This is a peer-reviewed, accepted author manuscript of the following article: Taheri, B., Chalmers, D., Wilson, J., & Arshed, N. (2021). Would you really recommend it? Antecedents of word-of-mouth in medical tourism. *Tourism Management*, *83*, [104209]. https://doi.org/10.1016/j.tourman.2020.104209

Taheri, B., Chalmers, D., Wilson, J., & Arshed, N. (2020). Would you really recommend it? Antecedents of word-of-mouth in Medical Tourism, *Tourism Management.* [ABS 4*, impact factor: 7.432]

Abstract

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

Keywords: Medical Tourism; word of mouth; mixed methods; Iran

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; Mathijsen, 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). Mathijsen (2019, p. 374), for example, categorises a range of factors for medical tourists travelling aboard 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 simultaneously being holidaymakers."	Motivations for medical tourists in Asia	Discussion piece - conceptual	Multi - country	Not stated	Garcia-Altes, (2005)

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

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

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

2.1.1 Medical Tourism in Iran

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

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

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

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

2.2 Word of Mouth

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

WoM is a well-established concept in marketing literature, with significant theoretical development that draws upon cognitive, emotional and interactionist perspectives (Berger, 2014; Gannon, Taheri, & Olya, 2019; De Matos & Rossi, 2008). The most widely accepted definition of WoM is as "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). WoM is influential in-service sectors such as medical tourism, owing to the intangible and experiential nature of product offerings (Zeithaml, Berry, & Parasuraman, 1993). Empirical evidence has shown that WoM referrals provide a means of reducing the risk inherent to such transactions (Musa et al., 2012).

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

Table 2

Multidisciplinary definitions of WoM.

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

		"oral, person-to-person communication between a perceived non-commercial communicator and a receiver concerning a brand, a product, or a service offered for sale" (Arndt, 1967, p. 190).	
Fillieri and McLeay (2013)	Consumer Behaviour	E-WoM has been defined as "any positive or negative statement made by potential, actual or former customers about a product or company, that is made available to a multitude of people and institutions via the internet" (Hennig-Thurau et al., 2004, p. 39).	Not addressed
Harrison-Walker (2001)	Services Marketing	Favourable WoM may include "relating pleasant, vivid, or novel experiences; recommendations to others; and even conspicuous display" (Anderson, 1998, p. 6). 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

2.3 Conceptual model

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

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

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

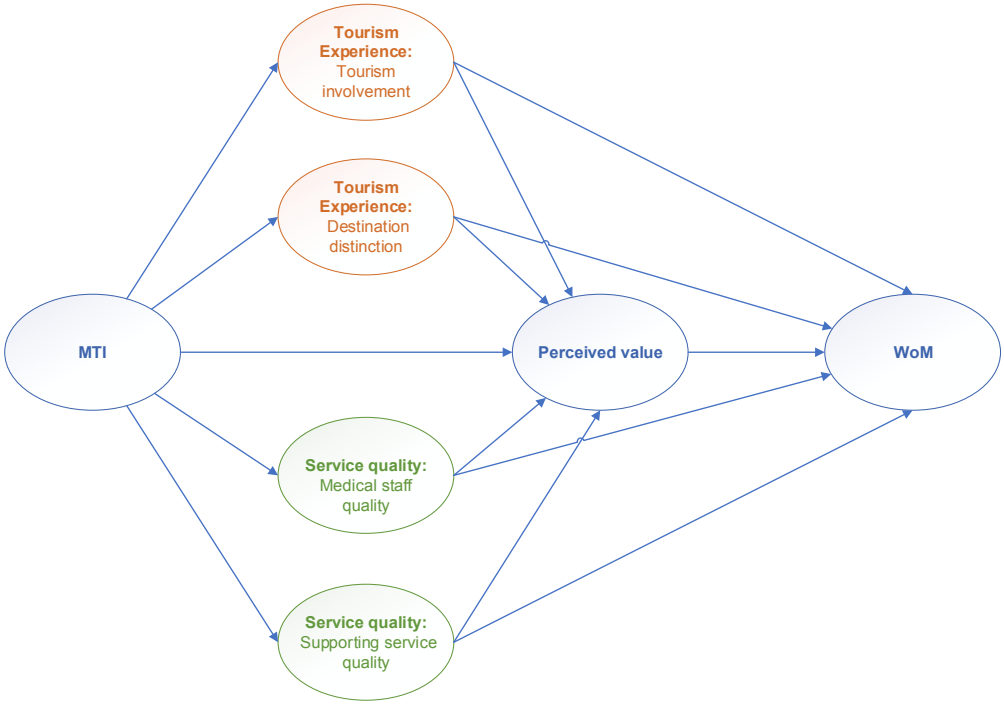


Fig. 1. Conceptual model

2.3.1 Antecedents of WoM

2.3.1.1 Perceived Value

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

2.3.1.2 Service Quality

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

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

2.3.1.3 Tourism Experience

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

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

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

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

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

2.3.1.4 Medical Tourism Index

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

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

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

3. Methodology

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

3.1 Research Context

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

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

3.1 Qualitative study

3.1.1 Data gathering

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

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

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

Table 3

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

3.1.2 Data analysis

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

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

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

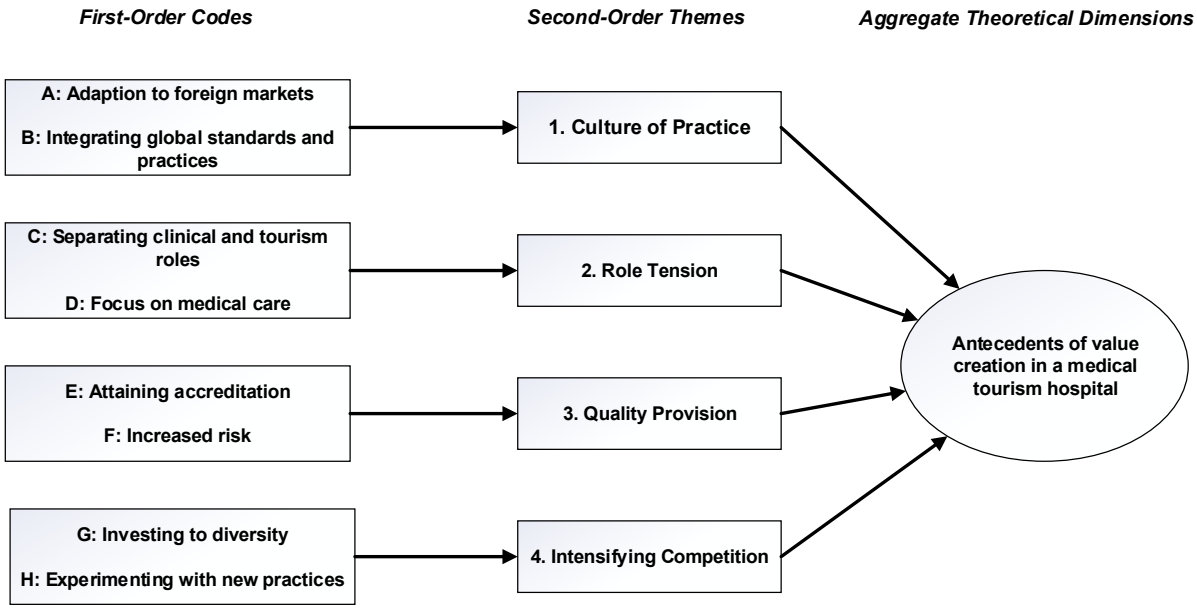


Fig. 2. Data structure.

3.2 Quantitative study

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

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

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

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

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

3.2.1 Measurement of variables

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

3.2.2 Analytical technique

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

3.2.3 Common Method Variance

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

4. Results and discussion

4.1 Qualitative analysis

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

4.1.1 Culture of Practice

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.

562 **Table 4**

563 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).

564

4.1.2 Role Tension

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

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

4.1.1 Quality provision

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

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

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

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

4.1.2 Intensifying competition

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

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

4.2 Quantitative analysis

4.2.1 Assessment of the measurement model

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

646 **Table 5**

647 Descriptive statistics, validity, reliability of the constructs.

Constructs	Items	Mean	SD	Skewness	Kurtosis	Loadings*	AVE	CR	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	-.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			

	Short waiting time for the medical examination from the nurses and medical staff	4.57	1.766	-2.261	-0.782	0.744			
Supporting Services Quality							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			
	Hospital care facilities (laboratory and doctors' office) were easy to find	4.81	2.210	-3.027	-1.415	0.684			
	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			
Tourism Involvement							0.575	0.778	0.744
	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							0.576	0.844	0.758
	This city is unique	4.13	2.188	-3.266	-1.465	0.692			
	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							0.547	0.784	0.703
	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			
	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 value as compared to other medical treatment/healthcare places/clinics and cities	4.89	1.002	1.408	2.073	0.702			
WoM							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			

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

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**

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

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

Table 7

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 Staff Quality	0.027	0.041	0.026	0.230	0.068	0.347				
(8) Medical Tourism Costs	0.706	0.019	0.402	0.002	0.703	0.065	0.061			
(9) Perceived Value	0.096	0.436	0.004	0.735	0.133	0.436	0.321	0.010		
(10) Supporting Service	0.031	0.000	0.033	0.366	0.065	0.543	0.684	0.044	0.455	
(11) Tourism Destination	0.743	0.026	0.331	0.015	0.640	0.010	0.040	0.643	0.116	0.035

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.

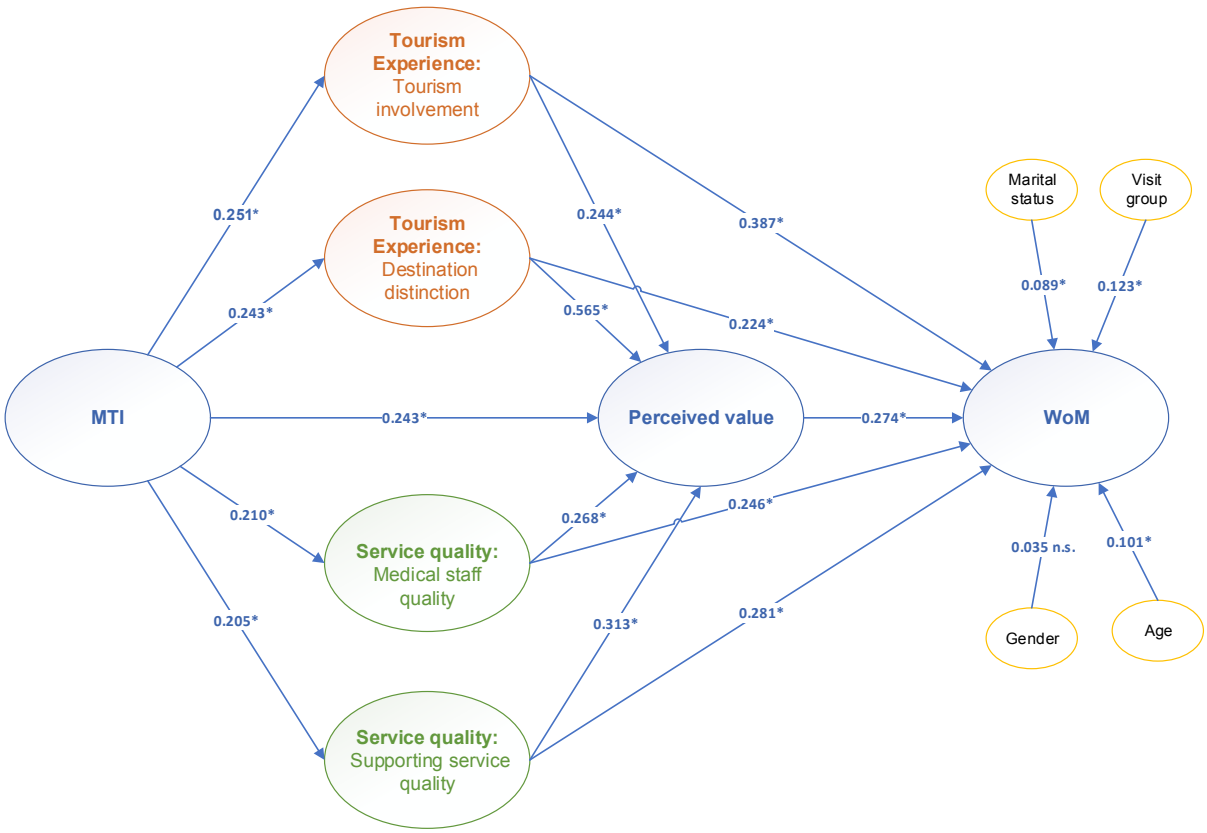
MTI-Dimension	Spearman's rank correlation coefficient	Weight*
Country Environment	0.242*	0.719*

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

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

4.2.2 Assessment of the structural model

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



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

Fig. 3. Results of structural model.

4.2.3 Post-hoc analysis of the indirect effects

The findings proposed the potential existence of mediating relationships for the study (i.e., post-hoc analysis of the indirect effects). Following Williams and MacKinnon (2008) 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**).

Table 9
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

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

5. Conclusion and implications

5.1 Theoretical contributions

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

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

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

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

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

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

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

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

5.2 Practical Implications

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

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

5.3 Limitations and future research agenda

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

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

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

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