ISSN 2467-933X

THE GAZE

JOURNAL OF TOURISM AND HOSPITALITY

Vol. 10 **No.1** **Year 2019**

Editor-in-Chief
Prof. Ramesh Raj Kunwar

International School of Tourism and Hotel Management
(Affiliated to Salzburg University of Applied Sciences, Austria)

Editorial Policy

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THE GAZE

JOURNAL OF TOURISM AND HOSPITALITY

Vol. 10 **No.1** **Year 2019**

Published by
International School of Tourism and Hotel Management
Gyaneswor, P.O. Box: 5196, Kathmandu, Nepal
Tel: 977 1 4434350, 4434185
Email: info@ist.org.np
Website: www.ist.org.np

Editorial Note

We are very happy to offer *The GAZE Journal of Tourism and Hospitality* Vol. 10, No. 1, 2019 to our readers. This journal is published annually in English by International School of Tourism and Hotel Management, which is affiliated to Salzburg University of Applied Sciences of Austria.

The purpose of this journal is to disseminate the knowledge and ideas of tourism to the students, researchers, journalists, policy makers, planners, entrepreneurs and other general readers.

We have realized that it is high time to make this effort for tourism innovation and development. We strongly believe that this knowledge based platform will make the industry and the institutions stronger.

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JOURNAL OF TOURISM AND HOSPITALITY

The Concept of Post-humanism and Its Reflections on Tourism Education

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Abstract

The aim of this manuscript is to investigate the influence the impacts of post-humanism on tourism education. The paper will start with a body of literature on post-humanism based on the previous studies and debates in the academia. The methodology will be literature review and critical evaluation of the findings. As a conclusion, the study suggests that the Post-humanist reflection in tourism education will contribute positively to the tourism sector, specifically regarding to sustainability issues. The manuscript will also suggest a model in order to provide a quantitative analysis for the post-humanism, including the technological advancements and environmental regeneration variables, along with possible economic and social impacts. In short, establishment of a tourism education that considerably pays attention to the benefits of post-humanism will be essential for functionality and effectiveness of tourism practice in the future.

Keywords: *Post-humanism, humanism, tourism, education*

Introduction

The understanding of human is subject to change across time. Historically, humanism came up parallel to the Renaissance movement in 15th century, emphasizing the dignity of human-beings, and their value and agency. In order to explain growing human impacts on environment in today's world, the term Anthropocene was coined in the beginning of 2000s by Nobel Prize winner chemist Paul Crutzen, who emphasizes the hegemony of humans over nature. Although various methods that

Published by: International School of Tourism and Hotel Management, Kathmandu, Nepal
ISSN 2467-933X

underline empirical or theoretical aspects for different purposes have been carried out in human education and pedagogy within the course of history, the current Anthropocene shapes the purpose of education in a way that education should focus on cultural modification between communities and across generations, and it is responsible for transforming the spaces and practices to maintain the adaptation of humans to their social structures (Robbins, 2013; Lloro-Bidart, 2015:132). The purpose of education may include the development of adaptive behaviors, especially considering the long-lasting impact of Evolution by Charles Darwin, and underlying objective of education may be presented as developing social skills that will allow humans to survive in societies, which is the new nature in the age of human domination over nature.

Nevertheless, placing the human center in the world has caused various problems, such as environmental degradation and maltreatment for other living species, therefore recent critiques have been put the ultimate importance of human to the target in order to re-evaluate the possible impact of human to the environment. In this respect, one of the most significant critiques is provided by post-humanism, which refers to a state beyond being a human. From this point of view, post-humanism plays a crucial role on the understanding that solely relies on the assumption of "perfect human" which is the target of all social policies, educational systems, and naturally, touristic services.

Evaluation of post-humanism on anthropocentrism

In order to grasp the philosophy behind post-humanism, it is necessary to understand first the perspective of anthropocentricism, and specifically its conceptualization of nature-human relationship. Based on reconsidering what is "human" while conceptualizing the nature with its complexity of human and non-human elements, post-humanist vocabulary has begun to develop (Fenwick & Landri, 2012:4). Initially, the focus was on a human-centric perception and the whole epistemology has built onto an anthropocentric standpoint that put human-beings at first place. Back to the Enlightenment philosophical traditions, the dominant idea in Western formal education ensures "becoming human" that stresses on improving particular cognitive, social and moral capabilities (Pedersen, 2010:237). Although this focus has resulted in various achievements in different domains such as, scientific investigations, artistic products or literature masterpieces, the overall result was the prioritization and domination of human over other species.

The reflections are even more severe in some instances, such as the industrial animal production where animals are slaughtered arbitrarily or kept in smaller cages in unnatural conditions in order to provide people meat or dairy products. Deforestation of certain destinations to build touristic facilities as hotels, beaches etc.

and also fail to collaborate with local governments to overcome with water, air or land pollution due to the activities of these tourism agencies can be considered as clear examples of existing human-centered point of view in tourism activity. Considering the fact that tourism is heavily relied on environmental sustainability, since the main aim of tourists is to refrain from grey context of cities and spend some time within nature, either in a form of forests, mountains, etc. or within sea and sand concept, unless it is a cultural tourism activity in a completely artificial set up such as museum tourism. In short, protection of environment would allow tourism sector to maintain tourism activity as an economic source for the future periods.

Pursuing this further, according to anthropocentric point of view, humans used to be closer to the nature, but currently the life of humankind is unnatural and distant from nature, therefore proximity to nature is about learning in the course of education (Rautio, 2013). As a natural outcome of the point of view that humans are not nature, the question whether humans are more or less nature, connected to or disconnected from the nature, superior to or dominant over nature come to the stage (Malone, 2016). The development of settlements in urban life is one of the main causes for such a disparity. In the previous times, humans were living within the natural environment and they are connected with other elements in the environment. Currently, their interactions are restricted to a few non-human beings that are capable of living in the city conditions such as dogs, cats, some birds, some trees for decoration, and so on. Moreover, the residents of cities cannot involve in production of certain goods such as food, clothing, etc. and they only stand as "consumers" in a long production chain. For that reason, urban settlers lack experience with other natural aspects in the environment, they only interact with other people in social relationships, and therefore they perceive nature as composed of humans and other natural entities which are responsible for serving them. The activity of tourism plays a significant role in this sense, as tourism provides an opportunity for city residents to change their environment for a period, where they may engage in interactions with other natural beings, which will increase the likelihood for them to considered humans as something outside of nature.

In contrast to anthropocentrism, post-humanism enables the mutual existence of human beings in the nature with other type of species, where humans are sharing the resources in the form of coexistence and mutual dependence without being the masters of nature (Wang, 2018). Anthropogenic privileges of humankind, anthropocentric epistemology and humanistic ontology have become the subject of change in the course of post-humanistic transformation led by techno-scientific progress, and the importance of human is substituted by new concepts such as sustainable forms of production, recycling, environmental protection for co-existence, and so on (Marchesini, 2015; Ferrando, 2016). Especially after the developments in animal

research (Fenwick & Landri, 2012:5) animals begin to be perceived as "valuable" as human-beings, as they were previously perceived as mere objects. In general, the shift from anthropocentricism to post-humanism has occurred in various domains, as people acknowledge the inadequacy of humans and start to question the omnipotence of human-beings in nature.

Nevertheless, post-humanism do not refer to "anti"-humanism, since the claim of post-humanism is based on constant questioning of human-centric activities (Edwards, 2010) rather than minimizing the importance of humans by degrading their value in the nature. Humans are valuable agents of the world, they have equal importance with other elements within the nature, and they have a capacity to repair the adverse impact of their activities and prevent other elements from other possible future influences. For this reason, human-beings are the important part of post-humanism since they are capable of limiting their power if educated in a respectful manner to other components of nature.

The doubt for anthropocentricism by questioning the so-called "essential" binary between human and non-human forms the basis of post-humanism in the educational context, including tourism as well (Taylor, 2016). Furthermore, post-humanistic educational philosophy is not only concerned with how human and non-human complexity influences the educational practices, but it also points out the open spaces for possible changes, as the previous "matters of fact" is now replaced with "matters of concern", which prioritize the co-existence of human with other natural entities with respect to growing impact of nature-related problems such as global warming, natural catastrophes, and so on (Fenwick & Landri, 2012:4).

As anthropocentric philosophy behind the tourism education gives its way to post-humanist approach, that considers the development of technology and the sustainability of environment, the effectiveness of tourism will be more likely to increase at a global scale. To achieve this, policies need to consider the educational aspects of tourism, since the future of tourism services will be in the hands of current young generations, and an educational background emphasizing the value of post-humanism will guarantee the maintenance of technological development and environmental protection.

Modeling the Effectiveness of Post-Humanist Tourism Education

Development of technology and mechanization plays an essential role for the post-humanism. Through mechanization, individuals would be more likely to question the importance of humanity on the world (Wang, 2018), since if the human beings can be substituted by machines, there will be no need to place the humans in the center of universe. Post-humanistic approach not only reminds human-being that they are not superior or irreplaceable but it also draws attention to ability of human mind to engage

in beyond human developments, as in the case of technological progress, that will ease the life for all. Specific to tourism sector, the focus on technological advancements has increased the volume of touristic activity, varying from technological applications in accommodation to the use of internet, navigational devices and social media to arrange every single detail for a decent or affordable holiday. Thus, technological advancement appears as an important determinant for the effectiveness of post-humanist tourism.

Apart from technology, environmental sustainability creates an important part of post-humanist approach, as it refutes the anthropocentric idea that nature is at the service of human use, and rather it emphasizes the environmental protection through sustainable tourism policies, that secures the nature for future generations. Protection of nature provides a healthy environment for every resident in a particular destination, increases the quality of life and maintains the economic activity of tourism. As previously discussed in detail, the fundamental change in the understanding of environment requires the co-existence of human with other elements in the nature, hence the sustainability of environment through environmental regeneration that refers to a reparation process of nature after persistent devastating impact of human-centric tourism activities. For that reason, the environmental regeneration is another factor for explaining the effect of post-humanist tourism.

Hence, the model can be considered as:

$PTE = ß_1 TA^t + ß_2 ER^t + \varepsilon$

Where,

PTE implies *Post-humanıst Tourism Effectiveness*

TA implies *the technological advancement*

ER implies the *Environmental Regeneration*

t implies *time* (or periods/seasons in which touristic markets work)

$ß_1$ and $ß_2$ imply coefficients

ε implies residual

In general, the effectiveness of post-humanist tourism can be measured through two main variables, namely the improvements in technology and the rate of environmental regeneration. Beside this, there may be other variables that can explain the variance in the effectiveness of post-humanist tourism education that this model has not captured. For that reason, a residual is presented in the model, which denotes the variance that cannot be explained by the three main variables.

Additionally, this model is suitable for any kind of numerical data since the aim of this suggested model is to measure the impact of post-humanist tourism education

in a quantitative manner. By modeling the effectiveness of post-humanist education in tourism with respect to two main variables, the research allows the measurement through statistical analysis and a mathematical structure for investigation rather than subjective methods which decrease the objectivity and reliability of findings.

Conclusion

In conclusion, post-humanism can be understood as response to inability of anthropocentrism to maintain pluralism, tolerance and equity for all in the natural environment; however it is limited in terms of explaining the ways for multiple interactions between cultural and natural or organic and inorganic domains (Whatmore, 2004; Pedersen, 2010:242). Some scholars have even claimed that post-humanism is a product of human, and the goals suggested by this tradition cannot be achieved in current global economic and political context (Braidotti, 2006). Nevertheless, this manuscript acknowledges the fact that post-humanist point of view has provided an important critique for a human-centric understanding of nature that lasts for more than 600 years in art, literature, science, philosophy as well as economic and political decisions. The contributions of post-humanism can be expanded via educational formation, and topics related to natural sustainability and co-existence may gain prominence rather than human-centric, self-interested, profit-oriented social mechanism.

Results suggest that post-humanist tourism education leads to growing emphasize on the development of technology as well as it increases the concerns on environmental degradation. The future of today's world, and maintenance of economic activities are dependent on technological progress and availability of a healthy environment. For this reason, replacing anthropocentric world view with a sustainable approach that gives equal importance for all species in the world will provide healthier environment across generations, and education plays a significant role in terms of transferring the consciousness achieved by post-humanist questioning of human-centric world setting. As mentioned previously, environmental protection is not a choice but rather a necessity for the sustainability of tourism activity. If tourism education includes the environmental concerns posed by post-humanistic point of view, local stakeholders in tourism activities as well as those who are responsible for creating policies for the development of tourism will be more careful about environmental burden, and a sustainable future will be achieved for all elements of nature. All in all, the nature belongs to all of living creatures, but human-beings have an extra responsibility, that is, to maintain the co-existence within the nature as a part of it.

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THE GAZE
JOURNAL OF TOURISM AND HOSPITALITY

Heritage Tourism in Japan and Nepal : A Study of Shikoku and Lumbini

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Abstract

Tourism, the world's largest industry, is essential to a community's economic vitality, sustainability and profitability. The word 'heritage' in its broader meaning is frequently associated with the word 'inheritance', that is, something transferred from one generation to another. Heritage might look old-after all, the language of heritage focuses on preservation, revitalization, and restoration-but closer inspection usually reveals contemporary concerns. Heritage is the symbolic embodiment of the past, reconstructed and reinterpreted in the collective memories and traditions of contemporary societies rather than being perceived as a mere apotheosis of bygone times. It is concerned with exploring both tangible and intangible remnants of the past. Important criterion for a designation as a World Cultural Heritage site is the "authenticity" and "sincerity" of a candidate site. The heritage sites are the most susceptible and vulnerable sectors. A large number of significant heritage sites around the world are fragile properties, and they are faced with different challenges. Both Japan and Nepal is home to a variety of frequently occurring disasters, which can cause wide-ranging damage to its cultural resources. Japan and Nepal's remarkable heritage is not only part of what makes both the countries a popular travel destination, but also something that needs to be properly protected, maintained and preserved, so that future generations can enjoy it as much as we do today. It has been interesting lesson to rest of the world that how Japan has been mitigating and surviving with large scale disasters. The Japanese culture, tradition and technology must have been playing significant role for this. The learning from Japan could be

Published by: International School of Tourism and Hotel Management, Kathmandu, Nepal
ISSN 2467-933X

instrumental to manage, rebuild and develop heritage sites and tourism in Nepal. This article is the partial outcome of my Postdoctoral research in Japan.

Keywords: *Authenticity, preservation, revitalization, disasters, challenges and sustainability.*

Background

Japan and Nepal have long history of cooperation and connection for the development of Nepal. Japan and Nepal's national identity tend to emphasize cultural values which often describe their people, traditions, customs, religion. Ekai Kawaguchi, a Buddhist monk known as an early explorer of Tibet, was the first Japanese visitor to Nepal. Kawaguchi came to Nepal in 1899 and a memento of Kawaguchi's Himalayan travels exists in Japan, in the Buddhist temple of Obaku-san Manpukuji on the outskirts of Kyoto. In 1912, he visited Lumbini on pilgrimage, accompanied by Prof. Junjiro Takakusu, Rev. Ryutai Hasebe, and others (Subedi, 1999; EJN, 2018).

The important events such as establishment of diplomatic relations between Japan and Nepal in 1956, successful conquest of Mt. Manaslu by the Japanese Expedition team in 1956, state and official visits of royal families of the both countries, establishment of Nepalese Embassy in Tokyo in 1965 and Japanese Embassy in Kathmandu in 1968 and many other events have contributed to develop tourism and attract Japanese tourists in Nepal. Takashi Miyahara, a mountaineer who came to Nepal first time in 1962, established the Hotel Everest View at 3,880 m in 1975. The iconic hotel became a model for foreign investment in Nepal's nascent tourism industry. He started Trans Himalayan Tours and introduced organized trekking to Japanese tourists. He also established Himalaya Hotel in Lalitpur and his next dream project Hotel Annapurna View in Sarangkot, Kaski is scheduled to open soon. Lumbini Hotel Kasai and Lumbini Hokke Hotel are also very nice hotels with Japanese investment in Nepal. Likewise, there are around 2500 Nepalese restaurants in Japan which are promoting and attracting Japanese tourists in Nepal.

Nepal Airlines Corporation (NAC) is preparing to resume its Japan service in September after a 10-year break with three weekly flights to Tokyo. Nepal and Japan had signed the ASA in 1993 and the national flag carrier launched its Japan service in 1994, flying to Osaka via Shanghai, China. In 2007, it was forced to suspend the route due to lack of aircraft. A Nepal Air Traffic Analysis conducted by Airbus in 2015 forecasted a traffic growth of 77 percent in five years from nearly 48,000 one-way travellers from Japan to Nepal. The country received 27,326 Japanese tourists last year. According to the Ministry of Foreign Affairs, the number of Nepalis living in Japan has swelled to more than 60,000. The Nepali community is the fifth largest foreign community in Japan (TKP, 2018).

Current situation of tourism in Japan and Nepal

JNTO (2018) reveals that a record-breaking number of international visitors travelled to Japan in 2017. The country welcomed 28.7 million international visitors with a 20 percent increase on the previous year. The results from last year show that Japan is well on the way to achieving its goal of attracting 40 million visitors by 2020, the year of the Tokyo Olympic and Paralympic Games. When the Visit Japan Campaign was launched in 2003, inbound tourists numbered 5.2 million. The campaign set out to increase the total to 10 million in seven years. MoCTCA (2018) writes year 2017 seems remarkable improvement in tourist arrivals. Tourist arrivals increased by 25 percent compared to 2016. Nepal welcomed 940218 tourists in 2017. Nepal is set to organize the year 2020 as Visit Nepal Year. It will be the third national level initiative to promote Nepal's tourism sector since the country first celebrated Visit Nepal Year in 1998 followed by the Nepal Tourism Year in 2011. It expects a growth of foreign tourists by 30 percent every year since 2018 to meet the target of 1.5 million tourists by 2020. WTTC (2018) shows that the total contribution of travel and tourism to GDP was JPY37,135.9bn (USD331.2bn), 6.8% of GDP, 6.4% of total employment (4,171,500 jobs) in Japan in 2017. Whereas the direct contribution of travel and tourism to GDP was NPR99.8bn (USD982.5mn), 4.0% of total GDP, supported 497,500 jobs (3.2% of total employment) in Nepal in 2017.

Research and methodologically

Primarily, this paper is the partial outcome of my postdoctoral research on "Buddhist pilgrimage: Comparison of Shikoku, Japan and Lumbini, Nepal". Methodologically, this research is exploratory and analytical in nature. The research has adopted both qualitative and quantitative inquiries based on primary and secondary sources, and self-collected data. Primary data were obtained from field visits, questionnaire surveys and formal and informal interviews in Shikoku and the secondary data and information were collected from publications such as journals, books, documents and reports from the library; bulletin, reports, plans published by Government and non-Governmental organizations, different seminar papers; and Internet search.

There were three categories of respondents: Tourists/pilgrims visiting Shikoku, tourism service providing organizations/agencies (Hotels, travels, temples, restaurants etc.) and experts (writers/head of temples/CEO). I developed three sets of questionnaire both in English and Japanese languages and distributed the questionnaires in an envelope with stamp personally to the respondents so that they could return it by post or alternatively, could also send a scan copy of it by email. The questionnaire for pilgrims/tourist was posted on social sites as well. I have also used some of the data from my PhD research on "Pilgrimage Tourism: Special focus on Lumbini.

Heritage tourism

Heritage tourism is concerned with exploring both material and immaterial, i.e., tangible and intangible remnants of the past (Kunwar & Chand, 2016). Cultural heritage tourism (or heritage tourism) is a branch of tourism oriented towards the cultural heritage of the location where tourism is occurring. As per the National Trust for Historic Preservation, heritage tourism (sometimes called cultural heritage tourism) as "traveling to experience the places, artifacts and activities that authentically represent the stories and people of the past and present. It includes cultural, historic and natural resources." Timothy (2011; in Kunwar & Chand, 2016) states that heritage tourism is highly inclusive- probably the most encompassing type of tourism yet to be identified. It revolves directly around living cultures, the built environment, faith, traditions, folklore, arts and handicrafts, music and the everyday life of people.

Tourism, the world's largest industry, is essential to a community's economic vitality, sustainability, and profitability. More than simply visiting historic sites, heritage tourism is a personal encounter with traditions, history, and culture. Heritage tourism is based upon the concept that each community has a story to tell. This is a rapidly growing niche market that is directed towards experiencing the local customs, traditions, arts, history, sites, and culture that authentically represent a particular place. To the heritage tourist, this culture must be unique and it must be authentic (Speno, 2010). What makes the sites or toured objects authentic? Authenticity is conventionally defined as originality, genuineness or sincerity.

World Heritage, linked to global power, impacts powerfully on the tourist gaze directed to landscapes and tourists' senses of place. The most important criterion for a designation as a World Cultural Heritage site is the "authenticity" and "sincerity" of a candidate site, which are necessarily demonstrated as an exemplification of national properties. The local authorities are proud that their authentic sites have been designated as World Heritage. They often speak about the "world" or the "global." (Yasuda, 2010). Heritage, as Hoelscher (2006) states, "is not merely a way of looking at the past, but a force of the present that affects the future." Park (2014; in Kunwar & Chand, 2016)) views heritage as a symbolic embodiment of the past, reconstructed and reinterpreted in the collective memories and traditions of contemporary societies rather than being perceived as a mere apotheosis of bygone times. Heritage is culturally ascribed and socially constructed and is a flexible concept where heritage today, is related with the increasing contemporary use of the past, as manifested in the popularity of a 'heritage industry'. Heritage tourism is becoming an increasingly significant component of the global tourism industry and the growth of the heritage industry has undoubtedly contributed to expanding the scope and appeal of heritage. Pedersen (2002) writes that the commodification

in heritage has led to creating and fabricating a new environment in which different possibilities and potentials of heritage can coexist for different audience. Within the context of tourism development, heritage often becomes a commercially driven entity that is carefully selected, packaged and promoted. Heritage tourism is a broad category that embraces both eco-tourism and cultural tourism, with an emphasis on conserving natural and cultural heritage. It is a category or market segment that includes visits to historic sites, museums and art galleries, and exploring national and forest parks. Heritage tourism, because of the large number of activities it covers, is difficult to define and measure. In recent years, city planners interested in urban regeneration have adopted the term to describe many tourism programmes, a strategy that has received support from business and banks. Garrod & Fyall (2000) surprising inscribes that the heritage tourism sector has received relatively little attention from scholars interested in the concept of sustainable tourism. A little academic attention has been paid to exploring the relationship between heritage tourism and sustainability because the two concepts evidently share a common theme. Yet the heritage sector represents a highly significant component of tourism in many developed economies.

Cultural heritage holds great importance for communities around the world. Heritage connects us to the past and provides invaluable insights into our identities and evolution. It can play an important role in economic growth, poverty reduction, and sustainable development (WBG, 2017). The former includes built heritage such as religious buildings, museums, monuments, and archaeological sites, as well as movable heritage such as works of art and manuscripts. Intangible cultural heritage includes customs, music, fashion and other traditions within a particular culture. Cultural heritage tourism defined as travel concerned with experiencing the visual and performing arts, heritage buildings, areas, landscapes, and special lifestyles, values, traditions and events has become a major force in the tourism industry. It includes handicrafts, language, gastronomy, art and music, architecture, sense of place, historic sites, festivals and events, heritage resources, the nature of the work environment and technology, religion, education, and dress. Cultural heritage tourism brings together the accepted practices of research, site development, design, planning, construction, preservation technology, interpretation, and visitor services and connects them to the practice of tourism in marketing, research, product development, and promotion. It integrates tourism planning and development practices into the heritage resource management process. Within the planning process it is important to note that cultural tourism may take many forms. (Jamieson, 1998). The conservation community, as well as tourism interests, should have a long- term view in planning and heritage resource protection if resources are to be conserved for future generations.

Heritages of Japan

Religion and culture in Japan reflects a long history during which various religious beliefs and practices - some indigenous, some "imported" from other places - have been adopted and adapted to Japanese culture. The ancient indigenous folk religion, later formalized as Shinto, was based on feelings of awe toward the sacred powers (kami) that brought life to the earth and human community. According to *Nihon Shoki* (the Chronicles of Japan), Buddhism was introduced to Japan in 552 AD by Korean monks. Sutras were later brought from China, temples and shrines were built and monastic communities established. Both Confucianism and Taoism migrated to Japan, impacting Japanese culture, religion, philosophy, and politics. Japanese religion adopted Chinese Buddhist rituals, Taoist story-telling and divination, as well as Confucian concepts of piety and ancestor veneration. Pure Land, Zen, and Nichiren Buddhism all developed in Japan, with the Nichiren School taking on a uniquely Japanese character.

The Japanese perception of World Heritage is related to their admiration of Western culture and its hegemonic power. Therefore, Japanese autonomous bodies enthusiastically want their sites to be designated as World Heritage site, associating with Western aesthetics. The terms, "world" and "global" are synonyms for the terms, "Western" and "Europe" for the Japanese. The designation of the World Heritage indicates that the site is highly valued by Western society. The Japanese attempt to purchase the World Heritage of a global cultural brand as cultural capital even though they spend enormous amounts of money on it. Thus, World Heritage works as an agency of Western culture promoting cultural imperialism, at least in Japan (Yasuda, 2010). With its long history, traditional culture and beautiful nature, Japan has twenty-two locations/properties inscribed on the World Heritage Sites (UNESCO, 2018).

Heritages of Nepal

Nepal, the Himalayan country situated between China and India steeped in several unique cultures, legends and myths. A beautiful, awe-inspiring land, Nepal is the birthplace of Buddha, the country with the Mount Everest and home to the Kumārī: the living goddesses. Nepal has a unique and diverse living history and culture. It has been blending and carrying the history of thousands of years (Ghimire, 2017). The culture, festivals, traditions, rituals, legends, temples, monasteries, stupas, religious books, archeological remains, structures, caste/ethnic groups and the welcoming nature of Nepalese people are more than enough to prove its authenticity (Kunwar & Ghimire, 2012). The unique and diverse Nepalese culture has been the attraction for rest of the world. UNESCO has listed four World Heritage Sites in Nepal. Two cultural sites are: Kathmandu Valley which is connected and combined with seven other sites (Durbar Squares of Hanuman Dhoka (Kathmandu), Patan and Bhaktapur,

the Buddhist stupas: Swayambhu and Bauddhanath and the Hindu temples: Pashupati and Changu Narayan; and Lumbini, the Birthplace of the Lord Buddha. Two natural sites are: Chitwan National Park and Sagarmatha National Park.

Disaster and heritage sites

World Heritage properties and heritage sites in general are exposed to the impacts of natural and man-triggered catastrophic events, which threaten their integrity and may compromise their value. The heritage sites are the most susceptible and vulnerable sectors. A large number of significant heritage sites around the world are fragile properties, and they are faced with different challenges. Cultural heritage is always under pressure from a variety of risks. Risks to heritage sites are dependent on the nature, specific characteristics, inherent vulnerability and geographical environment of the site. The loss or deterioration of these outstanding properties has severely negative impacts on local and national communities, because of their cultural importance and socio-economic value. Cultural heritage is increasingly exposed to disasters caused by natural and human induced hazards. Natural disasters are escalating from the local level to the national level and the global level, such as tornado, sudden torrential rain, typhoons, storms, in-land earthquake, volcanic eruptions, sea-trench earthquake, and so on. They are becoming more frequent, larger, more wide spread, more diverse, more complex and more difficult to predict. Prevention and mitigation of disaster damage can be a role that World Cultural Heritage and World Natural Heritage can adopt. Natural disasters such as volcanic eruption, earthquake, tsunami, tornado and typhoons damage people's lives and also ecosystems. They are natural phenomena, but human elements and social factors are also important. Prevention, recovery and restoration from natural disasters provide opportunities for us to explore new possibilities for the conservation and promotion of World Heritage sites (Sugio, 2015).

Both Japan and Nepal is home to a variety of frequently occurring disasters, which can cause wide-ranging damage to its cultural resources. For this reason, the country has taken specialized measures in establishing a disaster risk management system and methodology for post-disaster emergency response and recovery. Shuri Castle, a palace of the Ryukyu Kingdom first built in the 14th century, was destroyed during the Battle of Okinawa in the World War II. The Japanese forces had set up a defense perimeter which goes through the underground of the castle. U.S. military targeted this location by shelling with the battleship USS Mississippi (BB-41) for three days in May 1945. The castle burned down subsequently after. It was later reconstructed in the 1990s. Kinkaku-ji (Golden Pavilion) of Kyoto, Japan was burnt down by an arsonist in 1950, but was restored in 1955 (Wikipedia, 2018). When a powerful earthquake struck East Japan in March 2011, more than 700 national landmarks were damaged by the earthquake, most located in the Tōhoku and Kantō regions. In addition to these sites, many other traditional buildings and historic townscapes were damaged

in places such as the coastal city of Kesennuma in the Tōhoku region. The repair and restoration of built heritage has proved to be an important social element for communities recovering from disaster. Local authorities in Japan have prioritized the needs of different sites and communities affected by the earthquake. The work in affected area aimed to help reinvigorate the local economy and boost town morale by rebuilding the tourist economy. The ecosystems characteristics of Japan are important elements of World Natural Heritage sites. Damage due to the rapid increase in the population of deer since around 1990 is spreading. Deer eat the lower parts of trees and once their favorite plants have disappeared, they eat trees that they do not usually prefer. As a result, only the bare ground remains. The soil is washed away, and the forest is destroyed. Conflicts with human activities and damage to agriculture and forestry from deer impact have exceeded the tolerable limit of local economies in many places. Furthermore, there are concerns about the survival of rare plants and the possibility of reduced forest renewal (Sugio, 2015:749).

Nepal offers a vivid example of the human and economic toll arising from the impact of disasters on cultural heritage (WBG, 2017). The damage and negative impacts of devastating earthquakes on April 25, 2015 and its aftershocks were significantly large in the history of Nepal. There had been "extensive and irreversible damage" at the world heritage site in the Kathmandu valley, the capital city of Nepal. The earthquake affected about 2,900 heritage structures with cultural and religious values. World Heritage Monument Zones were severely damaged and many collapsed completely. The earthquake's impact on heritage places was extensive throughout the Kathmandu valley, which is home to hundreds of sacred Buddhist and Hindu sites. The three urban zones at the site are Durbar squares - meaning "noble courts" - in the settlements of Kathmandu, Bhaktapur and Patan. These three complexes as "almost fully destroyed". The four other zones are religious sites: Buddhist stupas (monuments) at Swayambhunath and Boudhanath, Hindu temple complexes at Pashupatinath and Changu Narayan were also damaged. The Durbar Square is a mesh of palaces, courtyards and temples. UNESCO calls it "the social, religious and urban focal point" of the Nepalese capital. Basantapur Durbar Square was the residence of Nepal's royal family until the 19th century. Amongst the most immediately noticeable losses is the toppling of the Dharahara Tower, a nine story tower that offered visitors who braved its spiral staircase a magnificent view of Kathmandu. Even after more than three years, the temples and palaces at the world's largest concentration of UNESCO World Heritage Sites remain heaps of rubble, other structures that had suffered seismic damage were still being propped up by wooden beams, but a very little reconstruction has taken place. The earthquake-damaged world heritage sites in Kathmandu Valley are at risk of being put on the UNESCO list of World Heritage in Danger if they are not renovated/preserved within a given time (Ghimire, 2016).

Cultural heritage is vulnerable to the adverse impacts of natural disasters. Floods, earthquakes, landslides, fires, long-term climate effects, and other natural hazards can cause damage or even total destruction of cultural heritage. In part, the vulnerability of heritage assets relates to their location and physical characteristics, including quality of construction and conservation. Urbanization and agglomeration of economic activity have created situations in which historic heritage assets—including monuments, places of worship, or natural heritage—find themselves surrounded by new construction activity in which the work is done poorly and without an authorizing legal framework that takes proximity to heritage sites into account. Unlike disaster damage to regular infrastructure, disaster damage to cultural heritage is often irreversible; in addition to economic losses and livelihoods impacts (WBG, 2017).

Pilgrimage in Shikoku

Pilgrimage has been one of the important aspects of the Japanese culture and heritage tourism in Japan. Pilgrimage in Japan had developed gradually. The ascetic wanderings of individuals took the form of pilgrimage routes, which were then adopted by the aristocracy and, later, the common masses. Pilgrimage became popular in the Heian period among the aristocracy, who visited places like Ise Shrine, Hasedera and Shitennoji. During the Edo period, pilgrimage became popular for all classes of people (Kodansha, 1983). Shinno Toshikazu has described pilgrimage as "one of the great pillars" of Japanese religion. Pilgrimages are important in Japanese religious development, and play specific and crucial roles within the functioning of the various religious organizations with which they are associated, it has been voluntary pilgrimages such as the Ise pilgrimage and multiple-site types such as the Saikoku *junrei*, the Shikoku *henro*, and the various regional "copied" pilgrimages, that have tended to attract the greatest levels of mass participation and to have had the greatest influence in the broader development of Japanese pilgrimage culture. It is these pilgrimages in particular that are focused on in this volume, and it is to these, and the typological differentiations that may be made between them, that we now turn (Reader & Swanson, 1997: 238). In Japan, pilgrimages can be classified into two general types: (1) multi-site circuits and (2) single-site pilgrimages. Multi-site circuits involve a number of sacred places linked together numerically, with each location devoted to the same single deity or to a group of related deities. This is known as *honzon junrei.* Single-site pilgrimages involve a journey to one particular sacred site. There are a number of aspects of the pilgrimage which are rich in symbolism - particularly its association with death. The clothing worn and items carried by a pilgrim indicate that he or she is 'dead to the world' (Reader, 1993: 107; in MacGregor, 2002: 11). What attracted pilgrims were temples known for their miracle efficacy, in other words miracle temples in Japan. Kannon was clearly the most popular deity venerated at these miracle temples. Furthermore, the

most popular pilgrimage temples belonged to three sects in Japan: Tendai, hmgon, and Hosso (Ambros, 1997: 304).

Schumacher (2013) writes pilgrimages were first undertaken in the Nara Period (710-794 AD), but the custom did not become popular until the Heian Era (794-1185 AD). Kumano, in southern Wakayama Prefecture, became a large center for adherents and pilgrims of the Shugendo Sect during the Heian Period. Other popular pilgrimages at the time were to Hasedera (Kyoto), Shitenno-ji (Osaka), and Mt. Koya. In the Edo Period (1600-1868 AD) the number of people making pilgrimages to both Buddhist temples and Shinto shrines increased rapidly, especially to Ise Shrine, Kotohira Shrine (Kagawa), the 88 temples of Shikoku and Western Japan, to Zenkoji (Nagano), Kiso Ontake (Nagoya), and Mt. Fuji (Shizuoka). One phenomenon of the Edo era was Okage Mairi - the special pilgrimage to the Ise Jingu Shrine. The Okage Mairi tradition continues unabated even today, with approximately six million people visiting Ise Jingu Jingu yearly. In Japan, as Pye (2014) writes that pilgrimages have been turned into considerably less arduous ordeals than they were in the past thanks to public transport, comfortable lodgings, good food and an ample supply of vending machines. Reader (2005) elicits that the *henro* was one of several pilgrimages that emerged in the latter Heian period linked to the activities of religious mendicants and wandering proselytizers known as *hijiri*, whose seminal role in popularizing folk Buddhist faith in Japan has been widely discussed by Japanese scholars. The *hijiri* promoted the virtues of Buddhist figures of worship and emphasized pilgrimages to important temples and other holy places as a way of deepening faith, attaining salvation in this or the next life, and gaining merit and worldly benefits (107). Likewise, Shinnen was the seminal figure in the development of the *henro*, making the pilgrimage more widely known through his stones, guidebooks, and miracle tales. It is a striking example of how individuals can help make the pilgrimage and create a series of footsteps for others to follow (121).

"Sacred Sites and Pilgrimage Routes in the Kii Mountain Range" is one of the important World Heritage sites in Japan. Sacred Sites in the Kii Mountain Range consist of Kumano Sanzan, Yoshino, Ohgake, and Koyasan, and are the religious amalgamation of Shinto, Buddhism, and Shugendo. The Sacred Sites have attracted a large number of pilgrims from all over Japan. In particular, the Kumano area is considered to be a heritage site as it is deeply associated with the creation myth of Japan. Kumano Kodo are pilgrimage routes for Kumano Sanzan (three shrines). There are primarily four routes, Koheji, Nakaheji, Oheji, and Iseji, which are accessible from various areas. Kumano Moude (pilgrimage) began in the middle of the Heian era (10th century). Kumano Sanzan was regarded as a heaven, and emperors and aristocrats often went on a pilgrimage wishing for a cure for illness or for material benefits. The whole Kumano area was regarded as another world. Therefore, Kumano

is a mythical place representing Japanese cosmology. Emperor Uda began Kumano Moude (pilgrimage) for the first time in 907, and Emperor Shirakawa popularized it. (Yasuda, 2010). The Shikoku pilgrimage is the most famous type of pilgrimage and most frequently referred to as *henro* a term specific to this pilgrimage or *meguri*, which literally means 'to go round,' but 'is most widely used in cases where the sites on a pilgrimage route are not united by their dedication to a single figure of worship,' (Reader & Swanson, 1997: 233). Perhaps the most famous pilgrimage in Japan -around the island of Shikoku - appears in chronicles of the Heian era (latter half of the eleventh century), when it developed as an ascetic practice involving religious sites. By the seventeenth century a more structured route had developed, involving the eighty-eight temples still visited today. It seems that, in the latter part of the Muromachi period (1338-1573), the trip to Shikoku became "a widespread practice involving participants other than religious specialists and ascetics" (Reader 1987: 116). Statler, (1983: 97) notes the Japanese people are an optimistic. In Japan, over the centuries, Buddhism was transformed into an optimistic creed. Kobo Daishi's contribution to this was his insistence that man and women too, for whom earlier Buddhism held out no hope had within him the seed of Buddha; by hard practice following strict precepts anyone could find and nurture that seed, could manifest his innate Buddha nature –could achieve enlightenment. In pilgrimage typologies developed by Japanese scholars, Shikoku is classified as a *seiseki* pilgrimage- one associated with the sacred traces or presence of a holy person. In Shikoku this figure is Kobo Daishi, a miracle-working figure with origins in the Japanese Buddhist tradition whose presence permeates the pilgrimage and binds it to the island of Shikoku (Reader, 2005: 10).

The beginnings of the Shikoku pilgrimage are said to date back to the ninth century when the Buddhist priest Kukai, later known as Kobo Daishi (774–835), made a journey around the Shikoku Island in search of enlightenment. Kukai developed the Shikoku pilgrimage route comprising of 88 main Buddhist temples and numerous additional temples and shrines with several ancient local pilgrimages. By the 17th century, the fame of the *henro* had spread, and become popular among ordinary Japanese. Iannarone (2013) writes Kobo Daishi, founder of the Shingon sect of Buddhism, is one of the most important people in Japanese history, and he still holds considerable sway and respect in Japan today. Aside from being a priest, he was also a master calligrapher, poet, scholar and advisor to the emperor. In his early years, he turned away from his aristocratic upbringing and became a wandering ascetic in the mountains and valleys of Shikoku; the 88 temple pilgrimage recreates his journeys around the island.

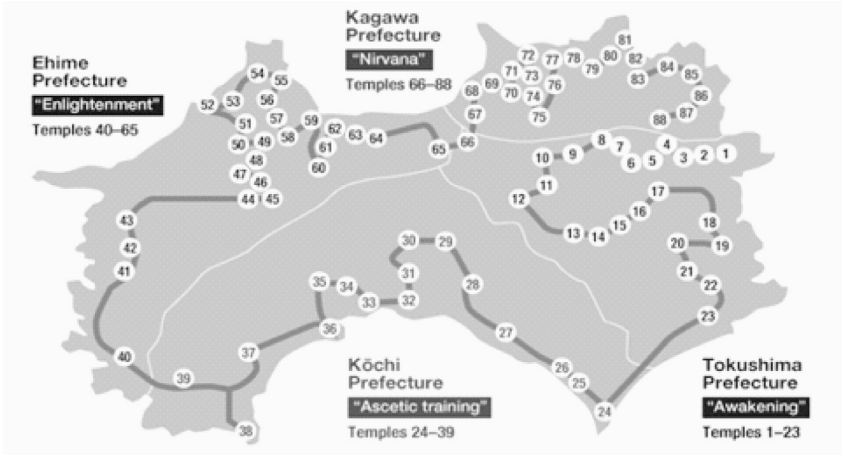
The Shikoku Eighty-Eight Sacred Places Pilgrimage is the most famous type of pilgrimage. It is one of the most prominent, evocative and photogenic pilgrimages in

Japan with a highly developed pilgrimage culture which is one of the most prominent elements in Japanese religious structure (Reader, 2005: 9). The Shikoku pilgrimage has become an international pilgrimage destination. People with other religious faiths than Buddhism also make pilgrimage in Shikoku.

Figure 1: Shikoku Island and location map of 88 temples

Geographically, Shikoku is one of the four main islands of Japan. It is located in the southwestern part of the Japanese archipelago at latitude of 34°N. Shikoku is comprised of four prefectures, Tokushima, Kagawa, Ehime and Kochi. Shikoku has a mild and warm climate with successive seasonal beauty.

Henro and numbering of temples



One of the standard Japanese words for pilgrimage is junrei. However, the Shikoku pilgrimage is called henro. Shikoku literally means "four provinces" and the pilgrim's journey through the four provinces is considered to be a symbolic path to enlightenment. The theme of Tokushima prefecture (temples 1–23) is Awakening; Kōchi prefecture (temples 24–39) is Ascetic training; Ehime prefecture (temples 40–65) is Enlightenment; and Kagawa prefecture (temples 66–88) is Nirvana. Since pilgrims have to visit all eighty-eight temples to complete the pilgrimage, all of them are equal; however, some may be more equal than others in the eyes of the pilgrims. Temples with dramatic physical settings or with powerful historical connections tend to have a greater effect on pilgrims.

Ohenro practices at temples

Mostly, the pilgrimage starts from Ryōzenji (Temple No. 1) in Tokushima and ends at Ōkuboji (Temple No. 88) in Kagawa. The pilgrims are given the Buddhist Ten Commandments to follow at least during the pilgrimages at temple number one. These are: Do not kill. Do not steal. Do not commit adultery. Do not tell a lie. Do not

use flowery language. Do not speak ill of others. Do not be double-tongued. Do not be covetous. Do not be angry. Do not be perverse.

Traditionally, the pilgrims (O-henro) perform the following optional actions at each temple in Shikoku:

- At the main gate: To ward off evil spirits, the pilgrims bow once facing the main hall.
- At the wash basin: To purify themselves, pilgrims wash their hands and mouth.
- At the bell tower: Pilgrims ring the bell to mark their arrival.
- At the main hall: The main deity can be seen here. First, pilgrims light incense and a candle, ring the bell once, and declare to the main deity that they have come to worship. Drop the name-slip (osame-fuda) and copied sutra (shakyō) in the box, recite the sutras.
- At the Daishi hall: A figure of Kōbō Daishi can be seen here. Pilgrims worship in the same way as at the main hall.
- At the Stamp Office: Pilgrims receive the temple stamp in their stamp book.
- At the main gate: Pilgrims again face the main gate and bow once

Shikoku Ohenro costumes

O-henro are free to wear whatever they please on their pilgrimage. However, the pilgrim's traditional costume (special symbolic clothing) comprises a white shirt with Japanese script indicating they are a pilgrim, a conical sedge Chinese hat, a shoulder bag, and a walking stick. By choosing these items, one will be identified and respected as a pilgrim by those one meets along the way. Foreign pilgrims gain a sense of belonging to a privileged group in Shikoku. Once you start walking in the white O-henro costume, you are no longer treated as a foreigner but as an O-henro-san like everybody else. It is really a unique experience that you cannot experience anywhere else. O-henro do indeed cross boundaries of language, culture, and nationality (Moreton 2016). On the other hand, pilgrims—in a vehicle or on foot—consider themselves to be traveling alone with Kōbō Daishi as their companion and guide. This spiritual presence is expressed by the words dōgyō ninin (two traveling together) written on the hats.The temperature and weather of mid-March to May in spring, and October to November in autumn, are most suitable for undertaking the pilgrimage in Shikoku. In the normal cycle of yearly weather, during the rainy season of June and July, there is a lot of rain. In August and September the weather is stable, but this is the season when occasional typhoons will make their appearance. Reader (2005, 1) writes that there is a Japanese saying that in spring Shikoku comes alive

with the sound of pilgrims' bells. The trail itself is very well marked by the ubiquitous red arrows and other markers that populate the trail. There are many ways to do the Shikoku pilgrimage. Everyone has their own personal circumstances, such as the ability to walk, paying capacity, time availability, interest, and so forth.

Table 1: Basic Cost for Pilgrimage in Shikoku

Pilgrimage option	Days	Tentative cost
Walking entire pilgrimage at one time	45-60 days	¥400,000 (less than ¥10,000/day)
Bicycle pilgrimage	15-20 days	¥200,000 (At least)
Small groups (charter small busses or taxis)	8days	¥500,000 (At least)
Tourist bus tours	9-12 days	¥225,000 - ¥250,000

Lumbini: An international pilgrimage destination

Lumbini hallowed by the birth of the Sakyamuni Buddha, one of the most significant pilgrimage destinations in the world lies in the southwestern plains of Nepal. Nepal is honored to have on its territory Lumbini (Kunwar & Ghimire, 2012), the birthplace Lord Buddha, the greatest, the brightest, and the light of peace and indeed the most illustrious son of Nepal (Guruge, 1998: 26). The newly born Prince Siddhartha (who later distinguished as Lord Buddha) took his seven steps and uttered an epoch-making message to the suffering humanity in Lumbini. The famous Indian Maurya Emperor Asoka guided by his spiritual teacher Upagupta made a pilgrimage visit to this holy site in 249 B.C. Famous Chinese pilgrims Tseng Tsai (4th century), Fa-Hsien (5th century) and Hiuen-Tsang (7th century) visited Lumbini for pilgrimage and study about Buddhism and spirituality. The visits of the Chinese travelers brought more records out about Lumbini. Hiuen Tsang's records are the most informative of all for he not only traveled to see Lumbini and other Buddhist sites, but he also maintained a detailed description of his travel. UN Secretary General U Thant's pilgrimage to Lumbini in 1967 was taken as milestone in the history of Lumbini. The historic events held in Lumbini reconfirmed and enhanced Lumbini's status as the Fountain of World Peace and sacred pilgrimage shrine of the Buddhists and peace-loving people and a symbol of international brotherhood, peace and prosperity, and helped to project it as a World Peace City and important touristic destination in the world. Geographically; Lumbini, the birthplace of Lord Buddha which has been internationally recognized, is situated in Rupandehi District of Southern Terai at an altitude of 105m above the sea level and around 300 Km southwest of Kathmandu-the capital of Nepal.

After the *parinirvana* (physical death) of the Buddha, the relics of His body were collected from the funeral pyre and divided into eight parts. These were distributed to the claimants and *stupas*, were erected on the relics. The practice of pilgrimage in Buddhism probably started with visits to these places, and the purpose could be to achieve personal advantages such as rebirth in a good location, as well as to honour the great master. Thus the custom of pilgrimage has been widespread among Buddhist for many centuries. Buddha had emphasized about the importance of pilgrimage (Buddhanet, 2010). The Buddha advises for pilgrimage without which there is no release from grief and unless the end of the world is to be reached. So let a man be a world-knower, wise, world-ender (Kunwar, 2006). It was the Buddha himself who enshrined pilgrimage as an important act in the life of a practitioner. In answer to Venerable Ananda's concern that the monks would no longer be able to see the Buddha and pay their respects after His Mahaparinirbana, the Buddha mentioned four places which a pious disciple should visit and look upon with feelings of reverence. They are:

- Lumbini: "Here the Tathagata (the Buddha) was born!
- Buddhagaya: "Here the Tathagata became fully enlightened, in unsurpassed, Supreme Enlightenment!
- Sarnath: "Here the Tathagata set rolling the unexcelled Wheel of the Law!
- Kusinagara: "Here the Tathagata passed away into Nirvana.

In visiting those places, early Buddhist pilgrims not only walked in the Buddha's footsteps, thereby metaphorically treading the same path to enlightenment while being in his presence, but did so alongside fellow pilgrims walking the same path and hence experienced a sense of community. Pilgrimage has been especially conducive concept as its focus on the notion of life as a journey toward higher goals and because of its emphasis on transience in Buddhist tradition. The Buddha was the first Buddhist pilgrim, and his life story is one of pilgrimage, in which he leaves home to travel in search of the truth. Indeed, key places associated with his life and significant turning points in Buddhist history (Reader, 2012). Furthermore, the Buddha said, "And whosoever, Ananda, should die on such a pilgrimage, with his heart established in faith, he at the breaking up of the body, after death, will be reborn in a realm of heavenly happiness" (Mahaparinirbana Sutra Chapter V; in San, 2002: 15). There are other important sites as well where the Buddha performed his great miracles and those where he and the *sangha* held their rain retreats.

Pilgrimage to the holy places mentioned by the Buddha is a once-a-lifetime undertaking by Buddhists. A pilgrimage is a journey to a sacred place as an act of devotion and faith (*shraddha*). A strong desire stems from one's devotion to undertake a pilgrimage in order to heed the Buddha's advice. In the course of visiting the sacred

places, pilgrims feel the need to be in the Master's presence and this fullness of faith conduces to joy and the observance of morality and the foundation of all merit. After the journey is over, one should always try to recollect the joyful moments spent at holy places to keep them vivid in one's memory (San, 2002: 11). Reader (2012) writes that as Buddhism spread across Asia, it also created new places of pilgrimage in every region that Buddhism permeated - from sacred mountain sites in Tibet to places such as the Shwe Dagon Temple in the Burmese capital of Rangoon, which according to popular belief houses relics of the Buddha's hair, and the Temple of Tooth in Kandy, Sri Lanka, which also houses a reputed relic of the Buddha. In such places, it was believed; pilgrims could thus "meet" the holy figure at the center of their religion and acquire his spiritual grace.

The grove of Lumbini changed into a pilgrimage site soon after the parinirvana (physical death) of the Buddha. Lumbini's strengths in this respect are - to name just a few - that it is a top class pilgrimage site, declared as World Peace City, a World Heritage Site and hailed as the Fountain of World Peace that may provide ultimate peace and nirvana. It hosts national and international Buddhist monasteries and therefore, is the home of monks, nuns, peace lovers, and spiritual leaders. There are more than 160 religious, historical and archaeological sites related to the Buddha and his life in and around. The importance of Lumbini is so great that the Buddha himself advised his followers to make the pilgrimage to Lumbini. Lord Buddha explained the significance of Lumbini in the words: "Lumbini should be (visited) seen by person of devotion, and which would cause awareness and apprehension of the nature of impermanence ……" because Lumbini is the foremost Buddhist pilgrimage site in relationship to the other sacred sites. Many scholars designate Lumbini as an unmatched spiritual destination of the Buddhist world. The visitors are overwhelmed with the sanctity and serenity of Lumbini. The spiritual feeling of being at the holy birthplace of the Enlightened One nurtures devotion and faith in their mind and fills their heart with purity, compassion and wisdom (Ghimire, 2013).

Spirituality and peace are the fundamental aspect of Buddhism and it should exist at Lumbini. The Lumbini region encompasses dozens of Buddhist-spiritual sites and houses beautiful flora and fauna which can evoke spirituality, serenity and satisfaction in the mind of visitors. Lumbini, the world heritage site with outstanding universal value has great importance to be one of the top class spiritual and pilgrimage destinations in the world (Ghimire & Rai, 2015). Pilgrims and visitors come to Lumbini and express their religious and spiritual sentiments in various ways, often linked to their diverse cultures. They come to meditate, chant, and beat on drums, offer gold leaves, offer coins, incense or milk. They all come with the expectations of peace and harmony (UNESCO, 2013:11). The spiritual feeling of being at the holy birthplace of the Enlightened One nurtures devotion and faith in their mind and fills their heart

with purity, compassion and wisdom. Today, Buddhists from all over the world, as well as other travelers, are interested in the ancient history and culture of Nepal.

Shikoku survey findings

In this section, an attempt has been made to present the results of some of the primary data collected from Shikoku analytically. Various methods of presentation have been used to illustrate and present data.

Purpose of visit in Shikoku: The purpose of visit could be one of the motivating factors for travel that makes tourists move away from their home to a desired destination. An inquiry was made to know the purpose of visit of the respondents. Tourists/pilgrims visit Shikoku with various purposes. In the multiple response question, survey participants could respond to more than one purpose. As can be seen, 85.3% visited Shikoku for pilgrimage whereas 21.6% visited Shikoku for sightseeing, and so on. It shows that Shikoku is an important sightseeing destination as well.

Furthermore, an attempt was made to see the cross-tabulation between the nationality and purpose of visit of the respondents in Shikoku. The result shows that 87.7% of Japanese visited for pilgrimage and 80.0% of Canadians visited for sightseeing. Likewise, the cross-tabulation between sex, age group, religion, and purpose of visit shows that 92.4% Buddhists, 75% Christian, 100% Shintoists, 100% Hindus, and 75.9% of those of other religions visited for the purpose of pilgrimage. It shows that quite large numbers of people with other religious faiths than Buddhism also participated in the pilgrimage in Shikoku.

Table 2: Multiple Responses on Purpose of Visit

Purpose of visit	Responses		Percentage of Cases**
	N	Percentage*	
Pilgrimage	99	73.3%	85.3%
Sightseeing	25	18.5%	21.6%
Research	2	1.5%	1.7%
Others	9	6.7%	7.8%
Total	135	100.0%	116.4%

*Percentage of all ticks

**Percentage out of the respondents who ticked

Influencing factor to visit Shikoku: There are various factors influencing pilgrims/tourists to visit Shikoku. The most influential factors are religious belief and respect for Kōbō Daishi, to honor and remember the ancestors, participation in rituals, to gain a sense of Buddhism and Japanese culture, information from books and other publications, friends, yoga teachers, travel agents, websites, advertisements, natural beauty, and hiking outdoors. One pilgrim was influenced by previous visits (p-21); another pilgrim found a picture of Shikoku pilgrimage on Santiago's way (p-15). One

met a Japanese pilgrim who talked about Shikoku while walking Camino; others love walking on pilgrimages and the spiritual experience (p-78). One heard the voice of the Buddha, respects the Buddha, and will walk for twelve years (p-30). Some others sought family happiness and better health, or relief from the stress of work, or from retirement.

Mode of transportation in Shikoku pilgrimage: Pilgrims/tourists have several options of travel modes for the Shikoku pilgrimage. These include bus, car, motorbike, scooter, bicycle, and walking. Many of the pilgrims/tourists travel in groups via bus or mini-taxi these days; however, walking is the best way to do the pilgrimage. A significant number of pilgrims— mostly foreigners—still walked the route; however, it does not suit all pilgrims/ tourists depending upon their age, physical situation, time, and desires. Among the five categories of mode of transportation in the Shikoku pilgrimage, the respondents could answer as many as appropriate. The result shows that a majority (52.59%) of the respondents chose walking, followed by 35.34% using tourist buses and so on. Furthermore, a cross-tabulation analysis was made between the age groups of the respondents and the mode of travel. The majority (80%) of respondents for the 21–40 age group walked, whereas 44.60% of the respondents of those aged above 61 were using tourist buses. Younger people preferred walking and travelling individually, whereas the older groups preferred group travel and tourist buses.

Table 3: Cross-tabulation of mode of travels by age-group in Shikoku

Age group		Mode of travels in Shikoku pilgrimage					Total
		Walking	Private car	Tourist bus	Motor/ bicycle	Others	
21-40	Count	16	3	4	2	4	20
	% within age	80.00%	15.00%	20.00%	10.00%	20.00%	
41-60	Count	27	10	12	1	6	39
	% within age	69.20%	25.60%	30.80%	2.60%	15.40%	
Above 61	Count	17	13	25	0	3	56
	% within age	30.40%	23.20%	44.60%	0.00%	5.40%	
Not mention	Count	1	0	0	1	0	1
	% within age	100.00%	0.00%	0.00%	100.00%	0.00%	
Total	Count	61	26	41	4	13	116

Organizer of the visit: The respondents were asked about the organizer of their visit. The data shows that a majority of the respondents (66.4%) organized their visit themselves, 26.7% visited with a guided tour, and 4.3% respondent's visit were organized by others, whereas 2.6% of the respondents did not mention.

Stay in Shikoku: Pilgrims/tourists have various options for accommodation during the Shikoku pilgrimage. The respondents were asked about their stay in Shikoku—they could give as many answers as appropriate. A majority of the respondents (83.6%) stayed in hotels, 54.3% in temples, 28.4% in lodges, 29.3% in other places (such as tents), 4.3% in the houses of relatives or friends, and 1.7% did not mention where they stayed. Most pilgrims search for budget-class accommodation. The respondents opined that the hotels in Shikoku are expensive. The lodging should be cheaper (p-13), more affordable accommodations that are flexible with arrival time, bath time, meals, and so forth (p-104), and some accommodation places were booked out by bus pilgrims/tourists so there was no space for individual henro (p-24).

Willingness to visit Lumbini: An attempt was made to inquire about willingness to visit Lumbini in Nepal. The result shows that a majority of the respondents (76.7%) expressed that they do not want to visit Lumbini, 21.6% want to visit, and 1.7% of respondents did not give their opinion. In a cross-tabulation analysis between the nationalities of the respondents and their plans to visit Lumbini, a majority (87.7%) of Japanese respondents do not have any plans to visit. On the other hand, 100% of Italian and 42.9% of German respondents want to visit Lumbini.

Expectation from Shikoku pilgrimage: "Why do people go and what do they expect from the Shikoku pilgrimage?" is one of the important questions. As noted by one of the respondents (E-3), people have different expectations and they want to gain something from the Shikoku pilgrimage. Other expert respondents opined that Shikoku has a unique culture which is very precious. People go on pilgrimage to reflect on themselves, clear their mind and spirit (E-4), gain worldly benefits and memorials for their ancestors (E-2), and recall old memories and get relief from sickness and the death of parents (E-1). There seems to be a "pilgrimage boom" and people want to try a pilgrimage that is not well known. Some want to experience a lengthy religious journey in Japan, or want to interact with the Japanese in a countryside setting (E-5). One pilgrim respondent said that it changed her as a person, being impressed with the generosity of the people, the peacefulness of the surroundings, and the profoundly surreal way of life that she could have never imagined. It was an experience of a lifetime that she still thinks about today (p-107). Other expectations were to experience the unique culture of Shikoku, improve mental health, for spiritual development, interaction and involvement with the locals, experience Japanese culture, enjoy and reconnect with nature, self-improvement and personal satisfaction, a sense of achievement, discovering things about oneself, deep emotional feelings, a chance to escape everyday life, for a broader understanding of Buddhism, more insight into cultural and religious beliefs in Japan, spiritual comfort, to improve mental and personal health, develop a positive attitude, fulfillment of a wish, and more. P-41 was

expecting time for reflection upon her life. She wanted to be on her own and to get rid of bad things from the past. She expected to come to terms with her mother's death. It had changed her life, her way of looking at people, and she became a Buddhist. She learned to bear bad weather and still stay positive. Some others expected to learn about history, culture, and Buddhism, tourism and health, or had an interest in gifts and food sold at local shops, or to sleep outside and to remain healthy.

Opinion regarding extended circuit between Lumbini and Shikoku: In response to the question, "What is your opinion regarding an extended Buddhist circuit between Lumbini and Shikoku?," most of the respondents took it as a spectacular idea. They opined that it is good for Buddhists or pilgrimage lovers to have a connection between the Buddha's birthplace from where the Buddhism originated and developed, and Shikoku. People who do pilgrimages are always interested in the next one. Given that the Buddha was born in Lumbini, it is natural that Buddhist pilgrims would love to go there. It could be a long journey of a few weeks combining pilgrimage and tourism. P-68 asked, when can I go? However, most of the people visiting Shikoku are not aware of Lumbini. Many, on the other hand, found the connection between Shikoku and Lumbini very interesting, with possible connections between people from different countries and places, and to connect the two regions and see how Buddhism evolved between South and East Asia. It could be highly interesting for those who want to explore, and for those who want to learn more about Buddhism, and interesting for specific interest groups. It would be a great opportunity for Japanese and people from other countries to know about the place which is the origin of Buddhism, and also to know about Nepal and do pilgrimages. It would be good for Buddhism and both countries, to have a connection between two important Buddhist sites and countries with similar faiths and beliefs. Many Japanese will visit Nepal, and Nepalese will visit Japan. Alternatively, some other respondents asked, how is Lumbini promoted? How can I get information if I want to visit Lumbini? There should be more advertisements internationally, with books, articles, and other resources, as long as it does not become just another reason for a commercial enterprise. Shikoku is basically centered on Kōbō Daishi, and Lumbini is the birthplace of Shakyamuni, so it might be difficult to connect them directly. Japanese and Nepalese have differences in Buddhist culture and tradition, which also might make it difficult to make connections.

Impacts of pilgrimage tourism in Shikoku: Pilgrimage tourism has various impacts in Shikoku. Among them, the economic impact is one of the most important. In an enquiry to identify the economic impacts of pilgrimage tourism in Shikoku, 73.3% cited that there is an economic impact, 6.8% stated no, and 19.9% did not give their opinion. Those who felt the economic impact and replied "yes" were further asked to indicate as many of these as appropriate. Most of the first time visitors and

foreigners were unsure of the impact. The multiple response output result shows that 90.6% responded to the consumption of local products, 52.8% responded to job opportunities, 51.9% responded to increased communication, and so on.

Further, positive and negative impacts perceived by the respondents are given in the following table.

Table 4: Impacts Perceived by Respondents

Positive	Negative
• Meet people from different countries/ places • Provide trade for local business (hotels, restaurants, travel companies), promote region that might otherwise lose out to mainland regions • Employment for local people, buying local products and staying in local facilities by visitors • Support small business such as accommodation, food etc., must be positive for the local people as it brings much needed income onto the island • Many accommodation places at short distances • Respect for other cultures (both ways) and nature • Better facilities for pilgrims (e.g. henro huts), more jobs in hotels/ other accommodation • Sense of satisfaction • Preserve long history of Buddhism, culture and nature of Japan • Economic and infrastructures development • Rural areas become more active	• Tourism can impact on spiritual atmosphere • Increased traffic on small roads • Mass-tourism can change the feeling of the places and make them unpleasant • Shikoku people can be intimidated, because it is so crowded in April/ May and October/November • Perhaps Henro becoming a bit commercialized and many basic rather than spiritual tourists • It would be destroyed by mass tourism • Garbage and environmental problem • Interfere with local society and culture • During the busy seasons there are so many pilgrimage bus tours and the temple grounds and temple office can get quite crowded making it difficult to enjoy the usual serenity of each sacred site. As well, the focus is turned towards the masses and not the walking pilgrims. There is always a problem of parking lot size, noise from traffic, garbage, the need for large washrooms etc.

• Local communities' involvement in tourism	• The teaching of Buddhism are not being transmitted • Language problem to the foreigners • I find it very sad that the Japanese in their amazing generosity and eagerness to please, feel they must adapt and change ancient customs to attract westerners/ non-Japanese to what is inherently a Buddhist/Japanese pilgrimage. I love Japan and the Japanese culture with a passion and have been coming to Japan since 1977 (over 20 times) and do not want to see Japan trying to be more like the westerners / especially like the Americans. It can only harm the beautiful Japanese culture and ways (p-78)

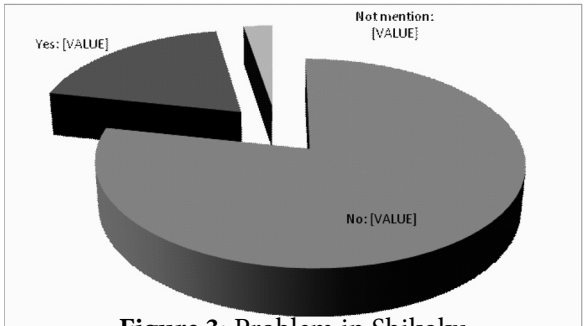


Figure 3: Problem in Shikoku

Problems in and around Shikoku: The pilgrims/tourists will be satisfied with the visit, enjoy their trip, and might repeat their visit if they have no problem at that destination. The tourism providers should work carefully to minimize problems. The respondents were asked whether they had problems in Shikoku or not. The majority of the respondents (78.4%) stated that there were no problems; however, 19% of the respondents experienced different problems in Shikoku and 2.6% of the respondents were unable to give their opinion. Furthermore, the respondents were asked to state their problems during the Shikoku pilgrimage. P-78 explains that "as a Western woman people tended to turn me away rather than treat me differently to how they think I should be treated. I was often told at temples there was no accommodation (when I knew there was). I would get Japanese people to make the calls to the temples and some ryokans on my behalf to make a booking and very often—at least once a week!—there would be availability, until they hear my name and learn that I am a westerner and a woman—then I am told no availability, we

are full!" Problems faced by other pilgrims were signs for non-Japanese readers/ speakers, hard-to-read menus, labels, and name as they were basically in Japanese, and irregular public transportation.

In answer to the question, "What are the weaknesses to develop pilgrimage tourism?" (E-5) explains that there needs to be a balance between "pilgrimage" and "tourism." If things become too touristy, then the religious or spiritual side of the pilgrimage disappears. Some foreigners have mentioned that they do not want to see the Shikoku pilgrimage turn into a Disneyland type of place. (E-6) emphasizes that temples and the temple association need to make a concerted effort to make the walk easier for walking non-Japanese pilgrims. Lodging issues, places to sit out of the rain at temples, and so forth are important. I believe that there is a general lack of concern for non-Japanese pilgrims. The temples want the numbers to increase, but no one is trying to make life easier for them. Likewise, it should be a spiritual journey to fulfill pilgrims' desires (E-3), and many travel agencies are interested only in profit (E-2). There is no official policy; most of the development is from individual interest (E-3), and young people have insufficient knowledge (E-1). (E-5) further recommends having a "Cultural/Historical Center" for the Shikoku pilgrimage near Temple 1. Many of the respondents recommended various strategies to improve Shikoku pilgrimage/tourism such as development of English Language materials, multi-lingual signs, English speakers at hotels and temples, Timetables at the bus and train stops and stations. Lodging should be cheaper, flexible with arrival time, bath time, meals etc., making it more accessible to walking pilgrims with cheaper hotels like Santiago's way…, luggage store in Tokushima for foreigners, more access to DATA and PHONE sim for short term. However, there are few voices against commercialization and bringing UNESCO something in Shikoku that could burn Shikoku out with rampant tourism. Do not kill the 'pilgrimage' spirit, culture and tradition. Reduce garbage and improve services to cater larger number of pilgrims/ tourists in the days to come.

Benefit of heritage tourism

Heritage tourism protects historic, cultural, and natural resources in towns and cities by involving people in their community. When they can relate to their personal, local, regional, or national heritage, people are more often motivated to safeguard their historic resources. Heritage tourism educates residents and visitors about local and regional history and shared traditions. Through involvement and exposure to local historic sites, residents become better informed about their history and traditions. Understanding the importance of one's heritage provides continuity and context for a community's residents, and it strengthens citizenship values, builds community pride, and improves quality of life. When a community's heritage is at the core of what you offer visitors, it is essential to protect that heritage. One has to make sure

that increased tourism does not destroy the very qualities that attracted tourists in the first place. Tourism has an impact on the resources and puts stress and strain on infrastructure such as roads, airports, water supplies, and public services. By protecting the historic landmarks and places, unique qualities, and special traditions that attract visitors, you are safeguarding these resources, and the future and vitality of your community (Speno, 2010). Tourism became the method by which the heritages could be commodified. In the hopes of halting rural out-migration and increasing visits to rural areas, the central government encouraged rural villages to recreate the *furusato* (lit. old village) or native place ideal for tourists and encouraged tourists to reconnect with their rural past by visiting such places in Japan (McMorran, 2008). It is argued that heritage has a value far beyond the price that can be put on it; a cultural value to society, both present and future, which one must not allow to become compromised by base commercial values (Garrod & Fyall, 2000). Heritage has been protected for over a thousand years in Japan. Shoso-in, the first museum in Japan, dates back to the 8th century; it is an Imperial storehouse aTodai-ji temple and a designated national treasure (included in the World Heritage List), which contains many artifacts and books from the Nara era (8th century). Many precious artifacts, buildings, and other valuable items throughout Japan have been protected by stakeholders for a variety of purposes: religious, educational, and social (Kakiuchi, 2014).

Matter of discussion

Cultural heritage plays an important role as a reflection of cultural, historical, and social values, and is often crucial for sustainable development. Cultural heritage is understood to be valuable to national and community identities, links to the past, and ongoing social cohesion. But cultural heritage is also important in promoting economic development and can play a key role in growth and poverty reduction; it can also contribute to sustainable development and to the resilience of communities and societies. To protect lives, livelihoods, and cultural heritage, it is important to strengthen the resilience of assets at risk and make disaster resilience an intrinsic part of cultural heritage management. Ongoing practice and lessons learned can help inform broader approaches to resilience for countries whose heritage assets are highly exposed to natural hazards. Multi-hazard risk and vulnerability assessments and multidisciplinary studies of heritage sites should be conducted on a periodic basis for a better understanding of risks and more effective risk mitigation investments and planning. It is important to build the capacity of government and other stakeholders for identification and monitoring of risks, risk reduction and response to disasters, and recovery and restoration efforts. Community engagement in disaster risk management is of great significance. Networks of professionals trained in risk identification, risk reduction, post-disaster recovery, and preservation of cultural heritage should be formed. In addition, agencies should be encouraged

to collaborate with academia to promote research in this area. In Japan, the work of the Institute of Disaster Mitigation for Urban Cultural Heritage at Ritsumeikan University (R-DMUCH) is recognized globally for its training of professionals across the world, and for its knowledge-sharing and capacity building efforts in Japan and beyond (WBG, 2017).

It has been interesting lesson to rest of the world how Japan has been mitigating and surviving with large scale disasters. The Japanese culture, tradition and technology must have been playing significant role for this. In response to that humanitarian crisis, it is learnt that the recovery effort was prompt in Japan. The repair and restoration of built heritage has proved to be an important social element for communities recovering from disaster. Local advocates formed a coalition to catalog the damage and coordinate domestic and international aid for the rehabilitation of cultural heritage. Local authorities in Japan have been prioritizing the needs of different sites and communities affected by the disasters. The work in affected area aimed to help reinvigorate the local economy and boost town morale by rebuilding the tourist economy. Each year visitor rates continued to grow, and substantial funds had been raised to continue assisting local residents and business owners in their recovery efforts. On the other hand, it has been more than three years that the devastating earthquake in 2015 had damaged the cultural heritages of Kathmandu valley. The temples and palaces at the world's largest concentration of UNESCO World Heritage Sites remain heaps of rubble, other structures that had suffered seismic damage were still being propped up by wooden beams, and a very little reconstruction has taken place. The earthquake-damaged world heritage sites in Kathmandu Valley are at risk of being put on the UNESCO list of World Heritage in DANGER if they are not renovated/preserved within a given time. Likewise, another cultural heritage Lumbini is also facing many problems as the Lumbini Master Plan has not been completed on time. There are problems at natural heritages as well. Heritage tourism has great prospects in Nepal. The country can benefit a lot from it and the learning from Japan could be instrumental to manage, rebuild and develop heritage sites and tourism in Nepal.

Conclusion

Japan and Nepal's remarkable heritage is not only part of what makes both the countries a popular travel destination, but also something that needs to be properly protected, maintained and preserved, so that future generations can enjoy it as much as we do today. Both Japan and Nepal have to be very optimistic about the future of tourism, particularly in heritage as it has huge potentials to be the top class tourist destinations. Tourists can experience, enjoy and feel the difference with diverse tourist attractions, unique cultures, history and religion in Japan and Nepal. Specially, Nepal can have multiple benefits from tourism. Tourists visiting means directly helping

rebuilt the country. Their contribution means a lot to boost up the tourism activities and economy, transform the best technology and practices to the needy ones. A well-preserved heritage enables communities to learn about their cultural history truly and chronologically. Cultural tourism creates jobs and new business opportunities and strengthens local economy. Heritage tourism helps also to protect cultural heritage and to improve the quality of life of residents and visitors. Linking tourism with heritage and culture will benefit the local economy. The main idea in cultural heritage tourism is to save urban heritage and culture, to share it with visitors, and to reach economic benefits.

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The Gaze Journal of Tourism and Hospitality 10 (2019) 37-50

THE GAZE
JOURNAL OF TOURISM AND HOSPITALITY

Tourism Policy of Nepal and Sustainable Mountain Tourism Development in Retrospect

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Abstract

The modern history of tourism in Nepal began with mountain tourism embodying the diversity of nature and culture, diversity, marginality, access difficulty, fragility, niche and aesthetics. Despite huge scope, Nepal has been unable to take full benefits of mountains, due to inadequate policies and fragile implementation. Pedestaled on secondary data, the key objective of this paper is to make a retrospective assessment of tourism policy and sustainable mountain tourism development efforts in Nepal. The sustainable development of mountain tourism relies on the government's plans and policies and the efficient coordination between stakeholders. But the tourism policies have not been able to adequately address mountain tourism, and this has led to unbalanced growth of tourism sector. Despite the implementation of new Tourism Policy in 2008, adequate focus on mountain tourism is still missing. There is a lacuna of adequate driving force in tourism policy and it has failed to address vital areas of mountain tourism. Hence, there is an instant need of specific and separate mountain tourism policy encompassing integrated approach (abiding federal structure and local participation in planning and management) hence making mountain tourism sustainable, responsible and sensitive--ecologically and culturally.

Keywords: *Shangri-La, mountaineering activities, touristification of globe, royalty*

Published by: International School of Tourism and Hotel Management, Kathmandu, Nepal
ISSN 2467-933X

Introduction

Tourism is a movement of financial operation which transfers money from visitors to local place. Visitors exchange money in holiday destinations: therefore tourism is also a sort of transferring operation financially (Escobar, 1994). The economic dimension of tourism is related to interconnection between tourism and economic development of the destination. With the growth of income in different countries after 1970, international travels have grown enormously and consequently tourism has been achieved as an alternative policy by different countries to support economic growth. Tourism has supported in providing foreign exchange earning to aid their import and economic development. Mill and Morrison (1992) argue that other than approaching tourism sector as a tool for development of the whole economy of or country, it brings economic benefits for the settlements; since tourism includes may subsector from transportation to entertainment; from shopping to accommodation. In the 21st century tourism has become one of the fastest growing industries in the world for the socio-economic development of many developed and developing countries. But the growth is tourism is difficult to quantity because few countries collect statistics in a way which separates purely rural from other forms of tourism (Seth, 1999).

Tourism in Nepal is the important source of foreign exchange earnings and has great prospective for the economic development of the country. Due to the bequest of beautiful landscape, natural wealth, cultural, religious and archaeological heritages, Nepal is an important tourist destination in the world. As a country of Mount Everest, the land of world famous climbers *Sherpas*, mystery of the *Yeti*, the land of Lord Buddha, Hindu and Buddhist religious shrines, splendid snow peaks, hills/mountains, rivers, lakes, waterfalls, favorable climate and mysterious charms of *Shangri-La* image, Nepal is a prime destination to foreign visitors. Having the entire key component for *holistic* tourism development, visitors are attracted to visit Nepal that provides foreign exchange earnings, provides employment opportunities at different levels and promotes cottage industries, handicrafts, trade and other services sectors. In the fiscal year 2017, 940,218 tourists arrived in Nepal which was a 24.8% growth in tourist arrival compared to 2016 (*Tourism in Nepal,* 2017).

Mountains of Nepal are the main source of attraction for tourists, trekkers and mountaineers. Of the world's 14 snow-topped high mountains over-8000m in height, 8 peaks are located in Nepal. Hence, mountaineering and trekking are the major tourism products of Nepal's mountain tourism that increases the length of stay of the tourists, support the rural economy and create a pivotal impact upon the entire tourism industry. Mountaineering and trekking in Nepal are mainly concentrated in three areas viz. the Annapurna, Everest and Langtang region because they were popularized by foreign mountaineering expedition teams. At present, mountain

tourism is a part of adventure tourism, revolving around the mountains including mountaineering expeditions, trekking, hiking, rafting, skiing, mountain biking, rock climbing, horse riding, kayaking, mountain sports, golf, ultra light aircraft, paragliding, jungle safari, bungee jumping, cannoning and study of the cultural, social, and economic reflections of the mountain people/community and so on. Therefore, there is a great scope for developing mountain tourism in Nepal for the tourists, trekkers and mountaineers. There are around 3,310 peaks along the Himalayan range of Nepal, of which, there are 1,310 peaks above 6,000m (Shrestha, 2000). The government of Nepal has opened many peaks for mountaineering, but there are still numerous unclimbed peaks.

Samy and El-Barmelgy (2005) argue that the principles of sustainable tourism development are composed of environmental, economic, and socio-cultural aspects and equilibrium among these three dimensions must be established in order to be successful in the long-term. But, in Nepal, despite natural bequests, the mountains resources have not been harnessed adequately. Sustainable mountain tourism development encompasses different components viz. natural resources preservation on which tourism depends; promoting local communities' life quality; and augmentation of tourist satisfaction. However, there are different problems and hurdles related to these. Tourism policy loopholes, imbalanced growth in tourism, the safety and environmental concerns, tourism infrastructure development, marketing initiatives for promoting mountain tourism, labour migration for abroad jobs, and reposition of Nepal's mountain tourism image in international market are the key concerns. All these have resulted due to the inconsistent policies and lack of participatory planning and lacunae of adequate driving force in policies. For sustainable mountain tourism development, a number of questions have emerged. Have Nepal really been able to exploit its mountain tourism potentiality adequately? Have the tourism policies really contributed to the growth of mountain tourism? What needs to be done to balance development with potentiality? Only if these questions are answered, mountain tourism can be developed in a sustainable manner. In this paper, attempts have been made to assess the importance of tourism plans and policies for sustainable mountain tourism development, and to identify problems concerned and counsel measures for development of mountain tourism in Nepal especially mountaineering expeditions and trekking. Pedestaled on secondary data, the key objective of this paper is to make a retrospective assessment of tourism policy and sustainable mountain tourism development efforts in Nepal.

Historical development of tourism in Nepal

Nepal has a very long history of tourism since the ancient period to modern era. The foundation of tourism was laid during the ancient period.

1. Tourism in ancient Nepal

Tourists have arrived in Nepal in some form or the other from time immemorial. According to a legend, *Manjushree* from China had made Kathmandu valley suitable for human habitation by cutting the *Chovar* Hill of Kathmandu Valley with his sword and thereby letting the water low out from within the valley (Sharma, 2033 B.S.[1]; Bhandari 2030 B.S.). Hence Manjushree can be regarded as the *first tourist* ever visiting Nepal. During the ancient era, Gautam Buddha visited Nepal during the reign of Jitedasti, the seventh Kirat King who ruled Kathmandu (Satyal, 1988; K.C. 1984). The emperor of ancient India, Ashok visited Lumbini, the birth place of Lord Buddha in 3rd century B.C. and built the Ashok Pillar there (Satyal, 1988). The Licchavi period (400-750 AD) is regarded very significant from the tourism viewpoint. The way in which art and culture developed during that period inspired the Chinese travelers to come to Nepal and write about Nepal (Satyal, 1988). The marriage relations between Princess Bhrikuti, daughter of King Amshuverma, and Srong-sten Gampo, the king of Tibet in 592 A.D. led to the establishment of special relations between the two countries (Sharma, 2033 B.S.). Nepal was developed as the only route to visit China via Lhasa and travel from China to India via Lhasa. This led to the increase in arrivals of foreigners in Nepal (Sharma, 2033 B.S., Shakya, 2051 B.S.). Chinese traveler, Huien-Tsang travelled to India in 629 A.D. and returned to China via Nepal in 643 A.D. (Sharma, 2033). He also visited Lumbini. According to Pradhan (2045 B.S.), many prominent Buddhism preachers visited Nepal during Licchavi period. During the Malla regime (750-1480 A.D.), Hindu saints and devotees from India visit Nepal for pilgrimage. Many European Christian missionaries came to Nepal to spread Christianity (Chhetri and Rayamajhi, 2061). In broad-spectrum, the ancient foreign tourists visiting Nepal were Chinese, Tibetan, Indians and Christian missionaries who visited Nepal for religious and commercial motives. Nepalese traders visited Lhasa for business and the Tibetan traders come to Nepal in connection with their business activities. Thus, religious and trading motive contributed significantly to the development of tourism in ancient Nepal.

2. Tourism after unification of Nepal

Captain Kirkpatrick's book *An Account of the Kingdom of Nepal* published in 1812 helped to introduce Nepal to outsiders. A British Resident was appointed in Kathmandu for developing Nepal-Britain relation after 1816 and there were regular visits of British nationalities in Kathmandu. Rana Prime Minister Jung Bahadur's visit to Britain in 1850-51 brought Nepal into the limelight in Europe. During that time, several British botanists, naturalists and many other personalities visited Nepal. King George V and the Prince of Wales came to Nepal for hunting tigers in the terai forests in 1911 and 1921 respectively (Satyal, 1988). The earliest published record on foreign visitors to Nepal is found in Percival London's book *'Nepal'*, where 153

Europeans mostly British are listed to have visited Kathmandu in a period of 44 years from 1881 to 1925 (Gurung, 1978). Despite these developments, the Rana oligarch's despotic policy isolated Nepal from external influence for 104 years. During that period, Nepal was a *forbidden land* for foreigners except for the diplomats, small traders and Indian pilgrims.

3. Tourism after 1950: An era of mountain tourism

Development of modern tourism in Nepal began with mountain tourism in the Himalayas. 1950s is the most important period in Nepal's tourism development because up to 1949, foreigners were prohibited to enter Nepal and most of mountaineering activities in Nepal Himalayas took place from the Northern side, via Tibet. After the advent of democracy in 1950, foreigners started visiting Nepal and an era of modern tourism started. After the successful ascent of Mt. Annapurna I (8091m), in 1950, by Maurice Herzog, many mountaineers were attracted to Nepal. Annapurna I was the first successful ascent among the 14 over-8000m peaks of the world. In 1953, the successful conquest of Mt. Sagarmatha (8848m) by Tenzing Norgay Sherpa and Edmund Hillary was a milestone in the mountaineering history of the world. The successful ascent of Mt. Annapurna I and Mt. Sagarmatha of Nepal was publicized all over the world (Lama, 2003). All 8000m peaks were successfully climbed in the 50's decade, hence, the decade of 1950's is called the golden era of Nepalese mountaineering history that led to an outstanding growth in mountaineering activities and mountain tourism. Since then mountaineering has emerged as an important facet of Nepalese tourism. The 21st century mountain tourism is related to an era of consumption, ability and economy-- a product of modernity and a force helping to shape it facilitated by globalization, modern transportation and *Touristification of globe*. Supported by large investments-money and effort, it has both advantages and disadvantages--defining who we are by helping to place us in *space and time*.

Nepal's tourism policy in retrospect

Although a very lucrative touristic destination, there was no study, plan and policy regarding tourism in Nepal till 1950s. During First Five Year Plan (1956-61), Nepal Tourist Development Board (NTDB) was formed in 1957. "General Plan for Organization of Tourism of Nepal" prepared by French George Lebrec in 1959, was the first tourism plan that suggested making posters, postage stamps of Himalayan peak, flora/fauna, to use films and documentaries for promoting tourism and establishment of separate tourism offices. In 1965 Sir Eric Franklin from USA came to Nepal for the supervision of Tourism Department (Chhetri and Rayamajhi, 2061 B.S.). In 1969 Nepal Tourism Development Committee was established for formulating the tourist policy as well as to draw a long term development plan for this sector. With the joint effort of UNDP and ILO, Hotel Management and Tourism Training Centre

was established in 1972 with a view to produce trained manpower in tourism sector. Further, plans and policies were also defined for creating suitable environment for the growth of the tourism sector. The notable efforts were the Tourism Master Plan 1972, Review of the Master Plan 1984, and defining of Tourism Policy in 1995. For the planned development of tourism, 20-year 'Tourism Master Plan' was prepared in 1972 which recommended a separate Ministry of Tourism that was established in 1977 with a view to enhance tourism. High level bodies like Tourism Promotion Committee and Tourism Council were formed to create the necessary mechanism. These activities contributed to generate market and tourism marched ahead.

Full-fledged tourism policy was announced only in 1995. Before this, the tourism sector was steered by the industrial policy, industrial enterprises act and periodical plans. The main objective of 'Tourism Policy, 1995' was to promote Nepal as attractive destination utilizing its resources and make it a vehicle of national development. This tourism policy included different working policies some of which are- participation of the private sector and general people in tourism infrastructure to be upgraded, popular religious tourism sites to be promoted, to develop Nepal as a centre for adventure tourism, quality of service and security to be upgraded, regional imbalances to be corrected and marketing in tourist originating markets to be strengthened. In this tourism policy, the government's role was limited to the involvement in infrastructure development, coordination and motivation for tourism development and hereby encouraged the participation of the private sector in the overall development of the tourism sector (HMG/ N, 1995). Thus, the tourism policy of 1995 gave special significance to the role of the private sector in tourism development but the policy was partially successful in dealing with the practical challenges embedded with tourism industry of Nepal. Study by Shrestha (1998) reveal that Nepal's tourism policy 1995 was only average and, therefore, they needed attention. For example liberalizing the policies alone was not enough, facilitation and practical support to the efforts/endeavors of the private sector was insufficient, lacking supporting programmes. The policy was not based on pragmatic realities with problems in implementation.

In 2008, a new Tourism Policy 2008 was introduced and in 2012, *Tourism Vision 2020* was announced that shaped the priorities of Nepalese tourism with a slogan *Tourism for peace, people and prosperity.* Tourism vision 2020 envisions guiding tourism development throughout the country complementing the national endeavor of economic reform and incorporating a spirit of inclusiveness for a broad-based enabling environment that sets the pace of gradual but focused change in tourism sector. Following directions set by the policy; effort is to be made for development and expansion of tourism activities, quality improvement of tourism services, increasing revenue and expansion of employment opportunities to improve the living standard

of Nepalese people. Vision 2020 envisions increasing tourist arrival to two million and tourism related employment to one million (NTS, 2016).

The main focus of the new Tourism Policy, 2008 is the need for the distribution of benefits accruing from tourism services to local community and people. Its objective is to expand, promote rural tourism activities through search, identification of new tourism sites, tourism infrastructure development, enhancement of quality of services offered for tourists, increase in accessibility, safe destination, increasing length of stay, etc. It focuses mainly on:

- Leading role of private sector in tourism, partnership approach: Public-Private-People
- Emphasis on Rural Tourism, Community based Tourism and Home-stays
- Formation of Tourism Coordination Committee, Crisis Management Committee
- Activation of Tourism Council (Apex body chaired by the Prime minister)

This policy aimed at tourism development by aligning poverty alleviation and new economic development with foreign exchange earnings, increasing employment opportunities together with raising the living standard of the people. As the qualitative and quantitative development of the tourism sector is not possible with the efforts of the government only, the need was recognized for the joint partnership of the public, community and private sectors in the venture for tourism promotion to new heights for laying the ground for economic change (GoN, 2008). The tourism policy of 2008 has certain objectives in this direction-diversification and extension of the tourism sector for developing self-employment initiatives in the people for eco-tourism and village tourism in line with poverty alleviation to raise the living standard of the people, and prepare a major basis for the national economy, development and conservation of the natural, cultural, and other resources, besides the development of the tourism infrastructure.

The special features of the policy include attracting more tourists and making Nepal an all-season destination for tourists, developing a complete package program aimed at the different categories and levels of tourists and making an air service agreement with a tourist originating market. Promotional programs are to be organized in countries other than the traditional markets. It also talks about giving recognition as *Friends of Nepal* to world famous mountaineers, globally renowned personalities who have positive thoughts about Nepal. As per this policy, steps are to be undertaken for the diversification, expansion and development of mountaineering by making mountaineering more organized and environment-friendly, to make Nepal an excellent destination for mountaineering. The royalty fee is to be waived

for some time for mountaineering in feasible areas which have not come to light. The Himalayan peaks would be gradually opened up for mountaineering expeditions. The peaks that are below a specific height and considered easy by technical standards are to be developed as trekking peaks. The trekking tourism of Nepal, an excellent tourism heritage, would be made safer, reliable and attractive. The trekking related policy-level and other management tasks will come under the jurisdiction of the Ministry of Culture, Tourism & Civil Aviation with an attempt to attract high-income tourists by making the trekking areas in operation more organized. New trekking routes are also to be identified and developed for which government investment would be given priority. It also talks of making the participation of the local community more effective. Hence from the perspective of mountain tourism, some changes have been made in comparison to the Tourism Policy, 1995, but all the mountaineering-related issues have not been addressed adequately. Also, the proper implementation strategy is lacking to translate the plans/policies in action in order to attain favorable development of mountain tourism. Very little priority has been accorded to product development, presentation and diversification. For sustainable mountain tourism development, proper planning and policy formulation is needed. But, the policy 2008, and tourism vision 2020 did not sufficiently address the issues of mountain tourism in the lack of *separate and specific mountain tourism development policy*.

In the beginning, mountain tourism was not sincerely taken as an important tourism product, but later it was realized as an important tourism product with the dramatic increase in the number of tourists for mountain tourism or trekking/mountaineering, and a decline in the number of tourists coming for holiday/pleasure. For example, in 1965, only 0.4% of the tourists came for trekking/mountaineering but by 2001 the numbers peaked to 100,828 (27.9%). By 2009, 132,929 (26.1%) tourists came with the purpose of trekking/mountaineering (NTS, 2016). In 1965, the tourists coming for holiday/pleasure purpose was 93.9% but which declined to 8.0% in 2009. In 2009, most of the incoming tourists (26.1%) came for mountain tourism. In 2016, out of 753,002 foreign tourists visiting Nepal, 65 % tourists visited Nepal for holiday and pleasure, pilgrimage (11%), adventure (9%), business (3%), official purpose (3%), and conference/meeting (2%). 66,490 (8.83 %) tourists arrived for mountaineering/trekking compared to 9,162 (1.70 %) out of 538,970 tourists in 2015 (NTS, 2016). This confirms that mountain tourism is the prominent tourism product of Nepal and the country can be the market leader in this sector. Hence, it should receive due focus in the future tourism policy with proper identification of mountain tourism products, marketing and appropriate policy for competing with other countries.

Sustainable mountain tourism development: Policy related challenges

Imagining for the management of available resources in such a way that social, economic and aesthetics needs can be fulfilled while maintaining ecological processes,

cultural integrity, biological diversity, and life support systems, sustainable mountain tourism is concerned with meeting the needs of the present tourists and the host community of the mountains while safe-guarding and enhancing the opportunities for future generations. The policy issues related to sustainable mountain tourism development efforts especially mountaineering expeditions and trekking that need to be addressed are complex permit system, royalty fees, weak infrastructure, increasing pressure on popular mountains, overcrowding, pollution, commercialization of mountains, lack of modern equipment for mountaineering, too much ascents each season, accidents, inexperienced climbers, etc.

In Nepal getting the official permit for mountaineering and fulfilling other formalities are quite complex and lengthy. The need to go to various ministries and offices for permits is annoying and time-consuming. If the issuance of various permits required for mountaineering is done through one office at Base camp, the process would not only become simpler but would also be time-saving. Also, the expedition royalty fee in Nepal is very expensive. The operating costs for reaching peaks concerned for expedition teams are also very high. As expedition teams also have to bear the cost of the liaison officer, the expedition costs run high. The deputed liaison officer for mountaineering expeditions to peaks over 6,500m, and restricted trekking areas are usually inexperienced and rapacious, many of whom bargain for allowances and equipment. These make it necessary to make reforms in the present system of appointing liaison officers. This is the reason why despite the maximum number of high peaks in the world, Nepal has been unable to reap the benefits of attracting a greater number of mountaineers. The expedition royalty fees for the shared border peaks are far less in China and India than those fixed by Nepal. The royalty fees for mountaineering in Nepal for 8000m, 7000m and 6000m or peaks below that height are also very high compared to China, India and Pakistan (Shrestha, 2008). According to Nepal Tourism Statistics Report (2016), the amount of royalty received has reduced in 2016 compared to 2015. The main reason is less number of visitors to high royalty peaks. Mount Everest contributes almost 70 percent of the total royalty received. Therefore, it is necessary to make the necessary reforms in the royalty fee structure to attract a greater number of mountaineers to Nepal.

The weak infrastructure in Nepal has made the mountaineering activities time-consuming. Nepal does not have transportation facilities to the Base Camps of important Himalayan peaks like in other countries. As the transportation and other costs are very expensive for transporting the necessary goods to the Base Camps, therefore the operating costs become very high. Transporting goods by porters to the Base Camp and back is expensive as well as time-consuming. Hence, transportation facilities should be improved so that to attract mountaineers to peaks. Small airports, aid posts, refreshments/lodges in places need to be constructed and building new

road networks ought to be speeded up. It is urgent to formulate a policy for the development of the necessary infrastructure for mountain tourism development. Further, the high customs rates on imported vehicles and other goods for tourism purpose make it difficult to provide standard services. The high customs rates, in Nepal, on other goods for the tourism sector has led to a lower standard of services offered to the tourists. The customs duties and taxes levied on mountaineering activities are on commercial basis which has made mountaineering in Nepal very expensive. There is, therefore, the need for liberal customs rates on mountaineering equipment and other goods.

In 2014, in an effort to expand mountain tourism, the government published a list of 104 new peaks open for climbing, that resulted in commercialization of mountains, too many ascents each season, overcrowding and accidents posing a continuous danger for climbers. The melting glaciers and snow exposed more rocks and rubbish along the mountain trail which is detrimental for the diversity of Himalayan ecosystem and local communities as well to the climbers. It has resulted in rising mountain temperatures, pollution and global warming that brought about substantial negative environmental changes in the Himalayan landscape. Mountain Everest has become a mountain of trash and a *pyramid of human excrement* in snow that can be detrimental if leached into drinking water sources down slope to the local Sherpa community. However, the monitoring and supervision of the garbage management by the mountain expedition teams has not been effective in Nepal Himalayas (Shrestha, 2008). The garbage pile up in the Himalayas has increased rather than being on a declining trend which has created a severe environmental crisis in the Himalayas. Therefore, instead of the present Garbage Deposit system, the mountaineering expedition teams should be charged the Environment Fees based on the height of the peaks that they attempt. A special fund has to be created from the fees collected for utilization in garbage management, clean-up works of Nepal's popular mountains. The Garbage Deposit system is irrational because monitoring is difficult, there is more administrative annoyance, and refunding the deposit is complicated.

The mountaineering activities are restricted to the popular peaks; hence pressure has increased on these mountains, while trekking activities are very limited to the major trekking areas. Despite the opening up of other peaks for mountaineering, mountaineering activities are taking place only in few peaks while there is no activity on the other remaining open peaks. The lack of mountaineering and caravan routes to many peaks is the reason why mountaineers have not been attracted to other peaks, besides their publicity and promotion are inadequate. There are many feasible peaks for mountaineering, but they lack appropriate mapping, caravan routes, and have not been named which has resulted in their not being used for mountaineering activities.

Similarly, trekking is confined to specially Annapurna, Langtang and Sagarmatha areas. There are many trekking areas like Poonhill, Gokyo, Upper Dolpo, Kanchenjunga, Makalu, Manaslu, Lower Dolpa, Mustang, Upper Mustang, Dhorpatan Circuit, Kanchenjunga base camp etc but they have not been publicized and promoted. The Rara Lake also called *the nymph of heaven* lacks transportation facilities, high charges of trekking permit fees and has not received publicity/promotion. New trekking sites that need publicity are: Dhudpokhari Khaling Trekking, Jaljala Hill Trek Jaljala, Tsum Valley Trek, Numbur Cheese Trek, Pikey Peak Trail, Rolwaling Trekking, Tamang Heritage Trails in Langtang region. Likewise there are different short treks which need promotion viz. Ghorepani Ghandruk Trekking, Dhampus Trekking, Panchase, Ghandruk, Helambu.

Owing to inexperienced climbers and many other reasons, accidents are common during expeditions. To carry out rescue missions, the use of communications equipment like satellite phone, radio, and walkie-talkie is widespread during mountaineering in other countries and they have a liberal policy for such equipment. But in Nepal, such imported equipment are very expensive due to high custom rates. Thus, for the convenience of the mountaineers, trekkers and adventure seekers, the policy for the import of the communications equipment must be simplified and reforms must be made in custom rates.

Nepal has not been able to garner adequate benefits from the 92 mountain peaks of Nepal bordered with China and India, because many border peaks have not been opened for mountaineering in Nepal, and those peaks which have been opened lack the basic infrastructure to reach the Base Camp, and they have not become attractive destinations because of the lack of publicity and promotional activities. In order to take benefits from border peaks, policy reforms need to be made with necessary infrastructure building including developing transportation, waiving the royalty fees for particular peaks through selection, and need to do publicity for the promotion of border peaks. Both the old peaks and new peaks have to be promoted with adequate safety measures. The Great Himalaya Trail network of existing trails which together form one of the longest and highest walking trails in the world, needs adequate promotion so that to facilitate in the development of the remote and untouched areas. Nepal needs planned promotion of adventure products to get benefit from the flourishing adventure tourism keeping in minds the needs and expectations of modern travelers. It is of vital importance to strengthen the National Flag Carrier and to promote the credibility of Nepali airlines. Sustainable mountain tourism development is not feasible without the greater involvements of local communities; hence their active participations and contributions on participatory decision makings and benefits sharing are essential for the all-inclusive development of mountain tourism, and for the fulfillment of the livelihoods of mountain communities. Hence,

a review on existing tourism policies and regulation and crafting the measures to ensure local participation is necessary for the sustainable development of mountain tourism in Nepal. Protection and conservation of mountains and local communities and attracting more foreign tourists should be the key priority.

Conclusion

Modern tourism in Nepal started with mountain tourism, sector emerging as an important sector--a boon to local and national economy and for sustainable development of mountains. But due to weak policies and fragile implementation efforts, Nepal has been unable to capitalize on the huge possibility of mountain tourism. The tourism policies have not been able to adequately address the appropriate development of mountain tourism, and this has created problems with mountaineering expeditions and trekking. Sluggish, impractical policies/ strategies, lack of vision, expertise, harsh bureaucratic norms and procedure is affecting implementation. Political instability is also a contributing factor. As the development of mountain tourism relies on the plans and policies of the government and adequate coordination between all stakeholder-*public and private*, appropriate plans and policies are necessary to make mountain tourism development sustainable. As mountain tourism is the major product, there has to be appropriate plans and policies and their effective implementation. But, there is a lack of specific and separate policy for mountain tourism. In the beginning, there were very few tourists who came with the purpose of mountain tourism; therefore it is possible that this sector was included in general tourism policy. But now, with the raising number of mountain visitors, and mountain tourism as a prominent tourism product, there is a need for an appropriate, specific and separate mountain tourism policy. It is because of this reason Nepal is facing difficulty in competing with other countries which has not led to the requisite development of mountain tourism despite the potentiality. As sustainable mountain tourism is *responsible tourism* which should be both ecologically and culturally sensitive hence an integrated approach to mountain tourism planning and management is now required to achieve sustainable mountain tourism. Abiding by notion of federalism and local peoples participation, a code of practice should be established for mountain tourism at all levels - national, regional, and local. Also guidelines for tourism operations, impact assessment, monitoring of cumulative impacts, and limits to acceptable change should be established. In the process, education and training programs to improve and manage heritage and natural resources should be established by ensuring local participation. It is necessary to develop new types of products and consolidating products that are currently emerging and targeting new high yield markets. The focus and efforts should be on *consolidation* and *expansion* via quality control to maintain the quality improvements that have been achieved.

Concurring to Brown et al (1997) and Shackley's (1996) argument that the environmental and social carrying capacities of tourism in the Nepalese Himalayas have already been exceeded, adequate attention need to be given in tourism policy to environmental dimension of mountain tourism. Though tourism in the Nepalese Himalayas has not been overwhelmingly positive, positive changes for the livelihoods and the environment of the mountain dwellers are slowly taking place and will gain momentum given the right institutional and political setting in the country and support from the international community as claimed by Nepal (2000). For it, there is an immediate need for suitable, specific and separate mountain tourism policy in Nepal adequate enough to focus on maintaining ecological balance, cultural integrity, biological diversity, and life support systems while meeting the needs of the present tourists, the local mountain communities and safeguarding the opportunities for future generations.

Note

1. B.S. or Bikram Sambat is the Nepali calendar 56 years 8 months ahead of A.D.

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The Gaze Journal of Tourism and Hospitality 10 (2019) 51-66

THE GAZE
JOURNAL OF TOURISM AND HOSPITALITY

Destination Management: Nepalese Efforts, Experiences & Challenges

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Abstract

Nepal with diverse geographical landscapes, rivers, mountains and alluring religious and cultural sites, has been declared as top first destination amongst various global destinations. Standardized destination management efforts with designated entities has not gone satisfactorily as expected, resulting poor inbound tourism in Nepal. This article will go around the various initiatives taken for the destination management from both government and non-government level and their implications for successful ecotourism practices in Nepalese perspective. Ideal destination management is all about providing convincing safety and security, logistics, entertainment, health and sanitation and much other to the tourists.

Keywords: *Alluring, destinations, satisfaction, management, ecotourism*

Introduction

The places and venues which are visited by the tourists, both domestic and external, for their varied interests and purposes like entertainment; adventures, sightseeing, cultural assimilation etc. are the destinations in tourism literature. As tourists are attracted by the specific features that destinations hold, their frequency for the visit would go increasing, spending pattern goes changed and intensified and eventually their stay and occupancy too get longer. So, the management of such venues to coincide and concurrent to meeting their needs, interests and desires is of much value.

Destination management is the coordinated management of all the elements that make up a destination. It takes a strategic approach to link-up these sometimes very

Published by: International School of Tourism and Hotel Management, Kathmandu, Nepal
ISSN 2467-933X

very separate entities for the better management of destination. Joined up management can help avoid duplication of efforts with regards to promotion, visitor services, training, business support and identify any management gaps that are not being addressed.

It goes without saying that long-term investment in domestic tourism will also serve Nepali economy. The study by World Tourism and Travel Council (WTTC) on the economic impact of travel and tourism in Nepal reveals that in 2016, the direct contribution of travel and tourism to GDP was Rs 85.2 billion which is 3.6 per cent of the total GDP. Meanwhile, the same study shows that in 2016, the total contribution of travel and tourism in providing employment, including jobs indirectly supported by the industry was 6.4 per cent of total employment. The study clearly indicates that development in tourism sector paves the way for economic growth. It's now time for Nepali tourism sector to come up with concrete plans and take charge of domestic tourism, and for Nepalese to explore the wonder their country has to offer. (Bashyal,2018)

Tourism industry plays significant role in economic and overall development of the country. As per data of WTTC-World Travel & Tourism Council 2014, it depicts that travel and tourism generated US$ 7.6 trillion (10% of global GDP) and 277 million jobs (1:11 jobs) globally. In Nepal, it was NPR 171.6 billion (8.9 % of total GDP) and 1,059,000 jobs (7.5% of total job) (Gaire, 2011).

Literature review

Nepal is well known in the map of global tourism as one of the best destinations because of its unique natural beauty, immensely rich bio-diversity, multi-ethnicity, variety of languages and religion, social heterogeneity and historical as well as cultural heritages(MOTCA,2009).

Many travel planners and visitors regard Nepal as one of the top destinations to visit every year. (Khatri, 2018)

A tourist destination is a place which is very often visited by many domestic and international tourists. It can be a city, town, historical place, sea-beach, mountain, an amusement park, museum or some kinds of religiously important place. A tourism destination may contain one or more tourist attractions and sometimes some tourist traps. Tourists have different choices and that is why different tourists choose different kinds of tourist destinations. Like a simple place can be the most important and illusive place to someone who love sports if any big sports event is arranged in that place (Yeoman, 2008, 4-13)

Tourism is fast growing businesses in the world; it because the population have enlarged their free time and based on the cost of travel is not higher. Tourism

boosts the employment and the revenue generation; tourism also contributes to the international trade among countries and supply beneficial foreign exchange. (Regular, 2012). Therefore tourism is a quicker developing sector in the world, it because these days people have the ability spend the money go to travel see around the world. Ramgulam (2012) cites as World Travel and Tourism council, (2009) also stated that tourism is fast growing business, so that it smooth the progress of the tourism development the WTO support countries diversify their economy.

Destination is very vital in the tourism sector. Destination Management Organizations (DMOs) is playing a major role in the running destination network, and it also helps to raise the relationship between the cooperation and the destination actors. (Pechlaner, 2012). Moreover destination believes as a tourism product. A destination not creates by one action then can become a destination it needs other process just can build "a destination product such as the tourism attractions, tourism institutions, transportation, hospitality, food and beverage lastly is host community. Gather all the operation it can build a successful destination package. (Botti, 2009)."

Destination is 'a physical space in which a visitor spends at least one overnight. It includes tourism products such as support services and attractions, and tourism resources within a day's return travel time. It has physical and administrative boundaries defining its management, and images and perceptions defining its market competitiveness.' (UNWTO, 2007)

A Destination can be regarded as a combination (or even as a brand) of all products, services and ultimately experiences provided locally.(Kunwar,2017:169) The renowned destinations could raise their level of income, if the tourism products are diversified ensuring increased satisfaction level of the tourists.

Destination management is the functions focused towards a specific tourist destination to boost the level of satisfaction and extend the staying period of the tourists. The concept of destination management has been developed on the basis of recognized industrial economics and management theories (Keller & Koch,1997; Bieger, 2002.) Ideal destination management is all about providing convincing safety and security, logistics, entertainment, health and sanitation and much other to the tourists.

Destinations are the real competitive factors within the tourism industry (Pechlaner and Weiermair,1999;Bieger,2002).Destinations are areas where customers benefit from all the services they deem necessary for a stay according to their needs. The greater the distance from the resident country of the guest, the bigger the destination areas has to be defined , and the more specific the interests of the guest, the smaller the destination must be defined (Kunwar, 2017).

Nepal as a Himalayan nation has enormous tourism prospects. If many unexplored regions of Nepal are identified along with popular tourist destinations the Himalayan state can make remarkable progress in the field of tourism (Himalayanglacier, 2015)

Attributes of tourist destinations

Tourist chooses one destination over another because of the destination itself, customers' ability to access the area, cultural and social and physical appeal. It requires an equitable sharing of benefits, with a focus on alleviating poverty.

In dealing with tourist destination there are many characteristic that affect the appeal of the area, such as infant mortality, life expectancy, level of poverty and migration from rural to urban.

Destinations that fail to maintain the necessary infrastructure or build inappropriate infrastructure face significant risks. A destination's attractiveness can be diminished by violence , political instability, natural catastrophe and adverse environmental factors and overcrowding (Kotler & Armstrong,2002).

There are many destinations that have multiple attractions, which can appeal to a broad segment of the market. One way of categorizing destination attributes is based on the following.

- Natural resources (climate, beaches, mountains)
- Cultural resources(historical sites, museums, theatres and the people themselves)
- Convention and conference facilities (major public investments to attract business visitors to resort or city destinations)
- Recreational facilities (theme parks, ski slopes and marinas)
- Events (Mardi Gras in New Orleans, Rio Olympic games, marathons, international expositions, music festivals etc.)
- Specific activities (Gambling in Las Vegas or Monaco, Shopping in Hong Kong or theatre in New York)
- Psychological appeal of romance, adventure , and remoteness (Gee et al,1997:134)

With but little variation among studies (travelers in choosing a holiday destination), the list of the most important attributes are as follows:

Weather, Scenic beauty, Hospitable attitudes of the local people, Suitable accommodations, Interesting culture and way of life, Reasonable prices, Safety and security, Favorable currency exchange.

The five top destination features were identified by the Japan Travel Bureau Foundation for the 1990s as follows:

(i) Resort (ii) Safety (iii) Scenic Beauty (IV) a city's charm and (v) culture (Gee et al; 1997:134).

Elements of tourist destination

Destination should encompass some specific features and characteristics to attract and appeal large number of tourists with diverse interests, needs, desires and background. It needs to take in to account of their budgetary strengths and purchasing power as well so as tourism products and packages for the distance destination could be designed accordingly.

Destinations that fail to maintain the necessary infrastructure or build inappropriate infrastructure face significant risks. A destination's attractiveness can be diminished by violence, political instability, natural catastrophe and adverse environmental factors and overcrowding (Kotler & Armstrong, 2002)

Dickman's (1997) has suggested five A's of a Destination as follows: Five A's of a Destination

Attractions, Activities, Accessibility, Amenities and Accommodation

There are 8 A's to highlight the features of any destinations. They can be enumerated as follows.

Attractions: Natural (Himalaya, lake, sea, landscape, rivers, beaches, etc.)

Man made (historical monuments iconic buildings such as the Eiffel tower, heritage monuments, religious buildings, conference and sports facilities, museums, theatres, art galleries, cultural events)

Access: (Air, land, sea)

Accommodation: (hotel, resorts, home stay, camping, time sharing sites, recreational vehicles etc.)

Amenities: (facilities such as visitor information, recreations facilities, guides, operators and catering and shopping facilities) actions Resources

Activities: Natural (fishing, hunting, bird watching etc.), Man made (cultural show, swimming, game etc.)

Affinity: (relationship between host and guest), guest is god, decoration, smiling, hospitable behavior etc.

Actors: Stakeholders (Government, local community, business organization) Human resources: (skilled, semi-skilled, labor)

Act: Rules/regulation

Administration: Planning/Management

Working modality for Destination Management

Destination management could be successful if there is a proper coordination between and among the relevant stakeholders

Involvement of public and private sector stakeholders

- National (MOCTCA, NTB)
- Economic development agencies
- Local authorities/government (DDC, Municipality, VDC)
- Town centre management organizations
- National Park/ Protected Areas authorities
- Transport companies
- Event's Organizers
- Cultural organizations
- Accommodation providers (hotel, motel, resort etc.)
- Restaurant, leisure and retail operators
- Intermediaries (for example tour operators and conference organizers)
- Destination representation agencies
- Media
- Local tourism associations and partnerships (local tourism development committee)
- Representative Agencies (NATTA, TAAN, HAN, REBAN, TURGAN etc.)
- Skills development organizations.(Khadka,2016)

Co-ordination and co-operation mechanism of stakeholders

- Tourism management development groups
- Liaison groups
- Functional groups
- User groups for:
- Joint strategy development.
- Joint destination management planning.
- Implementation on a coordinated basis.
- Product development and promotion projects.
- Bringing together partners for focused project

- Planning (including investment planning) and
- Implementation over specific time scale (Khadka,2016).

The process.

The Destination Management Plan (DMP) is a key instrument for building partnership and commitment.

- Integrate the action of separate organizations
- Confirm and strengthen the link between strategy and action
- Apply the DMO's knowledge and expertise to the project planning of other organizations
- Foster an evidence-based and learning approach to destination promotion and management (Khadka, 2016).

Challenges of destination management

Spontaneous flow of the tourists can be ensured if the tourist destinations possess the characteristic features and values that majority stake of tourists prefer to. It is highly significant to develop a specific brand value of the tourist destination as per the situation that destination is being served to the tourists. The factors that pose hurdles to develop a place as an excellent tourism destinations are obviously the challenges of destination management. We can enumerate the numerous points as challenges of destination management in Nepalese context.

In Nepalese context, political variability comes as one of the major challenges and restraints in development of tourism sector. Decade long disturbance in Nepalese political scenario by Maoist insurgency changing of government time to time, disagreement among political parties and leaders has stalled the potential of tourism growth of Nepal. Moreover, Nepal ranks at top in context of foreign labor migration. Fact and figure of government and other says that there are more than one million Nepal migrant workers including 100 thousand female who are working outside Nepal. These have resulted in lack of youth and energetic work force needed in tourism field. (Khatri, 2018)

Overall increase in inbound tourism is an outcome of proper destination management over varied destinations in the country to some extent.

Some of the problems and challenges of destination management are as follows:

(i) Slow and slack of infrastructural development

Nepal is beautiful country with countless natural sceneries, historical and religious sites, arts & architecture and social cultures. Nepal can be the best tourism destination with the abundant availability of their unique features. But due to lack of

infrastructural development it is unable to utilize its features. If we are able to provide all the infrastructural facilities to the destinations, we can appeal a large number of tourists to visit our country due to only such appealing destinations.

(ii) Lack of conservation of cultural and religious sites:

Nepal is country rich in cultural and religious sites which helps to attract large number of tourists. Some tourists are researchers and nature lovers as well. The destinations where they can enjoy and envision the efforts of conservation and value retention, they would be more attracted towards such destinations.

But due to lack of conservation activities such sites are being deteriorated which hampers tourism development. (Gaire, 2011)

(iii) Inadequate means of entertainment:

The means of entertainment for tourists are not sufficient and properly managed. As mainly tourists visit Nepal to pass their leisure time by hoping to get more entertainment. But means of entertainment are not properly managed for tourists. So, it is a major problem of tourism industries.

(iv) Lack of tourists goods:

The goods which are used by tourists are not produced in Nepal. The tourist's goods are imported from different countries which are very expensive. If the required goods are manufactured in our country many tourists will visit Nepal.

(v) Lack of proper tourism centers:

We do not have proper tourism centers and help desks to provide them necessary information. Tourists does not want visit places without any information. So, tourism centers should be established in order to increase number of tourists.

(vi) Inadequate Publicity:

Nepal is the beautiful country with various natural, cultural and historical sites. But without its publicity it has got no importance. Efforts to publicize Nepal in international arena are not sufficient yet. Nepal is unknown to many peoples in the world which affects tourism development. Means of publicity should be tourists focused and so the information could flow to target tourists of varied nature.

(vii) Poor provision of facilities and safety for tourists: We are still poor in providing better facilities and security to the tourists which is deserting tourism development in our country. They should be free from fear and provided with better facilities which helps to increase number of tourists. Tourism destinations should concentrate their efforts towards the incorporation of trendy facilities considering the need and interests of tourists. And the tourists should feel safe and secure while

being involved in entertainment and adventurous activities like Trekking, paragliding, Bunzee Jumping, rafting etc.

(viii) Internal conflict:

Even though, decade long political turmoil has come to an end, there is a high chance of internal conflicts in Nepal such as strike, Banda, political movements etc. which damages the reputation of tourism development in Nepal among the tourist community. The destinations which fall into such reasons which are much prone to strikes and political movements would obviously lead to the flux of tourists than in the normal and fair condition.

(ix) Lack of effective marketing and management:

Potential destinations are not having suitable and timely advertisement and promotion. Even with existence of various tourism organizations, government bodies and others, the potentials of tourism have been left behind. One of the main causes is the absence of sound co-operation between these organizations which is very essential. Politics and interference can be found from lower level to upper level in most of the organizations.

(x) Lack of long run strategic and tourism plan and policies:

Nepal can explore and exhibit the high potential of religious tourism as we have well exercised the sense of religious harmony. We do not have conflicts in the name of religious sites, significance and celebrations. It could be one of the good points we have to show for the tourists. Devghat, Muktikshetra, Lumbini might be the exemplary destinations to show our religious harmony and tolerance.

Nepal can be cultural and pilgrimage tourism hub for Hinduism from India and Buddhism for China. But it should increase the carrying capacity of demanding arrival from both countries in future.

Timely review of policies is needed in order to assure plans are executing as expected and to eliminate the constraints that may arouse during execution. Moreover, government and private sector should work together to allure and create favourable environment for investors in infrastructure development such as attractions (natural and man-made) accommodation (hotel & homestay), accessibility (land, air, and sea) lastly amenities and facilities needed to facilitate tourist in visit like ATMs, restaurant, parks, information centres (Gaire, 2011).

xi) Lack of tapping seasonal visiting trend of Tourists at specific destinations.

Most of the Nepalese tourist destinations are popular on seasonal basis and get the number of tourists excessively swollen. It seems difficult to handle and accommodate such large number of tourists during the season. Once the season gets over and

number of tourists goes lower, it would be good to plan and implement the policies for the next season so as increasing number could be adjusted easily. But, there lacks such a trend and practice that there should be a new beginning from zero level in every newer season.

As there seems a higher trend of tourists to visit some specific destinations in certain seasons, such trend should be tapped well to attract more number of tourists for the season because need to wait another season for the flow of tourists again. Seasonal income should help sustain the administrative and subsistence cost for the remaining period with considerably poor number of visitors. As there is a long holiday trend in Nepal during Dashain and Tihar and thus people go for holidaying to Himalayan destinations, they should be well prepared to welcome larger flock of tourists during such festive seasons.

xii) Lack of regular destination development efforts

Need and interests of tourists keep changing as per time, situation and place. And so, destinations need to be developed considering these factors. Destinations developed once based on the need of a certain clusters and canopy of tourists, might not be the same in terms of their attraction and beauties. So, there should be regular efforts for their timely development to attract and retain the good flow of the tourist round the year.

xiii) Lack of 7 Ps analysis for destination marketing.

Destination package should be considered as a product or offerings for the tourists and so need to be quantified and exercised from product perspective. As in marketing a product in business, 7 Ps concept (Product, price, place, promotion, people, process and Physical evidence) should be exercised tactfully. Tourism destination branding is a general concept; destinations can be branded like products or people. The power of branding is in making people aware of the location and linking desirable associations (Damnjanovic, Kravic & Razek (n.d.).

Just as in the commercial marketplace, destination "brand image" provides a short cut to an informed buying decision. Branding acts like a calling card that opens door, creates trust and respect and raises the expectation of quality, competence and integrity (Anholt, 2009).

Nepalese efforts for destination Management

The prospects of domestic tourism in Nepal largely depend on the physical attraction of the destinations. Nepal has an immense opportunity for tourism development. Despite many political challenges and infrastructural hurdles, tourist arrival has been growing steadily in recent years. Investment in the hospitality industry has also been growing accordingly. Tourist arrival, which was hit hard by the earthquakes of 2015, started picking up from 2016, when the country welcomed

729,550. In 2012, tourist arrivals had hit an all-time high of 796,946 due to positive impacts of Nepal Tourism Year 2011 campaign (*Republica*, 2018).

Tourism is a people business and the involvement of local community in tourism sector makes the community more sustainable and also strengthens the sense of ownership. Majority of the tourist hotspots in Nepal lies in rural vicinity where people have gradually adopted professionalism in their business to adhere to the growing need of tourism.

The Nepali tourists are in great advantage as they have a variety of choices ranging from pilgrimage destination, wildlife destination, trekking destinations to holiday destination. There are plethora of activities like mountain climbing, rock climbing, kayaking, canoeing, rafting, bungee jumping, mountain biking for Nepali travelers who are enthusiastic about adventure tourism.

In order to uplift the sinking tourism industry, the government had declared the year 2073 as the Nepal Travel Year to promote domestic tourism. The Nepal Tourism Board (NTB) had allocated Rs 2 million for executing promotional activities. Last year, there was an exponential growth in the domestic tourism sector as around 4.5 million internal tourist visited different parts of the country. For the development of domestic tourism, NTB is currently continuing the last year's Travel Nepal programmers and has also added other programmes such as Photo Nepal for advocating Nepali tourism through photography, Safa Nepal to promote cleanliness around heritage sites and Chulo Nepal to promote Nepali food along with food hygiene. NTB is also running programs to support home stay services through market linkage, capacity building and other training schemes (Bashyal, 2017).

Domestic tourism in Nepal is mainly reliant upon seasonal trends. Majority of Nepalis pack their bags and head for tourists hotspots like Manang, Mustang, Rara Lake, Ghandruk etcetera only during peak season. As a result, the tourism entrepreneurs and investors in these places find it difficult to safeguard their investment and effort only through tourism. Therefore, the notion of tourism based economy is not a reality for these localities.

According to data compiled by Department of Immigration (DoI), Nepal welcomed 940,218 tourists in 2017. The government had set a target of welcoming one million visitors during the Nepal Tourism Year 2011 campaign. But the target has eluded the tourism sector so far. Though the target of welcoming one million tourists could not be achieved in 2017, tourism entrepreneurs are buoyed by the arrival figures. The tourists industry of the country is gradually improving with the increasing number of tourist arrival.

Over the years, more resources have been allocated for external tourism and this form of prioritization has led to the poor growth of domestic tourism in the country.

As per NTB, in line with Visit Nepal year 2018, it has designed some programmes under the campaign like photo exhibition, talk on mountaineering, 'Send a friend to Nepal' campaign, tourism promotion through Nepali restaurants in Europe, Buddha Jayanti and Everest Day celebration in Europe, FAM trips for travel tour operators and media, and training for Nepali diaspora to promote Nepal's tourism, among others.

Recommendations

Based on the above discussion and analysis, it seems better to furnish following recommendation for the destination management in Nepal.

- NTB should also engage in dialogue with the private sector and allocate budget for programmes after discussions and consultation."
- Infrastructure must be built across the country if we want to venture into new areas and engage people within the country for tourism purpose."
- Opportunity to compare the destinations in terms of their features and uniqueness.
- Proper incentive and motivation to the staffs from the specific destination
- Purpose analysis for Appropriate and trendy hospitality services

Development and execution of guidelines for the regulation to DMOs

Destination marketing organizations (DMOs) are responsible to promote the long-term development and marketing of a destination with its key components like attractions, transportation, restaurants, accommodations, events, guided tours and other retailers serving travelers in an exact model. DMOs are concentrating on convention sales, tourism marketing, and services. DMOs are also creating public awareness about their destination; arrange booking for the meetings and event business that feeds the economic engine of the region. Much of literature on destination marketing has focused on attempting to understand the competitive market environment for destinations. In spite of the collaboration need in promotion, less attention has been paid to enhance destination competitiveness all together. To contribute to broader destination development goals, all key components of a distinct destination have to come together. In the literature, the collaboration issue takes place as within and between destinations (www.researchgate.net).

Diversification and contextualization of tourism products and packages

Tourists may not prefer same types of products time and again rather seek varieties and novelty. Products should also be time and situation specific so as it can please and appeal tourists a lot.

Encouraging tourism package to ensure repeat visit of the tourists by different programs, packages or offers.

There should be the different packages to address the varied needs and economic level of the tourists so as all groups could enjoy at their fullest and be accommodated.

Regional cooperation and promotional campaigns within the country or outside the country

Destination management would go fruitful if all the relevant stakeholders from all level are taken into this journey together. All can play their respective roles, bigger or smaller, and eventually could feel their ownership over the success story.

Sensitization for community ownership

Involvement of local public for the planning and implementation of destination management projects and strategies as it creates sense of ownership is much important. The involvement of youths in adventure tourism is very positive for the industry. The tourism in rural areas must rely on the involvement of local communities. So there should be such packages to ensure public participation for wholesome community ownership at the end.

Development and execution of guidelines for the regulation to DMOs

- Coordination between and among the ministries and other administrative units of the government
- Development and promotion of trending and emerging destinations
- Designating celebrities and leaders as brand ambassador for the promotion of specific destinations
- Exposure visit between the management committees of various destination for mutual learning and sharing .
- Formulation of effective and implementable periodic plans
- Developing brand specific destinations like Dhaka Topi from Palpa, Khuwa from Thecho.

Conclusion

Nepalese tourism sector has managed to bounce back even if it had a serious blow by the devastating earthquake of 2015. It's all been possible due to meticulous planning, strong promotion and large investments. NTB, private sector, government authorities must demonstrate the same spirit in order to promote domestic tourism through effective destination management.

Tourism in Nepal has faced lots of up's and downs. Proper marketing and promotion is highly essential to establish good image of Nepal in international arena.

Domestic tourism needs to focus with promotional packages to suit income standard and purchase parity of the people. Similarly, rural and village tourism need to be considered as Nepal itself being a country full of villages and countryside. Government, tourism organizations, stakeholders in management, Police and Administration need equally be involved responsibly to control illegal and unethical practices in tourism sector and develop control of new destination, and vision for sustainable tourism development

Inadequate infrastructure, improper management of tourist destinations and lack of promotion are some of the major problems impinging the growth of domestic tourism. The fact that tourism destinations spread across the same region are not linked through road ways and visitors have to rely upon airways is a worrying factor that needs to be addressed. It is very difficult to implement a collective model for the development of tourism within a region due to poor transportation network. Lack of promotion is another matter that needs to be resolved. Even though Nepal is promoted globally as a perfect gateway to experience the beauty of rich natural environment and cultural heritages, lack of promotion of tourist destinations within the country is indirectly forcing people to tour foreign destinations.

Nepal with diverse geographical landscapes, rivers, mountains and alluring religious and cultural sites, has been declared as top first destination amongst various global destinations. Standardized destination management efforts with designated entities has not gone satisfactorily as expected, resulting poor inbound tourism in Nepal.

It's a high time to pay attention on destination development through quality assurance, sustainable transportation system and promotion of local distinctiveness. Plan should be devised to retain and repetition of the visit through revising tourism packages of the destination. Everything should run by plan and systems rather than by god's grace. Tourists sometimes, especially research and promotion focused, prefer to look into the convincing sustainability plan so as they could raise fund themselves for the promotion, development and diversification of the destination itself.

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The Gaze Journal of Tourism and Hospitality 10 (2019) 67-123

THE GAZE
JOURNAL OF TOURISM AND HOSPITALITY

Medical Tourism and Hospitality in Hospital

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Abstract

Medical tourism is a growing phenomenon with policy implications for health systems, particularly of destination countries. Both private sectors and the governments of such destinations are found playing important role for medical tourism promotion and development. This study tries to highlight a conceptual analysis of medical tourism, the targeting of *medical tourism flows and major destinations, and the proposed medical tourism development strategies based on the experience of several countries regarding medical facilities. Medical tourism, where patients travel overseas for operations, has grown rapidly in the past decade, especially cosmetic surgery. The review of current literature reveals that no integrated theoretical framework for the holistic study of the medical tourism industry exists. This study examined whether the scholars who studied medical tourism and hospitality in hospitals found interrelationship between those two different sectors. Those who studied medical tourism or healthcare tourism didn't touch on hospitality provided to hospital patients. Likewise, those who studied hospitality in hospitals also ignored the dimension of tourism. In this regard, this study shows the interrelationship between these two entities. i.e medical tourism and hospitality in hospitals which are very important for understanding the concept of medical tourism in better way. Additionally, this study also enters the sphere of cross cultural behavior and intercultural communication between the hosts and the guests.*

Keywords: *Medical tourism, hospitality, typology, authenticity, policy implications*

Published by: International School of Tourism and Hotel Management, Kathmandu, Nepal
ISSN 2467-933X

Background

Tourism is one of the leading economic forces. The travel and tourism industry accounts for $4.4 trillion of economic activity worldwide (World Bank Group,1998;in Bookman & Bookman,2007,p.21), leading UNCTAD to call it the world's largest industry (McLeran, 2003; in Bookman & Bookman,2007, p.21). Lundberg et al. (1995; in Bookman & Bookman, 2007, p.21) claim, "Tourism has become the world's largest business enterprise, overtaking the defense, manufacturing, oil and agriculture industries (Wharton Economic Forcasting Association; in Bookman & Bookman,2007,p.21). It has grown at twice the rate of world gross national product (GNP) during the 1990s[5] and in 2005, it accounted for over 10 percent of world GDP. As the fastest growing foreign income sector worldwide, tourism accounts for 8 percent of world export earnings and 37 percent of service exports (Benavides & Perer-Ducy,2001; in Bookman & Bookman, 2007, p.21). While most of the tourist activity that causes this growth tends to be concentrated in Western countries, developing countries are very impressed with its economic potential. They have come to view tourism as a panacea because it increases the flow of foreign currency, contributing directly to the current account of the balance of payments and generating successive rounds of economic activity; leaders are therefore quick to offer their natural resources. As Cynthia Enloe noted, countries are increasingly putting all their development eggs in the tourist basket (Bookman & Bookman, 2007, pp.21-22).

Hospitals are health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver medical, nursing and related services 24 hours per day, 7 days per week. Hospitals offer a varying range of acute, convalescent and terminal care using diagnostic and curative services in response to acute and chronic conditions arising from diseases as well as injuries and genetic anomalies. In doing so, they generate essential information for research, education and management. Traditionally oriented on individual care, hospitals are increasingly forging closer links with other parts of the health sector and communities in an effort to optimize the use of resources for the promotion and protection of individual and collective health status (WHO, 2018; in Hussain & Babalghith, 2014, p. 62).

In suggesting that there was a place for hospitality in the hospital setting, Cassee and Reuland (1983) highlighted the challenge of describing the concept of hospitality and in particular its relevance to hospitals. Initially, it seems that there is a good case for seeing hospitality as an important attribute of a satisfactory hospital stay and further that the more at ease people feel, in the hospital situation, the sooner they recover. To access how applicable the concept of hospitality is to the hospital situation, a closer examination of the concept is required (Hepple, Kipps & Thompson, 1990, p. 305).

Although the words hospital and hospitality have the same root, some hospitals have been seen as not very hospitable places. During the 1980, when hospitals and other types of health care organisations began to compete for patients, being hospitable was seen as offering a competitive advantage (Super, 1986; in King, 1996, p. 219). In order to improve patient satisfaction and retention, some hospital constituted guest relation programs, in imitation of companies such as Marriott and Disney (Zemke, 1987; Betts & Baum, 1992; in King, 1996, 219). Many of these programs failed to achieve results, and by the late 1980s, guest relations programmes were labeled as fads (Bennett & Tibbits. 1989; Ummel, 1991; in King, 1996, p. 219). One reason for the failure was a narrow focus on training from line employees to be courteous to patients or improving their interpersonal communication and complaint handling skills (Peterson, 1988; in King, 1996, p. 219).

Hepple, Kipps and Thompson (1990) reviewed the existing literature for definitions of hospitality, and identified four characteristics of hospitality in its modern sense.

- It is conferred by a host on a guest who is away from home.
- It is interactive, involving the coming together of a provider and receiver.
- It is comprised of a blend of tangible and intangible factors.
- The host provides for the guest's security, psychological and physiological comfort.

They examined the concept of hospitality as applied to hospital patients, and they operationalized the four characteristics as "feeling at home". Then they identified 10 factors as measures of this feeling in a hospital setting. The factors included friendly staff, admission procedure, information regarding daily routine, plain cooking and menu choice, privacy, comfortable furniture, recreational facilities and attractive décor. Only some of these, such as menu choice, cooking privacy, furniture and décor concern a home-like setting.

Along with the World Trade Organisation (WTO), the United Nations Conference on Trade and Development has been heavily involved in the promotion of trade in the health services sector. The General Agreement on Trade in Services (GATS) (1995), developed by the WTO, provided the legal framework for the liberalisation of the international trade in health services. The GATS defines four trade modes of international trade in health services, as follows (Smith, Blouin, and Drager2006 ; in (Whittaker, et al., 2010, p.338):

Mode 1, "cross-border supply," includes services such as telemedicine, teleradiology, or telepathology, involving the international outsourcing of the interpretation of diagnostic images or test results.

Mode 2, "consumption abroad," is concerned with the movement of patients across international borders.

> Mode 3, "commercial presence," includes health care institutions providing services in locations outside their countries.
>
> Mode 4, "presence of natural persons," involves the movements of health staff to be employed in other countries' health systems (Whittaker, et al., 2010, p.338).

The growth in medical and surgical travel includes dentistry, optometry, complementary "alternative" faith-based and traditional therapies, other allied health professional services, and pharmaceutical products, in addition to the kinds of procedures described in this issue. This growth in travel is driven by a number of factors: the changing demographic profile of aging populations in high- and middle-income countries seeking health care, the ease of international travel and global communication, the retreat of neoliberal states from the provision of public services, and the increasing port-ability of health insurance (Whittaker, et al., 2010, p.338).

Adding medicine for foreigners to the mix further expands the economic opportunities of developing countries. Worldwide, health services are estimated to be worth some $3 trillion,[9] and the health-care sector is among the highest growth sectors in the mid-2000s.[10] Trade in medical services is a small but growing component of overall medical care. As a result, medical tourism has been described as having endless opportunities and benefits for developing countries that manage to break into the market (Bookman & Bookman, 2007, pp. 21-22).

The rapidly growing medical travel industry has implications for the health systems of both sending and receiving countries (Whittaker, Manderson & Cartwright, 2010, p.336). Travel for health purposes is not new. However, the scale, extent of promotion, and organisation of medical services for fee-paying patients, regardless of citizenship status, is new; so too is the ease of travel and the links with global corporate capital and networks (Whittaker, et al., 2010, p.337).

Medical tourism and tourist

Before defining and describing medical tourism, it is very essential to know about the general meaning of 'hospital' and 'medical'. In the past, hospital had been understood as Organised Delivery Systems (ODSs) and later on its understanding has been broadly shifted to Accountable Care Organisations (ACOs). The term hospital also has been defined as a network of organisations which provide or arrange to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served (Shalowitz, 2013). The term 'medical' in its noun form has been defined as 'an examination to access a person's state of physical health'. In the course of the development of tourism, medical and tourism were strongly linked to each other.

Medical tourism comprises both medicine and tourism. Although the core product is medical treatment, both attractive hospitality and travel options are also essential. Hence, medical tourism requires good coordination of the healthcare and tourism industries. Realizing the full potential of this sector requires strategic planning and coordination among such key players as hospitals, medical travel agencies, hotels, and the medical tourists themselves.

Medical tourism, according to Connell (2006), is a niche in the sector by the fact that tourist travel from their home for the purposes gaining medical attention. It is like ecotourism, religious tourism, and adventure tourism. Medical tourism refers to a vacation that involves travelling across international borders to obtain a broad range of medical services. It usually includes leisure, fun, and relaxation activities, as well as wellness and health-care service. Patients who seek to reduce their health expenditures travel to medical centres in other countries to obtain dental, medical and surgical services that are less expensive than that at home (Connell, 2006, p.1095). Robinson and Novelli describe tourist niches as depending on the existence of a market as well as an audience for the product. Such tourism does not draw masses but rather it appeals to a select number of people whose demand is big enough to generate sufficient business. Medical tourism, with its component medical and tourist parts, has both a market and an audience. Unlike ecotourism, in which a traveller will choose a destination and then seek an ecological focus, in medical tourism the traveller chooses medical care first, and only then pairs it with a destination and possibly even a vacation tie-in. As all tourism is goal oriented (in the sense that travellers want to see a sight, or experience a tribal encounter, or touch a historical artifact, or simply party), so too medical tourism occurs with a specific goal in mind. The travelling patient aims to purchase a particular service and to achieve a defined health goal. That patient seeks to maximize utility subject to his income constraints. In that calculation, medical services dominate, but nonmedical services, including the accommodations, restaurant meals, excursions, and ground transportation, are not insignificant to the total experience (Bookman & Bookman, 2007, p.41).

Similarly, to typologies created on tourism in general (for example see Cohen, 1984), some authors further divide medical tourism into subcategories, where life-saving procedures are separated from life-enhancing procedures. For Connell (2006b) and Voigt et al. (2010), essential treatments designated to target acute or chronic conditions (such as cancer treatment) are differentiated from non-essential or elective treatments. Connell (2006b; in Cook, 2010, p.140) further suggests that some treatments, such as certain forms of dental treatment, straddle both medical tourism categories.

Within the European context a medical tourist may be categorized in one of two ways. First, there are those citizens who use their European citizenship rights to

access medical care in EU Member States and their national purchaser reimburses the costs of their treatment abroad. This is allowed because European citizens, under specific circumstances, have rights to receive medical care in other EU countries. Such rights have been established by successive rulings of the European Court of Justice on private cases regarding consumption of health care in another EU Member State and reimbursement by the (national) purchasing body in the home country (Bertinato et al., 2005; in Lunt et al., n.d.,p.8).

Goodrich and Goodrich (1987) defined health care tourism as "the attempt on the part of a tourist facility or destination to attract tourists by deliberately promoting its health-care service and facilities, in addition to its regular tourist amenities" (p. 217), thus emphasizing the supply side. Van Sliepen (as cited in Hall, 1992) placed stronger emphasis on the demand side and viewed health tourism as comprising three elements: staying away from home, health as the primary motive, and occurring in a leisure setting.

The entrance into medical tourism is an effective healthcare system for tourists. For this purpose, scientific research needs to be done to identify the health service seeking practice and behavior of the tourists. This study therefore provides the basic groundwork for developing effective strategies for tourists' healthcare. A new niche has emerged in the tourist industry while some writers continue to use the phrase ' health tourism' to cover all form of health related tourism (e.g. Harcia-Altes, 2005; in Connell, 2006, p.1094). It seems more useful to distinguish 'medical tourism ' as one involving specific medical intervention (Connell, 2006, p, 1094).

The definitions and classifications of health and wellness tourism vary, as they do for health, medical and wellness tourism. Several scholars do not differentiate between wellness tourism and medical tourism and place wellness-related categories under the general terms of medical tourism. For instance, one typology (Voigt et al, 2010, p.30; in Pirnar, 2012, p. 129) suggests the four medical tourism categories of:

1. Illness: medical check-ups, medical surgery, dental treatment.
2. Wellness: beauty care, spa treatment, yoga, herbal healing.
3. Enhancement: cosmetic surgery
4. Reproduction: fertility treatment and birth tourism.

Many different scholars who studied medical tourism have defined medical tourism in their own way. Unlike other forms of tourism, where tourism is more noticeable, in the health system, identifying tourism functions is more complicated. The nomenclatures used in the literature define medical tourism as international medical travel involving a trip (Fedorov et al., 2009, Cormany & Baloglu, 2010,

Crozier & Baylis, 2010; in Carmen, Iordache, Iuliana, Ciochina, 2014, p. 62), medical services outsourcing across borders (Jones si Keith, 2006; in Carmen et al., 2014, p. 62), medical refugees (Milstein si Smith, 2006; in Carmen, et al., 2014, p. 62) and even biotechnological pilgrims (Song, 2010; in Carmen et al., 2014, p. 62).

It is a truism that tourism is supposed to be about relaxation, pleasure and an increase in wellbeing and even health (Connell, 2006, p. 1093). Tourists need not necessarily be hedonists, but they anticipate a beneficial outcome. In the past decade the attempt to achieve better health while on holiday, through relaxation, exercise or visits to spas, has been taken to a new level with the emergence of a new a distinct niche in the tourist industry; medical tourism (Connell, 2006, p. 1093). The tourism industry is continually developing and expanding to meet the needs of changing consumer expectations (Tresidder, 2011, p. 266). Travel for its direct and indirect health benefits has a long history, but healthcare tourism is currently enjoying a new popularity with an increase in the provision of its assorted forms, which range from health surgery to herbal remedies (Henderson, 2004, p. 111). Medical tourism is about to become the new and emerging international business, a growing phenomenon involving both social and economic benefits and risks (Carmen, Iordache, Iuliana & Ciochina, n.d., p. 68). The limited studies on medical and health tourism also tend to focus on a business perspective, and often seek to understand and limit the phenomenon to static, universal definitions (Sobo, 2009; in Cook, 2010,p.136).

Goeldner (1989; in Boga & Weiermair, 2013) and Kasper (1996; in Boga & Weiermair, 2013) health tourism as featuring two determining elements: i) Staying away from home and ii) Health as the most important motive. In addition, Goeldner (1989) adds a third determining element done in a leisure setting. Kasper differentiates the second element further by defining health and tourism as travelling for the maintenance, enhancement or restoration of wellbeing in body, mind and soul. A similar definition can be found in Carrera and Bridges (2006)

Carrera and Bridges (2006; in Pocock & Phua, 2011, pp. 1-2) define medical tourism as "the organized travel outside one's natural healthcare jurisdiction for the enhancement or restoration of the individual's health through medical intervention", using but not limited to invasive technology. The authors define medical tourism as a subset of health tourism, whose broader definition involves "the organized travel outside one's local environment for the maintenance, enhancement or restoration of the individual's wellbeing in mind and body". Medical tourism constitutes an individual solution to what is traditionally considered a public (government) concern, health for its citizen, who at the micro level are responding to market incentives by seeking lower cost and/ or high-quality care overseas that cannot be found at home. Travelling overseas for medical care has historical roots, previously limited to elites from developing countries to developed ones, when health care was inadequate

or unavailable at home. Now however, the direction of medical travel is changing towards developing countries (Carrera & Bridges, 2006; in Pocock & Phua, 2011, pp. 1-2), and globalisation and increasing of health services as a market commodity have led to a new trend; organized medical tourism for fee paying patients, regardless of citizenship, who shop for health services overseas using new information sources, new agents to connect them to providers and inexpensive air travel to reach destination medical (Whittaker, Manderson, & Cartwright, 2010; in Pocock & Phua, 2011, pp. 1-2).

Medical tourism is categorized as a segment or sub-sector of health tourism defined by Erfurt-Cooper and Cooper's textbook (2009, p.6; in Pirnar, 2012, p. 128). Medical tourists not surprisingly are mainly from rich countries where the costs of medical care may be very high, but where the ability to pay for alternatives is also high. Most are from North America, Western Europe and the Middle East (Connell, 2006, p. 1096).

The objective of studying this subject is to understand tourism as an economic powerhouse which is linked with medical tourism and hospitality. Medical tourism is getting more popular and this has driven developing countries to consider developing medical services for the international patients. Though there is limited research on medical tourism, the researcher made an effort to disseminate the knowledge on medical tourism and hospitality in hospitals. This work will be useful to the students and researchers of medicine, nursing, tourism and hospitality studies/ management including the other areas of academia. It has also been assumed that the review will help many students and researchers. Knowledge production and dissemination will be possible two ways: either through original research work which requires financial support; if not the alternative will be review of secondary sources.

Medical tourism is a growing industry around the world. The trend of patients going abroad for non-emergency treatment is increasing significantly. According to Asia Medical Tourism Analysis and Forecast for 2015, Asia is expected to welcome 10 million medical tourists by 2015 with Thailand, India and Singapore controlling more than 80% market share.

Medical tourism doesn't have a standard definition, but it is a term initially coined by travel agencies and mass media to publicize the new form of medical travel, and now widely used by academic and industry researchers, policy makers, provider and consumers (Samir & Karim, 2011; in Mogaka et al., 2017,p.2).

Glinos et al. (2011) agree medical tourism may have little to do with general tourism (Lunt et al., n.d., p.9). The term emphasizes the commoditisation and commercialisation of health travel. Medical tourism also highlights the role of the

industry, issues of advertising, supplier-induced demand and extends beyond the notion of willingness to travel (Lunt et al., n.d., p.9).

Medical tourism is defined as the sum of all the relationships and phenomena resulting from a journey by people whose primary motive is to treat or cure a medical condition. This includes taking advantage of medical intervention services away from their usual place of residence while typically combining this journey with a vacation or tourism elements in the conventional sense (Voigt et al., 2010: 36, emphasis added in Cook, 2010, p.140).

Medical tourism refers to a vacation that involves travelling across international borders to obtain a broad range of medical services. It usually includes leisure, fun, and relaxation activities, as well as wellness and health-care service. Patients who seek to reduce their health-care expenditures travel to medical centres in other countries to obtain dental, medical, and surgical services that are less expensive than those at home. Medical tourism is now a US$60 billion global business, with an average annual growth rate of 20% (Macready, 2007; "Medical Tourism, Asia's Growth Industry," 2006).

Lunt et al. (n.d.) defines medical tourism as when consumers elect to travel across international borders with the intention of receiving some form of medical treatment. Medical tourism is related to the broader notion of health tourism which, in some countries, has long standing historical antecedents of spa towns and coastal localities, and other therapeutic landscapes. Some commentators have considered health and medical tourism as a combined phenomenon but with different emphases.

Tresidder (2011, p. 268) defines medical tourism as undertaking a medical intervention away from the home country, where the medical element is the central theme of the activity. It has emerged because affordable, accessible transport (e.g. low-cost airlines) has made it easier for people to travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers in the conventional sense. In simple words, medical tourism refers to people travelling to a country other than their own to obtain medical treatment. Medical tourism may also refer to those from developed countries who travel to developing countries for lower priced medical treatments. In other words, medical tourism is the travel where the primary purpose is treatment in pursuit of better health. It is identified with general health and wellbeing combining surgical or dental intervention to improve or restore health in the long term.

Medical tourism continues with the patient and their body, it travels with them, regardless of location and time. According to Goodrich and Goodrich (1987, pp. 217- 222), medical tourism focuses on travel for more serious treatments usually primarily on the grounds of cost or availability.

Ultimately 'tourism' is rather more than just a cosmetic noun for an activity that otherwise has little to do with conventional notions of tourism, since most visitors and certainly those who accompany them, find some time for tourism. Moreover, at the same time, the whole infrastructure of tourist industry (travel agents, airlines, hotels, taxis etc.) all benefit considerably from this new niche. Indeed, since for a significant proportion of patients there may be a lengthy period of recuperation, the rewards to the tourist industry, and especially the hotel sector, are considerable. Such benefits are presently unquantifiable though one estimate is that medical tourism in Thailand was worth US$1.6 billion in 2003 (Taffel, 2004; in Connell, 2006, p. 1098), while medical tourists in South Africa were estimated to have spent between US$30-40 million in the same year (Connell, 2006, p. 1098).

Medical tourism, as Cook (2005, p. 4) describes, is the idea of combining medical treatment with holiday- is one which is becoming increasingly fuzzy, precisely because medical treatment is merging into the tourist experience, and because it is sometimes hard to see the boundaries between body modification and medical treatment.

Many countries have recognized the business opportunity that medical travel, particularly when combined with tourism, represents. In 2005, for example, India, Malaysia, Singapore, and Thailand attracted more than 2.5 million medical travellers (United Nations Economic and Social Commission for Asia and the Pacific [UNESCAP], 2008); and Singapore, India, Thailand, Brunei, Cuba, Hong Kong, Hungary, Israel, Jordan, Lithuania, Malaysia, the Philippines, and the United Arab Emirates are now emerging as major health-care destinations. Many other countries, including Colombia, Argentina, Bolivia, Brazil, Costa Rica, Mexico, and Turkey are also in the process of making themselves attractive health-care destinations, particularly for cosmetic surgery (Singh, 2008). At present, however, Asia remains the main region for medical tourism (Connell, 2006).

Gupta (2004) has stated that, medical tourism is the provision of cost-effective medical care to patients in collaboration with the tourism industry. This process is usually facilitated by the private medical sector, whereas both the private and public sectors are involved in the tourism industry. By travelling abroad to have surgery or other medical treatment, medical tourists also take advantage of the opportunity to visit a popular travel destination, thus combining health care with a vacation.

Incidental medical tourists

Some eight percent of travellers to developing countries require medical care while on their trip (or immediately after). Usually it is for the treatment of diarrhoea, although for travellers to Africa, the primary reason is malaria. These are not illnesses tourists plan for, and therefore, their treatment is also unplanned. Foreigners who require incidental medical care in developing countries can be divided into two

categories according to the duration of their visit. Long-term stayers include students pursing training or degree courses that require residence of several months or years. Another group of long-term stayers are foreign workers. They are migrants or expatriates working in multinational or national enterprises (in countries such as Chile, many expatriates came with the spread of multinationals in the 1980s and 1990s) (Bookman & Bookman, 2007, p.46).

The second category of incidental medical tourists consists of ordinary tourists who travel for a short period of time to enjoy beaches, jungles, and historical sites. Globally, such tourists made 700 million international trips in 2000, up from 25 million in 1950. It is no surprise that some of them got sick while on their trip. These are usually emergency care services, since routine care or minor health concerns will be shelved until a traveller's return home. The chances of healthy people becoming ill while travelling is higher than if they stayed at home, given freely floating respiratory illnesses in airplane cabins as well as exposure to digestive and other illnesses that may not exist in one's home environment. Moreover, some types of tourist activities are more likely to result in accidents that require care (for example, mountain climbing, skiing, scuba diving, or hurricane chasing).

Review of literature

This paper reviewed the secondary sources such as books, research articles and the research notes. The scholars in their previous works have made attempts to highlight the significance of medical tourism in relation with health, hospital, heeling, medicine, cost and benefit, marketing, policies, economic development, human capital expertise, tourist and the destinations. Though there are various approaches of reviewing the literature, the author followed textual narrative approach instead of following narratives synthesis (in-depth approach) which is drawn from a number of studies, both qualitative and quantitative. According to May et al.(2005; in Mair, Ritchie, & Walter, 2014, p.4), narrative reviews may include thematic analysis.

In the academic literature, conceptual analysis of medical tourism has emerged from a tourism management perspective, analyzing supply and demand factors (Connell, 2006; Garcia, 2005; Henderson, 2004; Heung, 2010; in Pocock & Phua, 2011, p. 3) and as a node in the trade in health perspective (Smith, 2009; in Pocock & Phua, 2011, p. 3). Legal literature is beginning to cover patient liability issues when surgery is carried out overseas (Cohen, 2010; in Pocock & Phua, 2011, p. 3).

It is Cook (2010) who analyzed medical tourism by following sociological theory i.e. authenticity. Cook's (2010, p.136) concentration is how the medical tourism industry constructs itself and its patients and how medical tourists are the impetus and embodiment with these practices. This is achieved through an interactions

framework of authenticity. The performances of places, spaces, practices, objects and bodies which constitutes the significant social phenomena.

Recent work has begun to analyze medical tourism and its potential impacts on health systems in specific countries (Chee, 2010; in Pockock & Phua, 2011; Fergione, 2006). Yet not all health systems functions are analyzed in these accounts. A core concern is whether medical tourism diverts resources from public components of health systems in destination countries (Pennings, 2010; in Pockock & Phua, 2011). Furthermore, conceptual framework in the health systems literature focus on the impact of targeted vertical interventions in health system (Atun, De Jongh, Secci, Ohri & Adei, 2010; in Pockock & Phua, 2011). But medical tourism is a phenomenon rather than an intervention; its policy implications have yet to be considered within the context of the health system.

This paper presents a conceptual framework of medical tourism and policy implications as developed by previous researchers. It provides a basis for more detailed country specific studies on the benefits and disadvantages of medical tourism, of special relevance for policymakers and industry practitioners. Bridging the social science discipline, the public policy approach to research is a pragmatic one, with the end goal of translating research into useful policy recommendations, in this instance, those that optimize the benefits of medical tourism for both foreign and local consumers and mitigate the risks.

In course of studying medical tourism, Whittaker, Manderson, and Cartwright (2010) have shed light on the political economy of medical tourism industry and the potential opportunities and disadvantages it poses for access, equity and the right to health. Bookman and Bookman in their book *Medical Tourism* (2007) discuss on the economic and health resources implication, demand and supply of the trade, the involvement of the state, and the advantages of its promotion and its role in economic development. As Sobo (2009; in Whittaker et al., 2010, p. 340) noted, anthropology has an important role to play in generating detailed data from specific locales that can be used by program planners and policy makers as they design programs to take advantage of the benefits of medical travel as they address the disadvantages created by this same activity. Lunt, Smith, Exworthy, Green, Horsfall, and Mannion (n.d.) have identified the key emerging policy issues relating to the rise of medical tourism with the concentration of medical tourists' flow between countries and discussed on the interaction of the demand for, and supply of, medical tourism services (p. 2).

It is Henderson (2004) who studied on healthcare tourism in Southeast Asian destinations. He concentrates on the sector's development and marketing in which the selected countries are assessed, revealing problems and opportunities with special focus on demand and supply. There is another work on medical tourism carried out

by Heung, Kucukusta & Song (2010) who have developed integrated model which has been suggested that this model will be useful not only as implications for future research but also it will be impetus for practitioners in the field of medical tourism industry. Besides they have also focused on demand and supply side. As Connell (2006) writes, the rise of medical tourism emphasizes the privatisation of health care, the growing dependence on technology, uneven access to health resources and accelerates globalisation of both health care and tourism. The author sees it as a new niche that has emerged in the tourist industry (p.1094). Carmen, Iordache, Juliana, and Ciochin (2014) in their study have shown how medical tourism is economically viable. Besides this, they have critically analyzed two areas of social life: Travel and Hospitalisation. As they write," while tourism is associated with relaxation and leisure, development and fun, hospital is evoking images of constraints, suffering and feelings of helplessness" (p. 62). Mogaka, Masamba-Thompson, Tsoka-Gwegwen, and Mupara (2017) have also carried out a study on medical tourism on health systems in Africa, where they used a systems-based approach.

Within studies of tourism, it is possible to identify instances whereby each of the three approaches has significant analytical potential (Coles et al., 2006: 309312), for example, with respect to medical tourism. Health and medical reasons have long been identified as motives for travel, with early visitors to spas and resorts travelling to enjoy their recuperative properties. The current multibillion-dollar global medical tourism sector has emerged over time on the basis of much wider demand for medical treatment (TRAM, 2006; in Hannam, 2009, pp.91-92). Where once this might have been for spa treatments or climatic conditions for respiratory complaints, now this ranges from standard procedures for routine complaints such as hip replacements, cataract removals, dentistry and cosmetic enhancements to more intricate and involved courses of treatment on cancers, HIV-AIDS, fertilisation and xeno-transplantation the transplantation of nonhuman cells and tissue into humans (Coles, 2007b). Standard approaches to tourism (through 'business post-disciplinary tourism' and 'interdisciplinarity' see in detail Kunwar, 2018) enable to the researchers to identify the considerable volume and value in medical tourism flows and their importance to host destinations and state economies. Without embracing insights from medical sciences, bioethics and political science, we would not be able to develop as full an understanding of these visitor flows in terms of issues such as citizenship, health provision and bioregulation as key push-pull factors (Hall, 2007; Coles, 2007b; Hannam, 2009, p.92).

There is considerable controversy between health tourism and medical tourism advocating supremacy of one's own field or studied area. Medical tourism can be distinguished as a specific type that incorporates health screening, hospitalisation, and surgical operations, in contrast to nonessential cosmetic surgery and the often

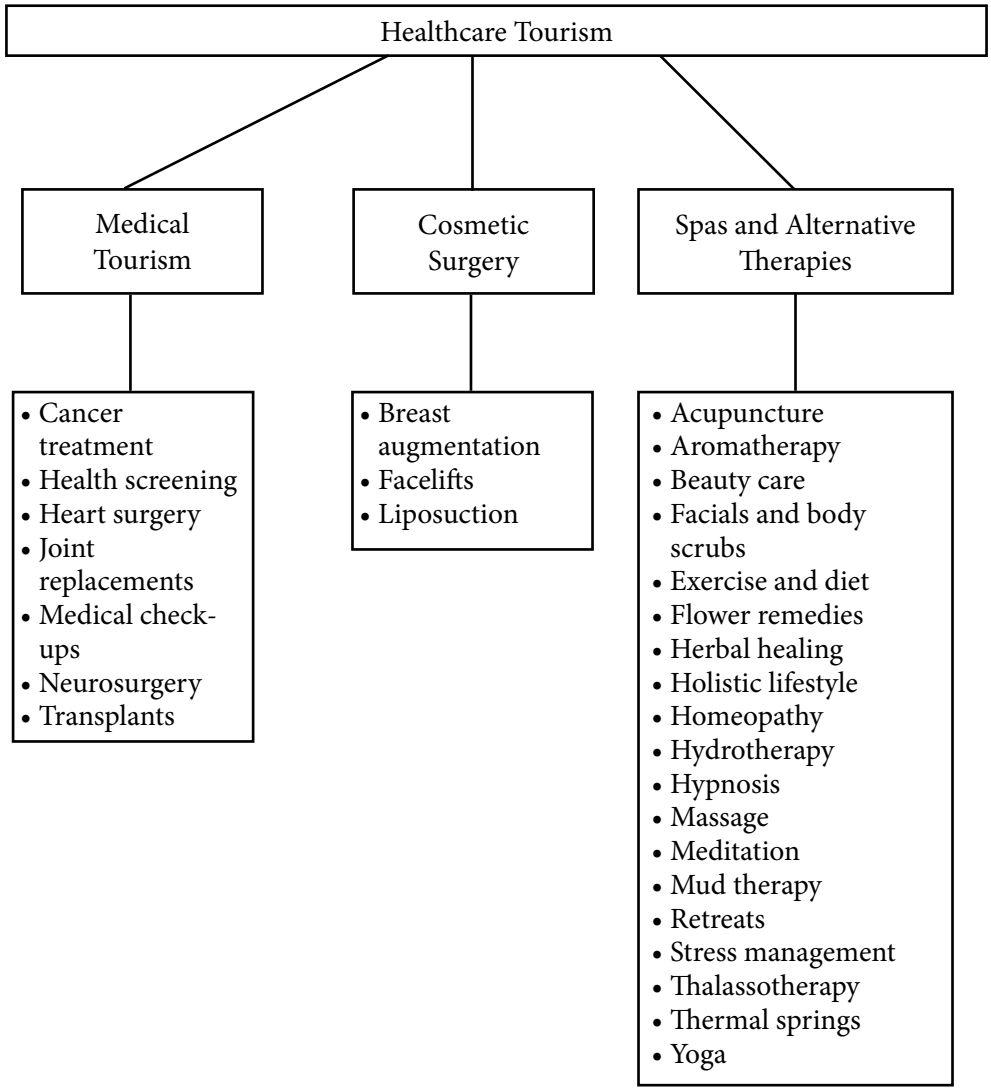
more hedonistic indulgences of spas and alternative therapies (Henderson, 2004, p. 113).This differs from other forms of health-based tourism by the fact that the trip or vacation involves some form of medical intervention, which may vary from simple plastic surgery to liver or kidney transplants. The expanded options are also signified by a new term, medical tourism.

Though there are many problems of defining medical tourism, Connell sees medical tourism is an industry in its own right (Connell, 2006b; in Cook, 2010, p.136). Yet, in spite of the economic, geographical, social and political significance of medical tourism, it has received scant academic attention. Sobo (2009; in Cook, 2010,p.136) suggests that this has been due to the traditional lack of human movement for medical services, and the traditional flow of patients from poor health facilities in less developed countries to higher quality facilities in developed countries.

In this regard, Heung et al., (2010, p. 237) focused on health tourism rather than focusing on medical tourism because they consider that health tourism is broader phenomenon because it encompasses both wellness tourism and medical tourism. Although some scholars sometimes differentiated health tourism with medical tourism, there are some scholars who have maintained neutrality and came up with the conclusion that there are no striking differences between both phrases. Those who advocate the importance of health tourism within the framework of medical tourism, Carrera & Bridges (2006, p.447; in Lunt, Smith, Exworthy, Green, Horsfall, & Mannion, n.d., p.7) define health tourism as the organized travel outside one's local environment for the maintenance, enhancement or restoration of an individual's well-being in mind and body. This definition encompasses medical tourism which is delimited to organized travel outside one's natural health care jurisdiction for the enhancement or restoration of the individual's health through medical intervention (Lunt et al., n.d. p.7).

There is found considerable differences between medical tourism and health tourism as that has been showed by Henderson (2011) which he developed a model showed in the following table.

Figure: The spectrum of healthcare tourism



Source: Henderson (2004, p. 113)

It is Connell (2006a; in Cook,2010,p.140) who replicates wellness features of health tourism but separates medical tourism, defining it as the movement of people who, in addition to holidaying as tourist, undergo medical, dental and surgical intervention that might be for serious life-threatening conditions (Whittaker, 2008). In addition, Carrera and Bridges (2006: 447,449) believe medical tourism to be subset of health

tourism, as 'the organized travel outside of one's natural healthcare jurisdiction for the enhancement or restoration of the individual's health through medical intervention'. Many of the elements commonly identified as medical tourism are encompassed in this recent definition:

In the literature, the connections between tourism and health have been referred to variously, including health tourism, healthcare tourism, global healthcare and medical tourism. As will be explored below, some authors believe that these terms are transposable while others assert that they are different and therefore need to be distinguished. The majority of existing definitions of health and medical tourism focus on the perceived desires or motivations of the consumer. Pollock and Williams (2000), Laws (1996, in Henderson, 2004) and Schofield (2004) separate health tourism from the everyday world of work and home, emphasizing that it involves 'leisure, recreational and educational activities' (Pollock &Williams, 2000: 165; in Cook, 2010,p.139) that are concerned with an improvement of 'physical, mental and social wellbeing' (Schofield, 2004: 137; in Cook, 2010,p.139). Similarly Bennett et al., (2004: 123; in Cook, 2010, p.139), liberally define health tourism as 'any pleasure-orientated tourism which involves an element of stress relief', but highlight a more comprehensive definition encompassing health-related pilgrimages, climatotherapy, cruises with health treatments, government promotion of health services to international tourists (a supply angle), thalassotherapy, sanitourism for the ill and their families, and health resorts.

Tourism typologies

The important thing in the study of medical tourism is that the researcher must be familiar with various typologies of medical tourism. In this regard, the literature shows different concepts and understanding of different scholars in the field of medical tourism. for example, Goodrich and Goodrich, as cited by Bookman and Bookman (2007, p.43) have coined the term health-care tourism instead of medical tourism. Likewise, Henderson (2004; in Bookman & Bookman, 2007, p.43) divided health-care tourism into three categories: spas and alternative therapies (massage, yoga, beauticare, etc.), cosmetic surgery and medical tourism. Unlike this, Hunter-Jones, in her study of the role of holidays in managing cancer, distinguished between health tourism, spa tourism, health-care tourism, and wellness tourism but Bookman and Bookman (2007, p.43) is in favour of addressing medical tourism which includes the entire industry.

The term typology refers to classification of any given entity. Different scholars have opined on the concept of tourism into different forms such as wellness tourism and xenotourism. Though medical tourism and wellness tourism are not completely interdependent with each other, they complement one another. So, it is necessary

to mention what wellness tourism is about. Along with medical tourism, the health and wellness industry has also been recognized as the fastest-growing tourism niche markets (Yeoman, 2008; Voigt & Pforr, 2014; in Hull, 2015, p.26). Wellness tourism is differentiated from medical and health tourism and is defined by Smith and Puczkó (2014, p.25; in Hull, 2015, p.26) as 'trips aiming at a state of health where the main domains of wellness (body, mind, spirit) are harmonized or balanced. There is emphasis on prevention rather than care, but some medical treatment may be used to lifestyle based therapies '. The Global Spa Summit (2011; in Hull, 2015) also adds that wellness tourism involves people who are maintaining or enhancing their personal health and wellbeing and who are seeking unique, authentic, location-based experiences. Wellness is described as including the following dimensions: multi-dimensional, holistic, changing over time, personal influenced by the environment and encouraging self-responsibility (GSS, 2010; in Hull, 2015, p. 27).

The study of Khanal (2018) shows that Nepal has a huge potential in the field of natural healing systems like Ayurveda, Yoga, Meditation, Naturopathy, Homeopathy and Tibetan medicine.

Medical tourism is distinguished from health tourism by virtue of the differences with regard to the types of intervention, setting and inputs.

A good example is health and wellness tourism which can be broken down into at least six micro-niches:

Health and Wellness Tourism Micro-Niches	Typical Activities	Typical Visitors
Spa tourism	Healing with medical or mineral waters	Elderly visitors with health problems
Holistic tourism	Body, mind, spirit treatments in a retreat	Middle-aged professionals/executive
Spiritual tourism	Pilgrimages, ashrams, meditation retreats	Mainly over-30s, some backpackers
Yoga tourism	Asanas and meditation in retreats	Mainly professional women over 40
Medical tourism	Operations, plastic surgery	Primarily Western women over 40 women
Beauty tourism	Massage, facial treatments in a spa or hotel	Women over 25, professionals or executives

Source: Smith, MacLeod & Hart Robertson (2010, p. 1)

According to Cook (2005, p. 5), medical tourism is similar to xenotourism. Xenotourism is a contemporary development in medical tourism. It is connected to and derives from medical procedures around xenotransplantation. Xenotransplantation involves the transplantation of living animal cells, tissues or organs into a human recipient. The possibility of xenotransplantation becoming available to international patients has recently raised some concerns. While this 'xenotourism' possesses obvious similarities to transplant tourism, xenotourism raises far more dangerous for the international community. One of these dangerous is trans-species viral infection. The new intimacies created by xenotransplantation could mean viruses not previously capable of infecting humans would become infectious and create new diseases capable of generating human epidemics. According to Hall (2013, pp. 61-75), xenotransplantation poses the risk of unknown infections crossing the species barrier. As in the case of other human infectious of animal origin (for example, severe acute respiratory syndrome (SARS) and human immunodeficiency virus (HIV)), viruses are not constrained by geopolitical borders, meaning xenotransplantation produces local, national and global angst. Consequently, this globalisation of infectious disease risk highlights a need to consider xenotourism in regulatory frameworks, as evidenced in the New Zealand community.

Medicity

For the first time, when Fitz (2010) wrote an article on medicity, it played important role for making medical tourism more popular. Later on, this became part of medical tourism marketing for organisations.

Medical cities have been designed to be comprehensive in scope and incorporate advanced technologies and medical practices. These services are comprehensive of most, if not all, clinical service lines and include the full spectrum of diagnostics and therapeutic treatments. The scale and scope of medical cities usually demands an advanced level of care – both in technology and approaches – to create an attractive destination for care. This attractiveness is necessary to ensure the high level of patient volumes required to support such a large operation (Fitz, 2010, p.82).

Often, medical cities will also incorporate substantial non-medical services to support the staff, patients and visitors. These include retail, hotel and transportation systems. More often than not, medical cities also include academic and research activities that draw upon the large numbers of patients, the mix of learning opportunities and the access to high-tech facilities (Fitz, 2010, p.82).

"Medical cities will always require a significant amount of patient volume from the local population in addition to needing the human resources and community infrastructure that a city setting provides."

Specifically related to medical tourism, medical cities offer several attractive attributes in support of attracting foreign or 'non-local' patients. First, they have the ability to support advanced medicine and high technology services. As medical cities are of a larger scale and better represent the full continuum of care, they have the ability to support services that are highly specialized – services that often struggle to see sufficient volume to support a business case. These can be sub specialized services within larger services lines, such as heart transplants or highly focused technology items such as robotic surgery systems or image guidance in the operating room. These advanced services in term provide excellent marketing support for those organisations looking to capitalize on patients seeking this type of care (Fitz, 2010, p.83).

The second area where medical cities can strongly support a medical tourism initiative is in the ability to create a true destination healthcare experience. Family accommodations, more expansive retail services and convenient pre- and post-acute care resources create an environment where the patient and the family needs can be fully met – especially for services that might normally be more involved and time consuming, such as cancer care or operations with long recovery periods. Beyond the scope of services and access to advanced care, medical cities might offer additional medical tourism benefits in the increased research opportunities and the ability to support information technology investment for the provision of virtual services such as telemedicine (Fitz, 2010, pp.83-84).

Medicity target the perceived desires of medical tourists by clustering medical and non-medical care with research and training facilities, rehabilitation centres and commercial facilities such as retail and accommodation (Fitz, 2010, pp. 82-84). Various governments are also encouraging and supporting medical tourism by providing medical tourists and their companions with medical visas (see Chinai and Groswami 2007; in Cook, 2010, p.141) and some US employers are paying for their employees to travel abroad for medical treatments rather than provide expensive health insurance or treatment in the US (Konard 2007; in Cook, 2010, p.141).

Medical tourism and economy

Loosely defined as travel with the aim of improving one's health, medical tourism is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism. According to the World Health Organisation (WHO), it is a growing trend with enormous economic implications (Woodward et al., 2002; in Bookman & Bookman 2007,p.2,186). As early as 1989, an Organisation for Economic Cooperation and Development (OECD) report noted that trade in health services provided developing countries with a competitive opportunity in this arena, given their abundance of labour and availability of capital and skills in medicine (Bookman & Bookman, 2007, pp.1- 2).

Medical tourism entails the splicing of two sectors, medicine and tourism. Both are service industries that face a high-income elasticity of demand. Both are labour intensive, and both rely heavily on the Internet to spread information. However, medicine is more high tech than tourism and has higher barriers to entry while tourism has higher price elasticity of demand. One is precise and involves rational decision making, and the other ephemeral, resting on imagination and the exotic and the transport into something outside of one's own culture. Medical tourism thus walks on two legs. Each leg is necessary but neither is strong enough on its own to drive the creation of a successful medical tourism sector. On their own, both tourism and medicine are high-growth industries in many parts of the world (Bookman & Bookman, 2007, pp. 21-22).

The multifaceted aspect of medicine and tourism both in linear graph (medicine and tourism only) and nonlinear graph (medicine, tourism and other complimentary sectors) attract larger intersection of economic activity. This aspect is shown by countries like Thailand, India, Singapore and many other countries. They share significant, if not, not a small section in GDP contribution to states' economy with statistics showing the industry worldwide to generate about US$60 billion annually. Medical tourism in Malaysia, Thailand, Singapore, and India alone is projected to generate more than US$4.4 billion per year by 2012 (Singh, 2008). The sector proceeds in India are estimated to reach as much as US$2.2 billion a year by 2012 (Smith et al., 2009; Bookman & Bookman, 2007). Singapore has set itself the target of attracting 1 million foreign patients annually by that year which would push the sector's GDP contribution to the city state to more than US$1.6 billion, whereas neighbouring Malaysia expects medical tourism income to reach around US$590 million per year in 5 years' time ("Medical Tourism, Asia's Growth Industry," 2006). In Thailand and South Korea, this industry is confidently set to exceed US$4 billion annually by 2012 ("Medical Tourism, Asia's Growth Industry").

Economics effectively calibrates the rise of medical tourism. Price differentials between most Asian states and more developed countries are considerable and are presently diverging even further. This may be accentuated or influenced by long waiting lists. For complex surgery the differences are considerable. In 2003 a small child in the United States with a hole in her heart was faced with a bill of around $70,000 there, but the operation was carried out in Bangalore, India at a cost of $4400 (Neelankantan, 2003; Connell, 2006, p. 1097). Open heart surgery may cost about $70,000 in Britain and up to $150,000 in the United States but in India's best hospitals it costs between $3000 and $10,000 depending on how complicated it is. Dental, eye and cosmetic surgery costs about a quarter of that in western countries (Neelankantan, 2003; Connell, 2006, p. 1097).

Thailand is also one of the crucial destinations of medical tourism in Asia. Where in 2004 some 247,238 Japanese, 118,701 American, 95,941 UK and 35,092 Australian patients were reported treating in Thai hospitals, though this includes locally based expatriates and other injured and sick tourists (Levett, 2005; in Connell, 2006, p. 1096). If there is an apex in the hierarchy of hospital services in Asia, it is Bumrungrad hospital in Bangkok. Aiming at what John D. Rockefeller Jr. called "catalytic bigness," this 554-bed facility with a staff of 2600 has spent the past decade striving to be the biggest and best in its class (De Arellano, 2007, p. 195). In 2003, Bumrungrad treated one million patients. In 2005, it treated 55,000 American patients, three-quarters of whom flew directly from the United States (De Arellano, 2007, p. 195).

It is Henderson (2004) who has presented estimated earnings, number of foreign patients, country's origin and specialty of health services which are given below:

Export of health services

	Estimated Earnings	**No. of foreign patients**	**Origin of patients (in order of volume)**	**Specialty**
Thailand (2006)	Baht 36 billion (US$ 1.1 billion)	1.4 million	Japan, USA, South Asia, UK, Middle East, ASEAN countries	Cosmetic and sex change surgery
Singapore (2007)	S$ 1.7 billion (US$ 1.2 billion)	571 000	Indonesia, Malaysia, Middle East	Cardiac and neuro surgery, joint replacements, liver transplants
Malaysia (2007)	253.84 million MYR (US$ 78 million)	341 288	Indonesia, Singapore, Japan, India, Europe	Cardiac and cosmetic surgery

Source: Henderson (2004, p. 113)

Since the costs of different surgeries may not be stable, the AMA-OMSS Governing Council Report B presented the costs for the United States, India, Thailand and Singapore (see in detail in the given table below).

Comparative costs of medical procedures by country

Procedure	U.S.	India	Thailand	Singapore
Heart bypass	$ 130,000	$ 10,000	$ 11,000	$ 18,500
Heart valve replacement	$ 160,000	$ 9,000	$ 10,000	$ 12,500
Angioplasty	$ 57,000	$ 11,000	$ 13,000	$ 13,000
Hip replacement	$ 43,000	$ 9,000	$ 12,000	$ 12,000
Hysterectomy	$ 20,000	$ 3,000	$ 4,500	$ 6,000
Knee replacement	$ 40,000	$ 8,500	$ 10,000	$ 13,000
Spinal fusion	$ 62,000	$ 5,500	$ 7,000	$ 9,000

Source: AMA-OMSS Governing Council Report B June 2007- Appendix A.

Follow-up care once the patient returns home can also be a problem. Mary Percak Dennett said: "When I returned and went to see my doctor, he was furious. He said no American doctor would treat someone who had surgery overseas. However, he looked at my knee and my x-rays and concluded they had done an excellent job." He noted they had left my knee cap in place and that was good because the knee would heal much faster (York, 2008, p. 101).

Medical tourism and hospitality

A medical tourism product is a medical service with a leisure component. Although coordinating the resources and services of the health-care and tourism sectors is a challenge, strategically such coordination is often carried out at the governmental level. Once an individual decides to have a medical procedure performed in a foreign country, he or she requires both health-care and tourism services. Detailed travel arrangements must be made (including obtaining visas, airline tickets, etc.), the availability of a doctor must be ascertained, and other medical arrangements, including recuperation services, must be planned. All of these services require cooperation between the two sectors (Chacko, 2006); in Heung et al., 2010, p.238).

As the popularity and reputation of medical tourism continue to grow, so too will the opportunities for both hospitality and health care industries (Hume & DeMicco, 2007; in Heung et al., 2010, p.238). It is noteworthy to highlight the concept of hospitality and its historical development for its broad understanding.

The historical development of hospitality has been summarized by Borer (1972), Taylor and Bush (1974) and Taylor (1977) for the United Kingdom and by White (1968) for the United States. What emerges from the literature has been summarized by Christian (1979) in his statement, 'Hospitality throughout history has been centred on security, physical comfort and psychological comfort (provided) to others by a host

(Nailon, 1982, p. 137). Deeply imbedded in the tradition of hospitality management is the concept of service (Nailon, 1982).

Hospitals are health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver services 24 hours per day, 7 days per week. They offer a varying range of acute, convalescent and terminal care using diagnostic and curative services. According to the WHO (2018), hospitals should be organized around people's needs, working closely with other health and social care services and contributing to strengthening primary health care (PHC) and public health services, to substantially contribute to Universally Health Coverage (UHC) (WHO, 2018). Like any institution, hospitals need to survive….if everyone comes in with medical issues but no input (money) is provided to compensate for the services, and the needs of the patient come first (according to WHO) then the hospital will treat people until they go broke and must shut down. So more realistically, the hospital must find equilibrium with its current resources for long term survival and the immediate needs of the patients.

The trade press has noted the phenomenal growth in medical tourism over the past few years. The media have documented the fact that many medical destinations are making significant commitments to improve their facilities. Many offshore hospitals are either making major improvements or building new facilities that will cater to medical tourists. It is not uncommon to find hospitals abroad with "tourism wings", with English speaking personnel and special services tailored for Americans. New destinations are also springing up monthly. For example, Stephano points out that Dubai is in the process of constructing a new "medical city" that will be designed specifically for medical tourists (Moody, 2018, p.3).

Hospitality has been studied by many scholars, but they have not been succeeded to link the 'ity' (Pizam, 2007, p.500) factor in relation with hospital and hospitality. A hospital setting where the patient is a sick guest provides an extreme example of the host/guest exchange. According to Pizam (2007, p.500), "the difference between hospitals and hospitality is "ity" but that "ity" can make a significant difference in the recovery of hospital patients. That if applied to a hospital can make it "hospitable" to its customers in which Pizam uses the term customers rather than patients for those who visit hospitals for treatment.

The "ity" factor is nothing less than a philosophy of ultimate service to one's customers and the total dedication to their needs and wants. It is a culture and ideology that permeates the entire organisation (Pizam, 2007, p.500).

In service-centric organisations that practice the "ity" factor, management persistently trains and motivates employees to meet the customers' needs, desires and expectations and to always perform this duty with a smile and a kind word.

Employees are coached and stimulated to be courteous, respectful, concerned, caring, compassionate, helpful and sensitive to the special needs that some customers might have. When all of the above have been implemented the "ity" factor will be accomplished and an organisation will achieve ultimate state of being truly "hospitable" to both its external and internal customers. As Pizam strongly believes that the hospitality industry can finally make a significant and original contribution to other industries by exporting the "ity" factor and redesigning service organisations into "service-ity" organisations that will have the unique and wonderful characteristics that hospitality organisation possess. In doing so they will fulfill Conrad Hilton's decree: "Fill the world with the light and warmth of hospitality" (Pizam, 2007, p.501).

Patients are sick, vulnerable, stressed, and in a new environment. Visitors might be equally upset (Berry and Bendapudi, 2007). Employees (i.e. administrative and clinical) are also stressed since they are directly or indirectly trying to restore health (e.g. nurses are the employees most likely to burnout, as are front-line hospitality employees) (Belicki & Woolcott, 1996; Price & Spence, 1994). Managing a combination of sick guests and employees at high risk for burnout provides the organisation with additional responsibilities and challenges to retention.

Many hospital administrators have taken notice of the benefits of implementing hotel-style amenities, including private rooms, concierge services, and restaurant-type foodservice menus. Studies have revealed these hotel-style amenities are associated with positive patient experiences (Randall & Senior, 1994; Sheehan-Smith, 2006). However, no study has explored a philosophy of hospitality and programs offered beyond the simple offering of enhancements such as concierge.

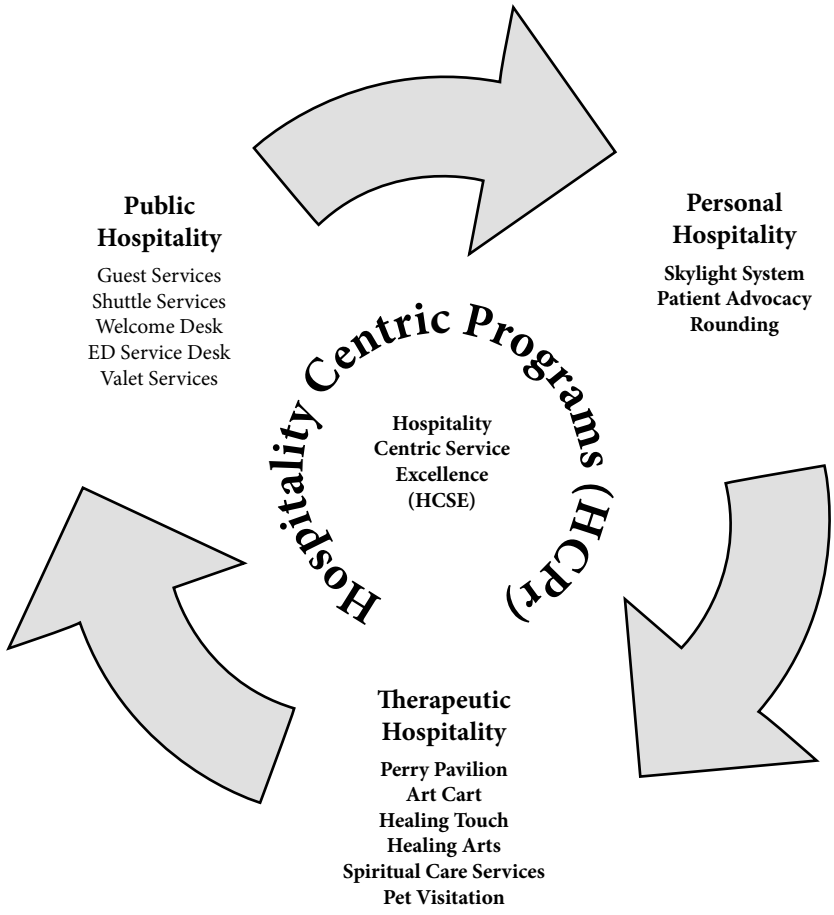
Though few studies have directly studied hospitality as a philosophy applicable organisation wide, a recent hospital case study supported the importance of the alignment of the service mission statement with strategy, systems, and staffing (Ford et al., 2006; in Severt & Aiello, 2008, p. 666). A more traditional recent hospitality research study by Reynolds & Leeman (2007) described how hospitality-based support services (e.g. foodservice, housekeeping, maintenance, and concierge) operated more efficiently when managed together. For the most part, hospitality industry studies have remained focused on the foodservice and amenity portion of the patient experience leaving much room for the further study of a philosophy of hospitality in a hospital setting.

These consumer behaviors are well supported by the theory of planned behavior and the theory of reasoned action (Ajzen, 1985, 1987, 1991; Bagozzi, 1992; in Severt & Aiello, 2008, p. 666). Many empirical studies from various industries (e.g. hotel, banking, restaurants) support the theories and subsequent behaviors (Boulding et al., 1993; Cronin et al., 2000; Hemmington, 2007; in Severt & Aiello, 2008, p. 666).

For a luxury hotel, a medical tourism service could fit well into the services it already offers. For example, after a patient undergoes surgery, he or she could spend an extended period of time recuperating in a luxury hotel. Together with specially designed rooms, the hotel would need to offer good follow up care in coordination with a medical expert. (Heung et al., 2010, p.239). Safety is paramount where health and medical services are concerned and is of primary concern for those travelling to another country to obtain such services. Hence, a well-coordinated partnership between medical institutions and hotels is required to meet the needs of medical tourist. (Heung et al., 2010, p.239).

In this context, Connell (2006b) and Moody (2007) report that hospitals in less developed countries are targeting medical tourists by altering their spatial-material design to create dedicated hospital wings and single rooms that are similar to high quality hotel rooms, while also hiring multilingual staff, arranging airport pick-ups and drop-ups, and providing one-on-one nursing care. The question comes what nursing care is in the context of medical tourism and hospitality.

Patten (1994; in Severt & Aiello, 2008, p.667) recognized the importance of hospitality in health care services as ideal for caregivers. The paper suggested that the caregiver embrace three types of hospitality applicable across the patient experience to include consideration of public, personal and therapeutic hospitality. Public hospitality is basic courtesy exemplified by the courtesy expected in hotels, airlines, and restaurants. For a hospital setting, public hospitality can be translated into everyday interactions in the gift shop, reception desk, or cafeteria. Personal hospitality however goes beyond common exchanges (e.g. personal interactions, self-disclosure and sharing of interests). In the hospital setting, personal hospitality is evident in nursing units where contacts extend over a longer period of time, and in emergency rooms where interactions are short, vital, emotionally intense and intimate. Both of these involve little social distance between caregiver and provider (e.g. housekeeping, volunteer, nurse, nurse assistant, housekeeping, and physician). Finally, therapeutic hospitality indicates a service to mankind with the idea of encompassing a moral/ethical element. Therapeutic hospitality is used to connect people in order to reduce the sense of separation and loneliness, while advocating healing and care. Patten (1994; in Severt & Aiello, 2008, p.667) suggested that nurses embrace a mission of managing therapeutic hospitality within their organisations to enhance both patient satisfaction and progressive healing. In course of studying hospitality in hospital, which is quite essential, Severt and Aiello (2008) have developed a model which is known as Hospitality Centric Service Excellence (HCSE). The following model has given different attributes of hospitality centric programs.



Source: Severt & Aiello (2008, p.667)

For the foreign patient, this may surpass their expectations and experiences of authenticity, as formed by their cultural understandings of medical treatment and care from home. This is hyperauthenticity; it is beyond their expectations. This situation could mean that the medical tourist now views medical services at home to be deficient, though not necessarily less authentic (Connell, 2010, p.114).

Similarly, formalized links with widely recognized "brands" of medical providers and educators, such as Harvard Medical International, the Mayo Clinic, and John Hopkins, are used increasingly to increase brand recognition and trust among patient-consumers.

The development of health tourism requires not only a health-care facility or destination (Carrera & Bridges, 2006) but also the availability of health-related human

resources, technologies, products and services (Law 1996, Kim et al., 2011). The expansion of the health-tourism market has enabled many countries to design and develop their own health-tourism sectors using existing infrastructure and resources. In addition, as a result of competition, many countries have created lower cost and higher quality health services in order to attract health tourists in a competitive market.

Based on the available data, they devised a model that describes the market structure of the medical tourism industry and considers all of the stakeholders involved. The model also allows consumer benefits, branding, legal framework, infrastructure, product, target market, communication channels, operators, intermediaries, and social issues to be taken into account in the analysis and description of this industry.

Medical tourism appears to be a rapidly growing tourism product and market (Mun & Musa, 2013, p. 167). In capturing the medical-tourism market, Connell (2006) recommended the branding strategy. One of the important branding exercises is perhaps hospital accreditation. For medical tourism, the most sought after hospital tourism accreditation is the Joint Commission International (JCI; a not-for-profit American Organisation that provides standards and qualifications for medical facilities) (Mun & Musa, 2013, p. 168). In tourism, health related services have become a growing market segment and a billion dollar business. For 2010, The Global Spa Summit estimated the global market size of health tourism (medical and wellness tourism) to be US$ 156 billion (Global Spa Summit 2010). The development in health tourism can be attributed mainly to two driving forces: economic-based driving forces such as exploding costs for medical treatments in industrial nations, and socio-psychological driving forces, such as value changes in aging societies (Boga & Weiermair, 2013, p. 139).

The literature on branding in health tourism is still rather limited. Branding is especially difficult with regards to the sub-sector of medical tourism. In medical tourism, where the focus is curative and the traveller is, by tendency, ill (Hall, 2011; in Boga & Weiermair, 2013, p. 140), the perceived risk tends to be much higher as much more is at stake than in other sub-sectors of health tourism, for example, wellness tourism, where the focus is on wellbeing in general (Boga & Weiermair, 2013, p. 140).

In the context of tourism, Clarke (2000; in Boga & Weiermair, 2013, p. 142) refers to the reduction of the impact of intangibility as one of the benefits of branding. According to him, a strong brand is able to minimize intangibility and perceived risk. Especially in health and medical tourism a strong brand appears to be of great importance. Boga (2011; in Boga & Weiermair, 2013, p.145) expresses, with increasing importance of personal values in the context of the buying behaviour for

health tourism perceived mental intangibility decreases. Accordingly, it seems highly appropriate in health and medical tourism to augment a brand with relevant personal values (Boga & Weiermair, 2013, p.145).

Kim et al. (2011) explained the development of health tourism in relation to four resources: nature, knowledge, artificial, and expenses, and suggested that destinations should produce innovative and specialized products that can attract international demand and differentiate their products and services from other destinations. Smith and Forgione (2007) constructed a two-stage model for medical-tourism product selection: the first stage being the evaluation of the foreign country and the second stage the selection of the health-care facility. In the first stage, it was found that country-specific characteristics influence the country of choice which includes economic condition, political climate, and regulator policies. In the second stage, it was indicated that costs, hospital accreditation, quality of care, and physician training had an impact on the selection of health-care facility. Caballero-Danellaand Mugomba (2007) employed 11 factors to explain the comments of medical tourism market: product, social issues, the legal framework, consumer benefits, target market, infrastructure, distribution channels, operators, intermediaries, and communication and promotion. Among those facts, *benefit sought* (Haley 1968; Goodrich 1977; Woodside and Jacobs 1985; Gitelson and Kerstetter 1990; Jang et al. 2002; Pierskalla et al. 2004) and *brand equity* (Aakar 1991, 1996; Yoo & Donthu, 2001, 2002; Kim & Kim 2005) have been often highlighted and examined in many previous studies to measure consumer's intention to purchase products or visit destinations.

Although medical tourism is advantageous for developing destinations in economic terms, it may be disadvantageous for the general health systems of those destinations. If the medical tourism industry grows dramatically, then the physical and socio-psychological well-being of the local population may be placed at risk (Burkett, 2007; Tan, 2007). According to Awadzi and Panda (2006), another negative effect of growth in the medical tourism sector may be the diversion of infrastructure building funds from other areas of the economy. Although the costs of medical procedures in a given destination may be reasonable for individuals from developed countries/ regions, they may be prohibitively expensive for the local populace.

Many factors affect travel decisions. In addition to costs, the quality of medical treatment and care is also essential in a medical tourist's decision-making process, particularly when it comes to selecting a hospital. Many doctors in developing countries were educated, and are licensed to practice in developed countries, such as the United States, United Kingdom, Canada, and Australia. The existence of well-trained doctors and specialists who speak their language plays an important role in attracting medical tourists to a particular destination.

Some researchers draw on motivation theory, in which the concept of need takes centre stage, to explain why people travel (Crompton, 1979; Dann, 1977; Pearce & Caltabiano, 1983; Yuan & McDonald, 1990; in Heung et al., 2010). Maslow's (1954; in Heung et al., 2010) five-stage hierarchy of needs, for example, offers a systematic approach to motivation. Five basic needs—namely, physiological, safety, social, esteem, and self-actualisation needs—provide increased motivation in hierarchical order (Jang & Cai, 2002; in Heung et al., 2010); that is, once the most basic human need is satisfied, an individual is motivated to fulfill the next. Based on Maslow's hierarchy of needs, Pearce (1988; in Heung et al., 2010) developed a model known as the "Travel Career Ladder," which represents a ranking system of tourists' learning experiences. Tourists' motivations vary from group to group (Crompton, 1979; Mayo & Jarvis, 1981; in Heung et al., 2010), and individuals may have different reasons for taking vacations. The tourism motivators in Dann's (1977; in Heung et al., 2010) travel decision model, which incorporates push-and-pull factors, can also be linked to Maslow's hierarchy of needs. Push factors are internal to the individual and prompt him or her to travel, whereas pull factors are external and affect the choice of travel destination. This choice may be influenced by many other factors, such as age, income, personality, cost, distance, risk, and motivation. Drawing on Dann's study, Crompton identified nine motives, seven of which are identified as push factors, i.e., the desire for escape, rest and relaxation, adventure, social interaction, health or prestige, and two of which are identified as pull factors, i.e., novelty and education. The destination selection process is related to tourists' assessment of destination attributes and their perceived utility value (Kozak, 2002; in Heung et al., 2010).

Supply and demand

The supply side of the model encompasses all of the efforts, facilities, and services offered by the medical tourism host destination. Several basic factors represent the supply side of medical tourism as a whole. For example, a destination's infrastructure, superstructure, and state-of-the-art medical facilities, and the quality of these facilities and services, should meet patient expectations. To provide an international standard of medical care, a destination needs to have a good communication structure in place, as well as medical staff who speak a variety of languages. Perhaps most importantly, its medical tourism industry should be promoted by government authorities (e.g., through national campaigns or overseas marketing strategies).

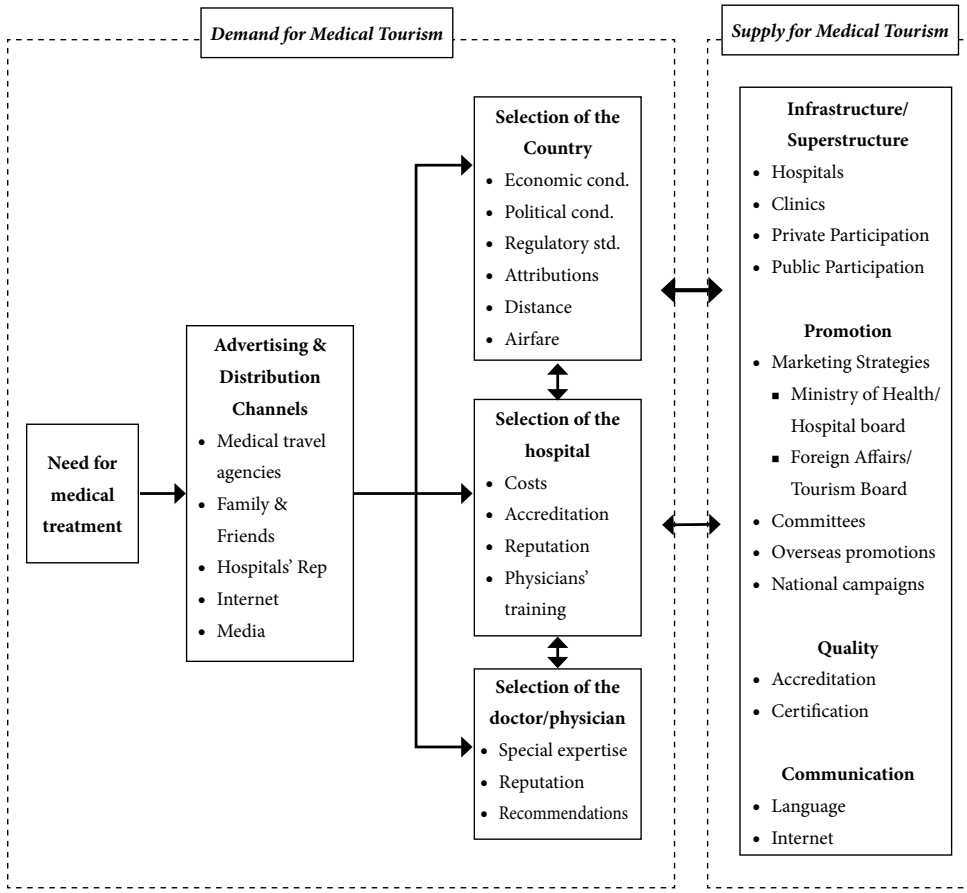
The supply side of Heung et al.'s (2010, p. 246) proposed integrated model reflects the existing situation of the medical tourism industry in terms of the infrastructure/superstructure facilities, promotional activities, quality assurance, and communication facilities that are generally supplied by the private and public sectors. Medical tourism supply in the model focuses on how an individual medical tourist's requirements

interact with the activities of the private, public, and governmental sectors of medical tourism destinations during the selection procedure.

The number of countries seeking to develop medical tourism continues to grow rapidly. The success of medical tourism in Asia especially has prompted growing global interest and competition, and optimism is seemingly unbounded. Singapore, for example, though a relatively high-cost destination, is seeking to attract 1 million patients by 2012, which would generate US$1.8 billion in revenues, create at least 13,000 jobs (Ai-Lien, 2005; in Connell, 2006, p. 1099) and even restore economic growth after the recession in the IT industry at the end of the century. The governments of a number of countries, including Greece, South Africa, Jordan, India, Malaysia, the Philippines, and Singapore are actively promoting medical tourism (Heung et al., 2010, p. 246).

Whilst most trade in health services takes place outside the framework of existing trade agreement, whether bilateral or multilateral, trade in health services including medical tourism is officially provisioned for under the General Agreement on Trade in Services (GATs). The four modes of supply include; 1. The cross-border supply of services (remote service provision, e.g. telemedicine, diagnostics, medical transcriptions), 2. Consumption of services abroad (medical tourism, medical and nursing education for overseas students), 3. Foreign Direct Education (e.g. foreign ownership of health facilities) and 4. Movement of health professionals (Carrera & Bridges, 2006; in Pocock & Phua, 2011, p.4).

Proposed supply and demand model of medical tourism



Source: Heung, Kucukusta & Song (2010, p. 240)

Heung et al.'s (2010) proposed integrated model comprises two components, demand and supply, to provide a holistic view about the medical tourism market in terms of the medical tourists' decision making process which involves interaction between the two.

The term "demand" in the integrated model refers to the factors that affect tourists' decisions in terms of destination and their medical options. These demand factors represent the expectations of a potential medical tourist based on his or her specific needs, which drive the tourism decision. Such a potential tourist is in need of medical treatment and wants to make the best possible decision. Growing demand for health services is a global phenomenon, linked to economic development that generates rising incomes and education (Heung et al., 2010, p.1).

Medical tourism is a growing phenomenon with policy implications for health systems, particularly of destination countries. Private actors and government in South East Asia are promoting the medical tourist industry but the potential impact on health systems, particularly in terms of equity in access and availability for local consumers, is unclear (Pocock & Phua, 2013,p.1)

This has raised the sense of equity in access to care. In the words of the dean of the King Edward Memorial Hospital in Mumbai, "the need to benefit Indian patients is the main goal, the medical tourism cannot be at their cost" (*The Hindu* April 17, 2005; in De Arellano, 2007,p.197). And another critique has attacked the current policies are undermining equity in both India and countries of origin (Gupta, 2004; in De Arellano, 2007, P.197): Medical tourism… reinforces the medicalized view of health care. By promoting the notion that medical services can be bought of the sell from the lowest priced provide anywhere in the globe. It also takes away the pressure from the government to provide comprehensive health care to all its citizens…. The services are cost effective for those who can pay and come from countries where medical care costs are exorbitant because of the failure of the government to provide affordable medical care.

Smith and Forgione (2007 ; in Heung et al., 2010) argued that country-specific characteristics, such as economic conditions, political climate, and regulatory policies, influence the choice of destination; whereas such factors as costs, hospital accreditation, quality of care, and physician training have an impact on the choice of health-care facilities. According to their two-stage model, medical tourists first select a destination and then consider the medical/tourism facilities or infrastructure in that destination.

To provide a better understanding of both the current status of medical tourism and anticipated developments, Caballero-Danell and Mugomba (2007; in Heung et al., 2010) developed a map to document all information collected from the electronic media, newspapers, periodicals, magazines, and academic material (see above figure).

Caballero-Danell and Mugomba (2007; in Heung et al., 2010) also proposed a model that identifies and categorizes three distribution channels that link consumers to destinations: operators; representatives within the target consumer markets, which are also referred to as intermediaries; and word of mouth. Based on Bitner and Zeithaml's (2003; in Heung et al., 2010) argument that traditional service providers such as doctors in a limited distribution area distribute their services directly to consumers, a direct arrow is used to represent consumers' contact with a destination without the need for intermediaries.

Current theoretical models do not adequately explain the medical tourism phenomenon, Therefore, Heung et al. (2010) propose a theoretical framework for

the study of medical tourism that includes both the supply and demand perspectives. They consider each aspect of the medical tourism industry in their proposed integrated model, which is general enough to and could accommodate different types of medical tourists (e.g., those seeking relatively simple procedures such as Lasik eye surgery and those in need of more complex procedures such as heart surgery).

Medical tourism destination

A destination is a place where tourists intend to spend their time away from home. The destination is often considered to be a tourism product in itself. The product could be described as total tourism experience which comprises a combination of all the service elements, which the tourist consumes from the time they leave home to the time of return (Cho, 2000, pp.144-145). Tourism destination is closely related with image (ideas and the beliefs which tourists hold that concentrates on price for travel, accommodation and participation in a range of selected services while staying there). There are two facets of destination images: cognitive and affective images (Baloglu & McCleary's, 1999a; in Chew & Jahari, 2014, p.385). It is noteworthy to mention here as cognitive image refers to beliefs and knowledge about a travel destination's attributes and affective image refers to emotion or feelings attached to the destination. Both images have only recently been integrated to understand destination image (Pyke & Ryan, 2004; in Chew & Jahari, 2014, p.385; Kunwar, 2017, pp.167-168).

People choose to travel to a foreign country for medical treatment for a variety of reasons, and the destination they choose also depends on a number of factors. Smith and Forgione (2007; in Heung et al., 2010) argued that destination-specific characteristics, including economic conditions, the political climate, and regulatory policies, influence this choice. Accordingly, these factors, along with a number of others, constitute the selection criteria on the demand side of our integrated medical tourism model.

Since economic liberalisation in the mid-1990s private hospitals have expanded and found it easier to import technology and other medical goods, thus bringing infrastructures in the best hospitals to western levels. The link to India's highly successful IT industry are also advertised and specific salaries increased, so doctors returned from overseas (Connell, 2006, p.195). India is normally regarded as the contemporary global centre for medical tourism, and it advertises itself as offering everything from alternative Ayurvedic therapy to coronary bypasses and cosmetic surgery (Connell, 2006, p.1095).

Cosmetic surgery, which is rarely covered by insurance policies, is one of the most popular medical treatments in the medical tourism market and, arguably, gave rise to the medical tourism phenomenon (Marlowe & Sullivan, 2007; in Heung et al., 2010).

The main country for medical tourism in Asia, Thailand became known as a destination for medical tourism as early as the 1970s because it specialized in sex change operations, and later moved into cosmetic surgery. Malaysia became involved after 1998 in the wake of the Asian economic crisis and the need for economic diversification, as did many Thai hospitals, when local patients were no longer able to afford private health care. Singapore has belatedly sought to compete with Malaysia and Thailand, deliberately set rates just below those in Thailand… (Connell, 2006, p. 1095).

Internationally recognized accreditation and certification schemes, such as the Joint Commission International (JCI) scheme, the International Organisation for Standardisation (ISO) scheme, and the Trent Accreditation Scheme (TAS, 2001), are making the standards of medical services worldwide increasingly transparent. Such international accreditation serves to demonstrate that the hospital employs only licensed, well-educated and experienced medical, nursing, and other professional staff (Ramanna, 2006).

Medical tourism destinations

Asia/Middle East	Americas	Europe	Africa	Other
China	Argentina	Belgium	South Africa	Australia
India	Brazil	Czech Republic	Tunisia	Barbados
Israel	Canada	Germany		Cuba
Jordan	Colombia	Hungary		Jamaica
Malaysia	Costa Rica	Italy		
Singapore	Ecuador	Latvia		
South Korea	Mexico	Lithuania		
Philippines	United States	Poland		
Taiwan		Portugal		
Turkey		Romania		
United Arab Emirates		Russia		
		Spain		

Source: MedGenMed (2007, p.33, in Carmen et al., 2014, p.64)

Top destinations for medical tourism 2012

	Countries	Performances
1.	Thailand	leader in cheap cosmetic Procedures
2.	India	neurology, cardiology, endocrinology, urology
3.	Costa Rica	cosmetic procedures, dental
4.	Panama	dental treatment, gynecology, cosmetic surgery, orthopedic
5.	Malaezia	cardiology, gastroenterology dental surgery
6.	Singapore	organ transplant, stem cell Transplant
7.	Brazilia	cosmetic surgery-the largest no. interventions capita in the world
8.	Coreea de Sud	specific procedures of the spine
9.	Turcia	liposuction, orthodontics, rhinoplasty and breast augmentation, cardiovascular and brain surgery
10.	Ungaria	cosmetics, laboratory, ophthalmology, dentistry, general surgery

Best hospital in the world who practice medical tourism

	Hospital	Location
1.	Fortis (formerly Wockhardt) Hospital	Bangalore, India
2.	Gleneagles Hospital	Singapore
3.	Prince Court Medical Centre	Kuala Lumpur, Malaysia
4.	Shouldice Hospital	Toronto, Canada
5.	Schoen-Kliniken	Munich, Germany
6.	Bumrungrad International	Bangkok, Thailand
7.	Bangkok Hospital Medical Center	Bangkok, Thailand
8.	Wooridul Spine Hospital	Seoul, Korea
9.	Clemenceau Medical Center	Beirut, Lebanon
10.	Christus Muguerza Super Specialty Hospital	Monterrey, Mexico

Source: www.mtqua.org; in Carmen et. al. (2014, p.65)

Medical tourism and authenticity

It is Cook (2010), who studied medical tourism from sociological perspective and focused on authenticity. In this study, authenticity has been linked with Boorstin's (1964), MacCannell's (1976) and Wang's (1999) theory. The author has deeply analyzed and produced the outcome of the study through an interactionist framework of authenticity, considering both constructivist and existential authenticity.

The interactionist approach to authenticity allows a consideration of how individual and social processes are constructed and experienced. For Cook, this is constructivist authenticity that reveals how the objects and subjects of medical tourism can only be authentic if recognized as such. These social practices and processes rely on power relationships and dialectics, such as who has the authority to certify, make decisions and authenticate (Bruner, 1994; Wang, 1999). This contrasts to traditional approaches to authenticity in tourism studies, labelled as objective authenticity (Wang, 1999), where authenticity is considered to be an inherent quality of object that is independent of humans, as witnessed in the contrast between the inauthentic modern and the authentic primitive or pre-modern (for example Boorstin, 1963; MacCannell, 1973, 1976). However, a constructivist perspective would assert that both the modern and the pre-modern could be authentic – it all depends on how the social phenomenon is evaluated and by whom. Consequently, authenticity is a value judgment made by observer(s).

However, the constructivist approach does not acknowledge that medical tourism is not simply perceived and judged; it is also lived, experienced and felt. This is where an existential understanding can assist with analyzing medical tourism. This approach is concerned with the 'degree of congruence between one's actions and one's core self- conceptions – consisting of fundamental values, beliefs, and identities to which one is committed and in terms of which one defines oneself' (Vannini & Burgess, 2009: 104; in Cook, 2010,p.137). The focus is therefore placed on the inner self, rather than external factors or forces. The key to existential authenticity is seeking personal growth and fulfillment to achieve the 'real self' or being true to oneself. Cook refers to the authentic self. As medical tourism is directed towards and takes place on or in the tourist's body, how one internally feels or reacts to the experience in a transformation of self, is vital and important.

In this paper, Cook (2010) explores how constructivist and existential authenticity interplays with the multiple bodies, objects, spaces, practices and places, to render medical tourism a diverse social phenomenon that transcends any simple classification or typological scheme. This includes acknowledging that the tourist has a body (Veijola & Jokinsen, 1994; in Cook, 2010, p.137), which foregrounds how medical

tourism is an industry that has emerged from the tourist's body and is projected onto and performed by the embodied patient/tourist. Addressing how medical tourism is embodied and located deepens and complicates the theoretical shortfalls around this important social phenomenon by unravelling what medical tourism means in practice and experience. Thus, this paper expands on the previous work on authenticity and on medical tourism by explicitly connecting the two and emphasizing the complexities and constructions of medical tourism from the industry and individual patients. To begin, I will briefly explore the relevance of constructivist and existential authenticity, before navigating the multiple definitions of health and medical tourism, to illustrate the ambiguity surrounding these phenomena.

Similarly, MacCannell (1973, 1976) identifies that modern life is characterized by inauthentic experiences that are contrived and alienating. However, where Boorstin (1963) identified inauthenticity in both everyday life and tourism, MacCannell (1973, 1976) believes that the tourist identifies authenticity as residing elsewhere. Consequently, the tourist desire is to temporarily leave behind the everyday, modern experiences of alienation and, with a sense of nostalgia, seek out the real and authentic in other people and places (the primitive). Authenticity is therefore seen to reside in a previous time or in another place, and the objects that are found 'there' in contrast to 'here' (Olsen, 2002: 161). The desire to experience authenticity due to its lack in modern life is, however, a futile attempt. For MacCannell (1973, 1976), tourist destinations are commoditized and distorted to meet the needs of hosts and guests. In constantly encountering this staged authenticity, the tourist continues to seek the authentic only to be confronted by the inauthentic.

As noted by Wang (1999), Boorstin (1963) and MacCannell (1973, 1976) both focus on objective authenticity. This is based on a concern with whether the originals are authentic. Authenticity exists externally to the tourist, being a characteristic that is inherently found within an object, such as a product, an event, culture or place. Here, constructivist authenticity suggests that authenticity does not actually exist, but rather is created through a projection of interests and desires. This means that 'Things appear authentic not because they are inherently authentic but because they are constructed as such in terms of points of view, beliefs, perspectives, or powers' (Wang, 1999: 351). Authenticity is a cultural value that is attributed, rather than intrinsic, to objects or subjects (Bruner, 1994; Olsen, 2002; in Cook, 2010, p. 138). This means authenticity is negotiable – whether it is authentic or not is irrelevant – and dependent on the tourist's experience.

However, Wang (1999; in Cook, 2010, p.139) asserts that constructivist authenticity cannot account for the tourist's personal feelings, experiences and values. As a result, he advances existential authenticity, which focuses on the knowledge and an awareness of self. This approach considers authenticity to be an emotional investment that is

judged in relation to the self, such as whether personal growth has been achieved or if inner desires have been met.

Thus, existential authenticity involves an internal fulfilment while constructivist authenticity is an external projection of expectations. While following Olsen (2002:164; in Cook, 2010, p.139) he believes that the feelings and experiences of existential authenticity are constructed in social processes and therefore can be understood under constructivist authenticity. He believes that by using both concepts of authenticity, the dynamism of medical tourism, such as the interdependency of and relationships between the places, spaces, objects and subjects that practice and embody medical tourism, can be more effectively understood and analyzed.

MacCannell asserted that authenticity cannot be found in modern life, the authenticity in medical tourism is located in modern medical facilities and training undertaken in advanced industrial nations. This is then used as the benchmark for all medical services and treatment, thus those located in less developed or pre-industrial societies must reach this standard if they wish to advance claims of authenticity. The modern world, and its spaces (hospitals) and knowledge (medical training) are authenticated, with in authenticity located in less developed countries. However, this authenticity cannot be inherently found. It is a sociocultural construction that is reinforced by uneven power relationships (Cook, 2010, p.143).

In the desire to be authentic, however, medical tourism providers that are not in the West may go beyond this reproduction of authenticity by surpassing the cultural values and expectations typical of the West; they become 'hyper authentic'. Connell (2006b) and Moody (2007; in Cook,2010,p.144) report that hospitals in less developed countries are targeting medical tourists by altering their spatial–material design to create dedicated hospital wings and single rooms that are similar to high-quality hotel rooms, while also hiring multilingual staff, arranging airport pick-ups and drop-offs, and providing one-on-one nursing care. For the foreign patient, this may surpass their expectations and experiences of authenticity, as formed by their cultural understandings of medical treatment and care from home. This is hyper authenticity; it is beyond their expectations. This situation could mean that the medical tourist now views medical services at home to be deficient, though not necessarily less authentic. The tourist's gaze is very sensitive and scrutinizing in uncovering the intricate differences to unveil something that is 'new' (Urry, 1990, 2002; in Cook, 2010, p.144). Alterations to spatial–material organisation and design are not just evaluated through the gaze but are also actively experienced and evaluated through the body. As will be explored, medical tourism is an active, ongoing embodied event and process (Cook, 2010, p.144).

Many hospitals have integrated programs that have enhanced patient stays by adapting strategies used in the hospitality industry (Studer, 2003; in Severt & Aiello, 2008, p. 665). These programs are directed at enhancing the process and people interactions across the patient experience (i.e. Resemble the functional quality aspects of service). This includes enhancing the genuine reception, psychological, and emotional well-being of those consumers involved in the host/guest or patient/provider exchange (Ferguson et al., 1999; in Severt & Aiello, 2008, p.665).Other parallels can be drawn between the host/guest exchange in hotels and hospitals and for some time the two industries have been compared in some regards to amenities offered. Parallels include round-the-clock residential services including bedding, maintenance, security, and foodservice.

For the hospital, the patients may be out-patient, emergency room, or patients hospitalized for an extended period. Most times, the patients will have visitors creating an indirect guest. For most hotel stays, guests are vacationing, on business and have usually planned the trip. In both the hospital environment and the hotel environment the guests and the visitors evaluate their perceived experience and build future intentions (to return or not return, to recommend to others, to not recommend to others) surrounding their unfolding service experience. These consumer behaviours are well supported by the theory of planned behaviour and the theory of reasoned action (Ajzen, 1985, 1987, 1991; Bagozzi, 1992; in Severt & Aiello, 2008, p.666). Many empirical studies from various industries (e.g. hotel, banking, restaurants) support the theories and subsequent behaviours (Boulding et al., 1993; Cronin et al., 2000; Hemmington, 2007; in Severt & Aiello, 2008, p. 666).

Patients are sick, vulnerable, stressed, and in a new environment. Visitors might be equally upset (Berry & Bendapudi, 2007; in Severt & Aiello, 2008, p. 666). Employees (i.e. administrative and clinical) are also stressed since they are directly or indirectly trying to restore health (e.g. nurses are the employees most likely to burnout, as are front-line hospitality employees) (Belickiand Woolcott, 1996; Price & Spence, 1994; in Severt & Aiello, 2008, p.666).Managing a combination of sick guests and employees at high risk for burnout provides the organisation with additional responsibilities and challenges to retention.

Many hospital administrators have taken notice of the benefits of implementing hotel-style amenities, including private rooms, concierge services, and restaurant-type foodservice menus. Studies have revealed these hotel-style amenities are associated with positive patient experiences (Randall and Senior, 1994; Sheehan-Smith, 2006; in Severt & Aiello, 2008, p.666). However, no study has explored a philosophy of hospitality and programs offered beyond the simple offering of enhancements such as concierge.

Patient satisfaction is an important dimension of healthcare treatment. Relatively little is known about the experience and satisfaction of medical tourists. According to Ehrbeck et al. (2008, p.7; in Lunt et al., n.d., p.24), patients report generally high satisfaction with quality of care received overseas but it is not clear that this can be extrapolated outside of the US and to a range of treatments. Patient clinical outcomes and satisfaction do not necessarily go together, and satisfaction is not always the primary indicator for some treatments such as dental work. Similarly, with regard to cosmetic surgery there is evidence that a small percentage of patients may suffer from psychological body-related issues that make such judgments problematic (Grossbart & Sarwer, 2003; in Lunt et al., n.d., p.24). Conversely, Hanna et al (2009; in Lunt et al., n.d., p.24).) note that for a sample of outsourced patients (rather than medical tourists) whilst the majority of patients operated upon abroad obtained comparable functional results with those expected locally, they were often dissatisfied with the overall experience. There is a gap in understanding of patient expectations and how these may be raised by individuals paying a market-price and taking responsibility for choosing a provider (Lunt et al., n.d., pp.24-25).

As related to a goal or philosophy of hospitality, the following quotation provides the key informants open-ended views when asked about hospitality in the hospital:

Most patients share only a few hospital experiences in their lifetime. Due to the high emotional value associated with hospital encounters, there are enhanced memories. These stories are then shared in a positive or negative light. By integrating a strong hospitality component, the first visit can be one of comfort instead of one of fear. I believe the patient's health and experience are stronger with hospitality.

Internally, the Service Excellence Council consisted of department heads, clinicians, and staff workers who met monthly to review services cores and initiatives. Externally, a Hospitality Advisory Board consisted of executives from the hospitality industry, hospitality education and administrators from the larger hospital system.

System theory and health system

In the study of medical tourism, the authors such as Mogaka et al. (2017, p.31) have followed system theory developed by Zakus and Bhattacharya (2007; in Mogaka et al., 2017, p.3). According to this theory, health systems may be viewed as the continuum of inputs, process, and outputs. The input consists of people in need of health care services (health care consumers), those who deliver health care services (care providers) and the systematic arrangements that ensure that care is delivered. In this paper, system theory has been used as a framework to describe how medical tourism interacts with the various components of health care systems and the relationship so produced, and systems ability to change and adapt to response to internal and external forces of medical tourism (Yaseen, 2007 ; in Mogaka et al., 2017, p.3). Medical tourism interacts

and influences public and private agencies that organize, plan, regulate, finance, and coordinate medical care services. These agencies consist of hospitals, clinics, insurance companies and other programs that pay for medical services, all operating in various configurations of groups, networks, and independent practices. Professional schools, agencies and industry associations that research and monitor the quality of health care services, licensing and accreditation institutions and the companies that produce medical technology, equipment, and pharmaceuticals also influence or are influenced by medical tourism (in Mogaka et al., 2017, p.3).

The structure of the health system consist of health care facilities, including hospitals, clinics, health care professionals including specialists physicians, general practitioners , auxiliary and allied staff; and technology that create the capacity to extend health care services to customers depending on the structural resources of health facilities and organisation, while the collective resources and relationship of the health care system determine its structural capacity to carry out health care processes (Mogaka et al., 2017).

Structural and strategic innovations in medical tourism seem to have achieved organisational economies of scale, improved utilisation of resources, enhanced access to capital and extended scope of the market, while the traditional national health systems lack these entrepreneurial innovations, largely dominated by payment systems that rewards in terms of time spent rather than value of care. In medical tourism there is specialisation especially in ambulatory walk-in services, reduced prices and lower costs. Previously unimagined techniques seem suddenly within reach (Turner, 2007a, Turner, 2007b; in Mogaka et al., 2017, p.12).

Although medical tourism serves a fraction of population that can pay the rates, with more empowered patients, more diverse delivery models, new roles and stakeholders and necessary incentives, the market of medical tourism keeps on growing (World-Economic Forum, 2013 ;in Mogaka et al., 2017,pp.2-3).

Hospitality in hospital

According to Lashley and Morrison (2000), hospitality provides a commitment to meeting guests' needs as the primary focus in commercial operations through a host and guest relationship. The host and guest relationship is further characterized by hospitableness typically extended by the host to the guests then reciprocated by the guest to the host. Hospitableness includes a welcoming attitude and environment (Brotherton, 1999; in Severt & Aiello, 2008, pp.664-665). These two, backed by genuine company actions; go beyond excellent service to create unforgettable experiences (Hemmington, 2007; in Severt & Aiello, 2008, p. 665). Viewed from this lens, an organisation wide philosophy of hospitality is applicable to, and can help improve exchanges for any business.

For hospitals, the use of hospitality goals from another industry may provide helpful incentive for improvement. In the case study explored, the management of the hospital has the goal of comparing hospital style initiatives with those found in top-rated hotels, likely offering enhanced opportunities for synergy (Randall and Senior, 1994; Sheehan-Smith, 2006; in Severt & Aiello, 2008, p. 674).

In suggesting that there was a place for hospitality in the hospital setting, Cassee and Reuland (1983) highlighted the challenge of describing the concept of hospitality and in particular its relevance to hospitals. Initially, it seems that there is a good case for seeing hospitality as an important attribute of a satisfactory hospital stay and further that the more at ease people feel, in the hospital situation, the sooner they recover. To access how applicable the concept of hospitality is to the hospital situation, a closer examination of the concept is required (Hepple, Kipps, & Thompson, 1990, 0. 305).

During the 1980s, when hospitals and other types of health care organisations began to compete for patients, being hospitable was seen as offering a competitive advantage (Super, 1986; in King, 1996, p. 219). In order to improve patient satisfaction and retention, some hospitals constituted guest relation programs, in imitation of companies such as Marriott and Disney (Zemke, 1987; Betts & Baum, 1992; in King, 1996, p.219). Many of these programs failed to achieve results, and by the late 1980s, guest relations program were labeled as fads (Bennett & Tibbits. 1989; Ummel, 1991; in King, 1996, p.219). One reason for the failure was a narrow focus on training from line employees to be courteous to patients or improving their interpersonal communication and complaint handling skills (Peterson, 1988; in King, 1996, p. 219).

Hepple et al. (1990) reviewed the existing literature for definitions of hospitality and identified four characteristics of hospitality in its modern sense.

- It is conferred by a host on a guest who is away from home.
- It is interactive, involving the coming together of a provider and receiver.
- It is comprised of a blend of tangible and intangible factors.
- The host provides for the guest's security, psychological and physiological comfort.

They examined the concept of hospitality as applied to hospital patients, and they operationalized the four characteristics as "feeling at home". Then they identified 10 factors as measures of this feeling in a hospital setting. The factors included friendly staff, admission procedure, information regarding daily routine, plain cooking and menu choice, privacy, comfortable furniture, recreational facilities and attractive décor. Only some of these, such as menu choice, cooking privacy, furniture and décor concern a home-like setting.

A more traditional recent hospitality research study by Reynolds and Leeman (2007; in Severt & Aiello, 2008, p.666) described how hospitality-based support services (e.g. food service, housekeeping, maintenance, and concierge) operated more efficiently when managed together. For the most part, hospitality industry studies have remained focused on the foodservice and amenity portion of the patient experience leaving much room for the further study of a philosophy of hospitality in a hospital setting.

The traditional standards of service, which were interpreted as personal and individual attention to individual needs can only be maintained in a way specific type of operation for customers prepared to pay the price of such labour-intensive activity (Nailon, 1982, p.138). Broadly speaking, as Nailon (1982) expresses, there seem to be two different types of service which are sought by a range of customers and those can be described as 'hedonistic' or pleasure seeking, which may contain an element of entertainment, and 'utilitarian' which is a substitute for the normal domestic type of requirements (See in detail Nailon, 1982, p.138).

According to Berry (1999 p.247; in Severt & Aiello, 2008, p.675), "great service companies are human companies that humanely serve customers and the broader communities in which they live." The case study above seems to support the assertion of Berry. From this viewpoint, service excellence has to be in place.

The working definition suggested is that the individual patient should feel as 'at home' as possible during their hospital stay. The phrase 'at home' is intended to indicate a standard of security, physiological comfort, and psychological comfort which the patient knows and is satisfied with. This phrase does not make allowance for those who have unhappy, unsatisfactory home lives, however, it is suggested that even such patients would be aware of the concept of 'feeling at home' and are likely to take the phrase in the spirit in which it is intended. The inclusion of the phrase 'as possible' in the definition allows for the judgment of the patient to compare their expectations of hospital hospitality with their experience of that hospitality (Hepple et al., 1990, p.309).

Some groups did find certain factors of particular importance to them, for example those in the thoracic ward studied were very concerned to have plain cooking; this may well be due to their medical condition. Those patients undergoing lengthy hospital stays may be more concerned with recreational facilities than those patients undergoing short hospital stays. However, generally some agreement was found regarding the sequence in which patients regard the hospitality factors as important to a satisfactory hospital stay. This sequence represents the average importance all respondents assign to each factor, starting with the factor considered to be most important and progressing to the factor considered to be least important.

The sequence is as follows: Friendly medical staff, Smooth admissions procedure, Friendly non-medical staff, Information regarding routine, Varied choice on the menu, Adequate provision for visitors/visiting, Comfortable furniture, Privacy, Plain cooking, Attractive surrounding/décor, Clear sign posting, Adequate recreational facilities (Hepple et al., 1990, p.315).

As medical science become increasingly more complex, with sophisticated techniques and more availability of alternatives, it is inevitable that the rift of knowledge and communication, between the professional and the layman, becomes increasingly difficult, and yet increasingly important to bridge. Additional staff may go towards easing the problem but it is the researcher's opinion that awareness of all staff, by training and refresher courses to counter complacency is most important (Hepple et al., 1990). Education within hospitals is, however, a worthy aim, and that the hospital is seen to set a good example of healthy behaviour seems very reasonable; however, the extent of its success, with respect to long-term changes within a community are limited.

With the 'value-for-money' comes the vexed question of quality and service. It is considered that most current definitions incorporate some aspects of quality, either explicitly (Nailon, 1981), or implicitly (Christian in Nailon, 1982) using the word 'comfort'. This is not a specific standard and gives flexibility across a range of service qualities. Both 'quality' and 'service' are difficult to define:

In writing about Quality, Pirsig (1976; in Nailon, 1982, p.138) indicates the problems involved "Quality… you know what it is, yet you don't know what it is. But that is self-contradictory. But some things are better than others that is they have more quality. But then you try to say what quality is, apart from things that have it, it all goes poof! …What the hell is quality?"

Quality, or more usually service, is invariably linked with an adjective such as 'good', 'bad', 'fast', 'slow', and 'highest' standards of service. But what does this mean? At the utilitarian level, it consists of a routine to establish the narrow definition of limited choice in the situation, such as onions are required with a hamburger and the speed of with which the task is accomplished. In a hedonistic transaction, the boundaries are much wider to meet a personalized requirement, it may involve a discussion, not only the choice of wine but also its vintage (Nailon, 1982, p.138).

Airey et al., (2015) writes, "In fact, a whole industry is devoted to quality as evidenced by concepts such as "Total Quality Care" and symbols such as kite marks provide heuristic guides to quality. In tourism itself, there are many such symbols such as the star ratings of hotels (quality of accommodation) or the blue flagging of beaches (quality of environment (and more recently a range of Web 2.0 enabled consumer quality as exemplified by Trip Advisor. Quality also projects its own scale,

aligning itself at the top and with excellence and implying its polar opposite of inferiority" (p. 141).

Beyond this, healthcare and hospitality research integrating a specific philosophy of hospitality is limited though both are replete with many typical service quality and satisfaction studies. The study starts this conversation, adding hospitality to the discussion as a slight modification from the aforementioned quality and satisfaction research by suggesting hospitality centric service excellence as a new type of excellence beyond service excellence. However, a guiding premise for the study is that service excellence must be in place and delivered in an organisation before hospitality centric service excellence can be achieved.

A frequent complaint of patients is that they feel depersonalized by hospitalisation. Many authors have highlighted this problem, including Kennedy (1983), Iliffe (1983), Garner (1979), Martin (1984), Robb (1967), Franklin (1974) and also Millard (1984). The extent to which the patient's individuality is acknowledged depends on the attitude of the health service workers. It is recognized that where patients are made to feel individual and important, and where medical staff assess the 'whole patient', including an evaluation of emotional, domestic and social contexts, the recovery time is shorter, and it is suggested that the patient feels more satisfied with the treatment received (Hepple et al., 1990, p.308).

When faced with the prospect of hospitalisation, reactions vary. In a study of patient reaction to surgery, Janis (1971; in Burns (1980) noted three patterns of emotional responses before surgery each of which indicated a predictable reaction after surgery. The reactions were, to some extent, related to the patient's personality, however some researchers, for example Moran (1963) and Wolffe et al., (1964) in Burns (1980), claim that prehospitalisation information can reduce the negative responses to some extent. Leary (1983), describes some reasons for anxiety which will affect people going into hospital (Hepple et al., 1990, pp.308-309).

Tourism service facilities

Other industry players include a growing number of "medical facilitation" companies, which assist patients by arranging care with particular hospitals, air travel and transfers, concierge and translation services if required, and tours in the destination country (Whittaker, et al., 2010, p.339). Airlines, hotels, travel agents, and resorts are all involved in the industry, many with dedicated arrangements with particular hospitals. The industry has also spawned representative associations that lobby stake-holders such as insurers, governments, and regulators to promote the industry, such as the Medical Tourism Association, which itself provides a certification program for medical facilitator companies, the International Medical Tourism Association based in Singapore and HealthCare Tourism International in

the United States, which accredits facilitator companies, hotels, and tourism operators (Whittaker, et al., 2010, p.339).

The principal corporate hospital chains employee teams of interpreters, though India has benefited because of its widespread English-speaking ability. Thailand's Phuket hospital provides interpreters in 15 languages and receives about 20,000 international patients a year, while the now famous Bumrungrad International Hospital in Bangkok claims to employ 70 interpreters, all of its staff speak English and it has 200 Surgeons certified in the United States (Connell, 2006, p.1095).

Goodrich and Goodrich (1987) defined health-care tourism as "the attempt on the part of a tourist facility or destination to attract tourist by deliberately promoting its health care services and facilities, in addition to its regular tourist amenities" (p.217 ; in Heung et al., 2010, p.237), thus emphasizing the supply side. Van Slieper (as cited in Hall, 1992) placed stronger emphasis on the demand side and viewed health tourism as comprising three elements: staying away from home, health as the primary motive, and occurring in a leisure setting.

Hospitality service facilities

Service disciplines developed from the fundamental belief that services are different from goods and require novel ideas, approaches, tools, and strategies (Berry and Parasuraman 1993). Health care illustrates just how much services can differ. Health care is a deeply troubled but critically important service sector. It costs too much, wastes too much, errs too much, discriminates too much (Berry & Bendapudi, 2007, p. 112).

Although numerous support services affect the customer—the patient in this case—those typically considered as hospitality-related support services are foodservice, housekeeping (sometimes called environmental services), and maintenance (Anderson, 1988; in Reynolds & Leeman, 2007, p. 183). Foodservice typically carries the largest labor cost owing to its size and organizational reach; it is also the one hospitality service that generates revenue, usually from sales in the cafeteria. Housekeeping, which is also labor intensive, does not have the same apparent impact on customers; nonetheless, it plays a very important role, given the critical importance of sanitation in a health care setting (Raynolds & Leeman, 2007, p. 183).

Hospitality-related support services in health care organizations have traditionally operated independently within a firm's overarching operating structure. For example, managers and employees are hired and trained to provide a specific service, whether it is foodservice, housekeeping, or maintenance. It matters little that the foodservice employee scrubs the dining room floor exactly as the housekeeper cleans the lobby floor or that many of the services draw from the same labor pool. This silo approach is the natural evolution within an industry where the most visible support

service—foodservice—established operating standards less than 200 years ago and was recognized as a unique segment (i.e., on-site) within the foodservice industry only a few decades ago (Reynolds, 1997; in Raynolds & Leeman, 2007, p. 182).

Additional advantages cited by study participants include:

- contributes to meeting the hospital's mission;
- increases foodservice employees' pride in their job;
- improves food temperatures;
- eliminates nursing staff's responsibility for meal delivery;
- provides more food choices;
- decreases plate waste;
- decreases the number of complaints about food;
- empowers the patient;
- improves food quality; and
- decreases food cost.

The main disadvantage cited by 52% of the management level participants was increased cost, mainly a result of the greater number of full-time equivalents required to provide room service (Sheehan-Smith, 2006, p. 584).

One of the objectives of the present study was to identify best practices in hotel-style room service. A best practice can be defined as any practice, know-how, or experience that has proved valuable or effective in a specific setting or within one organization that may have applicability in other organizations (Hiebler, Kelly, & Ketterman 1998; Reynolds, 2003; in Sheehan-Smith, 2006, p. 585).

Sheehan-Smith's (2006) study shows that many hospitals undertook such a massive change in their meal delivery process. First was the hospital administration's desire to be more patient-oriented. They viewed the implementation of hotel-style room service as a component of their overall customer-service strategy. Second was the quest to improve patient satisfaction. Third, administrators looked at this new meal-delivery process as a means to gain a niche in a very competitive market. Each of the hospitals in the study was the first to implement hotel-style room service in either their city or surrounding geographical area (Sheehan-Smith, 2006, p. 583).

Though numerous studies have explored meal-distribution systems and patient satisfaction with foodservice quality, this study is one of the first to focus on room service in some hospitals of the United States of America (Sheehan-Smith, 2006, p. 584).

Foodservice has been included as a component of care in most hospitals in the United States since the 18th century (American Dietetic Association, 1984, pp. 17-27; in Sheehan-Smith, 2006, p. 585). Throughout the years, the type of food served to patients and the method used to deliver it has changed, yet as one study participant claimed "that old stigma of hospital food" appears to remain constant. If the small sampling of facilities in this study is any indication, hotel-style room service may contribute to eliminating that old stigma because the patients "think they're in a four- or five-star hotel." (Sheehan-Smith, 2006, p. 585)

Medical tourism and globalisation

In 2005, for example, India, Malaysia, Singapore and Thailand attracted more than 2.5 million medical travellers (United Nations Economic and Social Commission for Asia and the Pacific-[UNESCAP], 2008; in Heung et al., 2010, pp.236-237) and Singapore, India, Thailand, Brunei, Cuba, Hong Kong, Hungary, Israel, Jordan, Lithuania, Malaysia, the Philippines and the United Arab Emirates are now emerging as major health-care destinations. Many other countries, including Colombia, Argentina, Bolivia, Brazil, Costa Rica, Mexico, and Turkey are also in the process of making themselves attractive health-care destinations particularly for cosmetic surgery (Singh, 2008; in Heung et al., 2010, pp.236-237). At present, however, Asia remains the main region for medical tourism (Connell, 2006).

Due to the major changes in the world economy, tourism has had a significant growth, hence its feature given by numerous authors as a "phenomenon typical of the modern world" or a "constituent of daily life" (Iordache, 2013; in Carmen et al., 2014, p. 63). Rising cost of health care in industrialized countries increased willingness to move patients for high quality health services to emerging and developing countries, at prices much lower. However, improved communication technology, in particular by extending the Internet, the development of medical knowledge and technology services enlargement may be associated with medical tourism. Actually, in this century medicine is taking a globalizing process: hundreds of thousands of people travelling along and across the world in search of cheaper medical care or other services in the field.

Medical tourism and marketing

The competition for health and medical tourists' money, and attempts to create 'niche' markets, has led to a diversification of the types of health and medical interventions on offer. These range from superficial treatments (such as facials and massages) to highly invasive and risky surgical procedures (such as open heart surgery and organ transplantation), or a combination of both (such as cosmetic tourism, which can encompass invasive and non-invasive cosmetic enhancements and some forms of dentistry) (Cook, 2010, p.136).

Governments can also promote medical tourism as part of national tourism marketing campaigns. In addition, they can support this niche area by developing policies that decrease marketing expenses in foreign countries through tax deductions, by providing financial support for equipment, by setting aside land for medical tourism without affecting public health services, and by supporting overseas investments in this type of tourism (UNESCAP, 2007).

Medical tourism is an emerging global industry, with a range of key stakeholders with commercial interests including brokers, health care providers, insurance provision, website providers and conference and media services.

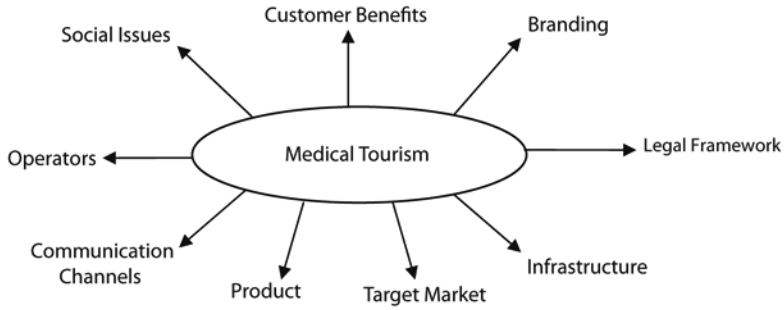
From marketing materials (both print and web-based sources), it is apparent that the range of treatments available overseas for prospective medical tourists are wide, including:

- Cosmetic surgery (breast, face, liposuction)
- Dentistry (cosmetic and reconstruction)
- Cardiology/cardiac surgery (by-pass, valve replacement)
- Orthopedic surgery (hip replacement, resurfacing, knee replacement, joint surgery)
- Bariatric surgery (gastric by-pass, gastric banding)
- Fertility/reproductive system (In vitro fertilisation -IVF, gender reassignment)
- Organ, cell and tissue transplantation (organ transplantation; stem cell)
- Eye surgery
- Diagnostics and check-ups.

Collectively, not all of these treatments would be classed as acute and life-threatening and some are clearly more marginal to mainstream health care. Some forms of plastic surgery would be excluded from health spending (e.g. for solely cosmetic reasons); other forms of medical tourism (e.g. IVF) would be counted within the remit of health trade (OECD, 2010; in Lunt et al., n.d.,p.11).

Smith and Forgione (2007) developed a two-stage model that indicates the factors that influence a patient's decision to seek health-care services abroad. Their model suggests that there is no dominant factor that affects such a decision; rather, all factors seem equally at play. In the first stage of the model, the factors involved in choosing a destination are identified. Then, in the second stage, those involved in choosing a health-care facility are evaluated.

Figure: Market description



Source: Caballero-Danell &Mugomba, 2007; in Heung, Kucukusta & Song, 2010, p. 241

The marketing of medical tourism may not be compatible with conventional tourism advertising, and relevant organisations must assess the most effective presentation, choice of media, and channels of communication for its promotion (Henderson, 2004, p. 117). It can be seen that medical tourism flows consist of foreign patients from developed countries that hospitals are turning to emerging markets in Asia, Europe and Latin America, except Africa and Oceania, the main driver being cost advantage (Carmen, Iordache, Iuliana, Ciochină, 2014, p.65).

Building on its experience in selling its labour and expertise in information technology on the international market, India is following Thailand in promoting "in-tech" healing to become a global health destination. The country has already established a reputation in cardiac care, cosmetic surgery, joint replacement and dentistry and is actively working to expand into other areas that may attract well-healed foreigners and the 12 million Indian expatriates who can combine regular to India with non-emergency medical procedures. India also hopes to capitalize on its traditions Auyrvedic and other non-allopathic treatment which might contribute a special niche and attract another clientele (Pocock & Phua, 2011).

Policy of medical tourism promotion

While writing about policy of medical tourism promotion, Carmen et al. (2014, p.67) have followed the works of different authors such as Zarrilli (2002); (Caballero-Danella & Mugomba, 2007); Bookman and Bookman (2007); Brenzel (2004); and Chanda (2001). All their works have proposed the following six policies for promoting medical tourism.

1. *Incentives such as reducing tariffs* on imports of equipment for hospitals (for example, in the Philippines, in 2004, they are included in the Investment Priorities Plan), reduced import duties for equipment needed medical tourism (e.g., India) and incentives provided directly by hospitals (e.g. in Malaysia,

the government provides incentives for private hospitals which have foreign patients, through tax cuts).

2. *Promotion by governments, of policy investment* assets for developing a general improvement of road transport network, electrification and communication systems and infrastructure development specific medical tourism industry including hotels, resorts and hospitals. In India, for example, the Ministry of Health and Family Welfare and the Ministry of Tourism has actively developed infrastructure policies and tools to promote industry growth the government being involved in some way.
3. *Encourage cooperation in the public sector* by forming alliances between ministries of health, tourism, commerce and offices that deal with migration tourist patients. For example, the success of Cuban medical tourism is due to the strategy of the Ministry of Health coordination and collaboration with institutions in the areas of tourism, trade and industry.
4. *Establish partnerships between the public and private sectors.* Zarrilli (2002) points out that while the ultimate goal of the public sector is to provide a fair and appropriate health care for all citizens, private sector primarily objective is to maximize profits by attracting patients from abroad. Therefore, medical tourism success can only be achieved through collaboration between the two sectors. Bookman and Bookman, (2007) point out that although formal partnerships have been implemented in the medical tourism industry, many medical tourism destinations have informal and voluntary cooperation between the public and private sectors.
5. *Government incentives or subsidies to attract private sector investment* are essential for the sustainable growth of medical tourism industry. Brenzel (2004) acknowledges that both sectors can mutually strengthen the public health system. In countries where medical tourism industry is being led by the private sector, the role of governments should provide a legal framework for private entrepreneurs to target support (financial, technical know) without local people's access to health services is not jeopardized.
6. *Subsidize the public and private sectors in healthcare* This suggests that the cross-subsidisation, a portion of the revenues from the provision of healthcare for foreign visitors can be allocated to improve quality and access to medical assistance of domestic population. It can be achieved, for example, by taxing income from "export" of health services. Moreover, many authors suggest that cross-subsidisation could be implemented by providing free or at least subsidized places by the local population, while foreign patients are required to pay (Bookman & Bookman, 2007).

There are, however, challenges. Connell (2006b; in Cook, 2010, p.143) outlines that medical tourism providers in less developed countries face the difficulty of convincing patients from developed countries of their authenticity, such as the quality of treatment, provision of care, quality of outcome, standards of safety, and institutional and healthcare management. Creating methods that provide authority to authenticity is one mechanism through which this can occur. For example, certification from Western accreditation bodies has become integral to medical tourism authentication, exposing how cultural values are key in the construction of authenticity. Various hospitals in India and the health and wellness group, Manipal Cure and Care (MCC), have sought accreditation from the Australian Council on Healthcare Standards International (ACHSI). This is because 'Accreditation is important as benchmarking of service and recognition by an independent organisation instills confidence and acceptance.

Conclusion

The financial rewards from medical tourism have created an increasing international interest in this phenomenon from governments and the healthcare industry. As part of this competition, various locals seek to exhibit their distinctive features to separate them from their opponents. Along with the increasing affordability of international travel, these mounting options have allowed patients to access medical procedures of choice without the restriction of national borders and healthcare policies. Despite these developments, academic attention has been scarce, with a limited focus placed on defining medical tourism and breaking it down into typologies. However, this approach provides little insight into how medical tourism is structured, experienced and embodied. By theoretically examining medical tourism in the framework of authenticity, this paper begins the journey towards understanding the complexities of this phenomenon.

The readers may get confused with the various terminologies which are used by different scholars, such as health tourism, healthcare tourism, wellness tourism, xenotourism, spa tourism and medical tourism. Though the previous authors seem to be valid in their spaces, the researchers should aware of all those different typologies if they are studying medical tourism. This study focuses on both tourism and hospitality which are embodied within each other and where there is a symbiotic relationship between medical tourism and hospitality in hospitals. In one's absence the other one cannot survive. Those who studied medical tourism or healthcare tourism didn't touch on hospitality provided to hospital patients. Likewise, those who studied hospitality in hospitals also ignored the dimension of tourism. This study also suggests the stakeholders to understand the cross-cultural behaviour or intercultural communication between the hosts and the guests.

While there is a debate around the usefulness of authenticity in tourism studies, I have demonstrated in this paper that constructivist and existential authenticity can explain the process of medical tourism from the view points of the provider and the consumer. For example, the medical tourism industry seeks to authenticate its services and practice through reproduction and accreditation.

However, these places, spaces, practices and objects cannot be separated from the embodied patient, who is at the centre of medical tourism. For this reason, medical tourism is not the search for a particular geographical locale, to connect with a lost or pre-modern time, to gaze passively on a site, or to discover the inherent authenticity of an object. It is not motivated by a desire to witness or observe cultural events or activities. Rather, medical tourism is based on a tourist's embodiment as it exists and as they want it to be. They travel for a service and a product that is focused on and marketed towards their current embodied state and what they desire it to be. The outcome of their tourist experience is associated with their body, such as a change in their appearance or shape (cosmetic tourism), improved blood circulation to and from the heart (heart valve surgery), correcting physical movement or pain (hip or knee replacement surgery), or a reduction of debilitating disease symptoms or to lessen disease progression (stem cell tourism and xenotourism).

Acknowledgements

First and foremost, I would like to express my sincere thanks to Michale Strobel of Berlin, Germany who without any hesitation helped to edit this final article. It is Richan Shrestha of Gateway College also deserves my sincere gratitude. I equally thank to Mibit Dahal, Rajan Kumar Rai, Sajin Bikram Kunwar, Neeru Karki and Anub Bhandari of Conflict, Peace and Development Studies, TU. I finally thank to Mr. Madhav Tripathi of IST College and Rishikesh Lamichhane of Boudhanath Printers.

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Published by
International School of Tourism and Hotel Management
Gyaneswor, P.O. Box: 5196, Kathmandu, Nepal
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Email: info@ist.org.np
Website: www.ist.org.np