



Taheri, B., Chalmers, D., Wilson, J. and Arshed, N. (2020) Would you really recommend it? Antecedents of word-of-mouth in medical tourism. *Tourism Management*, 83, 104209. (doi: [10.1016/j.tourman.2020.104209](https://doi.org/10.1016/j.tourman.2020.104209))

There may be differences between this version and the published version. You are advised to consult the publisher's version if you wish to cite from it.

<http://eprints.gla.ac.uk/222623/>

Deposited on 27 August 2020

Enlighten – Research publications by members of the University of Glasgow
<http://eprints.gla.ac.uk>

1 **Taheri, B., Chalmers, D., Wilson, J., & Arshed, N. (2020). Would you really recommend**
2 **it? Antecedents of word-of-mouth in Medical Tourism, *Tourism Management*.**

3
4 **Abstract**

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

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

19
20 Corresponding author: b.taheri@hw.ac.uk

22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70

1. Introduction

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

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

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

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

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

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

To address these questions, we conduct a two-stage mixed-methods study based at a leading private hospital in north-west Iran. We draw on in-depth qualitative interview data from 61 medical and support staff (study 1) and survey data from 785 medical tourism patients (study 2). We find support for country environment, tourism destination, medical tourism costs/facilities and services as important in the perceived value of MT choices, and ultimately, the likelihood of referring this service to others. We explore for the first time both the MT patient and those involved in service delivery at the MT destination. The analysis highlights novel findings relating to role tensions within MT facilities and threats to medical professional identities, that can manifest in the overall service experience of patients. Finally, we raise some practical implications for MT providers by considering the significance of balancing destination involvement with medical care provision and the likelihood of WoM referrals as competition intensifies within the sector.

2. Literature review

2.1 Medical Tourism

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

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

Table 1
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	Motivations for medical tourists in Asia	Discussion piece - conceptual	Multi - country	Not stated	Garcia-Altes, (2005)

	simultaneously being holidaymakers.”					
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	Cross cultural study of medical tourists’ perspectives	Survey	785 Chinese, Japanese and Korean Tourists in Korea	Not explicitly stated. Focus on motivation	Reed (2008)

also the search
for destinations
that have the
most technical
proficiency, and
which provide it
at the most
competitive
prices,
combination of
services and the
tourism
industry.”

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

124 125 *2.1.1 Medical Tourism in Iran*

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

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

147 Iran is internationally renowned medical services and staff with expertise in organ
148 transplant and aesthetic surgery (Momeni et al., 2018; Seyfi & Hall, 2018). Its services are
149 relatively low cost in comparison with other competitor markets (Seyfi & Hall, 2018) and it

150 also has relatively short waiting times for treatments (Jabbari et al., 2013). However, there are
 151 challenges to the development of the sector, including insufficient numbers of medical
 152 centres and a lack of integrated support services such as marketing and travel agencies to
 153 facilitate international tourist uptake of the medical services on offer (Azadi, Maleki, Tabibi,
 154 & Azmal, 2012).

155
 156 *2.2 Word of Mouth*
 157

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

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

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

184
 185 **Table 2**
 186 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	Marketing	“informal communications directed at other consumers about the ownership,	Satisfaction, loyalty, quality,

(2008)		usage, or characteristics of particular goods and services and/or their sellers” (Westbrook, 1987, p. 261). “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).	commitment, trust, perceived value
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). 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

187

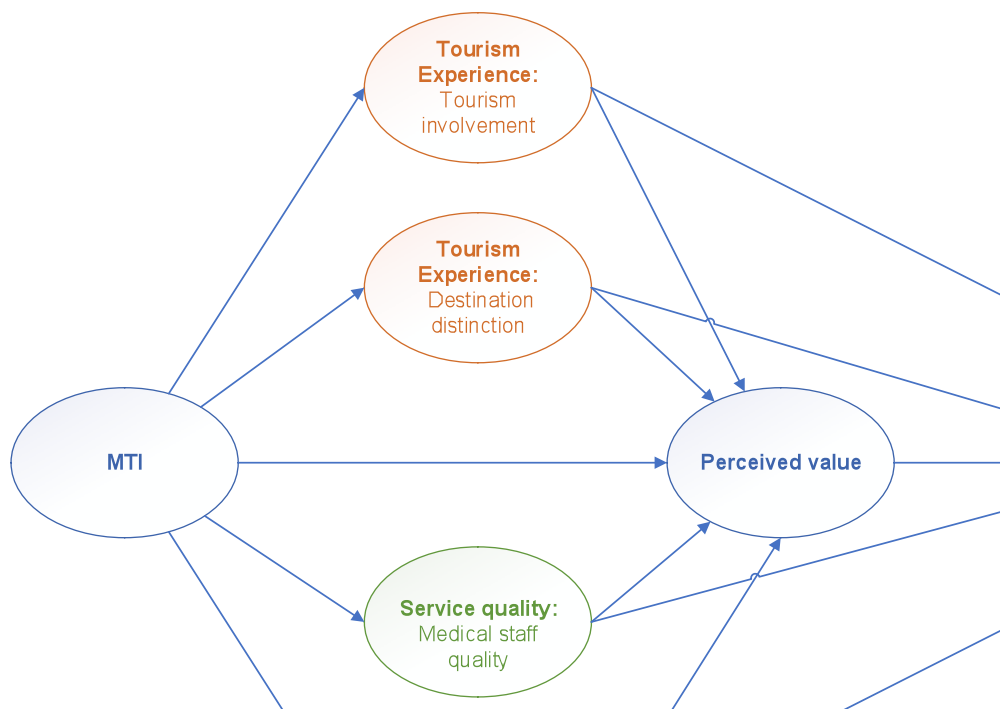
188 *2.3 Conceptual model*

189

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

198 Our conceptual research model presented in **Fig. 1** therefore proposes the effect of
199 medical service quality (medical staff quality and supporting service quality) and tourism

200 experience (tourism involvement and destination distinction) on perceived value and WoM.
 201 We developed the conceptual framework shown in **Fig. 1** based on a review of the WoM
 202 literature, relating this specifically to the MT context. Drawing on MT literature we argue
 203 that the intention of patients to refer a MT provider to others through WoM referrals, is
 204 related to their perceptions of value following a treatment, based on both service experience
 205 and expectations of that experience prior to treatment. In a MT context, we propose that this
 206 perception of value is derived from both factors related to the service quality provision and
 207 overall tourism experience. We also propose that these factors in themselves may have a
 208 direct effect on the likelihood of WoM referrals. The theoretical rationale for the relationships
 209 proposed in the conceptual model is discussed in following sections.
 210



211 **Fig. 1.** Conceptual model
 212

213
 214 *2.3.1 Antecedents of WoM*
 215

216 *2.3.1.1 Perceived Value*
 217

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

232 financial savings, convenience and medical service lead to an increase in tourist’s perceptions
233 of high perceived value in the medical tourism hotel. This meant that medical tourists would
234 be willing to visit, and critically, would recommend it to others.

235 2.3.1.2 *Service Quality*

236

237 Drawing on wider service literature (Gannon et al., 2019; Zeithaml, 1988; Zeithaml et
238 al., 1993), we propose that perceptions of medical service quality will have a direct effect on
239 WoM, and it will have an indirect effect through perceptions of value. Here, service quality
240 can be defined as “the outcome of a process in which consumers’ expectations for the service
241 are compared with their perceptions of the service actually delivered” (Mangold & Babakus,
242 1991, p. 60). Thus, perceptions of quality are implicitly related to expectations (Zeithaml et
243 al., 1993). There has been less focus on medical service providers than consumers within the
244 medical tourism field, but most who have explored this area have adapted the well-known
245 SERVQUAL scale to evaluate service standards in medical tourism (Debata et al., 2015;
246 Guiry & Vequist, 2011; Manaf et al., 2015; Wang, 2012). This scale identifies five key
247 quality dimensions related to the physical facilities of the service provider: the reliability and
248 dependability of the service; the responsiveness of the service provision and willingness to
249 help customers; assurance of employees in terms of knowledge and courtesy; empathy in
250 terms of care provision; and finally, individualised attention (Zeithaml, Bitner, & Gremler,
251 2009; Parasuraman, Zeithaml & Berry, 1988; 1991).

252 These dimensions can be further grouped into those related to medical staff quality;
253 those supporting services quality; and those related to administrative services quality (Abd
254 Manaf et al., 2015; 2017; Fetscherin & Stephano, 2016; Heung et al., 2011; Moghavvemi et
255 al., 2017; Smith & Forgione, 2007). Empirical research evidences that they are important
256 dimensions in terms of patient satisfaction, perceived value and future intention for treatment,
257 with medical staff quality highlighted as the most important factor of the three (Heung et al.,
258 2011; Mattoo & Rathindran, 2006).

259

260 2.3.1.3 *Tourism Experience*

261

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

281 be a significant predictor of satisfaction and future intention (Kim, Kim, & Kim, 2009; Lee &
282 Beeler, 2009).

283 The literature on destination distinctiveness draws on place branding, destination
284 marketing and tourism destination image (Beerli & Martin, 2004; Gallarza et al., 2002; Pike
285 & Page, 2014; Viladrich & Baron-Faust, 2014). Tourism destination image is a set of beliefs,
286 ideas and impressions generated by tourists (Crompton, 1979), and can be defined as “all that
287 the destination evokes in the individual; any idea, belief, feeling or attitude that tourists
288 associate with the place” (Alcañiz, García, & Blas, 2009, p. 716). It has been shown to
289 influence the cognitive evaluation and subsequent decision-making in relation to destination
290 choice (Lu et al., 2015). It has both cognitive and affective components comprising the
291 tangible properties of a destination and prospective tourists’ feelings and evaluations towards
292 that destination (Pike & Ryan, 2004; Wang & Hsu, 2010).

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

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

309 310 *2.3.1.4 Medical Tourism Index* 311

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

330 attractions; weather and attractiveness; popularity and; exoticness as a tourist destination
331 (Fetscherin & Stephano, 2016; Lovelock & Lovelock, 2018).

332 The rapid development of MT and the concomitant access to advanced medical
333 technology has meant that the medical infrastructure and systems used by private hospitals
334 has developed rapidly and healthcare costs reduced. The relatively lower costs of accessing
335 medical treatment abroad has been found to be a key driver of medical tourism (Connell,
336 2006; Smith & Forgione, 2007; Yu & Ko, 2012). The quality of medical facilities and
337 services have also been shown to be key factors in the decision to choose particular medical
338 service providers (Abd Manaf et al., 2017; Fetscherin & Stephano, 2016; Heung et al., 2011;
339 Moghavvemi et al., 2017; Smith & Forgione, 2007). Some elements are related to the quality
340 of the actual facility in terms of reputation, accreditation and medical equipment (Connell,
341 2006; Heung, Kucukusta, & Song, 2011; Moghavvemi et al., 2017; Smith & Forgione, 2007;
342 Yu & Ko, 2012). Others relate to the quality of care given by medical staff and their medical
343 reputation (Berkowitz & Flexner, 1980; Heung et al., 2011; Manaf et al., 2017; Mattoo &
344 Rathindran, 2006).

345

346 **3. Methodology**

347

348 To answer our research questions, we adopted a two-stage explanatory design
349 approach combining quantitative and qualitative data (Alexander, MacLaren, O'Gorman, &
350 Taheri, 2012; Creswell & Creswell, 2018; Teddlie & Tashakkori, 2009). The combination of
351 quantitative and qualitative methods offers more insightful and more complex answers to
352 research questions compared to either of them alone; it further provides a platform for
353 integrating quantitative accuracy with narrative complexity (Creswell & Creswell, 2018;
354 Teddlie & Tashakkori, 2009). For our first study, a series of semi-structured interviews were
355 conducted with medical and support staff at a leading private hospital in north-west Iran. The
356 objective of this study was to examine the complex nature of value creation (O'Cass & Sok,
357 2015; Taheri et al., 2017) through ongoing service delivery by clinical and non-clinical
358 employees. This was followed by a second study, which was operationalised through a
359 survey of in-patients at the same hospital, exploring their reasons for choosing this service
360 provider and their experiences whilst there.

361

362 *3.1 Research Context*

363

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

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

378

379 3.1 Qualitative study

380

381 3.1.1 Data gathering

382

383 In total we undertook 61 semi-structured interviews with full-time employees of a
384 single MT hospital in Iran (see **Table 3**). The interviews were conducted in the months of
385 February and March 2016. The study deployed two complementary sampling strategies:
386 purposive and snowball sampling (Ritchie, Lewis, & Elam, 2003; Wells, Gregory-Smith,
387 Taheri, Manika, & McCowlen, 2016a). Purposive sampling facilitated the identification of
388 appropriate participants for the study, while snowball sampling allowed selected individuals
389 to identify others that they knew to be information-rich as the research progressed (Lincoln &
390 Guba, 1985). Our intention was to gather a representative range of respondents that broadly
391 reflected the various jobs families within the hospital (e.g., clinical, management,
392 administrative, tourism-related, marketing and service/maintenance/cleaning). Our final
393 sample achieved a good balance, albeit it was skewed slightly towards clinical respondents,
394 largely owing to their more detailed knowledge of MT, and their willingness to discuss
395 matters candidly and on-the-record.

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

413

414 **Table 3**

415 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

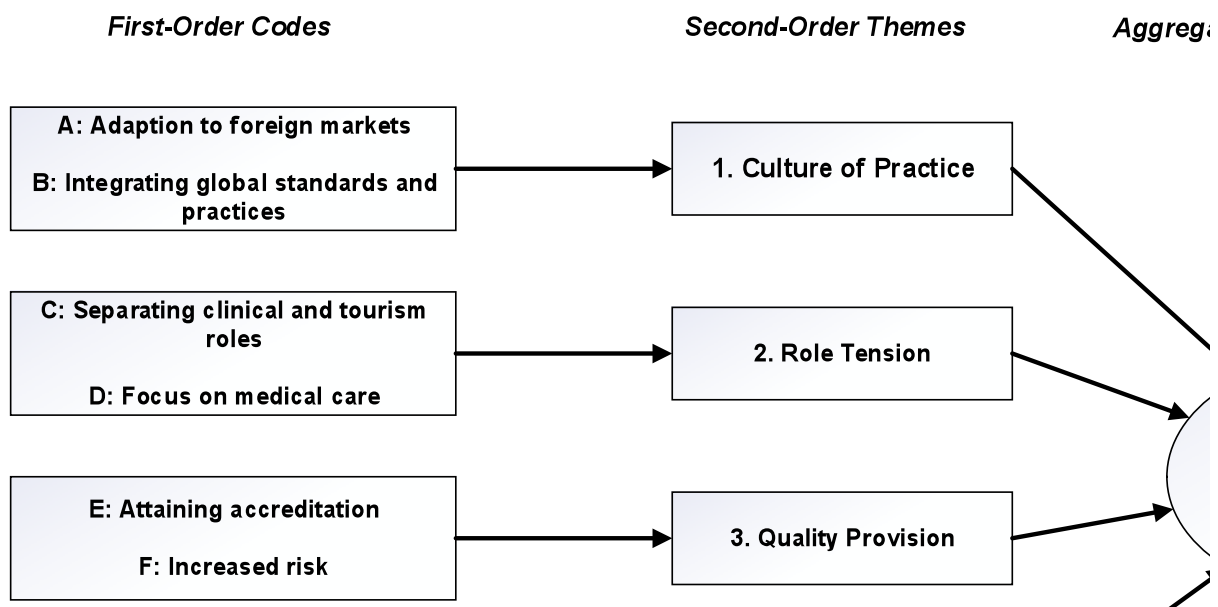
417 *3.1.2 Data analysis*

418

419 We followed the approach developed by Gioia, Corley and Hamilton (2013) to
 420 generate findings around phenomena of interest by using research subjects' own words. With
 421 this in mind, the first step in the analysis was to transcribe each interview (verbatim) after it
 422 had taken place. Across the 61 interviewees more than 60 hours of audio were recorded with
 423 transcriptions amounting to over 1,000 double-spaced pages. Furthermore, field notes and
 424 memos were taken during and after the interviews and were triangulated with the audio to
 425 strengthen the validity and credibility of the research (Miles & Huberman, 1994). After this
 426 initial step, we manually coded our data and identified empirical themes. We categorised a
 427 series of 'first order' codes that reflected broad activities relating to the creation and delivery
 428 of patient value, where key words, phrases, sentences, and paragraphs from the transcripts,
 429 memos, field notes and secondary data were underpinned by our emerging analysis (Miles &
 430 Huberman, 1994).

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

443



444

445 **Fig. 2.** Data structure.

446

447 *3.2 Quantitative study*

448

449 A survey was then conducted with international medical travellers who had visited
 450 Iran for medical attention within 6 months in 2016. The questionnaires were distributed to

451 international patients receiving medical care in the private hospital in the last day of their
452 visit within the hospital (on site in order to safeguard high response and usability rates). We
453 designed the questionnaire and provided exact instructions on how data collection should be
454 undertaken. Patients were approached directly to improve the validity of our study. Using
455 non-probability judgmental sampling, we only conducted our questionnaire from those
456 travellers who had previous international medical-tourism experience. As Wells et al. (2016a,
457 p. 67) note: “this sampling technique has been noted as an effective way of collecting data
458 where the aim is theoretical advancement rather than generalisation and is used frequently in
459 tourism and hospitality studies”. We prepared several different versions of the questionnaire
460 (English, Azeri, Russian and Arabic), since the majority of the international patients could
461 communicate in one of these languages. We used a back-translation method in order to gain a
462 higher level of consistency and accuracy (Wells et al., 2016b).

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

475 We used the mean replacement technique to overcome missing values across the
476 dataset. This “replaces the missing values for a variable with the mean value of that variable
477 calculated from all responses” (Hair, Black, Babin, & Anderson, 2010, p. 53) and does not
478 change the sample size or mean of variables. According to Tabachnick and Fidell (2013), the
479 mean replacement technique can overcome missing values across the dataset if there are <5%
480 incomplete data. In this study, the percentage of missing values was 1.022%. Garson (2016)
481 also suggests missing values significantly impact structural models when more than 5% of
482 values are missing. Thus, missing values do not have a significant impact in this study. Full
483 details of items, mean values, and standard deviations (SD) under respective constructs are
484 provided in **Table 2**. The values of Skewness and Kurtosis for some scale items did not fall
485 within the acceptable range (± 3), indicating non-normal data distribution (Wells et al.,
486 2016b).

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

492

493 *3.2.1 Measurement of variables*

494

495 The items of the constructs were adapted from existing scales. All constructs were
496 anchored at 1 = *strongly disagree* and 7 = *strongly agree*. Medical staff quality was measured
497 by 12 items adapted from Abd Manaf et al. (2015). Three items adapted from Lu et al. (2015)
498 measured visitors’ involvement. The perceived value measure included 4 items from Han and
499 Hwang (2013). For measuring destination distinction, four items adapted from Brocato et al.
500 (2015). For supporting service quality, we used 4 items from Abd Manaf et al. (2015). From

501 items on WoM adapted from Maxham and Netemeyer (2002) and Salanova, Agut, and Peiró
502 (2005). Finally, the second-order MTI construct (including for first-order dimensions:
503 country environment (5-item), tourism destination (5-item), medical tourism costs (5-item)
504 and medical facility and services (17-item) borrowed from Fetscherin and Stephano (2016).
505 A pilot questionnaire was conducted with 30 participants and some necessary changes were
506 made to the questionnaire.

507

508 3.2.2 Analytical technique

509 Partial least squares structural equation modelling (PLS-SEM) was used as the
510 method of analysis this study for various reasons. (1) PLS-SEM is desired technique for
511 estimating path coefficients in SEM as it does not require normal distribution (Wells et al.,
512 2016a; do Valle & Assaker, 2015). We tested for multivariate normality examination by
513 calculating z-scores for kurtosis and skewness for all items. The findings indicated that some
514 items have the skewness and kurtoses above mandatory cut-off point of -3 and +3 (Hair et al.,
515 2010; Mardia, 1970) (**Table 2**). (2) It is a powerful technique for assessing formative,
516 reflective and higher-order models (Hair, Hult, Ringle, & Sarstedt, 2017; Henseler, Ringle, &
517 Sinkovics, 2009; Lee, Hallak, & Sinkovi, 2016). Our model is a combination of higher-order
518 and reflective measures. We followed the suggested two-stage analytical technique including
519 (Chin, 2010; Hair et al., 2017): assessing reliability and validity of the measurement model
520 (reflective models and higher-order model) and examining the structural model, using
521 SmartPLS 3.2.4 software.

522

523 3.2.3 Common Method Variance

524

525 As with all self-reported data, there is a potential threat of common method variance
526 (CMV), which may be caused by multiple sources (Liang, Saraf, Hu, & Xue, 2007;
527 Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). In practice, we assured respondents
528 anonymity and confidentiality of their response in order to reduce social desirability bias. We
529 have placed dependent and independent variables in different section of the questionnaire.
530 We used Harman's single-factor. Principal component analysis (PCA) (with varimax
531 rotation) on the questionnaire items presented the existence of 6 distinctive factors (F1:
532 9.011; F2: 4.315; F3: 2.103; F4: 2.002; F5: 1.604; F6: 1.023) with eigenvalue greater than 1,
533 yielding 66.511% of the total variance with the first factor accounting for only 24.1 percent
534 of the total variance (i.e., less than 50% which did not describe most of the variance). We
535 also used the unmeasured method factor approach suggested by Min, Park and Kim (2016)
536 and Liang et al. (2007) to further examine the CMV. The findings indicate that the average
537 substantively explained variance of the indicators is 0.62, while the average method-based
538 variance is 0.089, yielding a ratio of 69:1. Thus, we contend that the CMV is unlikely to be a
539 serious concern for this study.

540

541 4. Results and discussion

542

543 4.1 Qualitative analysis

544

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

549

550 4.1.1 Culture of Practice

551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569

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

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

570
571

Table 4
Exemplar data representing analytical codes.

Overarching Dimension: Organisational-level Antecedents of Value Creation in a Medical Tourism Hospital	
1. Culture of Practice	
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).
2. Role Tension	
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).
3. Quality Provision	
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).
4. Intensifying Competition	
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).

572

572 4.1.2 Role Tension

573

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

586 This is a phenomenon that is recognisable across other industrial contexts, including
587 social entrepreneurship, in which entrepreneurs experience a tension between mission-
588 derived activities and profit-based activities (Pache & Santos, 2013), and creative industries
589 where artists and managers navigate difficult relations (Bierne, 2012). In the MT context
590 however, we note that there was a division of labour in our case study hospital which
591 compartmentalised the leisure/hedonic aspects of packages and clinical care, leading to
592 potentially inconsistent approaches to value creation/customer experience (O’Cass & Sok,
593 2015; Taheri et al., 2017).

594

595 4.1.1 Quality provision

596

597 Medical and support staff were very aware of the importance of their care and support
598 on the overall perception of the hospital, supporting research focusing on medical service
599 users (Abd Manaf et al., 2015; Hall, 2017; Han & Hwang, 2013; Lovelock & Lovelock,
600 2018). Staff also acknowledged the importance of reputation and accreditation on their
601 attractiveness as a destination of choice (Lunt & Carrera, 2011; Moghavvemi et al., 2017;
602 Smith & Forgione, 2007): “*You know if we do our job properly with regards to whatever*
603 *government asks us to do, we will stay as a high ranked hospital which is good”* (Participant
604 19).

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

614 However, even whilst acknowledging the importance of the monitoring of quality of
615 provision on actual service offer to patients (Abd Manaf et al., 2017; Fetscherin & Stephano,
616 2016; Moghavvemi et al., 2017), some interviewees stressed how this service focus impacted
617 upon their day-to-day roles. Particular issues highlighted were the work involved in what
618 were regarded as extra administrative tasks and the time this took them away from their other
619 more patient-focused roles. Some interviewees felt particularly conflicted by what they felt to
620 be an increasingly controlling environment, with punitive measures enforced for those not
621 following the rules. Whilst they understood the rationale behind these measures they felt

622 these were overly-driven by the financial targets of the hospital and that these controls also
623 had negative impacts on the day to day working experiences of staff at the *hospital*: "You
624 know there are always some fines involved if we do not follow them" (Participant 37).

625

626 *4.1.2 Intensifying competition*

627

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

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

642

643 *4.2 Quantitative analysis*

644

645 *4.2.1 Assessment of the measurement model*

646

647 Convergent validity of reflective constructs were assessed using composite reliability
648 (CR), Cronbach’s Alpha (α), factor loadings and average variance extracted (AVE). CR and α
649 indicated values above the mandatory thresholds of 0.7. The AVE values exceeded the
650 threshold of 0.5 for all constructs and factor loadings exceeded the recommended value of 0.6
651 (Hair et al., 2010) (see **Table 5**). We assessed discriminant validity with various methods.
652 Following Fornell and Larcker (1981) suggestion, the square root of the AVE (diagonal
653 values) of all constructs were larger than all other cross correlations in **Table 6**. The
654 correlations among all first-order reflective constructs were well below the 0.7 cut-off value
655 in **Table 6**.

656

Table 5

657

Descriptive statistics, validity, reliability of the constructs.

Constructs	Items	Mean	SD	Skewness	Kurtosis	Loadings*	AVE	CR	α
MTI- Country 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 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 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 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								
		I think this hospital and city provide me great	4.89	1.002	1.408	2.073	0.702								

WoM	value as compared to other medical treatment/healthcare places/clinics and cities						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			

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

659

660
661

Table 6
Discriminant validity.

	1	2	3	4	5	6	7	8	9	10	11
(1) MTI	n/a										
(2) WoM	0.047	0.720									
(3) Country Environment	0.519	0.049	0.772								
(4) Destination Distinction	0.043	0.267	0.003	0.758							
(5) Facility and Services	0.611	0.048	0.275	0.064	0.712						
(6) Tourism Involvement	0.051	0.396	0.010	0.356	0.065	0.758					
(7) Medical Staff Quality	0.010	0.001	0.027	0.208	0.003	0.214	0.725				
(8) Medical Tourism Costs	0.643	0.009	0.299	0.002	0.565	0.036	0.035	0.759			
(9) Perceived Value	0.053	0.316	0.009	0.610	0.066	0.248	0.254	0.007	0.739		
(10) Supporting Service	0.005	0.006	0.028	0.288	0.006	0.315	0.618	0.036	0.316	0.730	
(11) Tourism Destination	0.624	0.022	0.268	0.018	0.533	0.009	0.026	0.464	0.075	0.026	0.758

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

665

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

672

673

674 **Table 7**
675 HTMT results.

	1	2	3	4	5	6	7	8	9	10	11
(1) MTI											
(2) WoM	0.056										
(3) Country Environment	0.679	0.070									
(4) Destination Distinction	0.063	0.338	0.003								
(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	0.027	0.041	0.026	0.230	0.068	0.347					

Staff Quality										
(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

676

677

678

679

680

681

682

683

684

685

686

687

688

689

690

691

692

693

694

695

696

697

698

699

700

701

702

703

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, α , 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 Tourism Destination	0.242*	0.719*
Medical Tourism Costs Facility and Services	0.341*	0.724*
	0.318*	0.743*
	0.338*	0.911*

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

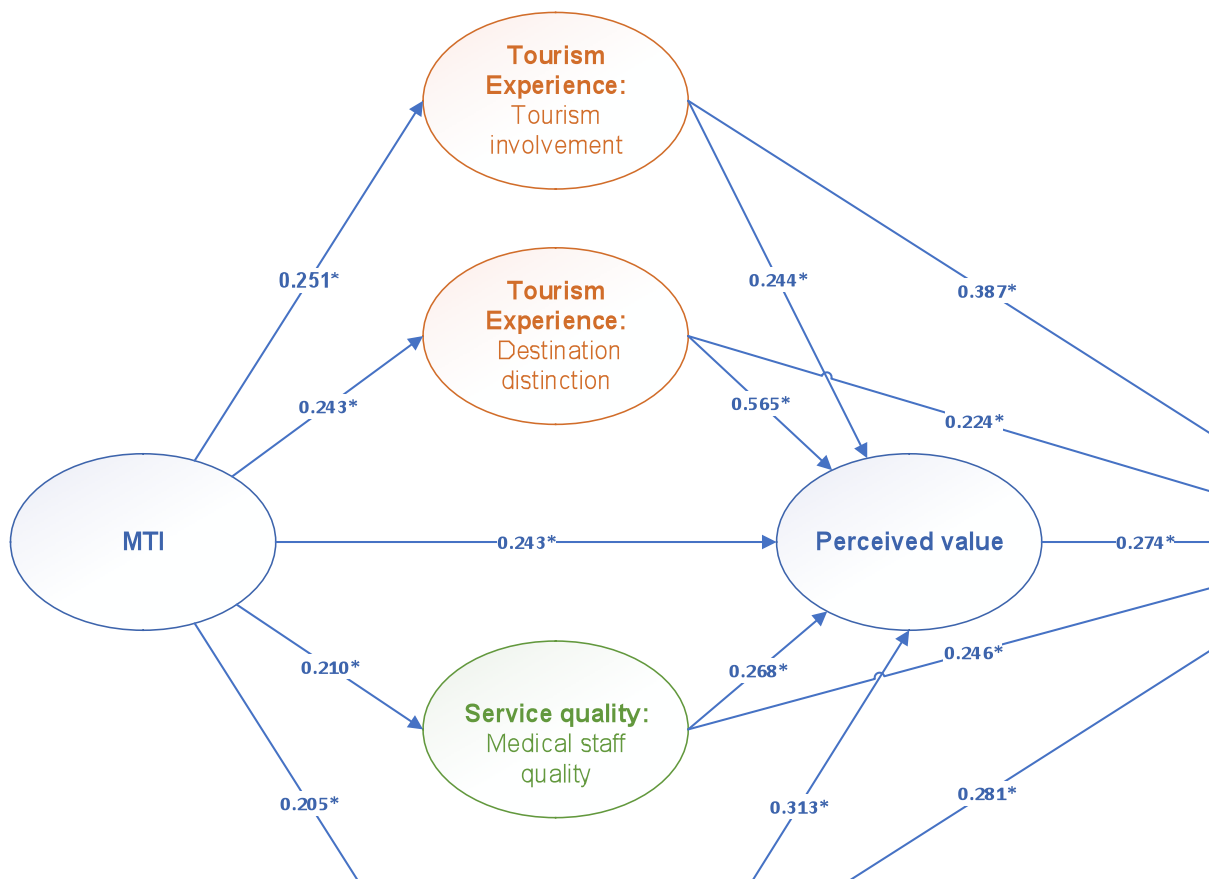
705

706 4.2.2 Assessment of the structural model

707

708 For the structural model, the non-parametric bootstrapping technique was tested with
709 785 cases, 5000 subsamples. Stone-Geisser's Q^2 value tested the criterion of predictive
710 relevance (Hair et al., 2017). The Q^2 value was achieved by using the blindfolding procedure.
711 For this study, we employed cross-validated redundancy procedure to assess Q^2 . A Q^2 value
712 greater than 0 indicates the model has predictive relevance. Q^2 values are above this threshold
713 in our study. We also used SRMR (standardised root mean square residual) as a fit indicator
714 (Henseler et al., 2014). Our SRMR value is 0.037 which is less than recommended value of
715 0.08. We also tested Cohen's effect sizes (f^2). Cohen's effect sizes (f^2) signifies 0.01 for
716 small, 0.06 for medium, and 0.14 for large effects within a structural equation modelling
717 approach. (Khalilzadeh & Tasci, 2017). The model explains 18% of tourism involvement,
718 22% of destination distinction, 33% of medical staff quality, 17% supporting service quality,
719 39% of perceived value and 34% of WoM. As shown in **Fig 3**, all path relationships were
720 supported. In practice, we connected the control variables to WoM. In terms of the control
721 variables, age, visit group and marital status found to be significantly connected to
722 participants WoM. Gender has no significant effect on the WoM.

723



724

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

726

727 4.2.3 Post-hoc analysis of the indirect effects

728

729 The findings proposed the potential existence of mediating relationships for the study
730 (i.e., post-hoc analysis of the indirect effects). Following Williams and MacKinnon (2008)
731 and Perez-Vega, Taheri, Farrington, and O’Gorman (2018) recommendations, bootstrapping

analysis for the significance of the indirect effects considering the *t*-values as well as the confidence interval (CI) were used. Following **Table 9**, the results indicate that MTI indirectly influences perceived value through tourism involvement (95% CI = [0.103, 0.147]), destination distinction (95% CI = [0.202, 0.256]), medical staff quality (95% CI = [0.123, 0.157]) and supporting service quality (95% CI = [0.250, 0.293]). Since the direct effect were significant, the results reveal that involvement, destination distinction, medical staff quality and supporting service quality partially mediate the influence of MTI on perceived value. Similarly, results reveal indirect effect of tourism involvement (95% CI = [0.289, 0.346]), destination distinction (95% CI = [0.266, 0.298]), medical staff quality (95% CI = [0.217, 0.1247]) and supporting service quality (95% CI = [0.248, 0.284]) through perceived value on WoM were significant. Since the direct effects were significant, the results indicate that perceived value partially mediate the influence of tourism involvement, destination distinction, medical staff quality and supporting service quality on WoM (see **Table 9**).

746

747 **Table 9**

748 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

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

750

751 **5. Conclusion and implications**

752

753 *5.1 Theoretical contributions*

754

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

759 In answering these questions, our study makes a number of contributions to MT
760 research. First, our model integrates constructs relating to destination distinction, healthcare
761 provision and the perceived value of the treatment package. From our quantitative study, we
762 found MTI positively influences tourism involvement, destination distinction, medical staff
763 quality, supporting service quality and perceived value, aligning with previous studies by
764 (e.g., Abd Manaf et al., 2015; Gursoy & Gavcar, 2003; Han & Hyuan, 2012; Lee, 2010; Qu et
765 al, 201; Kim & Han, 2008; Prayag & Ryan 2012; Viladrich & Baron-Faust, 2014). Tourism
766 involvement, destination distinction, medical staff quality and supporting service quality
767 positively influence perceived value which further supports previous studies (e.g., Abd Manaf
768 et al., 2015; Kim & Han, 2008; Lee, 2010; Lovelock & Lovelock, 2018; Prayag & Ryan,
769 2012; Qu et al., 2011). Finally, tourism involvement, destination distinction, medical staff
770 quality, supporting service quality and perceive value positively impact on WoM, supporting

771 previous studies (e.g., Abd Manaf et al., 2015; Fetscherin & Stephano, 2016; Gursoy &
772 Gavcar, 2003; Lu et al., 2015; Prayag & Ryan, 2012; Pike & Ryan, 2004). The results also
773 provide several indirect effects between constructs (**Table 9**) which we propose require
774 further investigation. Thus, we found that aspects of service experience (around medical
775 treatment) and destination, positively influence perceived value and ultimately result in the
776 intention to recommend and refer the MT provider. We believe the results are robust since we
777 controlled for control variables in our study.

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

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

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

814 We also offer a novel perspective on MT by soliciting data from both consumers of
815 MT services and those who participate in the delivery of MT services (ranging from doctors
816 to hospital managers). Extant MT research has typically focussed on patient data alone (e.g.,
817 Yeoh et al., 2013) and this has restricted understanding of the service dimension of MT. We
818 therefore offer a valuable insight into aspects of service delivery through our qualitative data
819 by unpacking how everyday service delivery tensions encountered by medics and support
820 staff may influence evaluations from MT patients. Our MT provider data for example, shows

821 some of the tensions faced within medical facilities by those who have to provide medical
822 care, while also providing a tourism ‘experience.’ Rather than finding outright hostility, or
823 resentment towards the dual role, we found staff across different positions keen to try
824 adapting to the competitive situation, though this is not without challenges, as our data
825 indicates.

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

829

830 *5.2 Practical Implications*

831

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

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

861

862 *5.3 Limitations and future research agenda*

863

864 While we believe our model can be applied to a broad range of contexts, we recognise
865 that there are distinct socio-cultural aspects to our case that necessarily bound our theory.
866 Similarly, our data does not consider the nature of treatment as a potentially significant
867 variable in how WoM is configured. Studies have begun to unpick the differences is purely
868 cosmetic treatments and those that are more essential to long-term health (Chuang et al.,
869 2014) and we recommend this warrants further examination.

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

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

890

890

891 **References**

892

893 Abubakar, A. M., & Ilkan, M. (2016). Impact of online WoM on destination trust and
894 intention to travel: A medical tourism perspective. *Journal of Destination Marketing
895 & Management*, 5(3), 192-201.

896 Alcañiz, E. B., García, I. S., & Blas, S. S. (2009). The functional-psychological continuum in
897 the cognitive image of a destination: A confirmatory analysis. *Tourism Management*,
898 30(5), 715-723.

899 Alves, S., Abrantes, J. L., Antunes, M. J., Seabra, C., & Herstein, R. (2016). WOM
900 antecedents in backpacker travellers. *Journal of Business Research*, 69(5), 1851-1856.

901 Anderson, E. W. (1998). Customer satisfaction and word of mouth. *Journal of Service
902 Research*, 1(1), 5-17.

903 Armstrong, J.S, & Overton, T.S. (1977) Estimating nonresponse bias in mail surveys. *Journal
904 of Marketing Research* 14: 396-402.

905 Abd Manaf, N. H., Hussin, H., Kassim, P. N. J., Alavi, R., & Dahari, Z. (2015). Medical
906 tourism service quality: finally some empirical findings. *Total Quality Management &
907 Business Excellence*, 26(9), 1017-1028.

908 Abd Manaf, N. H., Maulan, S., Hussin, H., Jahn Kassim, P. N., & Alavi, R. (2017). Service
909 quality, value, satisfaction and future intention in medical tourism. *Journal of
910 Tourism, Hospitality & Culinary Arts*, 9(3), 1-12.

911 AMAR. (2016). Statistical Centre of Iran Retrieved Dec, 2016, from
912 [https://www.amar.org.ir/english/Statistics-by-Topic/Education-and-
913 Research#2217482-meta-data](https://www.amar.org.ir/english/Statistics-by-Topic/Education-and-Research#2217482-meta-data)

914 Azadi, F., Maleki, M., Tabibi, S. J., & Azmal, M. (2012). A medical tourist perception of
915 Iranian hospital quality: Limited employee foreign language skills negatively impact
916 communication. *International Journal of Hospital Research*, 1(2), 85-90.

917 Bagozzi, R.P. (1980). *Causal models in marketing*. Wiley, New York.

918 Alexander, M., MacLaren, A., O’Gorman, K., & Taheri, B. (2012). “He just didn’t seem to
919 understand the banter”: Bullying or simply establishing social cohesion? *Tourism
920 Management*, 33(5), 1245-1255.

921 Becker, J.-M., Klein, K., & Wetzels, M. (2012). Hierarchical latent variable models in PLS-
922 SEM: Guidelines for using reflective-formative type models. *Long Range Planning*,
923 45, 359-394.

924 Beerli A., & Martín J. D. (2004). Factors influencing destination image. *Annals of Tourism
925 Research*, 31(3), 657–681.

926 Berger, J. (2014). Word of mouth and interpersonal communication: A review and directions
927 for future research. *Journal of Consumer Psychology*, 24(4), 586-607.

928 Berkowitz, E. N., & Flexner, W. (1980). The market for health services: is there a non-
929 traditional consumer? *Journal of Health Care Marketing*, 1(1).

930 Bierne, M. (2012). Creative tension? Negotiating the space between the arts and
931 management. *Journal of Arts & Communities*, 4(3), 149-160.

932 Broderick, A. J., & Mueller, R. D. (1999). A theoretical and empirical exegesis of the
933 consumer involvement construct: The psychology of the food shopper. *Journal of
934 Marketing Theory and Practice*, 7(4), 97-108.

935 Brocato, E. D., Baker, J., & Voorhees, C. M. (2015). Creating consumer attachment to retail
936 service firms through sense of place. *Journal of the Academy of Marketing
937 Science*, 43(2), 200-220.

938 Brotman, B. A. (2010). Medical tourism private hospitals: Focus India. *Journal of Health
939 Care Finance*, 37(1), 45-50.

- 940 Brown, T. J., Barry, T. E., Dacin, P. A., & Gunst, R. F. (2005). Spreading the word:
941 Investigating antecedents of consumers' positive word-of-mouth intentions and
942 behaviors in a retailing context. *Journal of the Academy of Marketing Science*, 33(2),
943 123-138.
- 944 Buttle, F. A. (1998). Word of mouth: understanding and managing referral
945 marketing. *Journal of Strategic Marketing*, 6(3), 241-254.
- 946 Carroll, B. A., & Ahuvia, A. C. (2006). Some antecedents and outcomes of brand love.
947 *Marketing Letters*, 17(2), 79-89.
- 948 Chin, W. W. (2010). How to write up and report PLS analyses. In V. Esposito Vinzi, W.W.
949 Chin, J. Henseler, & H. Wang (Eds.), *Handbook of partial least squares: Concepts,*
950 *methods and application* (pp. 645–689).
- 951 Chi, C.G.Q. & Qu, H. (2008). Examining the structural relationships of destination image,
952 tourist satisfaction and destination loyalty: an integrated approach. *Tourism*
953 *Management*, 29 (4), pp. 624-636.
- 954 Chuang, T. C., Liu, J. S., Lu, L. Y., & Lee, Y. (2014). The main paths of medical tourism:
955 From transplantation to beautification. *Tourism Management*, 45, 49-58.
- 956 Creswell, J.W., & Creswell, J.D. (2018). *Research Design: Qualitative, Quantitative, and*
957 *Mixed Methods Approaches*, Sage, USA.
- 958 Crompton, J. L. (1979). An assessment of the image of Mexico as a vacation destination and
959 the influence of geographical location upon that image. *Journal of Travel Research*,
960 17(4), 18-23.
- 961 Currás-Pérez, R., Bigné-Alcañiz, E. & Alvarado-Herrera, A. (2009). The role of self-
962 definitional principles in consumer identification with a socially responsible company.
963 *Journal of Business Ethics*, 89 (4) (2009), 547-564.
- 964 Cohen, E. C. E. (2008). Medical tourism in Thailand. *AU-GSB e-journal*, 1(1).
- 965 Connell, J. (2006). Medical tourism: Sea, sun, sand and... surgery. *Tourism*
966 *Management*, 27(6), 1093-1100.
- 967 Connell, J. (2013). Contemporary medical tourism: Conceptualisation, culture and
968 commodification. *Tourism Management*, 34, 1-13.
- 969 Crooks, V. A., Turner, L., Snyder, J., Johnston, R., & Kingsbury, P. (2011). Promoting
970 medical tourism to India: Messages, images, and the marketing of international
971 patient travel. *Social Science & Medicine*, 72(5), 726-732.
- 972 Crompton, J. L. (1979). An Assessment of the Image of Mexico as a Vacation Destination
973 and the Influence of Geographical Location upon the Image. *Journal of Travel*
974 *Research* 18(4):18–23
- 975 Crompton, J. (1992). Structure of vacation destination choice sets. *Annals of Tourism*
976 *Research*, 19(3), 420-434.
- 977 de la Hoz-Correa, A., Muñoz-Leiva, F., & Bakucz, M. (2018). Past themes and future trends
978 in medical tourism research: A co-word analysis. *Tourism Management*, 65, 200-211.
- 979 Debata, B. R., Patnaik, B., Mahapatra, S. S., & Sree, K. (2015). Interrelations of service
980 quality and service loyalty dimensions in medical tourism: a structural equation
981 modelling approach. *Benchmarking: An International Journal*, 22(1), 18-55.
- 982 De Matos, C. A., & Rossi, C. A. V. (2008). Word-of-mouth communications in marketing: a
983 meta-analytic review of the antecedents and moderators. *Journal of the Academy of*
984 *Marketing Science*, 36(4), 578-596.
- 985 do Valle, P. O., & Assaker, G. (2016). Using partial least squares structural equation
986 modeling in tourism research: A review of past research and recommendations for
987 future applications. *Journal of Travel Research*, 55(6), 695-708.
- 988 Easterby-Smith, M., Thorpe, R., & Lowe, A. (2002). *Management Research: An*
989 *Introduction* (2nd ed.). Sage Publications, London.

- 990 Eisenhardt, K. M. (1989). Making fast strategic decisions in high-velocity
 991 environments. *Academy of Management Journal*, 32(3), 543-576.
- 992 Fernandes, T., & Fernandes, F. (2018). Sharing dissatisfaction online: Analyzing the nature
 993 and predictors of hotel guests' negative reviews. *Journal of Hospitality Marketing &*
 994 *Management*, 27(2), 127-150.
- 995 Fetscherin, M., & Stephano, R. M. (2016). The medical tourism index: Scale development
 996 and validation. *Tourism Management*, 52, 539-556.
- 997 Fillieri, R. and McLeay, F. (2013). E-WoM and Accommodation: An Analysis of the Factors
 998 That Influence Travelers' Adoption of Information from Online Reviews. *Journal of*
 999 *Travel Research*, Vol. 53, No. 1, pp. 44-57.
- 1000 Fornell, C., & Larcker, D. F. (1981). Evaluating structural equation models with
 1001 unobservable variables and measurement error. *Journal of Marketing Research*, 39-
 1002 50.
- 1003 Funk, D. C., Ridinger, L. L., & Moorman, A. M. (2004). Exploring origins of involvement:
 1004 Understanding the relationship between consumer motives and involvement with
 1005 professional sport teams. *Leisure Sciences*, 26(1), 35-61.
- 1006 Gannon, M.J., Baxter, I.W., Collinson, E., & Maxwell-Stuart, R. (2017). Travelling for
 1007 Umrah: destination attributes, destination image, and post-travel intentions. *The*
 1008 *Service Industries Journal*, 37(7-8), 448-465.
- 1009 Gannon, M., Taheri, B., & Olya, H. (2019). Festival quality, self-connection and bragging.
 1010 *Annals of Tourism Research*, 76, 239-252.
- 1011 Gallarza, M. G., Saura, I. G., & García, H. C. (2002). Destination image: Towards a
 1012 conceptual framework. *Annals of Tourism Research*, 29(1), 56-78.
- 1013 Garcia-Altes, A. (2005). The development of health tourism services. *Annals of Tourism*
 1014 *Research*, 32(1), 262-266.
- 1015 Garson, D. (2016). *Partial Least Squares: Regression and Structural Equation Models*,
 1016 Statistical Associates Blue Book Series.
- 1017 Ghosh, T., & Mandal, S. (2019). Medical tourism experience: Conceptualization, scale
 1018 development, and validation. *Journal of Travel Research*, 58(8), 1288-1301.
- 1019 Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking qualitative rigor in inductive
 1020 research notes on the Gioia methodology. *Organizational Research Methods*, 16(1),
 1021 15-31.
- 1022 Goodrich, J. N., & Goodrich, G. E. (1987). Health-care tourism—An exploratory study.
 1023 *Tourism Management*, 8(3), 217-222.
- 1024 Guiry, M., & Vequist, D. G. (2011). Traveling abroad for medical care: US medical tourists'
 1025 expectations and perceptions of service quality. *Health Marketing Quarterly*, 28(3),
 1026 253-269.
- 1027 Gursoy, D., & Gavcar, E. (2003). International leisure tourists' involvement profile. *Annals*
 1028 *of Tourism Research*, 30(4), 906-926.
- 1029 Hair, J. F. Black. W. C., Babin., B. J., & Anderson R. E., (2010) (2010) *Multivariate Data*
 1030 *Analysis: A Global Perspective*. Pearson, USA.
- 1031 Hair, J. F., Hult, T. M., Ringle, C. M., & Sarstedt, M. (2017) *A primer on Partial Least*
 1032 *Squares Structural Equation Modeling (PLS-SEM)*: Sage; Los Angeles, CA.
- 1033 Hall, M. (2017). *Medical Tourism: The ethics, regulation, and marketing of health mobility*.
 1034 Routledge Publication.
- 1035 Han, H. (2013) The healthcare hotel: Distinctive attributes for international medical
 1036 travellers. *Tourism Management*, 36: 257-268.
- 1037 Han, H., & Hyun, S. S. (2015). Customer retention in the medical tourism industry: Impact of
 1038 quality, satisfaction, trust, and price reasonableness. *Tourism Management*, 46, 20-29.

- 1039 Han, H., & Hwang, J. (2013). Multi-dimensions of the perceived benefits in a medical hotel
1040 and their roles in international travellers' decision-making process. *International*
1041 *Journal of Hospitality Management*, 35, 100-108.
- 1042 Han, H., Meng, B., & Kim, W. (2017). Bike-traveling as a growing phenomenon: Role of
1043 attributes, value, satisfaction, desire, and gender in developing loyalty. *Tourism*
1044 *Management*, 59, 91-103.
- 1045 Harrigan, P., Evers, U., Miles, M., & Daly, T. (2017). Customer engagement with tourism
1046 social media brands. *Tourism Management*, 59, 597-609.
- 1047 Harrison-Walker, L. J. (2001). The measurement of word-of-mouth communication and an
1048 investigation of service quality and customer commitment as potential antecedents.
1049 *Journal of Service Research*, 4(1), 60-75.
- 1050 Hennig-Thurau, T., Gwinner, K. P., Walsh, G., & Gremler, D. D. (2004). Electronic word-of-
1051 mouth via consumer-opinion platforms: what motivates consumers to articulate
1052 themselves on the internet?. *Journal of Interactive Marketing*, 18(1), 38-52.
- 1053 Henseler, J., Dijkstra, T. K., Sarstedt, M., Ringle, C. M., Diamantopoulos, A., Straub, D. W.,
1054 ... & Calantone, R. J. (2014). Common beliefs and reality about PLS: Comments on
1055 Rönkkö and Evermann (2013). *Organizational Research Methods*, 17(2), 182-209.
- 1056 Henseler, J., Ringle, C. M., & Sarstedt, M. (2015). A new criterion for assessing discriminant
1057 validity in variance-based structural equation modeling. *Journal of the Academy of*
1058 *Marketing Science*, 43(1), 115-135.
- 1059 Henseler, J., Ringle, C. M., & Sinkovics, R. R. (2009) The use of partial least squares path
1060 modeling in international marketing. *Advances in International Marketing*, 20: 277-
1061 319.
- 1062 Heung, V. C., Kucukusta, D., & Song, H. (2011). Medical tourism development in Hong
1063 Kong: An assessment of the barriers. *Tourism Management*, 32(5), 995-1005.
- 1064 Heung, V. C., Kucukusta, D., & Song, H. (2010). A conceptual model of medical tourism:
1065 Implications for future research. *Journal of Travel & Tourism Marketing*, 27(3), 236-
1066 251.
- 1067 Hudson, L. A., & Ozanne, J. L. (1988). Alternative ways of seeking knowledge in consumer
1068 research. *Journal of Consumer Research*, 14(4), 508-521.
- 1069 Hunt, K. H. (1977). *CS/D – Overview and future research direction, in Conceptualization*
1070 *and Measurement of Consumer Satisfaction and Dissatisfaction*, H. Keith Hunt (ed.).
1071 Marketing Science Institution, Cambridge, Mass.
- 1072 Hwang, S. N., Lee, C., & Chen, H. J. (2005). The relationship among tourists' involvement,
1073 place attachment and interpretation satisfaction in Taiwan's national parks. *Tourism*
1074 *Management*, 26(2), 143-156.
- 1075 ICHTO (2018). "Handcraft and Tourism Organization" Tourism statistics of Iran. Heritage,
1076 Iran Cultural. Available from: <https://www.mcth.ir/english>
- 1077 Jabbari, A., Ferdosi, M., Keyvanara, M., & Agharahimi, Z. (2013). Stakeholders' analysis of
1078 the medical tourism industry: development strategies in Isfahan. *Journal of Education*
1079 *and Health Promotion*, 2.
- 1080 Jafari, A., Taheri, B., & vom Lehn, D. (2013). Cultural consumption, interactive sociality,
1081 and the museum. *Journal of Marketing Management*, 29(15-16), 1729-1752.
- 1082 Jiang, K., Luk, S. T. K., & Cardinali, S. (2018). The role of pre-consumption experience in
1083 perceived value of retailer brands: Consumers' experience from emerging
1084 markets. *Journal of Business Research*, 86, 374-385.
- 1085 Johnston, R., Crooks, V. A., & Snyder, J. (2012). "I didn't even know what I was looking
1086 for": A qualitative study of the decision-making processes of Canadian medical
1087 tourists. *Globalization and Health*, 8(1), 23.

- 1088 Kim, T. T., Kim, W. G., & Kim, H. B. (2009). The effects of perceived justice on recovery
1089 satisfaction, trust, word-of-mouth, and revisit intention in upscale hotels. *Tourism*
1090 *Management*, 30(1), 51-62.
- 1091 Khalilzadeh, J., & Tasci, A. D. (2017). Large sample size, significance level, and the effect
1092 size: Solutions to perils of using big data for academic research. *Tourism*
1093 *Management*, 62, 89-96.
- 1094 Kim, W. & Han, H. (2008). Determinants of restaurant customers' loyalty intentions: a
1095 mediating effect of relationship quality. *Journal of Quality Assurance in Hospitality*
1096 *and Tourism*, 9 (3), 218-238
- 1097 Kreiner, G. E., Hollensbe, E. C., & Sheep, M. L. (2006). Where is the "me" among the "we"?
1098 Identity work and the search for optimal balance. *Academy of Management*
1099 *Journal*, 49(5), 1031-1057.
- 1100 Lee, C. G. (2010). Health care and tourism: Evidence from Singapore. *Tourism*
1101 *Management*, 31(4), 486-488.
- 1102 Lee, J., & Beeler, C. (2009). An investigation of predictors of satisfaction and future
1103 intention: links to motivation, involvement, and service quality in a local
1104 festival. *Event Management*, 13(1), 17-29.
- 1105 Lee, O. F., & Davis, T. R. (2005). International patients: A lucrative market for US hospitals.
1106 *Health Marketing Quarterly*, 22(1), 41-56.
- 1107 Lee, C., Hallak, R., & Sardeshmukh, S. R. (2016). Innovation, entrepreneurship, and
1108 restaurant performance: A higher-order structural model. *Tourism Management*, 53,
1109 215-228.
- 1110 Liang, H., Saraf, N., Hu, Q., & Xue, Y. (2007). Assimilation of Enterprise Systems: The
1111 Effect of Institutional Pressures and The Mediating Role of Top Management. *MIS*
1112 *Quarterly* 31: 59-87.
- 1113 Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage
1114 Publications, Inc.
- 1115 Litvin, S. W., Goldsmith, R. E., & Pan, B. (2008). Electronic word-of-mouth in hospitality
1116 and tourism management. *Tourism Management*, 29(3), 458-468.
- 1117 Lovelock, B., & Lovelock, K. (2018). "We had a ball... as long as you kept taking your
1118 painkillers" just how much tourism is there in medical tourism? Experiences of the
1119 patient tourist. *Tourism Management*, 69, 145-154.
- 1120 Lovelock, B., Lovelock, K., & Lyons, K. (2018). The impact of outbound medical (dental)
1121 tourism on the generating region: New Zealand dental professionals' perspectives.
1122 *Tourism Management*, 67, 399-410.
- 1123 Lu, H. Y., Wu, W. Y., & Chen, S. H. (2016). Influences on the perceived value of medical
1124 travel: the moderating roles of risk attitude, self-esteem and word-of-mouth. *Current*
1125 *Issues in Tourism*, 19(5), 477-491.
- 1126 Lu, L., Chi, C. G., & Liu, Y. (2015). Authenticity, involvement, and image: Evaluating
1127 tourist experiences at historic districts. *Tourism Management*, 50, 85-96.
- 1128 Lunt, N., & Carrera, P. (2011). Systematic review of web sites for prospective medical
1129 tourists. *Tourism Review*, 66(1/2), 57-67.
- 1130 Mangold, G. W., & Babakus, E. (1991). Service quality: The front-stage vs. the back-stage
1131 perspective. *Journal of Services Marketing*, 5(4), 59-70.
- 1132 Manaf, N. H. A., Hussin, H., Kassim, P. N. J., Alavi, R., & Dahari, Z. (2015). Medical
1133 tourism service quality: finally some empirical findings. *Total Quality Management &*
1134 *Business Excellence*, 26(9-10), 1017-1028.
- 1135 Market Analysis Report (2020). Medical Tourism Market Size, Share & Trends Analysis
1136 Report By Country (Thailand, India, Costa Rica, Mexico, Malaysia, Singapore,

- 1137 Brazil, Colombia, Turkey, Taiwan, South Korea, Spain, Czech Republic), And
 1138 Segment Forecasts, 2020 – 2027.
- 1139 Mathijssen, A. (2019). Home, sweet home? Understanding diasporic medical tourism
 1140 behaviour. Exploratory research of Polish immigrants in Belgium. *Tourism
 1141 Management*, 72, 373-385.
- 1142 Mardia, K. V. (1970). Measures of multivariate skewness and kurtosis with
 1143 applications. *Biometrika*, 57(3), 519-530.
- 1144 Mattoo, A., & Rathindran, R. (2006). How Health Insurance Inhibits Trade In Health Care.
 1145 Health Affairs, 25, no.2 (2006):358-368. Available from
 1146 <http://content.healthaffairs.org/content/25/2/358.full.html>
- 1147 Maxham III, J. G., & Netemeyer, R. G. (2002). A longitudinal study of complaining
 1148 customers' evaluations of multiple service failures and recovery efforts. *Journal of
 1149 Marketing*, 66(4), 57-71.
- 1150 Miles, M. B., & Huberman, M. A. (1994). *Qualitative data analysis - an expanded
 1151 sourcebook*. Sage Publications, Newbury Park.
- 1152 Min, H., Park, J. & Kim, H.J. (2016). Common method bias in hospitality research: A critical
 1153 review of literature and an empirical study. *International Journal of Hospitality
 1154 Management*, 56, 126-135.
- 1155 Moghavvemi, S., Ormond, M., Musa, G., Isa, C. R. M., Thirumoorthi, T., Mustapha, M. Z.
 1156 B., & Chandy, J. J. C. (2017). Connecting with prospective medical tourists online: A
 1157 cross-sectional analysis of private hospital websites promoting medical tourism in
 1158 India, Malaysia and Thailand. *Tourism Management*, 58, 154-163.
- 1159 Moghimehfar, F., & Nasr-Esfahani, M. H. (2011). Decisive factors in medical tourism
 1160 destination choice: A case study of Isfahan, Iran and fertility treatments. *Tourism
 1161 Management*, 32(6), 1431-1434.
- 1162 Momeni, K., Janati, A., Imani, A., & Khodayari-Zarnaq, R. (2018). Barriers to the
 1163 development of medical tourism in East Azerbaijan province, Iran: A qualitative
 1164 study. *Tourism Management*, 69, 307-316.
- 1165 Monroe, K. B. (1990). *Pricing: Making profitable decisions*. McGraw-Hill Companies, USA.
- 1166 Musa, G., Thirumoorthi, T., & Doshi, D. (2012). Travel behaviour among inbound medical
 1167 tourists in Kuala Lumpur. *Current Issues in Tourism*, 15(6), 525-543.
- 1168 Musa, G., Doshi, D. R., Wong, K. M., & Thirumoorthy, T. (2012). How satisfied are inbound
 1169 medical tourists in Malaysia? A study on private hospitals in Kuala Lumpur. *Journal
 1170 of Travel & Tourism Marketing*, 29(7), 629-646.
- 1171 Nahai, F. (2009). It's procedure, not tourism. *Medical Tourism*, 1, 106.
- 1172 Oh, H. (2000). The effect of brand class, brand awareness, and price on customer value and
 1173 behavioral intentions. *Journal of Hospitality & Tourism Research*, 24(2), 136-162.
- 1174 O'Cass, A. & Sok, P. (2015). An exploratory study into managing value creation in tourism
 1175 service firms: Understanding value creation phases at the intersection of the tourism
 1176 service firm and their customers, *Tourism Management*, 51, 186-200.
- 1177 Pache, A. C., & Santos, F. (2013). Inside the hybrid organization: Selective coupling as a
 1178 response to competing institutional logics. *Academy of Management Journal*, 56(4),
 1179 972-1001.
- 1180 Parasuraman, A., Zeithaml, V., & Berry, L. (1988). SERVQUAL: A multiple-item scale for
 1181 measuring consumer perceptions of service quality. *Journal of Retailing*, 64, 12-40.
- 1182 Parasuraman, A., Berry, L. L., & Zeithaml, V. A. (1991). Perceived service quality as a
 1183 customer-based performance measure: An empirical examination of organizational
 1184 barriers using an extended service quality model. *Human Resource Management*,
 1185 30(3), 335-364.

- 1186 Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury
 1187 Park, CA: Sage Publications, Inc.
- 1188 Perez-Vega, R., Taheri, B., Farrington, T., & O’Gorman, K. (2018). On being attractive,
 1189 social and visually appealing in social media: The effects of anthropomorphic tourism
 1190 brands on Facebook fan pages. *Tourism Management*, 66, 339-347.
- 1191 Penney, K., Snyder, J., Crooks, V. A., & Johnston, R. (2011). Risk communication and
 1192 informed consent in the medical tourism industry: a thematic content analysis of
 1193 Canadian broker websites. *BMC medical ethics*, 12(1), 17.
- 1194 Pike, S., & Ryan, C. (2004). Destination positioning analysis through a comparison of
 1195 cognitive, affective, and conative perceptions. *Journal of Travel Research*, 42(4),
 1196 333-342.
- 1197 Pike, S., & Page, S.J. (2014). Destination Marketing Organizations and destination
 1198 marketing: A narrative analysis of the literature, *Tourism Management*, 41: 202-227.
- 1199 Podsakoff, P. M., MacKenzie, S. B., Lee, J. Y., & Podsakoff, N. P. (2003). Common method
 1200 biases in behavioral research: A critical review of the literature and recommended
 1201 remedies. *Journal of Applied Psychology*, 88(5), 879.
- 1202 Pope, J. (2008). The globalisation of medicine: the emerging market of medical tourists-
 1203 estimates, challenges and prospects. In *Medical tourism: Perspectives and specific*
 1204 *country experiences* (pp. 3-27). ICFAI University Press.
- 1205 Prayag, G., & Ryan, C. (2012). Antecedents of tourists’ loyalty to Mauritius: The role and
 1206 influence of destination image, place attachment, personal involvement, and
 1207 satisfaction. *Journal of Travel Research*, 51(3), 342-356.
- 1208 Qu, H., Kim, L. H., & Im, H. H. (2011). A model of destination branding: Integrating the
 1209 concepts of the branding and destination image. *Tourism Management*, 32(3), 465-
 1210 476.
- 1211 Reddy, S. G., York, V. K., & Brannon, L. A. (2010). Travel for treatment: Students’
 1212 perspective on medical tourism. *International Journal of Tourism Research*, 12(5),
 1213 510–522.
- 1214 Reed, C. M. (2008). Medical tourism. *Medical Clinics of North America*, 92(6), 1433-1446.
- 1215 Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research*
 1216 *practice: A guide for social science students and researchers*. Sage, USA.
- 1217 Salanova, M., Agut, S., & Peiró, J. M. (2005). Linking organizational resources and work
 1218 engagement to employee performance and customer loyalty: the mediation of service
 1219 climate. *Journal of Applied Psychology*, 90(6), 1217.
- 1220 Sánchez-Fernández, R., & Iniesta-Bonillo, M. Á. (2007). The concept of perceived value: a
 1221 systematic review of the research. *Marketing Theory*, 7(4), 427-451.
- 1222 Seyfi, S., & Hall, C. M. (Eds.). (2018). *Tourism in Iran: Challenges, development and issues*.
 1223 Routledge.
- 1224 Skountridaki, L. (2017). Barriers to business relations between medical tourism facilitators
 1225 and medical professionals. *Tourism Management*, 59, 254-266.
- 1226 Smith, R., Álvarez, M. M., & Chanda, R. (2011). Medical tourism: a review of the literature
 1227 and analysis of a role for bi-lateral trade. *Health Policy*, 103(2-3), 276-282.
- 1228 Smith, P. C., & Forgione, D. A. (2007). Global outsourcing of healthcare: a medical tourism
 1229 decision model. *Journal of Information Technology Case and Application*
 1230 *Research*, 9(3), 19-30.
- 1231 Sweeney, J. C., & Soutar, G. N. (2001). Consumer perceived value: The development of a
 1232 multiple item scale. *Journal of Retailing*, 77(2), 203-220.
- 1233 Tabachnick, B.G., & Fidell, L.S. (2013). *Using multivariate statistics (Sixth ed.)*. Boston:
 1234 Pearson Education.

- 1235 Taheri, B., Jafari, A., & O'Gorman, K. (2014). Keeping your audience: Presenting a visitor
1236 engagement scale. *Tourism Management*, 42, 321-329.
- 1237 Taheri, B., Coelho, F.J., Sousa, C.M.P., & Evanschitzky, H. (2017). Mood regulation,
1238 customer participation, and customer value creation in hospitality services,
1239 *International Journal of Contemporary Hospitality Management*, 29 (12), 3063-3081.
- 1240 Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating*
1241 *quantitative and qualitative approaches in the social and behavioral sciences*. Sage,
1242 USA.
- 1243 Uchida, Y. (2015). Medical Tourism or 'Medical Examination and Treatment Abroad': An
1244 Economic Study of the Phenomenon. In *Current Issues and Emerging Trends in*
1245 *Medical Tourism* (pp. 18-30). IGI Global.
- 1246 Viladrich, A., & Baron-Faust, R. (2014). Medical tourism in tango paradise: The internet
1247 branding of cosmetic surgery in Argentina. *Annals of Tourism Research*, 45, 116-131.
- 1248 Wang, H. Y. (2012). Value as a medical tourism driver. *Managing Service Quality: An*
1249 *International Journal*, 22(5), 465-491.
- 1250 Wang, C. Y., & Hsu, M. K. (2010). The relationships of destination image, satisfaction, and
1251 behavioral intentions: An integrated model. *Journal of Travel & Tourism Marketing*,
1252 27(8), 829-843.
- 1253 Wanous, J. P., Reichers, A. E., & Hudy, M. J. (1997). Overall job satisfaction: how good are
1254 single-item measures? *Journal of Applied Psychology*, 82(2), 247.
- 1255 Wardi, Y., Abror, A., & Trinanda, O. (2018). Halal tourism: antecedent of tourist's
1256 satisfaction and word of mouth (WOM). *Asia Pacific Journal of Tourism Research*,
1257 23(5), 463-472.
- 1258 Wells, V. K., Smith, D. G., Taheri, B., Manika, D., & McCowlen, C. (2016a). An exploration
1259 of CSR development in heritage tourism. *Annals of Tourism Research*, 58, 1-17.
- 1260 Wells, V. K., Taheri, B., Gregory-Smith, D., & Manika, D. (2016b). The role of generativity
1261 and attitudes on employees' home and workplace water and energy saving
1262 behaviours. *Tourism Management*, 56, 63-74.
- 1263 Westbrook, R. A. (1987). Product/consumption-based affective responses and postpurchase
1264 processes. *Journal of Marketing Research*, 258-270.
- 1265 Williams, J., & MacKinnon, D. P. (2008). Resampling and distribution of the product
1266 methods for testing indirect effects in complex models. *Structural Equation*
1267 *Modeling*, 15(1), 23-51.
- 1268 Wongkit, M., & McKercher, B. (2013). Toward a typology of medical tourists: A case study
1269 of Thailand. *Tourism Management*, 38, 4-12.
- 1270 Yang, Z., & Peterson, R. T. (2004). Customer perceived value, satisfaction, and loyalty: The
1271 role of switching costs. *Psychology & Marketing*, 21(10), 799-822.
- 1272 Ye, B. H., Yuen, P. P., Qiu, H. Z., & Zhang, V. H. (2008, July). Motivation of medical
1273 tourists: An exploratory case study of Hong Kong medical tourists. In *Asia Pacific*
1274 *Tourism Association (APTA) Annual Conference, Bangkok, Thailand*.
- 1275 Yeoh, E., Othman, K., & Ahmad, H. (2013). Understanding medical tourists: Word-of-mouth
1276 and viral marketing as potent marketing tools. *Tourism Management*, 34, 196-201.
- 1277 Yu, J. Y., & Ko, T. G. (2012). A cross-cultural study of perceptions of medical tourism
1278 among Chinese, Japanese and Korean tourists in Korea. *Tourism Management*, 33(1),
1279 80-88.
- 1280 Zeithaml, V. A. (1988). Consumer perceptions of price, quality and value: A means-end
1281 model and synthesis of evidence. *Journal of Marketing*, 52, 2-2.
- 1282 Zeithaml, V. A., Berry, L. L., & Parasuraman, A. (1993). The nature and determinants of
1283 customer expectations of service. *Journal of the Academy of Marketing*
1284 *Science*, 21(1), 1-12.

1285 Zeithaml, V. A., Bitner, M. J., & Gremler, D. D. (2009). *Services marketing: Integrating*
1286 *customer focus across the firm* (5th ed.). New York: McGraw-Hill/Irwin.
1287