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## Would you really recommend it? Antecedents of word-of-mouth in medical tourism

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1 **Taheri, B., Chalmers, D., Wilson, J., & Arshed, N. (2020). Would you really recommend**  
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4  
5 **Abstract**

6 Medical tourism (MT) is a valuable component of many national service economies.  
7 Understanding the marketing and recruitment of MT patients is therefore an important  
8 consideration for MT providers. Research shows that word of mouth (WoM) remains the most  
9 important acquisition channel in this sector. Yet, there is only a limited understanding of  
10 antecedent factors behind a patient referral. We develop a framework for WoM, finding support  
11 for tourism factors, service quality and perceived value as key antecedents on WoM referrals.  
12 We further extend the MT literature by integrating a novel perspective on value creation that  
13 surfaces the experiences of frontline service providers for the first time. This paper incorporates  
14 two complementary studies, one with a focus on value creation, the other on perceived value.  
15 By combing the two in a mixed-methods approach, we emphasise the role of service delivery  
16 on WoM. Several implications can be drawn from the study's findings.

17  
18 **Keywords:** Medical Tourism; word of mouth; mixed methods; Iran  
19  
20

## 21 1. Introduction

22  
23 Medical tourism (MT) is an increasingly valuable component of many national service  
24 economies (Connell, 2013). Across both developed and developing contexts, medical care has  
25 been successfully packaged and marketed towards cross-border consumers (Connell, 2006;  
26 Han, 2013). The scope of such MT activity is broad and inclusive; services offered range from  
27 bariatric care and fertility treatment to a range of cosmetic and non-essential procedures. The  
28 driving factors behind medical tourists seeking overseas treatment are varied, and encompass  
29 quality (Lu, Wu, & Chen, 2016), value (Wang, 2012), speed of access to care and even tourism  
30 involvement relating to the destination of the medical facility (Crooks et al., 2011). The overall  
31 MT sector is significant and growing, with predictions that by 2027 it will reach USD 207.9  
32 billion (Market Analysis Report, 2020).

33 While the research field examining health and medical tourism has expanded  
34 considerably (Connell, 2013), theoretical understanding of economic and marketing issues are  
35 recognised as topics requiring further scholarly attention (Chuang, Liu, Lu, & Lee, 2014). One  
36 marketing aspect of MT that remains notably underexplored relates to the recruitment of  
37 patients. To date, only a limited body of research has examined the configurations of marketing  
38 channels and business development practices utilised by medical providers to participate in  
39 competitively intensifying global marketplaces (Abubakar & Ilkan, 2016; Yeoh, Othman, &  
40 Ahmad, 2013).

41 Prior research has found that an individual patient's intention to choose a particular  
42 medical service provider is related to the service and destination offer (Connell, 2006; Heung,  
43 Kucukusta, & Song, 2011; Moghimehfar & Nasr-Esfahani, 2011; Smith & Forgione, 2007).  
44 Other research has focused on the importance of 'perceived value' on an individual's post-  
45 operative evaluations of their experience. This is shown to predict individuals  
46 favourable/unfavourable intentions to refer that experience to others and provides an insight  
47 into the benefits MT consumers derive from the service (Han & Hwang, 2013; Han & Hyun,  
48 2015; Lee, 2010). While this research offers valuable insight into MT, it has not yet offered an  
49 integrated analysis of MT decision-making and patient recruitment, nor has it advanced a MT  
50 provider perspective on how value is created by those interacting with patients at MT hospitals.

51 This paper extends existing research by developing two complementary studies that  
52 seek to theorise the drivers of WoM in a MT context. In study one, we examine value creation  
53 through service delivery in MT facilities. Owing to the underexplored nature of value creation  
54 (O'Cass & Sok, 2015; Taheri, Coelho, Sousa, & Evanschitzky, 2017) in this context, we utilise  
55 an inductive approach to explore ways in which MT staff (both clinical and non-clinical)  
56 navigate organisational tensions to provide a positive experience for patients (which will  
57 influence likelihood of a WoM referral). Study two examines how patients perceive value  
58 following their treatment and tourism experience. We link the outcomes of this evaluation to  
59 the likelihood of them providing a WoM recommendation for the MT facility. Then, in our  
60 discussion, we integrate the findings of study one and two to emphasise the role of service  
61 delivery on WoM. Our research questions are thus:

62  
63 **RQ1:** How is value created through service delivery within a MT hospital and what  
64 organisational factors influence MT patient experience?

65 **RQ2:** What effect do the expectations and experiences of MT have on WoM referrals?  
66

67 To address these questions, we conduct a two-stage mixed-methods study based at a  
68 leading private hospital in north-west Iran. We draw on in-depth qualitative interview data from  
69 61 medical and support staff (study 1) and survey data from 785 medical tourism patients (study  
70 2). We find support for country environment, tourism destination, medical tourism

71 costs/facilities and services as important in the perceived value of MT choices, and ultimately,  
 72 the likelihood of referring this service to others. We explore for the first time both the MT  
 73 patient and those involved in service delivery at the MT destination. The analysis highlights  
 74 novel findings relating to role tensions within MT facilities and threats to medical professional  
 75 identities, that can manifest in the overall service experience of patients. Finally, we raise some  
 76 practical implications for MT providers by considering the significance of balancing  
 77 destination involvement with medical care provision and the likelihood of WoM referrals as  
 78 competition intensifies within the sector.

79

80 **2. Literature review**

81

82 *2.1 Medical Tourism*

83

84 There are a number of definitions of the term ‘medical tourism’ in the literature, but  
 85 nearly all centre around the notion of travel, usually abroad, with the dual intentions of seeking  
 86 medical care and holiday-making (**Table 1**). Most research has focused on the motivations of  
 87 those undertaking medical tourism, the ‘medical tourists’ (see Connell, 2006; Heung et al.,  
 88 2010; Ghosh & Mandal, 2019; Mathijssen, 2019; Yu & Ko, 2012 amongst others). Key drivers  
 89 for this type of activity can be broadly grouped into factors related to cost, accessibility, and  
 90 broader factors related to the tourism pull of the country of destination. Research has also  
 91 examined the motivations of medical healthcare providers and the wider tourism industry in  
 92 promoting medical tourism (Goodrich & Goodrich, 1987). Mathijssen (2019, p. 374), for  
 93 example, categorises a range of factors for medical tourists travelling aboard for a treatment,  
 94 including:

95

96 “...the relative price of domestic treatment (broadly defined as ‘cost saving’); the  
 97 relative waiting time of the domestic treatment (‘long waiting lists’); quality of  
 98 healthcare; diversity of facilities and choice; inadequate or non-existent insurance;  
 99 ability to maintain anonymity and maintain privacy; cultural affinity in terms of  
 100 language, norms, religion, food; access to the latest technologies and treatments;  
 101 unavailable (‘circumvention tourism’) or unaffordable procedures in their own  
 102 countries; distrust and unfamiliarity with healthcare systems of receiving country; [and  
 103 the] added benefit of a holiday.”

104

105 **Table 1**

106 Summary of main definitions of medical tourism.

| Source                  | Definition   | Focus                                    | Method                        | Sample and Region | Conceptualisation/Theoretical Framing | See also             |
|-------------------------|--|--|-------------------------------|-------------------|---------------------------------------|----------------------|
| Connell (2006, p. 1094) | “where people often travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers.” | Motivations for medical tourists in Asia | Discussion piece - conceptual | Multi - country   | Not stated                            | Garcia-Altes, (2005) |

|   |  |  |   |  |  |  |
|---|--|--|---|--|--|--|
| Goodrich and Goodrich (1987, p. 217)      | “The attempt on the part of a tourist facility or destination to attract tourists by deliberately promoting its health-care services and facilities, in addition to its regular tourist amenities”                                 | Exploration of the concept of healthcare tourism   | Survey and content analysis of marketing material | 206 tourists, 22 travel agents, 12 medical doctors, 2 herbalists, 24 countries | Not explicitly stated  | n/a  |
| Heung, Kucukusta, and Song (2011, p. 236) | “vacation that involves traveling across international borders to obtain a broad range of medical services. Medical tourism usually includes leisure, fun and relaxation activities, as well as wellness and health-care service.” | Conceptual model of medical tourism  | Conceptual  | Not stated   | Critique of previous two-stage; distribution channel; and motivation models. Presents integrated supply and demand side model. | Smith & Forgione (2007); Ye, Yuen, Qiu, & Zhang (2008) |
| Reddy, York, and Brannon (2010, p. 511)   | “The act of travelling abroad for healthcare”  | Student’s perspectives of medical tourism  | Student survey                                    | 336, U.S. undergraduates   | Theory of Planned Behaviour  | de la Hoz-Correa, Munoz-Leiva, and Bakucz (2018)       |
| Wongkit and McKercher, 2013, p. 5         | “The travel of people to a specific destination to seek medical help that forms the primary purpose of their trip.”  | Motivations of medical tourists seeking treatment in Thailand. Development of a typology | Survey  | 345 patients in Thailand   | Not explicitly stated. Focus on motivations  | Cohen (2008); Brotman (2010); Pope (2008)              |
| Yu and Ko (2012, p. 81)                   | “medical tourism involves not only going overseas for medical treatment, but also the search for destinations that have the most technical   | Cross cultural study of medical tourists’ perspectives                                   | Survey  | 785 Chinese, Japanese and Korean Tourists in Korea                             | Not explicitly stated. Focus on motivation   | Reed (2008)  |

proficiency, and  
which provide it  
at the most  
competitive  
prices,  
combination of  
services and the  
tourism  
industry.”

---

107  
108 Yu and Ko (2012, p. 82) suggest “medical tourism is conceptually full of nuances,  
109 contradictions and contrasts,” leading to a lack of construct clarity (Crompton, 1992; Fetscherin  
110 & Stephano, 2016; Ghosh & Mandal, 2019; Mathijssen, 2019). Some scholars emphasise the  
111 medical aspect of MT, suggesting that we should refer to medical examinations that take place  
112 abroad rather than medical ‘tourism’ (Connell, 2013; Ghosh & Mandal, 2019; Johnston,  
113 Crooks, & Snyder, 2012; Mathijssen, 2019; Nahai, 2009; Uchida, 2015). In doing so, they argue  
114 that “those who travel internationally are patients, not tourists for shopping and a pleasurable  
115 holiday” (Uchida, 2015, p. 19). Others, argue that tourism factors are in fact a key component  
116 of the MT destination choice, though note the balance of decision making will vary from  
117 individual to individual, and will be influenced by the type of medical procedure they are  
118 choosing to undergo (Cohen, 2008; Fetscherin & Stephano, 2016; Lovelock & Lovelock, 2018;  
119 Wongkit & McKercher, 2013).

### 120 121 *2.1.1 Medical Tourism in Iran*

122  
123 Tourism in the Middle East in general is one of the least studied sectors in the world,  
124 and there is very limited coverage in international tourism literature (Seyfi & Hall, 2018). A  
125 long history of political instability in Iran has negatively affected the development of its  
126 tourism industry despite its substantial natural, historical and cultural resources (Seyfi & Hall,  
127 2018). In addition, there is some debate within Iran as to the merits of encouraging tourism,  
128 with differences between reformists and fundamentalists as to whether it presents an  
129 opportunity or a threat (Baum & O’Gorman, 2010). That said, since 2010 there has been a  
130 focus on the promotion of tourism as a way of reducing dependence on oil export revenues  
131 (Jabbari, Zarchi, Kavosi, Shafaghat, & Keshtkaran, 2013; Momeni, Janati, Imani, &  
132 Khodayari-Zarnaq, 2018).

133 One area of particular focus has been medical tourism. Since 2010 this sector has had  
134 a growth rate of 20-25% (ICHTO, 2018). The Government’s fifth economic development plan  
135 (2017-2022) has a strategic target of an increase in revenue from health tourism to \$2.5 billion  
136 and to increase the numbers of health tourists by 600,000 per annum (Momeni et al., 2018).  
137 There are a number of factors that will facilitate this growth and the increasing development of  
138 the sector. Iran is geographical proximate to a large number of other countries making it an  
139 easily accessible location (Momeni et al., 2018). It is bordered to the south by Azerbaijan,  
140 Armenia and the Arabic countries of UAE, Qatar, Bahrain, Saudi Arabia, Kuwait and Oman.  
141 Pakistan and Afghanistan sit on its east, to the east, Turkmenistan to the north and Turkey and  
142 Iraq to the west.

143 Iran is internationally renowned medical services and staff with expertise in organ  
144 transplant and aesthetic surgery (Momeni et al., 2018; Seyfi & Hall, 2018). Its services are  
145 relatively low cost in comparison with other competitor markets (Seyfi & Hall, 2018) and it  
146 also has relatively short waiting times for treatments (Jabbari et al., 2013). However, there are  
147 challenges to the development of the sector, including insufficient numbers of medical centres  
148 and a lack of integrated support services such as marketing and travel agencies to facilitate

149 international tourist uptake of the medical services on offer (Azadi, Maleki, Tabibi, & Azmal,  
150 2012).

151  
152 *2.2 Word of Mouth*  
153

154 While MT research has confirmed that WoM influences customer acquisition and  
155 retention (Han & Hyun, 2015; Yeoh et al., 2013), there is no detailed understanding of what  
156 drives a referral in the MT context. Empirical evidence suggests that MT consumers are largely  
157 influenced by a WoM recommendation from friends and family (e.g., Musa, Thirumoorthi &  
158 Doshi, 2012), with the internet being only a secondary influencer (e.g., Chuang et al., 2014;  
159 Connell, 2013). Connell (2013) argues that, as MT develops, WoM is becoming more  
160 important, with online channels serving largely functional roles in the checking of facts and  
161 booking treatment packages.

162 WoM is a well-established concept in marketing literature, with significant theoretical  
163 development that draws upon cognitive, emotional and interactionist perspectives (Berger,  
164 2014; Gannon, Taheri, & Olya, 2019; De Matos & Rossi, 2008). The most widely accepted  
165 definition of WoM is as “informal communications directed at other consumers about the  
166 ownership, usage, or characteristics of particular goods and services and/or their sellers”  
167 (Westbrook, 1987, p. 261). WoM is influential in-service sectors such as medical tourism,  
168 owing to the intangible and experiential nature of product offerings (Zeithaml, Berry, &  
169 Parasuraman, 1993). Empirical evidence has shown that WoM referrals provide a means of  
170 reducing the risk inherent to such transactions (Musa et al., 2012).

171 Research into the antecedents of WoM in a MT context has been limited and there have  
172 been repeated calls for more analysis (cf. Alves et al., 2016; Fernandes & Fernandes, 2017;  
173 Han, Meng, & Kim, 2017; Harrigan, Evers, Miles, & Daly, 2017; Wardi, Abror, & Trinanda,  
174 2018). Existing studies have typically focused on the direct effects of consumer satisfaction  
175 and dissatisfaction (Brown, Barry, Dacin, & Gunst, 2005). Others have focused on a limited  
176 number of key constructs such as perceived value, service quality or customer commitment  
177 (see **Table 2**). In the most comprehensive review to date, of 127 quantitative studies of  
178 antecedents of WoM, de Matos and Rossi (2008) find support for a direct effect of commitment,  
179 perceived value, quality, trust, satisfaction and loyalty on WoM.

180  
181 **Table 2**  
182 **Multidisciplinary definitions of WoM.**

| Source                    | Discipline             | Definition  | Antecedents  |
|---------------------------|------------------------|---|--|
| Brown et al. (2005)       | Relationship Marketing | WoM communication includes any information about a target object (e.g., company, brand) transferred from one individual to another either in person or via some communication medium. | Satisfaction, commitment   |
| Carroll and Ahuvia (1982) | Marketing              | After Westbrook (1987) “as the degree to which the consumer praises the brand to others” (Carroll & Ahuvia, p. 84).   | Brand love   |
| DeMatos and Rossi (2008)  | Marketing              | “informal communications directed at other consumers about the ownership, usage, or characteristics of particular goods and services and/or their sellers” (Westbrook, 1987, p. 261). | Satisfaction, loyalty, quality, commitment, trust, perceived value |

|                            |                    |   |  |
|----------------------------|--------------------|---|--|
|                            |                    | “oral, person-to-person communication between a perceived non-commercial communicator and a receiver concerning a brand, a product, or a service offered for sale” (Arndt, 1967, p. 190).   |  |
| Fillieri and McLeay (2013) | Consumer Behaviour | E-WoM has been defined as “any positive or negative statement made by potential, actual or former customers about a product or company, that is made available to a multitude of people and institutions via the internet” (Hennig-Thurau et al., 2004, p. 39).   | Not addressed  |
| Harrison-Walker (2001)     | Services Marketing | Favourable WoM may include “relating pleasant, vivid, or novel experiences; recommendations to others; and even conspicuous display” (Anderson, 1998, p. 6).<br>WoM may be defined as informal, person-to -person communication between a perceived non-commercial communicator and a receiver regarding a brand, a product, an organisation, or a service (Anderson, 1998; Arndt, 1968; Buttle, 1998). | Service quality and customer commitment                                |
| Litvin et al. (2008)       | Tourism Management | “all informal communications directed at other consumers about the ownership, usage, or characteristics of particular goods and services and/or their sellers” (Westbrook, 1987, p. 261)  | Not explicitly addressed, but satisfaction discussed as key antecedent |

183

184 *2.3 Conceptual model*

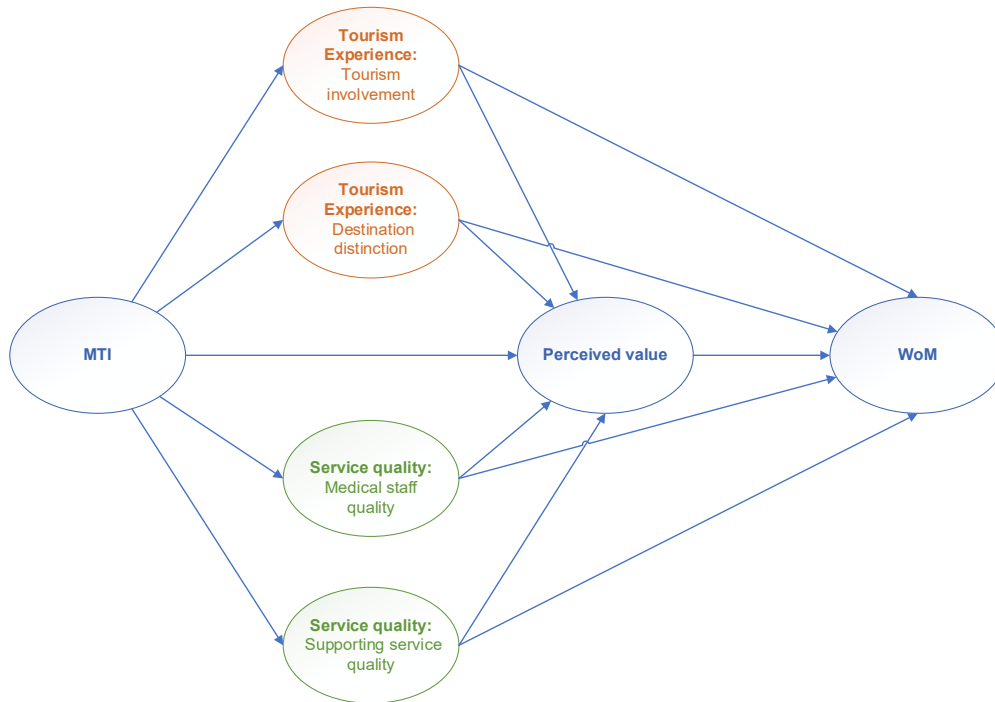
185

186 O’Cass and Sok (2015, p. 187) argue that “...value is created at the point of proposition  
187 by the firm, while perceived use value... is subjectively assessed by the customer, and  
188 exchange value is realised at the point of exchange via firm–customer interaction.” Here,  
189 “customers assess the value creation through their views of what is given, how it is participated  
190 and what is expected” (Taheri et al., 2017, p. 3065). To this end, we evaluate how medical  
191 tourists perceive value following their treatment and their tourism experience by linking the  
192 outcomes of their value evaluation to the likelihood of them providing a WoM  
193 recommendation.

194 Our conceptual research model presented in **Fig. 1** therefore proposes the effect of  
195 medical service quality (medical staff quality and supporting service quality) and tourism  
196 experience (tourism involvement and destination distinction) on perceived value and WoM.  
197 We developed the conceptual framework shown in **Fig. 1** based on a review of the WoM  
198 literature, relating this specifically to the MT context. Drawing on MT literature we argue that



199 the intention of patients to refer a MT provider to others through WoM referrals, is related to  
 200 their perceptions of value following a treatment, based on both service experience and  
 201 expectations of that experience prior to treatment. In a MT context, we propose that this  
 202 perception of value is derived from both factors related to the service quality provision and  
 203 overall tourism experience. We also propose that these factors in themselves may have a direct  
 204 effect on the likelihood of WoM referrals. The theoretical rationale for the relationships  
 205 proposed in the conceptual model is discussed in following sections.  
 206



207  
 208 **Fig. 1.** Conceptual model

209  
 210 *2.3.1 Antecedents of WoM*

211  
 212 *2.3.1.1 Perceived Value*

213  
 214 Marketing literature highlights the important role of perceived value in a patient's  
 215 intention to refer a service to others through WoM (Sanchez-Fernandez & Iniesta-Bonillo,  
 216 2007; Sweeney & Soutar, 2001; Zeithaml, 1988). Perceived value can be defined as the  
 217 “consumer’s overall assessment of the utility of a product (or service) based on perceptions of  
 218 what is received and what is given” (Zeithaml, 1988, p. 14). It is based on a trade-off between  
 219 the quality, or benefits, customers receive from a service, and a customers’ sacrifices to obtain  
 220 such quality/benefits (Monroe, 1990; Oh, 2000; Yang & Peterson, 2004; Zeithaml, 1988).  
 221 Within the tourism literature it has been identified as a key component in the choice of one  
 222 destination over another (Han & Hyuan, 2012; Lee, 2010). However, there has been limited  
 223 empirical research on the importance of perceived value on behavioural intention within the  
 224 medical tourism literature. In one of the few studies examining the impact of perceived value  
 225 on medical tourism choice, Han and Hwang (2013) found that perceived value was  
 226 significantly related to the perceived benefits of a medical hotel and that perceived value  
 227 positively affected behavioural intentions. In particular, they found that increases in financial  
 228 savings, convenience and medical service lead to an increase in tourist’s perceptions of high  
 229 perceived value in the medical tourism hotel. This meant that medical tourists would be willing  
 230 to visit, and critically, would recommend it to others.

231 2.3.1.2 *Service Quality*

232

233 Drawing on wider service literature (Gannon et al., 2019; Zeithaml, 1988; Zeithaml et  
234 al., 1993), we propose that perceptions of medical service quality will have a direct effect on  
235 WoM, and it will have an indirect effect through perceptions of value. Here, service quality  
236 can be defined as “the outcome of a process in which consumers’ expectations for the service  
237 are compared with their perceptions of the service actually delivered” (Mangold & Babakus,  
238 1991, p. 60). Thus, perceptions of quality are implicitly related to expectations (Zeithaml et al.,  
239 1993). There has been less focus on medical service providers than consumers within the  
240 medical tourism field, but most who have explored this area have adapted the well-known  
241 SERVQUAL scale to evaluate service standards in medical tourism (Debata et al., 2015; Guiry  
242 & Vequist, 2011; Manaf et al., 2015; Wang, 2012). This scale identifies five key quality  
243 dimensions related to the physical facilities of the service provider: the reliability and  
244 dependability of the service; the responsiveness of the service provision and willingness to help  
245 customers; assurance of employees in terms of knowledge and courtesy; empathy in terms of  
246 care provision; and finally, individualised attention (Zeithaml, Bitner, & Gremler, 2009;  
247 Parasuraman, Zeithaml & Berry, 1988; 1991).

248 These dimensions can be further grouped into those related to medical staff quality;  
249 those supporting services quality; and those related to administrative services quality (Abd  
250 Manaf et al., 2015; 2017; Fetscherin & Stephano, 2016; Heung et al., 2011; Moghavvemi et  
251 al., 2017; Smith & Forgione, 2007). Empirical research evidences that they are important  
252 dimensions in terms of patient satisfaction, perceived value and future intention for treatment,  
253 with medical staff quality highlighted as the most important factor of the three (Heung et al.,  
254 2011; Mattoo & Rathindran, 2006).

255

256 2.3.1.3 *Tourism Experience*

257

258 We propose that the tourism experience will have a direct effect on WoM referrals and  
259 an indirect effect again through perceived value. As discussed above, tourism factors are a key  
260 part of the cognitive decision-making process for medical tourists (Cohen, 2008; Fetscherin &  
261 Stephano, 2016; Lovelock & Lovelock, 2018; Wongkit & McKercher, 2013). The overall  
262 image of a country has been shown to be a key factor in choice as a tourist destination, and this  
263 factor applies to the MT context as well (Beerli & Martin, 2004; Gallarza, Saura, & García,  
264 2002). The importance of tourism-specific factors has been highlighted by other research in  
265 this area, with scholars noting cultural and natural attractions, weather and attractiveness,  
266 popularity, and exoticness as a tourist destination as important dimensions (Fetscherin &  
267 Stephano, 2016; Lovelock & Lovelock, 2018). Tourism “involvement is ... described as the  
268 state of motivation and desire towards an activity or an associated item” (Lu et al., 2015, p.  
269 88). Involvement has been measured as both a unidimensional and multidimensional concept  
270 and opinions on the preferred number of dimensions remain mixed. However, studies concur  
271 that personal interest is an important factor, and all current conceptualisation includes this  
272 dimension (Gursoy & Gavcar, 2003; Lee & Beeler, 2009; Lu et al., 2015). Numerous studies  
273 have highlighted the importance of tourism involvement in tourist’s evaluations of their  
274 activities and their future behavioural intentions (Funk, Ridinger, & Moorman, 2004; Gursoy  
275 & Gavcar, 2003; Lu et al., 2015; Hwang, Lee, & Chen, 2005; Lee & Beeler, 2009). Several  
276 studies have found involvement to be a significant predictor of satisfaction and future intention  
277 (Kim, Kim, & Kim, 2009; Lee & Beeler, 2009).

278 The literature on destination distinctiveness draws on place branding, destination  
279 marketing and tourism destination image (Beerli & Martin, 2004; Gallarza et al., 2002; Pike &  
280 Page, 2014; Viladrich & Baron-Faust, 2014). Tourism destination image is a set of beliefs,

281 ideas and impressions generated by tourists (Crompton, 1979), and can be defined as “all that  
282 the destination evokes in the individual; any idea, belief, feeling or attitude that tourists  
283 associate with the place” (Alcañiz, García, & Blas, 2009, p. 716). It has been shown to influence  
284 the cognitive evaluation and subsequent decision-making in relation to destination choice (Lu  
285 et al., 2015). It has both cognitive and affective components comprising the tangible properties  
286 of a destination and prospective tourists’ feelings and evaluations towards that destination (Pike  
287 & Ryan, 2004; Wang & Hsu, 2010).

288 The branding of a destination as distinctive, is a way of communicating a uniqueness  
289 that sets it apart from its competitors (Pike & Page, 2014; Qu, Kim, & Im, 2011). The  
290 perception of this distinctiveness by tourists gives a location a competitive advantage that is  
291 notionally difficult for others to replicate. In turn this will increase its attractiveness vis-a-vis  
292 other locations and has been shown to lead to positive intentions to both purchase (Currás-  
293 Pérez, Bigné-Alcañiz, & Alvarado-Herrera, 2009) and to refer to others (Qu et al., 2011).  
294 Studies have shown the strong relationship between destination distinctiveness and place  
295 dependence (Brocato, Baker, & Voorhees, 2015), tourist revisit intentions and intentions to  
296 spread positive WoM (Chi & Qu, 2008).

297 Studies have also shown distinctiveness to be an influential factor in both pre-purchase  
298 decision-making and post-purchase evaluation of the perceived value of an experience and the  
299 likelihood of referring a service to others (Brocato et al., 2015; Viladrich & Baron-Faust, 2014).  
300 In a recent qualitative study of the touristic component of cognitive decision-making in relation  
301 to medical tourists, Lovelock and Lovelock (2018) found some influence of destination  
302 distinctiveness on destination choices, particularly in relation to key low culture destination  
303 attributes such as beaches, shopping and relaxation activities.

#### 304 305 *2.3.1.4 Medical Tourism Index*

306  
307 Finally, we suggest that the expectations around the attractiveness of a country as a MT  
308 destination will influence tourism experience and service quality during the actual service  
309 encounter. This in turn will affect perceived value and WoM. These expectations will also have  
310 a direct effect on perceptions of MT perceived value. These expectations consist of factors  
311 related to both the medical and tourism experience, and the overall environment and image of  
312 the MT destination country. Prior research has argued that an individual patient’s intention to  
313 choose a particular medical service provider is related to three key factors: the overall  
314 environment of the particular country of choice; that country’s healthcare and wider tourism  
315 industries; and, the specific quality of the medical facility and associated services (Connell,  
316 2006; Heung, Kucukusta, & Song, 2011; Moghimehfar & Nasr-Esfahani, 2011; Smith &  
317 Forgione, 2007). Most recently, these factors have been successfully conceptualised as the  
318 Medical Tourism Index (MTI) (Fetscherin & Stephano, 2016). The overall image of a country  
319 has been shown to be a key factor in choice as a tourist destination and this factor also relates  
320 to choose for MT (Beerli & Martin, 2004; Gallarza, Saura, & García, 2002). In addition to  
321 image, other key country-related factors include the political and economic environment  
322 (Connell, 2006; Smith, Álvarez, & Chanda, 2011; Yu & Ko, 2012) and; cultural similarity and  
323 cultural distance (Lee & Davis, 2005; Yu & Ko, 2012). The importance of tourism specific  
324 factors has been highlighted by other research, such as: cultural and natural attractions; weather  
325 and attractiveness; popularity and; exoticness as a tourist destination (Fetscherin & Stephano,  
326 2016; Lovelock & Lovelock, 2018).

327 The rapid development of MT and the concomitant access to advanced medical  
328 technology has meant that the medical infrastructure and systems used by private hospitals has  
329 developed rapidly and healthcare costs reduced. The relatively lower costs of accessing medical  
330 treatment abroad has been found to be a key driver of medical tourism (Connell, 2006; Smith

331 & Forgione, 2007; Yu & Ko, 2012). The quality of medical facilities and services have also  
332 been shown to be key factors in the decision to choose particular medical service providers  
333 (Abd Manaf et al., 2017; Fetscherin & Stephano, 2016; Heung et al., 2011; Moghavvemi et al.,  
334 2017; Smith & Forgione, 2007). Some elements are related to the quality of the actual facility  
335 in terms of reputation, accreditation and medical equipment (Connell, 2006; Heung,  
336 Kucukusta, & Song, 2011; Moghavvemi et al., 2017; Smith & Forgione, 2007; Yu & Ko,  
337 2012). Others relate to the quality of care given by medical staff and their medical reputation  
338 (Berkowitz & Flexner, 1980; Heung et al., 2011; Manaf et al., 2017; Mattoo & Rathindran,  
339 2006).

340

### 341 **3. Methodology**

342

343 To answer our research questions, we adopted a two-stage explanatory design approach  
344 combining quantitative and qualitative data (Alexander, MacLaren, O’Gorman, & Taheri,  
345 2012; Creswell & Creswell, 2018; Teddlie & Tashakkori, 2009). The combination of  
346 quantitative and qualitative methods offers more insightful and more complex answers to  
347 research questions compared to either of them alone; it further provides a platform for  
348 integrating quantitative accuracy with narrative complexity (Creswell & Creswell, 2018;  
349 Teddlie & Tashakkori, 2009). For our first study, a series of semi-structured interviews were  
350 conducted with medical and support staff at a leading private hospital in north-west Iran. The  
351 objective of this study was to examine the complex nature of value creation (O’Cass & Sok,  
352 2015; Taheri et al., 2017) through ongoing service delivery by clinical and non-clinical  
353 employees. This was followed by a second study, which was operationalised through a survey  
354 of in-patients at the same hospital, exploring their reasons for choosing this service provider  
355 and their experiences whilst there.

356

#### 357 *3.1 Research Context*

358

359 The Iranian health system has been subject to various reforms over the past three  
360 decades. According to the Constitution of the Islamic Republic of Iran, every Iranian should  
361 enjoy the highest level of healthcare and medical service. There is public (over 90% of  
362 treatment costs covered by the state) and private healthcare (which remains at a lower cost than  
363 neighbouring countries such as Azerbaijan, Iraq, Turkey, India and Pakistan). Both healthcare  
364 systems are monitored by Ministry of Health and Education (MOHME) of Iran who are  
365 responsible for supervision and regulations in health care service. Iran has over 800 medical  
366 establishments with over 120,000 beds in all, of which 550 are managed by the MOHME and  
367 250 are privately owned (AMAR, 2016). There are 0.7 beds per 1,000 people in Iran.

368 The hospital which formed the focal organisation in our study is one of the most  
369 internationally recognised private hospitals in Western Asia. It is noted for a range of service  
370 factors including cheaper treatment, highly qualified staff and doctors, and a picturesque travel  
371 destination in the north-west of Iran (AMAR, 2016).

372

#### 373 *3.1 Qualitative study*

374

##### 375 *3.1.1 Data gathering*

376

377 In total we undertook 61 semi-structured interviews with full-time employees of a  
378 single MT hospital in Iran (see **Table 3**). The interviews were conducted in the months of  
379 February and March 2016. The study deployed two complementary sampling strategies:  
380 purposive and snowball sampling (Ritchie, Lewis, & Elam, 2003; Wells, Gregory-Smith,

381 Taheri, Manika, & McCowlen, 2016a). Purposive sampling facilitated the identification of  
 382 appropriate participants for the study, while snowball sampling allowed selected individuals to  
 383 identify others that they knew to be information-rich as the research progressed (Lincoln &  
 384 Guba, 1985). Our intention was to gather a representative range of respondents that broadly  
 385 reflected the various jobs families within the hospital (e.g., clinical, management,  
 386 administrative, tourism-related, marketing and service/maintenance/cleaning). Our final  
 387 sample achieved a good balance, albeit it was skewed slightly towards clinical respondents,  
 388 largely owing to their more detailed knowledge of MT, and their willingness to discuss matters  
 389 candidly and on-the-record.

390 All interviews were undertaken by a native speaker (of both Farsi and English  
 391 languages), a member of the research team. The interviews were audio-taped and transcribed  
 392 verbatim, and confidentiality of participants was assured. In order to maintain the anonymity  
 393 of participants and the organisation, identifying details have been modified and pseudonyms  
 394 are used throughout this research. The interviews were semi-structured and alternated between  
 395 short intercept-style interviews to longer in-depth interviews. The first five individual  
 396 interviews took the form of open-ended ‘chats’, as we aimed to construct a bigger picture of  
 397 the hospital employees’ view on their daily work and interactions with one another (Hudson &  
 398 Ozanne, 1988; Jafari, Taheri, & vom Lehn, 2013). We then added further questions to  
 399 subsequent participant interviews based on our literature review findings, specifically around  
 400 those themes relating to service quality, service delivery, destination distinction and tourism  
 401 involvement. We encouraged further insights by asking open questions around the more  
 402 general experiences of working in a MT facility. From these open questions we discovered  
 403 tensions between commercial (i.e. revenue-generating) and care-giving provision, and  
 404 accordingly we incorporated this theme in to ensuing interviews with respondents. Our  
 405 participants were encouraged to illuminate their views with specific workplace examples,  
 406 stories and personal narratives (Jafari et al., 2013).

407

408 **Table 3**

409 Interview participants profile.

| ID | Organisational role  | Sex    | Age         |
|----|----------------------|--------|-------------|
| 1  | Nurse                | Male   | 20-30       |
| 2  | Frontline staff      | Male   | 31-40       |
| 3  | Doctor               | Male   | 41- 50      |
| 4  | Hospitality          | Female | 20-30       |
| 5  | Frontline staff      | Female | 20-30       |
| 6  | Technical support    | Male   | 31-40       |
| 7  | Clinical support     | Male   | 31-40       |
| 8  | Nurse                | Female | 20-30       |
| 9  | Nurse                | Female | 31-40       |
| 10 | Nurse                | Male   | 31-40       |
| 11 | Clinical support     | Male   | 20-30       |
| 12 | Non-clinical support | Male   | 51 and over |
| 13 | Clinical support     | Female | 31-40       |
| 14 | Technical support    | Male   | 51 and over |
| 15 | Non-clinical support | Male   | 20-30       |
| 16 | Non-clinical support | Male   | 51 and over |
| 17 | Nurse                | Female | 20-30       |
| 18 | Clinical support     | Male   | 41- 50      |
| 19 | Nurse                | Female | 31-40       |
| 20 | Hospitality          | Male   | 20-30       |

|    |                      |        |             |
|----|----------------------|--------|-------------|
| 21 | Clinical support     | Male   | 31-40       |
| 22 | Nurse                | Female | 31-40       |
| 23 | Clinical support     | Male   | 41- 50      |
| 24 | Nurse                | Female | 20-30       |
| 25 | Doctor               | Female | 31-40       |
| 26 | Frontline staff      | Female | 51 and over |
| 27 | Hospitality          | Female | 31-40       |
| 28 | Technical support    | Male   | 20-30       |
| 29 | Doctor               | Male   | 31-40       |
| 30 | Clinical support     | Male   | 41- 50      |
| 31 | Frontline staff      | Female | 51 and over |
| 32 | Technical support    | Male   | 20-30       |
| 33 | Frontline staff      | Male   | 51 and over |
| 34 | Technical support    | Male   | 31-40       |
| 35 | Clinical support     | Female | 20-30       |
| 36 | Technical support    | Male   | 51 and over |
| 37 | Nurse                | Female | 41- 50      |
| 38 | Hospitality          | Male   | 20-30       |
| 39 | Clinical support     | Female | 51 and over |
| 40 | Frontline staff      | Male   | 51 and over |
| 41 | Doctor               | Female | 41- 50      |
| 42 | Nurse                | Male   | 31-40       |
| 43 | Non-clinical support | Male   | 20-30       |
| 44 | Clinical support     | Male   | 51 and over |
| 45 | Technical support    | Male   | 51 and over |
| 46 | Doctor               | Male   | 41- 50      |
| 47 | Nurse                | Female | 41- 50      |
| 48 | Hospitality          | Female | 31-40       |
| 49 | Nurse                | Female | 20-30       |
| 50 | Doctor               | Male   | 41- 50      |
| 51 | Clinical support     | Male   | 20-30       |
| 52 | Nurse                | Male   | 51 and over |
| 53 | Frontline staff      | Female | 20-30       |
| 54 | Clinical support     | Male   | 51 and over |
| 55 | Technical support    | Male   | 51 and over |
| 56 | Hospitality          | Female | 20-30       |
| 57 | Technical support    | Male   | 51 and over |
| 58 | Clinical support     | Male   | 41- 50      |
| 59 | Frontline staff      | Female | 20-30       |
| 60 | Doctor               | Male   | 41- 50      |
| 61 | Clinical support     | Male   | 20-30       |

---

410

411 *3.1.2 Data analysis*

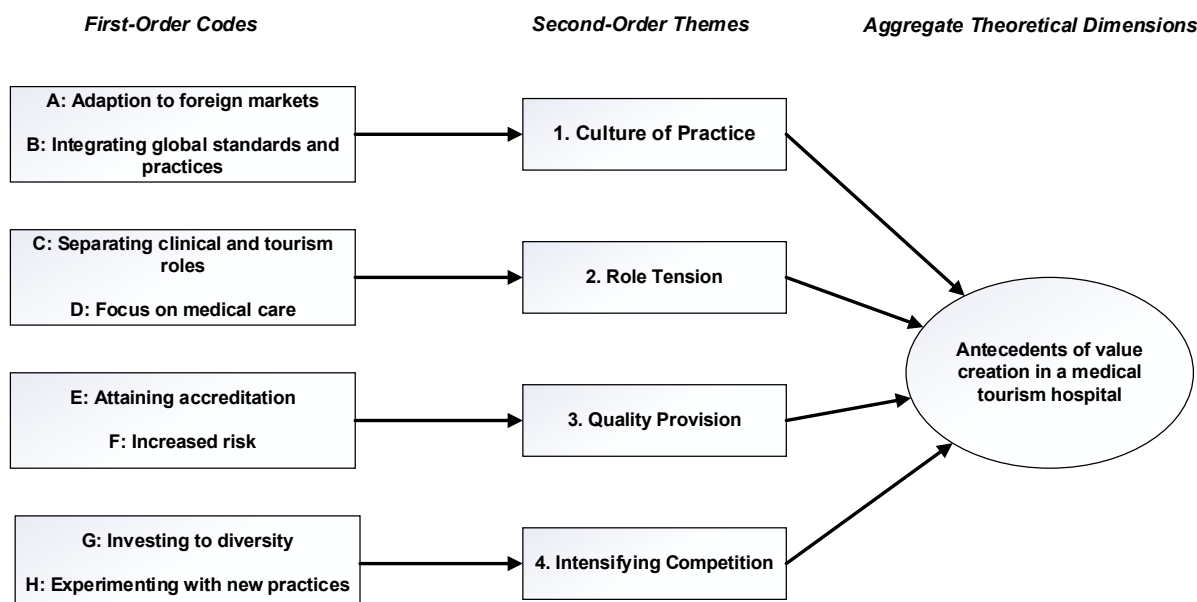
412

413 We followed the approach developed by Gioia, Corley and Hamilton (2013) to generate  
414 findings around phenomena of interest by using research subjects' own words. With this in  
415 mind, the first step in the analysis was to transcribe each interview (verbatim) after it had taken  
416 place. Across the 61 interviewees more than 60 hours of audio were recorded with  
417 transcriptions amounting to over 1,000 double-spaced pages. Furthermore, field notes and  
418 memos were taken during and after the interviews and were triangulated with the audio to

419 strengthen the validity and credibility of the research (Miles & Huberman, 1994). After this  
 420 initial step, we manually coded our data and identified empirical themes. We categorised a  
 421 series of ‘first order’ codes that reflected broad activities relating to the creation and delivery  
 422 of patient value, where key words, phrases, sentences, and paragraphs from the transcripts,  
 423 memos, field notes and secondary data were underpinned by our emerging analysis (Miles &  
 424 Huberman, 1994).

425 The final stage involved further coding and interpretation through the use of NVivo.  
 426 This aided verification of the data, re-coding it where necessary and linking key concepts as  
 427 patterns until the relationships among the emerging categories of data became obvious  
 428 (Kreiner, Hollensbe, & Sheep, 2006). The template enabled these to be coded and arranged in  
 429 a hierarchical fashion to depict the relationship between themes, with the broadest themes at  
 430 the top, and more specific second-order themes which included recurring issues relating to:  
 431 culture(s) of practice, role tension, quality provision and intensifying competition, and then  
 432 first-order sub-themes beneath. This stage of analysis aimed to ensure that the findings  
 433 emerging in the first round of coding could be systematically evidenced in the data, thus  
 434 ensuring validity. The analysis process was not linear; rather, it proceeded iteratively, moving  
 435 between data, emerging patterns, and the literature until the data were refined into adequate  
 436 conceptual themes (Eisenhardt, 1989). The resulting data structure is illustrated in Fig 2.

437



438

439 **Fig. 2.** Data structure.

440

441 *3.2 Quantitative study*

442

443 A survey was then conducted with international medical travellers who had visited Iran  
 444 for medical attention within 6 months in 2016. The questionnaires were distributed to  
 445 international patients receiving medical care in the private hospital in the last day of their visit  
 446 within the hospital (on site in order to safeguard high response and usability rates). We  
 447 designed the questionnaire and provided exact instructions on how data collection should be  
 448 undertaken. Patients were approached directly to improve the validity of our study. Using non-  
 449 probability judgmental sampling, we only conducted our questionnaire from those travellers  
 450 who had previous international medical-tourism experience. As Wells et al. (2016a, p. 67) note:  
 451 “this sampling technique has been noted as an effective way of collecting data where the aim  
 452 is theoretical advancement rather than generalisation and is used frequently in tourism and

453 hospitality studies”. We prepared several different versions of the questionnaire (English,  
454 Azeri, Russian and Arabic), since the majority of the international patients could communicate  
455 in one of these languages. We used a back-translation method in order to gain a higher level of  
456 consistency and accuracy (Wells et al., 2016b).

457 Out of the 785 respondents, 48.2% (378) were male and 51.8% the rest were female  
458 (407). An overwhelming number of participants were in the age range of 18 to 35 years old  
459 (46.2%) and 36 to 64 years old (50.1%), and 4.7% were 65 years old and older. The majority  
460 of respondent were married or in a relationship (95.9%). Similarly, most participants visiting  
461 the hospital with friends or a member of family member (89.4%). 35.4% of the respondents  
462 had a college degree, 56.7% a university degree, and 7.9% basic education or high school  
463 diploma. In terms of nationality, 59.4% of the respondents come from post-Soviet states or  
464 Turkey, 25% from the Persian Gulf, 12% from Europe and the rest from other parts of the  
465 world (3.7%). These respondents had been treated for many reasons, including: cancer; heart  
466 conditions; kidney-related issues; gynaecological issues; plastic and other cosmetic surgeries  
467 in the hospital. All participants stayed in the city between 7 and 14 days. Each questionnaire  
468 took approximately 15 minutes to complete.

469 We used the mean replacement technique to overcome missing values across the  
470 dataset. This “replaces the missing values for a variable with the mean value of that variable  
471 calculated from all responses” (Hair, Black, Babin, & Anderson, 2010, p. 53) and does not  
472 change the sample size or mean of variables. According to Tabachnick and Fidell (2013), the  
473 mean replacement technique can overcome missing values across the dataset if there are <5%  
474 incomplete data. In this study, the percentage of missing values was 1.022%. Garson (2016)  
475 also suggests missing values significantly impact structural models when more than 5% of  
476 values are missing. Thus, missing values do not have a significant impact in this study. Full  
477 details of items, mean values, and standard deviations (SD) under respective constructs are  
478 provided in **Table 2**. The values of Skewness and Kurtosis for some scale items did not fall  
479 within the acceptable range ( $\pm 3$ ), indicating non-normal data distribution (Wells et al., 2016b).

480 To test non-response bias, we compared the early and late participants based on the  
481 differences in characteristics. The results indicate no significant differences, yielding that non-  
482 response bias was not an issue for our study (Armstrong & Overton, 1977). Finally, we  
483 controlled for several variables that could threaten the accuracy of our conceptual model  
484 estimation including age, gender, visit group and marital status.

485

### 486 *3.2.1 Measurement of variables*

487

488 The items of the constructs were adapted from existing scales. All constructs were  
489 anchored at 1 = *strongly disagree* and 7 = *strongly agree*. Medical staff quality was measured  
490 by 12 items adapted from Abd Manaf et al. (2015). Three items adapted from Lu et al. (2015)  
491 measured visitors’ involvement. The perceived value measure included 4 items from Han and  
492 Hwang (2013). For measuring destination distinction, four items adapted from Brocato et al.  
493 (2015). For supporting service quality, we used 4 items from Abd Manaf et al. (2015). From  
494 items on WoM adapted from Maxham and Netemeyer (2002) and Salanova, Agut, and Peiró  
495 (2005). Finally, the second-order MTI construct (including for first-order dimensions: country  
496 environment (5-item), tourism destination (5-item), medical tourism costs (5-item) and medical  
497 facility and services (17-item) borrowed from Fetscherin and Stephano (2016). A pilot  
498 questionnaire was conducted with 30 participants and some necessary changes were made to  
499 the questionnaire.

500

### 501 *3.2.2 Analytical technique*



502 Partial least squares structural equation modelling (PLS-SEM) was used as the method  
503 of analysis this study for various reasons. (1) PLS-SEM is desired technique for estimating  
504 path coefficients in SEM as it does not require normal distribution (Wells et al., 2016a; do  
505 Valle & Assaker, 2015). We tested for multivariate normality examination by calculating z-  
506 scores for kurtosis and skewness for all items. The findings indicated that some items have the  
507 skewness and kurtoses above mandatory cut-off point of -3 and +3 (Hair et al., 2010; Mardia,  
508 1970) (**Table 2**). (2) It is a powerful technique for assessing formative, reflective and higher-  
509 order models (Hair, Hult, Ringle, & Sarstedt, 2017; Henseler, Ringle, & Sinkovics, 2009; Lee,  
510 Hallak, & Sinkovi, 2016). Our model is a combination of higher-order and reflective measures.  
511 We followed the suggested two-stage analytical technique including (Chin, 2010; Hair et al.,  
512 2017): assessing reliability and validity of the measurement model (reflective models and  
513 higher-order model) and examining the structural model, using SmartPLS 3.2.4 software.

514

### 515 *3.2.3 Common Method Variance*

516

517 As with all self-reported data, there is a potential threat of common method variance  
518 (CMV), which may be caused by multiple sources (Liang, Saraf, Hu, & Xue, 2007; Podsakoff,  
519 MacKenzie, Lee, & Podsakoff, 2003). In practice, we assured respondents anonymity and  
520 confidentiality of their response in order to reduce social desirability bias. We have placed  
521 dependent and independent variables in different section of the questionnaire. We used  
522 Harman's single-factor. Principal component analysis (PCA) (with varimax rotation) on the  
523 questionnaire items presented the existence of 6 distinctive factors (F1: 9.011; F2: 4.315; F3:  
524 2.103; F4: 2.002; F5: 1.604; F6: 1.023) with eigenvalue greater than 1, yielding 66.511% of  
525 the total variance with the first factor accounting for only 24.1 percent of the total variance  
526 (i.e., less than 50% which did not describe most of the variance). We also used the unmeasured  
527 method factor approach suggested by Min, Park and Kim (2016) and Liang et al. (2007) to  
528 further examine the CMV. The findings indicate that the average substantively explained  
529 variance of the indicators is 0.62, while the average method-based variance is 0.089, yielding  
530 a ratio of 69:1. Thus, we contend that the CMV is unlikely to be a serious concern for this  
531 study.

532

## 533 **4. Results and discussion**

534

### 535 *4.1 Qualitative analysis*

536

537 We use our qualitative analysis to answer our first research question, which asks: *How*  
538 *is value created within a MT hospital, and what organisational factors influence MT consumer*  
539 *experience?* We present our model and data structures in **Fig 2** and **Table 4** respectively and  
540 discuss the emergent themes in the following section.

541

#### 542 *4.1.1 Culture of Practice*

543

544 Staff highlighted the importance of culture in shaping how patient value was created  
545 within the MT facility. In particular, they noted the cultural specificities of working in Iran,  
546 which meant that systems developed elsewhere did not necessarily transpose into this particular  
547 context, risk-free (Connell, 2013; Momeni et al., 2018; Fetscherin & Stephano, 2016). This  
548 was salient, as the internal culture was being driven by need to emulate perceived 'gold  
549 standard' practices imported from various Western healthcare systems.

550 Others noted the effort required by employees in both adapting to external cultures and  
551 embedding those cultures within an Iranian context. Interviewees understood the importance

552 of ‘cultural match’ on the choice of their offer by foreign patients (Lee & Davis, 2005; Yu &  
553 Ko, 2012) and talked of the ways in which they had tried to accommodate service users from  
554 different cultural backgrounds. However, they also acknowledged that whilst striving to  
555 minimise issues related to cultural distance, the measures enacted thus far had not alleviated  
556 issues entirely: *“I think the new system is very good, however we could improve it, particularly*  
557 *if we want to provide service to our foreign visitors from neighbouring countries!”* (Participant  
558 25). Thus, it was recognised that with an increasingly cosmopolitan range of visitors, drawn  
559 from both neighbouring countries and further afar, adapting to each patient’s cultural  
560 expectations and specificities were challenging, in turn contributing to the risk of decreased  
561 value creation.

562  
563

**Table 4**

Exemplar data representing analytical codes.

| <b>Overarching Dimension: Organisational-level Antecedents of Value Creation in a Medical Tourism Hospital</b> |  |
|--|--|
| <b>1. Culture of Practice</b>  |  |
| A. Adaption to foreign markets   | A1: "This is a great hospital. We have changed a lot to accommodate our foreign visitors' expectations. We hope that we did a good job here!" (Participant 60).  |
| B. Integrating global standards and practices  | B1: "A couple of years ago the government adapted the UK NHS system in Iran with some cultural tweak. That seems like a good one. But, you know, the cultural tweak part sometimes it is not working" (Participant 12).  |
| <b>2. Role Tension</b>   |  |
| C. Separating clinical and tourism roles   | C1: "As far as I understand the roles and medical services, responsibility for the patient should stay with us during and after the service...I take care of medical treatments and the tourism stuff stays with our medical tourism division. I disappear after my service to my patient... I keep my doctor and patient relationship seriously but I am not a tour guide!... I am sure they will come back to us based on excellent service from our hospital" (Participant 25). |
| D. Focus on medical care   | D1: "I am a doctor. I am not an entertainer. I do my professional job which is taking care of my patients, and I am busy. I cannot put them in the car and drive around...Also, I want to keep my doctor and patient relationship in a way it is supposed to be... I think they appreciate service more than tourism, and I know this as I have several foreign patients... they bring more patients to us... their family and friends I mean" (Participant 60).                   |
| <b>3. Quality Provision</b>  |  |
| E. Attaining accreditation   | E1: "You know if we receive a good recognition from the accreditation body. I think that will impact on our organisation and personally I will feel proud. However, a lot of paperwork is involved! I do not like it - it means more work for us" (Participant 50).  |
| F. Increased risk  | F1: "You know for me, some of this control process is good and some is bad. It might help to increase the profit and I cannot think about the negative side of it, but I am sure it has some. Also, you know there are always some fines involved if we do not follow them" (Participant 37).  |
| <b>4. Intensifying Competition</b>   |  |
| G. Investing to diversify  | G1: "We are not alone in this city. There are a couple of hospitals and health clinics. Some of them provide different health things which we do not have here. But it seems we want to extend our hospital. Hopefully we will cover all different aspects" (Participant 10).  |
| H. Experimenting with new practices  | H1: "We have tried to change a lot things in our hospital last several years. We want to get more international visitors. It is a tough business and there is a lot of competition going on at the moment in the city. We are not the only hospital in the city" (Participant 22).   |

564

565 4.1.2 Role Tension

566

567 An aspect of medical tourism that has been overlooked in extant literature is the role-  
568 tension that employees, particularly on the clinical side, can experience. We found this impacts  
569 on value creation as clinical staff can experience additional pressures to meet patient  
570 expectations which are often founded on receiving a holistic ‘experience’. This causes some  
571 tension, as the clinical employees’ professional identities are at risk of being eroded as the  
572 medical component of MT is subsumed into the larger ‘package’, causing some medical staff  
573 to react assertively by reinforcing their medical credibility and undermining - or even  
574 sabotaging - the hedonic aspects of value creation by diminishing it when interacting with  
575 patients. This was evident from some medics we spoke with, who stated quite firmly: “*I*  
576 *appreciate we want to have more foreign patients in our hospital. But I think doctor should do*  
577 *the doctor job and tour person do his job. I believe the medical service is more important than*  
578 *entertaining them here”* (Participant 35).

579 This is a phenomenon that is recognisable across other industrial contexts, including  
580 social entrepreneurship, in which entrepreneurs experience a tension between mission-derived  
581 activities and profit-based activities (Pache & Santos, 2013), and creative industries where  
582 artists and managers navigate difficult relations (Bieme, 2012). In the MT context however,  
583 we note that there was a division of labour in our case study hospital which compartmentalised  
584 the leisure/hedonic aspects of packages and clinical care, leading to potentially inconsistent  
585 approaches to value creation/customer experience (O’Cass & Sok, 2015; Taheri et al., 2017).

586

587 4.1.1 Quality provision

588

589 Medical and support staff were very aware of the importance of their care and support  
590 on the overall perception of the hospital, supporting research focusing on medical service users  
591 (Abd Manaf et al., 2015; Hall, 2017; Han & Hwang, 2013; Lovelock & Lovelock, 2018). Staff  
592 also acknowledged the importance of reputation and accreditation on their attractiveness as a  
593 destination of choice (Lunt & Carrera, 2011; Moghavvemi et al., 2017; Smith & Forgione,  
594 2007): “*You know if we do our job properly with regards to whatever government asks us to*  
595 *do, we will stay as a high ranked hospital which is good”* (Participant 19).

596 The importance of quality of provision on tourist's choice of this particular facility and  
597 appraisal of the service offered (Fetscherin & Stephano, 2016) was recognised by management  
598 and there were clear structures and systems in place to ensure that the level of care was  
599 consistently high. In order to maintain accreditation incentives were developed to encourage  
600 compliance. We found that, in the main, staff also showed understanding of the rules and also  
601 the importance of transparency of systems and collaboration across departments. Many staff  
602 expressed a personal pride in achieving international recognition, and there was a realisation  
603 that this was an important means of attracting international patients, which in turn, secures the  
604 future and prosperity of the hospital.

605 However, even whilst acknowledging the importance of the monitoring of quality of  
606 provision on actual service offer to patients (Abd Manaf et al., 2017; Fetscherin & Stephano,  
607 2016; Moghavvemi et al., 2017), some interviewees stressed how this service focus impacted  
608 upon their day-to-day roles. Particular issues highlighted were the work involved in what were  
609 regarded as extra administrative tasks and the time this took them away from their other more  
610 patient-focused roles. Some interviewees felt particularly conflicted by what they felt to be an  
611 increasingly controlling environment, with punitive measures enforced for those not following  
612 the rules. Whilst they understood the rationale behind these measures they felt these were  
613 overly-driven by the financial targets of the hospital and that these controls also had negative

614 impacts on the day to day working experiences of staff at the *hospital*: "You know there are  
615 *always some fines involved if we do not follow them*" (Participant 37).

616

#### 617 *4.1.2 Intensifying competition*

618

619 Our qualitative interviews surfaced some insights into the effects of competition on MT  
620 providers. MT is seen as a potentially lucrative business proposition and interviewees talked  
621 of the increasing local competition in this market. Providers reacted to local competitive  
622 pressures by considering ways to provide enhanced value (Hall, 2017; Momeni et al., 2018).  
623 They did this in a number of ways, including a focus on the quality of their service, extending  
624 the variety of treatments on offer and focusing on the growing demand from the international  
625 market.

626 Thus, the competitiveness of the neighbouring markets had a positive impact on value  
627 creation (O’Cass & Sok, 2015; Taheri et al., 2017), as it led to the MT facility investing more  
628 in-service delivery as a means of differentiating the value proposition. Furthermore, it caused  
629 them to reflect critically on various aspects of practice, and they displayed an openness to  
630 removing ineffective processes and replacing them with newer ways of doing things. However,  
631 it was noted that competition in the local market had the potential to drive down prices, which  
632 again led to a focus on differentiated, higher-value treatments.

633

#### 634 *4.2 Quantitative analysis*

635

##### 636 *4.2.1 Assessment of the measurement model*

637

638 Convergent validity of reflective constructs were assessed using composite reliability  
639 (CR), Cronbach’s Alpha ( $\alpha$ ), factor loadings and average variance extracted (AVE). CR and  $\alpha$   
640 indicated values above the mandatory thresholds of 0.7. The AVE values exceeded the  
641 threshold of 0.5 for all constructs and factor loadings exceeded the recommended value of 0.6  
642 (Hair et al., 2010) (see **Table 5**). We assessed discriminant validity with various methods.  
643 Following Fornell and Larcker (1981) suggestion, the square root of the AVE (diagonal values)  
644 of all constructs were larger than all other cross correlations in **Table 6**. The correlations among  
645 all first-order reflective constructs were well below the 0.7 cut-off value in **Table 6**.

646

**Table 5**

647

Descriptive statistics, validity, reliability of the constructs.

| Constructs                         | Items   | Mean  | SD     | Skewness | Kurtosis | Loadings* | AVE   | CR    | $\alpha$ |
|------------------------------------|---|-------|--------|----------|----------|-----------|-------|-------|----------|
| MTI- Country<br>Environment (D1)   |   |       |        |          |          |           | 0.596 | 0.870 | 0.822    |
|                                    | Stable exchange rate  | 4.89  | 1.182  | -1.021   | -0.858   | 0.687     |       |       |          |
|                                    | Low corruption  | 4.03  | 1.819  | -1.218   | -0.912   | 0.665     |       |       |          |
|                                    | Cultural similarity   | 4.34  | 2.125  | 1.327    | -1.235   | 0.789     |       |       |          |
|                                    | Overall positive country image                                | 4.92  | 1.928  | 1.643    | -0.697   | 0.707     |       |       |          |
|                                    | Language similarity   | 4.77  | 1.792  | 1.626    | -0.693   | 0.764     |       |       |          |
|                                    | Safe to travel to country                                     | 4.77  | 1.111  | -1.077   | -0.811   | 0.776     |       |       |          |
| Stable economy                     | 4.56  | 1.019 | -1.569 | -0.936   | 0.780    |           |       |       |          |
| MTI- Tourism<br>Destination (D2)   |   |       |        |          |          |           | 0.518 | 0.843 | 0.767    |
|                                    | Popular tourist destination                                   | 4.83  | 1.647  | 1.027    | -0.168   | 0.769     |       |       |          |
|                                    | Exotic tourist destination                                    | 4.12  | 1.259  | 1.003    | 0.463    | 0.740     |       |       |          |
|                                    | Weather conditions  | 4.17  | 1.642  | 2.311    | -3.449   | 0.690     |       |       |          |
|                                    | Attractiveness of the country as a tourist destination        | 5.06  | 1.258  | -2.003   | 3.411    | 0.701     |       |       |          |
|                                    | Many cultural and natural attractions                         | 4.09  | 1.551  | -1.339   | -0.656   | 0.695     |       |       |          |
| MTI- Medical Tourism<br>Costs (D3) |   |       |        |          |          |           | 0.577 | 0.815 | 0.711    |
|                                    | Low cost of treatment   | 4.58  | 1.171  | -2.078   | -4.069   | 0.692     |       |       |          |
|                                    | Lower healthcare costs  | 4.47  | 1.601  | 1.381    | -0.994   | 0.669     |       |       |          |
|                                    | Low cost of accommodation                                     | 4.08  | 1.364  | 2.159    | -1.019   | 0.767     |       |       |          |
|                                    | Low costs to travel   | 5.93  | 0.961  | 2.171    | 3.811    | 0.811     |       |       |          |
|                                    | Affordability of airfares                                     | 5.91  | 0.801  | 1.370    | 2.721    | 0.756     |       |       |          |
| MTI- Facility and<br>Services (D4) |   |       |        |          |          |           | 0.507 | 0.889 | 0.864    |
|                                    | Doctor's training   | 4.08  | 2.076  | -1.120   | -1.300   | 0.616     |       |       |          |
|                                    | Doctor's expertise  | 4.81  | 2.210  | -1.027   | -1.415   | 0.601     |       |       |          |
|                                    | High healthcare quality indicators (e.g., low infection rate) | 4.49  | 1.987  | -1.257   | -4.206   | 0.638     |       |       |          |
|                                    | Reputation of doctors   | 4.91  | 1.918  | -2.011   | -2.981   | 0.696     |       |       |          |
|                                    | High quality standards  | 4.50  | 2.032  | 1.323    | -1.036   | 0.692     |       |       |          |

|                       |   |      |       |        |        |       |       |       |       |
|-----------------------|---|------|-------|--------|--------|-------|-------|-------|-------|
|                       | High quality of care  | 4.72 | 2.069 | 1.110  | 0.071  | 0.663 |       |       |       |
|                       | State-of-the-art medical equipment  | 4.76 | 2.197 | 1.082  | -1.469 | 0.716 |       |       |       |
|                       | Quality in treatments and materials   | 4.13 | 2.188 | -3.266 | -3.465 | 0.642 |       |       |       |
|                       | Accreditation of the medical facility   | 4.85 | 1.774 | -1.449 | -1.040 | 0.615 |       |       |       |
|                       | Reputation of the hospital/facility   | 4.89 | 1.802 | -1.334 | -0.977 | 0.723 |       |       |       |
|                       | Country medical reputation  | 4.91 | 1.907 | -3.431 | -0.991 | 0.750 |       |       |       |
|                       | International certified doctors   | 4.72 | 1.483 | -1.302 | 0.153  | 0.669 |       |       |       |
|                       | Internationally certified staff   | 4.20 | 1.893 | -4.115 | -1.208 | 0.669 |       |       |       |
|                       | International educated doctors  | 4.69 | 1.419 | -1.191 | -1.050 | 0.678 |       |       |       |
|                       | Friendliness of staff and doctors   | 5.77 | 1.521 | -4.410 | -1.037 | 0.609 |       |       |       |
|                       | Family recommendation of doctors  | 4.92 | 1.395 | 1.259  | 0.718  | 0.648 |       |       |       |
|                       | Family/friend recommendation of the hospital/facility                                 | 4.82 | 1.891 | 4.287  | -2.929 | 0.659 |       |       |       |
| Medical Staff Quality |   |      |       |        |        |       | 0.526 | 0.895 | 0.875 |
|                       | The nurses allowed me to ask many questions, enough to clarify everything             | 4.89 | 1.182 | -1.029 | -0.858 | 0.719 |       |       |       |
|                       | The nurses adequately explained my condition, examination results and medical process | 4.03 | 1.819 | -2.218 | -0.912 | 0.719 |       |       |       |
|                       | There was ease of assembling and transmitting of medical record/information           | 4.34 | 2.125 | 4.327  | -1.235 | 0.606 |       |       |       |
|                       | Medical staff were polite and friendly  | 4.92 | 1.928 | 2.643  | -0.697 | 0.676 |       |       |       |
|                       | The process for setting up the medical procedure appointment was simple and easy      | 4.77 | 1.792 | 1.626  | -0.693 | 0.689 |       |       |       |
|                       | The nurses paid enough attention to my concerns in deciding on a medical procedure    | 4.58 | 1.171 | -1.078 | -1.069 | 0.641 |       |       |       |
|                       | The hospital has adequate grievance channel for patients                              | 4.47 | 1.603 | 1.381  | -0.994 | 0.731 |       |       |       |
|                       | The hospital has acceptable protection against medical malpractice and liability      | 4.08 | 1.311 | 1.159  | -1.019 | 0.621 |       |       |       |
|                       | The medical staff have good communication skills                                      | 4.93 | 0.968 | 1.471  | 2.811  | 0.727 |       |       |       |
|                       | Arrangement for language interpretation service is provided                           | 4.91 | 2.823 | 4.370  | 2.721  | 0.747 |       |       |       |
|                       | Availability of medical staff and nurses who can speak my language                    | 4.40 | 1.951 | -3.074 | -1.164 | 0.766 |       |       |       |

|                         |          |   |      |       |        |        |       |       |       |       |
|-------------------------|----------|---|------|-------|--------|--------|-------|-------|-------|-------|
| Supporting Quality      | Services | Short waiting time for the medical examination from the nurses and medical staff            | 4.57 | 1.766 | -2.261 | -0.782 | 0.744 | 0.534 | 0.872 | 0.824 |
|                         |          | The hospital amenities (cafeteria and public telephone) were conveniently located           | 4.78 | 2.076 | -3.120 | -1.300 | 0.695 |       |       |       |
| Tourism Involvement     |          | Hospital care facilities (laboratory and doctors' office) were easy to find                 | 4.81 | 2.210 | -3.027 | -1.415 | 0.684 | 0.575 | 0.778 | 0.744 |
|                         |          | The hospital's attention to patient s' privacy, confidentiality and disclosure is good      | 4.11 | 1.695 | -2.257 | -1.206 | 0.803 |       |       |       |
|                         |          | The hospital has state-of-the-art facilities and equipment                                  | 4.91 | 1.918 | -1.011 | -0.981 | 0.802 |       |       |       |
|                         |          | The hospital provides free Internet access  | 4.77 | 2.076 | 3.720  | 0.987  | 0.762 |       |       |       |
|                         |          | The payment procedure was quick and simple  | 4.81 | 2.210 | 1.323  | -1.036 | 0.717 |       |       |       |
|                         |          | There are a variety activity for you to participate in                                      | 4.93 | 2.032 | 4.323  | -1.036 | 0.605 |       |       |       |
|                         |          | The activities that you can participate in are interesting                                  | 4.72 | 2.069 | 1.110  | 0.071  | 0.904 |       |       |       |
|                         |          | You can freely participate in various tourist activities                                    | 4.76 | 2.197 | 1.082  | -1.469 | 0.904 |       |       |       |
| Destination Distinction |          | This city is unique   | 4.13 | 2.188 | -3.266 | -1.465 | 0.692 | 0.576 | 0.844 | 0.758 |
|                         |          | This city has distinctive features that are not offered anywhere else                       | 4.85 | 1.774 | -1.449 | -1.040 | 0.769 |       |       |       |
|                         |          | This city offers something different than the norm  | 4.89 | 1.802 | -1.334 | -0.977 | 0.783 |       |       |       |
|                         |          | This city is the only one of its kind   | 4.91 | 1.907 | -2.431 | -0.991 | 0.787 |       |       |       |
| Perceived Value         |          | The medical treatment service and city offerings in this hospital is worth the price I paid | 4.58 | 1.961 | 0.071  | 2.811  | 0.772 | 0.547 | 0.784 | 0.703 |
|                         |          | I think this hospital and city provide a good deal and service                              | 4.43 | 1.801 | 0.370  | 2.721  | 0.743 |       |       |       |



|     |   |      |       |        |        |       |       |       |       |
|-----|---|------|-------|--------|--------|-------|-------|-------|-------|
| WoM | I think this hospital and city provide me great value as compared to other medical treatment/healthcare places/clinics and cities | 4.89 | 1.002 | 1.408  | 2.073  | 0.702 |       |       |       |
|     |   |      |       |        |        |       | 0.530 | 0.817 | 0.714 |
|     | I will say positive things about this hospital and City to other people   | 4.69 | 1.951 | -1.074 | -1.164 | 0.618 |       |       |       |
|     | I will recommend this hospital and City to someone who seeks my advice  | 4.51 | 1.766 | -1.261 | -0.780 | 0.801 |       |       |       |
|     | I will encourage friends and relatives to stay at this hospital and City  | 4.87 | 1.861 | -1.581 | -1.970 | 0.773 |       |       |       |
|     | I'm likely to spread positive word-of-mouth about this hospital and City  | 4.91 | 1.694 | -1.387 | -1.738 | 0.706 |       |       |       |

648 Note: *t*-values for the item loadings to two-tailed test:  $t > 2.57$  at  $*p < 0.01$ .  
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**Table 6**  
Discriminant validity.

|              | 1          | 2           | 3           | 4           | 5           | 6           | 7           | 8           | 9           | 10          | 11          |
|--------------|------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| (1) MTI      | <b>n/a</b> |             |             |             |             |             |             |             |             |             |             |
| (2) WoM      | 0.04       | <b>0.72</b> |             |             |             |             |             |             |             |             |             |
|              | 7          | <b>0</b>    |             |             |             |             |             |             |             |             |             |
| (3) Country  | 0.51       | 0.04        | <b>0.77</b> |             |             |             |             |             |             |             |             |
| Environmen   | 9          | 9           | <b>2</b>    |             |             |             |             |             |             |             |             |
| t            |            |             |             |             |             |             |             |             |             |             |             |
| (4)          | 0.04       | 0.26        | 0.00        | <b>0.75</b> |             |             |             |             |             |             |             |
| Destination  | 3          | 7           | 3           | <b>8</b>    |             |             |             |             |             |             |             |
| Distinction  |            |             |             |             |             |             |             |             |             |             |             |
| (5) Facility | 0.61       | 0.04        | 0.27        | 0.06        | <b>0.71</b> |             |             |             |             |             |             |
| and Services | 1          | 8           | 5           | 4           | <b>2</b>    |             |             |             |             |             |             |
| (6) Tourism  | 0.05       | 0.39        | 0.01        | 0.35        | 0.06        | <b>0.75</b> |             |             |             |             |             |
| Involvement  | 1          | 6           | 0           | 6           | 5           | <b>8</b>    |             |             |             |             |             |
| (7) Medical  | 0.01       | 0.00        | 0.02        | 0.20        | 0.00        | 0.21        | <b>0.72</b> |             |             |             |             |
| Staff        | 0          | 1           | 7           | 8           | 3           | 4           | <b>5</b>    |             |             |             |             |
| Quality      |            |             |             |             |             |             |             |             |             |             |             |
| (8) Medical  | 0.64       | 0.00        | 0.29        | 0.00        | 0.56        | 0.03        | 0.03        | <b>0.75</b> |             |             |             |
| Tourism      | 3          | 9           | 9           | 2           | 5           | 6           | 5           | <b>9</b>    |             |             |             |
| Costs        |            |             |             |             |             |             |             |             |             |             |             |
| (9)          | 0.05       | 0.31        | 0.00        | 0.61        | 0.06        | 0.24        | 0.25        | 0.00        | <b>0.73</b> |             |             |
| Perceived    | 3          | 6           | 9           | 0           | 6           | 8           | 4           | 7           | <b>9</b>    |             |             |
| Value        |            |             |             |             |             |             |             |             |             |             |             |
| (10)         | 0.00       | 0.00        | 0.02        | 0.28        | 0.00        | 0.31        | 0.61        | 0.03        | 0.31        | <b>0.73</b> |             |
| Supporting   | 5          | 6           | 8           | 8           | 6           | 5           | 8           | 6           | 6           | <b>0</b>    |             |
| Service      |            |             |             |             |             |             |             |             |             |             |             |
| (11)         | 0.62       | 0.02        | 0.26        | 0.01        | 0.53        | 0.00        | 0.02        | 0.46        | 0.07        | 0.02        | <b>0.75</b> |
| Tourism      | 4          | 2           | 8           | 8           | 3           | 9           | 6           | 4           | 5           | 6           | <b>8</b>    |
| Destination  |            |             |             |             |             |             |             |             |             |             |             |

652 Note: AVE square value of MTI construct is absent as MTI was specified as a higher-order model, with  
653 AVEs only relevant to its 4 dimensions. Values on the bolded diagonal are square root of the AVE.

654

655 Henseler, Ringle, and Sarstedt (2015) also criticised Fornell and Larker (1981) criteria  
656 by suggesting alternative approach of the heterotrait-monotrait (HTMT) ratio of correlations.  
657 If the HTMT value is lower than 0.85, discriminant validity should be documented between  
658 constructs. In our study, HTMT values of the first-order constructs surpassed HTMT 0.85  
659 (**Table 7**) (Henseler et al., 2015). Thus, the reflective constructs have adequate convergent and  
660 discriminant validity.

661

662

663 **Table 7**  
664 HTMT results.

|             | 1     | 2     | 3     | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|-------------|-------|-------|-------|---|---|---|---|---|---|----|----|
| (1) MTI     |       |       |       |   |   |   |   |   |   |    |    |
| (2) WoM     | 0.056 |       |       |   |   |   |   |   |   |    |    |
| (3) Country | 0.679 | 0.070 |       |   |   |   |   |   |   |    |    |
| Environment |       |       |       |   |   |   |   |   |   |    |    |
| (4)         | 0.063 | 0.338 | 0.003 |   |   |   |   |   |   |    |    |
| Destination |       |       |       |   |   |   |   |   |   |    |    |
| Distinction |       |       |       |   |   |   |   |   |   |    |    |

|                           |       |       |       |       |       |       |       |       |       |       |
|---------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| (5) Facility and Services | 0.016 | 0.047 | 0.336 | 0.104 |       |       |       |       |       |       |
| (6) Tourism Involvement   | 0.104 | 0.588 | 0.044 | 0.547 | 0.136 |       |       |       |       |       |
| (7) Medical Staff Quality | 0.027 | 0.041 | 0.026 | 0.230 | 0.068 | 0.347 |       |       |       |       |
| (8) Medical Tourism Costs | 0.706 | 0.019 | 0.402 | 0.002 | 0.703 | 0.065 | 0.061 |       |       |       |
| (9) Perceived Value       | 0.096 | 0.436 | 0.004 | 0.735 | 0.133 | 0.436 | 0.321 | 0.010 |       |       |
| (10) Supporting Service   | 0.031 | 0.000 | 0.033 | 0.366 | 0.065 | 0.543 | 0.684 | 0.044 | 0.455 |       |
| (11) Tourism Destination  | 0.743 | 0.026 | 0.331 | 0.015 | 0.640 | 0.010 | 0.040 | 0.643 | 0.116 | 0.035 |

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Following Becker et al. (2012) recommendation, we applied formative-formative hierarchical component model. For the MTI second-order construct, we assessed convergent validity, multicollinearity, external validity and nomological validity (Hair et al., 2017). Four first-order reflective dimensions of MTI had CR,  $\alpha$ , AVE values above the required threshold values. Thus, each dimension demonstrated convergent validity. We checked multicollinearity among the indicators (Fetscherin & Stephano, 2016) by calculating the variance inflation factor (VIF) and the tolerance test of multicollinearity. Multi-collinearity was assessed using variance inflation factors (VIF) for the 4 sub-scales comprising the second-order MTI construct and the significance of outer weights (**Table 8**). The results are acceptable as VIFs for all four comprising the second-order construct are <3 (Hair et al., 2017). The tolerance statistics all well above 0.33 (ranging from 0.427 to 0.751), thus we can safely conclude that there is no collinearity within our data. Furthermore, we tested the external validity by calculating whether each dimension significantly correlated with a ‘global item’ that recaps the spirit of the MTI (i.e., meta-analytic approach) (Taheri, Jafari, & O’Gorman, 2014; Wanous & Reichers, 1999). In doing so, we used an item in our survey based on the definition of MTI: ‘In my opinion, a medical tourism destination should provide overall country environment, healthcare costs and tourism attractiveness, and quality of medical facilities and services’. As shown in **Table 8**, all four dimensions significantly correlate with the global item. Thus, external validity was established. Finally, we tested nomological validity in our PLS-SEM to assure if our MTI construct acts as expected (Bagozzi, 1980; Fetscherin & Stephano, 2016; Hair et al., 2017; Hair et al., 2010). **Table 8** represents weights of the first order constructs on the second order construct. The weights illustrate items with greater effect in the explanation of each construct. All related path relationships are significant, which supports the nomological validity of MTI construct.

**Table 8**

Weights of the first order constructs on the second order construct.

| MTI-Dimension       | Spearman’s rank correlation | Weight* |
|---------------------|-----------------------------|---------|
| Country Environment | 0.242*                      | 0.719*  |

|                       |        |        |
|-----------------------|--------|--------|
| Tourism Destination   | 0.341* | 0.724* |
| Medical Tourism Costs | 0.318* | 0.743* |
| Facility and Services | 0.338* | 0.911* |

693 Note: *t*-values for the item loadings to two-tailed test:  $t > 2.57$  at  $*p < 0.01$ .

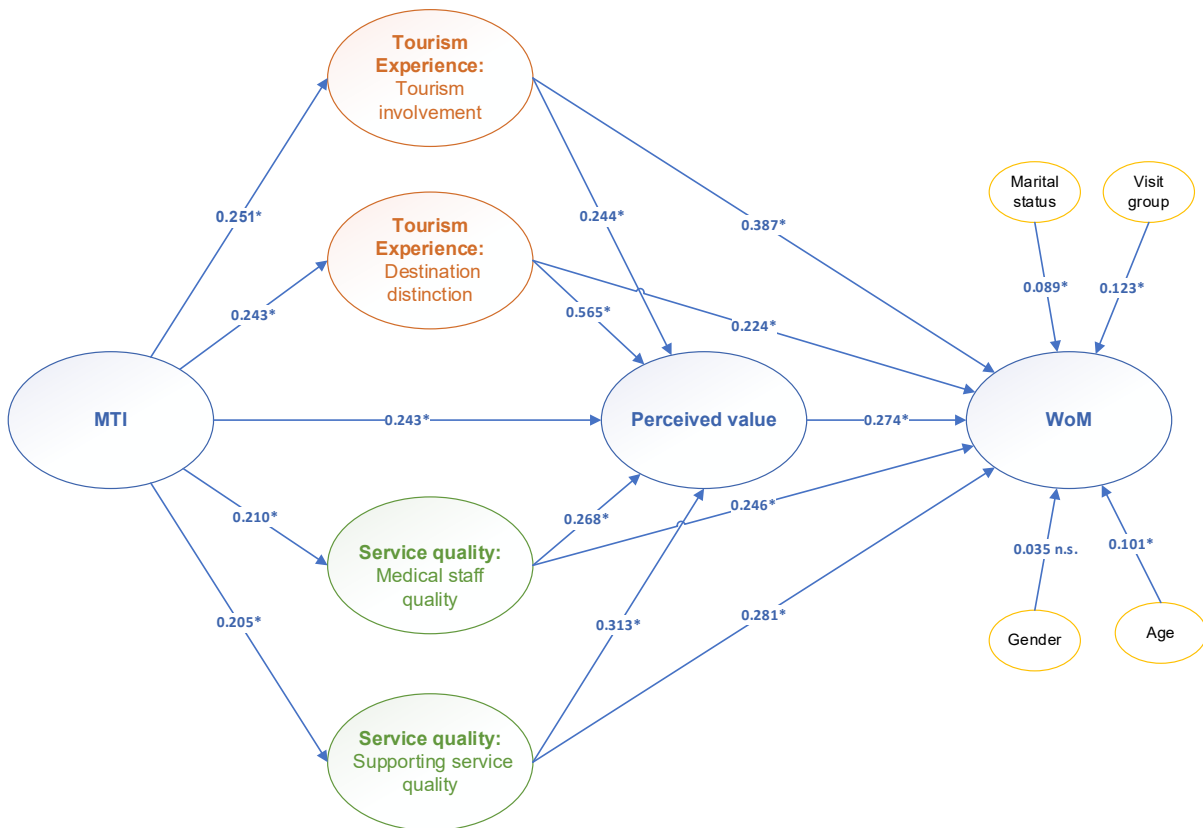
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695 *4.2.2 Assessment of the structural model*

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697 For the structural model, the non-parametric bootstrapping technique was tested with  
698 785 cases, 5000 subsamples. Stone-Geisser's  $Q^2$  value tested the criterion of predictive  
699 relevance (Hair et al., 2017). The  $Q^2$  value was achieved by using the blindfolding procedure.  
700 For this study, we employed cross-validated redundancy procedure to assess  $Q^2$ . A  $Q^2$  value  
701 greater than 0 indicates the model has predictive relevance.  $Q^2$  values are above this threshold  
702 in our study. We also used SRMR (standardised root mean square residual) as a fit indicator  
703 (Henseler et al., 2014). Our SRMR value is 0.037 which is less than recommended value of  
704 0.08. We also tested Cohen's effect sizes ( $f^2$ ). Cohen's effect sizes ( $f^2$ ) signifies 0.01 for small,  
705 0.06 for medium, and 0.14 for large effects within a structural equation modelling approach.  
706 (Khalilzadeh & Tasci, 2017). The model explains 18% of tourism involvement, 22% of  
707 destination distinction, 33% of medical staff quality, 17% supporting service quality, 39% of  
708 perceived value and 34% of WoM. As shown in **Fig 3**, all path relationships were supported.  
709 In practice, we connected the control variables to WoM. In terms of the control variables, age,  
710 visit group and marital status found to be significantly connected to participants WoM. Gender  
711 has no significant effect on the WoM.

712



Note: *t*-values for the item loadings to two-tailed test:  $t > 2.57$  at  $*p < 0.01$ ; n.s. = non-significant.

713

714 **Fig. 3.** Results of structural model.

715

716 *4.2.3 Post-hoc analysis of the indirect effects*

717

718 The findings proposed the potential existence of mediating relationships for the study  
719 (i.e., post-hoc analysis of the indirect effects). Following Williams and MacKinnon (2008) and  
720 Perez-Vega, Taheri, Farrington, and O’Gorman (2018) recommendations, bootstrapping  
721 analysis for the significance of the indirect effects considering the *t*-values as well as the  
722 confidence interval (CI) were used. Following **Table 9**, the results indicate that MTI indirectly  
723 influences perceived value through tourism involvement (95% CI = [0.103, 0.147]), destination  
724 distinction (95% CI = [0.202, 0.256]), medical staff quality (95% CI = [0.123, 0.157]) and  
725 supporting service quality (95% CI = [0.250, 0.293]). Since the direct effect were significant,  
726 the results reveal that involvement, destination distinction, medical staff quality and supporting  
727 service quality partially mediate the influence of MTI on perceived value. Similarly, results  
728 reveal indirect effect of tourism involvement (95% CI = [0.289, 0.346]), destination distinction  
729 (95% CI = [0.266, 0.298]), medical staff quality (95% CI = [0.217, 0.1247]) and supporting  
730 service quality (95% CI = [0.248, 0.284]) through perceived value on WoM were significant.  
731 Since the direct effects were significant, the results indicate that perceived value partially  
732 mediate the influence of tourism involvement, destination distinction, medical staff quality and  
733 supporting service quality on WoM (see **Table 9**).

734

735 **Table 9**

736 *Estimates of indirect effects.*

| Indirect path                                      | Indirect effect* | Low CI | High CI |
|--|------------------|--------|---------|
| MTI → Tourism Involvement → Perceived value        | 0.123            | 0.103  | 0.147   |
| MTI → Destination Distinction → Perceived value    | 0.238            | 0.202  | 0.256   |
| MTI → Medical Staff Quality → Perceived value      | 0.139            | 0.123  | 0.157   |
| MTI → Supporting Service Quality → Perceived value | 0.278            | 0.250  | 0.293   |
| Tourism Involvement → Perceived value → WoM        | 0.321            | 0.289  | 0.346   |
| Destination Distinction → Perceived value → WoM    | 0.289            | 0.266  | 0.298   |
| Medical Staff Quality → Perceived value → WoM      | 0.233            | 0.217  | 0.247   |
| Supporting service Quality → Perceived value → WoM | 0.268            | 0.248  | 0.284   |

737 Note: *t*-values for the item loadings to two-tailed test:  $t > 2.57$  at  $*p < 0.01$ .

738

739 **5. Conclusion and implications**

740

741 *5.1 Theoretical contributions*

742

743 The paper has examined, using mixed methods, two core questions: 1) How is value  
744 created through service delivery within a MT hospital and what organisational factors influence  
745 MT patient experience? and; 2) What effect do the expectations and experience of medical  
746 tourism have on word of mouth referrals?

747 In answering these questions, our study makes a number of contributions to MT  
748 research. First, our model integrates constructs relating to destination distinction, healthcare  
749 provision and the perceived value of the treatment package. From our quantitative study, we  
750 found MTI positively influences tourism involvement, destination distinction, medical staff  
751 quality, supporting service quality and perceived value, aligning with previous studies by (e.g.,  
752 Abd Manaf et al., 2015; Gursoy & Gavcar, 2003; Han & Hyuan, 2012; Lee, 2010; Qu et al,

201; Kim & Han, 2008; Prayag & Ryan 2012; Viladrich & Baron-Faust, 2014). Tourism involvement, destination distinction, medical staff quality and supporting service quality positively influence perceived value which further supports previous studies (e.g., Abd Manaf et al., 2015; Kim & Han, 2008; Lee, 2010; Lovelock & Lovelock, 2018; Prayag & Ryan, 2012; Qu et al., 2011). Finally, tourism involvement, destination distinction, medical staff quality, supporting service quality and perceive value positively impact on WoM, supporting previous studies (e.g., Abd Manaf et al., 2015; Fetscherin & Stephano, 2016; Gursoy & Gavcar, 2003; Lu et al., 2015; Prayag & Ryan, 2012; Pike & Ryan, 2004). The results also provide several indirect effects between constructs (**Table 9**) which we propose require further investigation. Thus, we found that aspects of service experience (around medical treatment) and destination, positively influence perceived value and ultimately result in the intention to recommend and refer the MT provider. We believe the results are robust since we controlled for control variables in our study.

Medical tourism is a significant economic trend. The market for medical tourism is expanding, and many developing countries are capitalising on both their distinct medical competences and cultural assets to attract foreign visitors to their hospitals. A recent comprehensive analysis of 392 MT articles concluded that scholars should shift attention towards “economic and marketing issues” to advance the research field (Chuang et al., 2014, p. 57). Accordingly, we use the case of a MT hospital in Iran to explore the antecedents of WoM and the perceived value of treatment packages. WoM is critical for MT providers as it has been identified by scholars as the most significant marketing channel for prospective patients (Lee, 2010; Yeoh et al., 2013). We diverge from previous MT studies however, by examining the drivers rather than consequences of WoM (e.g., Abubakar, 2016) and in doing so advance a detailed theoretical model of the cognitive factors influencing WoM referrals.

Our service-delivery focus offers an important new perspective on the organisational-level dynamics that are shaping WoM in a MT context. The role of professional identity and the increasing commercialisation of medical care has been overlooked as a research topic, with only a small body of literature examining this key facet of MT (Skountridaki, 2017). Recognising that patient evaluations of their experience at a MT facility can be formed by interactions with *any* member of staff (from porter through to surgeon), we draw on empirical materials from all job families in the hospital to understand some of the positive and negative factors influencing value creation (O’Cass & Sok, 2015; Taheri et al., 2017). Interestingly, while senior medics worry about their professional identity (i.e., not being viewed as ‘entertainers’), administrative and support staff were increasingly consumed by pressures relating to accreditation and ranking. These findings offer an interesting counterpoint to recent research from a patient perspective (Lovelock & Lovelock, 2018) which stresses that medical tourists have often high expectations of a leisure component, which we suggest could be undermined by clinical staff who are not sufficiently ‘on board.’

Research has highlighted the importance of WoM for MT service providers, yet the key antecedents in a medical tourism context are, thus far, less understood. MT providers must deliver service provision to patients who have dual expectations related to their medical treatment and also their wider tourism experience (Yu & Ko, 2012). In this research, we find that tourism and service experience are both positively related to WoM referrals and that perceptions of value are determined by both. We conclude by highlighting the criticality of perceptions of service quality on WoM directly and also mediated through perceived value. Our findings highlight the salience of supporting service quality to the overall service experience of MT patients. Thus, medical service providers need to pay attention to the ‘softer’ elements of service delivery such as ease of payments, free internet provision and hospital amenities as well as the actual medical care.

802 We also offer a novel perspective on MT by soliciting data from both consumers of  
803 MT services and those who participate in the delivery of MT services (ranging from doctors to  
804 hospital managers). Extant MT research has typically focussed on patient data alone (e.g., Yeoh  
805 et al., 2013) and this has restricted understanding of the service dimension of MT. We therefore  
806 offer a valuable insight into aspects of service delivery through our qualitative data by  
807 unpacking how everyday service delivery tensions encountered by medics and support staff  
808 may influence evaluations from MT patients. Our MT provider data for example, shows some  
809 of the tensions faced within medical facilities by those who have to provide medical care, while  
810 also providing a tourism ‘experience.’ Rather than finding outright hostility, or resentment  
811 towards the dual role, we found staff across different positions keen to try adapting to the  
812 competitive situation, though this is not without challenges, as our data indicates.

813 We suggest future studies develop this perspective further to understand how those with  
814 different roles might experience the demands of MT care differently, and how this leads to  
815 variances in how they interact with patients and influence WoM.

## 816 5.2 *Practical Implications*

817 Our findings provide some important implications for practitioners too. Specifically,  
818 we confirm the importance of destination and medical care on perceived value (and ultimately,  
819 likelihood of the patient to refer). As past literature underlines the importance of WoM for  
820 generating medical tourism business (Abubakar, 2016), we emphasise the need for hospital  
821 managers to consider both aspects of service delivery proportionately. This may entail MT  
822 providers working to extend their influence over external destination factors that may presently  
823 be beyond their control. For example, we note successful instances of retail and tourism  
824 businesses working together to fund business or tourism improvement districts that shape  
825 broader aspects of destination experience (e.g., language support for workers at key sites of  
826 interest, public realm upgrading, cleanliness and transport improvement). Second, we find that  
827 MT providers use other local hospitals as competitive benchmarks, and a result there is a trend  
828 towards replicating each other's strategies (which mostly involves adding more services and  
829 expanding). We suggest an alternative strategy for MT providers in crowded local markets is  
830 to identify differentiating high-value specialisms that will draw patients from non-traditional  
831 markets. Existing strategies risk dilution of capabilities and a race to the bottom in terms of  
832 price, which undermines the sustainability of the MT sector in Iran. Third, the quantitative  
833 results confirmed the direct and/or indirect effects of MTI, tourism involvement, destination  
834 distinction, medical staff quality, supporting service quality, perceived value on medical  
835 tourists’ WoM. Understanding tourism experience and medical service quality may prove  
836 critical to producing a sustainable medical tourism economy in the developing Iranian context.  
837 To provide a high-quality medical tourism, local authorities, hospital staff and tourism planners  
838 should invest both time and money in increasing level of tourism experience (i.e., tourism  
839 involvement and destination distinction) and medical service quality (i.e., medical staff quality  
840 and supporting service quality).

841 Moreover, by carefully crafting marketing communications, service trails and creating  
842 awareness through targeted campaigns in different places with the aim of motivating WoM  
843 communication (e.g., billboards in international airports, instant photo sharing about different  
844 medical and tourism experiences in social media platforms), the tourism experience and  
845 medical service quality elements can be promoted to different target audiences and segments.

## 846 5.3 *Limitations and future research agenda*

851 While we believe our model can be applied to a broad range of contexts, we recognise  
852 that there are distinct socio-cultural aspects to our case that necessarily bound our theory.  
853 Similarly, our data does not consider the nature of treatment as a potentially significant variable  
854 in how WoM is configured. Studies have begun to unpick the differences is purely cosmetic  
855 treatments and those that are more essential to long-term health (Chuang et al., 2014) and we  
856 recommend this warrants further examination.

857 Additionally, we recognise that few scholars (e.g., Lovelock & Lovelock, 2018) have  
858 considered how those *accompanying* patients on trips may shape WoM (89.4% of our survey  
859 participants had a friend or family member accompanying them). The interpersonal dynamics  
860 between the patient and these additional travellers may yield further insights into WoM. For  
861 example, as one may imagine emotions such as guilt at travelling to a destination with high  
862 medical staff quality but lower tourism involvement (and hence a worse experience for travel  
863 companions) skewing WoM. Thus, we advocate a move from studying the patient as the focal  
864 unit of analysis in MT (Fetscherin & Stephano, 2016) and encourage a move towards a holistic  
865 ‘customer decision-making unit’ that involves patients *and* travel companions. This, we  
866 conclude, would more accurately reflect the cognitive work associated with WoM and the  
867 reality of MT service consumption.

868 Finally, Momeni et al. (2018) and Penney, Snyder, Crooks, and Johnston (2011) note  
869 the potentially negative role of ‘brokers’ in medical tourism transactions. Brokers act as  
870 intermediaries between MT hospitals and patients, and, as such, may influence WoM referral  
871 where patients do not distinguish between different actors in the MT value chain. While our  
872 empirical sample focussed solely on direct employees of the MT facility, future research should  
873 therefore incorporate other (often indirect) actors in the MT value chain (for example brokers,  
874 airlines, taxi drivers) who contribute to the overall WoM recommendation. This could extend  
875 recent research that has examined how pre-consumption experiences influence perceived value  
876 of products and services (Jiang, Luk, & Cardinali, 2018).

877



878 **References**

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