development of many towns and regions (Loubeau, 2009; Jurišić, Radović, 2017). Some CEE countries, e.g. Serbia (Ignjatijević, Čavlin, 2016), despite having the necessary potential for dental tourism development, have to face management and marketing problems that arise as early as at the level of direct providers of dental services. The graphical description of the dental tourism phenomenon shows the main factors in the selection of a given dental clinic (Figure 1). It can be seen clearly that there are a lot of determinants of dentourism development, but it is the clinic itself – the way its representatives communicate with potential consumers, the image they create and, generally, how they present the services they have on offer – that seems to be the key to success.

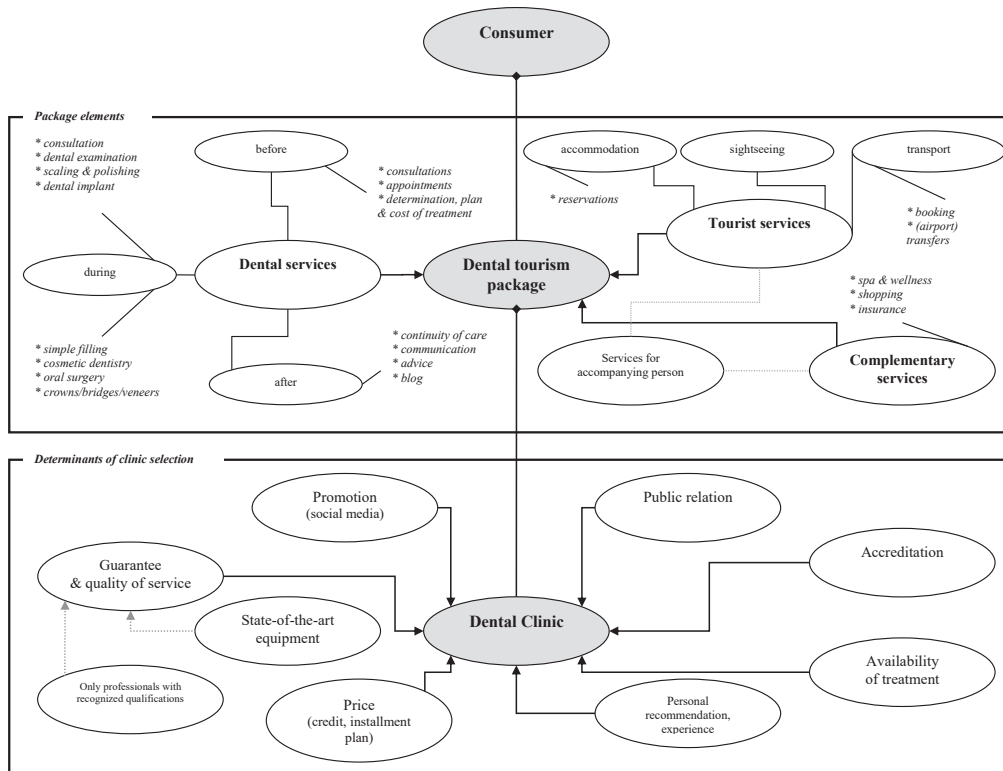


Figure 1. Dental tourism package elements – market perspective

Source: own.

The desired market should offer a dental tourism package made up of dental, tourist and complementary services. The results of the studies conducted by Jaapar et al. (2017) indicate that it is the last of these three components that has a significant impact on the dental tourist satisfaction. However, considering the consumers' needs, it is rather the dental services component that should be taken into account. The services should be appropriately tailored to meet the patients' specific needs not only when treatment is already in progress, but also before the patients leave and after they return to their place of residence. The package itself has to be flexible, for example to take account of persons that might possibly accompany the patient (Gheorghe, Zürcher, Filippi, 2017). Additionally, the package distribution channel should be selected carefully. A special role is assigned here to medical tourism facilitators/brokers (MTF/B) co-operating with employing establishments, insurance agencies or tourist offices offering dental tourism services in the first place. In the case of a direct channel, communication between the dental clinic representatives and the consumer is essential. The Internet is of key importance here (Constantin, Kavoura, 2016). It enables contact and development of mutual relations between the patient and the service provider based on trust, understanding and equal partnership.

Functioning of dental clinics on the CEE medical tourism market – selected aspects

In Poland, inbound and domestic dental tourism is exclusively provided for by private dental establishments. This is a consequence of the fact that a vast majority of dental practices are private and operate under no contracts with the National Health Fund. Also in other CEE countries dental service costs are covered from the consumers' own financial means, which is probably the effect of increasing incomes per person in households (Janoś-Kresło, 2007). As a result, it is possible for those consumers (for the others it seems rather a necessity) to seek treatment in clinics beyond their permanent residence area that will be cheaper but demonstrate the same standard of service.

The prices of dental services in CEE are attractive for consumers from western countries. For example, having a dental implant procedure performed in Poland, citizens of the UK or Germany can save more than 60% (Figure 2). Compared to Poland or Slovenia, the service price is even more attractive in Belarus, Bosnia and Herzegovina, and Moldova (savings of up to and higher than 80%) Therefore, it comes as no surprise that Britons and Germans prefer buying dental treatment abroad, where they can make savings of almost 70%, let alone the lower costs related to food, accommodation and transport. The selection of Poland as the dental services consumption destination is also dictated by the availability of transport, the high quality of medical services offered at a reasonable price, the availability of medical technologies in dental surgery and prosthetics (the most specialized region is the Silesian voivodeship, with the second highest number of dental practitioners in the country after the Mazowieckie voivodeship) and a well-operating system of health care (Rab-Przybyłowicz, 2016; Romaniuk, Szromek, 2016; Wisła, Sierotowicz, 2016).

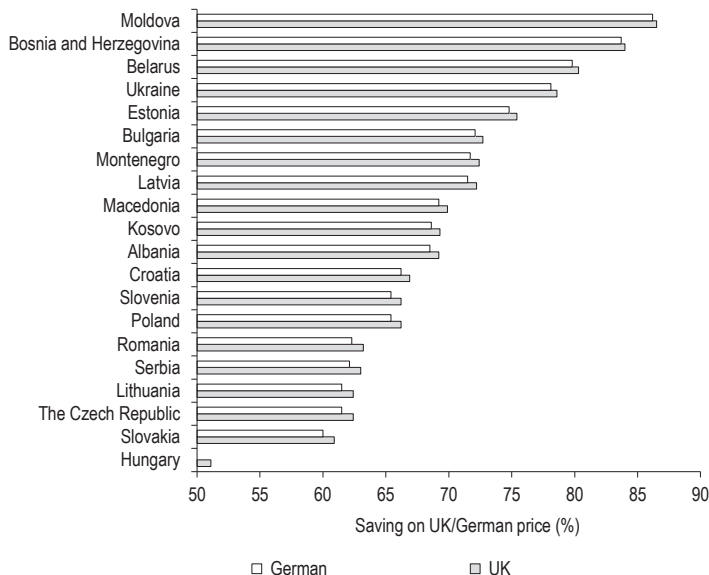


Figure 2. Savings on dental implants in CEE compared to average prices in the UK and Germany (USD)

Source: own.

Compared to other CEE countries, the number of dentists in Poland is rather low. However, it should be noted that the range of their qualifications is wider compared to dentists in the UK, Hungary or Slovenia. For example, they may specialize in maxillofacial surgery, whereas in other countries this is only possible for doctors. Moreover, Poland – despite the competition among others the Czech Republic – is the only CEE country listed in the *Medical Tourism Index*, as a country where dentourism is in the oligopolistic position (Lubowiecki-Vikuk, Rab-Przybyłowicz, 2015; Lubowiecki-Vikuk, Kurkowiak, 2017). Due to the specificity of dental services, the country's promotion as a dental travel destination and tourism competitiveness, Hungary emerges as Poland's strong competitor. It has the highest number of dental clinics in CEE. Other factors play a role here too: Hungary is easy to reach, the dentists' reputation is high and there are enough of them to choose from (Chang, Chang, 2013). Kovacs and Szocska (2013) name the following to prove the high quality of the dental profession in Hungary: (1) Hungarian dentists are extremely well-qualified; (2) dental practice standards are up-to-date and often supervised; and (3) dental techniques match European standards and make use of state-of-the-art materials and equipment.

Dental clinics may apply for accreditation from the 'Global Clinic Rating' (GCR, 2017), and thereby be included in the international ranking of this type of establishments. Clinics from the following CEE countries are rated the highest: Lithuania, Croatia, Montenegro, and Serbia, whereas Poland, the Czech Republic and Kosovo are ranked the lowest. Interestingly enough, Serbia and Montenegro rank so high despite the fact that, as indicated by the Eurostat data (2016), the number of dentists per 100,000 inhabitants there is lower compared to other CEE countries. Bulgaria, which has the highest number of dentists, does not rank high. The presented rankings should not be treated as the most essential argument in the discussion of the development of dentourism in CEE, but rather as a point of reference to reality. With regard to the dental tourism industry and its development, Adams et al. (2017) point to the need to analyse specific conditions or structures of control.

Conclusions

A dentourism package requires personalization and a wide range of services, which is imposed by the nature of the demand side. This can be achieved in modern dental clinics with sufficient accommodation (or co-operating with hotel facilities) and a large number of specialists, including coordinators dealing with foreign patients. In this respect, the leading CEE countries are Hungary, Croatia, Poland and the Czech Republic. Individual medical practices are based on their dentists' reputation, on the quality of the specialist services they render (e.g. prosthetics) and co-operation with foreign institutions. It seems that such can be more flexible in attending to the patients' needs, potential and availability. Their services are available all year round on the 24/7 basis and they allow payment by instalments. Patients are found without the participation of MTF/B's. Word-of-mouth marketing is used here instead.

The paper presents characteristics of the dental tourism phenomenon but the presentation is by no means complete. It is just a contribution to further studies taking account of the patients' leisure activities and the following dysfunctions of this leading medical tourism category: (1) social differences between inhabitants and their incomes in individual CEE countries; (2) draining of local resources (personnel, equipment and infrastructure) by dental tourists; (3) treating dental treatment as a business area only; and (4) inflating prices of dental services for local patients.

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