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BOOK CHAPTER
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GROWTH AND DEVELOPMENT OF THE INDIAN ECONOMY IN THE 21ST CENTURY : TOWARDS ECONOMY 4.0



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GROWTH AND DEVELOPMENT OF THE INDIAN ECONOMY
IN THE 21ST CENTURY:TOWARDS ECONOMY 4.0

*Growth and Development of the Indian Economy in the 21st Century: Towards
Economy 4.0*

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Growth and Development of the Indian Economy in the 21st Century: Towards Economy 4.0

Preface

The Indian economy has undergone remarkable transformation in the 21st century, emerging as one of the fastest-growing economies in the world. With the advancement of globalization, technological innovation, and policy reforms, India has steadily moved from a traditional economy toward a knowledge-driven and digitally enabled economic system. The concept of Economy 4.0 reflects this transition, where digital technologies, automation, artificial intelligence, and data-driven decision-making play a crucial role in shaping economic activities and development.

In recent decades, India has experienced significant growth across various sectors such as manufacturing, services, agriculture, and digital infrastructure. Government initiatives aimed at economic reforms, financial inclusion, digitalization, and industrial development have contributed to strengthening the country's economic foundation. Programs such as Digital India, Make in India, and Startup India highlight India's commitment to building a modern and innovation-driven economy.

The emergence of Economy 4.0, inspired by the principles of Industry 4.0, emphasizes the integration of advanced technologies such as artificial intelligence, big data analytics, the Internet of Things (IoT), and automation into economic systems. This transformation is reshaping production processes, financial systems, governance, and employment patterns, creating new opportunities while also presenting significant challenges.

This work aims to explore the growth and development of the Indian economy in the 21st century and analyze the country's journey toward Economy 4.0. It examines the structural changes in key sectors, the role of technological innovation, policy initiatives, and the impact of digital transformation on sustainable economic growth. Understanding these developments is essential for policymakers, researchers, academicians, and students who seek to comprehend the evolving dynamics of India's economic landscape.

***Dr. R. Rajesh Kanna: Dr.A. Abdulraheem: Dr. M. Dillip Anand: Dr. A. Krishnan:
Dr. N Shanmugasundaram.***

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“TOWARDS ECONOMY 4.0”**

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**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 asserting itself as a major power in the worldwide tourism sector, now holding the position of the third-largest generator of foreign currency. India's success is a story of compassion crossing borders. We are a top destination because we offer a healing journey that is both medically advanced and financially accessible, allowing people everywhere to reclaim their health. This position is solidified by providing excellent medical facilities, highly trained experts, and significant cost savings. For example, normal knee surgery costs 40% to 60% less than it does in the United States. Researchers acknowledged that the swiftly expanding health tourism industry must be comprehended from the perspective of the patients themselves. To gain this deeper understanding, they initiated a study that entailed gathering first-hand data from 400 domestic health tourists in Tamil Nadu. This was a direct, personal examination that sought to understand the human experience behind the numbers. The main part of the research was to get a clear picture of these travelers by looking at their social and economic lives to learn more about them, listing the medical conditions or needs that made them travel, and keeping track of the different ways they found and got the medical care they needed. The analysis was conducted utilizing SPSS V-15. The study delineated a distinct profile for the typical medical tourist: primarily Indian nationals (72.5%), exhibiting a significant level of education (78.5%), predominantly married (64.5%), and generally situated within the middle-age demographic (31–40 years). The findings showed that most of the people who took part in the study were city dwellers, with the largest number of travelers coming from major metropolitan centers like Delhi, various parts of Tamil Nadu itself, and Kolkata.

Key Words: socio-economic profiles, medical issues, domestic tourists, foreign patients, medical treatment, healthcare tourists

Background of the study

Tourism is now a significant, expanding, and service-oriented industry widely recognized as a major contributor to national wealth and a primary catalyst for economic development. It has overtaken the importance of traditional manufacturing and extractive industries in spurring development globally and domestically. Tourism brings positive changes across a country's economic, social, cultural, and environmental landscape. It is a powerful source of both direct and indirect employment and holds major potential for earning foreign exchange. This industry is

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deeply interconnected with numerous other sectors, including transport (airlines, railways), hospitality (hotels, cafes), and leisure infrastructure (theme parks, travel agencies). The growth of the tourism industry is supported by better quality of life in developed countries, where people benefit from increased free time, higher earnings, and greater ease of travel. While its initial growth was linked to the early 20th-century transport revolution (private cars, coaches), contemporary factors like enhanced living standards, increased global awareness via media, infrastructure improvements, fewer international barriers, and the rise of affordable air travel and hotel chains have accelerated its current boom. Recognizing the sector's capability to attract foreign currency, many developing countries, including India, are now heavily investing in it. India, in particular, has become the third-largest foreign exchange earner from tourism and has made the industry a national priority. India attracts visitors because it offers diverse and charming places, ancient culture and heritage, rich architectural traditions, and a vast, affordable workforce (both skilled and unskilled). Despite these considerable assets, they have not yet been fully leveraged to maximize tourist attraction, indicating massive untapped potential for further growth and substantial socioeconomic benefits for the population. At its core, tourism is best characterized as the temporary movement and residence of individuals outside of their usual home or employment location.

The advent of India in medical tourism

Medical tourism—the act of journeying to another country for medical or surgical treatment—is a significant global trend, and India has established itself as the leading destination. This popularity stems from India's potent combination of superb healthcare quality and exceptional cost-effectiveness. The country provides highly skilled, experienced doctors and state-of-the-art hospitals comparable to those in Western countries, complete with modern technology and specialized personnel. The main attraction for foreign patients is the major cost savings, achieved through beneficial currency rates and low operating expenses, without sacrificing quality. The comprehensive cost of an elective knee surgery, including travel and all fees, can be 40% to 60% less than the cost in the United States. This low cost, coupled with a lack of adequate insurance coverage and extended wait times in Western nations for elective treatments (such as cosmetic procedures, joint replacements, and dental work), makes India a highly attractive option.

Medical tourism is accessible to everyone, regardless of insurance or financial status, and covers a wide range of needs, from purely cosmetic surgeries (like facelifts) to critical, life-changing operations (like cardiac bypasses). However, prospective patients must understand that this is serious medical intervention far from home, not merely leisure travel. While technology, particularly the internet, facilitates the discovery of global healthcare options, users must exercise caution. The selection of a provider should never be based exclusively on the lowest price. Thorough investigation of all treatment factors is critical to ensure true value, given the foreign environment and the severity of the medical procedure.

Review of Literature

Tourism is known to be a very important and expanding service business that is largely seen as a major source of national income and an engine of economic expansion. Its importance often surpasses that of traditional manufacturing and extractive sectors, therefore propelling national and worldwide advancement (Alikutty, 2025; Biju & Aishwarya Biju, 2015). The sector provides a lot of jobs, both directly and indirectly, and it has a lot of potential to bring in foreign currency (Biju & Aishwarya Biju, 2015). The UNWTO says that international tourism will keep growing at an average rate of 4% per year. A substantial correlation exists between a country's per capita tourism spending and its global impact. This indicates that predictions about tourism can help us guess how a country will do in the future on the world stage (Aishwarya Biju, 2014). In countries like India, a lot of money has been spent by the government to improve tourism infrastructure. This includes making it easier to fly, improving roads and train networks, and adding more places to stay, such as heritage hotels (Biju & Aishwarya Biju, 2015). Medical tourism is a growing and

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specialized part of the travel industry. It is officially described as traveling overseas mainly to get medical or surgical care, which is basically combining international travel with getting services from top-notch medical institutions and clinics (Mashika et al., 2021; Jermy Synder & Crooks Valorie, 2012). In a broader sense, people often think of the term as "traveling abroad to get medical care" (Balaban & Marano, 2010). This kind of foreign travel for medical services is becoming more and more common as a way for people to do business around the world. This is shown by the steady growth in the number of travelers, the amount of money they spend, and the number of places they go (Jermy Synder & Crooks Valorie, 2012). The need for healthcare outside of the US is mostly because Western healthcare systems are not good enough. This includes the millions of Americans who will not have health insurance under the Affordable Care Act (ACA) and the long wait periods of up to six months for routine operations in the UK's National Health Service (NHS) (Obama, 2010). A lot of people mistake that wellness tourism and medical tourism are the same thing. Wellness tourism is travel that helps you stay well physically and mentally through activities like yoga and meditation. These two groups make up the complete field of health tourism (Voigt et al., 2010). Tourism is seen as a complicated mix of interests, activities, and people that fit the supply chain idea perfectly. This concept, which comes from economics, shows how different groups work together to make a final product. When we talk about tourism, the entire experience matters it's not just about sightseeing. It covers everything from the roads and buildings we use, to where we stay and what we eat, all the way up to specialized offerings like medical care (Stephen, 2015). Separately, Rural Tourism (RT) offers a significant pathway for job creation and economic enhancement in non-urban areas. This development is primarily driven by empowering communities to leverage and preserve their unique cultural heritage—including local crafts, traditional festivals, and distinct agricultural practices—as appealing "cultural products" to attract visitors (Ramaiah, 2015). A crucial area for future research is the thorough evaluation of how tourism affects rural areas (RT), specifically focusing on its socio-economic impacts and the various mechanisms through which those changes occur. Researchers need to clearly understand the overall benefits and challenges rural communities experience—economically and socially—as a result of tourism development. There are significant deficiencies in existing research, specifically in: 1) examining the impact of demographic factors on tourist decision-making in rural areas; 2) determining the variables that influence wage determinants and job preferences among local employees in the sector; and 3) evaluating the extent and efficacy of community involvement in tourism development and growth (Alikutty, 2025).

Research Methods

This study employed primary data collected from a sample of 400 domestic medical tourists in Tamil Nadu. The participants were selected by a Random Sampling Technique. Data collection was done via personal interviews using a detailed, three-part questionnaire. To ensure accuracy and clarity, the interview schedule was pre-tested with the same sample size of 400 respondents, allowing for necessary revisions to remove any ambiguity or redundant questions. Following data collection, the information was carefully checked, edited, and organized for tabulation. Finally, the analysis was performed using SPSS V-15 to conduct a micro-level examination of the tourists' socioeconomic profiles and medical concerns.

Analysis of data and results

The dataset on the age distribution of 400 survey respondents is divided into three categories. The largest segment is the 31 to 40 age group, which includes 170 individuals, making up 42.5% of the total. A significant portion is also represented by respondents Below 30, totalling 96 people, or 24.0% of the sample. Lastly, the above 41 category is substantial, comprising 134 respondents, which is 33.5% of the overall group. When combining the two younger groups (those below 30 and those between 31 to 40), the data reveals that the majority—66.5%—of the respondents are 40 years old or younger.

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Table 1.1 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 centre 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.

Source: Computed

Table 1.2 shows how the 400 people who answered (Total N=400) were split by gender. It looks like the gender variable is coded, with 1 for Male and 2 for Female, or the other way around. The sample has a distribution that is almost completely balanced between men and women. The largest group of people who answered is women, who make up 50.5% of the total (202 people). There are 198 men who answered, which is 49.5% of the total. The difference in frequency is small (just 4 participants), which shows that the sample is very reflective of the gender balance. The cumulative percent matches the total count, and the Female group makes the cumulative total 100.0%.

Table 1.2 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.

Source: Computed

Table 1.3 shows the nationalities of the 400 people who answered the survey (Total N=400). There are two groups: Indian and NRI (non-resident Indian). The vast majority of the persons that answered are Indian, making up 72.5% of the sample (290 participants). Non-Resident Indians

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(NRI) are a notable minority, comprising 27.5% of the sample (110 individuals). The data shows that the study's focus or recruitment was mostly on those who live in India.

Table 1.3 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.

Source: Computed

Table 1.4 shows how the 400 people who answered the survey (Total N=400) were spread out throughout five major Indian cities/states. The sample participation is very high in three areas: [i] Delhi has the most responses, with 101 persons (25.3% of the total). [ii] Tamil Nadu is almost as well represented, with 100 persons (25.0%) responding. Calcutta also makes a big contribution, with 23.3% (93 people). These three areas—Delhi, Tamil Nadu, and Calcutta—make up 73.6% of the overall sample (25.3% + 25.0% + 23.3%). Andhra Pradesh (14.5%) and Mumbai (12.0%) are not as involved as the other states. Mumbai has the fewest people taking part.

Table 1.4 Indian States/Cities Participation Data

Statistic	Value	Interpretation
Mean	3.17	The mean of 3.17 is between the codes for Delhi (3) and Andhra 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, Andhra 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.

Source: Computed

Table 1.5 shows how the 400 people who answered the question (Total N=400) were divided into "Educated" and "Uneducated" groups based on their level of education. 78.5% of the sample (314 persons) are educated, which is a large majority. The Uneducated group is a large minority, making about 21.5% of the sample (86 persons). The data shows a clear bias in favor of including people who have some formal education.

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If the coding is "Educated" = 1 and "Uneducated" = 2, then the mean of 1.22 is quite near to 1. This figure demonstrates that the distribution is very skewed, which means that most people who answered the question are classified 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.

Source: Computed

Table 1.6 shows how the 400 respondents (Total N=400) were married or not married. Most of the persons in the sample are married (258 people), which is 64.5% of the total. The Unmarried group is a significant minority, making up 35.5% of the sample (142 persons). The data indicates that over two-thirds of the respondents are married, implying that the study's conclusions will predominantly reflect the viewpoints of married individuals.

Table 1.6 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.

Source: Computed

Table 1.7 shows how the 400 people who answered (Total N=400) are spread out among five job categories. The biggest group of persons who work is government employees, who make up 25.3% of all respondents (101 people). Two other groups are also well-represented, which shows that the sample is diverse: [i] Student/Technician: 24.5% (98 persons). [ii] Private Employee: 19.5% (78 persons). Business (15.8%) and Agriculture (15.0%) are two categories that have less representation but are nevertheless important. The three groups of employees (Government, Private, and Business) make up 60.6% (25.3% + 19.5% + 15.8%) of the sample.

Table 1.7 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.

Source: Computed

Table 1.8 shows how the 400 people who answered (Total N=400) reported their medical difficulties. The problems are divided into "Major/life time" and "Minor" categories. The overwhelming majority of the sample, 71.5% (286 persons), said they had Minor medical concerns. A significant percentage of respondents, 28.5% of the sample (114 persons), reported major or lifetime medical issues. The data shows that most of the people in the sample are dealing with modest or less serious health problems.

Table 1.8 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.

Source: Computed

Table 1.9 shows the exact medical conditions or diseases that the 400 people who answered (Total N=400) said they had. The most reported category is orthopaedics, which includes arthroscopic, thoracoscopic, and laparoscopic procedures. This group made up 41.3% of all responders, or 165 persons. This shows that the sample is very interested in musculoskeletal and minimally invasive surgical needs. The second most prevalent concern is ophthalmology (eye-related issues), which

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affects 22.8% of the sample (91 persons). Important chronic and surgical needs: Diabetes is responsible for 16.5% of the issues (66 individuals). Hip-knee and major organ replacement procedures (collectively called "Hip-knee (liver, multiorgan replacement)") make up 12.5% of the total (50 persons). Open heart surgery is the least common serious problem, with only 7.0% of people (28 people). 64.0% of all reported disorders are in orthopaedics and ophthalmology.

Table 1.9 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 (Orthopaedics) to 5 (Diabetes). This mean is a little lower than predicted because the first category (Orthopaedics, 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. Orthopaedics 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.

Source: Computed

Table 1.10 shows the ways that the 400 respondents (Total N=400) looked for help or remedies for their medical difficulties. The most frequent way to get help is to see a local doctor, which 186 people (46.5% of all responses) did. Informal channels are quite important. Friends and family are the second most prevalent source of guidance, used by 22.0% of respondents (88 persons). Formal/Commercial Channels: [i] 19.5% of respondents (78 persons) use hospitals, intermediates, or agents. [ii] The Based on pricing & services method is the least prevalent, used by 12.0% of respondents (48 people). The two most popular ways, Local Doctors and Friends & Relatives, make up 68.5% of the overall sample.

Table 1.10 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

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		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.

Source: Computed

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 Orthopaedics' (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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