

# Socio-Economic Profiles And Medical Problems Of The Medical Domestic Tourists In Tamilnadu: A Micro Level Study

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## Abstract

India is rapidly establishing itself as a significant force in the global tourist industry, now ranking as the third-largest source of foreign money. The success of India exemplifies compassion transcending borders. We are a premier destination, providing a medically sophisticated and economically attainable healing journey, enabling individuals globally to restore their health. This stance is reinforced by the provision of superior medical facilities, highly skilled professionals, and substantial cost reductions. For instance, typical knee surgery expenses are 40% to 60% lower than those in the United States. Researchers recognized that the rapidly growing health tourism sector must be understood from the patients' perspective. To get this profound comprehension, they commenced a study that involved collecting primary data from 400 domestic health tourists in Tamil Nadu. This was a direct, personal inquiry aimed at comprehending the human experience underlying the statistics. The primary objective of the research was to obtain a comprehensive understanding of these passengers by examining their social and economic circumstances, identifying the medical issues or requirements that prompted their visit, and documenting the various methods through which they accessed the necessary medical care. The analysis was performed using SPSS V-15. The research outlined a specific profile for the average medical tourist: mainly Indian citizens (72.5%), demonstrating a high level of education (78.5%), predominantly married (64.5%), and typically belonging to the middle-aged group (31–40 years). The results indicated that the majority of participants in the survey were urban residents, with the highest number of travellers originating from prominent metropolitan areas such as Delhi, various regions of Tamil Nadu, and Kolkata.

**Keywords:** socio-economic profiles, health concerns, domestic tourists, international patients, medical care, healthcare travellers.

## 1.1 Background of the study

Tourism is today a substantial, growing, and service-driven business acknowledged as a key contributor to national wealth and a main driver of economic development. It has surpassed the significance of conventional industrial and extractive sectors in driving development both internationally and domestically. Tourism induces beneficial transformations in a nation's economic, social, cultural, and environmental domains. It serves as a significant source of both direct and indirect employment and possesses considerable potential for generating foreign exchange. This industry is intricately linked with various other sectors, including transportation (airlines, trains), hospitality (hotels, cafes), and recreational infrastructure (theme parks, travel agencies). The expansion of the tourist sector is facilitated by an enhanced quality of life in industrialized nations, where individuals have increased leisure time, elevated incomes, and

improved travel accessibility. The initial growth was associated with the early 20th-century transport revolution (private automobiles, coaches), while contemporary factors such as improved living standards, heightened global awareness through media, infrastructure advancements, reduced international barriers, and the emergence of economical air travel and hotel chains have propelled its current expansion.

Many developing nations, including India, are increasingly significantly investing in the sector due to its potential to attract foreign currency. India has emerged as the third-largest foreign exchange generator from tourism and has prioritized the industry at a national level. India entices visitors with its diverse and captivating locales, ancient culture and heritage, rich architectural traditions, and a large, cost-effective workforce (both skilled and unskilled). However, these significant assets have not been fully utilized to enhance tourist appeal, revealing

considerable untapped potential for further growth and substantial socioeconomic advantages for the populace. Tourism fundamentally involves the transient relocation and habitation of humans away from their customary residence or workplace.

### 1.1.1 The advent of India in medical tourism

Medical tourism, defined as traveling to another country for medical or surgical care, is a prominent global phenomenon, with India emerging as the foremost destination. This appeal arises from India's formidable blend of excellent healthcare quality and remarkable cost-effectiveness. The nation has highly proficient, seasoned physicians and advanced medical facilities like to those in Western nations, equipped with contemporary technology and specialist staff. The primary appeal for international patients is significant cost savings, realized through favorable currency exchange rates and low operational costs, while maintaining quality standards. The total expense of elective knee surgery, with travel and all associated fees, may be 40% to 60% lower than the cost in the United States. The low cost, along with insufficient insurance coverage and prolonged wait times in Western countries for elective procedures (including cosmetic surgeries, joint replacements, and dental treatments), renders India a particularly appealing choice.

Medical tourism is available to all individuals, irrespective of insurance or financial circumstances, and encompasses a broad spectrum of requirements, ranging from elective cosmetic procedures (such as facelifts) to essential, life-altering treatments (such as heart bypasses). Prospective patients must recognize that this constitutes a significant medical intervention away from home, rather than just recreational travel. Although technology, especially the internet, enables the exploration of worldwide healthcare alternatives, users must remain vigilant. The choice of a supplier should not solely rely on the lowest cost. A comprehensive examination of all therapy variables is essential to ascertain genuine value, including the external context and the gravity of the medical intervention.

## 1.2 Review of Literature

Tourism is recognized as a significant and growing service sector, seen as a primary source of national revenue and a catalyst for economic growth. Its significance frequently exceeds that of conventional industrial and extractive industries, hence driving national and global progress (Alikutty, 2025; Biju & Aishwarya Biju, 2015). The sector generates numerous employment opportunities, both directly and indirectly, and possesses significant potential for foreign currency generation (Biju & Aishwarya Biju, 2015). The UNWTO asserts that international tourism will continue to expand at an average annual

rate of 4%. A significant association exists between a nation's per capita tourism expenditure and its worldwide influence. This suggests that forecasts regarding tourism can inform our expectations of a country's future performance on the global arena (Aishwarya Biju, 2014).

In nations such as India, substantial funds have been allocated by the government to enhance tourism infrastructure. This encompasses facilitating air travel, enhancing road and rail infrastructure, and increasing accommodation options, including heritage hotels (Biju & Aishwarya Biju, 2015). Medical tourism is an expanding and specialized sector of the travel business. It is legally defined as visiting abroad primarily for medical or surgical treatment, effectively merging international travel with services from premier medical facilities and clinics (Mashika et al., 2021; Jermy Synder & Crooks Valorie, 2012). More broadly, individuals frequently interpret the term as "seeking medical treatment overseas" (Balaban & Marano, 2010).

International travel for medical services is more prevalent as a means for individuals to conduct business globally. This is evidenced by the consistent increase in the volume of tourists, their expenditure, and the variety of destinations they visit (Jermy Synder & Crooks Valorie, 2012). The demand for healthcare beyond the United States primarily arises from the inadequacies of Western healthcare systems. This encompasses the millions of Americans lacking health insurance under the Affordable Care Act (ACA) and the prolonged wait times of up to six months for common procedures within the UK's National Health Service (NHS) (Obama, 2010). Many individuals erroneously conflate wellness tourism with medical tourism. Wellness tourism is travel that promotes physical and mental well-being through activities such as yoga and meditation. The entirety of health tourism is comprised of these two groups (Voigt et al., 2010).

Tourism is perceived as a complex amalgamation of interests, activities, and individuals that aligns seamlessly with the concept of a supply chain. This economic idea illustrates the collaboration of various parties to produce a final product. In discussions about tourism, the overall experience is paramount; it transcends just sightseeing. It encompasses all aspects, including infrastructure, accommodations, nutrition, and specialist services such as healthcare (Stephen, 2015). Rural Tourism (RT) provides a substantial avenue for employment generation and economic development in rural regions. This initiative is chiefly motivated by enabling communities to utilize and safeguard their distinctive cultural heritage—encompassing local crafts, traditional festivals, and unique farming practices—as attractive "cultural products" to draw visitors (Ramaiah, 2015).

An essential domain for forthcoming research is the comprehensive assessment of tourism's effects on rural regions (RT), particularly emphasizing its socio-economic ramifications and the diverse methods by which these transformations transpire. Researchers must comprehensively grasp the economic and social advantages and problems that rural communities encounter due to tourism development. Existing research exhibits notable deficiencies, particularly in: 1) analyzing the influence of demographic factors on tourist decision-making in rural locales; 2) identifying the variables that affect wage determinants and job preferences among local employees in the sector; and 3) assessing the scope and effectiveness of community engagement in tourism development and expansion (Alikutty, 2025).

**1.3 Research Methods**

This research utilized primary data gathered from a sample of 400 domestic medical tourists in Tamil Nadu. The participants were chosen using a Random Sampling Technique. Data collection was conducted through personal interviews utilizing a comprehensive, three-section questionnaire. The

interview schedule was pre-tested with a sample of 400 respondents to assure correctness and clarity, facilitating essential adjustments to eliminate ambiguity and superfluous questions. Subsequent to data gathering, the information was meticulously verified, refined, and structured for tabulation. The analysis was conducted using SPSS V-15 to provide a micro-level examination of the tourists' socioeconomic profiles and health issues.

**1.5 Analysis of data and results**

The dataset regarding the age distribution of 400 survey participants is categorized into three segments. The predominant segment is the 31 to 40 age group, comprising 170 individuals, which constitutes 42.5% of the overall population. A substantial segment comprises respondents under 30, amounting to 96 individuals, or 24.0% of the sample. Finally, the Above 41 category is significant, consisting of 134 respondents, or 33.5% of the whole group. When aggregating the two younger cohorts (those under 30 and those aged 31 to 40), the data indicates that the majority—66.5%—of respondents are 40 years of age or younger.

**Table 1.1 Estimated age distribution**

Statistic	Value	Interpretation
Mean	2.10	The age groups are probably categorized as one to three (1=Below 30, 2 corresponds to between 31 and 40, and 3=Above 41). A mean of 2.10 means that the typical respondent is marginally in the "Between 31 and 40" group. This shows that most of the people that answered are in the middle of the age group.
Standard Deviation (SD)	0.753	The SD of 0.753 shows that the ages are spread out rather evenly throughout the three coded categories. This means that the center group is the biggest, but the remaining two categories (under the age of 30 and Above 41) still make up a major part of the total sample.
Standard Error (SE)	0.038	The modest standard error of 0.038 shows that the sample average (2.10) is a very accurate guess of the actual population average for the assigned age groups.

Table 1.2 illustrates the gender distribution of the 400 respondents (Total N=400). The gender variable appears to be encoded, with 1 representing Male and 2 representing Female, or vice versa. The sample exhibits a distribution that is nearly evenly divided between males and females. The predominant demographic among respondents is women, constituting 50.5% of the total (202 individuals). One hundred ninety-eight males responded, constituting 49.5% of the total. The frequency disparity is minimal (merely 4 individuals), indicating that the sample accurately represents the gender balance. The cumulative percentage corresponds to the entire count, with the Female group contributing to a cumulative total of 100.0%.

**Table 1.2 Estimated Gender Distribution Data**

Statistic	Value	Interpretation
Mean	1.510	If Male = 1 as well as Female = 2, then an average of 1.510 is very close to the middle of 1.5. This supports the conclusion that the population in question is about evenly divided, with a little preference for the 'Female' category (coded as 2).
Standard Deviation (SD)	0.501	When the probability distribution is 50%/50%, the standard deviation (SD of 0.501 is quite near to the expected maximal deviation of the distribution (0.500) for the binary variable in question (0 or as 1, or in this example 1 or 2). This number shows that the two groups are almost evenly split.
Standard Error (SE)	0.025	The small standard error of 0.025 shows that the calculated mean is very accurate. This means that the sample's almost perfect gender balance is a good estimate.

Table 1.3 presents the nationalities of the 400 respondents to the poll (Total N=400). There exist two categories: Indian and NRI (non-resident Indian). The predominant demographic of respondents is Indian, constituting 72.5% of the sample (290 individuals). Non-Resident Indians (NRI) constitute a significant minority, representing 27.5% of the sample (110 persons). The data indicates that the study mostly targeted individuals residing in India.

**Table 1.3 Estimated Nationality Distribution Data**

Statistic	Value	Interpretation
Mean	1.28	If Indian = 1 and NRI = 2, then the mean of 1.28 is quite near to 1. This result explicitly shows that the distribution is rather uneven, which confirms that the average respondent is an Indian citizen.
Standard Deviation (SD)	0.447	As expected, the SD of 0.447 is lower than the SD of a properly divided binary variable (0.500). This number shows that the nationality data doesn't change much because the Indian group is so big.
Standard Error (SE)	0.022	The tiny standard error (SE) of 0.022 shows that the calculated sample mean (1.28) is a very accurate estimate of the true population mean for this coded variable.

Table 1.4 illustrates the distribution of the 400 respondents (Total N=400) across five principal Indian cities/states. Participation in the sample is notably high in three regions: [i] Delhi received the highest number of replies, totaling 101 individuals (25.3% of the overall). Tamil Nadu is similarly represented, with 100 individuals (25.0%) replying. Calcutta contributes significantly, accounting for 23.3% (93 individuals). The three regions—Delhi, Tamil Nadu, and Calcutta—constitute 73.6% of the total sample (25.3% + 25.0% + 23.3%). Andhra Pradesh (14.5%) and Mumbai (12.0%) have lesser engagement compared to the other states. Mumbai has the lowest participation rate.

**Table 1.4 Estimated Indian States/Cities Participation Data**

Statistic	Value	Interpretation
Mean	3.17	The mean of 3.17 is between the codes for Delhi (3) and Andra Pradesh (4). The regions are coded from 1 (Mumbai) to 5 (Tamil Nadu). This figure shows that involvement is relatively evenly dispersed among the categories, with a small bias toward the mid-to-high coded areas (Delhi, Andra Pradesh, and Tamil Nadu).
Standard Deviation (SD)	1.354	The large SD of 1.354 shows that involvement varies a lot across the five regions. Even though a few areas stand out, the fact that all five categories are well represented keeps the SD from being low.
Standard Error (SE)	0.068	The tiny SE of 0.068 means that the calculated sample mean (3.17) is a good guess of the true population mean for the coded region variable.

Table 1.5 illustrates the categorization of the 400 respondents (Total N=400) into "Educated" and "Uneducated" categories according to their educational attainment. 78.5% of the sample (314 individuals) possess an education, constituting a significant majority. The Uneducated group constitutes a significant minority, comprising approximately 21.5% of the sample (86 individuals). The data indicates a distinct bias favoring the inclusion of those with formal education. If the coding designates "Educated" as 1 and "Uneducated" as 2, then the mean of 1.22 is rather close to 1. This chart illustrates a pronounced skew in the distribution, indicating that the majority of respondents are categorized as Educated.

**Table 1.5 Educational Qualification Data**

Statistic	Value	Interpretation
Mean	1.22	If Educated is 1 and Uneducated is 2, then the mean of 1.22 is quite near to 1. This figure confirms the very skewed distribution, which shows that the typical person who answered is classified as Educated.
Standard Deviation (SD)	0.411	The SD of 0.411 is low, which means that this binary variable doesn't change much. This is what we predicted because a big majority (78.5%) fits into one group (Educated).
Standard Error (SE)	0.021	The relatively modest standard error (SE) of 0.021 shows that the calculated sample mean (1.22) is a very accurate guess of the true population mean for this coded variable.

Table 1.6 illustrates the marital status of the 400 respondents (Total N=400), indicating whether they are married or unmarried. The majority of

individuals in the sample are married, totaling 258, which constitutes 64.5% of the overall population. The Unmarried group constitutes a notable minority,

comprising 35.5% of the sample (142 individuals). The data reveals that more than two-thirds of respondents are married, suggesting that the study's

conclusions will primarily represent the perspectives of married individuals.

**Table 1.6 Estimated Marital Status Data**

Statistic	Value	Interpretation
Mean	1.36	If Married = 1 and Unmarried = 2, then the mean of 1.36 is closer to 1. This figure validates the skewed distribution, which means that most people who answered the question are married.
Standard Deviation (SD)	0.479	For a binary variable, the SD of 0.479 is rather high; it's close to the maximum (0.500) for an even split (50%/50%). This number shows that there is a substantial amount of variation or spread between the two groups, even though one group is clearly larger (64.5% vs. 35.5%).
Standard Error (SE)	0.024	The modest SE of 0.024 shows that the calculated sample mean (1.36) is a very accurate guess of the true population mean for this coded variable.

Table 1.7 illustrates the distribution of the 400 respondents (Total N=400) among five employment categories. The largest cohort of individuals employed consists of government personnel, including 25.3% of all respondents (101 individuals). Two more groups are also prominently represented, indicating a diversified sample: [i] Student/Technician: 24.5% (98 individuals). Private Employee: 19.5% (78 individuals). Business (15.8%) and Agriculture (15.0%) are two underrepresented yet significant categories. The three employee categories (Government, Private, and Business) constitute 60.6% of the sample (25.3% + 19.5% + 15.8%).

**Table 1.7 Estimated Occupational distribution**

Statistic	Value	Interpretation
Mean	3.22	The mean of 3.22 falls between the third (Govt. Employee) and fourth (Pvt. Employee) categories, which are coded from 1 (Business) to 5 (Student/Technician). This means that the average person who answered is just past the middle of the coded categories, which is in line with the fact that there are a lot of Govt. Employees, Pvt. Employees, and Students/Technicians.
Standard Deviation (SD)	1.383	The SD of 1.383 is high (near to the maximum for five categories), which means that there is a lot of variation and spread across the five occupational groupings. This shows that the sample is not focused on one or two groups, but is spread out over all of the mentioned jobs.
Standard Error (SE)	0.069	The tiny standard error of 0.069 means that the sample mean of 3.22 is a very accurate estimate of the true population mean for the coded occupation variable.

Table 1.8 illustrates the medical challenges identified by the 400 respondents (Total N=400). The issues are classified into "Major/lifetime" and "Minor" categories. A significant majority of the sample, 71.5% (286 individuals), reported having minor medical issues. A notable proportion of participants,

28.5% of the sample (114 individuals), indicated substantial or lifelong medical conditions. The data indicates that the majority of individuals in the sample are experiencing mild or less severe health issues.

**Table 1.8 Estimated Medical Problems Data**

Statistic	Value	Interpretation
Mean	1.72	If Major/life time = 1 and Minor = 2, then the mean of 1.72 is significantly closer to 2. This value shows that the distribution is very skewed, which means that most respondents are classed as having minor medical concerns.
Standard Deviation (SD)	0.452	The SD of 0.452 is rather low for a binary variable, which means that the data points aren't evenly spread out. This makes sense because 71.5% of them fit into one group. This shows that the severity of claimed medical problems doesn't change much.
Standard Error (SE)	0.023	The relatively small SE of 0.023 shows that the sample mean (1.72) is a fairly accurate guess of the true population mean for this coded variable.

Table 1.9 delineates the specific medical disorders or diseases reported by the 400 respondents (Total N=400). The predominant category mentioned is orthopedics, encompassing arthroscopic, thoracoscopic, and laparoscopic operations. This cohort constituted 41.3% of all respondents, totaling 165 individuals. This indicates that the

sample exhibits a strong interest in musculoskeletal and minimally invasive surgical requirements. The second most common condition is ophthalmology, impacting 22.8% of the sample, or 91 individuals. Diabetes accounts for 16.5% of chronic and surgical demands, affecting 66 persons. Hip-knee and major organ replacement procedures, collectively termed "Hip-knee (liver, multiorgan replacement)," constitute 12.5% of the total (50 individuals). Open heart surgery represents the least prevalent serious condition, affecting merely 7.0% of the population (28 individuals). Orthopedic and ophthalmological disorders account for 64.0% of all reported ailments.

**Table 1.9 Estimated Medical Problems/Diseases Data**

Statistic	Value	Interpretation
Mean	2.40	The average of 2.40 lies between the second (Ophthalmology) and third (Open heart surgery) categories. The disorders are categorized from 1 (Orthopedics) to 5 (Diabetes). This mean is a little lower than predicted because the first category (Orthopedics, 41.3%) has the most values, which brings the average of the coded values closer to 1.
Standard Deviation (SD)	1.520	The SD of 1.520 is high (the highest for 5 categories is roughly 1.41 for a uniform distribution), which means that the sorts of medical problems reported are very different from each other. Orthopedics is the most common type of doctor, but there are also a lot of other types, including Ophthalmology and Diabetes. This means that the data is well-distributed over the range of ailments provided.
Standard Error (SE)	0.076	The modest SE of 0.076 means that the calculated sample mean (2.40) is a very good guess of the real population mean for the coded illness variable.

Table 1.10 delineates the methods employed by the 400 respondents (Total N=400) in seeking assistance or remedies for their medical issues. The predominant approach is consulting a local doctor, utilized by 186 individuals (46.5% of total responses). Informal channels hold significant importance, with friends and family serving as the second most common source of guidance, accessed by 22.0% of respondents (88 individuals). In terms of formal/commercial channels, [i] 19.5% of respondents (78 individuals) resort to hospitals, intermediaries, or agents, while [ii] the pricing and services method is the least utilized, engaged by 12.0% of respondents (48 individuals). The two most favored methods, Local Doctors and Friends & Relatives, account for 68.5% of the overall sample.

**Table 1.10 Estimated Medical Problems – Approaches Data**

Statistic	Value	Interpretation
Mean	1.97	The mean of 1.97 is extremely near to 2, and the approaches are categorized from 1 (Local Doctors) to 4 (Based on price & services). This means that the average person who answered chose between the first (Local Doctors) and second (Friends & Relatives) groups, but is closer to the first category, which has a high percentage (46.5%) of people.
Standard Deviation (SD)	1.069	The SD of 1.069 is rather high for four categories, which means that the approaches are fairly different from each other. "Local Doctors" is the most common category, but the other three categories together make up more than half of the sample (53.5%), which shows that there were a lot of different beginning methods.
Standard Error (SE)	0.053	This means the finding that the average (mean) approach variable is 1.97 is highly trustworthy and very close to the actual average you would get if you could survey the entire population. The small standard error of \$0.053\$ indicates that there's very little chance of significant difference between what the study found and the real-world truth.

**1.6 Conclusion**

The burgeoning medical tourism sector represents a significant opportunity for India, promising substantial economic growth and a valuable boost to the GDP. Recognizing the huge economic potential of medical travel, several Indian states—including Kerala, Delhi, Maharashtra, Karnataka, and West Bengal—are actively competing to attract patients from around the globe. Leading industry groups like the CII and FICCI are driving this effort, with the CII optimistically forecasting that India could soon welcome two million medical tourists annually, generating an impressive \$5 billion for the economy. This goal is achievable because of India's distinct

advantages: a strong healthcare network staffed by highly skilled professionals, complemented by world-famous tourist sites. India is well-positioned to become a global leader by highlighting its expertise in holistic and alternative therapies like Ayurveda, yoga, and wellness treatments, alongside the rapid development of accredited, modern hospitals. Ultimately, to make India the world's top destination for medical tourism, the entire sector must prioritize quality care and ensure every patient leaves satisfied.

The 400 domestic medical tourists chosen for the study represent a distinctive and relatively youthful group. A significant majority of the participants are

middle-aged, specifically falling within the 31 to 40 age bracket. Overall, the sample clearly skews younger, with a substantial 66.5 percent of the tourists being 40 years old or below. There are almost as many men as women (50.5% women and 49.5% men). Most of the people who live there are Indian citizens (72.5%), and most of them are married (64.5%) and have a college degree (78.5%). The groupings of government workers, students/technicians, and private workers all have a number of diverse jobs. Most of the people who took part live in Delhi, Tamil Nadu, and Calcutta. They gave roughly three-quarters of the data, which means that these areas are likely the main reasons for the outcomes. 71.5% of the respondents who took the survey said they were worried about their health in some way. The most common concerns are in Orthopedics (41.3%) and Ophthalmology (22.8%), but there is also a lot of need for Diabetes (16.5%) and serious surgical needs. This illustrates that humans need a lot of different medical specialties. When people want to know anything, they usually turn to trustworthy sources like their local doctor (46.5%) or their friends and family (22.0%). This suggests that trust and personal relationships are more significant than business options like agents or price/service comparisons when making the first decision.

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