A STUDY OF MEDICAL TOURISTS' BEHAVIOURAL INTENTION IN RELATION TO HOSPITAL BRAND IMAGE AND THE MEDIATING EFFECTS OF PERCEIVED VALUE AND TRUST

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By

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ABSTRACT

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Cham Tat Huei

Medical tourism, a form of tourism activity for patients to travel beyond borders for medical treatments, has been growing over the past decades. This scenario has boosted the growth of the industry; requiring many hospitals to consistently equip themselves with excellent medical services and effective marketing strategies to remain relevant in the industry. In view of the competitive landscape in medical tourism, the impact of hospital brand image on the behaviours of medical tourists towards hospitals has become an important issue. Therefore, the aim of this study is to examine the relationship among hospital brand image, service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention. A quantitative study was performed on 386 medical tourists from private hospitals in Penang, Malaysia. The survey questionnaires were distributed to the respondents using the quota sampling method. Both Analysis of Moment Structures (AMOS) and Statistical Package for the Social Sciences (SPSS) statistical software were used to test the hypothesised relationships for this study. The results from this study revealed that hospitals' brand image have a significant positive influence on medical tourists' perceived service quality. Likewise, all the hypothesised relationships among constructs namely perceived service quality, perceived

trust, perceived value, patient satisfaction and behavioural intention were also supported. Consequently, this study proposes that hospital managers should strive to create and maintain the positive hospital brand image to enhance service quality. Furthermore, several strategies have been suggested to assist hospital managements in developing successful medical tourism strategies in the hope of attracting more potential international medical tourists. Lastly, the results from this study provide useful insights to the advancement of medical tourism industry in terms of theoretical and practical knowledge.

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DECLARATION

I hereby declare that the dissertation is based on my original work except for quotations and citations which have been duly acknowledged. I also declare that it has not been previously or concurrently submitted for any other degree at UTAR or other institutions.

(Cham Tat Huei)
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LIST OF ABBREVIATIONS

ACSI	American Customer Satisfaction Index
AMOS	Analysis Of Moment Structures
AVE	Average Variance Extracted
ASV	Average-Shared-Squared-Variance
C.A	Cronbach's Alpha
C.R	Composite Reliability
CFA	Confirmatory Factor Analysis
CFI	Comparative Fix Index
F.L	Factor Loading
GFI	Goodness Of Fit Index
JCI	Joint Commission International
Lisrel	Linear Structural Relations
MHTC	Malaysia Healthcare Travel Council
MSQH	Malaysian Society For Quality In Health
MSV	Maximum-Shared-Squared-Variance
RMSEA	Root-Mean Square-Error Of Approximation
SEM	Structural Equation Modelling
SPSS	Statistical Package For The Social Sciences
TOL	Detection-Tolerance
TLI	Tucker Lewis Index
TRAM	Tourism Research and Marketing
WOM	Word Of Mouth
VIF	Variance Inflation Factor

CHAPTER 1

INTRODUCTION

1.1 Background of Study

In the tourism context, service offerings that are based on health and wellness have become an important fragment of an international service industry that is growing in the rapid pace. Although patients from the less developed countries have often visited developed countries for advance medical facilities and to avail themselves to the access of reputable and skilled doctors in the early days, this trend began to reverse since the early 1990s whereby more and more patients begin to travel to developing countries for the purpose of medical services attributable to the improving healthcare infrastructures and lower medical costs in these countries (Rogers, 2008). This trend was distinctively known as “medical tourism” and it commonly occur when people travel beyond their national border for medical treatment, while simultaneously being holidaymakers (Connell, 2006). Since then, medical tourism became an emerging phenomenon in the healthcare industry, which resulted from the high worldwide demand (Yu & Ko, 2012). Moreover, the business of the global medical tourism thrived over time with the industry being joined by many countries over the world and participated by various socio-economic classes of stakeholders (Connell, 2013). This scenario placed medical tourism as one of the significant modern industries on the map of global economy.

In addition, it was found that the factors that promote the growth and acceptance of medical tourism are largely due to the declining standards of care in most of the developed countries, the long waiting lists, consistent tourism strategies adopted by countries involved with medical tourism, and the increase of the cost for medical services in many developed countries (Caballero-Danell & Mugomba, 2007). Due to the substantial demand for medical tourism, many industry experts in medical tourism have proposed that there is a significant future potential growth in this industry. One of the widely cited statistics by the Taiwan Institute of Economic Research (2009), a private independent institute that provides consultations to the government and enterprises of Taiwan, reported that the medical tourists comprised more than four percent of the global travel industry. Moreover, it was predicted that medical tourism industry will continuously grow at 20 percent per annum and will be worth more than US$ 50 billion in value in 2014 (Forbes, 2014). Forbes (2014) also further anticipated that this industry will continuously enjoy steady growth especially with the rising numbers of Western medical tourists who participated in this industry. Furthermore, the promising trend of global medical tourism has made Asia as one of the most well-known destinations for this industry. For instance, it was reported that the market of medical tourism in Asia was valued at more than US$ 6 billion with an estimation of more than four million medical tourists having visited Asia annually (KPMG International, 2011). Therefore, there is no doubt that there are numerous countries in Asia, such as Malaysia, South Korea, Singapore, Thailand, Taiwan, Philippines, Vietnam, and India that are competing for a market share in this industry (smarttravelasia.com, 2015).

Given the competitive nature of medical tourism, this scenario resulted in the emphasis of qualities of care among medical tourists. Therefore, the concept of service quality attracted attention among the industry players, medical practitioners, researchers, and academics. This is because service quality was argued in having a substantial impact on the healthcare industry in the context of patient satisfaction, business performance, profitability, and most importantly medical tourists' future intention. Moreover, the significance of service quality is gradually being recognised in connection with the economic growth throughout the world and the rising of living standards (Olorunniwo, Hsu, & Udo, 2006). Hence, there is no exception to this rule for the medical tourism industry that the evaluation of medical tourists' perception of service quality was regarded as a strategic approach for the healthcare industry in attracting and retaining their customers (Choi, Lee, Kim, & Lee, 2005; Rivers & Glover, 2008). In view of that, the concern towards service quality in medical tourism was significantly emphasised in various hospitals throughout the world where they experience an increase of competition that forces them into becoming more efficient, to continuously creating competitive edge, and to craft sustainable business models (Ehrbeck, Guevara, & Mango, 2008).

In addition to the above discussion, it was reported that the provision of high-quality services has been considered as one of the key factors of successful operation in the service setting (Parasuraman & Grewal, 2000; Malik, 2012). Moreover, elevating the service quality presented by hospitals in fulfilling the customer needs is not only able to retain existing customers but

also in creating patient satisfaction and positive behavioural intention among patients (Alrubaiee & Alkaa'ida, 2011). McMullan and Gilmore (2008) asserted that profit for a business can be improved significantly if the particular business focuses on the initiatives to retain their current customers. These "profits" are usually generated from the savings of costs in the firm's marketing activities and expenses. This notion seems to be important for hospitals that are involved in medical tourism to remain competitive and relevant to the medical tourists' needs and the medical tourism industry. Therefore, many of the hospitals that are involved with medical tourism have proactively taken action to understand how medical tourists perceived service quality on the hospital that they visited, and what more is important is how these insights can be further translated into patient satisfaction, perceived value, perceived trust, and creating positive behavioural intention among them (Lertwannawit & Gulid, 2012; Musa, Doshi, Wong, & Thirumoorthy, 2012).

Furthermore, with the increase in competition within the healthcare industry, branding seemed to play an important role in patients' decision making process (Wu, 2011). Studies showed that brand image have the ability to influence customers' perception and their evaluation of the service performance. Moreover, brand image can effectively create awareness among the first-time customers and competitive advantages may be subsequently formed (Riezebos, 2003; Wu, 2011). Despite the notable impact of brand image on patients' perception, relatively little empirical and theoretical research was conducted in the medical tourism context (Cham, Lim, & Aik, 2015). Therefore, this research was designed to contribute to the

understanding of the impact of brand image on the service quality model in the medical tourism industry. Apart from that, this study also intended to gather information with regards to the perceptions of the medical tourists who visited Malaysia. The findings of this study will be able to assist medical policy makers and hospital management to develop successful medical tourism competitive strategies in the context of competitive medical tourism industry.

1.2 Overview of the Medical Tourism Industry

Since its inception, scholars and practitioners described medical tourism as a new phenomenon, the ultimate out-sourcing, the future of health services, and a new type of international business (Marlowe & Sullivan, 2007; Nath, 2007; Horowitz, Rosensweig, & Jones, 2007). With today's technological advancements, the marketplace of medical tourism transformed overtime whereby patients can easily learn about the existing medical facilities, information is within the reach for patients anywhere in the world, and at the same time allowing them to make comparisons and selections based on the most efficient medical facilities that suit their specific requirements (King, Gakidou, Imai, Lakin, Moore, Nall, & Llamas, 2009). This favorable situation triggered the growth of medical tourism throughout the world especially with the rising demand from the patients from the developed countries. It was reported that the evolving progress of medical tourism resulted with at least 28 countries from a different parts of the world that take part in this industry, with at least a million of patients visiting hospitals that were outside their own country (Woodman, 2007).

In addition, the growing demands for medical tourism have triggered various developing nations in many regions over the world to promote themselves as a medical tourism destination. These countries include South Africa in the African continent; Mexico and Cuba for South America region; Hungary, Bulgaria, Serbia, Croatia, and Romania in the Eastern Europe region; Malaysia, Thailand, Israel, India, Turkey and Jordan in Asia (Woodman, 2007). Moreover, Deloitte (2008) reported that the minor hubs for medical tourism destinations are Hungary, South Africa, and Costa Rica whereas the main hub for medical tourism is mostly distributed in the Asian countries that include Malaysia, Singapore, Thailand, India, and South Korea. According to Renub Research (2014), it was reported that Asian countries contributed significantly to the global medical tourism industry by constantly attracting more 1.5 million of medical tourists into this market annually, and it is estimated to worth at US$8.5 billion in market value.

As for medical tourism, Bookman and Bookman (2007) reported that there are various factors that significantly contribute to the growth of this industry in developing countries, namely a high and increasing cost of healthcare in developed nations, major improvements in the healthcare sector with the use of state-of-art facilities, ease and affordability of international travel, long waiting time, and the growth of the internet usage. Moreover, previous research studies consistently maintained that the central drive for patients from developed nations to search for medical treatments beyond their national border is mainly due to the expensive costs incurred in their home country (Han, Kim, Kim, & Ham, 2015; Singh, 2014; Zhan, 2014). For

instance, the common treatments in the United States of America (USA) charges coronary artery surgery for $88,000, while this surgery only be charged at $20,800 to $54,500 in most of the hospitals in South East Asian countries. Besides, hip replacement surgery in USA would costs patients for $33,000, while it is only priced in the range of $12,500 to $21,400 in South East Asian countries (Patientbeyondborders.com, 2014).

In addition to the above, Youngman (2007) in his study found that medical tourists that are involved in medical tourism generally come from Europe, North America, United Kingdom, Japan, and Middle East. This is because those countries have higher expenses of health care, large populations, increasingly high expectations on healthcare, comparatively high wealth and lack of healthcare options locally. For example, it was found that Japanese firms usually send their staff to countries like Singapore and Thailand for medical checkup and other treatments due the high quality medical services in these countries and cheaper medical fees (Connell, 2006). Similarly, United States is found to have the same practices whereby they outsourced some of the treatments (e.g. hip and knee replacement, cosmetic surgery, heart surgery, etc.) to India due to long waiting times, lack of insurance coverage on certain treatments, and the expensive medical costs in their country (Bies & Zacharia, 2007).

1.2.1 Medical Tourism in Malaysia

Since the introduction of medical tourism in the modern industry platform, Malaysia was regarded as one of the most recognised developing nations and has made a successful presence in this industry, particularly in the Asian region. Thus, healthcare in Malaysia was earmarked as one of the 12 main economic areas of growth in the country, in which medical tourism became a significant contributor to Malaysia's healthcare and tourism industry. Realising this tremendous potential, Malaysian government took an initiative by emphasising it in the Eight Malaysia plan, with inclusion of various parties from the Government (Prime Minister's Department, Ministry of Tourism, Ministry of Health, etc.) and private sectors to promote medical tourism. Subsequently, Malaysia Healthcare Travel Council (MHTC) was formed by the Malaysian government to actively promoting Malaysia as a unique medical tourism destination throughout the world. The aim and the main objective behind this initiative is to make Malaysia the primary medical tourism hub in the global context and in the region of South East Asia in particular.

Having located in the heart of Kuala Lumpur, the capital of Malaysia, MHTC is functioning actively in various activities that are related to Malaysian medical tourism industry, such as providing training for their members, acting as a call center for medical tourists, a business and networking development centre, policies-making body, acting as regulatory body, marketing and media center, research center, visa application center for potential medical tourists, holding medical tourism seminars and exhibitions,

and so on. Moreover, in order to ensure that the medical tourists experience the warmth of Malaysian hospitality and comfort on their arrival and departure, MHTC has also set up their world-leading concierge and lounge at both Kuala Lumpur International Airport and the Penang International Airport. The MHTC's concierge functioned as the one-stop centre that provides medical tourists with information for their stay in Malaysia. On the other hand, MHTC's lounge at the airports is to facilitate medical tourists after their arrival. In the international front, MHTC has also set up their representative in Indonesia and Hong Kong, which functioned as a one-stop information centre for potential Indonesian medical tourists. As part of the MHTC's initiative to promote Malaysian medical tourism at the international front, MHTC works closely with all the relevant industry stakeholders via collaboration and programmes that are related to medical tourism.

Under the Malaysia's medical tourism promotion drive, there are as many as 72 private hospitals in Malaysia that participated in the Malaysia medical tourism program. All of them are accredited by the Malaysian Society for Quality in Health (MSQH) to handle international medical tourists (International Trade Centre, 2014). To date, there are nine hospitals in Malaysia that were recognised by the Joint Commission International (JCI), which is an imperative accreditation for hospitals healthcare programmes from United States and this accreditation is considered important for the medical tourism sector (The Malaysian Reserve, 2012). As a recognised player in the medical tourism industry, Malaysia offer various types of medical treatments that includes cosmetic surgeries, dental, cardiology and cardiothoracic

surgery, cancer treatment and pain management, general health screening, fertility treatment, rehabilitative medicine, orthopedics surgery and many more (Bernama, 2010). Moreover, the success of Malaysia in medical tourism was recognised as the "Destination of the Year of 2015" for medical tourism by the International Medical Travel Journal, a reputable medical tourism's journal which provides insights for customers (The Star, 2015).

According to statistics published by MHTC, the medical tourism industry in Malaysia is experiencing astounding growth in the recent years. For instance, Table 1.1 illustrates the number of medical tourists in Malaysia has increased from 102,946 in 2003 to 770,134 in 2013 with an estimated revenue of RM 680 million in 2013. Moreover, it was reported by Ormond (2011) that among the total influx of medical tourists that visited Malaysia, Kuala Lumpur (the capital of Malaysia) received 11 percent of medical tourists, followed by Malacca (19 percent), and Penang (one of the northern state in Malaysia), which hosts the highest percentage (61 %) of medical tourist. In the context of medical costs in Malaysia, Table 1.2 shows the comparison of prices for medical treatments in the United States and other international medical treatment destinations in Asian countries like Thailand, Singapore, and Malaysia.

In addition, in comparison with other neighboring countries such as Singapore and Thailand, Malaysia's pricing for medical treatments are almost similar to Thailand but cheaper compared to Singapore. Table 1 shows that the average saving on the pricing for medical treatments in Malaysia which are

competitive to the neighboring countries (e.g. Singapore and Thailand) and 60% to 80% cheaper than the costs from the United States.

Table 1.1: Malaysia: Foreign Patients and Receipts, 2003–2013

YEAR	FOREIGN PATIENTS	RECEIPTS
	Numbers	(RM) Millions
2003	102,946	58.90
2004	174,189	105.92
2005	232,161	150.92
2006	296,687	203.66
2007	341,288	253.84
2008	374,063	299.10
2009	336,225	288.21
2010	392,956	378.95
2011	578,403	509.77
2012	672,000	594.00
2013	770,134	680.00

Notes.

a *Numbers of foreign patients from 2003 to 2007. Adapted from Socio-economic Research Institute (2009)*

b *Numbers of foreign patients for 2008. Adopted from The New Straits Times (2009)*

c *Numbers of foreign patients for 2009. Adopted from The Sun Daily (2009)*

d *Numbers of foreign patients from 2010 to 2011. Adopted from Business Time (2012)*

e *Numbers of foreign patients for 2012. Adopted from freemalaysiatoday.com (2014)*

f *Numbers of foreign patients for 2013. Adopted from The Star (2015)*

Table 1.2: Comparing Medical Treatment Pricing for United States, Singapore, Thailand, and Malaysia (US$)

Procedures	US Cost	Singapore	Thailand	Malaysia
Average Savings		25% to 40%	50% to 75%	60% to 80%
Coronary artery bypass graft - CABG	88,000	54,500	23,000	20,800
Valve replacement with bypass	85,000	49,000	22,000	18,500
Hip replacement	33,000	21,400	16,500	12,500
Knee replacement	34,000	19,200	11,500	12,500
Spinal fusion	41,000	27,800	16,000	17,900
IVF cycle (*excluding medication*)	15,000	9,450	6,500	7,200
Gastric bypass	18,000	13,500	12,000	8,200
Full facelift	12,500	8,750	5,300	5,500
Rhinoplasty	6,200	4,750	4,300	3,600

Note. The Value of medical treatments across countries. Adopted from Patientbeyondborders.com (2014).

With the understanding of the overview of medical tourism industry, both on the international platform and the Malaysian context, the subsequent section will discuss the research gaps that need further research to be conducted in this area.

1.3 Problem Statement

Although medical tourism was extensively studied in the research setting, there are several gaps identified by the researcher after reviewing the past literature. The gaps identified are: (1) lacking of inputs from the medical tourists, (2) the factors that determined the perception of brand image that needs further investigation, (3) the effect of brand image on the perceived service quality were not fully explored, and (4) the relationship between

perceived service quality, patient satisfaction, perceived trust, and perceived value that need further attention and investigation in the medical tourism context. Therefore, the following subsections will address each of these research gaps that were identified.

(1) Inadequate Inputs from the Medical Tourists

Medical tourism is a growing segment in global tourism where this industry significantly provided an opportunity for hospitals throughout the world to grow by tapping into this promising and developing market (Cham et al., 2015; Connell, 2006; Han et al., 2015). With the aim to form a sustainable competitive advantage, healthcare providers in medical tourism are compelled to integrate effective health service outcomes that take into consideration patients' concerns and interests (Teh & Chu, 2005). However, most of the past research studies with regards to medical tourism focused almost exclusively on the import side or the service providers' viewpoint instead from the inputs from the medical tourists' perspective (Abd Manaf, Hussin, Kassim, Alavi, & Dahari, 2015; Cham et al., 2015; Hudson & Li, 2012; Saiprasert, 2011). Therefore, this drawback denotes a significant shortcoming in the marketing and medical tourism perspective because medical tourists are one of the important entities in gauging the success of a hospital operation and they are those who influence the success of the industry as a whole. In view of that, this research was designed to gather medical tourists' opinions with regards to medical tourism in Malaysia. It is foreseen that by understanding the inputs from the medical tourists, all the parties that are involved in medical tourism

will benefit in the aspect of policy making, strategies development and so forth.

(2) The influence of Brand Image: Social Media and Word-of-Mouth Communications

Branding in the business landscape has become a valuable yet intangible asset of a company, especially in this competitive business environment. According to Kim, Kim, Kim, Kim, and Kang (2008), it was found that superior branding is able to facilitate customers in product/ service visualisation, product/service evaluation, risk assessment of product/service, and a better understanding of certain product/ service. Moreover, positive branding can also help businesses in achieving a sustainable competitive edge and business performance (Kim et al., 2008). In view of that, branding became a growing research interest among practitioners and academics that encouraged further investigation with respect to the subject of brand image. This interest growth is through the claim that a strong and superior brand image can directly assist businesses in gaining competitive advantage and favourable reputation (Cham et al., 2015; Porter & Claycomb, 1997; Wu, 2011).

In addition, the branding literature revealed that there are limited studies conducted to address the factors that influence the perception of brand image (Riezebos, 2003). To the best knowledge of researcher, there is virtually no study conducted to examine factors that influence customers' perception of

brand image in the healthcare and medical tourism industry. Moreover, there is also a limited understanding on the part of brand managers and researchers in relation to the impacts of social media communication (Bruhn, Schoenmueller, & Schäfer, 2012; Schivinski & Dabrowski, 2014) and word of mouth communication (Jalilvand & Samiei, 2012) on brand image. Furthermore, the empirical evidence on the importance of word of mouth communication in the pre-purchase setting remained scant in the marketing literature. Since brand image was reported to have an influence on the first-time/ potential customers, consideration of factors that influence medical tourists' perception of brand image should also be highlighted in this study in order to further understand the factors that influence hospitals' brand image in the context of medical tourism. By understanding the factors that influence brand image in the medical tourism industry will directly help the hospital marketing managers to develop an appropriate competitive strategy to stay relevant in the industry.

(3) The Effect of Brand Image on the Perceived Service Quality were not Fully Explored

It was claimed that a superior brand image can influence customers directly through their perception of quality and their level of satisfaction (Da Silva & Alwi, 2008; Lai, Griffin, & Babin, 2009). As for the healthcare context, brand image was argued to play an important role in creating awareness and influencing perception among patients, especially when competing services in healthcare were perceived to be identical by patients in

terms of availability, price, and service performance (Wu, 2011). Unfortunately, most of the research studies pertaining to brand image are focused on the tangible product and retail contexts (e.g. Bian & Moutinho, 2011; Cretu & Brodie, 2007; Lai et al., 2009), and limited brand image research was conducted in the service industry. Therefore due to this particular reason, this aspect is considered to be important for medical tourism because a hospital's brand image has significant influence on medical tourists' hospital selection and how they perceived the level of service quality accommodated by the hospitals that they have engaged for medical services.

(4) The Relationships between Perceived Service Quality, Patient Satisfaction, Perceived Trust, Perceived Value, and Behavioural Intention

In the research setting, it was found that literature pertaining to service marketing research constantly indicated that either through attitudes or behaviours- perceived service quality, perceived value, perceived trust, and customer satisfaction has a significant impact on customer behavioural intention (Lertwannawit & Gulid, 2011). However, in the context of healthcare and general service, these relationships usually were independently studied. Despite the importance of these variables in the service industry, very few studies examined the interrelationships among perceived service quality, perceived value, perceived trusts, and patient satisfaction that could potentially affect customers' future behavioural intention.

Many service providers are aware of the directional links between perceived service quality, customer satisfaction, and behavioural intention (Akbar & Parvez, 2009; Kheng, Mahamad, & Ramayah, 2010; Parasuraman, Zeithaml, & Malhotra, 2005). However, these links may not be as straightforward as they seemed (Ažman & Gomišček, 2015; Finn, 2011; Fullerton & Taylor, 2002). This is because the so-called "chain models" in most research studies neglected the importance of perceived trust and gained little empirical evidence (Armstrong, Rose, Peters, Long, McMurphy, & Shea, 2006). Therefore, it is important for this study to consider perceived trust because it plays an important role for the medical tourists to decide whether they trust the medical services from the hospital that they engaged. Although patient trust is reported to be a vital component in the healthcare, the empirical research relating to patient trust is still considered inadequate up to this date (Chang, Chen, & Lan, 2013; Nummela, Sulander, Rahkonen, Karisto, & Uutela, 2008; Mohseni & Lindstrom, 2007). Most importantly, to what extent patient trust can be translated into patient satisfaction still remains unexplored by many research studies.

In addition to above, efforts to understand a concept of customer perceived value has drawn attention and increased in popularity since its inception in the late 1990s. Like any other marketing concepts (e.g. customer satisfaction, customer loyalty, and service quality), customer perceived value has been regarded as one of the most imperative management practice in attracting customers regardless of any service industries. This is because perceived value by customers from the business transaction point of view is

regarded as a prominent competitive advantage for the business firms, especially in environments that were exposed to globalised competition and by consumers who have become highly demanding. Although perceived value was considered to be extremely important in retail and general service setting, there are limited empirical studies that addressed this concept in the healthcare industry and medical tourism.

The above research deficiency is considered important in the context of medical tourism because medical tourists would have to sacrifice their resources in terms of money, effort, and time in order for them to visit another country for medical services. In view of that, the integration of perceived value in the service context, particularly in medical tourism, is a necessity. The inclusion of perceived value in service quality research not only enhances the predictive power for the research model, it could also provide better understanding of the factors that enhance patient satisfaction. Although many studies were conducted in a general service context, studies that addressed the mediating effect of perceived value in the service quality models are still limited (Frank & Enkawa, 2007; Malik, 2012). Hence, this can be seen as paucity in the service marketing landscape that is worth being explored, especially in the context of medical tourism where value is considered to be an important concept for a tourism product.

Despite the well-recognised significance of the influence on perceived service quality on patient satisfaction, there are limited studies that examined the indirect relationships between perceived service quality and patient

satisfaction via perceived trust and perceived value in the healthcare perspective. Conducting a study in this highly customer involved industry is necessary as the hospitals' in the medical tourism must not assume that superior service delivery will directly lead to patient satisfaction, but to also consider the impact from both perceived value and trust among the respective patients. In view of the gaps identified, therefore, an integrated model is required in order to elucidate the interrelationships of the above-mentioned concepts in the context of medical tourism. It is foreseen that understanding the relationships across the above-mentioned concepts will promote positive behavioural intention among medical tourists and at the same time help hospitals to develop an appropriate competitive strategy.

1.4 Aims of Study and Research Objectives

With the identified problem statement in mind, this research has two main purposes. The first purpose is to access the opinions of the medical tourist on the factors that influence brand image among the hospitals that participated in Malaysia's medical tourism. The second purpose is to empirically examine the conceptual model of this study in relation to the relationships among the constructs (e.g. social media, word of mouth, brand image, perceived service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention) based on the perspective from medical tourists who travelled to Malaysia for the purpose of medical treatments. In particular, this study is anticipated to achieve the objectives as follows:

- To assess the influence of social media communication and word of mouth communication on hospitals' brand image.
- To investigate the influence of hospitals' brand image on the perception of hospitals' service quality.
- To examine the interrelationship between perceived service quality, perceived trust, perceived value, and patient satisfaction.
- To examine the relationship between patient satisfaction and behavioural intention.

1.5 Significance of the Study

Since its inception, the medical tourism sector has contributed significantly to the growth of the healthcare and tourism industry in Malaysia (The Star, 2009). As a result of the ongoing growth of medical tourism industry, medical service providers in Malaysia ought to provide superior medical services and to consider all the marketing aspects in order to attract more potential medical tourists, especially when Malaysia's medical tourism has begun to gain attention from the Western medical tourists. Thus, this study highlights the importance of hospitals' brand image and service quality that are vital to medical tourists and to propose few recommendations to improve hospitals' brand image, hospitals' service quality, patient satisfaction, and their future positive behavioural intention towards Malaysia's medical tourism effort. Apart from that, this study aims to highlight the practical implications for the relevant parties in this industry by suggesting relevant and effective marketing approaches for the healthcare industry in Malaysia.

In addition, this study is expected to contribute to the marketing literature for both practical and academic standpoints after achieving the research objectives in this study. In the context of an academic standpoint, this study will be expected to contribute to the literature of service marketing in various aspects. Firstly, this study will determine the influence of social media and word of mouth communication on medical tourists' perception on brand image. Secondly, this study will provide a conclusive understanding of the influence of a hospital's brand image on the hospital's service quality practice. This aspect is vital because the perceptions from the medical tourists are important for the development of marketing strategies for Malaysia medical tourism sector. Thirdly, this research will also provide an understanding of the importance of perceived value and trust that influences the satisfaction level among the medical tourists. Both perceived value and trust were considered to be important concepts for the medical tourism sector because value and trust in the service marketing were proven to have an impact on customer satisfaction. Moreover, the mediation effect of perceived value and trust were also highlighted in this study. Lastly, this study aimed to integrate several important service marketing constructs in the medical tourism context namely as hospital brand image, perceived service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention in order to form a structural model for medical tourism. This model is anticipated to clarify the perceptions of medical tourists that would be useful and pertinent to the Malaysia's medical tourism platform.

From a practical perspective, conducting such research in the medical tourism landscape is extremely important to assist hospitals that are involved in medical tourism in developing competitive and sustainable marketing strategies. By understanding the customer perception on service quality and its determinant such as brand image will help the marketing managers of Malaysia's hospitals to develop appropriate competitive strategies in the medical tourism industry. Moreover, it will also show the interrelationship of brand image, perceived service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention in the medical tourism sector, whereby this will enable the hospitals to be aware with the customers' needs and to developed suitable marketing and operating strategies to retained the existing customers and attracting new customers at the same time. This research will also benefit the Government of Malaysia in the healthcare and tourism industry by providing them with the opinions from the international tourists that can be the most important guide for them in the aspect of medical tourism policies development and forming successful medical tourism competitive strategies in the medical tourism industry. In short, this study provides an opportunity for better understanding about the medical tourism in the healthcare market in Malaysia.

1.6 Delimitations

According to Creswell (2012), delimitation in the research can help the researchers in sorting out what is most relevant and creating clarity for the research. In other words, this approach reflects how a study was narrowed in scope. In this section, the delimitation of this thesis was presented as follows:

1. The study is delimited to the Indonesian tourists who visited Malaysia for medical purposes and at the same time engaged in tourism activities.
2. The study is delimited to Indonesian medical tourists visiting Penang, one of the states that located at the northern region of Malaysia. The reason why Penang state was chosen is because the majority of medical tourism activities for Malaysia took place in this state.
3. The study focuses on four private hospitals in Penang state as the host of medical tourists. The hospitals selected for this study are the main private hospitals in Penang that have similarity with respect to facilities, operational size, and variety of medical services offered.

Having discussed the delimitation for this study, the definition of terms used in this study was presented in the subsequent section.

1.7 Definition of Terms

Since the focus of the research is on the medical tourism, it is necessary to provide clear definitions of some of the key terms used in the present study. The following terms for the constructs employed in this study are defined in the context of this research and presented as follows**:**

Medical Tourism – *"a set of activities in which a person travels often long distances or across the border, to avail medical services with direct or indirect engagement in leisure, business or other purposes"* (Jagyasi, 2008, p. 9).

Social Media – "*Social media, i.e. social networks, weblogs, Internet forums, wikis, websites, microblogs, etc., has been defined as a group of Internet-based applications that build on the technological and ideological foundations of Web 2.0 which allow the creation and exchange of the user-generated content*" (Kaplan & Haenlein, 2010, p. 61).

Word of Mouth Communication – "*Personal communication about medical services in relation to medical tourism between family members, friends, and associates*" (Adapted from Kotler, 2006).

Brand Image – "*a set of perceptions about a brand as reflected by brand associations in consumer's memory*" (Keller, 1993, p. 3).

Perceived Service Quality – "*A global judgment, or attitude, relating to the superiority of the service*" (Parasuraman, Zeithaml, & Berry, 1988, p. 12).

Perceived Value – "*The consumer's overall assessment of the utility of product based on perceptions of what is received and what is given*" (Zeithaml, 1988, p.14).

Perceived Trust – "*The optimistic acceptance of a vulnerable situation in which the patient believes the healthcare provider will take care of the patient's interests*" (Dugan, Trachtenberg, & Hall, 2005, p. 64).

Patient Satisfaction – "*As the degree of congruency between a patient's expectations of ideal care and his /her perception of the real care him /her receives*" (Aragon & Gesell, 2003, p. 229).

Behavioural Intention – "*an affirmed likelihood to engage in a certain behaviour*" (Oliver, 1997, p. 13).

Medical Tourists – "*individuals who travel long distances or across the border, to avail medical services with direct or indirect engagement in leisure, business, or other purposes*" (Adapted from Jagyasi, 2008).

1.8 Outline of the Research

The study attempts to identify the influence of social media and word of mouth communication on brand image that in turn will create an impact on the perception of service quality, and to assess the interrelationship among perceived service quality, patient satisfaction, perceived value, perceived trust and behavioural intention in the medical tourism industry of Malaysia. Chapter 1 provides the background of the research and overview of medical tourism both at International and Malaysian context. Moreover, the research problems established for this study was based on the gaps identified from the existing research. Subsequently, the aim of the study and the research objectives are presented.

Chapter 2 presents the definition of medical tourism and its attributes. Moreover, a theory underlying this study was extensively discussed, and an overview of concepts in social media, word of mouth communication, brand image, perceived service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention, in the service and healthcare context are reviewed and presented.

Chapter 3 discusses the hypotheses developed for this study based on the review of literature from the earlier chapter. Moreover, the empirical evidences were also included in this chapter to support the hypotheses previously developed.

Chapter 4 presents the research methodologies that were used to empirically test the hypotheses developed. In this chapter, the research design, measurements of variables, the method of data collection, and the description on the sampling strategy are extensively discussed. Furthermore, the statistical procedures that were implemented in data analysis and the ethical consideration are also presented.

Chapter 5 integrates the all the statistical results in response to the research objectives and hypotheses developed in this study. In this chapter, the profile of the respondents, results of preliminary data examination, descriptive analysis, results of confirmatory factor analysis, results of path analysis, and results of mediation tests are presented.

Chapter 6 discusses the results obtained from chapter five. In this chapter, the implications for the study, both theoretical and practical, are discussed and presented. Moreover, the research limitation and future research are also presented. Having the introduction of this research being presented in this chapter, the subsequent chapter will review the literature for the theory adapted and constructs used in this study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to discuss medical tourism and its attributes. This chapter also introduces the theory that was used in this study and reviews the theoretical and empirical literature relative to the concepts of social media communication, word of mouth communication, brand image, perceived service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention that are adopted in this study. In the current competitive landscape, healthcare organisations need to seek strategies that promote effective competition with rivals, to remain competitive and financially successful, and most importantly; provide a superior quality of medical service that meets customers' expectations (Rose, Uli, Abdul, & Ng, 2004; Yesilada & Direktör, 2010). However, the behaviours of today's customers have changed; they are more discerning and demanding in the services they engaged (Presbury, Fitzgerald, & Champman, 2005). Therefore, in order to ensure customers are satisfied, hospitals that are involved with medical tourism need to ensure that their services provided to customers are appropriate and beyond customers' expectations, while at the same time, considering the importance of customers' perception of value and their trust with the service organisation.

In addition, as service quality is shown to play an important function that leads to customer satisfaction, there is a critical need in understanding the impact of brand image. Studies have shown that brand image has the capability to influence customers' perception on the service performance of one service entity. Moreover, an intention to revisit a healthcare service provider in the future is an indicator of service quality satisfaction of a particular healthcare service provider perceived by customers. This scenario shows that the "traditional" marketing approach in the healthcare sector needs to be improved in order to remain relevant to the requirements from the current service industry that endeavours for a larger market share and customer loyalty (Zineldin, 2006b). Besides, the competitive nature in the market also revealed that there is a need for service providers to emphasise on the importance of relationship marketing in order for them to remain relevant in the marketplace. This is because a relationship marketing approach is an important strategy in service marketing, inter-organisational, and high-contact contexts because service firms in theory have always been regarded as "relationship orientated" (O'Malley & Tynan, 1999).

According to relationship marketing theory, Egan (2008) claimed that positive evaluation on service quality will further lead to customer satisfaction based upon the value received, which in turn has an impact on the relationship strength, longevity, and profitability. Stated otherwise, service quality plays an important role as a catalyst in relationship marketing in the service context, which will have a vast impact on customer satisfaction, which eventually influence behavioural intention among customers. In realising the ongoing

competition that occurs within the industry, many service firms in the service industry have shifted their focus to relationship marketing (Antony, Antony, & Ghosh, 2004). With an increased bargaining power consumers obtained, service providers are realising that the essential ingredient for their success in the industry is by accentuating more effort on strategic relationship marketing, particularly through an evaluation of customers' future behaviour intention (Antony et al., 2004). Since medical tourism is a part of the tourism products and services-oriented in nature, therefore, this study was designed based on the foundation of this theory. With that, the foundation of the relationship marketing theory will be presented in the later section in this chapter. Correspondingly, the concepts of brand image, service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention for this study; together with their empirical researches in the healthcare industry is reviewed in this chapter.

2.2 Definitions of Medical Tourism

These days, the landscape of the healthcare system in developed countries has changed whereby more patients travel across their national borders to seek for low cost and high quality medical services. This form of travelling was known and classified as, "medical tourism" by most of the industry players and media. It was found that medical tourism was considered as a promising industry that contributes positively to the economy of developing countries. However, up to date, there are no any agreed or universal definitions of medical tourism across literature. This is because the agreed definitions among research studies and reports are unlikely due to

several problems that arise in the context of medical tourism namely as, difference procedure and duration, discrepancies over the nature of "leisure" and "tourism", diverse intention of medical tourists, amount of resources and time allocated for individual activities, and diverse socioeconomics. Therefore, in order to establish the meaning of medical tourism precisely, Jagyasi (2008) suggested that the terms of "medical" and "tourism" should be defined firstly. In this case, medical aspect is referred to as any medical services pertaining to diagnosis, hospitalisation, surgical operations and other medical related services to improve or restore health. Furthermore, tourism aspect is referred to the activities of experiencing the attractions of the visited countries, touring, hospitality, and vacationing.

Although the word of "tourism" in this industry was questioned by some scholars (e.g. Gonzales, Brenzel, & Sancho, 2001; Kangas 2010), Stackpole and Associates (2010) argued that a "tourism" aspect should be included because international patients travel to their destination choice for medical care and consumed services associated with their travel, such as transportation, hospitality, and lodging, which is part of the tourism products. The inclusion of a "tourism" aspect in medical tourism was also supported by the past literature (e.g. Bookman & Bookman, 2007; Conell, 2006; Jagyasi, 2008; Heung, Kucukusta, & Song, 2010). With that, the present researcher used the term medical tourism throughout the research because this is what this industry has labelled itself. The definitions for the medical tourism based on the past studies are presented in Table 2.1. For example, medical tourism was defined by Lee and Spisto (2007) as a "travel activity that involves a

medical procedure or activities that promote the well-being of the tourist" (p. 1). Moreover, medical tourism is defined as, "an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism" (Bookman & Bookman, 2007, p. 1).

In addition to above, Jagyasi (2008) defined medical tourism as "a set of activities in which a person travels often long distances or across the border, to avail medical services with direct or indirect engagement in leisure, business or other purposes" (p. 9). According to Jagyasi (2008), the aspect of "indirect engagement" can be explained as the consumption of services (e.g. lodging facilities, transportation services, etc.) that are related to leisure, business, or other purposes by medical tourists. Since that the definition by Jagyasi (2008) is suitable for the nature of the present study, thus, this definition was adopted for this study.

Table 2.1: Definitions of Medical Tourism

Authors	Definition
Clift and Grabowsky (1997, p.119)	Travelling for health purposes is a combination of two main themes, namely the importance of getting the best medical treatment as possible while having a good leisure time
Conell (2006, p.1094)	Popular mass- culture where people travel often long distances to other destinations such as India, Thailand, and Malaysia to obtain medical services such as dental, cosmetic and non-cosmetic care and at the same time enjoying their holidays
Bookman and Bookman (2007, p.1)	Medical tourism as travel with the aim of improving one's health, and also an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism
Lee and Spisto (2007, p. 1)	Travel activity that involves a medical procedure or activities that promote the well being of the tourist
Yap, Chen, and Nones (2008)	Patients travel abroad to receive medical treatment, which may be cosmetic surgery or some special treatment or periodic health examination
*Jagyasi (2008, p.9)	Set of activities in which a person travels often long distances or across the border, to avail medical services with direct or indirect engagement in leisure, business or other purposes
Heung et al. (2010, p.236)	A vacation that involves travelling across international borders to obtain a broad range of medical services. It usually includes leisure, fun and relaxation activities, as well as wellness and health-care service

Note. *Definition adopted in the present study

2.2.1 The Attributes of Medical Tourism

Since the inception of the medical tourism industry, the attributes of medical tourism and health tourism were reported "overlapping" with one another and were always used interchangeably, although the elucidation for each term are different from one another. Carrera and Bridges (2006) reported that medical tourism and health tourism are interrelated, but diverse in some context whereby conceptually, medical tourism is part of the health tourism. Therefore, in order to recognise medical tourism within health tourism, Cook (2008) in his study explained that medical tourism implies diagnosis, surgical operations, and hospitalisation to restore or improve health of in the long term whereas health tourism are treatments used to improve health (e.g. by alternative treatments or health spa). As this study focus on medical tourism, therefore, the attributes of both concepts above need to be highlighted in order to illustrate the difference between medical tourism and health tourism. With that, the Tourism Research and Marketing (TRAM), an independent tourism consultancy firm based in London, suggested that the combination of medical and health treatments can form a new area for the healthcare and medical sector known as, "medical and healthcare tourism", which can be the platform to differentiate attributes between both medical tourism and health tourism.

In addition, TRAM (2006) reported that the components of medical and healthcare treatments can be further categorised into four categories, namely as treatments of wellness, enhancement, reproduction, and illnesses (see Figure 2.1). According to Lee and Spisto (2007), the "illness" treatments

represent an extensive range of medical services, which require qualified medical intervention. This medical procedure usually includes organ transplants, cancer treatment, heart surgery, dental treatment, comprehensive medical check-ups, neurosurgery, joint replacements, and so forth. For the context of "reproduction" treatments, these procedures can be known by patients traveling offshore in search of fertilisation procedures. The treatments include *in vivo* and *in vitro* fertilisation treatments and other similar procedures. As for "enhancement" treatment, these procedures were designed for the purpose of self-enhancement and are non-disease related. Some of these treatments require qualified physician intervention in performing certain treatments, such as cosmetic dental work, breast surgery, liposuction, facelifts, and others relevant to cosmetic surgery.

On top of that, "wellness" treatments are categorised under the context of alternative healthcare services. Under this segment, the healthcare services are namely as beauty care, homeopathy, herbal healing, acupuncture, aromatherapy, massage, exercise and diet, spas, facials, and yoga. All of these services are generally performed by professionals who are accredited and recognised by health associations and organisations from both local and international context. Moreover, Lee and Spisto (2007) further added that these treatments should not be considered as part of the attributes for medical tourism as almost all of the practices do not need medical intervention. As a result, based on the explanation of each category, Lee and Spisto (2007) maintained that any treatments that require certified medical doctors, physicians, and licensed facilities should be categorised under the term of

"medical tourism". Consistent with the notion by Lee and Spisto, previous studies also reported that medical procedures that are involved with medical tourism must involve licensed physicians in performing medical treatments (e.g. Bookman & Bookman, 2007; Connell, 2006). Having understood the nature of medical tourism and its attributes, the theory for this study will be discussed in the following section.

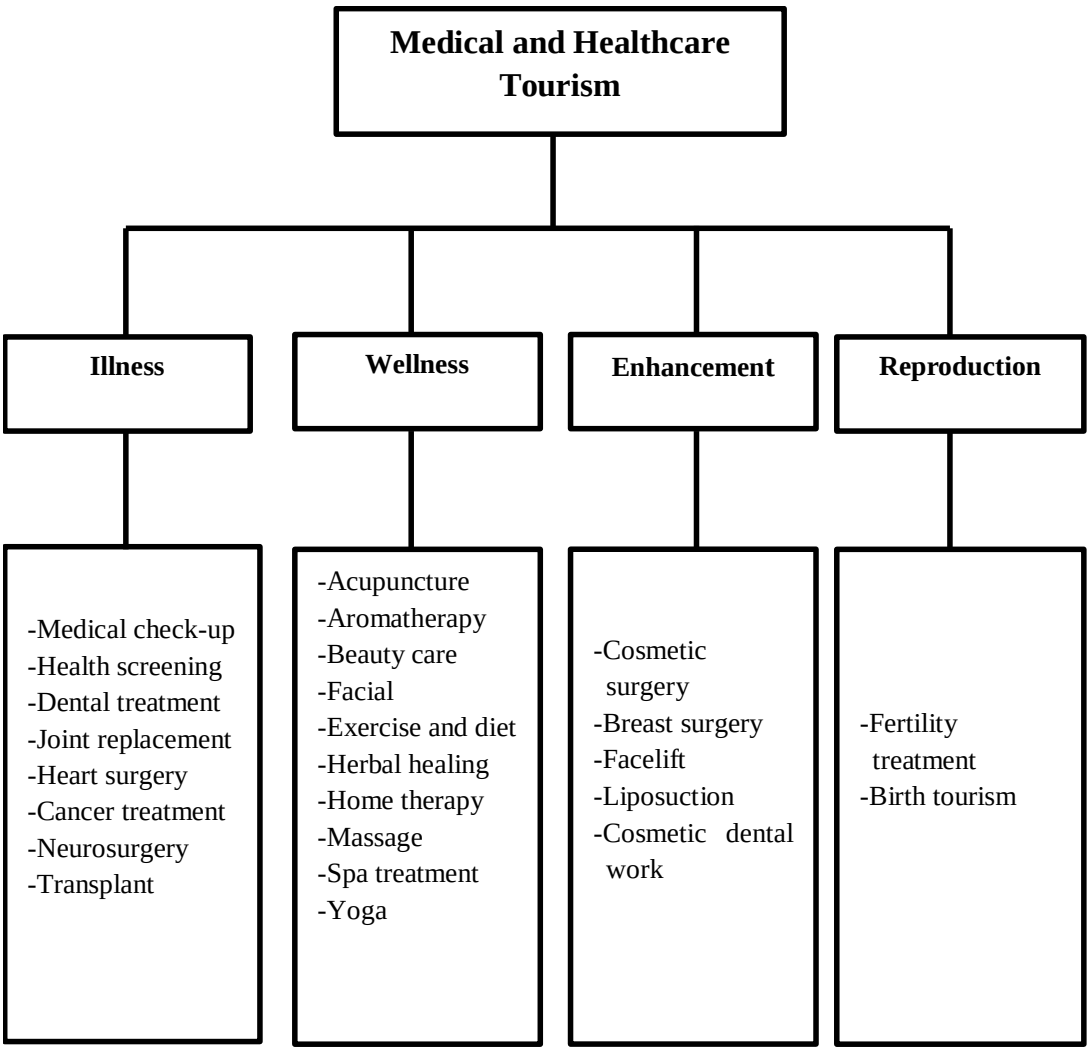


Figure 2.1: Medical and Healthcare Tourism and Components

2.3 Relationship Marketing: The Foundation of this Study

Since its introduction in the early 1980s, relationship marketing became one of the main topics in marketing that were widely studied due to its impact on many businesses (Berry, 1983). In terms of definition, relationship marketing was defined "as a process that concerns in attracting, developing, and retaining customer relationships" (Berry, 1983, p. 25). Furthermore, relationship marketing was also defined as "all marketing activities directed towards establishing, developing, and maintaining successful relationships" (Morgan & Hunt, 1994, p. 11). Berry (1995) claimed that the core of relationship marketing is to focus on building and maintaining relationships between players in the micro-environment, namely as market intermediaries, suppliers, and most importantly; customers. Moreover, Yau, McFetridge, Chow, Lee, Sin, and Alan (2000) argued that good relationships between business organisations and their customers would encourage and promote successful business practices both in the local and global context. In view of that, Athanasopoulou (2009) claimed that the long-term relationships would favour both suppliers and buyers, whereby this finding was well supported by previous academic research in high-tech marketing (De Ruyter, Moorman, & Lemmink, 2001), business-to-business marketing (Cox, 2004), and service marketing (Ndubisi, 2007; Sin, Tse, Yau, Lee, & Chow, 2002).

Furthermore, relationship marketing has evolved as one of the major marketing disciplines, as it was reported that the present-day relationship marketing gained its popularity due to environmental factors, which derived in

two ways (Aijo, 1996; Szmigin & Bourne, 1998). First, relationship marketing was acknowledged through the transformations of businesses in general, particularly resulting from the radical and rapid changes within the environmental factors. Second, the importance of relationship was gained through relationships in service marketing and industrial marketing. With that, the emphasis on relationship marketing has growth in response to the need from claims of environment as this is one of the best ways that a business, regardless from any industry, can achieve a competitive advantage and sustain in the marketplace (Salem, 2004; Samaha, Beck, & Palmatier, 2014).

Moreover, based on relationship marketing theory, the profitability of the firm depends on the degree of customer retention for the firm (Egan, 2008). Ravald and Grönroos (1996) argued that customer retention in relationship marketing can provide long-term, stable, and mutually profitable relationships for all parties involved. Similarly, Hoffman and Bateson (2010) also found that firms that are engaged in customer retention with an intention to develop long-term relationships with its customers will directly help the business to grow. This scenario is supported by the fact that attracting new customers are five times more costly and ineffective than retaining the current customers whereby it has resulted in many businesses to emphasised on the relationship marketing pratices in the hope to establish close and long-term relationships with the customers (Egan, 2008). Moreover, a relationship marketing goal seems to add value to a customer, in which it is foreseen to raise customer satisfaction and in turn, will instil loyalty among customers. Therefore, within the context of a service and tourism setting, there is no

doubt that value creation is important for the relationships between service providers and services recipients (Özgener & İraz, 2006). The attributes of relationship marketing approach are illustrated in Table 2.2

Table 2.2: Attributes of Relationship Marketing

Relationship Marketing
1) Negotiate for a 'win-win' sale situation and stay around being a resource for better results
2) Promote values
3) Long-term thinking and acting
4) Build the business based on relationships
5) Keeping customers
6) Structure created to support relationships
7) Relationship focused
8) Provide long-term empathy and rapport to the customers
9) Provide incentive for long-term relationship and revenue
10) Emphasised on foundation of revenue trust
11) After-sales service as investment in relationship
12) People expectations and perception focused
13) Rewards incentives for maintaining and growing relationships and revenue
14) The sale is the beginning of the relationship

Source: Egan (2008)

In referring to the relationship marketing theory, the researcher extended the research scope by considering the importance of brand image in relationship marketing. This is generally because the past research studies maintained that brand image has a substantial effect on the service and tourism industry (Keller, 2003; Robert & Patrick, 2009). Therefore, the inclusion of brand image in the research model would somehow provide a more conclusive understanding on the significance of brand image in relation to the theory of relationship marketing. Moreover, factors that influence brand image, such as social media communication and word of mouth communication were further

addressed in this study. This research study also examines the relationships between perceived service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention. The following section provides a review of the variables in the present study.

2.4 Description of Variables included in the Study

This section reviews each of the variables included in the present study.

2.4.1 Factors that Influence Brand Image

With reference to customers' psychological frame, "image" can be considered as a complex concept due to the fact that image is not only limited to the factual attributes of a business organisation (Kandampully & Hu, 2007). It was reported that brand image is formed from the combinations of a firm's emotional (intangible aspect) and factual (tangible aspect) elements that can potentially influence consumers' perception and impression on a particular brand (Keaveney & Hunt, 1992; Riezebos, 2003). In the context of factors that influence brand for product or service, Riezebos (2003) suggested that the inductive inference acts as an image forming theory, whereby inductive inference refers to the processes that influence consumers' image creation of a brand. The image in a consumer's mind emerges when they are evaluating experiences, associations, and thoughts of the brand. According to Riezebos (2003), there are three inductive processes that potentially influence a recipient's brand image: social influence (through word of mouth

communication), consumption experiences, and marketing communication (e.g. social media communication, advertising, etc.).

In addition to the above, Lee, Park, Baek, and Lee (2008) suggested that image can be instiled in the mind of customers via promotion strategies (e.g. word of mouth communication, public relations, advertising, etc.) and customers' direct experience with products or services. Moreover, Robert and Patrick (2009) added that brand image does not exist in the technology of the product, or even the function, but it is shaped and formed based on the characters of the accepters, campaign context, and with the use of relevant marketing programs. Similar to the argument above, Villarejo-Ramos & Sánchez-Franco (2005) asserted that brand image is formed in the mind of the customers and is developed based on marketing approaches used by marketers. The above scholars consistently emphasised that brand image can be crafted on the product and services directly based on marketing activities and it has the potential to influence a group of first-timers too. Besides being affected by promotional communication from marketers and direct personal experience, Park, Jun, and Shocker (1996) claimed that brand image also can be formed based on brand association with other entities, such as event, place, person, country, distribution channel, or the company itself.

Among the factors influencing brand image mentioned above, only social media communication and word-of-mouth were deemed to be relevant and therefore included in this study. A preliminary investigation by the researcher indicated that Malaysian hospitals rarely advertise their services in

the international media. Therefore, this study has excluded the impacts of traditional media communication, such as magazines, newspaper ads, and other publications on brand image. Furthermore, the consumption experience was excluded from this study as some of the medical tourists might be the first-time patients. The focus of the study in relation to hospital brand image is before the experience, not after. Medical tourists should have developed a certain image about a service provider via some inductive inference before they make the actual visits, e.g. before they experience the transaction. With that, the combined effect of social media communication and word of mouth communication in this study is further discussed in the following subsection as to further understand its impact on medical tourists' brand image perception.

2.4.1.1 Social Media Communication

In the new age of information superhighway and vast improvement of technologies, the present media platform experienced significant changes over the past decades as the marketing communication tools for products and services are also part of these phenomenal changes (Mangold & Faulds, 2009). Before the establishment of the internet, products/services branding and advertising were performed with the use of traditional advertising through television, newspapers, radio, direct mail, and magazines (Scott & Orlikowski, 2012). Scott and Orlikowski (2012) further argued that this type of advertising approach may still work for some organisations that carry products/services with a large target audience; however, business entities nowadays no longer enjoy this privilege and are forced to compete with the new marketing channel

on the internet via social media, especially when they are competing in the era of globalisation. Moreover, it was claimed that social media's viral attributes has a better capacity in reaching the mass public compared to the traditional media like print advertisements, radio, and television (Thackeray, Neiger, & Keller, 2012). According to Kaplan and Haenlein (2010), social media (e.g. weblogs, social networks, internet forums, wikis, websites, microblogs, etc.) was defined as "a group of Internet-based applications that builds on the technological and the ideological foundations of Web 2.0, which allows the creation and the exchange of user-generated content" (p. 61).

Since the social media platform was regarded as one of the ultimate influential marketing tools, it was reported that businesses throughout the world invested up to $16.10 billion in 2014 for the social network advertisement (emarketer.com, 2015). In fact, it was anticipated that the usage of social media will continue to grow steadily (emarketer.com, 2015). This scenario is supported by the statistics report from globalwebindex (2013), as it revealed that one in every nine people on earth is using social media. Additionally, Stelzner (2011), in a social media marketing industry report, conveyed that among all the marketers interviewed and surveyed, 90 percent of them claimed social media were viewed as an important marketing tool for their businesses and 88 percent claimed that social media marketing can generate more business exposure, while 72 percent claimed that social media can increase company's website traffic, and 62 percent of the marketers argued that it can improve business website search rankings in the internet database. Therefore, social media was considered as one of the most important

channels for consumers and organisations that are frequent users of social media to collaborate, discuss, and share marketing information in the marketplace (Jones, 2010; Miller & Lammas, 2010) as well as healthcare setting (Glover, Khalilzadeh, Choy, Prabhakar, Pandharipande, & Gazelle, 2015).

Firm-created Social Media

In addition, Bruhn et al. (2012) suggested that the social media platform in the business sector should have an unswerving impact on the marketplace via two forms: (1) from the group of customers alone (user-generated social media) and (2) from the media that were developed by firms (firm-created social media). In the context of business platform (firm-created social media), social media were known as contemporary web-based applications in the context of marketing as they are utilised to target customers who cannot be reached via traditional media (Yang, Kim, & Dhalwani, 2008). As a new form of marketing channel, many businesses employed social media in order (1) to build a unique and contemporary business model that includes participation of customers, and (2) to create and maintain the sturdy relationships with consumers effectively overtime (Bolotaeva & Cata, 2010; Chung & Buhalis, 2008; Schivinski & Dabrowski, 2014). For example, many major companies, including Air Asia, Starbucks, Singapore Airline, etc. have actively engaged on social media to interact with the public, assist customers, apologise for their mistakes, and share information within the stakeholders. By using social media in such a manner, these companies has successfully created

transparency, managed to resolved customers' problems efficiently with lesser costs, and effectively enhance their brand image (Ulusu, 2010).

In addition, with the use of social media, marketers can now customise their offering and to have a better understanding of consumers' needs and expectations based on information collected from consumers' content posted in social media. This approach will help marketers to advertise their new offerings and create awareness among the targeted consumers in the most efficient manner (Chung & Buhalis, 2008). Moreover, Kaplan and Haenlein (2010) added that social media allows businesses to engage with customers in an effective fashion at greater levels of efficiency and relatively lower in cost than the traditional approach of marketing communication. This directly spells out that social media are appropriate for large organisations, and also for small and medium sized companies, especially those hospitals that are involved in medical tourism, as it would be extremely costly for these entities to invest in traditional communications throughout the world due to expensive advertisement costs.

User-generated Social Media

Meanwhile, in the perspective of customers (user-generated social media), social media have caused a paradigm shift in the power relationship between marketers and consumers as customers nowadays are more involved in marketing activities and are constantly turning away from traditional media for products/services information (Diffley, Kearns, Bennett, & Kawalek, 2011; Mangold & Faulds, 2009). This is because social media also allows customers

to become broadcasters, engage in the conversations and they no longer simply listen to marketers (Diffley et al., 2011). Moreover, the usage of social media allows consumers to participate and assess the media content directly, permitted multi-way conversations, and shares their opinions with other consumers (Diffley et al., 2011; Fournier & Avery, 2011). This setting facilitates consumer-to-consumer communication, which directly creates an impact for all business' products and services (Duan, Gu, & Whinston, 2008). For example, user-generated content can benefit other users who are looking for trustworthy reviews and feedback with regard to certain product/services rather than sponsored promotional sources.

In addition, social media websites that comprises of user-generated reviews and comments can potentially influence consumers' awareness and their perception on the image of brands (Xiang & Gretzel, 2010). This is because, user-generated communication is an influential source of information and the information is reported to be more reliable and trustworthy (Dellarocas, 2003; Foux, 2006). Moreover, Bruhn et al. (2012) reported that consumer-to-consumer communication can create significant impact on their perception towards a brand for a particular product/service and corporation performance. Therefore, marketers nowadays must be aware that the brand communication process were also participated by consumers (e.g. user-generated content) and therefore, marketers must consistently ensure that their products and services are able to fulfil the expectations of consumers (Bruhn, et al., 2012). With the participation of users in businesses' social media, customers can also easily express their dissatisfaction with products/services

over a social media website if they found the particular product/service was not up to their expectation. Although this scenario might not be favourable to some businesses, they should not have doubts in participating in social media, especially when this channel is popular among customers nowadays and has become the main competitive advantage for the success of business in the current marketplace (Wang & Fesenmaier, 2004).

2.4.1.2 Word of Mouth Communication (WOM)

Since Word of Mouth (WOM) was regarded as an important subject in the current business platform, this concept received tremendous research attention from diverse perspectives in consumer research and marketing. WOM is a developed topic of marketing research for a number of decades, whereby numerous definitions for the concept are available. For example, WOM was defined as "any informal, person-to-person communication process between a perceived non-commercial communicator and a receiver regarding a service, an organisation, a brand, or a product" (Harrison-Walker, 2001, p. 63). Moreover, Word of Mouth Marketing Association (2014) defined WOM as "the act of consumers in providing information on the products or services to other consumers". Furthermore, WOM is also defined as "the informal communication between private parties in which products or services are evaluated" (Lim & Chung, 2011; Sweeney, Soutar, & Mazzarol, 2012). Similarly, WOM was also defined as "Informal advice passed between consumers. It is usually interactive, swift, and lacking in commercial bias" by East, Hammond, and Lomax (2008, p. 215). Due to similarities among

definitions available from the past literature, WOM in this study was defined based on the suggestion by Kotler (2006) as "personal communication pertaining to medical services in relation to medical tourism between family members, friends, and associates".

As far as marketing communication tools are concerned, WOM was referred to as one of the most powerful forces in business (Buttle, 1998; Oetting & Jacob, 2010). WOM comes from the consumers groups, such as buyers' acquaintances, colleagues, relatives, and friends (Kuan & Bock, 2007). Many customers prioritised and rely on WOM communications instead of traditional media sources because they view this source of information as inclusive, reliable, objective, and less of profit motivation (Litvin, Goldsmith, & Pan, 2008; Tucker, 2011). The profit motivation is generally not present when recommendations come from peers, family, and friends. Therefore, WOM was viewed as an important force in the marketplace and as a consumer-dominated channel of marketing communication, which directly make WOM being perceived as a more empathetic, trustworthy, relevant, credible, exponentially growing, timesaving, and reliable source of information by consumers compared to firm-created information sources (Porter & Golan, 2006). Moreover, WOM is also perceived to be more effective comparing to the traditional marketing communication approaches like personal selling approach, conventional advertising media, and conventional printed media, although this marketer generated information is important to develop consumer interest towards their products (Smith, Menon, & Sivakumar, 2005; Cheung & Thadani, 2012).

In addition, previous research studies documented and acknowledged the idea that WOM is a very influential means towards customers because it acts as a persuasive communication tool and a reliable source of information (Schindler & Bickart, 2012). This supports the explanation on why WOM has a positive and strong influence on consumers' actual behaviour, intentions, awareness, attitudes, perceptions, expectations, and on new customer acquisition (Lam, Lee, & Mizerski, 2009; Trusov, Bucklin, & Pauwels, 2009). Likewise, it was reported by prior literature that interpersonal communication and social influence through WOM were proven to possess significant impact on consumer buying behaviours and final purchase decisions (Schindler & Bickart, 2012). Apart from that, WOM in the marketing perspective was also argued as one of the important elements that potentially drive a product or brand to be successful (Podoshen, 2008; Oetting & Jacob, 2010). This is generally because WOM can positively enhance brand association and brand awareness among customers that eventually leads to higher sales (Page & Lepkowska-White, 2002). This is supported by a study conducted by Inc. Magazine, which reported that as many as 82 percent of the fastest growing private companies throughout the world depend on WOM techniques as part of their marketing tools (Ferguson, 2008).

The nature of services (i.e. perishability, simultaneous production and consumption, heterogeneity, need for consumer participation, and Intangibility) results in the fact that customers can only experience the services after they purchase it. Services, therefore, are classified as high in experience and credence elements, which consumers can only evaluate it as

they consumed it (Zeithaml & Bitner, 2000). It was found that customers often rely on personal communication and experiences from other customers before they made a purchase (Ferguson, 2008; Swanson & Kelley 2001). The factors that usually influence WOM in the service market depend on the level of responsiveness and dissatisfaction of customers towards the service provider. When customers feel that the response is what they have expected and their complaints are well handled, they will have high tendency in spreading positive WOM of the services consumed, which is eventually part of the information that is transmitted to their acquaintances, and this will definitely create a direct impact on first-time users (Ferguson, 2008).

Additionally, the healthcare industry also revealed a similar trend, whereby WOM is engaged as a part of information sources among patients (Ferguson, Paulin, & Bergeron, 2010; Klinkenberg, Boslaugh, Waterman, Otani, Inguanzo, Gnida, & Dunagan, 2011). This scenario is common among patients because healthcare services are related to high personal risks, quality is difficult to determine, high involvement, and have credence in nature that resulted in many patients to rely on reliable and appropriate information, which are more than other customers in different markets (Ferguson et al., 2010; Robinowitz & Dudley, 2006). Although patients are provided with numerous channels of information, ranging from printed ads to a hospital's website, this information is often criticised for lacking in comprehensibility, overloading of information, and inadequately targeted at future patients (Walsh & Mitchell, 2010; Wood, Shinogle, & McInnes, 2010). Therefore, recommendations by family, relatives, and friends through the form of WOM

are attributed as the most common source of information for patients due to the complex nature of medical services and the difficulty in obtaining and understanding medical information (Leister & Stausberg, 2007; Ferguson et al., 2010).

Furthermore, relying on recommendations from family, relatives, and friends can facilitate the challenging decision-making process, especially when patients are often confused and lost with the information available (Dobele & Lindgreen, 2011). In fact, prior research studies in the context of medical tourism in South Korea found that positive WOM was significant in helping medical service providers to consistently attract new customers and to stay relevant to this industry (Lee, Han, & Lockyer, 2012; Ko & Kim, 2011). Therefore, this evidence revealed that WOM certainly plays a significant role in relationship marketing and should be emphasised in further research, especially in the context of medical tourism.

2.4.2 Brand Image

At present, it is important to create a good brand impression on customers, especially with the rising competition in the service market. Therefore, brand image became an important element for businesses due to its enormous implications on firm's performance and strategic management activities. Theoretically, the image concept was initiated by Martineau (1958) on store personality, which referred to a shopper's perception on psychological and functional aspects of a store that they visited. Since

Martineau's work, the concept of brand image have gained more attention from industry players and researchers. Moreover, the concept of brand image was considered as an imperative area in the subject of marketing as it was reported that brand image conceptually is one of the elements of brand equity (Keller, 2003). Furthermore, brand image was also claimed as the main reason that has an impact on customers' purchasing decision, especially when they need to make choices among several brands available (Kwon, 1990). Consistent with this reasoning, Ataman and Ülengin (2003) maintained that favourable brand image has a strong effect on customers' preferred brand in their products and services selection. Although brand image became a central attention among researchers and been regarded as one of the important areas in marketing, there is less agreement on its definition (Mazanec, 1995).

In terms of its definition, brand image was defined as "a cluster of attributes and associations that consumers connect to the brand name" (Biel, 1992, p.6). Magid, Cox, and Cox (2006) defined brand image as "customer responses to brand name, sign, or impression, and represented the symbol of the product quality" (p. 2). Moreover, Robert and Patrick (2009) defined brand image as "the brand concept that customers hold in mind, which was also known as the subjectively perceived image that is interpreted from the rationality or the sensitivity of customers" (p. 351). In view of the discrepancy in the way brand image was defined, Dobni and Zinkhan (1990) firmly argued that there are four crucial elements of brand image that should be considered when defining brand image: (1) Brand image is principally a perceptual and subjective interpretation by customers, (2) Brand image is shaped from the

characteristics of the perceiver, use of marketing activities, and other context variables, (3) Brand image is the understanding held by customers about a brand, and (4) When brand image is concerned, the perception is more important compared to the reality. Therefore, based on the suggestion by Dobni and Zinkhan (2003) and the nature of this study, the definition proposed by Keller (1993), who defined brand image as "a set of perceptions about a brand as reflected by brand associations in consumer's memory" (p. 93) was adopted in the present study.

In addition, previous research work also suggested that a superior brand image can influence consumers' purchasing decision, which lead to customer's satisfaction, and is able to instil loyalty in them (Aaker, 1996; Gensch, 1978; Rory, 2000). Since brand image was claimed as a mean of combination from the esteem and perceived quality dimensions, therefore brand image has direct influence on customers' perception and impression of the particular brand (Grönroos, 1984). With that, Yagci, Biswas, and Dutta (2009) accentuated the significance of brand image for the service organisations due to the fact that customers usually evaluate the service providers particularly based on their brand image before the consumption of that particular service. As a result, a favourable brand image can be regarded as a resilient predictor for the customers' perception of service quality (Cretu & Brodie, 2007). As brand image is considered important for both product and services, it was widely adopted and examined by past literature among diverse industries (e.g. Grönroos, 2000; Pitt, Opoku, Hultman, Abratt, & Spyropoulou, 2007; Roberts & Dowling, 2002; Wu & Fu, 2009).

Meanwhile, Kotler and Clarke (1987) suggested that hospital brand image in the context of the healthcare sector was considered as the summation of impressions, ideas, and beliefs that a patient holds towards a hospital. Moreover, the past studies revealed that customers/patients' perception on a hospital's brand image can also be formed based on the marketing programs of the supplier, which is the hospital (e.g. Javalgi, Whipple, McManamon, & Edick, 1992; Lee et al., 2008; Robert & Patrick, 2009). In order to support this fact, a study by Gayathri (2009) on the brand image for Apollo Hospital in India, which is directly involved with medical tourism, argued that hospital formed their brand image towards their target audience (medical tourists) through the hospital's website, patient testimonials, accreditation and certifications, facilities, and past achievements. Additionally, hospital brand image can strategically assist hospitals to outreach their target market in the most effective and efficient manner (Cham et al., 2015; Gayathri, 2009; Wu, 2011). Therefore, evidence shows that a favourable hospital brand image helps to strengthen a patient's intention in selecting a hospital, and it is very important for hospitals to understand its consequences towards patient's perceived service quality, satisfaction, and loyalty.

2.4.3 Perceived Service Quality

For the past decades, the concept of service quality has attracted the attention among managers, practitioners, and researchers, due to its extensive effect on customer satisfaction, business profitability, lowering operational costs, customer loyalty, and the improvement of business performance (Atilgan, Akinci, & Aksoy, 2003; Cronin & Taylor, 1992; Seth, Deshmukh, & Vrat, 2005; Naik, Gantasala, & Prabhakar, 2010). With that, service quality was acknowledged as a main competitive strategy for many business organisations as it has direct influences on customer purchasing behaviour and organisation performance (Kayaman & Arasli, 2007; McCain, Jang, & Hu, 2005). Due to the importance of service quality for any firm, this concept was studied across industries in the recent decades (Brady & Cronin, 2001; Ekinci, Dawes, & Massey, 2008). Moreover, service quality was always prioritised in firm's operation strategy owing to the fact that service quality can directly influence the success of one's business entity.

Although service quality was actively studied since its inception, however, there was little agreement on its dimensionality, consequences, measurement, and conceptualisation (Ladhari, 2008; Lau, Akbar, & Fie, 2005; Zeithaml, Berry, & Parasuraman, 1996). According to Rust and Oliver (1994), the lacking of agreement for service quality may be resulted by the distinctive nature of services, such as heterogeneity, inseparability, and intangibility of services. Moreover, Zineldin (2006b) argued that there is not any universal definition for service quality as most of the researchers defined it based on

their own justification. Therefore, Table 2.3 illustrates various definitions for service quality that were formed by researchers across prior literature. Among the definitions available, the definition for service quality developed by Parasuraman et al. (1988) who defined perceived service quality as "a global judgment, or attitude, relating to the superiority of the service" (p. 12) was found to be the most widely cited and thus was adopted in this study.

Table 2.3: Definitions of Service Quality

Author	***Definition***
Bergman and Klefsjö (1994, p. 282)	An ability to satisfy the needs and expectations of the customer.
Bojanic (1991, p.28)	The ability of a service in providing customer satisfaction related to other alternatives.
Evans and Lindsay (1996, p.15)	The total characteristics of service related to its ability to satisfy given needs of customer.
Grönroos (1984, p.38)	A result of what consumers receive and how they receive it.
Lewis and Booms (1983, p. 26)	A measure of how well the service level matches customers' expectations.
*Parasuraman et al. (1988, p.12)	A global judgment, or attitude, relating to the superiority of the service.
Webster (1989, p. 340)	A measure of how well the service level delivered matches customers' expectations on a consistent basis.

Note. * represent the definition adopted in the present study

Additionally, a review of past service marketing literature found that there are two types of conceptualisation for service quality, namely the American and Nordic approach. In terms of the American approach, it was proposed that service quality comprised of several dimensions, such as assurances, reliability, tangibles, empathy, and responsiveness. According to Zeithaml et al. (1996), all of these dimensions can be known as SERVQUAL,

which was formed based on the Expectancy-Disconfirmation Theory. Meanwhile, in regards to the Nordic context, this approach proposed that service quality is a customer's overall perception on a firm's technical and functional qualities (Brady & Cronin, 2001; Kang & James, 2004). In this case, the technical aspect refers to what a customer gets after the process of service delivery (Grönroos, 1984; Kang & James, 2004), while the functional aspect was being referred to as the interaction that took place between customers and service providers throughout the service consumption (Lau et al., 2005). According Brady and Cronin (2001), although majority of researchers are in favour of the American approach compared to the Nordic approach, it was reported that neither approach was deemed to be universally superior. Moreover, the choice of either an American or Nordic approach usually depends on the characteristic and the nature of the industry being studied (Kang & James, 2004). Based upon the discussion above and the nature to this study, this study adopted the American approach as it is the most common approach adopted in the healthcare context.

In addition, literature pertaining to service quality suggests that the perceived quality of customer depends on the trade-off between performance and customer's expectation (Brady & Cronin, 2001; Parasuraman et al., 1988). Quality is highly perceived if performance out-performs a customer's expectation. Contrastingly, quality is perceived low if the service performance is below the level of customer's expectation (Cham & Easvaralingam, 2012). Therefore, it is important for a service organisation to determine what customers expect before developing service products that meets or exceeds

those expectations (Presbury et al., 2005). Hence, managers from the service industry must diligently strive for service superiority to perform above adequate quest service levels, while consistently strive for continuous improvements if they have intention to turn service quality into a great competitive edge (Alexandris, Dimitriadis, & Markata, 2002).

In keeping pace with world advances of technologies and internet, people nowadays are more aware, well-informed, and concerned with their health based on information that is easily available. Therefore, this situation have resulted in consumers having a higher level of expectations for the overall healthcare services, particularly in the context of empathy, responsiveness, tangibility, reliability, and accuracy. In consistent with the above notion, Lim and Tang (2000) argued that these groups of consumers demand for superior overall healthcare services in comparison to the past, and is becoming critical with the quality of the healthcare services consumed. In general, the past studies (e.g. Pickering, 1991; Zineldin, 2006a) maintained that patients have a right to receive good quality medical services and offering superior quality medical treatments is an ethical responsibility of medical service providers. Therefore, the evidence above shows that there is a need for hospitals to understand the perception and expectation from patients in which it will facilitate them in the process of service quality improvement (Aziz, Yusof, Ayob, Bakar, & Awang, 2015; Lim & Tang, 2000).

In addition, it was found that the quality of healthcare services is more difficult to evaluate compared to tangible products (Zeithaml, Parasuraman, & Berry, 1990). This is due to the fact that healthcare services like any other service industry have three unique characteristics (e.g. heterogeneity, intangibility, and inseparability) that make it difficult to be accessed and measured. First is the aspect of heterogeneity, this aspect claimed that a service provider may experience inconsistency of service delivery across different situations, individuals, and time. For instance, the service delivery among medical staff in this study may be different from one another, although the hospital already has a standard of procedures in handling certain processes. Therefore, due to this matter, patients do not have clear criteria for the purpose of medical service evaluation. As for the context of intangibility, this scenario directly indicated that services are intangible in nature and medical patients can only experience and evaluate the services during and after the service performance. Additionally, the third unique feature of medical service is inseparability. This means that a patient will be needed to participate in the process of service production and the quality of the healthcare service can only be determined during the service delivery.

On top of that, it was also documented that the quality of healthcare service can be categorised as client quality and technical quality (Øvretveit, 1992). According to McGlynn (1995), technical quality was regarded as the ability of medical service providers to solve patients' health problems via medical diagnosis, procedures, treatments, and lastly; creating physiological or physical improvement on the patients. In other words, technical quality can be

explained as how well treatments were provided to patients. Tomes and Ng (1995) explained that technical quality includes various factors that can influence the procedures of medical service delivery, namely as laboratory knowledge in performing laboratory tests, pharmacists' expertise and knowledge, clinical and competency skills of doctors and nurses, and so on. Meanwhile, client quality is classified as the interpersonal care quality that directly relates to the patient's perceptions on the service regarding reliability, information given, and friendliness of the staff. Moreover, the interaction between patient and medical service provider can be accessed via three channels: communication, manner, and relationship.

Although both client quality and technical quality were seemingly equally important, Zineldin (2006b) argued that most of the researchers have focus on the prominence of client quality as it was considered as an important factor in the healthcare business that is able to influence the overall perception of patients towards the healthcare service provider. Likewise, Collier (1994) stated that client quality is more important in the healthcare setting because low levels of clinical quality can be overcome with high levels of client quality. In addition, Newcome (1997) also further argued that client quality is more important because client quality can be easily accessed by patients, while technical quality is difficult to access due to their lacking of knowledge in the context of medical platform. Therefore, studies by Babakus and Mangold (1992) and Mostafa (2005), reported that the technical aspects are not a significant determinant in addressing the quality of healthcare service. In view of this, many studies in the healthcare services mainly focused on client

quality in which SERVQUAL was used (e.g. Butt & de Run, 2010; Choudhury, 2008; Marković, Lončarić, & Lončarić, 2014; Nazem & Mohamed, 2015; Papanikolaou & Zygiaris, 2014; Quader, 2009; Yesilada & Direktör, 2010; Zarei, Arab, Froushani, Rashidian, & Tabatabaei, 2012).

2.4.4 Perceived Value

In the current competitive business landscape, businesses need to know what customers value in order to compete effectively and sustain in the intense market (Wilkie & Moore, 2003). Although the meanings of value were established in modern management literature, however, there was no agreeable consensus for the definition of customer perceived value (e.g. Anderson & Narus, 1999; Ramsay, 2005; Vargo, Maglio, & Akaka, 2008). Moreover, it was argued that the dynamic and subjective nature of customer value was the reason why researches have difficulty in defining it (Vargo et al., 2008). This is probably because every person has their own way of evaluating value, thus, establishing a common and acceptable definition is close to being impossible. However, there is an agreeable consensus among researchers that suppliers cannot pre-determine customer value as this can only be determined by customers themselves (Vargo & Lusch, 2004). Therefore, Khalifa (2004) claimed that value in the business transaction is a combination of processes that customers experience (e.g. acquisition, consumption, and disposition of products/ services) from the transaction.

In addition, Woodruff (1997) asserted that researchers often used various definitions for value, although a majority of them are having the same connotation. The past literature shows that value in the marketing are commonly known as customer value (e.g. Chen & Dubinsky, 2003; Lam, Shankar, Erramilli, & Murthy, 2004), value (Berry & Yadav 1996; Ostrom & Iacobucci, 1995), value for money (Pearson & Rawlins, 2005; Pollock, Shaoul, & Vickers, 2002), perceived value (e.g. Chen & Chen, 2010; Chen & Dubinsky, 2003; Yang & Peterson, 2004), service value (e.g. Basole & Rouse, 2008; Ruiz, Gremler, Washburn, & Carrión, 2008), and perceived service value (Caruana, Money, & Berthon, 2000; LeBlanc & Nguyen, 2001). In general, Woodruff (1997) asserted that customer perceived value was described as the perception of customer's preference based on their evaluation on the performances, consequences, and attributes of the product in relation to their needs and requirements. Moreover, Kotler, Kartajaya, and Setiawan (2010) further added that customer perceived value was derived from the differences as perceived by customers between benefits of the product in comparison with the cost and sacrifices needed in getting it.

Although the terms of perceived value remained as the subject to debate, Woodruff (1997) asserted that perceived value have commonalities in its definition, which includes, (1) perceived value is linked or inherent based on the usage of certain product or service and (2) perceived value is usually determined from the trade-off between what customers sacrifice in order to receive and acquire a certain product or service. In fact, most of the definitions across literature came to a conclusion that the perceived value should be

defined based on the suggestion by Zeithaml (1988), as a "consumer's overall assessment of the utility of a service based on perceptions of what is received and what is given" (p.14). Moreover, prior studies also reported that the definition by Zeithaml (1988) claimed to be the most common definition for studies pertaining to the concept of perceived value in a different industry setting (Chen & Chen, 2010; Grönroos, 2000; Kotler et al., 2010; Zeithaml & Bitner, 2000). Therefore, this study adopted the definition developed by Zeithaml (1988) as this definition was successfully and widely adopted in many prior studies, both in the service and the tourism contexts.

Additionally, Roig, Garcia, Tena, and Monzonis (2006) claimed that there are two important characteristics that must be in the context of customer value in order to clarify the actual meaning of value in marketing and as perceived by customers. First, perceived value is created based on the use of product and services. Second, it cannot be determined by the sellers from the transaction. In view of this, Roig et al. (2006) contended that it is those customers who are in the position to evaluate whether the product or service consumed offers value. Moreover, Woodall (2003) further argued that there are three stages in values creation for customers. First, customers will have certain value preconceptions when they plan to make a purchase. Second, customer experiences the value for the deal they make at the point of transaction where the process of acquisition or exchange takes place. Lastly, customer will evaluate and realise the values from the deal after the post-purchase situation. It was argued that customer perceives value from the

transaction they make if the value received at post-purchase stage exceeds the pre-consumption expectation.

Meanwhile, in a service management context, providing customers with superior value experience was identified to have a positive effect on both employees and customers since customer value was linked to customer loyalty (Keiningham, Cooil, Aksoy, Andreassen, & Weiner, 2007; Kim et al., 2008), customer satisfaction (Frank & Enkawa, 2007; Lin & Wang, 2006), and strong customer orientation (Nasution & Mavondo, 2008). Therefore, customers' perceived value can be considered as a source of competitive advantage for a business (Lindgreen & Wynstra, 2005; Lusch & Vargo, 2014). Similarly, Naumann (1995) claimed that customers' perceived value provides firms with advantages in forming customer satisfaction and profits. Moreover, prior literature (e.g. Cretu & Brodie, 2007; Slater, 1997) claimed that marketers should realise the importance of consumers' perceived value as it is the key element for a company's success and the reason for its existence. In view of the importance and benefits of perceived value in the service context, this concept was emphasised in various industry sectors, such as retail stores (Ailawadi, Kusum, Neslin, & Gedenk, 2001; Baker, Parasuraman, Grewal, & Voss, 2002), e-commerce (Brynjolfsson, Hu, & Smith, 2003; Chen & Dubinsky, 2003), leisure (Duman, 2002), tourism (Sanchez, Callarisa, Rodriguez, & Moliner, 2006), restaurant (Oh, 2000), hotels (Clemes, Wu, Hu, & Gan, 2009; Cretu & Brodie, 2007; Lai et al., 2009), and healthcare (Moliner, 2009; Saiprasert, 2011).

The evidence from the above literature revealed that marketers from the service platform consistently were forced to increase the value in their offerings in order to stay relevant to the customers' needs (Anderson & Narus, 1999; Sheth, Mittal, & Newman, 1999). Although customer perceived value seems to be critically important, however, Chahal and Kumari (2011) in their recent study argued that perceived value was neglected as an important concept in the healthcare industry, especially in the context of strategies creation. This is important due to the significance of value in influencing patients' satisfaction and the complicated nature of the healthcare industry, which is more complex than other industries as it requires high level of service customisation for the patients' requirements (McKone-Sweet, Hamilton, & Willis, 2005; Pedroso & Nakano, 2009). Therefore, based on the importance of perceived value in the healthcare setting, Mechinda, Serirat, Anuwichanont, and Gulid (2010) in their study argued that customer perceived value should be included in medical tourism research in order to understand whether the trip made by medical tourists are worthwhile in comparison to the sacrifices they have made for the trip.

In addition, Chahal and Kumari (2011) mentioned that the "sacrifices" of patients comes in two different types, namely as (1) non-monetary costs, namely as the physical and mental stress experienced, and the time spent and in receiving the medical care, and (2) monetary costs, such as the components of perceived quality that they sacrificed and the price that patients have to pay for the medical services that they engaged. Moreover, the existing literature in the healthcare industry agreed that the benefits of the perceived value are

mainly the result of the superior quality of service (Chahal & Kumari, 2011; Choi, Cho, Lee, Lee, & Kim 2004; Cronin, Brady, Brand, Roscoe, & Shemwell, 1997; Manaf, Hussin, Kassim, Alavi, & Dahari, 2015). Convincingly, with the support from the literature, there is no doubt that value is an important element in the service delivery of healthcare industry as it can assure customer satisfaction and profitability of the medical centre. Given the importance of customer perceived value, this construct was included in the recent healthcare studies, for example, Cengiz and Kirkbir (2007), Moliner (2009), and Wu (2011). Moreover, considering that perceived value is important in influencing the attitude and behaviour of the customers, substantial attention should be given to this concept in the high credence services context, particularly medical tourism.

2.4.5 Perceived Trust

Since its establishment, trust was considered as one of the most widely studied topics across various disciplines, such as management, psychology, economics, and philosophy. Traditionally, trust is usually treated differently in all disciplines due to the varied assumption about the nature of this concept. For instance, trust in psychology is formed from the individual attributes of both trustees and trustors (Tyler, 2003), trust in economics are viewed as an institutional and calculative aspect of financial agreements (North, 1990) whereas in marketing, trust was mostly considered and studied in the context of relational exchanges (i.e. relationship marketing) between customers and sellers (Ploetner & Ehret, 2006; Sirdeshmukh, Singh, & Sabol, 2002) or

between a buyer and a seller (Narayandas & Rangan, 2004; Lusch, O'Brien, & Sindhav, 2003). Moreover, it was found that the concept of trust contributed to marketing literature over the years (Moorman, Deshpande & Zaltman, 1993; Morganosky & Cude, 2000; McCole, 2002; Sirdeshmukh et al., 2002; Brashear, Boles, Bellenger & Brooks, 2003).

In addition, various definitions of trust were developed in the past due to its significant impact on consumer group and society at large. Based on the review of literature, the most common and widely accepted definition for trust is "the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other party will perform a particular action important to the trustor, irrespective of the ability to monitor or control the other party" (Mayer, Davis, & Schoorman, 1995, p. 712). In the business context, trust was defined as "the extent to which a firm believes that its exchange partner is honest and benevolent" (Geyskens & Steenkamp, 1995, p. 351). Moreover, customer trust in the perspective of service setting was defined as "expectations held by the customer that the service provider is dependable and can be relied on to deliver on its promises" (Sirdeshmukh et al., 2002, p. 17).

The definitions above clearly stated that trust is formed from the characteristic of the human base on their personality traits (Chu & Shiu, 2009), motives, and behaviours (Tian, Lai, & Daniel, 2008). Moreover, Chu and Shiu (2009) claimed that the perception and expectations of the trustors toward trustees are required in order for trust to develop. This directly means that the

level of trust may be varying among individuals in consideration of a diverse attitude and behaviour (Chu & Shiu, 2009). Although patient trust is an essential element in healthcare, it is complicated and difficult to measure, and empirical research pertaining to patient trust is still limited up to this date (Chang et al., 2013; Nummela et al, 2008; Mohseni & Lindstrom, 2007; Trachtenberg, Dugan, & Hall, 2005). Therefore, medical researchers argued that the definitions for patient trust are also inconsistent and often were defined in various ways depending on the nature of the study. For instance, patient trust was defined as "optimistic acceptance of a vulnerable situation in which the trustee believes the trustor will care for the trustee's interests" (Hall, Dugan, Zheng, & Mishra, 2001, p. 613), while "patient's belief that the physician will act in the patient's best interest and will provide appropriate treatment and medical care" (Thom & Campbell, 1997, p. 2011). Among all the definitions available, for this study, patients' perceived trust was defined as "the optimistic acceptance of a vulnerable situation in which the patient believes the healthcare provider will take care of the patient's interests" (Dugan et al., 2005, p. 64).

In order to acknowledge the existence of trust, there is an agreement on two necessary conditions for trust to emerge regardless on any industry or discipline (Rousseau, Sitkin, Burt, & Camerer, 1998). The conditions required for trust to emerge are interdependence of parties involved and risks involved (Rousseau et al., 1998). First, interdependence can be explained as an interest of an individual that can only be achieved with the reliance of others. Therefore, this scenario illustrates that the parties involved need to rely on one

another for trust to establish. Additionally, the second condition known as risk, which was defined by Billings, Milburn, and Schaalman (1980) as "the perceived probability of loss" (p. 308), which is another condition that is essential in psychological, sociological, and economic conceptualisations of trust. Moreover, it was claimed that trust can only be derived from a situation that has risks involved (Mayer et al., 1995). Mayer and colleague further argued that risks usually derived from behavioural uncertainty and environmental uncertainty. In this context, environmental uncertainties are those factors that are beyond the control of trustee, while behavioural uncertainties are under the control by trustee.

In addition, the trust literature in the service industry suggested that the foundations of relationships between seller and buyer are grounded in customer trust (Crotts & Turner, 1999; Selnes, 1998). According to Liang and Wang (2008), suppliers in the service setting only can be trusted if the suppliers are concerned about customers' interests, willing to make sacrifices to satisfy the needs from customers, and actively making relationship efforts in the relationship. As usual, practice in any service encounter, customers will form trust with the service providers before they engage to the services (Gilpin, 1996). Therefore, customers' trust is considered as a key factor in the relationship building because it fosters customers' confidence, cooperation, and gives a second chance to the service providers if any unfavourable things happened during and after the transactions (Morgan & Hunt, 1994). Moreover, the importance of customer trust in the marketing platform was acknowledged by the researchers as it has a direct significant positive impact on the firm's

inter-organisational and interpersonal relationships (Johnston, McCutcheon, Stuart, & Kerwood, 2004). For example, there are numerous research studies in marketing platform that included trust on the foundation of exchange relationships, whereby it was found that the customers who trusted the service providers will believe that they will fulfil all obligations of the relationship (Narayandas & Rangan, 2004; Tian et al., 2008).

Empirical research studies also documented that the role of trust in relationship was conceptualised as an important feature of relationship quality (Morgan & Hunt, 1994; Moorman et al., 1993; Wong & Sohal, 2002; Wong & Sohal, 2006). This is because customers will only continuously purchase products/services from a reliable company that they trust. For example, in the current competitive landscape of the service market, customers usually made the purchase decision based on their trust (Liang & Wang, 2008), perception (Liu, Li, Tao, & Wang, 2008), prior consuming experiences (Doney & Cannon, 1997), and expectations (Mayer et al., 1995) towards the service providers. Therefore, customer trust is considered important in practical business activities as to build a good reputation and long-term relationship between the sellers and buyers. According to Liu et al. (2008), customers would believe their trusted service providers will act in their favour and have a tendency to improve the relationship, even when the environment changes or any inevitable shortcoming occurs.

Furthermore, customer trust is something that has to be earned over a period of time and be able to create advantages for the firms that successfully achieved it. In reality, Srinivasan (2004) mentioned that customer trust is an essential ingredient for success in bringing continuous business. Kramer (1999) added that customer trust is able to lower the operational costs for the trusted firms and any costs of transaction that incurred on customers during the process of searching for the products' price information and the substitute available. This is generally because the high level of trust from customers will definitely make the product/services from a trusted firm to be their main choice. In other words, customer trust can improve the long-term relationship between sellers and buyers and to enhance customer's loyalty (Bowen & Shoemaker, 2003; Chu & Shiu, 2009). For example, Ganesan (1994) found that customer trust acts as a booster for firms to create customers' satisfaction based on past exchanges with the firms. Due to the importance of customer trust in the current market landscape, many researchers included and examined trust in their studies from diverse industries (Brashear et al., 2003; Hunt, Arnett, & Mashavaram, 2006, Morgan & Hunt, 1994; Eisingerich & Bell, 2007, Wong & Sohal, 2006).

Nonetheless, from the perspective of healthcare context, Ngobo (2004) claimed that failing to understand patient's expectations can result in mistrust among patients, in which it will create greater switching intentions to another healthcare service provider. Therefore, it is argued that medical centres' reliability and integrity is essential in forming trusts among patients (Arboleda-Arango, 2015; Mechinda et al., 2010). Similar to other industries,

past research studies in healthcare have also consistently affirmed that trust plays an important role in influencing the performance of hospital, improving profitability, enhancing the service delivery process, improving the level of satisfaction, and forming greater commitment from patients (Arboleda-Arango, 2015; Entwistle & Quick, 2006; Lewis & Soureli, 2006; Ngobo, 2004; Pearson & Raeke, 2000). In view of the importance of trust in the medical context, patient trust was considered as an imperative factor that leads to the success of healthcare industry (Pearson & Raeke, 2000; Entwistle & Quick, 2006).

2.4.6 Patient Satisfaction

Theoretically, customer satisfaction is considered as the outcome from the marketing activity that is related to the post-purchase phenomena (Holbrook, 1994; Pakdil & Harwood, 2005). The importance of customer satisfaction was acknowledged by many customers, researchers, and businesses due to its substantial impacts on firms' performance and its profitability. For example, the past studies claimed that satisfying customers is an imperative achievement for the marketing outcomes as it has potential effects on business profitability (Anderson & Fornell, 1994; Chitty et al., 2007), shareholder value (Anderson, Fornell, & Mazvancheryl, 2004), and customer future purchase behaviour (Riscinto-kozub, 2008; Yoo & Park, 2007). To begin the discussion on customer satisfaction, it is vital for the researcher to identify the definition of customer satisfaction in order to have a better understanding on this concept. For example, customer satisfaction was

defined as "global evaluative judgment about product usage/consumption" (Westbrook, 1980, p. 49). Moreover, Tse and Wilton (1988) defined customer satisfaction as “consumer’s response to the evaluation of the perceived discrepancy between prior expectation and the actual performance of the product as perceived after its consumption” (p. 204).

In addition, Zineldin (2006b) in a service context, defined customer satisfaction as a “summary of psychological state that results when the emotion surrounding disconfirmed expectation is coupled with consumer’s prior feelings about the consumption experience” (p. 430). Although there are various types of definition for customer satisfaction, however, most of the definitions agreed that satisfaction involving affective elements and cognitive elements is a complex human process, and as a response to an evaluation process (Bhattacharya & Singh, 2008; Giese & Cote, 2000). Based on the previous definitions available across literature, therefore, Chitty et al. (2007) summed that satisfaction (or dissatisfaction) is the perceived match or mismatch between the customers’ perceptions and their prior expectations from the business transaction they encounter. Different researchers defined the concept of customer satisfaction differently, but it is commonly viewed as a result of comparison of the consumption experience and expectation. Therefore, referring to the discussion from the prior literature, patient satisfaction in this study had been defined as “as the degree of congruency between a patient’s expectations of ideal care and his/her perception of the real care he/she receives” (Aragon & Gesell, 2003, p. 229).

Additionally, customer satisfaction is also known as post-consumption evaluations or judgment of customers towards the purchase of products or services over the relationship between customer and service provider (Russell, 2005). Moreover, Martin (2007) maintained that customers may not be happy with the services, although they are satisfied with the service encounter, and it was found that customers' expectation also has a substantial capability in influencing customer satisfaction. Therefore, it is important for businesses to understand all factors that drive customer satisfaction as it is an essential component to retain existing customers effectively (Martin, 2007). Similarly, Riscinto-kozub (2008) further added that the advantages of customer satisfaction evaluation is crucial when a service provider attempts to create intentions to recommend, identifying product and service differentiation, increase customer retention, and creating favourable word of mouth among their customers. Moreover, Riscinto-kozub (2008) also mentioned that some service providers have a natural ability to satisfy customers. For example, perfecting the quality of intangible elements, improving lines of communication, and pleasant gestures in the service orientation could be a few significant sources in forming satisfaction among customers. It can therefore be argued that service providers consistently evaluate the level of customer satisfaction and applying it for the purpose of service improvement would provide them with a great competitive advantage in the market (Gilbert & Veloutsou, 2006).

Furthermore, the use of the word “customer” or “patient” to describe the recipient of medical care is still being debated today (Press, 2002). Press (2002) distinguishes between the two terms by indicating that a “patient” is someone who receives medical care on a specific day, and as a result of the quality of medical treatments, the particular patient may become a customer in the future. Since medical tourists consumed medical services during their trip, therefore, patient satisfaction was used in the rest of the study. According to Kirsner and Federman (1997), patient satisfaction is an interactive process during healthcare experience as it reflects a patients’ evaluation on the quality of his or her experience with the medical service provider. With that, most of the studies in the healthcare setting usually explain patient satisfaction in terms of an outcome from the medical service experienced. For example, it was reported that patient satisfaction is as an attitudinal judgment made by patients towards their clinical encounter (Kane, Maciejewski, & Finch, 1997). Additionally, patient satisfaction can be measured through scales (Hawthorne, Sansoni, Hayes, Marosszeky, & Sansoni, 2014), contains both evaluative and affective components (Aiken, Clarke, and Sloane, 2002), and may range across a continuum from very satisfied to very dissatisfied (Collins & O’Cathain, 2003).

In general, today’s consumers when given a choice, are more willing to have their medical treatment elsewhere if healthcare providers do not provide them the medical services that they desire in a manner they find appropriate (Gill & White, 2009; Hausman, 2004). In view of that, dissatisfied patients may not return to the particular medical centre for future care (Zoller,

Lackland, & Silverstein, 2001) or may express their discontent among their peers, which may raise doubts about the quality of care on the particular medical centre (Press, 2002). Therefore, it was revealed that patient satisfaction plays an important role for healthcare to continuously attract new customers and to retain the current ones (Rahman & Osmangani, 2015). Apart from that, Aldaqal, Alghamdi, AlTurki, El-deek, and Kensarah (2012) indicated that there are few reasons that patient satisfaction needs to be emphasised. Firstly, patient satisfaction information allows hospital to ascertain the area of weaknesses in their organisation that can be useful for the purpose of quality improvement. Secondly, a high level of patient satisfaction can provide healthcare service providers with financial benefits (Braunsberger & Gates, 2002). Thirdly, it was reported that patients who are satisfied with the medical services experienced are more likely to stay loyal (Ancarani, Di-Mauro, & Giammanco, 2009).

Furthermore, there were further evidence in the literature documented that satisfied patients have no issue to comply with pharmaceutical and medical treatments (Choi et al., 2004), are more likely to recommend the hopsital to their family and friends (Fenton, Jerant, Bertakis, & Franks; 2012; Tung & Chang, 2014),are less likely to complain (Karatepe, 2006), will have higher perception on the quality of life (Howard, Rayens, El-Mallakh, & Clark, 2007), and are more likely to be loyal with the service provider (Gummerus, Liljander, Pura, & van Riel, 2004; Hausman, 2004). In summary, the evidence from the existing literature revealed that patient satisfaction is

important in the healthcare perspective. Therefore, considerable attention should be given to this concept in the context of the medical tourism industry.

2.4.7 Behavioural Intention

According to Kim and Hunter (1993), behavioural intention can be understood based on the individual's willingness or intention to get involved in certain behaviours. It was found that the earliest study for behavioural intention was originated from the literature of psychology (Ajzen & Fishbein, 1980). Subsequently, the concept of behavioural intention attracted attention among researchers and was applied in diverse platforms, including hospitality (Jang, Kim, & Bonn, 2011), human resource (Allen, Shore, & Griffeth, 2003), and tourism (Lam & Hsu, 2006) to name a few. For most tourism and service providers, customer retention was considered as key to the organisation's sustainable profitability (Deng, 2007). With that, Ajzen and Fishbein (1980) argued reports that behavioural intention is regularly used to measure customers' intention to revisit since behavioural intention was considered as an accurate predictor of future behaviour. Since then, behavioural intention has commonly been employed as a dependent variable in most of the research studies (e.g. Bigne, Sanchez, & Sanchez, 2001; Boulding, Kalra, Staelin, & Zeithmal, 1993), owing to the fact that behavioural intention has a useful prediction capability in predicting customers behaviour (Westaby, 2005; Ibrahim & Najjar, 2008).

In the context of definition, there is no consensus on the conceptual definition for behavioural intentions as this concept was widely used across

disciplines throughout the past literature. For example, Söderlund and Öhman (2005) argued that the limited intentions theories is the main reason why intention appears to be one of the most under defined constructs in consumer behaviour literature and has overlapping characteristics with customer loyalty. One of the earliest studies on behavioural intention by Fishbein and Ajzen (1975) defined behavioural intention as "the subjective probability that an individual will take in a particular action" (p. 288). Moreover, Ajzen (2002) defined behavioural intention as "an individual's anticipated or planned future behaviour, which is also an indication of an individual's readiness to perform a given behaviour" (p. 665). Armitage and Conner (2001) further added that behavioural intentions refer to a person's expectations of future behaviour towards an object. Among all the definitions available, the definition for behavioural intention in this study was based on the definition by Oliver (1997) who defined it as "an affirmed likelihood to engage in a certain behaviour" (p. 13).

In addition to above, loyalty as a marketing concept was categorised in different forms, namely as repurchase intention, willingness to recommend, positive word of mouth, and so forth (Dick & Basu, 1994; Riley, Niininen, Szivas, & Willis, 2001). Despite the diverse arguments if loyalty should be considered as an attitude, behaviour, or both, it was found that most of the research studies in the service setting conceptualised loyalty as behavioural intention (Buttle & Burton, 2002; East, Sinclair, & Gendall, 2000; Shukla, 2010). Moreover, Mekoth, Babu, Dalvi, Rajanala, and Nizomadinov (2011) claimed that customer loyalty in the service encounter related process should

be viewed as behavioural intention because service experienced by customers is highly subjective and does not happen on a frequent basis compared to product purchase. In consistent with the argument by Mekoth et al. (2011), the study in the tourism industry supported the fact that it is difficult to measure loyalty in the context of tourism since that the purchase is taken place infrequently and is a rare purchase (Jago & Shaw, 1998); and can be translated into intention to revisit in the future (Lam & Hsu, 2006). Therefore, the concept of behavioural intention was preferred in most of the tourism studies (Chen & Tsai, 2007; Lam & Hsu, 2006; Williams & Soutar, 2009).

In the perspective of a healthcare, there are research studies utilised revisit intention as a substitute for patient loyalty in the healthcare environment (e.g. Ko, 2010; Lee, 2005). Similarly, recent studies (e.g. Wu, 2011; Solayappan & Jayakrishnan, 2010) also discovered that patient loyalty is more appropriate to be conceptualised as a behavioural intention due to the nature that medical service is a rare purchase. In the perspective of medical tourism, Saipraset (2011) claimed that behavioural intention indicates the committed behaviour to participate in medical tourism, which is medical tourists' intention to return for the medical service provider, to recommend and to revisit. This notion is consistent with a study conducted by Chen and Tsai (2007), who asserted that willingness to recommend and the intention to repurchase (or revisit) are very strong indicators of customers' future behaviour. Regardless of the discussion that focuses on customer loyalty in the general service setting or patients' behavioural intention in the healthcare aspect; it was found that the same advantages of customer loyalty are

applicable and relevant to the behavioural intention. Therefore, behavioural intention was used in this study to explain the likelihood of medical tourists to recommend the hospital that they visited, say positive words about it, and consider returning to the same hospital in the future.

In addition, Ladhari (2009) claimed that customers' behavioural intention can be either unfavourable or favourable. According to Zeithaml and Bitner (1996), unfavourable intention will cause customers to spread negative word of mouth to their peers, showing a sign of unwillingness to pay premium prices, have a higher tendency to switch brand, and reduce their volume of purchase. In contrast, favourable intention among customers will increase their willingness to pay premium prices, promotes a better relationship between buyer-seller, has a lower tendency to switch brand, expressing positive word of mouth, and increase their purchase. Therefore, referring to the importance of behavioural intention, it was claimed that the success of one's company regardless of financial or operational context are very much depended on the level of customers' favourable behavioural intention (Dabholkar, Shepherd, & Thorpe, 2000).

Furthermore, in the service platform, all researchers agreed that positive behavioural intention of customers includes the willingness to pay a premium price, have a tendency to recommend the service to family and friends, spreading positive word of mouth about the service firm to others, and remain loyal to the firm (Ladhari, 2009; Tsaur, Lin & Wu 2005). In the current world, the availability of information technologies has resulted managers from

the service firm as to emphasise on the importance of customer's behavioural intentions (Liu, Furrer, & Sudharshan, 2001). This is due to the fact that customer's positive or negative word of mouth can influence others customers' perception in which it will influence their purchase decision. Therefore, there is no uncertainty surrounding the idea that customers' behavioural intentions are one of the most vital elements that leads to the success and sustainability of any service firms (González, Comesaña, & Brea, 2007; Baker & Crompton 2000; Tsaur et al., 2005), as well as the hospitals that are involved with medical tourism (Cham et al., 2015; Saipraset, 2011).

2.5 Chapter Summary

Based on the examination of previous literature in relation to general service, tourism, medical tourism, and healthcare industry, the researcher identified several areas in the literature that warrant further research. The researcher formulated a typology and literature classification based on service marketing that highlight the gaps in the literature that were examined in this research. Specifically, very limited research was conducted to understand the impact of brand image on customer's perception on service quality in the service setting. Moreover, the studies on the factors (e.g. social media and word of mouth communication) that influence brand image are virtually none. Besides that, the researcher leveraged the dichotomous approach to examine the interrelationships between perceived service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention in the context of medical tourism. In view of that, the researcher delved further in

understanding these gaps in the literature and developed a conceptual model that served as the foundation of this study in the following chapter.

CHAPTER 3

CONCEPTUAL FRAMEWORK

3.1 Introduction

Following the review of the theoretical and literature discussion from the earlier chapter, this chapter presents the conceptual model that was developed in this study. Moreover, this chapter also reveals the potential relationships that exist among the constructs that are employed in this study. In this chapter, there are four sections, whereby the first section is the introduction of this chapter, while section 3.2 discusses on the hypotheses development based on the justification from the past literature. Subsequently, section 3.3 presents the conceptual model, and finally, the last section in this chapter presents the summary of this chapter.

3.2 Hypotheses Development

Referring to the problem statement and research objectives that were identified, this research aims to contribute to the relationship marketing and service marketing knowledge by exploring the strategic roles of social media communication, word of mouth communication, brand image, perceived service quality, perceived value, perceived trust, patient satisfaction and customers' behavioural intention in the context of medical tourism in

Malaysia. In response to the research aim, the relationship between the studied constructs that were based on literature review is discussed as follows:

3.2.1 The Relationship between Social Media and Brand Image

Since its establishment, social media has been increasingly becoming the preferred method to create and consume media around the world. Nowadays, social media are no longer viewed as the channel of networking and for social purpose, this technology has gone way beyond conventional ground by shaping our surrounding, especially with its significant impact in the business world. As social media are implemented on marketing contexts in various methods, there is no any single standardised marketing strategy that fits all industries. This is because the strategies and tools for communicating with consumers have changed overtime and customers have begun to participate in the marketing process, especially with the availability of a social media. Moreover, social media tools, such as social websites, business websites, forums, blogs, chat rooms, and so forth have help companies to communicate with individual consumers effectively. This trend of marketing communication methods has constantly helped in creating long-term relationships between businesses and their respective customers. Additionally, this technology enables a company to advertise their product and services effectively and assist a company in educating other consumers about brands, services, products, and so forth (Berthon, Pitt, McCarthy, & Kates 2007; Kaplan & Haenlein, 2010).

Furthermore, based on the importance of social media communication in the business context, the past literature consistently reported that social media communication tools contribute to brand equity (Kim & Ko, 2012; Kotler, 2011), brand awareness (Schivinski & Dąbrowski, 2014), purchase decision (e.g. De Bruyn & Lilien, 2008; Iyengar, Han, & Gupta, 2009; Trusov et al., 2009), and brand loyalty (Gordhamer, 2009; Mangold & Foulds, 2009). However, Bruhn and colleagues (2012) further argued that the effect of social media comes from both consumers' communication (user-generated) and business marketing communication (firm-created). Therefore, it is vital to understand and address the impact of both forms of social media in influencing marketing activity and customers' perception of products, services, and brand (Bruhn et al., 2012; Schivinski & Dąbrowski, 2014). The discussion on the relationship between both user-generated and hospital-created social media with brand image are presented as follow:

The Relationship between Hospital-Created Social Media and Brand Image

In the past, consumers were highly restricted in their search of product and service information as they mostly depended on the content and communication that were controlled by business firms (De Bruyn & Lilien 2008). This traditional means of marketing was also inherited with the introduction of internet as firms unceasingly use their self-created contents in terms of social media communication to approach and to create awareness among their customers. According to Mangold and Faulds (2009), this communication tool allows a promotional mix for firm to be developed and

coordinated with a limited flow of information outside of this structure. It is argued that the long shelf life of this integrated marketing communications framework can be attributed with the high levels of control enjoyed by a particular firm (Hennig-Thurau, Malthouse, Friege, Gensler, Lobschat, Rangaswamy, & Skiera, 2010). Therefore, there is no doubt that many business firms depended on this channel of marketing communication tools to outreach to their customers effectively (Daugherty, Eastin, & Bright, 2008).

In addition, prior studies documented that firm-created social media is an important factor that influences brand equity (Gensler, Völckner, Liu-Thompkins, & Wiertz, 2013; De Pelsmacker & Janssens, 2007). Yoo, Donthu, and Lee (2000) argued that marketing communications by firms through social media resulted in a positive impact on perceived brand quality, brand associations, brand awareness, and brand loyalty. Moreover, firm-created social media can enhance the equity of the brand, influence customers' consideration process on a particular brand, shortening the process of purchase decision, and ultimately make the chosen brand as their preferred brand (Bruhn et al., 2012; Dijkmans, Kerkhof, & Beukeboom, 2015; Schivinski & Dąbrowski, 2014). Bruhn et al. (2012) further claimed that firm-created social media via Facebook, YouTube, forum posting, blog, twitter, online magazine, and so forth had shown a positive direct impact on brand image in the pharmaceuticals and telecommunications industries. Therefore, firm-created social media was claimed to be an effective marketing tool in brand image formation (Schivinski & Dąbrowski, 2014; Gensler et al., 2013).

Accordingly, the above evidence shows that firms are able to create awareness among their potential customers effectively since social media allow firms to communicate with their customers directly in providing offers and any other related information. However, to what extent firm-created social media have an impact on the hospital's brand image in medical tourism still remains unexplored by any empirical study. With that in mind, the following hypothesis was developed:

H1: Hospital-created social media will have a positive direct effect on brand image.

The Relationship between User-Generated Social Media and Brand Image

The availability of the internet has resulted the online media setting to experience a vibrant change due to the efficient formation and distribution of user-generated content in the social media context (Daugherty et al., 2008). According to Christodoulides, Jevons, and Bonhomme (2012), the current trend for the inclusion of user-generated contents represents a paradigm shift for marketing communications in the marketplace, whereby brands of products and services are shaped by consumers directly. Moreover, the growth of social media and other similar large scale consumer-to-consumer interaction platforms were reported to have an impact on branding (Gensler et al., 2013). This is because, customers nowadays are more empowered by the social media that allow them to share experiences, reviews, brand stories, and comments among their friends (Chintagunta, Gopinath, & Venkataraman 2010; Sun,

2012). Gensler et al. (2013) further argued that consumers usually share brand stories of products or services through social media when they had either a very negative or positive experience with the brand. This situation suggests that user-generated content may indeed affect the success of a brand in the marketplace. Therefore, it was claimed that sharing information from user-generated content is more influential and more persuasive since consumers in general tend to act and organise information like what other consumers do (Escalas, 2004).

Additionally, Dellarocas (2003) argued that communication that takes place among consumers was regarded as a powerful and persuasive channel of information transmission. In this context, social website that incorporates user reviews and comments can potentially benefit companies with more effectiveness in their communication process in terms of brand creation, promoting goods, and services; as well as in creating awareness in perceived quality, brand associations, and brand loyalty among the consumers (Chintagunta et al., 2010; Xiang & Gretzel, 2010). This scenario indicates that the inputs from the customers have a positive effect on the other consumers, especially in the context of their awareness and their perception of the brand image (Bruhn et al., 2012; Goodstein, 1993; Schivinski & Dąbrowski, 2014).

Furthermore, there are also established consensuses that user-generated social media communication has proven to have a positive influence on a company's profitability as well (De Bruyn & Lilien, 2008; Dellarocas, Zhang, & Awad, 2007; Liu, 2006). Based on support from the discussion above, it can

be foreseen that user-generated social media has a direct positive influence on medical tourists' perception of a hospital's brand image, and therefore, the second hypothesis was postulated as follows:

H2: User-generated social media will have a positive direct effect on brand image.

3.2.2 The Relationship between Word of Mouth and Brand Image

In the current competitive business landscape, branding is regarded as a core capital for various industries. According to Jalilvand and Samiei (2012), the creation of brand signifies a communication process of the elements in brand image in such way that the target customers are able to relate the brand with a set of associations that they have in mind. It is revealed that a strong brand image are foreseen in enabling customers to visualise clearer about the product/services, create awareness among them, increase customers' trust, and understand intangible factors underlying the product or service purchased (Pitt et al., 2007). Therefore, many businesses have significantly raising their capital investments in the development and the creation of brands in order to target and outreach towards their customers in the most effective and efficient approach. According to Riezebos (2003), social influence via word of mouth was considered as one of the most significant aspects that drives brand image. This is because, word of mouth was regarded as an effective approach that transmits information in the marketplace and is capable in stimulating individuals' decision making (Riezebos. 2003; Smith et al., 2005; Cheung &

Thadani, 2010; Oetting & Jacob, 2010). Moreover, in supporting the claim, word of mouth is usually initiated by a group of customers who are loyal and shared their experiences or information in order to help their acquaintances, especially the first-time users/customers to have an overall image of the brand and to make brand selection (Xu & Chan, 2010).

The past literature reported that word of mouth communication was consistently documented to form and influence consumers' awareness, attitudes, expectations, perceptions, and behavioural intentions to the products, services, and brands (e.g. Chevalier & Mayzlin, 2006; Sen & Lerman, 2007; Xia & Bechwati, 2008). Moreover, it was revealed that word of mouth is also one of the key factors that have a resilient impact on consumers brand image perception and the success of a brand (Podoshen, 2008). This is supported by an empirical study conducted by Jalilvand and Samiei (2012) in the automotive industry whereby the researchers found that word of mouth communications have a substantial influence on customers' perceived brand image and subsequently, their purchase intention. Their study revealed that word of mouth is able to instil brand messages in consumers' minds, and at the same time, to address the uncertainties experienced by customers, which in turn will lead them to have a better understanding and impression of the brand as a whole. Additionally, past literature also documented that word of mouth communications have a strong impact on brand trust (Ha, 2004; Ha & Perks, 2005), brand purchase intention (East et al., 2008; Wangenheim, 2005), brand awareness (Kiss & Bichler, 2008; Page & Lepkowska-White, 2002), consumer-based brand equity (Bambauer-Sachse & Mangold, 2011; Xu &

Chan, 2010) and forming purchase intentions (Park, Lee, & Han, 2007; Zhang & Tran, 2009).

In addition, the above studies spelt out the reality that word of mouth has indeed become a phenomenal component for marketing communication by having its mark on the branding perspective, such as brand image, brand equity, brand trust, brand awareness, and most importantly; customers' purchase decision. Nevertheless, up until now, limited studies were conducted to examine the influence of word of mouth towards brand image despite the plenty of evidence from past literature for the influence of WOM on other branding perspectives and consumer purchase intention (Jalilvand & Samiei, 2012; Riezebos, 2003). Based on the support from the prior literature concerning word of mouth and branding perspective, this study hypothesised that:

H3: Word of mouth communication will have a positive direct effect on brand image.

3.2.3 The Relationship between Brand Image and Perceived Service Quality

In the current business platform, Vargo and Lusch (2004) claimed that the differences on marketing approaches for business and consumers market are dwindling according to time due to the effect of globalisation and the advancement of information technologies. Nevertheless, there are still some differences that still remain relevant as far as branding is concerned especially when buying technical services that involves more direct interactions with the selling organisation (Mudambi, 2002). Therefore, this buying situation requires the influence from the reputation and the image of the service firm, in which it can have direct influence on the customers' purchase decision and consumption experience. For example, Berry (2000) in his study found that the ''company'' itself usually prioritised by their customers instead of the product or services offered. Moreover, Haque, Sadegzadeh, Khatibi, and Mahmud (2006) claimed that customers' familiarity and confidence for a marketing purchase are usually formed from the company's sales history and the brand of products/services. In these regards, the past literature consistently reported that customers' familiarity for a product or service can be created with strong brand image, previous usage satisfaction, and based on the long sales history of the firm (Coltman, Devinney, Latukefu, & Midgley, 2001; Huang, Schrank, & Dubinsky, 2004). These findings reflect that a brand image of a particular firm plays an important role in creating confidence among customers. In particular, brand image can represent all information linked to the product or services and was regarded as the customers' brand belief that

was formed from several product/ service attributes (Kotler & Armstrong, 1996).

Based on signalling theory in the marketing aspect, the "signal" can be regarded as indicators that influence consumers' behaviour in product purchase (Boulding & Kirmani, 1993). Cretu and Brodie (2007) argued that brand usually turnout as a "signal" to convey information to customers, represent credibility of the firm's product/service, and represent a firm's overall marketing strategies. Moreover, this signal helps customers to determine and consider the perceived risk and perceived quality that are associated with the product or service before any purchase is made (Cretu & Brodie, 2007; Hu, Rabinovich, & Hou, 2015; McCollough & Gremler, 2004). The past studies also found that there are evidence that suggest that customers' evaluative judgments (e.g. perceived quality) was affected by brand image (Cham et al., 2015; Chi & Qu, 2008; Severi & Ling, 2013). Alternatively, Grönroos (2000) suggested that if the brand image for a service provider is good, it becomes a shelter for services delivery. This directlty means that any shortcoming or problems derived in service delivery caused by reputable service providers are usually overlooked by customers due to the "sheltering effect" possessed by the brand image (Grönroos, 2000). Therefore, Riezebos (2003) argued that company's brand image has an imperative influence on the customers' buying processes, especially when brand image is viewed as a critical factor in service evaluation. Thus, there is no doubt that customers are likely to perceive firm's service quality to be greater for a firm with a favourable brand image (Cham et al., 2015; Wu, 2011).

Furthermore, Zeithaml (1988) claimed that brand image and perceived service quality are closely related whereby positive and favourable brand image encourages customers to evaluate firm's services favourably and reduces the level of perceived risks. In consistent with the argument by Zeithaml, Kotler (2006) also claimed that customers are depended on for the importance of brand image when purchasing a product/service that they are not familiar with. This is because brand image may indicate that product/service's reliability, quality, and its functions (Brodie, Whittome, & Brush, 2009). Moreover, it was also asserted that customers in the service industry are often depended on brand image as an indicator of quality of service, whereby brand image heavily influences their assessment (Brodie et al., 2009). Due to the importance of brand image in the service setting, past studies (e.g. Hsieh & Li, 2008; Jalilvand & Samiei, 2012; Madhavaram, Badrinarayanan, & McDonald, 2005; Magid et al., 2006; Reid, Luxton, & Mavondo, 2005) also highlighted the important influences of brand image in an integrated marketing communications environment.

In addition, most of the studies agreed that image affects customers' perception of service quality. For example, Bloemer, De Ruyter, and Peeters (1998) found that positive brand image of the bank can have a positive impact on perceived service quality among the customers. In the healthcare context, Wu (2011) has argued that there is a direct positive relationship between favourable hospital brand image and patients' perception of service quality. Moreover, the prior empirical researches found that brand image has a significant direct influences on perceived service quality in various industries,

namely education setting (Manhas, 2012), business market setting (Cretu & Brodie, 2007), medical tourism (Cham et al., 2015), and in airline setting (Brodie et al., 2009). In view of the existing evidence, the importance of developing a favourable brand image gained the attention among researchers and industry players. This is critical, particularly in the service setting, where many customers depend upon brand image in forming a perception of service quality (Kumar, Smart, Maddern, & Maull, 2008). In view of the support from the previous literature and the deficiency of the brand image studies in the context of medical tourism, the fourth hypothesis for the study was postulated as follows:

H4: Brand image will have a positive direct effect on patients' perceived service quality.

3.2.4 The Relationship between Perceived Service Quality and Perceived Value

Marketing studies from the past noticeably showed that perceived service quality and customer perceived value are important factors for any service providers in gaining a competitive advantage in the highly competitive industry (e.g. Ruiz et al., 2008; Shukla, 2010; Vargo & Lusch, 2004). In the context of relationship marketing, the relational aspect suggests that including customers' perceived value in service management is important in order to ensure that the services provided are at par level and fulfilled the customers' requirements (Gilbert, Veloutsou, Goode, & Moutinho, 2004; Roig et al.,

2006). However, not all customers are the same because what creates value seems to be idiosyncratic, varies among customers, and highly personal (Holbrook, 1994; Williams & Soutar, 2009; Woodall, 2003). Based on this fact, it is important for businesses to understand what creates value for their customers (Reichheld, 1996; Sánchez-Fernández & Iniesta-Bonillo, 2007; Vargo et al., 2008).

According to Zeithaml (1988), it was claimed that value was formed from the customers' comparison of the sacrifices made over the benefits obtained. Therefore, value was regarded as a highly personal and subjective concept as it is based on the customers' experiences and perception (Parasuraman Zeithaml, & Berry, 1985). Besides, it was reported that the service quality is the key aspect for the formation of perceived value, as it was known as a form of differentiation (Berry, 1995), source of competitive advantage (Roig et al., 2006), and it is hard to be replicated by the competitors (Parasuraman & Grewal, 2000). In fact, it was argued that if any of the benefits experienced by the customers surpasses the level of their sacrifices in obtaining the services, it would make them feel that the value exists for the service purchase (Gilbert et al., 2004). Moreover, early empirical studies also indicated that service quality is an imperative concept that promotes value for the customers (Cronin, Brady, & Hult, 2000; Parasuraman & Grewal, 2000). As a result, Malik (2012) in his recent study claimed that quality-related elements were anticipated as the most influential aspects for customer value, whereby it was found that a high level of perceived value can be formed with the high level of quality of service among service providers.

In addition to above, a review from past literature in the service setting established that a significant positive direct relationship exist between service quality and perceived value, whereby most of the studies found that customers' perceived value can be enhanced with the improvement of service quality (Bauer, Falk, & Hammerschmidt, 2006; Cronin et al., 2000; Brady, Robertson, & Cronin, 2001; Hu, Chiu, Cheng, & Hsieh, 2010; Ladhari & Morales, 2008; Malik, 2012). Although previous researchers have studied and examined the relationship between service quality and customers' perceived value in various service settings, truly understanding their effects on customer behaviour in healthcare and medical tourism still remain a key issue that requires further investigation. Therefore, it could be postulated that:

H5: Patient's perception of service quality will have a positive direct effect on perceived value.

3.2.5 The Relationship between Perceived Service Quality and Perceived Trust

Service quality has its roots in the business and management field since its inception in the early days (Parasuraman et al., 1988). Marketers realised that in order to support market growth and to retain customers at the same time, they must provide a superior quality of service (Dabholkar et al., 2000; Zeithaml, 2002). Researchers also revealed that superior service quality is able to enhance firms' profitability, established customer trust, enhanced corporate image, reduced marketing and operational costs, leads to positive word of

mouth recommendation, and ultimately; to form customer loyalty (Kang & James, 2004; Yoon & Suh, 2004). However, in order to enjoy the abovementioned privileges and to sustain the long-term relationships with their customers, businesses are required to build trust in their customers (Caceres & Paparoidamis, 2007; Donio', Massari, & Passiante, 2006; Ndubisi, Malhotra, & Wah, 2008; Ribbink, Riel, Liljander, & Streukens, 2004). This is because, when trust is soundly established in the relationship between customers and business organisations, both of the parties will do their best to maintain the relationship. Therefore, this scenario will allow firms to reduce their transactional cost and to improve their competitive advantages (Alrubaiee & Alkaa'ida, 2011; Chiou & Droge, 2006; Doney & Cannon, 1997; Doney, Barry, & Abratt, 2007).

In the perspective of business context, Söllner and Leimeister (2013) specified that customer trust derived from the customers' belief that the business organisations were serious, honest, capable, and kind towards them and their requirements. In other words, it means that when a customer trust a service firm, it reflects that the customer have belief and confidence in the performance, reliability, and quality of service offered by the particular firm. From the perspective of relationship marketing, Yoon (2002) in his study claimed that customer trust are conceptualised based on the customers' interaction with the firm and their experience with the service. It was found that trust are only established when firms react responsibly to all the requirements expected by customers. Moreover, the trust established between customer and service firm is able to reduce the feeling of uncertainties because

customers usually emphasized on the aspect of service quality and will assessed it before they trust the entity (Coulter & Coulter, 2002). Apart from that, it was maintained that service quality should be raised above comfort level, thereby contributing toward establishing trust and reducing the perception of risk among customers (Coulter & Coulter, 2002). Therefore, it can be assumed that good quality and consistent service delivery is able to create trust among customers (Kantsperger & Kunz, 2010).

In addition, customers' difficulty in assessing service outcomes of service delivery can also be the main reasons that resulted in a high level of uncertainty, especially for customers who engaged with professional, highly-technical, and high-credence services (Alrubaiee & Alkaa'ida, 2011). Since the level of customers' uncertainty can imply negative outcomes and result in service failures, customer trust becomes an essential element for a long-lasting relationship (Peppers & Rogers, 2004). Although it was argued by past literature that service quality has a positive direct impact on customer satisfaction, the relationship marketing literature have also documented that service quality also has a direct significant positive relationship with customer trust (Eisingerich & Bell, 2007; Gefen, 2002; Hazra & Srivastava, 2009; Herington & Weaven, 2007; Waheed, Gaur, & Peñaloza, 2012). This is supported in a study by Chiou, Droge, and Hanvanich (2002), whereby the researchers argued that customers will evaluate the implicit and explicit cues of the service provider in order to build trust with them. Therefore, it can be ascertained that customers will only have trust in the service provider if they perceived the service quality favourably (Chiou et al., 2002). Similarly, studies

by Ribbink et al. (2004) and Grönroos et al. (2000), which investigated the nature of the relationship between online service quality and customer trust, also revealed a positive association between these two concepts.

On top of that, Eisingerich and Bell (2007) reported that perceived service quality positively influence customer trust in the high credence service, namely financial industry. Eisingerich and Bell (2007) further claimed that service quality is an imperative contributing factor of customer trust owing to the fact that customers' perception towards the competency of the financial advisors is likely to influence their confidence in the service providers' expertise and reliability. Likewise, in the context of healthcare, a study conducted by Alrubaiee and Alkaa'ida (2011) showed that all the aspects in the healthcare quality were important in elucidating patient trust. Besides, due to the lacking of expertise among patients, as well as the highly intangible and complex nature of medical services, service outcomes are very critical in forming trust among patients based on their experiences with the healthcare service providers (Alrubaiee and Alkaa'ida, 2011).

Although the relationship between patients' perceived service quality and their trust is important in the service setting, the recent empirical research evidence demonstrates that there is still a lacking of concreteness in the high credence industries (e.g. medical services, financial services, teaching services, etc.), thus increases the need for research to address the significance impact of perceived service quality in creating consumer trust (Alrubaiee & Alkaa'ida, 2011; Kantsperger & Kunz, 2010). Further to the above research

deficiencies, to what extent a hospital's service quality that are involved with medical tourism in Malaysia can form trust within medical tourists remained unexplored. Therefore, it can be hypothesised that:

H6: Patient's perception of service quality will have a positive direct effect on perceived trust.

3.2.6 The Relationship between Perceived Service Quality and Patient Satisfaction

In the current competitive business landscape, both service quality and customer satisfaction are two important components for most organisations in the service sector. It was reported that both service quality and the degree of customer satisfaction were classified as a critical differentiating factor for firms with their competitors in almost every service setting (O'Neill & Palmer, 2004). As for the healthcare industry, the expansion and the rising of competition forced the healthcare service providers to constantly seek competitive edge in order to stay relevant to the market. Therefore, most of the healthcare service providers strive to provide superior service quality in an effort to satisfy their patients, and to become the leader within their segment of the industry. Over the years, service organisations considered that service quality and customer satisfaction formed a link of "cause and effect" that built on one another and cannot be separated individually in order to obtain and address the opinion from the customers with regards to their service experiences (Johnson & Gustafsson, 2000; Nimako, 2012). Thus,

professionals in the service setting are continuously searching for alternatives in order to deliver superior quality of service and to ensure that the customers are truly satisfied with the service experienced, which would further drive their loyalty.

Besides, providing a high level of service and ensuring greater satisfaction among customers have become strategic requirements for all the service firms. However, as far as the concepts of perceived service quality and customer satisfaction are concerned, the association between both constructs in the previous studies is still unclear. This is due to the uncertainty derived from the past literature, whereby some researchers used both of the terms interchangeably (e.g. Mano & Oliver 1993; Yi 1990) while others viewed them as independent constructs (e.g. Gotlieb, Grewal, & Brown, 1994; Iacobucci, Ostrom, & Grayson, 1995; Tam, 2004; Kumar et al., 2008; Ladhari, 2009; Tian-Cole, Crompton, & Willson, 2002). Hence, Parasuraman et al. (1988) distinguished perceived quality from satisfaction by claiming that perceived quality is a judgment about an agency's overall excellence and quality, and object quality, which they defined as an attitude derived from a comparison of the performance in relation to expectations. On the other hand, customer satisfaction is referred as a global judgment about a service as a whole.

In addition to above, Crompton and MacKay (1989) claimed that service quality represents the attributes of the service, while satisfaction is a psychological outcome that emerges from the service experience. It was

argued that service attributes can be manipulated and controlled by the firms, but the level of customer satisfaction is not the result solely based on service quality experienced (Crompton & MacKay, 1989). This is because there are other factors (e.g. value, trust, etc.) that also influence customer satisfaction. Thus, it can be abridged that perceived service quality is comparatively a long-term attitude, whereas patient satisfaction is a short-term judgment of a service encounter (Taylor, 1993). With that, the discussion above revealed that perceived service quality and customer satisfaction are two different concepts and should be uniquely operationalised and conceptualised (Taylor, 1993). Taylor and Cronin (1994) further added that distinguishing both of these constructs is vital in healthcare industry as it contributes to the development of both short-term patient satisfaction judgments and long-term health care attitudes.

Moreover, based on the past literature, there are various studies that have investigated the relationship between service quality and customer satisfaction. Overall, all of the studies in the general service context found that customer satisfaction can be achieved with the superior service quality (Birgelen, Ghijsen, & Semeijn, 2005; Collier & Beinstock, 2006; Ladhari, 2009; Landrum, Prybutok, & Zhang, 2007; Voon, 2011; Oyeniyi & Joachim, 2008; Parasuraman et al., 2005; Zhang & Prybutok, 2005). The same outcome is also found in tourism study whereby it claimed that tourists' perceptions of quality of performance strongly influenced the level of their satisfaction (Tian-Cole et al. 2002). In other words, if tourists' perceptions of service quality were high, they tend to have higher levels of satisfaction for the trip.

According to Tian-Cole et al. (2002), the tourists' satisfaction with a particular service experience eventually affects long-term satisfaction with the service provider and creates a lasting effect on tourists' future behaviour. Thus, in order to increase the level of satisfaction, agencies and organisations need to improve the performance of their individual service attributes in order to help customers to recognise the benefits that they receive from the service encountered.

Meanwhile, in the context of healthcare, study conducted by Oswald, Turner, Snipes, and Butler (1997) showed that 472 completed surveys of hospital patients revealed that quality perception to be closely related to their level of satisfaction. Similarly, Boshoff and Gray (2004) also found the same results in their study whereby patient satisfaction is significantly influenced by the level of a hospital's service quality. Taner and Antony (2006) further added that the perception of service quality by patients can influence their level of satisfaction towards the hospital that they visited, which in turn positively influences their revisit intention. Furthermore, the study by Kim et al. (2008) in South Korea found that medical service qualities, such as reliability of services, procedure of care, and the capability of the medical doctor have a positive influence upon patient satisfaction. Meanwhile, the recent study by Lee, Chen, Chen, and Chen (2010) discovered a positive association between medical service quality and patient satisfaction, while Yesilada and Direktör (2010) reported that service quality significantly influences patient satisfaction in both private and public hospitals.

Since patients are usually more concerned about their medical outcome, health condition, medication, and medical staff quality, they would always look for better healthcare service quality and expect the best out of it. So, it can be assumed that patient perception of service quality affects their choice of healthcare provider, and quality is a critical element in patients' choice of hospital and their satisfaction (Marković et al., 2014; Muhammad, Gladys, Noor, Pauline, & Jati, 2015; Rahman & Osmangani, 2015; Rashid & Jusoff, 2009; Rose et al., 2004). However, to what extent the perception of hospital service quality can influence medical tourists' satisfaction, in this case, remained uncertain, therefore, the seventh hypothesis for the study is postulated as follows:

H7: Patient's perceived service quality has a positive effect on patient satisfaction.

3.2.7 The Relationship between Perceived Value and Patient Satisfaction

At the conceptual level, Woodruff (1997) claimed that perceived value refers to the customers cognition based on the relational exchanges that they made with the service providers, while customer satisfaction are the outcome based on the feeling of customers towards the value that they received from the transaction. According to Cronin and Taylor (1992), prior to service consumption, the consumer will initially form specific expectations of value from the service; they are only satisfied if they received "adequate doses" of value from the service experience. Cronin and Taylor added that post-purchase

experiences indicate the value each customer accumulates from the transaction and this will indirectly form the perception of value from the services experiences. When customer perceived value exceeds their expectations, the customer is likely to be satisfied (Anderson & Fornell, 1994; Moliner, 2009). In view of that, it is irrefutable that superior value perceived by customers denotes a significant competitive advantage for the firm in creating customer satisfaction and generating profits (Frank & Enkawa, 2007).

Furthermore, the American Customer Satisfaction Index (ACSI) model was discovered in the study conducted by Fornell, Johnson, Anderson, Cha, and Bryant (1996) demonstrated that customer satisfaction are mostly influenced by the quality aspect, however, the importance of value in creating impact on customer satisfaction remains unquestioned until today (Cronin et al., 1997; Moliner, 2009). Subsequent to the study by Fornell et al. (1996), Cronin and colleague (2000) reinforced the relationship between customers' perceived value and their satisfaction by revealing that perceived value has a significant impact satisfaction. In support of this view, Lam et al. (2004) in their study of business-to-business service context asserted that customer satisfaction is a result of customer perceived value, and it is a fundamental indicator of a firm's performance. Based on the context of the disconfirmation paradigm, it was found that a customer's degree of satisfaction relies on the value expected by a customer in comparison to what he or she actually received from the business transaction (Gounaris, Tzempelikos, & Chatzipanagiotou, 2007). As a result, customer satisfaction is immensely dependent upon the perceived value of customers (Lee, Yoon, & Lee, 2007).

In addition, most of the empirical studies in the context of retailing revealed that perceived value positively affects customer satisfaction (e.g. Cronin et al., 2000; Eggert & Ulaga, 2002; Lee et al., 2007; McDougall & Levesque, 2000; Sanchez et al., 2006; Wang, Lo, & Yang, 2004). For example, it was found that customer satisfaction across various service sectors is generally affected by two significant factors, namely perceived value and perceived service quality (McDougall & Levesque, 2000). A similar result was also established in the research studies in relation to e-commerce and online shopping websites (e.g. Yang & Peterson, 2004; Hsu, 2006). The positive relationship between perceived value and customer satisfaction is also supported in the context of telecommunication industry; for example, the study of the SMS services in Singapore (Tung, 2004), the telecom industry in China (Wang et al., 2004), mobile commerce in Taiwan (Lin & Wang, 2006), mobile services in Canada (Turel & Serenko, 2006), and so on. Additionally, researches in the healthcare context also support the fact that perceived value had a positive effect on patient satisfaction (Caruana & Fenech, 2005; Moliner, 2009).

In view of the evidence above, it can be seen that marketers are continuously being challenged to create value in their product or services offering by reducing costs through productivity, improving the product/service benefits or both (Chen & Chen, 2010; Cengiz & Kirkbir, 2007; Sheth et al., 1999). Although the relationship between customers' perceived value and customer satisfaction had been supported across service industries, limited empirical studies were conducted in relation to the link between both

constructs in the healthcare context (Moliner, 2009). Therefore, there is a necessity to better determine the nature of the relationships between perceived value and patient satisfaction in the eyes of medical tourists. Hence, the eight hypotheses developed for this study is postulated as below:

H8: Perceived value will have a positive direct effect on patient satisfaction.

3.2.8 The Relationship between Perceived Trust and Patient Satisfaction

According to Berry and Parasuraman (2004), customer trust is a prerequisite condition in the service marketing context as customers usually make a decision based on their trust before they express their satisfaction towards the service experience. There are several empirical studies (e.g. Armstrong et al., 2006; Kaveh, 2012; Morgan & Hunt, 1994; Wong & Sohal, 2002) that indicated that a customer's trust will be established when customer has confidence in the integrity and reliability of the service provider based on their service encountered. Since that trust, as perceived by customers, can decrease the perceived risk in the exchange relationships, Armstrong and Kotler (2007) stated that customer satisfaction can be easily achieved when customers perceive a low level of risk in the transaction and the expectations from the customers are fulfilled. In order to support the relationship between customer trust and their satisfaction, Chiou et al. (2002), in their financial services study, found that customer trust positively influences their satisfaction.

In addition, it was found that customers will be satisfied with the service providers if they have trust in them (Kassim & Abdullah, 2008). Conversely, Kassim and Abdullah maintained that if a consumer does not has confidence in the service provider due to the consumer's former service encounter, the customer will most likely be dissatisfied with the vendor, and most probably turn to the competitors. Moreover, it was argued that customer's satisfaction can be enhanced over time if the customer has a feeling of confidence and faith in their experience with the service provider (Chiou & Droge, 2006; Kaveh, 2012; Kim, Ferrin, & Rao, 2009). Chiou et al. (2002) further claimed that customer trust precedes to satisfaction (customer trust → customer satisfaction) for the following reasons. Firstly, if a customer does not trust the service provider in the first place, it is probably due to dissatisfaction towards that service provider. Secondly, referring to the foundation of social exchange theory, it was reported that customers' trust for a purchase of product/ service will have a significant effect on their post-purchase satisfaction (Singh & Sirdeshmukh, 2000). Therefore, it can be ascertained that customer satisfaction is affected by the accumulated perceptions of trust. Thirdly, the findings from prior studies (e.g. Gwinner, Gremler, & Bitner, 1998; Chaudhuri & Holbrook, 2001) showed that in the relationships with the service provider, customers will experience three main kinds of benefits: (1) special-treatment benefits, (2) social benefits, and (3) confidence benefits (which are similar to trust in the present study). Based on the above benefits, it was found that the confidence is the most important aspect of benefits across various categories of services. Thus, Chiou et al.

(2002) suggested that customer's overall satisfaction will be enhanced when customers have confidence (trust) in the transaction with the service provider.

Furthermore, consumers usually may not know what would be the outcome from the services purchase (such as the healthcare services in this study) as there are many underlying credence elements in it, whereby some customers might not be able to differentiate the service performance before and after using it (Alrubaiee & Alkaa'ida, 2011; Trawick & Swan, 1981). Thus, Berry and Parasuraman (1995) asserted that customers' trust is particularly important in the marketing of services due to this matter. In fact, prior studies from various service contexts have also found the same outcome whereby it was claimed that customers' trust is important in determining their level of satisfaction (Chiou et al, 2002; Chiou & Droge, 2006; Kassim & Abdullah, 2008; Kaveh, 2012; Kim et al., 2009). As strong consumer confidence and trust is the paramount for healthcare services, therefore, the researcher expects a positive direct relationship between perceived trust and patient satisfaction is establish in the perspective of medical tourism. Thus, the ninth hypothesis for the study is formulated as such:

H9. Perceived trust will have a positive direct effect on patient satisfaction.

3.2.9 The Relationship between Patient Satisfaction and Behavioural Intention

With the constant changes of expectations and demands from the customers, many service providers today focus on the quality aspect of product or service as an alternative to differentiate themselves from competitors. It was found that most of the service providers complied to provide excellent service, to offer greater value, and to truly satisfy customers in order to become a leader within their segment of the industry (Jeong, Oh, & Gregoire, 2003). Moreover, besides retaining the existing customers, modern organisations are gradually becoming customer-oriented by embracing marketing approaches that aims to attract new customers, understand them, and build long-term relationship with them (Kotler, 2006). Hence, in order to establish and maintain long-term competitiveness and to retain existing customers effectively, Yüksel and Yüksel (2003) stated that the ability to successfully understand customer satisfaction levels and to apply that knowledge in business operations is the essential beginning point.

In addition, customer satisfaction help businesses in their customer retention process, and at the same time, strengthen the relationship between them and the customers (Hansemark & Albinsson, 2004). Udo, Bagchi, and Kirs (2008) argued that customers' behavioural intention is directly affected by the level of satisfaction that the customers experience during the service encounter. In the service setting for example, Zeithaml et al. (1996) found that when consumers are satisfied with the service experienced, they would have a

favourable behaviour intention and remain with the existing service provider, whereas dissatisfied consumers will have unfavourable behaviours and defect. This generally occurs because all their expectations are met, and thus, they are willing to return to same service providers. Moreover, the customers' positive behavioural intention for the service providers comes in various forms, such as saying positive things about the service providers, repeat patronage, and recommending it to their family and friends (Bodet, 2008; Keiningham et al., 2007; Voss, Godfrey, & Seiders, 2010).

The past research studies in the service setting also revealed that there is a direct positive relationship between customer satisfaction and behavioural intention (Cronin et al., 2000; Nimako, 2012; Zeithaml et al., 1996). Similarly, the past studies in the tourism industry also reported that the relationship between satisfaction and behavioural intention exists (Chen & Chen, 2010; Hutchinson, Lai, & Wang, 2009; Pakdil & Harwood, 2005). As for the perspective of medical service, it was found that there is a positive link between patient satisfaction and positive recommendation by patients who received maternity service in Greece (Chaniotakis & Lymperopoulos, 2009). Moreover, in a study by Choi et al. (2004) on a medical service from a hospital in South Korea, claimed that patients' satisfaction is directly related to their behavioural intention. Consistent with the above findings, the relationship between patient satisfaction and behavioural intention was also established in the healthcare context in many recent studies (Abd Manaf et al., 2015; Chaniotakis & Lymperopoulos, 2009; Kim et al., 2008; Shahijan, Rezaei, Preece, & Ismail, 2015; Wu, 2011). Therefore, it has indicated that

there is a direct positive relationship between customers' satisfaction and their behavioural intention in different industries. Referring to these evidence and support, the tenth hypothesis for this study is postulated as follows:

H10: Patient satisfaction will have a positive direct effect on patients' behavioural intentions.

3.2.10 The Mediating Role of Perceived Value and Perceived Trust on the Relationship between Perceived Service Quality and Patient Satisfaction

In the service platform, service quality and customer satisfaction were considered to be important concepts that are the root of marketing theory and practices (Akbar & Parvez, 2009; Spreng & Mackoy, 1996). Therefore, in today's world with intense competition, there is not even an iota of doubt that the key to sustain competitive advantage for many service entities throughout the world lies in delivering high quality services that are able to satisfy the customers (Hawthorne et al., 2014; Sureshchander, Rajendran, & Anatharaman, 2002). Moreover, Parasuraman et al. (1985) reported that, in order to compete effectively in the global platform, service organisations have to emphasise on the paradigm of service quality that reflects the customers' perspective. Based on this paradigm, it was claimed that if a customer thinks that the service experienced met or surpassed his or her expectation, this will lead to his or her satisfaction (Alexandris et al., 2002; Gilbert et al., 2004; Gilbert & Veloutsou, 2006; Krishnamurthy, Sivakumar, & Sellamuthu, 2010).

Based on the findings from previous studies, it can be assumed that the link between service quality and satisfaction is linear, which indicates high levels of service quality will improve the levels of satisfaction among customers (Pollack, 2008). However, the relationship between service quality and customer satisfaction was reported not to be linear or direct for most of the time (Anderson & Mittal, 2000; Ažman & Gomišček, 2015; Finn, 2011; Fullerton & Taylor, 2002). The prior researchers stated their concerns and doubts about the predictability of customer satisfaction, which ignores the importance of perceived value and trust as a predictor of satisfaction. In this case, service quality is not the only antecedent of patient satisfaction, but patient's perceived value and their trust are also important criteria that drive their satisfaction. Therefore, with the support from prior literature, the inclusion of service quality, perceived value, and perceived trust in the research model does not only highlight the importance of value and patient's trust, but also provides better explanation for patient satisfaction, which is important in creating positive behavioural intention among medical tourists. It is also suggested in the recent service research that service quality, trust, and value should be included when measuring customer satisfaction (Deng, Lu, Wei, & Zhang, 2010; Ouyang, 2010).

In addition, a comprehensive review of the literature found that the influence of service quality on customer satisfaction is indirectly influenced by the level of their value perception (Varki & Colgate, 2001; Yunus, Ismail, Juga, & Ishak, 2009). This is because perceived value is the comparison that is made by customers (patients) between the sacrifices they made and the

benefits they get from the services (Sánchez-Fernández & Iniesta-Bonillo, 2006). Moreover, Frank and Enkawa (2007) argued that customer satisfaction can be formed in two different ways: (1) delivering a higher quality of service, and also (2) lowering the price of the same quality delivered (value creation). The importance of value is pertinent to this study as medical tourists would expect that the money spent for the medical treatments in the host country to be worthwhile (Lertwannawit & Gulid, 2011). Therefore, besides service quality, it can be ascertained that medical tourists in this study would consider the significance of value that they received from the service consumption as part of the factor that influenced their satisfaction.

Consistent with the above arguments, a study by Eggert and Ulaga (2002) on 301 employees in US organisations found that the relationship between service quality characteristics (e.g. empathy, assurance responsiveness, reliability, and tangible) and customer satisfaction was indirectly affected by customer perceived value. Similarly, Tam (2004) in a restaurant setting also found that customer's perceived value mediated the relationship between perceived service quality and customers satisfaction. Moreover, a recent study by Malik (2012) showed that perceived value acted as partial mediator for the relationship between perceived service quality and customer satisfaction. With that, the mediation effect of perceived value on the relationship between perceived service quality and patient satisfaction was examined in the current study.

In regards to customer trust, Urban, Sultan, and Qualls (2000) stated that customer trust is an important component in developing strong customer relationships and the continuity of the market. In order to create trust among customers, it was consistently argued that superior service quality plays a significant role in forming customers' trust (Hazra & Srivastava, 2009; Kantsperger & Kunz, 2010). This is generally because service is something that is experienced and consumed by customers, whereby they are the individuals who can trust the service provider or vice-versa. This scenario directly orchestrates that customers' experiences on any service encountered will influence their level of trust in the service provider (Kantsperger & Kunz, 2010). Moreover, it was also found that trust formed from the service experienced will further lead to satisfaction of the customers (Chiou & Droge, 2006; Kim et al., 2009). For example, Kim et al. (2009) argued that customers will feel satisfied with the service experienced if they trust the service provider based on their impression, by feeling safe and secured with the way the services are delivered.

On top of that, the past literature also found that customers trust has a mediating effect on the association between service quality and customers satisfaction. In other words, there is an indirect relationship between service quality and customer satisfaction via customer trust. For example, Chiou et al. (2002) in his study concerning the financial industry (comparison of high and low knowledge groups), found that the service quality has direct and indirect effect on customer satisfaction through customer trust. The study revealed that customer trust partially mediated the relationship between service quality and

customer satisfaction for the high-knowledge customers whereas the customer trusts fully mediated the relationship between both constructs in the group of low-knowledge customers. The above evidence shows that the service quality and trust is extremely important in creating customer satisfaction in the financial service industries. Similarly, the mediating effect of customer trust for the relationship between service quality and customers' satisfaction was also found in the study by Ouyang (2010) in the service industry.

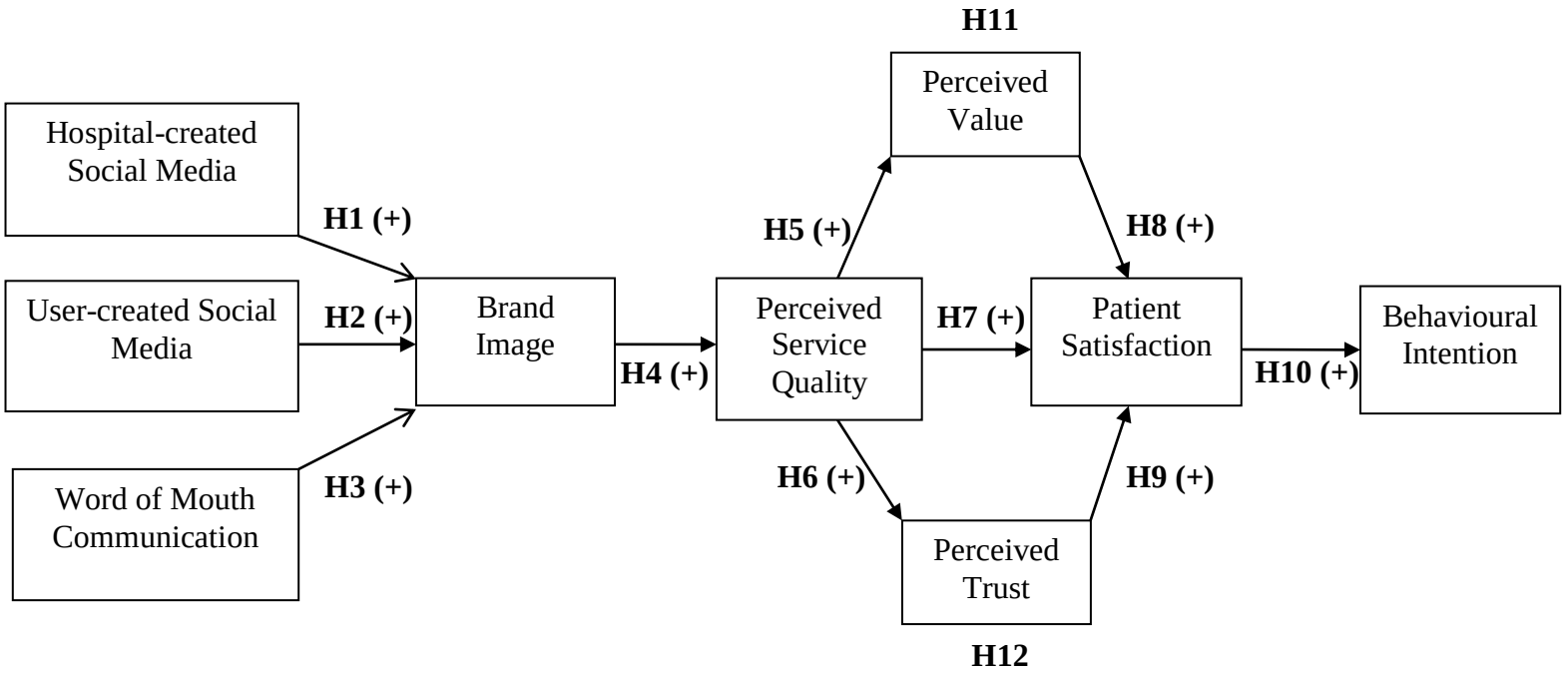
All the discussion above revealed that service quality is not the sole determinant of patient satisfaction, but also a result of indirect effect of customers' perceived value and trust. While some prior studies addressed the interrelationship of service quality, perceived value, and customer satisfaction (e.g. Malik, 2011; Sureshchander et al., 2002; Yunus et al., 2009), there are few empirical evidence that support the mediating role of perceived value in service quality models in the healthcare context. Although trust was considered as an important variable for the high-credence service context, the inclusion of trust in the healthcare context was still relatively scant. This situation is critically important for medical tourism as both trust and value seemed to be important variables in ensuring patient satisfaction, which in turn will create a positive future behavioural intention among the medical tourists. Based on the review of the literature, thus it could be postulated that:

H11: Perceived value mediates the relationship between service quality and patient satisfaction.

H12: Perceived trust mediates the relationship between service quality and patient satisfaction.

3.3 Conceptual Model

The proposed conceptual model can be considered as an integrative approach in examining the relationships of these concepts, specifically the relationships between brand image, service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention in the medical tourism industry in Malaysia. Based on the review of literature and the detailed study of previous researches in the healthcare industry, the proposed conceptual model for the present study is presented in Figure 3.1.



H11: Perceived value mediates the relationship between service quality and patient satisfaction.

H12: Perceived trust mediates the relationship between service quality and patient satisfaction.

Figure 3.1: The Conceptual Model and Hypotheses

3.4 Summary of Hypotheses

This section present the hypotheses developed from the review of literature for the present study. The hypotheses are such as follows:

H1: Hospital-created social media will have a positive direct effect on brand image.

H2: User-generated social media will have a positive direct effect on brand image.

H3: Word of mouth communication will have a positive direct effect on brand image.

H4: Brand image will have a positive direct effect on patients' perceived service quality.

H5: Patient's perception of service quality will have a positive direct effect on perceived value.

H6: Patient's perception of service quality will have a positive direct effect on perceived trust.

H7: Patient's perceived service quality will have a positive effect on patient satisfaction.

H8: Perceived value will have a positive direct effect on patient satisfaction.

H9: Perceived trust will have a positive direct effect on patient satisfaction.

H10: Patient satisfaction will have a positive direct effect on patients' behavioural intentions.

H11: Perceived value mediates the relationship between service quality and patient satisfaction.

H12: Perceived trust mediates the relationship between service quality and patient satisfaction.

3.5 Chapter Summary

This chapter discussed the factors that influence hospital brand image and their effects on the perception of the hospital service quality in the Malaysian medical tourism industry. Moreover, the interrelationships between service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention, as proposed in the research model were also discussed. Following the model development, the hypotheses for this study were also developed in this chapter. It is expected that testing these hypotheses can provide the answers to the research objectives, and most importantly, to fill the gaps identified in the existing literature. With that, the research method for this study is discussed in the following chapter.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

The purpose of this chapter is to address the research methodology used for this study. This chapter also encompasses an explanation of the research design, operationalisation of variables, data collection method, the development of the survey questionnaire, the sampling strategy, and procedures for data analyses. Moreover, the ethical considerations for this study are also presented in this chapter.

4.2 Research Design

In conducting any research study, a researcher needs to have a justifiable and reliable research design in order to address or answer the research problems and at the same time refine the robustness of the study (Saunders, Lewis, & Thornhill, 2012). Moreover, Saunders and colleagues in their study (i.e. layers of research onion) claimed that a researcher needs to addressed several aspects in designing a research, such as research paradigm, methodical choice, research strategy(ies), time horizon, and research techniques and procedures. It was further argued that all these aspects are essential to the development of a coherent and appropiate research design that

can have implications on the reliability and validity of the research and its outcomes (Saunders et al., 2012). In view of that, all of the abovementioned aspects for the present study were discussed as follows:

According to Neuman (2006), scientific research studies are governed by the paradigm chosen by the researcher. Taylor, Kermode, and Roberts (2007) defined paradigm as "a broad view or perspective of something" (p. 5). From the aspect of research, a paradigm can be described as a holistic approach underlying a research methodology (Creswell, 2002). In general, there are three research paradigms that can be identified in social research, namely: (1) positivist; (2) constructivist; and (3) critical. According to Peñaloza and Venkatesh (2006), the positivist paradigm can be explained as the scientific approach (e.g. with the use of statistic, formulas, etc.) to generate empirical evidence or to test the hypothesised relationships among the constructs in the study. This scientific approach posit that there are phenomena and things "out there" in the real world that exist independently and the researcher's job is to measure them in the natural order as objectively and as humanly possible. Perry, Riege, and Brown (1999) explained that the constructivist paradigm in research is grounded on social reality reflecting on how individuals attribute meaning to the phenomena they experienced. In other words, unlike the positivist approach, things "out there" in the real world only exist insofar as the researcher is able to construct some kind of meaning about what it is. It can also be explained as the phenomena and things are nothing in and of themselves and only become something when assigned meaning by people when they perceive its existence. As for critical theory, this

paradigm has some similarities to constructivism but examines and focuses extensively on social realities experienced by the members of the society and how people use power and authority to construct dominant meanings of things (Alvesson, 1994). Considering that the main intention of this study is to develop a structural model and to test hypotheses using statistical tools (e.g. Statistical Package for the Social Sciences [SPSS] and Analysis of Moment Structures [AMOS]), this study is categorised under the positivist paradigm.

In the context of methodical choice, the researcher has adopted a quantitative method in this study after considering the research purpose, objectives, hypotheses, and model that were developed in the earlier chapter. According to Zikmund and Babin (2007), quantitative research is a method used by researchers to explain the phenomena of research with the use of statistics. Moreover, it was reported that quantitative methods allow researchers to determine the strengths of the relationships between variables in a particular research with statistical evidence (Sekaran, 2005). Although some prior studies claimed that a qualitative method provides more in-depth explanations and results compared to a quantitative approach, quantitative methods can be used in testing hypotheses that are developed for a specific study and to determine the validity and the reliability of the measured variable (Sekaran, 2005). Additionally, it was found that the quantitative research approach is effectively adopted in service marketing studies, particularly in the healthcare and medical tourism setting (e.g. Cham et al., 2015; Choi et al., 2005; Lertwannawit & Gulid, 2011).

Among the options available in the quantitative approach (e.g. surveys, experiments, mechanical observation, stimulation, etc.), a survey-based research approach was used for this study. The main reason is because this approach is versatile, cost-effective, generalisable and reliable (Blackstone, 2012). Moreover, a survey-based research method collects a large amount of data from respondents at one time, is flexible, and is able to provide information about respondents' attitudes and beliefs (Zikmund & Babin, 2007). Based on the discussion above, survey-based research is considered the most appropriate method to collect data for this study because there are very limited published researches on medical tourism in Malaysia and this method allows the researcher to establish a broader picture of how medical tourism is practiced in the Malaysia context.

In addition, this study required a large sample size and the formulated hypotheses were tested in this study. As such, this research employed a cross sectional self-administered questionnaire, a specifically designed survey to be completed by respondents personally without any intervention by others (Lavrakas, 2008). Using a self-administered questionnaire was deemed to be suitable for this research because this method is an economical and efficient way of collecting primary data across hospitals (those involved in medical tourism) in Malaysia within a short period of time. Moreover, self-administered questionnaire was reported in having the capability in facilitating the data collection process by assisting researcher in distributing questionnaires to numerous respondents in different places at the same time. However, Seale (2012) claimed that this method has drawbacks too, such as

being influenced by respondents being illiterate, risk of respondent error in completing the questionnaire, lack of understanding of the questions (misunderstanding), and lack of control by the researcher. All of these issues may somehow affect the validity of the questionnaire and the reporting aspect of the research. In view of that, it is recommended that a researcher needs to use the tested and reliable scales for their research in order to overcome this matter (Hair, Black, Babin, Anderson, & Tatham, 2010).

4.3 Measurements of Variables in Study

Operationalisation is an important aspect for any measurement model; it defines the measurement items for the specific construct and determines how it is to be measured (Hair et al., 2010). Hair and colleagues maintained that a researcher needs to develop his or her own construct measurement if the support from prior research on the topic is inadequate. Therefore, it was recommended that prior and existing literature can be used to operationalise a particular construct if the literature provided sufficient support and discussion. Moreover, the adoption of existing variables from prior literature was recommended for the researcher because it can further enhance the reliability and validity aspects of the constructs measurements (Hair et al., 2010). Therefore, for the purpose of this research, two steps were taken by the researcher in order to obtain a reliable measurement scale items that will be employed in this study.

First, the researcher conducted an extensive review of literature from the platform of tourism, service marketing, hospitality, and healthcare to identify the initial measurements for the related constructs. In this stage, the researcher attempted to review the literature of the constructs that were included in this study (e.g. social media, word of mouth communication, brand image, perceived service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention) that were available in the healthcare and service industry. Second, after the literature review, the researcher adapted measurement constructs that were closely related to the nature and objective of the study. Moreover, all the constructs adapted in this research were also thoroughly defined and discussed in the earlier chapter. The following sections discuss the operationalisation of the constructs in this study.

4.3.1 Social Media Communication

Although social media communication has been established for quite some time now, its scale is rarely addressed and developed in the research platform (Akar & Topçu, 2011). To the best knowledge of the researcher and as far as the literature are concerned, most of the studies that addressed social media only reported on the conceptual basis and a limited number of studies developed a measurement scale exclusively for social media. In the business context for example, Akar and Topçu (2011) developed a scale for social media based on the users' perspective on social media in general, whereas Leung and Bai (2013) measured social media in terms of motivation, ability, and opportunity provided by social media. However, all the measurement

scales were deemed to be inappropriate and not suitable for the nature of this study because most of them did not address customers' perception and their experience in relation to product/service brand. In view of this drawback, the measurement scale for the social media communication in this study was adapted from Bruhn et al. (2012).

According to Bruhn et al. (2012), social media communication in the business sector has an unswerving impact on the marketplace through two forms: (1) from the media that was developed by the firm itself (firm-created social media) and (2) from the consumer groups alone (user-generated social media). Based on this scale, there were three items each for both firm-created social media and user-generated social media (Tables 4.1 and 4.2). Moreover, both the constructs fulfilled the minimum requirements for reliability and confirmatory factor analysis test. As this study was designed based on the medical tourism context, all the items were paraphrased and refined in both contextual applications and wording as appropriate to suit this research purposes. Hence, the constructs for both hospital-created (firm-created) social media and user-generated social media for this study were measured using three items, as depicted in Tables 4.1 and 4.2.

Table 4.1: Hospital-created Social Media Scale Items

No.	Original Scale Items from Bruhn et al. (2012)	Modified Scale Items Used in this Study
1	The level of this company's social media communications for [brand] meets my expectations.	The level of this hospital's social media communications for its brand meets my expectations.
2	Compared with the very good social media communications of other companies, this company's social media communication for [brand] performs well.	Compared with the very good social media communications of other competing hospitals, this hospital's social media communication for its brand performs well.
3	I am satisfied with the company's social media for [brand].	I am satisfied with this hospital's social media communications for its brand.

Table 4.2: User-generated Social Media Scale Items

No.	Original Scale Items from Bruhn et al. (2012)	Modified Scale Items Used in this Study
1	The level of the social media communications expressed by other users about [brand] meets my expectations.	The level of the social media communications feedback expressed by other users about this hospital's brand meets my expectations.
2	Compared with the very good social media communications of other users about other brands, the social media communications of users about [brand] performs well.	Compared with the very good social media communications of other users' feedback about other competing hospital brands, the social media communications of users' feedback about this hospital's brand performs well.
3	I am satisfied with the social media communications expressed by other users about [brand].	I am satisfied with the social media communications feedback expressed by other users about this hospital's brand.

4.3.2 Word of Mouth Communication

According to Goyette, Ricard, Bergeron, and Marticotte (2010), studies that are dedicated to Word of Mouth (WOM) measurement were scarce. Although the literature shows that studies on WOM has existed for many years, researchers, managers, and all parties from diverse industries are still interested in WOM because it is considered as an important driver of consumer behaviour. Moreover, the trend of research revealed that only limited studies focused explicitly on measuring it (Goyette et al., 2010; Godes & Mayzlin, 2004). Based upon the review of literature, it was revealed that studies conducted by Godes and Mayzlin (2004) and Harrison-Walker (2001) emphasised particularly on the development of WOM measurement. However, as for other studies, the measurement for WOM was reportedly follows the feeling of the need from the fellow researcher to include it as a dependent variable in their studies. Moreover, past studies reported that most of the WOM measurement scales from published researches were mostly unidimensional in nature (Bansal & Voyer, 2000; Godes & Mayzlin, 2004; Ranaweera & Prabhu, 2003; Goyette et al., 2010).

Besides, there are various types of measurement scales that were developed by researchers over the years. For example, a study by Kim, Han, and Lee (2001) in the hotel industry measured WOM based on the willingness to recommend the hotel they stayed in to their peers, whereas Ranaweera and Prabhu (2003) proposed a two-item measurement scale for WOM based on the recommendation of the service and involuntary recommendation in their

study. Similarly, Hennig-Thurau, Gwinner, and Gremler (2002) measured WOM in the service context based on personal recommendation. Among all the measurement scales available, the researcher adapted the WOM measurement scale developed by O'Cass and Grace (2004). This measurement scale was developed based on a prior study (e.g. Bansal & Voyer, 2000) and was verified using the factor analyses (e.g. exploratory factor analysis and confirmatory factor analysis). Overall, all the items in the variable were proven to be reliable indicators of WOM because they had good support in terms of validity and reliability tests (O'Cass & Grace, 2004). In addition, the WOM scale developed by O'Cass and Grace (2004) was also reported to be suitable for the pre-purchase scenario, which was appropriate for this study. Accordingly, the construct of WOM in this study was measured using five items as shown in Table 4.3.

Table 4.3: Word of Mouth Communication Scale Items

No.	Scale Items
1	My family/friends positively influenced my attitude towards this hospital's brand.
2	My family/friends mentioned positive things I had not considered about this hospital's brand.
3	My family/friends provided me with positive ideas about this hospital's brand.
4	My family/friends positively influenced my evaluation of this hospital's brand.
5	My family/friends helped me to make the decision in selecting this hospital's brand.

Note. The measurement scales were adapted from O'Cass and Grace (2004)

4.3.3 Brand Image

According to Faircloth, Capella, and Alford (2001), brand image was conceptualised and operationalised differently since its inception. Consistent with the notion mentioned, Martínez and de Chernatony (2004) also asserted that there was no global consensus for the measurement of brand image in a research setting due to the difference of subject examined. Additionally, the concepts of brand image were mostly addressed in the product context and therefore; the measurements were not applicable to certain brand groups, particularly in the service setting mainly because the nature of service was different from the physical product (Park & Srinivasan, 1994). Due to the different characteristics between product and services, empirical studies (e.g. Christensen & Askegaard, 2001; Suhartanto, 2011) suggested that the selection of measurement for brand image should be determined by the context of study and its research problems. Based on the existing literature, brand image is commonly operationalised based on the brand image scale developed by Malhotra (1981), attributes of product (e.g. Kandampully & Suhartanto, 2000; Koo, 2003), or based on brand benefits and values (e.g. Hsieh, Pan, & Setiono, 2004; Bhat & Reddy, 1998).

Furthermore, Aaker (1996) claimed that brand image is a multidimensional construct and can be measured with three dimensions that include brand characteristics (the association between customer perception and brand characteristics), brand associations (the associations of tangible and intangible features of product/services that customers show towards the

brand), and brand value (the basic condition and functional benefits expected from the brand). Moreover, Park, Jaworski, and Maclnnis (1986) in their study in a service setting proposed that brand image can be measured based on experiential, symbolic, and functional aspects. Park et al. (1986) further emphasised that the inclusion of these three dimensions would be considered sufficient in order to address the concept of brand image in any study. Following this notion, Porter and Claycomb (1997) measured brand image in the retail industry with two aspects, such as the (1) symbolic dimension and (2) functional dimension.

Upon examining the existing literature and research objective for this study, the researcher adapted the brand image measurement scale that was developed by Hsieh and Li (2008), which was based on the service context (in Table 4.4). Hsieh and Li's brand image scales were developed based on several studies, such as Bhat and Reddy (1998), Low and Lamb (2000), and Park et al. (1986). This measurement scale is also reported to fulfill all the requirements for confirmatory factor analysis, validity, and reliability that confirmed the scale to be valid and this measurement scale is comprised of experiential benefits, functional benefits, and symbolic benefits. As for this scale, the experiential aspect was referred to the service experiences. The functional aspect was related to the benefits possessed based on the service attributes. As for the symbolic benefits, this aspect was related to the personal expression, self-esteem, expectation, and the needs from the customers towards the attributes of the service. All the three items were paraphrased and refined in both contextual applications and wording to suit the purposes of this

research. Table 4.4 presents the comparison between the original versions of brand image measurement scale and the modified scale that the researcher used in this study.

Table 4.4: Brand Image Scale Items

No.	Original Scale Items from Hsieh and Li (2008)	Modified Scale Items Used in this Study
1	I feel that A company branding product possesses its practical function.	This hospital's brand possesses complete practical functions (medical services and adequate medical facilities).
2	I feel that A company branding product possesses a positive symbolic meaning.	This hospital's brand possesses a positive symbolic meaning (good reputation, credibility and positive image).
3	I feel that A company branding product can relate to the pleasant experience.	I feel that this hospital's brand can provides me with pleasant service experience.

4.3.4 Perceived Service Quality

Although the concept of service quality was practiced and operationalised across the service industry, service quality for the healthcare context is difficult to gauge. This is due to the nature of healthcare services, such as high degree of intangibility, requirement for professionals to deliver the services, and high abstractness. Moreover, Taner and Antony (2006) claimed that the complexity in measuring service quality also result from the fact that patients who consumed healthcare services are more concerned about the outcome of the services (e.g. medical treatments and its procedures) compared to the customers from other industries. Moreover, Gunawardane

(2011) argued based on the past literature that the diverse range of dimensions in healthcare resulted in the difficultly to access and measure healthcare services. For example, an examination of the dimensions of service quality in Table 4.5 indicates the presence of almost all the classifications of dimensions of service quality discussed above. Among all the dimensions of service quality that are available in literature, the five SERVQUAL dimensions (e.g. Assurance, Reliability, Tangibles, Responsiveness, and Empathy) seemed to be the most regularly used and widely cited in healthcare studies. Following the pioneer work on service quality by Parasuraman and his colleagues (1985), the SERVQUAL model was widely adopted by many researchers in order to address healthcare service quality (e.g. Babakus & Mangold, 1992; Kim & Bang, 2015; Lam, 1997, etc.).

Moreover, SERVQUAL is claimed to be useful for the purpose of service improvement and managing the effectiveness of service management for the service firms (Parasuraman et al., 1988). This is because SERVQUAL is able to highlight the importance of all the dimensions (four dimensions focus on the human aspects in service delivery and one of the dimension focuses on the tangibles aspect) in the service industry. Similarly, Shahin (2006) consistently argued that SERVQUAL was considered as the most powerful measurements scale for service quality due to following reasons: (1) SERVQUAL allows service firms to identify the customers' perception on their service quality, (2) firms can establish standards for their service delivery process, and (3) firms can identify the area of quality that needed attention/ improvement. In view on the dependability of SERVQUAL, the

conceptualisation and operationalisation of SERVQUAL has been adopted in many research in service marketing (e.g. Alexandris et al., 2002; Cham & Easvaralingam, 2012; Hasan, Ilias, Rahman, & Razak, 2009; Lau et. al., 2005; Presbury et. al., 2005).

Due to the results and the dependability of the model, the SERVQUAL model was widely adopted in various healthcare studies throughout the world. For example, SERVQUAL was adopted in Malaysia (Cham et al., 2015; Sohail, 2003), Egypt (Mostafa, 2005), Cyprus (Yesilada & Direktör, 2010), Hong Kong (Lam, 1997), Spain (González-Valentín, Padín-López, & de Ramón-Garrido, 2005; Fuentes, 1999), Singapore (Pawitra & Tan, 2003), USA (Babakus & Mangold, 1992), and UEA (Jabnoun & Chaker, 2003), to name a few. Moreover, the appropriateness of SERVQUAL dimensions in addressing service quality in the healthcare industry was strongly supported in prior literature (e.g. Babakus & Mangold, 1992; Lam, 1997; Taylor & Cronin, 1994). Additionally, prior studies also found that SERVQUAL was broadly adopted in both public and private hospitals in the United Kingdom (Youssef, 1996; Curry & Sinclair, 2002). Therefore, as this study was designed based on medical tourism, which is also part of the healthcare context, SERVQUAL model was employed to measure the medical tourists' perception on service quality of the hospitals that were involved with medical tourism.

Table 4.5: Dimensions of Healthcare Service Quality

Authors	Dimensions
Alden and Bhawuk (2004)	Tangibles, Access to services, Staff expertise, Personal care
Babakus and Mangold (1992); Chowdhury (2008); Headley and Miller (1992); Lam (1997); Licata, Mowen, and Chakraborty (1995); Lytle and Mokwa (1992); Quader (2009); Wisniewski and Wisniewski (2005)	Assurance, Reliability, Tangibles, Responsiveness, and Empathy (SERVQUAL dimensions)
Brown and Swartz (1989)	Professionalism, Skill of health professionals
Dean (1999)	Assurance, Tangibles, Empathy, Reliability/ Responsiveness
Gabbott and Hogg (1995)	Empathy, Credibility of physician, Range of services, Physical access, Situational factors, Responsiveness
Jun, Peterson, and Zsidisin (1998)	Tangibles, Courtesy, Reliability, Communication, Competence, Understanding, Access, Responsiveness, Caring, Clinical outcomes, Collaboration
Lee, Lee, and Yoo (2000)	Assurance, Empathy, Reliability, Responsiveness, Tangibles, Core medical service, Professionalism/skill
McCarthy, Oldham, and Sephton, (2005)	Clear diagnosis, Effective treatment, Information, Communication, Assurance, Access, Post care advice
U.S. Department of Health and Human Services (2009)	Access, Waiting times, Communication, Information, Courtesy and respect
Walbridge and Delene (1993)	Reliability, Professionalism/Skill, Empathy, Assurance, Core medical services, Responsiveness, Tangibles

Since SERVQUAL was well supported and established in past healthcare studies, hospital service quality measurement scales for this study were adopted from Lam (1997), which was designed for the hospital perspective. Moreover, the scale used by Lam (1997) was based on a hospital

in Hong Kong (which is among the Asian countries), thus making this measure appropriate for the nature of this study. Table 4.6 presents the measurement scale of perceived service quality employed in this study.

Table 4.6: Perceived Service Quality Scale Items

Factors	Scale Items
Tangible	This hospital has up-to-date equipment. The physical facilities of this hospital are visually appealing. The staffs of this hospital appearance are neat. The materials associated with this hospital are visually appealing.
Reliability	The staffs of this hospital perform the medical service right on the first time. The staffs of this hospital provided dependable services as promised. The staffs of this hospital are sincere to solve my problems. The staffs of this hospital provide services at the appointed time. This hospital keeps accurate medical records.
Responsiveness	The staffs of this hospital tell me when the services will be performed. I received prompt service from the staffs of this hospital. The staffs of this hospital are always willing to help me. The staffs of this hospital are never too busy to respond my requests.
Assurance	The staffs of this hospital have the knowledge to answer my questions. The staffs of this hospital are consistently courteous to me. The staffs of this hospital are trustworthy. I feel safe in receiving services from the staffs of this hospital.
Empathy	This hospital has convenient operating hours for my needs. The staffs of this hospital give individual attention to me. The staffs of this hospital give me personal attention. This hospital has my best interests at heart. The staffs of this hospital understand my specific needs.

Note. The measurement scales were adopted from Lam (1997)

4.3.5 Perceived Value

According to Smith and Colgate (2007), since its introduction in the early 1980's, there has been no generally accepted framework in measuring customer perceived value. However, there were a series of efforts by scholars to construct a model that was able to measure perceived value in the service setting. It was reported that the most common measurement models that were used to assess perceived value are known as (1) multidimensional models and (2) unidimensional models. The key differences between both of these models are based on its dimensionality and complexity. The multidimensional model, was derived based on the value framework by Holbrook (1996) and value was formed from various elements. For example, the PERVAL scale developed by Sweeney and Soutar (2001) measures values based on four dimensions: (1) value for money, (2) social perceptions, (3) emotional perceptions, and (4) performance/quality perceptions. Subsequent to PERVAL, Petrick (2002) developed a 25 items instrument that was distributed over five dimensions (e.g. behavioural price, reputation, monetary price, emotional response, and quality) to measure perceived value.

On the other hand, the second approach views perceived value as a unidimensional construct. This approach was based on a value framework developed by Zeithaml (1988). According to past studies, the most common approach for the unidimensional approach was based on the notion that value is created based on the difference between quality experienced from a product/ services purchased with the sacrifices made (e.g. price, effort, time, etc.) for

the purchased (Cronin et al., 2000; DeSarbo, Jedidi, & Sinha, 2001; Lin, Sher, & Shih, 2005; Malik, 2012; Nasution & Mavondo, 2008). Moreover, the unidimensional approach for customer value also has been widely adopted in the service setting over the past decades (Baker et al., 2002; Sanchéz-Fernandéz & Iniesta-Bonillo, 2007).

Overall, based on the past literature, measurement development in customer perceived value was fragmented and sporadic among unidimensional and multidimensional models. Although both measurement approaches were widely used, Sánchez-Fernández and Iniesta-Bonillo (2007) mentioned that the multidimensional approach proponents claimed that the unidimensional approach disregards the effect of several factors (e.g. emotional and hedonistic). On the other hand, the unidimensional approach proponents asserted that the multidimensional model provided lesser variance when the dimensions were measured en masse. Therefore, Sánchez and Iniesta concluded that there is no universal agreement in studies of perceived value because both methods were suggested to be equally good and widely practiced in various industries.

In addition, Lin et al. (2005) claimed that the unidimensional approach is more superior and is able to encounter limitations possessed by multidimensional approach. For instance, they claimed that the concept of value should not only consider value alone, but also to include the components of give and get. Referring to the definition of trade-off, give and get are in fact derived from the concept of value and thus it should be included in measuring

perceived value. In other words, this directly means that multidimensional approach for customer perceived value fails because it does not reflect the meaning of "give versus get" that were supposed to be the foundation of value (Lin et al, 2005). Moreover, Lin et al. (2005) further added that the unidimensional approach was recommended to be utilised by researchers when the nature of the study was to further understand the effects of perceived value on other variables, namely loyalty and satisfaction. These arguments suggest that a unidimensional approach was considered appropriate for this study due to the objectives and the nature of this study. Additionally, the unidimensional approach was supported by the recent studies in healthcare context (e.g. Hu Chiu, Cheng, & Hsieh, 2010; Kim et al, 2008) and medical tourism specifically (e.g. Lertwannawit & Gulid, 2011; Mechinda et al., 2010).

Based on the above discussion and the nature of this research, this research used the four items (Table 4.7) adopted from a study based on the medical tourism context in Thailand by Lertwannawit and Gulid (2011) to measure perceived value. In order to support the reliability of the items in the construct, Lertwannawit and Gulid (2011) developed the construct of perceived value based on the prior literature and was tested with validity and reliability tests, whereby the results showed that the constructs possessed good consistency and validity. The measurement of the value construct is based on four items that explained the value derived from the medical service experienced in exchange with effort, money, and time (Lertwannawit & Gulid, 2011). The items for the construct of perceived value in the present study are presented in Table 4.7.

Table 4.7: Perceived Value Scale Items

No.	Scale Items
1	The effort involved to decide on this medical service is worthwhile.
2	The time I spent flying from my country to this country to receive medical service is worthwhile.
3	The services provided by this hospital are good for what I have to pay.
4	The money I spent for this medical service is well worth it.

Note. The measurement scales were adopted from Lertwannawit and Gulid (2011)

4.3.6 Perceived Trust

According to the past literature, there are three main components associated with trust in a business context: (1) customers' perception of benevolence, (2) business competency, and (3) customer's assessment of the business's orientation towards problem solving. As for the perspective of benevolence, this component can be explained as a business inclination to curb self-serving opportunism, undertake fiduciary responsibility, and have a pro-consumer motivation (Ganesan & Hess, 1997; Morgan & Hunt, 1994). As for the context of business competency, this component can be explained as the degree to which a business possesses a capability and responsibly to serve the stakeholders and their day-to-day operation (Smith & Barclay, 1997). Finally, the third component concerns the customer's assessment of the business's orientation towards problem solving. This indicates the capability of the business to handle problems that take place during and after the business transaction (Sirdeshmukh et al., 2002). In consistent with the above notion, there are studies that conceptualised trust based on three dimensions (trustee's integrity, trustee's ability, and trustee's benevolence) to operationalise trust

(e.g. Aydin & Özer, 2005; Lin & Ding, 2005; Mayer et al., 1995, Tian et al., 2008).

Although customer trust is often regarded as a multidimensional concept, there are numerous studies that asserted there are only two key dimensions of trust: benevolence and credibility that are considered sufficient in operationalising customer trust (Doney & Cannon, 1997; Ganesan & Hess, 1997; Prigent-Simonin & Hérault-Fournier, 2005; Jambulingam, Kathuria, & Nevin, 2009; Prasarnphanich, 2007). In the perspective of service management, Ganesan (1994) however found that the abovementioned dimensions are indeed inseparable and closely correlated in practice. For this reason, therefore, the author considered trust scale should exhibit unidimensional form and include items that covered both "credibility" and "benevolence". Nevertheless, as far as the trust's literature is concerned, there is no any universal measurement scale developed to address patient trust in the healthcare context (Alrubaiee & Alkaa'ida, 2011).

In view of the limited measurement scale for trust that were developed in the healthcare industry, Platonova, Kennedy, and Shewchuk (2008) proposed that patient trust can be measured based on a patient's attitude towards medical service providers and physicians. Alrubaiee and Alkaa'ida (2011) proposed a set of unidimensional measurement scale for patient trust based on the consideration of their experience with hospitals during hospitalisation. Subsequently, Chang et al. (2013) measured patient trust based on their perceptions of the confidence in the integrity and the reliability of

medical service in the service encountered. Due to the nature of this study, perceived trust in this study was based on the study by Chang et al. (2013) because this measure was designed based on the perspective of relationship quality, which was pertinent to the course of medical tourism. Moreover, the study by Chang et al. (2013) confirmed and supported the existence of this construct based on the support from the confirmatory factor analysis and reliability test. Hence, the construct of perceived trust of the medical tourists in this study was measured using five items as shown in Table 4.8.

Table 4.8: Perceived Trust Scale Items

No.	Scale Items
1	The staffs of this hospital will honestly inform me about the result of diagnosis.
2	The staffs of this hospital will honor the agreement made with me.
3	My medical issues are well handled by the staffs of this hospital.
4	I can trust this hospital staffs' judgment based on my sickness.
5	I can rely on the staffs of this hospital to solve my medical issues.

Note. The measurement scales were adopted from Chang et al. (2013)

4.3.7 Patient Satisfaction

Due to the importance of customer satisfaction, many scholars consistently developed measurement approaches to address customer satisfaction. For that reason, theories like equity theory, expectation-disconfirmation theory, and comparison-level theory were developed (Skogland & Siguaw, 2004; Yi, 1990). Among all the theories available, the most well-known measurement used to measure customer satisfaction is the expectancy-disconfirmation theory. Moreover, Ekinci et al. (2008) further

explained that expectancy-disconfirmation theory was argued to be the most prominent and widely cited approach for operationalisation of customer satisfaction. According to the expectancy-disconfirmation theory, this approach compares the expectations with the actual performance from the product or services purchased. It was reported that performance is regarded as the customer's actual perception of goods/services whereas expectations usually referred to perception derived before the purchased of goods or services (Holbrook, 1994; Sinha & DeSarbo, 1998). Moreover, this theory has stated that disconfirmation is formed when there is a discrepancy between actual performance and prior expectation of goods and services (Wirtz & Lee, 2003).

In addition, Linder-Pelz (1982) in her healthcare study suggested five social-psychological determinants of patient satisfaction with the healthcare service experienced. These were value (based on the patients' evaluation on the healthcare services experienced), expectations (the patients' beliefs about medical services is associated with the perceived outcome), interpersonal comparisons (a comparison by the individual patient with all his/her prior healthcare services encounters), entitlement (the belief by individual that he/ she will achieved a particular outcome) and occurrences (perception of individual for what happened) with the objective to explain patient satisfaction. Meanwhile, Carson, Carson, and Roe (1998) identified that there are three aspects of quality that determines the satisfaction of patients: 1) Qualifications of the providers, 2) Process (whether appropriate therapeutic procedures were used in providing treatment), and 3) Outcomes (if the

interventions were effective). However, patients may only access the quality of healthcare service based on their impression on service provided in the context of professionalism, level of caring, and competence displayed by staff, which in turn affects their level of satisfaction (Carson et al., 1998). In other words, patients' evaluations of the medical received from physicians, nurses and other relevant sources represent a patient's satisfaction level (Singh, 1990).

Thi, Briancon, Empereur, and Guillemin (2002) proposed several factors that were related to patient satisfaction with surgical and medical care from private hospital in France. As for the study, seven dimensions were identified under the context of patient satisfaction, namely (1) medical care, (2) nursing and daily care, (3) information, admission, (4) ancillary staff and hospital environment, (5) overall quality of services and care, and (6) intentions or recommendations. Although there are several measurement scales available for patient satisfaction as shown above, all the items for the scales overlap and are quite similar to service quality. In view of this drawback, Panjakakornsak (2008) proposed a four-item measurement scale for patient satisfaction in terms of patients' affective response toward the overall service experience. Panjakakornsak (2008) argued that affective response is sufficient to evaluate the level of satisfaction among patients and to distinguish it from the service quality scale. Moreover, the scale developed by Panjakakornsak (2008) is more relevant to the nature of this study, especially when the first-time medical tourists were unable to draw service expectations for the hospital that they were about to visit for medical treatment. Apart from

that, the construct reported by Panjakakornsak (2008) fulfilled the requirements for both validity and reliability tests. Thus, based on above support, the construct of patient satisfaction in this study was measured using four items, as shown in Table 4.9.

Table 4.9: Patient Satisfaction Scale Items

No.	Scale Items
1	My choice to come to this hospital is a wise decision.
2	I am satisfied with my decision to use the service at this hospital.
3	I am not disappointed to use this hospital's service.
4	My experience at this hospital is satisfactory.

Note. The measurement scales were adopted from Panjakakornsak (2008)

4.3.8 Behavioural Intention

Behavioural intention was operationalised as an indication whether customers would defect from or remain with the company they dealt with. Zeithaml et al. (1996) viewed behavioural intention in terms of consumer bonding with organisations. It is argued that customers who have positive behavioural intention with a company usually praise the firm, expressing preference for the firm over others, continuing to purchase from it, may increase the volume of purchases, and agree to pay a premium price. With that, Zeithaml et al. (1996) designed a 13-item scale to measure behavioural intentions. These 13-item were then being categorised into five dimensions: (1) tendency to switch (switch), (2) external response to a problem (external response), (3) loyalty to firm (loyalty), (4) internal response to problem (internal response), and (5) willingness to pay more. In response to the work

by Zeithaml et al. (1996), there are scholars who argued that behavioural intention scale developed by Zeithaml and colleagues can be measured with only three items (Cronin et al., 2000; Brady et al., 2001). These three items were (1) repurchase intentions, (2) word of mouth, and (3) pay premium price.

In addition to above, Alexandris et al. (2002) asserted that behavioural intention is a multi-dimensional concept that consists of purchase intentions, price sensitivity, word of mouth (WOM), and complaining behaviour. Among the entire dimensions available in the concept of behavioural intention, word of mouth was emphasised and referred to as the most vital source of information for consumers in their decision making for the purchases. According to Litvin et al. (2008), this source of information is greatly important for customers in the service industry, such as tourism and hospitality industry, due to the intangible nature of the services. In the context of tourism, in order to assess customers' future behaviour, behavioural intention is often used as a measure because it is an accurate predictor of future behaviour (Ajzen & Fishbein, 1980). Consistent with the above notion, Dabholkar and Thorpe (1994) proposed that behavioural intention in the tourism sector can be measured with two items, such as intentions to recommend the place to others and patronage intention.

In the context of a healthcare setting, Tu and Lauer (2008) in their study on consumer attitudes towards healthcare, found that the majority of the patients depended on recommendations by family and friends when they choose the medical service provider. Having understood that recommendation

is an important factor that determines a patient's future behavioural intention and that medical service is a rare purchase, recent studies like Mekoth et al. (2011) and Kim et al. (2008), operationalised the behavioural intention construct in the healthcare with the intention to revisit and to recommend it. In a similar context, Wu (2011) measured behavioural intention in the aspect of intention to revisit and make a positive recommendation. Based on the support from recent literature discussed above, behavioural intention in the healthcare setting is more appropriate to be viewed as the intention to revisit and make a positive recommendation.

While various types of scales were developed to measure behavioural intention in the healthcare setting, this research mainly adapted the scales from Choi et al. (2004), which were based on the context of healthcare industry (see Table 4.10). The measurement items of behavioural intention from Choi and colleague includes three items pertaining to a patient's willingness to return for the same hospital when they need medical service in the future, patients' willingness to make a recommendation, and saying good things about the hospital. The researcher considered this measurement scale suitable for this research as the construct was tested with confirmatory factor analysis and reliability test, whereby the results showed that the construct has a good consistency and was valid. All the three items were refined and paraphrased in terms of wording in order to suit this research purposes. In view of the above support, the construct of behavioural intention for the study was measured using three items, as shown in Table 4.10.

Table 4.10: Behavioural Intention Scale Items

No.	Original Scale Items from Choi et al. (2004)	Original and Modified Scale Items Used in this Study
1	I will recommend that other people to use this hospital.	I will recommend that other people to use this hospital.
2	If I needed medical services in the future, I would consider this hospital as my first choice.	If I need medical services in the future outside my country of residence, I would consider this hospital as my first choice.
3	I will tell other people good things about this hospital.	I will tell other people good things about this hospital.

4.3.9 Response Mode

The constructs used in this study were adapted from the prior healthcare studies where continuous scales (Likert-scale) were used in measuring all the constructs. Although the odd number Likert-type scale (e.g. 5-point or 7-point) has always been the most common response mode adopted in the business research (Malhotra & Peterson, 2006), the past literature purported that the odd numbers scale possesses various disadvantages over the even scale (Garland, 1991; Kulas, Stachowski, & Haynes, 2008; Raaijmakers, Hoof, Hart, Verbogt, & Wollebergh, 2000; Worcester & Burns, 1975). One of the main issues with the odd scale is that the respondents use the midpoint to please the interviewers by avoiding sensitive questions and not to be against any socially acceptable response (Garland, 1991; Johns, 2010). This argument is consistent with the suggestion of Worcester and Burns (1975), whereby the scholars claimed that respondents tend to provide socially acceptable answer and to please the interviewers by giving a positive reply to the questions. Therefore, the use of a midpoint may no longer imply neutrality, but indirectly

encouraged respondents to use the midpoint in addressing certain questions even they have the answer for it and it is harmful to measurement validity reporting.

On top of that, Kulas et al. (2008) asserted that midpoints in the odd number scale of most research studies may often be regarded as a "dumping ground" for non-applicable or unsure responses by respondents. That is to say, midpoints in this case may not represent the opinion and the meaning of "neutral" or "neither agree nor disagree". Moreover, research conducted by Infosurv (2006) also reported that neutral answers for a research survey are rare because in the majority of the studies performed, only those respondents who had negative or positive experience/opinion will be interested in participating in a particular research study. As the medical tourists were involved directly with the purchase of medical service in this industry, it was therefore assumed and expected that the medical tourists would be able to explain and justify their perceptions and experiences for the services conclusively. With the support from the previous studies and the objectives of this study, the researcher adopted a 6-point Likert-type scale, whereby 1 (strongly disagree) to 6 (strongly agree) for the purpose of this study. Having selected the scales to be used for the present study, the subsequent section discusses the approaches used for questionnaire development.

4.4 Questionnaire Development

According to Churchill and Iacobucci (2005), one of the main criteria in questionnaire development is to ensure that the research objectives for the study can be answered with the information collected. As usual, the questionnaire design and administration are performed based on the research objectives, support from prior literature, hypotheses developed, and the operational definitions for each of the constructs adopted (Churchill & Iacobucci, 2005). Initially, the questionnaire was designed with the consideration of the sequencing aspect. This is because Malhotra (2004) found that the sequencing of questions in the questionnaire is substantial as it has a direct impact on the way respondents answer the questions. Thus, for the purpose of this study, the researcher ensured that the questionnaire was designed with all the topics covered being arranged in the sequential flow. This means that the respondents need to complete a section in the questionnaire before they can move on to the subsequent section.

In addition, a combination of both scale-response and closed-ended questions were used in this study. The closed-ended questions (Socio-Demographic Profile) were placed in the initial section of the questionnaire because closed-ended questions are claimed to "require less interviewer skills, take less time, and are easier for the respondent to answer" (Zikmund & Babin, 2007, p. 284). Successively, scale-response questions were placed in the subsequent section of the questionnaire for this study. As for this study, the first section of the questionnaire presented questions pertaining to medical

tourists' general information. Subsequently, the second section was related to medical tourists' perceptions of the hospital they visited. In this section, the questions were comprised of hospital-created social media communications (3 items), user-generated social media communications (3 items), word of mouth communication (5 items), brand image (3 items), perceived service quality (22 items), perceived value (4 items), perceived trust (5 items), patient satisfaction (4 items), and behavioural intention (3 items). Table 4.11 represents all the research variables that were included in this study, together with its corresponding items. Moreover, the instructions and the questions for the questionnaire used short, simple, comprehensible, unbiased, and clear wording in order to ease the process of answering the questionnaire. The questionnaire used in this study is presented in *Appendix 1*.

Table 4.11: Research Variables and Corresponding Items

Research Variables	Corresponding Items	Items Source
Hospital-created Social Media	1) The level of this hospital's social media communications for its brand meets my expectations. 2) Compared with the very good social media communications of other competing hospitals, this hospital's social media communication for its brand performs well 3) I am satisfied with this hospital's social media communications for its brand.	Bruhn et al. (2012)
User-generated Social Media	1) The level of the social media communications feedback expressed by other users about this hospital's brand meets my expectations. 2) Compared with the very good social media communications of other users' feedback about other competing hospital brands, the social media communications of users' feedback about this hospital's brand performs well. 3) I am satisfied with the social media communications feedback expressed by other users about this hospital's brand.	Bruhn et al. (2012)
Word of Mouth Communication	1) My family/friends positively influenced my attitude towards this hospital's brand. 2) My family/friends mentioned positive things I had not considered about this hospital's brand. 3) My family/friends provided me with positive ideas about this hospital's brand. 4) My family/friends positively influenced my evaluation of this hospital's brand. 5) My family/friends helped me make the decision in selecting this hospital's brand.	O'Cass and Grace (2004)
Brand Image	1) This hospital's brand possesses complete practical functions (medical services and adequate medical facilities). 2) This hospital's brand possesses a positive symbolic meaning (good reputation, credibility and positive image). 3) I feel that this hospital's brand can provides me with pleasant service experience.	Hsieh and Li (2008)

(continued)

Table 4.11: Research variables and Corresponding Items (continued)

Research Variables	Corresponding Items	Items Source
Perceived Service Quality	***Tangible***	Lam (1997)
	1) This hospital has up-to-date equipment.	
	2) The physical facilities of this hospital are visually appealing.	
	3) The staffs of this hospital appearance are neat.	
	4) The materials associated with this hospital are visually appealing.	
	Reliability	
	5) The staffs of this hospital perform the medical service right on the first time.	
	6) The staffs of this hospital provide dependable services as promised.	
	7) The staffs of this hospital are sincere to solve my problems.	
	8) The staffs of this hospital provide services at the appointed time.	
	9) This hospital keeps accurate medical records.	
	Responsiveness	
	10) The staffs of this hospital tell me when the services will be performed.	
	11) I received prompt service from the staffs of this hospital.	
	12) The staffs of this hospital are always willing to help me.	
	13) The staffs of this hospital are never too busy to respond my requests.	
	Assurance	
	14) The staffs of this hospital have the knowledge to answer my questions.	
	15) The staffs of this hospital are consistently courteous to me.	
	16) The staffs of this hospital are trustworthy.	
	17) I feel safe in receiving services from the staffs of this hospital.	
	Empathy	
	18) This hospital has convenient operating hours for my needs.	
	19) The staffs of this hospital give individual attention to me.	
	20) This hospital has my best interests at heart.	
	21) The staffs of this hospital understand my specific needs.	
	22) This hospital's staffs give me personal attention.	

(continued)

Table 4.11: Research variables and Corresponding Items (continued)

Research Variables	Corresponding Items	Items Source
Perceived Value	1) The effort involved to decide on this medical service is worthwhile. 2) The time I spent flying from my country to this country to receive medical service is worthwhile. 3) The services provided by this hospital are good for what I have to pay. 4) The money I spent for this medical service is well worth it.	Lertwannawit and Gulid (2011)
Perceived Trust	1) The staffs of this hospital will honestly inform me about the result of diagnosis. 2) The staffs of this hospital will honor the agreement made with me. 3) My medical issues are well handled by the staffs of this hospital. 4) I can trust this hospital staffs' judgment based on my sickness. 5) I can rely on the staffs of this hospital to solve my medical issues.	Chang et al. (2013)
Patient Satisfaction	1) I am satisfied with my decision to use the service at this hospital. 2) My choice to come to this hospital is a wise decision. 3) My experience at this hospital is satisfactory. 4) I am not disappointed to use this hospital's service.	Panjakakornsak (2008)
Behavioural Intention	1) I will recommend that other people to use this hospital. 2) I need medical services in the future outside my country of residence, I would consider this hospital as my first choice. 3) I will tell other people good things about this hospital.	Choi et al. (2004)

4.4.1 Questionnaire Translation and Back Translation

Since that this research was conducted in Penang, a state in Malaysia where the majority of medical tourists were Indonesians, this study required both English and Indonesian versions of the questionnaire. Thus, the questionnaire needed to be translated and back translated before distributed to the respondents. This study follows the suggestion by Brace (2008) in order to ensure that the process of translation and back translation for the questionnaire was performed in the appropriate manner. This is because it was reported that insensitivity of the researcher in the translation process may cause the questionnaire to lose its meaning and its nuances, thereby affecting the validity and reliability aspects of the questionnaire (Brace, 2008). Thus, Brace (2008) suggested that the most important step in questionnaire translation is to be performed by the native speakers who understand research as well. Following this suggestion, the English version of the questionnaire in this study was translated into Bahasa Indonesia by two native Indonesian certified translators who are familiar with both English and Indonesian language, and also marketing researchers in Indonesia.

After the translation process, Brace (2008) suggested that the questionnaire should then be back-translated into the original language. The purpose of this step is to highlight the changes of meaning that might happen from the prior translation process. Based on this suggestion, a back-translation of the questionnaire was performed by two other Indonesians who have good command in both English and Indonesian language in order to ensure

uniformity of the questionnaire translations. Based on the feedback from the translation process, the process resulted in some minor adjustments to the questionnaire. The translated questionnaire for this study is presented in the *Appendix 2*.

4.4.2 Pre-Test of the Questionnaire

After the questionnaire was translated, a pilot study was conducted in order to access certain concerns pertaining to the questionnaire. For instance, the issues of understanding the questionnaire by researcher and respondents, the availability of double-barrelled or ambiguous statements, the improper flow of the questionnaire, insufficient response code, and the length of the questionnaire are those common issues that will have a significant, direct effect on the reliability and validity of the questionnaire. Since this survey questionnaire was modified and adapted by the researcher, it is recommended by Malhotra (2004) that evaluation of the questionnaire from experts and academics are needed. Subsequently, a pre-testing of the questionnaire was conducted in order to access the validity of the questionnaire before the actual data collection. Firstly, in order to improve the face validity of the constructs in this study, the draft of the questionnaire was distributed to a panel of ten experts who specialised in healthcare, tourism, and marketing. The questionnaire was improved accordingly based on the feedback and suggestions received from the experts.

Secondly, the researcher conducted interviews with three of the senior management officers from the hospitals that were directly involved with medical tourism. The main aim of these interviews was to discover any underlying problems associated with the questionnaire and to determine the suitability of the questionnaire to collect data from hospitals. The interviews with the respective officers resulted in some minor changes (e.g. wordings in the questions), which were then amended. Finally, field pilot testing was conducted from May 1 to May 14, 2013 by distributing the questionnaire to 45 medical tourists in Penang. The sample size for the pilot testing in this study was consistent with the suggestion (ranged from 25 to 100 respondents) by the prior studies (e.g. Cooper & Schindler, 2003; Kothari, 2004). Moreover, a feedback form was attached together with the questionnaire in order to obtain comments and suggestions from the respondents. All the feedback received indicated that all the instructions and sentences for the questionnaire in this study were clear and well understood. Hence, there were no changes required for the questionnaire.

4.5 The Sampling Strategy

According to Zikmund and Babin (2007), sampling strategy is considered as one of the important aspects of marketing research. For example, it was reported that factors such as sample design and sample size should be given a great deal of attention by a researcher in order to obtain a justifiable research outcome and to reduce any ethical issues associated with the sampling strategy. Consistent with the above arguments, Morrison (2002)

reported that a sample design in a travel marketing and hospitality context should include three distinctive elements: (1) sample frame, (2) sample selection process, and (3) sample size as parts of the sampling strategy in the thesis. The considerations in determining the sampling design and sample size for this study are further discussed in the following sections.

4.5.1 Sampling Design

According to Lavrakas (2008), a sample design is the framework that serves as the foundation for sample selection of a research study. The choice to use probability or non-probability sampling is regarded as the most critical step in determining sampling design (Zikmund & Babin, 2007). It was reported that a researcher needs to have a sample frame in order to adopt probability sampling in their research (Malhotra & Peterson, 2006). Since that sampling frame cannot be compiled for this study, therefore, a non-probability method was used. Zikmund and Babin (2007) explained that non-probability sampling is a method where the researcher selects the sampling units for his or her study. Moreover, non-probability sampling methods can be advantageous when it is impractical or unfeasible to conduct probability sampling (Statistic Canada, 2015).

As for this study, the researcher adopts non-probability sampling due to few reasons. First, identifying target respondents in the medical tourism industry of Malaysia was difficult due to the unavailability of sample frame for this industry. Thus, it is unfeasible for the researcher to ensure that all

respondents are equally selected for this study. Second, the past literature claims that using non-probability sampling does not cause a problem for a study that tests the prediction of theory or hypothesis testing (Evans & Rooney, 2013; Reynolds, Simintiras, & Diamantopoulos, 2003). Since one of the main research objectives in this research was to examine the integration model and to test the hypotheses developed, using non-probability sampling was considered appropriate. Among the various types of non-probability sampling available across literature, the researcher applied quota sampling method under judgmental criteria in conducting this research. The questionnaires were equally distributed among four private hospitals involved in this study. The hospitals selected for this research study were based on the suggestion by the experts from the industry, whereby all of the chosen hospitals have similarities in terms of operation size and medical treatments provided. For ethical reasons, all information collected from the medical tourists in this study was kept private and confidential, was not referred to any particular hospital, and was analysed in an aggregate form. Moreover, the name of the hospitals was kept confidential and anonymous.

4.5.2 Sample Size

Sample size is defined as "the number of units to be included in a study" (Malhotra et al.., 2006, p. 365). Currently, the issues of sample size still remain as a subject of debate in the research community (Evans & Rooney, 2013). This is because there is no definitive and universal rule to define an appropriate sample size for research (Briggs, Morrison, & Coleman, 2012).

Therefore, there are different versions of methods in determining sample size in the research platform. As for this research, the numbers of sample size were based on the consideration from the following studies. For example, Manning and Munro (2007) asserted a rule of thumb regarding sample size, whereby the size exceeding 300 is considered "good", 200 is considered as "fair", and 100 is considered as "poor". Green (1991) claimed that the minimum sample size of 50 is needed in order to examine relationships with regression or correlation statistically analyses. Moreover, Saunders et al. (2012) reported that a sample size of 350 is considered reasonable to represent a large population.

As for SEM, there are no clear cut rules to determine the most appropriate sample size for the researchers who used SEM in their study (Raoprasert & Islam, 2010). Kline (2005) asserted that in deciding sample size using SEM, the sample size needed were dependent on the distributional characteristics of observed variables, the estimation method used, and the complexity of the research model. Hair et al. (2003) reported that a sample of 50 was able to generate a valid result and suggested that a minimum sample size ranging from 100 to 150 is needed to ensure the results of maximum likelihood estimation is stable. Later, Hair et al. (2010) suggested that a sample size in the range of 150 to 400 is ideal for research studies that use SEM.

Although the sample size for SEM is still a subject of debate, there are empirical studies that proposed a "critical sample size" of 200 (Kline, 2005; Schreiber, Nora, Stage, Barlow, & King, 2006; Sivo, Fan, Witta, & Willse,

2006). In other words, SEM can provide reliable and valid results with any sample size of 200. With these considerations in mind and based on the varying arguments among the scholars on the number of respondents, a sample size of 400 was considered suitable for this research study.

4.6 Survey Administration

The survey questionnaires were distributed to Indonesian tourists who travelled to Malaysia and received medical treatments from June 2013 – September 2013. The 400 survey questionnaires were distributed equally to the Indonesian medical tourists by the researcher personally at four major hospitals that were involved with medical tourism in Penang, one of the northern states in Malaysia and with the highest number of medical tourists (Ormond, 2011; theborneopost.com, 2013). The main reasons for the researcher to approach respondents personally in this study were because it is a reliable method to create a co-operative atmosphere among the target respondents, to improve the response rate, and to reduce any uncertainty (Malhotra, 2004).

In order to ensure reliable and justifiable responses, the researcher imposed two screening criteria before the questionnaires were distributed. The criteria were (1) the respondent must come to Malaysia for medical service, and (2) he or she must have a direct engagement in any tourism activities (e.g. accommodation services, transportation services, sightseeing, shopping, vacation, etc.) during the medical trip. The respondents who fulfilled these two

criteria would only then be qualified as a target respondent in this research. The requirements imposed by the researcher in selecting sample seemed to be appropriate as this approach concurred with the medical tourism definition adopted in this study. Considering the hospitals' policy to ensure that patients would receive minimum disturbances, the questionnaires were only distributed at the lobbies, cafeteria, and waiting areas in the hospitals where medical tourists were easily accessible. Moreover, informed consent was obtained from the respondents before their participation in this research and their participation was based on a voluntary basis. In this survey, a souvenir key chain was given to the respondents who completed the questionnaire as a token of appreciation.

4.7 Data Analysis Procedure

In this context, Kumar, Aaker, and Day (1999) stated that data analysis is an important element for any research due to its capability in influencing the results and findings of the research. Therefore, referring to this logic, the data analysis in this study was arranged in several steps by the researcher in order to generate reliable and justifiable results. The steps that were involved in this study began with the preliminary data analysis, followed by testing the confirmatory factor analysis, before finally testing the hypotheses developed for this research. The present researcher employed both AMOS and SPSS statistical software to analyse the data collected for this study. The following sections discussed each of the steps for data analysis adopted in this study.

4.7.1 Preliminary Data Analysis

According to Aaker, Kumar, Day, and Lawley (2005), the quality of statistical analysis in a research depends on how well a researcher prepared his or her data, and changed it into a form which is suitable for the statistical analysis that he or she selected for the research. Therefore, in order to obtain accurate and reliable statistical results, it is suggested that preliminary analysis should be performed on the raw data collected before conducting statistical analysis for the purpose of hypotheses testing (Aaker et al., 2005). As for the first stage of analysis, the researcher conducted the preliminary data analysis on the data by editing, cleaning, coding, and treating of missing data.

Following this process, testing of outliers, multicollinearity, and normality was conducted on the data (further explanation in section 4.7.2.1). Subsequently, frequency analysis and valid percentage were performed to determine the overall characteristics of respondents on various demographic variables. Moreover, the same analysis was also performed on the construct of hospital-created social media communication, user-generated social media communication, word of mouth communication, brand image, perceived service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention were presented. This descriptive analysis included mean value and standard deviation. As for the descriptive tests in this study, SPSS version 17 was used.

4.7.2 Structural Equation Modelling

Structural equation modelling (SEM) is a statistical method that combines both multiple regressions and factor analysis. Hair et al. (2010) claimed that SEM is a method that allows researchers to simultaneously test the interrelated relationships between latent constructs and its indicators and between numerous latent constructs at one time. In other words, SEM enables a researcher to present the results for individual parameter estimate tests and an overall test of model fit simultaneously (Hair et al., 2010). Meanwhile, SEM was regarded as a powerful statistical tool that gained popularity among researchers due to its ability to assess and modify a theoretical model, accept an assortment of types of variables, provide model measurement error, and for its ability to model different relationships between studied variables (Kline, 2005). Therefore, the above mentioned advantages were the reasons why the researcher considered SEM for this purpose of this study. Among many statistical packages that can conduct SEM (e.g. Lisrel, Mplus, AMOS, EQS, PLS, etc.), the researcher used AMOS 18.0 in performing SEM as this software is user friendly, and at the same time, provided a comprehensive and informative model picture.

In addition, Anderson and Gerbing (1988) asserted that there are two approaches in performing SEM, which are known as one-stage (or known as single-stage) and two-stage approaches. As for the context of one-stage approach, Anderson and Gerbing claimed that the one-stage approach serves to verify the measurement model (processes the analysis for both on the

measurement and structural models simultaneously). On the other hand, for the second-stage approach, this approach is consisting of stage 1 (verifying the measurement model) and stage 2, which is to test the structural model. Moreover, Kline (2005) reported that the main purpose for the two-stage approach is to prevent any interaction that might take place between the adopted constructs during testing of the structural model. Based on the advantages mentioned above, the two-stage approach was used in this study to test the hypotheses and hypothesised conceptual model. As for this study, the preliminary stage for the two-stage approach was to test the measurement model with the use of confirmatory factor analysis (CFA).

The CFA for the measurement model can be performed by examining the relationships between the latent variables and its observed items (Hair et al., 2010). The purpose of this step is to confirm the unidimensionality of a construct and to provide results for the discriminant and convergent validity tests for it (Anderson & Gerbing, 1988). After the validity and reliability tests were addressed, the researcher then proceeded to the second stage of SEM, which is to test the structural model by testing the hypotheses that were developed for this study. Moreover, the results of the path analysis were presented in this stage. Having discussed the advantage and procedure of the SEM procedure in this study, the subsequent subsection discusses the SEM criteria and goodness-of-fit related to testing the SEM used in this research. Moreover, the description of CFA is also discussed.

4.7.2.1 SEM Criteria

According to Ferdinand (2006), since SEM is a multivariate data analysis method, there are several criteria that need to be fulfilled on the data before a researcher can proceed with the structural model testing. The criteria were known as outliers, multicollinearity, and normality. As for the context of outliers, Tabachnick & Fidell (1989) explained that outliers are an observation with an extreme value that could distort and cause non-normality to the data. As for this study, the multivariate outliers were identified based on the Mahalanobis d^2 test as suggested by Kline (2005). Moreover, collinearity (or multicollinearity) can be explained as the undesirable situation where the correlations among the independent variables are strong (Hair et al., 2010). It was claimed that multicollinearity could misleadingly inflate the values of standard errors that potentially make some variables statistically insignificant, while they should be otherwise significant. As for this study, the case of multicollinearity was identified based on the value of detection-tolerance (TOL) and the variance inflation factor (VIF) suggested by Allison (2003). Lastly, Anderson & Gerbing (1988) explained that "normality" can be described as the degree to which the data are normally distributed. In order for data to be considered normal, Kline (2005) claimed that the acceptable range value of the skewness is (±3:3), and the range value of kurtosis is (±10:10). Therefore, the normality of the data for this study is based on suggestion above. Having discussed the criteria for SEM, the evaluation of the model fit is discussed in the subsequent section.

4.7.2.2 Evaluating the Fit of the Model

In the context of SEM, the fit indices are considered to be crucial indicators in assessing model fit for the structural model (Hair et al., 2010). It was reported that researchers can only measure the significant paths in the model only if the model fit is acceptable. Since that there are various indices for SEM across the literature, the researcher employed three fit indices: parsimonious index, incremental index, and absolute index as the criteria to determine the model fit, based on the recommendation by Hair et al. (2010). The fit of the measurement model and the structural model for the present study were assessed through the fit indices obtained from the output of AMOS version 18.0. Although there are a few indicators that can be found on each of the fit indices (e.g. parsimonious index, incremental index, and absolute index), Hair et al. (2010) recommended that at least one incremental index, one absolute index, and one parsimony index, in addition to the value of Chi-square and the degree of freedom, is sufficient to assess the model fit in any research. Furthermore, Hair et al. (2010) concluded that Chi-Square value, degree of freedom, root-mean square-error of approximation (RMSEA), and comparative fix index (CFI) are sufficient to validate the analysis of fit measures. As such, the commonly used fit indices, such as RMSEA, CFI, tucker lewis index (TLI), normed chi-square (χ^2/df), and goodness of fit index (GFI) were employed in the present study to measure the fit of the measurement model as well as the structural model. Table 4.12 presents the Goodness-of-Fit indices that were used in this study along with their threshold values for a good fit.

Table 4.12: Goodness-of-Fit Index

Index	Level of Acceptance	Note
Absolute Fit Index:		
- Goodness of Fit (GFI)	≥ 0.90	A value 0 is a poor fit, value 1 is a perfect fit
- Root Mean Square Error of Approximation (RMSEA)	≤ 0.80	A value less than 0.05 is perfect fit, between 0.05 to 0.08 is considered as acceptable fit
Incremental Fit Index:		
- Tucker Lewis Index (TLI) - Comparative Fit Index (CFI)	> 0.90	A value 0 is poor fit, value 1 is perfect fit
Parsimonious Fit Index:		
- Normed Chi-square (χ^2/df)	1.0 - 5.0	Less than 3 is preferred, up to 5 still acceptable

Source: Hair et al. (2010)

4.7.2.3 Reliability and Validity

In order to access the reliability and validity of the measurement constructs in this study, confirmatory factor analysis (CFA) was used. CFA is a statistical method used by researchers to examine how well the latent variables and the loadings of its measured variables are consistent with what was expected in the pre-establish theory. Moreover, CFA can be used to determine validity and reliability of the respective constructs (measurement model assessment) and the adequacy of their goodness-of-fit to the data. It was documented that validity and reliability tests should be emphasised in research in order to assess the usefulness and the quality of data (Hair et al., 2010; Sekaran & Bouie, 2010). Sekaran (2005) elucidated that the measurement for the constructs is "reliable" if the instrument is stable and consistent. Moreover, the measurement is considered "valid" if the instruments can measure what it

should measure. As for the context of reliability, a reliability test was used to test the consistency for the measurement. Commonly, Cronbach alpha was used to assess the internal homogeneity among measurement items, with the value of the coefficient alpha for the particular construct should exceed 0.70 (the cut off value for acceptable reliability) in order to be considered reliable.

On the other hand, the validity of the constructs can be explained as a degree to which a measured variable represents and are related to the theoretical latent construct (Hair et al., 2010). As for this study, there are two validity tests conducted: (1) convergent validity and (2) discriminant validity. Convergent validity for this study was conducted by accessing the value of the composite reliability, factor loadings, and average variance extracted (AVE). According to Sekaran & Bougie (2010), in order to achieve convergent validity, the following criteria must be met: (1) composite reliability for the variables should meet the threshold values 0.70, (2) the factor loadings for all items within a variable should exceed 0.60, and (3) the value of average variance extracted should meet the threshold values of 0.50. Convergent validity is only established if all the abovementioned criteria are met. It was then followed by an evaluation of discriminant validity to ensure all items were theoretically dissimilar, as well as allocated according to the different variables (Hair et al, 2010, Sekaran & Bougie, 2010).

In addition, the discriminant validity for the studied variables was accessed by comparing the values of Average-Shared-Squared-Variance (ASV) and Maximum-Shared-Squared-Variance (MSV) with the AVE of the

studied variables. Subsequently, the squared root of AVE for each variable is compared against the coefficient representing its correlation with other variables (Hair et al., 2010). It was reported that discriminant validity can only be established if both values of MSV and ASV are lower than AVE for the constructs, and the squared root of AVE for the constructs must surpasses the value of correlation between any other two constructs.

4.7.3 The Mediation Test

According to Baron and Kenny (1986), "mediation is a hypothesised causal chain, in which one variable affects the second variable that in turn affects a third variable" (p. 817-818). For testing the mediating effect of perceived trust and perceived value on the relationship between perceived service quality and patient satisfaction as hypothesised, this study follows the suggestion made by Wood, Goodman, Beckmann, and Cook (2008). According to Wood et al. (2008), the mediation effect can be determined based on the casual steps recommended by Baron and Kenny, Sobel test (or known as Z test), and Bootstrap method.

Based on past research works, the causal steps approach developed by Baron and Kenny (1986) for the purpose testing mediation effect are the most widely cited and used method in the service marketing research. As illustrated in Figure 4.1, an independent variable (X) is assumed to have an influence on the dependent variable variable (Y), while path c is known as the total effect. As shown in Figure 4.1 (b), Path C' is known as direct effects, and the indirect

effect is the path (e.g. Path ab) between the independent variable (X) and dependent variable (Y) that is mediated by a mediator (M).

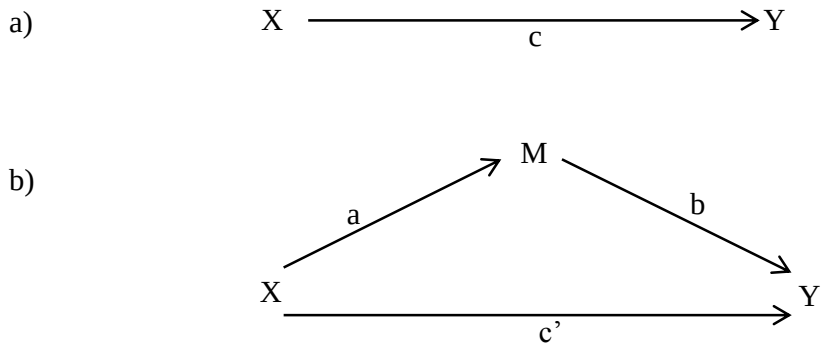


Figure 4.1: Testing Mediation with Regression Analysis

According to Baron and Kenny (1998), there are four criteria that need to be fulfilled in order to address the existence of a mediation effect. The logic of the procedures (based on Fugure 4.1) to identify the existence of mediation are: (1) the X (independent variable) is significantly related to Y (dependent variable); (2) the X (independent variable) is significantly related to the M (mediator); (3) the M (mediator) is significantly related to Y (dependent variable); and (4) the results of mediation are depended on the outcomes from the regression equation after the M (mediator) was added to the relationship between X (independent variable) and the Y (dependent variable). In this case, the findings support partial mediation if the regression coefficients for the relationship between X (independent variable) and Y (dependent variable) are reduced but still remain significant when the M (mediator variable) was added. On the other hand, the findings demonstrate full mediation if the relationship

between X (independent variable) and Y (dependent variable) is no longer significant when M (mediator variable) was added.

Despite the popularity of the causal steps developed by Baron and Kenny (1986), there are some potential limitations of this approach. Over the years, there were empirical studies (e.g. Frazier, Tix, & Barron, 2004; MacKinnon & Fairchild, 2009; Preacher & Hayes, 2004) which claimed that Baron and Kenny's approach was criticised for not being able to test the significance of the indirect pathway in the mediation analysis and for having low statistical power. In response to this drawback, Sobel's Z test was adopted in the present study to examine the influence of the indirect effect of the mediator. Sobel's Z test can be performed determining the z-statistic distribution that derives from the comparison of estimated standard error of measurement (Sobel, 1982). As for Sobel's test, the mediation effect exists when Sobel's test shows a significance level with a value for the indirect effect.

In addition to the above statistical approach, this study also considered the method of bootstrapping in order to support the mediation test. Bootstrapping was used in this study to overcome the limitations of statistical approaches because it can generate greater power of analysis and the data used does not have to be a "normal" distribution (Shrout & Bolger, 2002). Theoretically, bootstrapping can be described as the process of computing the statistic of interest for each sample via a repetitive process in the random sampling (Hair et al., 2010). Moreover, Shrout and Bolger (2002) added that

empirical approximation for the statistic can be created over many bootstrap resamples, and be used for hypotheses testing. It was claimed by the prior literature that bootstrapping has various advantages, such as providing an estimation of the confidence intervals and standard errors, have capability in checking and controlling the stability of the results, and most importantly, its simplicity (Hair et al., 2010; Shrout & Bolger, 2002; Wood et al., 2008). Referring to the discussion above and consistent with the suggestion made by Wood et al. (2008), this study utilised a statistical macro script developed by Preacher and Hayes (2004) in order to analyse mediation tests and to provide a conclusive discussion in this study. Having discussed all the statistical analysis that will be employed, figure 4.2 illustrate the summary flow of statistical analysis for this study.

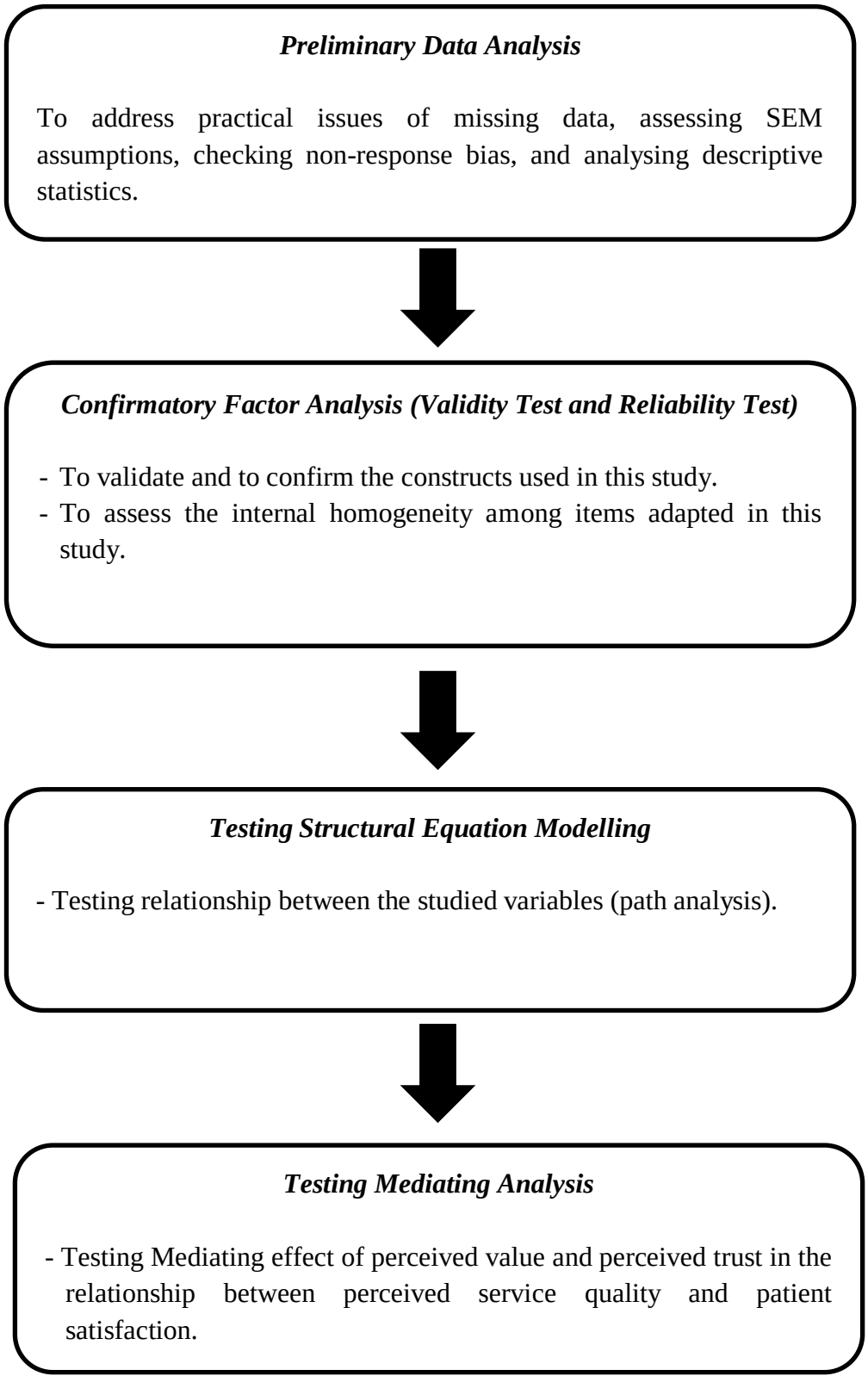


Figure 4.2: Flow of Data Analysis

4.8 Ethical Consideration

According to Fontana and Frey (2000), there are three aspects of ethical issues that need to be emphasised by a researcher while conducting a research: (1) protection from harm, (2) confidentiality, and (3) informed consent. Since that medical tourist (human) is the subject of this study, there are potential ethical concerns and dilemmas that must be highlighted. Therefore, the researcher adopted various considerations of ethics in order to address the potential ethical issues that might arise and to safeguard all the parties from any possible negative ethical issues related to this research. First, this research study was designed carefully in order to ensure that there were no risks associated with the research procedures when it comes to data collection, analysing the data, and presenting it as the output from the research.

Secondly, the researcher approached the selected hospitals personally, informed them about the research objectives for this study, and the benefits of the research for the Malaysian medical tourism. The researcher explained the schedule for the data collection and addressed all the matters pertaining to medical tourists' participation, confidentiality, and informed consent to the management team. Thirdly, due to confidentiality matter, all the hospitals names in this research were kept anonymous in this thesis. Likewise, the same approach was also applied to the medical tourists whereby there are no respondents' personal information was identified in the questionnaire. Moreover, the researcher also includes the researcher's background, research objectives, personal contact number, and email in the questionnaire in order to

ensure the respondents felt safe and comfortable in participating in this research. Lastly, the participation from the respondents was based on voluntarily basis and the respondents were being informed on the privacy and confidentiality of the questionnaire collected.

4.9 Chapter Summary

In conclusion, this chapter illustrated and justified the research methodology for this study. The adopted data collection method (e.g. self-administered survey) was justified in the thesis. The steps involved in the questionnaire design and administration includes specifying the information needed and operational definitions of the constructs and variables, selecting format of responses, assessing validity and reliability for the questionnaire, and finally, drafting and administering the questionnaire. Besides, sampling strategy, sample selection, and the processes involved were also justified. Upon collecting the questionnaires, data analysis was carried out and all the results obtained from the statistical tests are presented in the subsequent chapter.

CHAPTER 5

RESEARCH RESULTS

5.1 Introduction

This chapter provides the outline of the results of data analysis and the tests of hypotheses. Firstly, the preliminary examination of the data was conducted. Secondly, the results and discussion of medical tourist demographic profiles are presented. Then, the third section presents the results of descriptive analysis. The subsequent section presents the results for confirmatory factor analysis (CFA) for the entire studied concepts, followed by the reliability and validity testing of the data. The fifth section in this chapter presents the results of structural equation modelling (SEM), and followed by the results of mediation tests. Finally, the detailed results of hypotheses testing are presented.

5.2 Preliminary Examination of Data

This section presents the preliminary data analyses (cleaning and screening of the raw data), which are used for the purpose of this study. It was argued that the quality of analysis for a research depends on how well the research data are organised and converted into a form, which is appropriate and fit for further analysis (Hair et al., 2010). Therefore, preliminary data

analyses were performed in this study in order to assess missing data and to examine all the criteria for SEM (e.g. outliers, multicollinearity, and normality) before proceeding to the analyses for hypotheses testing (Hair et al., 2010; Sekaran & Bougie, 2010). The subsequent subsections discuss the outcomes of preliminary data analysis conducted.

5.2.1 Missing Data

For a data set, the issue of missing data can arise when a particular respondent failed to respond to one or more questions in a survey questionnaire. This scenario is considered important as a "systematic error" of missing data that can significantly influence the results of statistical analyses. As far as SEM is concerned, the estimation process, which is based on maximum likelihood, cannot be performed if there is any missing data in the dataset (Hair et al., 2010). Moreover, missing data is also considered as a critical problem for multivariate data because the case with missing data will be excluded from the analysis. Therefore, the researcher in the present study identifies and manages the missing data by screening the data with the use of frequency distributions and descriptive statistics, which is based on the SPSS statistical software. A frequency test was used to detect any missing or illegal response for each of the studied variables. As for this study, the results of SPSS test indicated that there was no occurrence of missing data identified in the data set. This scenario is plausible as the questionnaires were administered to the respondents personally and were checked thoroughly by the researcher before the respondents left the scene. After checking the missing data, the

subsequent section will discuss the preliminary data analyses which consist of detections of outliers, multicollinearity, and normality of the data.

5.2.2 Outliers, Multicollinearity, and Normality

Outliers, multicollinearity, and normality are fundamental issues in data analysis using SEM. It has been reported by the past studies that all of these matters are basic SEM's requirements that must be clarified and addressed before testing a strutural model (Ferdinand, 2006; Hair et al., 2010). The following discussion examines each of this issue.

For the aspect of outliers, it is argued that outliers can be both beneficial and problematic. Beneficial outliers may be considered as an indication of the population' characteristics while problematic outliers are not representative of the particular population and can distort the results of the statistical tests. However, Blunch (2008) stated that outliers could create problems related to SEM estimation. Therefore, due to the weightiness of the impact of outliers, it is important that the data is examined for the presence of outliers. Outliers are most easily detected through Mahalanobis distance (Tabachnick & Fidell, 2007). With that, this study assessed outliers based on the suggestion by Kline (2005), which is based on the use of Mahalanobis d^2 test. In this test, the cut-off values of p1 and p2 less than 0.05 were adopted in order to identify outliers. The past studies asserted that outliers can be deleted from the data and this can improve the robustness of multivariate analysis (e.g. Ghozali & Fuad, 2005; Hair et al., 2010). Therefore, upon examination of the

Mahalanobis distance output by the researcher (*Appendix 3*), 14 extreme outliers (which were outside the critical values with $p \leq 0.001$) were deleted from the data. Subsequently, after the outliers were removed, only 386 samples are left for further analysis.

The identification of the existence of multicollinearity in combined variables in this study had been conducted based on the recommendation by Allison (2003), which was based on the value of detection-tolerance (TOL) and the variance inflation factor (VIF). According to O'Brien (2007), multicollinearity problem can be identified if the value of TOL is less than 0.20 or VIF is above five. Moreover, O'Brien (2007) also reported that any higher correlations (> 0.8) among variables are also considered as the source of multicollinearity. Testing multicollinearity for this study with the use of SPSS statistical tool on the data set revealed that all the variables had acceptable TOL (all the variables > 0.20) and VIF (all the variables < 5) values (*Appendix 4*). Additionally, the correlations between variables were also less than 0.80. Therefore, these results indicated that there are no existences of multicollinearity in the data set and normality test was subsequently conducted.

In addition, this study has accessed the normality of the data based on the skewness and kurtosis approach. Skewness is a measure of asymmetry that describes the shape of the data distribution. It was reported that, the distribution of the data is said to be positively skewed, if the tail of distribution was longer on the right side of the normal curve and a distribution is

considered to be negatively skewed, if the tail of distribution was longer on the left side of the normal curve (Hair et al., 2010; Kline, 2005). In other words, the distribution is positively skewed if the value of skewness is positive while the distribution is negatively skewed if the value of skewness is negative. In addition, kurtosis is a statistics measurement of the "peakedness" of the probability distribution of a real-valued random variable (Hair et al., 2010; Kline, 2005). It is claimed that the higher the kurtosis value, more of the variance exists due to the infrequent extreme deviations.

As for the present study, the researcher used SPSS statistical software to obtain the value of skewness and kurtosis, and followed the suggestion by Kline (2005), who stated that the acceptable range value of the skewness is (±3:3), and the range value of kurtosis is (±10:10). This means that any of the measured variables' skewness and kurtosis values that fall within this range can be considered as normal (Kline, 2005). The results of normality (*Appendix 5*) for all the items in the measured variables had absolute values of skewness within the range of plus minus 3, and absolute values of kurtosis within the range of plus minus 10, indicating that the data were normally distributed (Hair et al., 2010; Kline, 2005). In sum, the results of checking outliers, multicollinearity, and normality indicated that the basic SEM criteria were met and can proceed with further analysis.

5.3 Respondents' Profile

After the preliminary examination of data in the earlier section, this section presents the profiles of medical tourists (*n=386*), including the demographic characteristics and their medical travel behaviour. In this study, the respondents' profiles were regarded as imperative information since they can provide further justifications to the research findings.

5.3.1 Respondents' Demographic Characteristics

Table 5.1 demonstrates the demographic characteristics of the medical tourists who participated in the research study. Based on the statistical figures in Table 5.1, approximately 54.4 % of the medical tourists were females and 45.6 % were males. In terms of marital status, the majority of medical tourists, or 77.8 %, who visited Malaysia were married and followed by single individuals who stood at 17.4 %. Moreover, majority of the medical tourists was in the age group of 46 – 55 years old (27.5 %) and was followed closely by patients from the age group of 36 – 45 years old (27 %). With regards to education level, the statistics revealed that a majority of the medical tourists earned a bachelor's degree (30.5 %) and also Certificate or Diploma (26.3 %). In addition, a majority of the medical tourist were business proprietors/Self-employed (27.50 %) and were in Executive/Managerial position (16.8 %) as far as employment was concerned.

Table 5.1: Demographic Profile of the Respondents

Variable	Classification	Frequency	Percentage (%)
Gender	Male	176	45.6
	Female	210	54.4
Marital	Single	67	17.4
	Married	301	77.8
	Divorced	9	2.3
	Widowed	8	2.2
	Others	1	0.3
Age Group	25 years old and below	17	4.4
	26 – 35 years old	71	18.3
	36 – 45 years old	104	27.0
	46 – 55 years old	106	27.5
	56 – 65 years old	70	18.1
	above 65 years old	18	4.7
Educational Level	High school or below	89	22.5
	Certificate or Diploma	101	26.3
	Professional certificate	43	11.3
	Bachelor's degree	117	30.5
	Postgraduate education	36	9.4
	Others	0	0
Employment	Professional position	55	14.3
	Production/Manufacturing position	14	3.6
	Business Proprietors/Self-employed	106	27.50
	Unemployed	47	12.2
	Executive/Managerial position	65	16.8
	Clerical/Administrative/Secretarial	26	6.7
	Retiree/Not in the work force	38	9.8
	Others	35	9.1

5.3.2 Medical Tourists' Travel Behaviour

Table 5.2 presents the travel behaviour of medical tourists. The respondents who visited Malaysia for medical treatments, on average, had visited Malaysia between three and four times (mean value= 3.75). Moreover, the statistics also revealed that the respondents who participated in this research study, on average, had visited the same hospitals they previously visited for up to three times (mean value =2.99). Table 5.2 also shows that a majority of the medical tourists (71.8 %) dealt directly with their preferred hospital when it comes to medical trip arrangement. In addition to the aspect of medical trip arrangement, the results also showed that as many as 19.7 % of the medical tourists depended on tour agency of their country of residence as part of the alternative for them to visit Malaysia, particularly Penang for medical services.

Next, for the context of seeking medical service, 23.3 % of the medical tourists sought orthopaedic treatments, 17.9 % sought cardiovascular surgery and care, 16.3 % sought comprehensive medical check-up, while 9.8 % pursued cancer treatment (Oncology), 9.6 % for Sight treatment/ Lasik treatment, 5.7 % sought fertility care, 5.5 % sought for Cosmetic/plastic/ reconstructive surgery. Lastly, the results in Table 5.2 showed that the majority of the medical tourist spent at least RM10,000 in Malaysia for the purpose of medical treatments for the past three years. This study also revealed that some of the medical tourists (2.80 %) spent more than

RM100,000 for medical treatments. The following section details the results of the descriptive analysis.

Table 5.2: Travel Behaviour of the Respondents

Variable	Classification	Frequency	Percentage
Numbers of medical trips to Malaysia (*mean value*)			*3.75*
Numbers of medical trips to current visiting hospitals (*mean value*)			*2.99*
Types of Medical Treatment Arrangement	Directly with the hospital	277	71.8
	Through medical travel intermediaries' websites (such as mhtc.org.my, myMEDholiday.com, malaysiahealthtour.com, etc.)	18	4.7
	Through tour agency of your country of residence	76	19.7
	Others	15	3.9
Types of Medical Services Sought	Orthopaedic (e.g. Joint, spine)	90	23.3
	Sight treatment/ Lasik	37	9.6
	Fertility care	22	5.7
	Comprehensive medical check-up	63	16.3
	Cosmetic/plastic/reconstructive surgery	21	5.5
	Cardiovascular surgery and care	69	17.9
	Oncology (Cancer treatments)	38	9.8
	Others	46	11.9
Amount spent on medical treatments in Malaysia for the past three years	Less than RM 10,000	88	22.8
	RM 10,001 – RM 20,000	106	27.5
	RM 20,001 – RM 30,000	70	18.1
	RM 30,001 – RM 40,000	35	9.1
	RM 40,001 – RM 50,000	22	5.7
	RM 50,001 – RM 60,000	14	3.6
	RM 60,001 – RM 70,000	15	3.9
	RM 70,001 – RM 80,000	10	2.6
	RM 80,001 – RM 90,000	9	2.3
	RM 90,001 – RM 100,000	6	1.6
	More than RM 100,001	11	2.8

5.4 Descriptive Analysis

Descriptive analyses were conducted on the entire studied variables in this study, namely as hospital-created social media, user-generated social media, word of mouth communication, brand image, service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention. In this study, the descriptive analyses consist of mean and standard deviation of these variables. The means and standard deviations generated from the data provided a representative value for the entire set of data. According to Hair et al. (2010), the mean for the data can be explained as the expected value that is derived from the central point of the random variable. Mean of the data can be computed based on the summation of all the data values in the measured variable by dividing the values with the number of items. On the other hand, standard deviation is commonly used to measure diversity or variability in statistics. In other words, standard deviation indicates how much variation (dispersion) there is from the mean. The following subsections further discuss the mean and standard deviation of all the variables included in this study.

Table 5.3 presents the summary of both the means and standard deviations for all the variables employed in this study. For hospital-created social media, the finding (mean = 4.333, standard deviation = 0.908) suggested that on average, the respondents agreed with the positive hospital-created social media statements. Similarly, the respondents also agreed with the positive feedback on user-generated social media statements where the mean value is above the midpoint of the scale (mean = 4.406, standard

deviation = 0.744). As for the context of word of mouth communication, the respondents in this study agreed with the positive word of mouth communication statements where the mean value for this variable is above the midpoint level (mean = 4.478, standard deviation = 1.013). Likewise, the same scenario was applied to the remaining variables in this study, namely brand image, service quality, perceived value, perceived trust, and their future behavioural intention.

The above scenario implies that the respondents, on average, perceived the hospitals that they visited had a favourable brand image (mean = 4.868, standard deviation = 0.566), agreed that the hospital that they visited provided good quality medical services (mean = 4.598, standard deviation = 0.423), perceived that the hospitals which they visited for medical treatments represented good value (mean = 4.573, standard deviation = 0.643), trusted the hospitals that they visited for medical services (mean = 4.782, standard deviation = 0. 506), satisfied with the hospitals they visited (mean = 4.653, standard deviation = 0.552) and had a positive level of behavioural intention to return to Malaysia for medical services in the future (mean = 4.688, standard deviation = 0.667). Having conducted the descriptive analysis for all the variables, the researcher proceeded with the testing of convergent validity in the subsequent section.

Table 5.3: Means and Standard Deviations for the Variables

Variables	Mean*	Standard Deviation
Hospital-created Social Media	4.333	0.908
User-generated Social Media	4.406	0.744
Word of Mouth Communication	4.478	1.013
Brand Image	4.868	0.566
Perceived Service Quality	4.598	0.423
Perceived Value	4.573	0.643
Perceived Trust	4.782	0. 506
Patient Satisfaction	4.653	0.552
Behavioural Intention	4.688	0.667

Note. * Six-points scale: 1 = strongly disagree; 6 = strongly agree

5.5 Validating the Measurement Model

After all the criteria of SEM has been met as stated in section 5.2, the researcher is able to evaluate the validity aspect of a construct based on covariance structural models with the use of AMOS (Hair et al., 2010). It was suggested that the casual relationship between the latent variable and their observed items should also be determined and presented in order to address the validity and reliability aspect of the construct (Anderson & Gerbing, 1988). Thus, confirmatory factor analysis (CFA) was seen as a necessary procedure in this study as it had been considered prudent statistically to ascertain if the measurement model and relevant survey had captured the factors or different dimensions, to determine the interrelationships between hospital-created social media, user-generated social media, word of mouth communication, brand image, perceived service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention in the context of

medical tourism in Malaysia. With that in mind, CFA was performed in this section, and at the same time, the validity and reliability of the constructs adopted in this study were examined as well.

Table 5.4 indicates that all the CFA indices fulfilled the threshold values. Although it was found that the Goodness of Fit index (GFI) was below the recommended value of 0.90, this does not mean that the model have a poor fit because other Goodness-of-fit indices (e.g. RMSEA= 0.030; CFI= 0.961; TLI= 0.958; Normed Chi-square= 1.357) have achieved the recommended threshold value. Based on the justification above, it can be asserted that the measurement model for this study was reasonably fit. Having satisfied the justification of model fit for the measurement model, the results of the validity (convergent and discriminant) and reliability tests were discussed in the following subsections.

Table 5.4: Goodness-of-fit Results for Measurement Model

Goodness of Fit Statistics	Desired Range of values for a good fit	Values
Goodness of Fit Index (GFI)	≥ 0.90	0.877
Root-Mean Square-Error of Approximation (RMSEA)	≤ 0.08	0.030
Comparative-Fit-Index (CFI)	> 0.90	0.961
Tucker Lewis Index (TLI)	> 0.90	0.958
Normed Chi-square (χ^2/df)	1.0 - 5.0	1.357
Chi-Square		1665.348
Degree of Freedom		1227

Note. All the cut-off value for the desired range of values for a good fit was based on the suggestion by Hair et al. (2010)

5.5.1 Convergent Validity Test

Factor loading was used in the present study to assess the loadings of the items for the latent construct. Hair et al. (2010) recommended that the standardised factor loading for the items should be significantly related to the latent construct with at least a loading value of 0.50 and ideally exceed the value of 0.70. However, the cut-off point for the factor loading above 0.60 is still acceptable as a good loading. Moreover, it is argued that the variable item with loading less than 0.60 is recommended to be dropped from the statistical consideration in order to improve the content validity of the scale (Hair et al., 2010). As presented in Table 5.5, factor loading for items of other variables in the study were: hospital-created social media (0.882 to 0.930), user-generated social media (0.815 to 0.884), word of mouth communication (0.825 to 0.911), brand image (0.707 to 0.835), perceived value (0.612 to 0.827), perceived trust (0.668 to 0.763), patient satisfaction (0.777 to 0.821), behavioural intention (0.774 to 0.819), and perceived service quality (0.641to 0.784). In summary, the factor loading for the entire observed variables in this study were above 0.60, which surpassed the cut-off values recommended by Hair et al. (2010). The results indicate that all the items for the measured variables were well-loaded on its latent variables and fulfilled the requirements of convergent validity.

Furthermore, the reliability for each variable in this study was measured using two main measurements of internal consistency: (1) Cronbach's alpha (α) and (2) composite reliability (CR). The measure of

internal consistency reports how closely the items are associated with its measured variables. A variable is considered to be reliable if both the Cronbach's alpha and composite reliability values meet or surpass the recommended level of 0.70 (Hair et al., 2010). Although the Cronbach's alpha index is widely used to assess reliability, some scholars argued that it underestimates the aspect of reliability. As such, the use of composite reliability had been suggested as a better alternative for Cronbach's Alpha (Jöreskog, 1971; Vehkalahti, Puntanen, & Tarkkonen, 2006). Therefore, the researcher included both values of Cronbach's alpha and composite reliability as the criteria in explaining reliability.

As presented in Table 5.5, the Cronbach's alpha and composite reliability values for other variables are: hospital-created social media (α=0.927; CR=0.928), user-generated social media (α=0.873; CR=0.878), word of mouth communication (α=0.947; CR=0.944), brand image (α=0.817; CR=0.822), perceived value (α=0.835; CR=0.818), perceived trust (α=0.832; CR=0.837), patient satisfaction (α=0.870; CR=0.872), band image (α=0.830; CR=0.832), and perceived service quality (α=0.808; CR=0.858). Overall, the Cronbach's alpha and composite reliability for all the constructs in this study were above the threshold value of 0.70, which indicates all the items within the particular variables were "reliable" and fulfilled the requirements of convergent validity.

On top of that, another indicator of convergent validity in this study is Average Variance Extracted (AVE), which is considered as a more

conservative test in addressing convergent validity. According to Fornell and Larcker (1981), AVE is used to measure the error-free variance from a set of items of a construct. That is to say, AVE is used to measures the amount of variance from the variance attributable to measurement error (Hair et al., 2010). Moreover, it has been claimed that convergent validity is considered to be only sufficient when the value of AVE is equal or more than 0.50. Referring to Table 5.5, the values of AVE for the variables measured in this study are: hospital-created social media (0.810), user-generated social media (0.705), word of mouth communication (0.772), brand image (0.607), perceived value (0.533), perceived trust (0.507), patient satisfaction (0.630), behavioural intention (0.623), and perceived service quality (0.549). The results directly revealed that all the values of AVE are above the recommended value of 0.50 which was suggested by Hair et al. (2010). Therefore, the above values of AVE revealed that the measurement model fulfilled the statistical requirements for convergent validity.

Table 5.5: Convergent Validity and Reliability of the Variables in Study

Variables	F.L	C.A	C.R	AVE
First Order Variables				
Hospital-created Social Media				
1) The level of this hospital's social media communications for its brand meets my expectations.	0.882	**0.927**	**0.928**	**0.810**
2) Compared with the very good social media -communications of other competing hospitals, this hospital's social media communication for its brand performs well.	0.930			
3) I am satisfied with this hospital's social media communications for its brand	0.888			

(continued)

Table 5.5: Convergent Validity and Reliability of the Variables in Study (continued)

Variables	F.L	C.A	C.R	AVE
Word of Mouth Communication				
1) My family/friends positively influenced my attitude towards this hospital's brand	0.825	**0.947**	**0.944**	**0.772**
2) My family/friends mentioned positive things I had not considered about this hospital's brand.	0.856			
3) My family/friends provided me with positive ideas about this hospital's brand.	0.888			
4) My family/friends positively influenced my evaluation of this hospital's brand.	0.910			
5) My family/friends helped me make the decision in selecting this hospital's brand.	0.911			
User-generated Social Media				
1) The level of the social media communications feedback expressed by other users about this hospital's brand meets my expectations.	0.819	**0.873**	**0.878**	**0.705**
2) Compared with the very good social media communications of other users' feedback about other competing hospital brands, the social media communications of users' feedback about this hospital's brand performs well.	0.884			
3) I am satisfied with the social media communications feedback expressed by other users about this hospital's brand.	0.815			
Brand Image				
1) This hospital's brand possesses complete practical functions (medical services and adequate medical facilities).	0.707	**0.817**	**0.822**	**0.607**
2) This hospital's brand possesses a positive symbolic meaning (good reputation, credibility and positive image).	0.835			
3) I feel that this hospital's brand can provides me with pleasant service experience.	0.789			
Perceived Value				
1) The effort involved to decide on this medical service is worthwhile.	0.612	**0.835**	**0.818**	**0.533**
2) The time I spent flying from my country to this country to receive medical service is worthwhile.	0.633			
3) The services provided by this hospital are good for what I have to pay.	0.827			
4) The money I spent for this medical service is well worth it.	0.821			

(continued)

Table 5.5: Convergent Validity and Reliability of the Variables in Study (continued)

Variables	F.L	C.A	C.R	AVE
Perceived Trust				
1) The staffs of this hospital will honestly inform me about the result of diagnosis.	0.701	**0.832**	**0.837**	**0.507**
2) The staffs of this hospital will honor the agreement made with me.	0.722			
3) My medical issues are well handled by the staffs of this hospital.	0.703			
4) I can trust this hospital staffs' judgment based on my sickness.	0.668			
5) I can rely on the staffs of this hospital to solve my medical issues.	0.763			
Patient Satisfaction				
1) I am satisfied with my decision to use the service at this hospital.	0.787	**0.870**	**0.872**	**0.630**
2) My choice to come to this hospital is a wise decision.	0.777			
3) My experience at this hospital is satisfactory.	0.788			
4) I am not disappointed to use this hospital's service.	0.821			
Behavioural Intention				
1) I will recommend that other people to use this hospital.	0.819	**0.830**	**0.832**	**0.623**
2) If I need medical services in the future outside my country of residence, I would consider this hospital as my first choice.	0.774			
3) I will tell other people good things about this hospital.	0.775			
Second Order Variable				
Perceived Service Quality				
1) Tangible	0.641	**0.808**	**0.858**	**0.549**
2) Reliability	0.784			
3) Responsiveness	0.747			
4) Assurance	0.756			
5) Empathy	0.767			

Notes. Recommended thresholds: Factor Loading (F.L) > 0.60; Cronbach Alpha (C.A)> 0.7; Composite Reliability (C.R) > 0.6; Average Variance extracted (AVE) > 0.5, (Hair et al., 2010; Nunnally & Berstein, 1994).

**** Composite Reliability (CR) was calculated based on formula by Fornell & Larker (1981)***

$$CR = \frac{\Sigma[\lambda i2]Var(X)}{\Sigma[\lambda i2]Var(X)+\Sigma[Var(\varepsilon_i)]}$$, λ = standardised factor loading, δ = error variance

***** AVE was calculated y based on formula by Fornell & Larker (1981)***

$$AVE = \frac{[\Sigma\lambda i_j]^2 Var(X)}{[\Sigma\lambda i_j]^2 Var(X)+\Sigma[Var(\varepsilon_i)]}$$, λ = standardised factor loading, δ = error variance

Based on above findings, the results of data analysis indicated that the values of factor loading, the values of AVE, Cronbach's alpha, and composite reliability for the hospital-created social media, user-generated social media, word of mouth communication, brand image, perceived service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention, were above the recommended threshold. Hence, the convergent validity of both items and variables levels were considered as adequate and satisfactory (DeVellis, 2011; Hair et al., 2010). In consideration of this, all the variables for the present study were valid and reliable for further assessment in the research model. After the convergent validity of the data had been examined, the discriminant validity was examined, as portrayed in the following section.

5.5.2 Discriminant Validity Test

According to Hair et al. (2010), a discriminant validity test is used to measure how a specific measured variable is significantly diverse from other variables. That is to say, discriminant validity can be explained as the degree to which the operationalisation of a construct is different from other constructs theoretically. At the variable level, discriminant validity refers to the extent to which the measured variables are different from one another. To be more exact, discriminant validity at the variable level is established when the variance shared within a variable and other variables in the model is less than the variance that a variable shares with its measures (Hair et al., 2010; Sekaran & Bougie, 2010). In this study, the results of correlation matrix, Average-

Shared-Squared-Variance (ASV), Maximum-Shared-Squared-Variance (MSV), and average variance extracted (AVE) were generated based on the statistical script developed by Gaskin (2012).

In order to test discriminant validity, this study undertook the approach as recommended by Fornell and Larcker (1981). As for this approach, the correlations between variables in the model are compared to the square root of AVE for a given variable. It was reported that the measured variable is closely related to its latent constructs if the values of square root of the AVE (bold and italic in Table 5.6) scores are greater than the off diagonal entries in the corresponding rows and columns. As revealed in Table 5.6, the square root of the AVE (in diagonal entries) showed that each of the latent constructs in the measurement model shared more variance among its own measured variables. Besides, the measured values for ASV and MSV were lower than the values of AVE (Hair et al., 2010). Considering the evidence above, discriminant validity in the present study was considered satisfactory and evidenced at the variable level (Fornell & Larker, 1981). Therefore, the evidence above indicated that the variables in this study were not related to one another and have met the statistical requirement for further analysis.

Collectively, the statistical evidence above revealed that both the convergent and discriminant validity for the variables was established in this study. Thus, this means that these variables had been considered as adequate at the level of acceptable fit and were used in subsequent analyses.

Table 5.6: Discriminant Validity of the Variables in Study

Variables	AVE	MSV	ASV	1	2	3	4	5	6	7	8	9
IMAGE	**0.607**	**0.201**	**0.117**	***0.779***								
INTENT	**0.623**	**0.511**	**0.230**	0.448	***0.790***							
VALUE	**0.533**	**0.314**	**0.142**	0.126	0.560	***0.730***						
PS	**0.630**	**0.511**	**0.205**	0.438	0.715	0.433	***0.793***					
WOM	**0.772**	**0.154**	**0.065**	0.234	0.393	0.253	0.253	***0.879***				
TRUST	**0.507**	**0.343**	**0.168**	0.423	0.479	0.470	0.539	0.187	***0.712***			
HCSM	**0.810**	**0.335**	**0.057**	0.233	0.084	0.088	0.116	0.119	0.132	***0.900***		
UGSM	**0.705**	**0.335**	**0.080**	0.197	0.175	0.243	0.180	0.294	0.178	0.579	***0.840***	
PSQ	**0.549**	**0.391**	**0.204**	0.448	0.625	0.516	0.590	0.215	0.586	0.087	0.171	***0.741***

Notes.

a) IMAGE= Brand Image, INTENT= Behavioural Intention, VALUE= Perceived Value, PS= Patient Satisfaction, WOM= Word of Mouth Communication, TRUST= Perceived Trust, HCSM= Hospital-created social media, UGSM= User-generated social media, PSQ= Service Quality.

b) The diagonal entries (in Bold and Italics) represent the squared roots average variance.

c) The Table is generated with "Stats Tools Package" script developed by Gaskin (2012)

5.6 Structural Equation Modelling

Structural Equation Modelling (SEM) is an emerging statistical tool that is gaining popularity in the research platform for social sciences (Tomarken & Waller, 2005). The structural equation model analysis was performed in order to examine the causal relationships as hypothesised based on the correlation coefficient (Jöreskog & Yang, 1996). As for this study, SEM has been used to examine the interrelationships of hospital-created social media, user-generated social media, word of mouth communication, brand image, perceived service quality, perceived value, perceived trust, patient satisfaction, and behavioural intention in the context of medical tourism in Malaysia. The overall fit of the structural model was initially examined in order to determine whether if the model was fit and valid before proceeding with analysing the structural links. The model fit for the structural links was further discussed in the subsequent subsection.

5.6.1 Model Fit

The results in Table 5.7 have indicated that the structural model was shown to be reasonably fit. The goodness-of-fit indices obtained in this study are summarised in Table 5.7. The values are GFI= 0.850; RMSEA= 0.033; CFI= 0.953; TLI= 0.950; Normed Chi-square= 1.424, Chi-Square= 1777.636, and degree of freedom= 1248. All the goodness-of-fit indices fulfilled the basic threshold values except the GFI value, which is below the recommended value of 0.90. In view of this matter, the researcher has conducted "item

parcelling" statistical technique on the construct of service quality (second order) in order to improve the values of goodness-of-fit indices. In this study, the process of creating composites was carried out, as outlined by Bandalos and Finney (2001) and Bandalos (2002), which was to sum the factor score weights for the SERVQUAL's dimensions (e.g. Tangible, Reliability, Responsiveness, Assurance, and Empathy) and then divide each dimensions score weight by the total. All the computed dimensions for SERVQUAL were generated with the use of SPSS statistical software.

In addition, it has been reported that the reduction of item provides optimum solutions, improve validity, provide less biased parameter estimates, and improve the model fit (Coffman & MacCallum, 2005; Mithas, Jones, & Mitchell, 2008; Schumacker & Lomax, 2004). In other words, it was reported that models with parcels as indicators will provide better fit values compared to the model that used items as indicators. This is because; the order of the item correlation matrix is larger than the order of the parcel correlation matrix (Bandalos & Finney, 2001). Moreover, Stephenson and Holbert (2003) claimed that the estimating relationships between the parcelled variables are having the same effect as estimating relationships between single-item observed variables. Therefore, it is not surprising that social and behavioural researchers have been opting to reduce the number of parameter estimates by using parcels of items as indicators for the second order construct in their research models (Mithas et al., 2008; Rocha & Chelladurai, 2012; Thompson, 2005).

After all of the items in the dimensions of SERVQUAL were parcelled accordingly, the results in Table 5.7 revealed that there was an increase in Goodness of Fit Index (GFI). The values of Goodness-of-fit indices (GFI= 0.895; RMSEA= 0.036; CFI= 0.967; TLI= 0.955; Normed Chi-square= 1.486, Chi-Square= 806.751, and degree of freedom= 543) shows that all the indices fulfilled the basic threshold values, except GFI. Although the GFI is still below the recommended value of 0.90, the parceling technique in fact did improve the value of GFI near to 0.90. In sum, the structural equation modeling results indicated that the causal model was considered adequately fit as other Goodness-of-fit indices for the model are well above its threshold value.

Table 5.7: Goodness-of-fit Results for the Structural Model

Goodness of Fit Statistics	**Values**		**Desired Range of values for a good fit**
	Before*	**After***	
Goodness of Fit Index (GFI)	0.850	0.895	≥ 0.90
Root-Mean Square-Error of Approximation (RMSEA)	0.033	0.036	≤ 0.80
Comparative-Fit-Index (CFI)	0.953	0.967	> 0.90
Tucker Lewis Index (TLI)	0.950	0.955	> 0.90
Normed Chi-square (χ^2/df)	1.424	1.486	1.0 - 5.0
Chi-Square	1777.636	806.751	
Degree of Freedom	1248	543	

Note. *Items parcelling for the constructs of Service Quality (SERVQUAL)

Having obtained and justified the model fit for the structural model, the path analysis for the hypothesised relationship of the present study were presented in the subsequent section.

5.6.2 Path Analysis

The goodness-of-fit indices of the research structural model above indicated in Table 5.7 suggest that the research model fits the data very well. That means that the conceptual model developed in the present study fitted the reality, as signified by the samples from the data collected (Sekaran, 2005). Table 5.8 shows that results from the structural model illustrate the path significance and standardised path coefficients for the hypotheses developed for this study. As shown in Table 5.8, it was indicated that only hospital-created social media ($\beta = 0.185$, $p < 0.05$) and word of mouth communication ($\beta = 0.214$, $p < 0.001$) had positive influences on patients' perception of brand image. In comparison, word of mouth communication had more significant impact on patients' perception of brand image in the context of medical tourism in Malaysia.

The findings also revealed that there was a positive impact of brand image on patients' perception of service quality ($\beta = 0.484$, $p < 0.001$). Similarly, the standardised estimate (β) between perception of service quality and perceived value is 0.550 ($p < 0.001$), which suggested a positive direct relationship between both variables. This scenario is also applicable to perceived trust based on the results obtained from the statistical results ($\beta = 0.633$, $p < 0.001$). Besides that, the findings of the study showed that the perception of service quality had a direct positive influence on patient satisfaction ($\beta = 0.425$, $p < 0.05$). The results from the analysis showed that both perceived value ($\beta = 0.162$, $p < 0.05$) and perceived trust ($\beta = 0.222$, $p <$

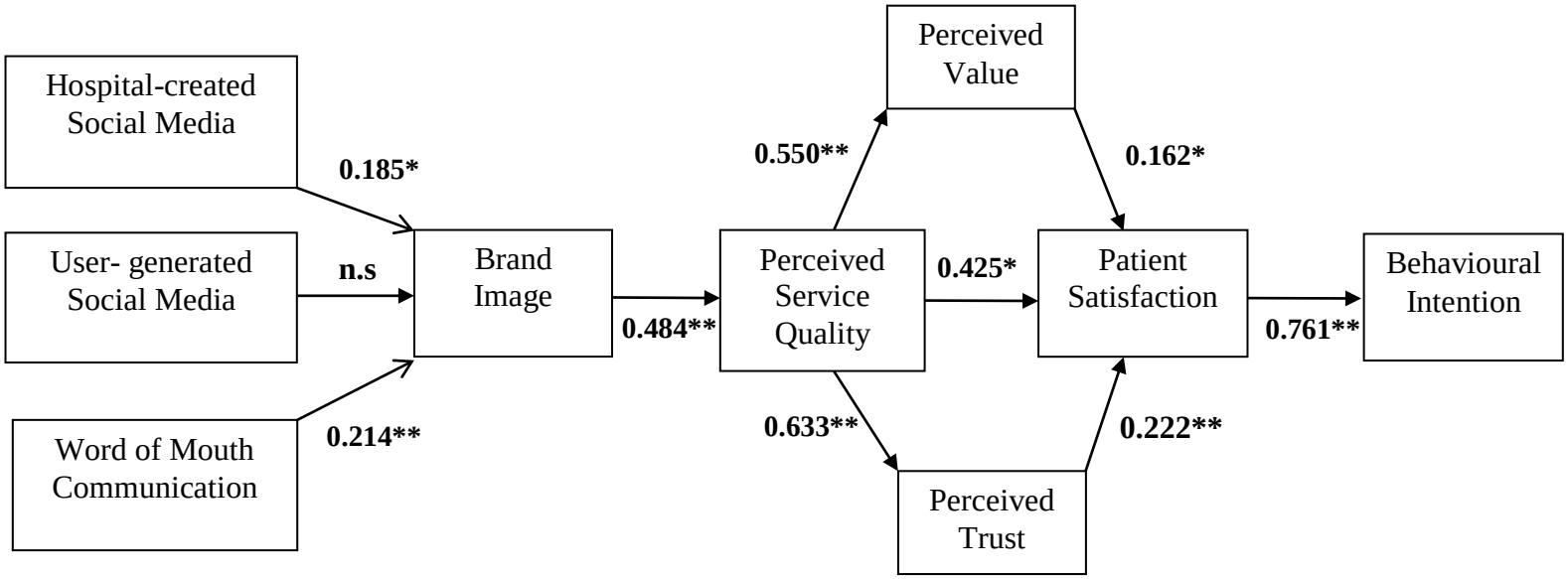
0.001) had a significant positive relationship on the patient satisfaction. In a similar vein, the statistical results also reported that patient satisfaction had a significant positive relationship with patients' behavioural intention (β= 0.761, p< 0.001).

Overall, the results, as shown in Table 5.8 and Figure 5.1, the results of the path analysis indicated that only nine hypothesised paths in the research model were significant, except for the relationship between user-generated social media and perception on brand image. The results for the H11 (*perceived value mediates the relationship between service quality and patient satisfaction*), and H12 (*patients trust mediates the relationship between service quality and patient satisfaction*), will be discussed in the subsequent sections.

Table 5.8: Results of Path Analysis

Paths	S.E	C.R	P Value
H1: Hospital-created Social Media → Brand Image	0.185	2.570	0.010
H2: User-generated Social Media → Brand Image	0.038	0.493	0.622
H3: WOM Communication → Brand Image	0.214	3.589	0.000
H4: Brand Image → Perceived Service Quality	0.484	7.145	0.000
H5: Perceived Service Quality → Perceived Value	0.550	8.168	0.000
H6: Perceived Service Quality → Perceived Trust	0.633	8.668	0.000
H7: Perceived Service Quality →Patient Satisfaction	0.425	4.851	0.009
H8: Perceived Value → Patient Satisfaction	0.162	2.594	0.002
H9: Perceived Trust → Patient Satisfaction	0.222	3.154	0.000
H10: Patient Satisfaction → Behavioural Intention	0.761	13.051	0.000

Note. S.E: Standardised Estimate; C.R: Critical Ratio



Note. **p-value < 0.001; *p-value < 0.005; n.s= not significant

Figure 5.1: Standardised Path Coefficients

5.6.3 Testing Mediating Effects

The proposed research model (Figure 3.1) indicates that there are two hypothesised mediation effects between perceived service quality and patient satisfaction. These mediation effects are (1) perceived value mediates the relationship between perceived service quality and satisfaction, and (2) perceived trust mediates the relationship between perceived service quality and satisfaction. As noted in the research methodology, this study has adopted three different methods as suggested by Wood et al. (2008) in order address the mediating effect. These methods were Baron and Kenny's causal steps tests, bootstrapping test, and Soble's Z test, which had been conducted with the use of statistical macro script developed by Preacher and Hayes (2004). The findings are discussed in the following sections.

Mediating Role of Perceived Value in the Relationship between Perceived Service Quality and Patient Satisfaction

As discussed in Chapter 4, Baron and Kenny's (1986) causal steps suggest four conditions to infer mediation. These conditions and the results of data analysis for the study are presented as below:

- Condition 1 – The independent variable (X) was a significant predictor of the dependent variable (Y). Based on the results of data analysis, perceived service quality (X) was significantly and positively related to

patient satisfaction (Y) ($b = 0.615$, $t = 10.492$, $p < 0.001$). Thus the first condition is fulfilled.

- Condition 2 – The independent variable (X) was a significant predictor of the mediator (M). Based on the findings, perceived service quality (X) was significantly and positively related to perceived value (M) ($b = 0.666$, $t = 9.598$, $p < 0.001$). As such, the second condition is fulfilled.

- Condition 3 – The mediator (M) was a significant predictor of the dependent variable (Y). Research finding indicated that perceived value (M) was significantly and positively related to patient satisfaction (Y) ($b = 0.186$, $t = 4.425$, $p < 0.001$). In view of that, the third condition is fulfilled.

- Condition 4 – The effects of independent variable (perceived service quality) on the dependent variable (patient satisfaction) were reduced when the mediating variable (perceived value) was added to the regression equation. The unstandardised coefficients (b) was reduced from 0.615 to 0.491, but still remained statistically significant at 99 percent level. As a result, the fourth condition was also fulfilled and the results indicated that perceived value partially mediated the relationship between perceived service quality and patient satisfaction.

In addition to the above, the Sobel's test ($Z= 4.002$, $p < 0.001$) also suggested that there was a mediation effect that existed with indirect effect of

0.124 for perceived value on the association between perceived service quality with patient satisfaction. Moreover, the ratio index of approximately 20 percent for this hypothesis was also in the acceptable range to support the existence of mediation (Jose, 2012). According to Jose (2012), the ratio can be computed by dividing the indirect effect (0.124) by the total effect (0.615), whereby in this study, it was 0.124/0.615 = 0.201(≈ 20 percent), which meant that about 20 percent of the effect of perceived service quality on patient satisfaction went through the perceived value (indirect effect), and about 80 percent of the effect was direct effect (patient satisfaction was influenced directly by perceived service quality). This resulted in a fairly typical example of partial mediation because full mediation usually yields a ration that is above 50 percent (Jose, 2008).

On top of that, bootstrapping estimation using 1000 samples revealed that the two tailed significance was 0.001 with the upper bounds (upper limit) of the 95% confidence interval was 0.194, while the lower bounds (lower limit) of the 95% confidence interval was 0.058 (*Appendix 6*). These results indicated that the indirect effect of perceived value on the association between perceived service quality and patient satisfaction had been significant from zero (Bauer et al., 2006). Specifically, perceived service quality had an indirect effect on patient satisfaction that was transmitted through perceived value. Therefore, hypothesis 11 which was developed for this study, is supported.

Mediating Role of Perceived Trust in the Relationship between Perceived Service Quality and Patient Satisfaction

In this section, the analysis for the mediating effect of perceived trust was conducted similarly to the above mediation analysis discussion. Initially, Baron and Kenny's 4 causal steps have been conducted and followed by Sobel's test and bootstrapping. For the context of Kenny and Baron's test, the conditions to infer mediation and the results of data analysis for the study are presented as below:

- Condition 1 – The independent variable (X) was a significant predictor of the dependent variable (Y). Based on the results of data analysis, perceived service quality (X) was significantly and positively related to patient satisfaction (Y) ($b = 0.615$, $t = 10.492$, $p < 0.001$). Thus the first condition is fulfilled.

- Condition 2 – The independent variable (X) was a significant predictor of the mediator (M). Based on the findings, perceived service quality (X) was significantly and positively related to perceived trust (M) ($b = 0.568$, $t = 10.598$, $p < 0.001$). As such, the second condition is fulfilled.

- Condition 3 – The mediator (M) was a significant predictor of the dependent variable (Y). Research finding indicated that perceived trust (M) had a significant positive influence on patient satisfaction (Y) (b =

0.336, t = 6.312, p < 0.001). In view of that, the third condition is fulfilled.

- Condition 4 – The effects of independent variable (perceived service quality) on the dependent variable (patient satisfaction) were reduced when the mediating variable (perceived trust) was added to the regression equation. The unstandardised coefficients (b) changed from 0.615 to 0.424 but remained statistically significant at 99 percent level. Thus, the fourth condition was also fulfilled and the results revealed that perceived trust partially mediated the relationship between perceived service quality and patient satisfaction.

In addition, the Sobel test (Z= 5.405, p < 0.001) also suggested that there was a mediation effect that occurs with indirect effect of 0.191 for perceived value on the relationship between perceived service quality and patient satisfaction. Moreover, the ratio index of approximately 31 percent (0.191/0.615) for this hypothesis was also mentioned in the acceptable range that supports the existence of partial mediation effect (Jose, 2012). This value indicated that about 31 percent of the effect of perceived service quality on patient satisfaction went through the perceived trust (indirect effect), and the rest were considered as direct effect (patient satisfaction was influenced directly by perceived service quality). Besides that, the bootstrapping estimation using 1000 samples on AMOS revealed two tailed significance of 0.001 with the upper bounds (upper limit) of the 95% confidence interval was 0.281, while the lower bounds (lower limit) of the 95% confidence interval

was 0.117 (*Appendix 7*). These findings indicated that the indirect effect of perceived trust on the association between perceived service quality and patient satisfaction was significant from zero, in which perceived service quality had an indirect effect on patient satisfaction through perceived trust. Hence, hypothesis 12 in this study had been supported.

5.7 Chapter Summary

This chapter has summarised the data obtained from the questionnaire survey in terms of sample characteristics, descriptive statistics, and results for the confirmatory factor analysis (convergent validity and discriminant validity) that were conducted on the variables in this study. Based on the data collected from the questionnaire survey, inferential statistical analysis using Structural Equation Modelling (SEM), Baron and Kenny's causal steps test, Sobel's Z Test, and bootstrapping estimates were performed in order to address the research questions and the hypotheses developed in this study.

Besides, the findings of the study indicated that social media communication (via hospital-created social media) and word of mouth communication had direct impacts on medical tourists' perception on brand image of a particular hospital, which in turn influenced the way patients evaluated the service quality they experienced. Moreover, the study confirmed the interrelationships of perceived service quality, patient satisfaction, perceived value, perceived trust, and behavioural intention. Another noteworthy finding of this study revealed that perceived value and perceived

trust served as partial mediators in the link between perceived quality and patient satisfaction in the Malaysian medical tourism context. Based on the results of analysis as above, the summary for hypotheses testing for all the hypotheses developed in this study are presented in Table 5.9. These results showed that all the hypotheses developed in this study have been supported, except hypothesis 2.

With the understanding of the research findings, the subsequent chapter in this study presents the discussion of the major findings, specifically those that amplify past researches; providing new insights to the current research context and to the medical tourism industry in particular. Moreover, the implications of the study both on the context of theory and managerial perspective are also presented.

Table 5.9: Summary of the Hypothesis Testing

	Hypothesis	Supported by the Data (Yes / No)
H1:	Hospital-created social media will have a positive direct effect on brand image.	**Yes**
H2:	User-generated social media will have a positive direct effect on brand image.	**No**
H3:	Word of mouth communication will have a positive direct effect on brand image.	**Yes**
H4:	Brand image will have a positive direct effect on patients' perceived service quality.	**Yes**
H5:	Patient's perception of service quality will have a positive direct effect on perceived value.	**Yes**
H6:	Patient's perception of service quality will have a positive direct effect on perceived trust.	**Yes**
H7:	Patient's perceived service quality will have a positive effect on patient satisfaction.	**Yes**
H8:	Perceived value will have a positive direct effect on patient satisfaction.	**Yes**
H9:	Perceived trust will have a positive direct effect on patient satisfaction.	**Yes**
H10:	Patient satisfaction will have a positive direct effect on patients' behavioural intentions.	**Yes**
H11:	Perceived value mediates the relationship between service quality and patient satisfaction.	**Yes**
H12:	Perceived trust mediates the relationship between service quality and patient satisfaction.	**Yes**

CHAPTER 6

DISCUSSION AND CONCLUSION

6.1 Introduction

Previous chapters in this study have outlined the introduction of the research, the review of literature, discussion of the research methods, and the analysis results from the data collected. In this chapter, the first section discusses the recapitulation of the study and the reviews the findings that were reported in chapter five are presented. This is followed by the implications of study for marketing theory and for a practical perspective, followed by a discussion on the limitations of the study. Thirdly, there are recommendations for future studies and a discussion on the contributions of the study towards the Malaysian medical tourism industry. As for the final part of this chapter, a conclusion remark is presented.

6.2 Recapitulation of the Study

Since the study was designed based on the context of medical tourism, it is revealed that the perception of the hospitals' brand image can be formed by medical tourists via hospital-created social media and word of mouth communication. In addition to this, brand image plays a significant role in creating a positive impression among medical tourists when it comes to

perceived service quality. It also revealed that medical tourists' perception of service quality, perceived trust, perceived value, and their satisfaction were interrelated and are widely acknowledged to be essential in developing effective marketing strategies of the hospitals, particularly those involved in medical tourism. Moreover, this study found that patients' satisfaction had a positive direct influence on their future behavioural intention. The review of the findings from the data gathered revealed the following noteworthy findings:

- Hospital-created social media and word of mouth communication have a positive impact on the medical tourists' perception of hospitals' brand image.
- Hospital brand image was significantly related to medical tourists' perception of the hospital service quality.
- Medical tourists' perceived service quality was significantly related to their level of perceived value, trust, and their satisfaction.
- Medical tourists' perceived value and trust was significantly related to their level of satisfaction.
- The level of medical tourists' satisfaction was significantly related to their behavioural intention.
- Medical tourists' perceived value and trust partly mediated the relationship between perception of service quality and patient satisfaction.

6.3 Review of the Findings

This section discusses the results from testing the hypotheses that developed to respond to the aim and research objective in this study. A discussion of the results obtained in this study was presented as follows:

The Relationship between Social Media Communication and Perception of Brand Image

In the current context, social media are no longer classified as the virtual space that brands of any business can operate, but rather an important space for businesses' brands that must be fully utilised and exploited if they want to keep up with the market changes and remain relevant in the marketplace. As the trend of social media has been growing over the years, the conventional social platforms were constantly evolving and adapting, more and more social platforms continue to arise, which resulted in a wide variety of platforms for business firms to display their brands for products and services effectively. Past studies have reported that the impact of social media must be considered in all marketing aspects and both firm-created social media and user-generated social media should be included when addressing social media in business environments (Bruhn et al., 2012; Schivinski & Dąbrowski, 2014). Since that the social media aspect in this study was designed based on the study by Bruhn et al. (2012), the two outcomes of the hypotheses (Hypothesis 1 and Hypothesis 2) are discussed in this section.

Based on the statistical results for this study, upon comparing both user-generated and hospital-created social media, it has revealed that only hospital-created social media had a significant positive influence on the perception of brand image ($\beta = 0.185$, $p<0.05$). This finding suggested that only hospital-created social media played a significant role in forming the brand image among medical tourists. Besides that, based on the preliminary investigation on medical tourists, this situation was plausible since the word of mouth and hospital websites played important roles for decision making among the Indonesian patients (who formed the majority group of medical tourists that visited Malaysia). Moreover, most of the hospitals that were involved in this study included their websites in their social media webpage and it shows that social media acted as a "link" for the international patients to visit the hospital's website. Therefore, medical tourists relied profoundly on hospital's social media in getting information about the hospital they visited. With that in mind, it was ascertained that hospital-created social media had a direct impact on the perception of brand image. The finding from this study was also consistent with the argument presented in a study conducted by Musa et al. (2012), which reported that the use of social media had a positive influence on the medical tourists' perception of the hospitals in Malaysia.

In addition, lack of participations among medical tourists in sharing their opinions in their social media account could also be the reason on why the user-generated social media did not support the existence of a relationship between user-generated social media and perception of brand image. This scenario can be acknowledged based on the low provision of testimonial and

feedback by medical tourists in the entire social media platform pertinent to hospitals and medical tourism in Malaysia although there are websites, such as www.mhtc.org.my, www.myMEDholiday.com, www.malaysiahealthtour.com, etc. that were established for this particular reason. Therefore, this drawback causes the medical tourists to be in favour of hospital-created social media compared to the user-generated social media in this study. Moreover, although the support for the relationship between social media communication and brand image is still considered relatively rare, this study successfully showed that social media communication, particularly hospital-created social media, had a direct positive impact on the hospital's brand image in the context of medical tourism. The significant relationship between firm-created social media and perception of brand image in this study was also supported and is consistent with prior studies (e.g. Bruhn et al., 2012; De Pelsmacker & Janssens, 2007; Schivinski & Dąbrowski, 2014; Wang, Yu, & Wei, 2012). Thus, the findings evidently indicate that Hospital-created social media will have a positive direct effect on brand image.

The Relationship between Word of Mouth Communication and Perception of Brand Image

As for this research, the researcher also addressed the association between word of mouth communication and perception of brand image. Based on the statistical output that was discussed in the earlier chapter, the result of $\beta = 0.214$ with 99 percent confidence level revealed that there was a significant positive relationship between word of mouth communication and the medical

tourists' perception towards the brand image of Malaysian hospitals that they visited. This scenario showed that when a medical tourist received a positive review and feedback from their families or friends about a Malaysian hospital, they were more likely to perceive the hospital's brand favourably. In other words, medical tourists would have a favourable perception of the hospital's brand in relation to the hospital's practical functions, symbolic meaning, and the hospital's medical services when they received positive and encouraging word of mouth message from their family and friends.

According to Xu and Chan (2010), those customers who experienced services from a particular service provider, who later committed to the particular brand and constantly shared their experiences or information in order to help others to make brand selection, usually initiate the word of mouth communication. It was asserted by many researchers that word of mouth communication is a powerful transmitting tool in a consumer market because it possessed more advantages compared to other marketing approaches, namely print advertising, personal selling, and radio advertising (Ferguson, 2008; Schindler & Bickart, 2012). Generally, this is because word of mouth communication was considered to be more trustworthy compared to other marketing means since the information was obtained from customers' relatives and friends in adding or supporting to what the customers already experienced and believed about the salient attributes of the services (Lim & Chung, 2011). It was also established in many service-related literature that word of mouth communication was considered as an important factor in determining the perception of brand image for products and services (Jalilvand

& Samiei, 2012; Riezebos, 2003; Podoshen, 2008). Thus, the importance of word of mouth communication for service settings is beyond any doubt and needs to be emphasised when it comes to strategic branding development for any service providers, regardless of any industry.

Furthermore, the importance of word of mouth communication is applicable to the nature of this study. This is because most hospitals in Malaysia do not actively advertise in the international media leading to most of the medical tourists had to obtain information and feedback from their relatives and friends. Moreover, due to the high risk in nature, intangible and high patients' involvement in the medical service delivery, the consideration of inputs from word of mouth communication is particularly important for medical tourists in selecting the brand of Malaysian hospitals for the purpose of medical treatment. Additionally, the use of word of mouth communication helps potential medical tourists to feel safe and confident with their hospital selection process based on the brand image they formed in their mind. Therefore, this outcome eventually orchestrated that word of mouth communication had a significant influence on the medical tourists' perception of hospitals' brand image.

On top of that, the finding from this study is also consistent with the earlier research works whereby there was a positive relationship between word of mouth communication and brand image (Riezebos, 2003; Jalilvand & Samiei, 2012). Although the support for this relationship is still relatively scant in the previous works, the influence of word of mouth communication

was widely studied in the branding perspective (Bambauer-Sachse & Mangold, 2011; East et al., 2008; Xu & Chan, 2010; Wangenheim, 2005). This indicates that the finding from the study indeed provides a clear validation on the relationship of word of mouth communication and brand image is established in the healthcare industry, particularly medical tourism.

The Relationship between Brand Image and Perceived Service Quality

In view of the growth of medical tourism throughout the world, the industry has unceasingly experienced unprecedented changes that becomes challenging for all the medical service providers that were involved in this industry. In order to increase awareness in the marketplace and remain competitive at the same time, most of the medical service providers in this industry are compelled to build a good brand impression among customers. This is generally because medical tourists usually make decisions on the basis of the brand image in selecting hospital (Cham et al., 2015). In addition, Wu (2011) also claimed that the transmission of a hospital's brand image to a target segment of customers (patients) became a vital marketing tool for all the healthcare service providers because brand image plays a significant role in influencing patients' perception of service quality for a particular hospital.

Similar to the findings by Cham et al. (2015) and Wu (2011), the statistical result of (β= 0.484, $p< 0.000$) in this study revealed that the brand image and perceived service quality were positively associated. In other words, the finding from this study suggested that when medical tourists

perceived the brand image of the hospital positively, it strengthened their beliefs towards the quality or benefits of a medical service that is superior. Thus, the weakened brand image creates a reciprocal amplification of perceptions of poor quality and lack of benefits.

Furthermore, the outcome from this study is congruent with the past empirical studies from diverse industries, which reported that a stronger brand image improves the perceptions of quality of service (Bloemer et al., 1998; Brodie et al., 2009; Cretu & Brodie, 2007; Manhas, 2012). Therefore, there is no doubt that consumers usually depend on brand image to maintain or to infer the quality of services, particularly when they consumed risky and high-credence services (Brodie et al., 2009; Wu, 2011). This scenario is relevant to the context of medical tourism because most patients depended on the hospital's brand in their hospital selection and perceive a hospital with a superior brand is able to provide reliable medical services and reduce their level of perceived risks associated with medical services (Cham et al., 2015). Based on the advantage of brand image in the service setting, brand image was classified as one of the strategic techniques that service firms engaged in establishing favourable and positive connection about their brand with the customers and to create a positive impression on the service (Park et al., 1986; Manhas, 2012).

Besides that, because medical service outcomes are very difficult to assess even after purchase, patients with no medical knowledge or experience with other hospitals beyond their country, for example, may not be able to

evaluate if the treatment accepted resulted in an acceptable level of risk and possessed a proper standard of quality for medical services. Thus, this is the reason why most of the patients depend profoundly on brand image in helping them to make decisions in the context of hospital selection. Moreover, a strong brand enhances positive evaluation of a service quality, providing a consistent image, and maintaining a high level of service awareness. This directly enhances the hospital in their market positioning, profitability, and most importantly, instiling confidence among patients, particularly in the context of their perception of the quality of medical services that are about to be experienced. In view of the findings and support from the existing literature, this study suggests and acknowledges that hospital's brand image have a direct positive influence on the perception of service quality in the context of medical tourism.

The Relationship between Perceived Service Quality and Perceived Value

Based on the quality standpoint, perceived value can be explained as the difference between the money paid and effort sacrificed for a certain service with the quality of the service experienced (Wilkie & Moore, 2003; Zeithaml & Bitner, 2000). In other words, positive value is experienced by the customers when less effort is sacrificed and less money is spent by them for high quality products or services. As for this study, the finding from the statistical aspect evidently indicated that perceived service quality was significantly associated with customer's perceived value ($\beta = 0.550$, $p<0.001$). This means that if the medical tourist perceived the service quality of the

hospital they visited to be superior and worthy in terms of effort and money spent; they are more likely to acknowledge the values they received from the service encountered. Therefore, the medical tourists' perception of service quality was considered to be a determinant factor that influences their perception of value on the medical services they experienced in Malaysia.

In addition to the above, the results from this study also indicated that medical tourists perceived the value they received was excellent and worthwhile in terms of the effort, time, and expenditures sacrificed when they visited the hospital which has remarkable medical service performance. This scenario is sensible as medical tourists are the one who traded their money, time, and effort in exchange for a good quality of medical services. If the medical services were performed poorly, this may result in the medical tourists to feel that they were exposed to risky and expensive medical procedures, which in turn will distort their perception of value towards the medical services that they were engaged in for their medical trip. This drawback may also affect the medical tourists' future intention to return to Malaysia for medical purposes in the future. Thus, the finding from this study is congruent with the study conducted by Keng, Huang, Zheng, and Hsu (2007), who maintained that perceived service excellence and value indicates customers' positive service experience and appreciation for the service provider that demonstrates reliability, expertise, and commitment in their service delivery. Thus, there is no doubt that the quality of service becomes a critical indicator for customer values formation in many research studies from various industries (Ladhari & Morales, 2008; Wilkie & Moore, 2003).

On top of that, the finding from this study is consistent with the prior studies which found that the perception of service quality is directly related to customers' perceived value (e.g. Bauer et al., 2006; Brady et al., 2001; Cronin et al., 2000; Hu et al., 2010; Malik, 2012). Therefore, the finding from this study shows that service quality indeed plays a crucial role in influencing the level of value perception among the medical tourists who visited Malaysia for medical purposes (Manaf et al., 2015). Moreover, as there is an increasing competition in the medical tourism industry, medical tourists' perception of value is seen to be an important component by hospitals to move a step ahead in the competition and to reap long-term benefits. Hence, in order to ensure the medical tourists continues to value Malaysia as medical destination in a positive manner, hospitals in this industry should work together in striving to improve the level of service quality, while ensuring all the effort, money, and time that medical tourists sacrificed for their medical trip are worthwhile.

The Relationship between Perceived Service Quality and Perceived Trust

As for this study, the association between perceived service quality and perceived trust was also addressed by the researcher. Based on the result of the statistical analysis in the earlier chapter, the findings indicated that there was a significant positive relationship between perceived service quality and perceived trust ($\beta = 0.633$, $p<0.001$). This directly indicated that when the hospitals in the present study were able to deliver a high quality of service, it will definitely enjoy greater trust from the medical tourists. The finding in this study is consistent with the prior studies whereby it was well documented that

service quality plays a significant role in forming trust among the customers (Alrubaiee & Alkaa'ida, 2011; Chang et al., 2013; Eisingerich & Bell, 2007; Gounaris & Venetis, 2002; Herington & Weaven, 2007; Hazra & Srivastava, 2009; Waheed et al., 2012).

In addition, it was reported that trust from customers can be formed based on their experiences and beliefs towards the service offered by the service providers. As usual, one of the most common ways to evaluate the performance of a particular service provider is based on the quality of service provided (Eisingerich & Bell, 2006; Eisingerich & Bell, 2007; Alrubaiee & Alkaa'ida, 2011). For example, according to Alrubaiee and Alkaa'ida (2011), the inclusion of diverse dimensions from a service quality perspective, namely tangibility, responsiveness, reliability, assurance, and empathy, provide a good platform for patients to evaluate if a particular hospital is functioning appropriately in terms of their medical service delivery. This claim is apposite because it is those patients who experience the service and eventually, they are the ones who have the capacity in evaluating the performance of the service provider.

Alrubaiee and Alkaa'ida (2011) also further argued that good quality of medical service can create confidence among the patients and eventually it can help to build trust in them. In a similar vein, Chang et al. (2013) also claimed that if a patient trusts a hospital, this trust itself usually derived from the quality and reliable service offered by the organisation. By taking into consideration on the evidence from the past studies as above, this notion

supports the argument that the level of trust among the patients is dependent on the level of medical service quality they experienced.

As for the nature of this study, it can be certain that service quality is a vital determinant of trust, as medical tourists' perception of the medical services is likely to have a significant influence on their level of confidence in a hospital's reliability and expertise. Due to the complexity, high-risk in nature, patients' direct involvement in the medical service delivery, as well as lack of expertise or information of patient, the consideration of perceived trust should be strongly emphasised in the context of the medical tourism industry in order to understand the medical tourists better. It is recommended that hospitals that are involved in this high-credence industry should consistently raise the level of service quality above the par level, thereby reducing the perception of risk and contributing toward establishing trust. In view of the support from the prior studies and also the finding from this study, the association between perceived service quality and perceived trust was soundly established in the context of medical tourism in this study.

The Relationship between Perceived Service Quality and Patient Satisfaction

As indicated by the significant standardised path estimate ($\beta = 0.425$, $p<0.005$), the finding from the present study revealed that there was a significant positive relationship between patients' perception of hospitals' service quality and patient satisfaction in the perspective of medical tourism in Malaysia. It was found that hospitals that were able to deliver high quality of

service would enjoy greater patient satisfaction. Hence, the quality of service needs to be designed by hospitals with serious care and attention, and there must be concerted effort to improve service quality on a timely basis so that the patients' requirements can be met in the most efficient and effective manner.

As mentioned in the previous chapters, the measure for the service quality in the present study was based on the SERVQUAL model. With that, the service quality in this study was divided into five key elements, while determining its value in the study. These five elements were empathy, reliability, tangibility, responsiveness and assurance. Collectively, all five aspects of dimensions of SERVQUAL model have distinctive roles during the delivery process of hospitals' services, and they have definite impacts on the overall patients' perception of service quality, which in turn influences their satisfaction. Thus, the findings in this study can be used as a guide for hospitals that participate in medical tourism to enhance essential medical service attributes during the delivery processes, and at the same time be used to improve the level of satisfaction among the medical tourists.

On top of that, the past studies agreed that service providers eventually need to ensure that their services are performed at par level or surpass customers' expectation in order to achieve their satisfaction (Ladhari, 2009; Landrum et al., 2007; Voon, 2011; Oyeniyi & Joachim, 2008; Parasuraman et al., 2005). Moreover, Pulman (2002) mentioned that it will cost an organisation six to fifteen times more in order to attract new customers than to

retain the existing ones. Thus, there is no doubt that a service organisation needs to consistently ensure that their customers are satisfied since satisfied customers are more likely to return for the same service provider compared to non-satisfied customers. In view of this matter, there is significant need for service providers, such as hospitals in this study, to establish appropriate service standards regarding customers' wishes and desires so that they will be satisfied with the services provided (Mostafa, 2005; Naidu, 2009). This outcome is relevant to medical tourism as healthcare service providers should focus upon their healthcare service quality issues in order to improve higher standard of patient satisfaction.

As for this study, the finding concurred with most of the previous studies in healthcare industry that found that the perception of service quality is positively related to patient satisfaction in Malaysia (e.g. Rashid & Jusoff, 2009) and in other countries (e.g. Andaleeb, 2000; Chaniotakis & Lymperopoulos, 2009; Kim et al., 2008; Muhammad et al., 2015; Naidu, 2009; Rahman & Osmangani, 2015; Yesilada & Direktör, 2010). This study showed that to improve service quality in all aspects, such as tangible, reliability, responsiveness, assurance, and empathy should be given due consideration. This is due to the fact that the various aspects of service quality may result in the ultimate perception of service quality among medical tourists (Nazem & Mohamed, 2015). If all the aspects or service quality are properly taken care of during the process of medical services being performed, then the level of patient satisfaction can be enhanced. Hence, based on the support from prior literature and findings of this study, it was established that there is a

significant relationship between perceived service quality and patient satisfaction in the medical tourism industry in Malaysia.

The Relationship between Perceived Value and Patient Satisfaction

In the current competitive business world, delivering superior value to customers is an ongoing concern for many service organisations. Sweeney and Soutar (2001) argued that value is created during the consumption of products or services that were purchased, whereas customer satisfaction is an outcome from the post-purchase stage of the products or services consumption. Therefore, it can be claimed that the perceived value is the antecedent of customer satisfaction whereas customer satisfaction is regarded as the resulting outcome. According to the past literature, empirical research that studied the association between perceived value and customer satisfaction, revealed that the level of customer satisfaction in most cases were usually influenced by the value perceived by customers (Cronin et al., 2000; Eggert & Ulaga, 2002). In other words, the greater the value perceived by customers in a transaction, the higher the level of customer satisfaction. This study also determined the relationship between medical tourists' perception of value and their satisfaction towards their medical services experienced in Malaysia. The results of this study indicated that the satisfaction of patients based on the medical service experienced was significantly affected by the level of perceived value among the medical tourists ($\beta = 0.162$, $p<0.05$).

In addition to the above, the role of value is an increasing concern by patients and hospitals because it is one of the most powerful forces in today's medical tourism marketplace (Lertwannawit & Gulid, 2011). Moreover, value is also considered to be a pivotal determinant of hospital choice and its importance was equalled to the quality aspect in determining patient satisfaction (Cengiz & Kirkbir, 2007). This claim can be supported by the means-end chain theory, which asserted that perceived values guide people's evaluations of the benefits and relevant attributes of a product or service and that these evaluations in turn will impact customers' satisfaction and their purchase behaviour (Koo, 2006). In this case, medical tourists are likely to be satisfied when they perceived the value they received from the service experience is worthwhile, which is in line with the result from the empirical customer satisfaction study by Fornell et al. (1996). The evidence from this study directly spelled out that medical tourists will only be satisfied with the services provided if the hospital they visited for medical purpose can provide equitable value to them.

Based on the discussion above, it was established that perceived value is derived from the comparison of the sacrifices medical tourists made in exchanged for the service benefits experienced, whereby it has shown in this study it is significantly related to patient satisfaction. The finding of this study is consistent with the prior studies that support the basis that perceived value is positively related to patient satisfaction (e.g. Cronin et al., 2000; Eggert & Ulaga, 2002; Lee et al., 2007; Wang et al., 2004). As such, it is evidently

revealed that perceived value will have a positive direct effect on patient satisfaction.

The Relationship between Perceived Trust and Patient Satisfaction

In this study, the relationship between perceived trust and patient satisfaction was also addressed by the researcher. Based on the statistical output from this study, the statistical result from the previous chapter revealed that there was a significant positive relationship between perceived trust and patient satisfaction ($\beta = 0.222$, $p<0.001$). Therefore, this directly means that as the trust level among medical tourists increased, the level of satisfaction felt by the medical tourist increased. In other words, when a medical tourist trusts a hospital that he or she visited, trust will directly influence his or her satisfaction towards the particular hospital.

From a business perspective, trust is typically viewed as one of the most important determinants for collaborative and stable relationships with customers. Therefore, researchers over the decades claimed that trust is important in building and sustaining long-term relationships between both seller and buyer (Singh & Sirdeshmukh, 2000; Kaveh, 2012). This is generally because when customers trust a service provider; their perception of risk will eventually be reduce, and the level of confidence towards the service provider will improve, which in turn lead to their satisfaction (Chiou & Droge, 2006; Doney et al., 2007). Moreover, it is argued that customers generally stay away from vendors who are not trustworthy (Kim, Ferrin, & Rao, 2008; Reichheld

& Schefter, 2000). Hence, if the customer does not have trust with the service provider based on his or her past experience, the same customer will probably be dissatisfied with the service provider and eventually will cause the customers to seek services from the other competitors (Cho, 2006; Ganesan, 1994; Geyskens, Steenkamp & Kumar, 1999; Kim, Ferrin, & Rao, 2003).

In a similar course, patient's satisfaction in his or her medical experience can be seen as their behavioural response that results from their post-treatment affective and cognitive evaluation of medical service encountered, which is formed from their trust and experiences with the service providers (Entwistle & Quick, 2006). As for this study, it can be acknowledged that when a medical tourist formed a stable trust relationship with the hospital that they visited, it would influence his or her attitude and satisfaction towards the effectiveness of medical service provided by the hospital. The finding from this study is congruent with the past research, whereby it was reported that customer trust is an antecedent for customer satisfaction (Chiou et al., 2002; Chiou & Droge, 2006; Kassim & Abdullah, 2008; Kaveh, 2012; Kim et al., 2009). As supported by the prior empirical research evidence, it can be concluded that trust can be considered as the key to enhance medical tourists' satisfaction.

The Relationship between Patient Satisfaction and Behavioural Intention

For the present study, the question that the researcher attempted to answer through the study was to examine if there was a link between patient satisfaction and their behavioural intention to the hospital that they had visited for their medical trip. Based on the data gathered and analysed in the earlier chapter, the researcher found that there was a positive direct relationship between patient satisfaction and their behavioural intention on the Malaysian hospitals that they visited ($\beta = 0.761$, $p<0.001$). This directly means when the satisfaction level among medical tourists increased, so does the level of their behavioural intention.

At present, many service organisations focused their efforts in building and strengthening the relationship between themselves and the customers (Shoemaker & Bowen, 2003). It was claimed by Shoemaker and Bowen (2003) that when building such relationship, information about the customers can be obtained by the service organisation where customers were asked to provide feedback on the services that they experienced. This in turn provides more information for the service firm to address numerous antecedents of customers' behavioural intention. Many of the service organisations nowadays prioritise superior service quality and customer satisfaction to form positive behavioural intention and to cultivate loyalty among their customers (Chaniotakis & Lymperopoulos, 2009; Hutchinson et al., 2009). Hence, in order for service organisations to enjoy a long-term success record in the market, it is important for the particular firm to expand and maintain its

potential customer base by forming positive behavioural intention among the customers (Kandampully & Suhartanto, 2000). In such case, when a hospital enjoys positive behavioural intention among the medical tourists, this is reflected in the customer's favourable attitudes toward the hospital. This means that, medical tourists with positive behavioural intention have more tendencies to make further trips to the particular hospital whenever they need medical services outside their country of residence. Moreover, they are also willing to recommend the medical institution to their family members and friends.

As noted in the previous chapter, researchers commonly supported the notion that customer satisfaction is an important indicator of customers' future behavioural intention. This is because a satisfied customer is more likely to remain with the same service provider due to the fact that customer satisfaction has a capability in retaining existing customers (Pulman, 2002). Based on the importance of both patient satisfaction and their behavioural intention, the relationship between both variables experienced a growth of popularity in the service marketing literature whereby marketing researchers recognised the importance of predicting and understanding consumer behaviour, especially with respect to the satisfaction-behavioural intention link (e.g. Chaniotakis & Lymperopoulos, 2009; Chen & Chen, 2010; Hutchinson et al., 2009). Moreover, the finding of this study evidently showed that the result is consistent with previous literature whereby both patient satisfaction and their behavioural intention was significantly related (Choi et al., 2004; Kim et al., 2008; Shahijan et al., 2015; Wu, 2011).

In addition, the hospitals need to identify the most potential service characteristics in influencing customers' satisfaction (Bowen & Chen, 2001). This is because by understanding customer satisfaction in the service industry, it can help the service providers to identify the important factors that have effect on the customers' purchase experience and their post-purchase behaviour, namely as price insensitivity, word of mouth, and their subsequent purchase (Kandampully & Hu, 2007). In this case, satisfied medical tourists are foreseen to promote positive word of mouth at no cost to the hospital they visited, which will have credible and reliable effect than the conventional advertising approach. Thus, patient satisfaction can be considered as the starting point to enhance medical tourists' behavioural intention, which could possibly lead to a long term relationship. This being so, hospitals that are involved with medical tourism need to work on enhancing the satisfaction of their international patients so that they can create positive behavioural intention among them.

Perceived Value and Perceived Trust Mediates the relationship between Perceived Service Quality and Patient Satisfaction.

As far as the service industry in concerned, many past literature have reported that service quality has a potential effect in influencing customer satisfaction. However, there are also researchers that are against the notion which stated that by solely consider a direct relationship between service quality and customer satisfaction is insufficient, they argued this would provide an imperfect picture of what drives customer satisfaction because the

roles of other concepts such as customer trust and sacrifices that are incorporated in perceived value, were virtually neglected (Kim et al., 2009; McDougall & Levesque, 2000). In the similar vein, a recent study that examined the relationship between service quality and customer satisfaction disclosed that the relationship between both variables does not seem to be linear at all times (Ažman & Gomišček, 2015; Finn, 2011). Therefore, for the purpose of this study, the inclusion of other variables such as perceived value and perceived trust, played an imperative role in explaining patient satisfaction. Moreover, Malik (2011) and Ouyang (2010) reported that the inclusion of perceived value and perceived trust in the research model does not only emphasise the significance of both variables, but it will offer an in-depth explanation of patient satisfaction.

Based on the statistical results in the previous section, all the relationships between (1) perceived service quality and patient satisfaction; (2) perceived service quality and perceived value; (3) perceived value and patient satisfaction; (4) perceived service quality and perceived trust; and (5) perceived trust and patient satisfaction was tested and found to be positively related. This directly means that service quality had direct positive relationship on patients' satisfaction, perceived trust and perceived value. Moreover, patients who trust the hospital and perceived the value to be higher than the service experienced would be satisfied with the medical service they experienced. Thus, it can be concluded that all of these variables are interrelated and have a significant impact on the medical tourism industry in Malaysia. As all the hypothesised relationships mentioned earlier are

supported and the prerequisite requirements for mediation test are met, the researcher conducted a mediation test and the statistical results in this research indicated that perceived service quality had an indirect relationship on patient satisfaction through perceived value and perceived trust. That is to say, perceived trust and perceived value in this study partially mediated the relationship between perceived service quality and patient satisfaction. Refering to this outcome, this study discovered that hospitals that are involved with medical tourism should not only depend on service quality to address patient satisfaction, but must also consider the impact of perceived value and perceived trust (as mediating factors) on patient satisfaction.

Besides that, the finding from the present study also concurred with the earlier research works, whereby perceived value (e.g. Malik, 2012; Walker, Johnson, & Leonard, 2006; Yunus et al., 2009) and perceived trust (e.g. Chiou et al., 2002; Ouyang, 2010) served as mediators in the link between service quality and customer satisfaction. This evidence indicated that the finding of the study provided a validation that perceived service quality had an indirect effect on patient satisfaction via both perceived trust and value. In other words, the association between perceived service quality and patient satisfaction is not linear and it is partially mediated by perceived value and perceived trust in the medical tourism context.

Additionally, this study also suggested that the inclusion of both perceived trust and perceived value in the model provided a better explanation of patient satisfaction as a whole. Despite the importance of service quality, it

is also important for the medical service provider in this industry to create trust and positive value among the medical tourists in order to enhance their level of satisfaction with the services experienced, which in turn leads to positive behavioural intention. Thus, perceived value and trust does contribute to medical tourists' satisfaction, hence, the importance of developing perceived value and trust in providing services to them cannot be undermined and ignored. Referring to the discussion and support of the results above, it can be ascertained that both perceived value and perceived trust have a mediation effect on the relationship between medical tourists' perceived service quality and their satisfaction.

6.4 Implications of the Study

As this study was considered to be one of the empirical studies in Malaysia in the context of medical tourism, several useful implications were discovered from the findings in this research. The following section further articulates the implications of this study on the theoretical as well as the managerial perspectives.

6.4.1 Implications for Theoretical Perspective

The findings of this study provided significant contributions to the existing literature for several reasons. As for the implications on marketing theory, it was found that factors, such as social media communication and word of mouth communication, play critical roles in impelling the way how

customers perceived the service providers' brand regardless of whether they have experienced the services or vice-versa. This finding suggests that word of mouth communication and social media are imperative in the context of medical tourism industry because most medical tourists depend on this channel for information acquisition. In view of that, this evidence revealed that both of these aspects should be considered in any service industry that addresses brand image. Moreover, this study also reported that brand image has a positive impact on customers' perception of service quality for a particular service provider. Therefore, the relationship between both variables revealed that brand image should be emphasised as the precedent to perception of service quality whenever evaluation on service providers is concerned.

As noted in the earlier chapter, the prior studies revealed that brand image of a particular service brand play a significant role in creating an impression and providing an initial understanding for the prospective customers of the service firms. However, the impact of brand image is less studied in the service context. Thus, this empirical study has highlighted the importance of brand image in the high-credence industry, especially in the medical tourism context, where brand image can be one of the main determinants in helping customers in their decision making and service valuation process. Additionally, the results of this study contributed towards the understanding on medical tourists' perception of brand image in relation to the perception of hospitals' service quality. This study is also considered as the first study conducted in the South East Asia context, especially in medical tourism marketing vis-à-vis using antecedent of brand image.

Furthermore, the findings of this study also provided theoretical implications in terms of developing a research framework by incorporating the impacts of word of mouth communication and social media communication on the perception of brand image in the relationship quality model, which was found to have limited empirical evidence. In addition, the interrelationships between perceived service quality, perceived trust, perceived value, patient satisfaction, and behaviour intention were further examined. The research model revealed that all the relationships established in the model contributed to the community of knowledge in the healthcare context and in addressing the importance of each and every construct in this study. For example, as noted in Chapter 3, some studies empirically studied the influence of perceived trust on the customer satisfaction in the general service context. However, the impact from perceived trust on patient satisfaction was hardly examined in the healthcare industry. Therefore, this study can be considered to be one of the empirical studies to examine the influence of perceived trust on patient satisfaction, especially in the medical tourism context. Since trust plays a major role in influencing customers' confidence, it is reasonable to claim that patients' trusts should be included in any study pertaining to the healthcare industry.

On top of that, researchers acknowledged the significant roles of service quality in predicting patient satisfaction. However, this study found that service quality is not the only sole indicator that influenced patient satisfaction as both perceived value and trust also significantly influenced patient satisfaction. The statistical results in this study also indicated that

perceived value and perceived trust had mediating effects on the relationship between perception of service quality and patient satisfaction. A review on the healthcare literature shows that a limited number of studies looked into the mediation effects of both constructs. Therefore, the findings of this research contributed significantly to the marketing theory by considering the mediating effects of perceived value and trust in the relationship between perception of service quality and patient satisfaction.

In addition to the above, this study revealed that the inclusion of both perceived trust and perceived value in the model did not only serve to emphasise on the importance of these concepts, but to provide a better clarification on patient satisfaction. Although the mediation effects of perceived trust and perceived value for the relationship between service quality and patient satisfaction was inferred in this study, it is important to note that there are alternative marketing factors that may possess equal mediating impacts on patient satisfaction. In reality, there is no single mediator that fully explains the relationship between an independent variable and an outcome variable. With that in mind, the finding confirmed that perceptions of a hospital's service quality, as experienced by the medical tourists, had a significant indirect effect on patient satisfaction via perceived value and trust.

In summary, the results of this study contributed to the understanding of strategic and relationship marketing theory from the standpoint of a developing country in the region of South East Asia. Referring to the evidence

of this research on the interdependence of social media communication, word of mouth communication, brand image, service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention, the findings of the present study further emphasised on the importance of marketing literature from an international perspective of medical tourism. In addition to the conceptual contribution of this model, the researcher held on to the belief that there are various practical benefits that can be driven exclusively by revealing the findings of the study whereby these valuable implications are described in the following sections.

6.4.2 Implications for Practical Perspective

The findings of this study revealed that there was a strong and significant interdependence of variables, such as word of mouth communication, social media communication, brand image, service quality, perceived trust, perceived value, patient satisfaction, and behavioural intention in the medical tourism industry of Malaysia. This was established after all the results applied to the relationships between the variables for this study were indeed significant and supported. Therefore, there are several important practical implications from both the managerial and government perspectives that are worthy to be highlighted in order to address the importance of the studied variables in this study.

For the managerial perspective, since that hospital's brand image acted as the main antecedent in the research model, it was anticipated that favourable and positive brand image for the hospital is a critical aspect for the success of the hospital in the medical tourism industry in Malaysia. This is because a favourable hospital brand image helps the hospital to maintain their higher perceptual position and be able to negate the inferior perceptions of their brand. Additionally, brand image was found to possess the capability in enhancing customers' perception of hospital service quality, which in turn promoted patient's satisfaction, perceived value, perceived trust, and their future behavioural intentions towards the hospital.

With the importance of brand image in mind, hospital managers along with the management team must fully understand the importance of brand image and how it is formed. It is suggested that a considerable business resources should be allocated for brand management and various integrated marketing communication strategies, namely advertising, public relations, and internet marketing via social media (e.g. blogs, Facebook, LinkedIn, Twitter, Youtube, forums, etc.), should be implemented to create and maintain the hospitals' brand image. By doing so, these strategies can promote word of mouth communication among medical tourists, which is vital in influencing their perception of hospitals' brand image.

Moreover, it is recommended for the hospitals to have a qualified team to manage the social media communication as this means of communication involved various subject of communication, ranging from general to specific/

technical enquiries in regards to the place and hospital that the medical tourist are about to visit. By having a credible team, this ensures the communication process can be conducted efficiently and is able to promote the professionalism image of the hospital. Besides that, collaboration of hospitals with the government of Malaysian agencies (e.g. Association of Private Hospitals of Malaysia [APHM], Malaysia Healthcare Travel Council [MHTC], etc.) in social media for the medical tourism program is considered to be one of the most effective channels to reach the potential target market, especially at the international platform. This move can enhance the hospital's brand image in the long-run, influence patients' perceived service quality, and to creates awareness among the potential medical tourists as a whole.

Furthermore, the findings retrieved from this study indicated that perceived service quality of the hospital was a very effective vehicle to promote and to improve patients' perceived value, perceived trust, and their satisfaction. This was determined by the significant results of all the relationships that were involved with the hypotheses developed among the variables. In view of the importance of perceived service quality, hospital managers are recommended to recognise the needs from the patients and should implement "patient oriented" service strategies for their medical service delivery. They should focus on providing high level medical services and must take into consideration the importance of the multidimensional aspects of service quality that include responsiveness, reliability, empathy, assurance, and tangibles. This is because failing to identify the needs of the patient could result in degrading hospital reputation, creating more dissatisfied

customers, increasing operational costs, or worse: becoming irrelevant to the industry. For instance, in relation to the aspect of tangibles, hospitals in medical tourism must constantly improve the following: the appearance of physical buildings and medical staff, the decoration of wards, lighting, ambience, background music, improvement of medical technologies, emphasise on the neatness of buildings, and the cleanliness of the overall environment. This is because tangible aspects are something easily accessed and experienced by customers who visit the service providers and have a direct effect on their responses, impression, and perceptions (e.g. Baker & Collier, 2005).

As for the context of empathy aspect, the medical staff should strongly emphasise on the soft skills performance, such as understanding patients' needs and concerns, being empathy, providing individualised attention, and so forth. For example, hospitals' staff should ensure that the medical tourists are comfortable whenever they enter the hospital premises and consistently check with them on what they need during the service encounter. This enables the medical tourists to feel the warmth of Malaysian hospitality and will likely reduce the feeling of uncertainty and anxiety among medical tourists who visit a Malaysia hospital for the first time. Meanwhile, for the aspect of reliability, the medical staff are recommended to put an extra effort in performing their jobs, namely as customer service, therapy, registration, follow-up for patients, and aftercare. This can be performed with the development of suitable and reliable standard operating procedures (SOPs) by the management team in order to facilitate all the processes for medical tourists, from beginning of their

registration to discharging. These procedures are important as it will reduce any uncertainties among the medical tourists and most importantly, to instil confidence in them. After the medical treatments, it is recommended for the staff to listen and take note of the customers' feedback and continuously use the feedback for improvement purposes.

As for the context of assurance, it is suggested that the medical staff should demonstrate excellent efficacy, technical skills, courtesy, and professionalism in order to gain confidence from the medical tourists. This can be performed by ensuring all the medical procedures comply with the procedures and codes of practices set by the Ministry of Health of Malaysia (MOH). This is important as these practices enable medical tourists to feel safe and secure when undergoing medical treatment. Moreover, the medical staff should be responsive, react swiftly to patients' requests, and partake in open communications when the responsiveness aspect is concerned. In this case, all the enquiries from the medical tourists should be attended to as soon as possible. Moreover, all the medical procedures must be performed at the time promised and professionally conducted. For example, the staff should be trained to promptly assist medical tourists for all common procedures, such as bring them to the doctor's consultation room, to the dispensary, make payment, telling them when is the next appointment, and so forth during their hospitalisation.

Furthermore, the model of this research should be considered as a useful guide for hospital managers to develop relationship marketing strategies. The results of this study suggested that hospital managers should be aware of patients' perceived value and their trust because both variables had mediating effects on the relationship between service quality and patient satisfaction. Thus, this fact revealed that creating trust and value among the medical tourists is an important strategy to develop patient satisfaction. However, increasing medical tourists perceived value and perceived trust is not an easy task because they can be influenced by many factors, such as time period and competitors. Although forming perceived trust and perceived value among customers of the service is not a new idea in marketing research, what this study proposed is both perceived trust and their perception of value are strongly predicted by service quality and have a significant impact on patient satisfaction.

As a result, in ensuring that a patient feels satisfied with the medical services, this study recommends that hospital management and their marketers should emphasise on the importance of service quality, reasonable pricing (competitive to competitors' pricing), improving the benefits of the services, and acquire additional staff who are capable of developing patients' trust through their services and understanding individual customer needs. These initiatives can make the medical tourist to feel that their effort and money spent for the medical trip was worthwhile. Moreover, in order to understand individual needs of the medical tourist with a different language and cultural background (e.g. Japanese, Korean, Chinese, Arabian, Indian, and Thailand, to

name a few), it is suggested that hospitals that are involved in medical tourism should develop a special department to handle these group of medical tourists. This approach can facilitate the medical service delivery process and to instil confidence and trust among these groups of medical tourists. Moreover, the entire medical staff that interacts directly with medical tourists should be informed and trained to meet service expectations from them. The improvement of staff's capabilities, skills, and knowledge can be accomplished by providing them with suitable and reliable training on both technical and human aspect.

Furthermore, the findings from the study also indicated that hospitals that are involved in medical tourism must be able to understand the importance of patient satisfaction. This is because patient satisfaction was used to measure other critical customer characteristics pertaining to patients' behavioural intention, such as customers' intention to use medical services in the future and customers' commitment towards the medical services. Therefore, there is no doubt that the aspect of patient satisfaction should be emphasised in long-term service oriented strategy development and to be included in the measurement tools in assessing the intention of the patients to return to the particular hospital in the future or vice-versa. This approach can be achieved through patient feedback programs (service evaluation) from time to time in order to capture patients' opinions pertaining to their perceptions towards the quality of the healthcare service and the level of satisfaction towards the services experienced.

Any discrepancies from the customers' perceptions with the performance provided by the hospitals in the service quality aspects must be accentuated and addressed by the hospital management team because this could allow the entity to further improve their performance. Moreover, this approach is expected to help hospital management to focus their efforts in improving all the factors in medical service context in order to provide superior medical services for the hospital compared to the competitors. With the emphasis being placed on patient satisfaction, this eventually allows the hospital to have a better understanding of customers' expectations, and ultimately creating a positive impact on the patients' behavioural intentions, which are the main root in ensuring a sustainable growth for the operation of the hospital.

As for the context of the Government, this research contributes to the policy and strategies making for both tourism and healthcare industries. For example, by understanding the importance on how medical tourists acquire information (e.g. social media and word of mouth communication) on the hospitals in Malaysia that are involved with medical tourism, it can assists the government in attracting potential medical tourists effectively. Based on the finding from this study, government agencies, such as Malaysia Healthcare Travel Council (MHTC), Malaysia Tourism Promotion Board, and related Destination Marketing Organisation (DMO) should work hand in hand to promote this promising industry. This method can be performed with the use of aggressive marketing approach by promoting Malaysian medical tourism together with the hospitals' brands over the agencies' websites and social

media, as well as through international promotional programmes, international fairs, and so on. Moreover, the government can encourage all the private tour agencies to promote medical tourism by including medical tourism services as part of their product line. In order to get all parties involved and to achieve the objectives, the government of Malaysia can consider a tax relief scheme as an incentive for the Malaysian tourism firms that actively promote medical tourism in the international front.

As for the healthcare sector, since the finding of this study revealed the importance of healthcare service quality, it is recommended for the Malaysian Government to implement medical regulation policies for hospitals that host medical tourist. This is because the concerns for the safety and quality of the medical services are the utmost importance in order to protect the medical tourists. Moreover, medical tourism is dealing with international patients and therefore the aspect of laws should be emphasised. Referring to the fact above, the Malaysian government can opt to set a new scale of accreditation for hospitals that are involved with medical tourism. It is recommended that the accreditation should be sensitive to changes, be in accordance with the results of the best available research, fit for purpose, and must be designed based on the factors that may make a difference towards quality of care. With this standard of accreditation, this scenario will enhance medical tourists' confidence in regards to the Malaysian medical tourism.

6.5 Limitations of the Study

In the research context, most studies are not without limitations. Though this study revealed several noteworthy findings that contributed to the body of healthcare marketing literature, there are two limitations associated with this research that needs to be highlighted. This section will discuss the limitations that were identified in this study.

Firstly, the main limitation in the present study was related to the matter of sampling. This is because, the data was collected based on non-probability sampling (quota sampling), it was only distributed among Indonesian medical tourists, limited geographical coverage in data collection, and was only distribute at once (cross sectional) to four major private hospitals located in Penang state of Malaysia. Therefore, the data collected might not represent other medical tourists who visited Malaysia during other periods of the year and for those who visited other hospitals in different states in Malaysia. Moreover, since Penang is popular among Indonesian medical tourists, this approach also failed to include medical tourists from other countries, such as Middle Eastern, Western, and the other parts of Asian regions. Therefore, the findings for this study only reflected the group of sample taken for the study and may have an issue with generalisability.

The second limitation identified in this study was the researcher did not include qualitative inputs (i.e. conduct interviews and focus groups) to compliment the survey approach. This is because replying to “close-ended”

questions which solely considered as quantitative approach would have constrain the truthful feedback from the respondents as they did not have a chance to give the opinions freely on the area of subject that was under examination. Moreover, this directly hinders the respondents in critically responding to the research questions and might result in biased responses. Nonetheless, this matter can be resolved if interviews were used because the method allows the researcher to collect more responses that reflect the perception and the feeling of the medical tourists. With the identified limitations of this study, the recommendations for the future research are discussed in the following section.

6.6 Recommendations for Future Research

In this study, there are a few research areas of interest that were identified that reflect the limitations acknowledged in the earlier section. The first limitation identified in this study was the coverage issue for data collection. Since that this study only focused on Penang state in Malaysia, this finding may result on the issue related to generalisability. Therefore, it is suggested that a future study should consider more ideal approaches, such as improvement of data collection that includes diversified samples (e.g. wider geographical coverage and including tourists from various countries) from all the hospitals that participated in Malaysia's medical tourism. This approach is expected to improve the generalisability and robustness of the study, and at the same time to ensure that the findings of this study are applicable to different settings.

Future study should also consider the longitudinal approach in data collection. This is because respondents' behaviour and attitude may change according to time (Gratton & Jones, 2004). Moreover, a longitudinal study can allow future researchers to use experimental designs that can benefit them in understanding the relationship of the related constructs with respect to sequencing of event of time. This approach will definitely allow the researchers to evaluate and to assess the changes of medical tourists' behaviour and attitude effectively over time. The understanding of the changes within consumer behaviour and attitude will come in two folds. First, it will provide an opportunity for the researchers to distinguish the changes in the characteristics of the sample (at both the individual and the group levels) and to validate research models over time. Second, the longitudinal approach also allows the practitioners to notice the changes within the market which influence their marketing strategies development in order to remain competitive in the market.

In addition, this study only depended on a survey questionnaire as a main tool in collecting information from the respondents. Although the survey questionnaire is a common method in quantitative research, it was reported that qualitative methodology such as in-depth interviews would be useful to gauge the respondents' feelings and emotions. This is because such information could not be expressed with the statistical analysis or numerical data. Therefore, it is suggested that future research consider the triangulation methods (e.g. combination of both qualitative and quantitative approaches) in

order to improve the robustness of the study and to provide conclusive findings that are applicable to the medical tourism industry as a whole.

6.7 Conclusion

Since the Malaysian medical tourism industry is demonstrating a promising growth, many private hospitals in Malaysia were established in order to satisfy the demand from this booming industry. As such, this scenario has created an intense competition among the private hospitals. Therefore, hospitals that are involved in medical tourism need to develop superior marketing strategies in order to have an advantage over their competitors. In view of these challenges, this study managed to contribute to the industry by providing insights on the aspects of hospitals' brand image and service quality, which are deemed to be important for the medical tourists. Besides, the researcher also suggested ways to improve the hospitals' brand image, service quality, and patient satisfaction. At the same time, the findings had practical implications for relevant and effective micro-marketing strategies for the medical industry in Malaysia.

This study has also contributed numerous significant findings for the medical tourism industry of Malaysia, specifically concerning to the service marketing and consumer behaviour theories. This study strongly emphasised the importance of the impact of hospital brand image, patients' perceived service quality, patient satisfaction, perceived value, and perceived trust in the hope of more effective marketing strategies could be implemented in order to

create positive future behavioural intention among the medical tourists. Moreover, the insights provided by this study can benefit the government of Malaysia too, especially in the aspect of policy making and promoting Malaysia as an outstanding medical tourist destination at the international platform. By realising the importance of hospitals' brand image and service quality perception, the government could consider to include the hospitals in the Malaysian tourism programme and to impose a service guideline and related certifications for the hospitals. This would encourage hospitals to provide intensive training for the entire human resource that are involved directly with the industry. This aspect is highly required and exceedingly important because this industry deals with tourists who come from diverse backgrounds and cultural beliefs.

Nevertheless, even if a hospital is able to improve patient satisfaction through service quality, there is no guarantee that the satisfied medical tourists will return in future. The reason is that even satisfied medical tourists are likely to be attracted by the competitive offerings on their behavioural intention based on the service expectations, brand, price, and services from other hospitals. Therefore, there is a significant need for hospitals to consistently seek ways to understand the influential factors to uphold and to emphasise on patients' future behavioural intention. As indicated by the findings of this study, while it is possible to have an objective evaluation of the hospital's service quality and patient's satisfaction, it is more difficult to gauge patients' perceived value and their trust because patients might be swayed by their emotions. This would influence the finding on the impact on

perceived value and trust on patient satisfaction that eventually affect patients' behavioural intention directly. Consistent with the intense competition, coupled along with growing sophistication of customers' demand, hospitals that are involved in medical tourism might also be required to rise up to the challenges of creating and strengthening positive behavioural intention so that the medical tourists would consider returning to the same medical service provider in future.

As a conclusion, by integrating perspectives from the relationship marketing and service marketing theories, this study offered theoretical and practical insights on how the parties involved in the medical tourism industry can apply them for strategic decision making. Most importantly, all of these research findings would assist them in formulating and implementing effective marketing strategies in order to boost their profit margin, to cope with the intense competition in the region, and to sustain in the industry.

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APPENDICES

Appendix 1: Survey Questionnaire (English Version)

Greetings and Welcome to Malaysia

Dear Respondent,

I am a student pursuing a doctorate degree at Universiti Tunku Abdul Rahman (UTAR), Malaysia. I am currently conducting a research study on hospitals' brand image and service quality in the context of medical tourism. This research project is being conducted as a partial fulfillment of the requirements of my doctoral degree. It is very much appreciated if you take part in this research study. Your participation is very much needed to enhance the understanding of service quality and patient's satisfaction with the hospitals in Malaysia.

Along with this letter, there is a short questionnaire for you to answer. Instructions for completing the questionnaire can be found on the form itself. It is very much appreciated if you could complete and return the questionnaire as soon as possible. It should take you about 15 minutes to complete the questionnaire.

Please do not state your name on the questionnaire form. Any of your responses will not be identified with you personally, and all the information provided by you will be kept strictly private and confidential. Your participation in this survey is on a voluntary basis. If you have any questions or concerns, please do not hesitate to contact me at +6012-5825266 or email me at jaysoncham@gmail.com.

Thank you for your time and cooperation; your participation in this survey study is very much appreciated.

Yours Sincerely,

Cham Tat Huei

Section A: General Information

Please tick (✓) on the appropriate box or fill in the blank for each of the questions given below.

1. What is your gender?

( ) Male ( ) Female

2. What is your marital status?

( ) Single
( ) Married
( ) Divorced
( ) Widowed
( ) Others (*please specify*) _____

3. What is your age group?

( ) 25 years old and below
( ) 26 – 35 years old
( ) 36 – 45 years old
( ) 46 – 55 years old
( ) 56 – 65 years old
( ) above 65 years old

4. What is your highest educational level?

( ) High school or below
( ) Certificate or Diploma
( ) Professional certificate
( ) Bachelor's degree
( ) Postgraduate education
( ) Others (*please specify*) _____

5. Which one of the following best describes your employment?

( ) Professional position
( ) Production/Manufacturing position
( ) Business Proprietors/Self-employed
( ) Unemployed
( ) Executive/Managerial position
( ) Clerical/Administrative/Secretarial
( ) Retiree/Not in the work force
( ) Others (please specify) _____

6. How many times have you traveled on a medical trip to Malaysia including this trip?

( ) First time
( ) 2 times
( ) 3 times
( ) 4 times
( ) more than 4 times (please specify) _____

7. How many times have you visited this hospital for medical services including this trip?

( ) First time
( ) 2 times
( ) 3 times
( ) 4 times
( ) more than 4 times (please specify) _____

8. How did you arrange for this medical trip?

( ) Directly with the hospital
( ) Through medical travel intermediaries' websites (such as mhtc.org.my, myMEDholiday.com, malaysiahealthtour.com, etc.)
( ) Through tour agency of your country of residence
( ) Others (*please specify*) _____

9. What kind of medical treatment are you seeking in this medical trip?

( ) Orthopedics (e.g. Joint, spine)
( ) Sight treatment/ Lasik
( ) Fertility care
( ) Comprehensive medical checkup
( ) Cosmetic/plastic/reconstructive surgery
( ) Cardiovascular surgery and care
( ) Oncology (Cancer treatments)
( ) Others (please specify) _____

10. For the past 3 years, how much have you spent on all the medical treatments done in Malaysia?

( ) Less than RM 10,000
( ) RM 10,001 – RM 20,000
( ) RM 20,001 – RM 30,000
( ) RM 30,001 – RM 40,000
( ) RM 40,001 – RM 50,000
( ) RM 50,001 – RM 60,000
( ) RM 60,001 – RM 70,000
( ) RM 70,001 – RM 80,000
( ) RM 80,001 – RM 90,000
( ) RM 90,001 – RM 100,000
( ) More than RM 100,001

Section B: Perceptions of the Hospital

The following section relates to your perceptions of the hospital that you are currently visiting. For each of the statements listed below, please rate how much you agree or disagree by circling the number that represents your opinion the most.

Hospital-Generated Social Media Communications
(*Refer to Hospital's Facebook, Blog, YouTube, Instagram, Twitter, MySpace, and others*)

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	The level of this hospital's social media communications for its brand meets my expectations.	1	2	3	4	5	6
2	Compared with the very good social media communications of other competing hospitals, this hospital's social media communication for its brand performs well.	1	2	3	4	5	6
3	I am satisfied with this hospital's social media communications for its brand.	1	2	3	4	5	6

Word of Mouth Communication

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	My family/friends influenced my attitude towards this hospital's brand.	1	2	3	4	5	6
2	My family/friends mentioned some things I had not considered about this hospital's brand.	1	2	3	4	5	6
3	My family/friends provided some different ideas about this hospital's brand.	1	2	3	4	5	6
4	My family/friends influenced my evaluation of this hospital's brand.	1	2	3	4	5	6
5	My family/friends helped me make a decision in selecting this hospital's brand.	1	2	3	4	5	6

User-Generated Social Media Communications

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	The level of the social media communications feedback expressed by other users about this hospital's brand meets my expectations.	1	2	3	4	5	6
2	Compared with the very good social media communications of other users' feedback about other competing hospital brands, the social media communications of users' feedback about this hospital's brand performs well.	1	2	3	4	5	6
3	I am satisfied with the social media communications feedback expressed by other users about this hospital's brand.	1	2	3	4	5	6

Hospital's Brand Image

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	This hospital's brand possesses complete practical functions (medical services and adequate medical facilities).	1	2	3	4	5	6
2	This hospital's brand possesses a positive symbolic meaning (good reputation, credibility and positive image).	1	2	3	4	5	6
3	I feel that this hospital's brand can provides me with pleasant service experience.	1	2	3	4	5	6

Service Quality

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
	Tangible						
1	This hospital has up-to-date equipment.	1	2	3	4	5	6
2	The physical facilities of this hospital are visually appealing.	1	2	3	4	5	6
3	The staffs of this hospital appearance are neat.	1	2	3	4	5	6
4	The materials associated with this hospital are visually appealing.	1	2	3	4	5	6
	Reliability						
1	The staffs of this hospital perform the medical service right on the first time.	1	2	3	4	5	6
2	The staffs of this hospital provided dependable services as promised.	1	2	3	4	5	6
3	The staffs of this hospital are sincere to solve my problems.	1	2	3	4	5	6
4	The staffs of this hospital provide services at the appointed time.	1	2	3	4	5	6
5	This hospital keeps accurate medical records.	1	2	3	4	5	6
	Assurance						
1	The staffs of this hospital are trustworthy.	1	2	3	4	5	6
2	I feel safe in receiving services from the staffs of this hospital.	1	2	3	4	5	6
3	The staffs of this hospital are consistently courteous to me.	1	2	3	4	5	6
4	The staffs of this hospital have the knowledge to answer my questions.	1	2	3	4	5	6
	Empathy						
1	The staffs of this hospital give individual attention to me.	1	2	3	4	5	6
2	This hospital has convenient operating hours for my needs.	1	2	3	4	5	6
3	This hospital has my best interests at heart.	1	2	3	4	5	6
4	The staffs of this hospital understand my specific needs.	1	2	3	4	5	6
5	The staffs of this hospital give me personal attention.	1	2	3	4	5	6
	Responsiveness						
1	The staffs of this hospital are never too busy to respond my requests.	1	2	3	4	5	6
2	The staffs of this hospital tell me when the services will be performed.	1	2	3	4	5	6
3	The staffs of this hospital are always willing to help me.	1	2	3	4	5	6
4	I received prompt service from the staffs of this hospital.	1	2	3	4	5	6

Perceived Value

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	The effort involved to decide on this medical service is worthwhile.	1	2	3	4	5	6
2	The time I spent flying from my country to this country to receive medical service is worthwhile.	1	2	3	4	5	6
3	The services provided by this hospital are good for what I have to pay.	1	2	3	4	5	6
4	The money I spent for this medical service is well worth it.	1	2	3	4	5	6

Perceived Trust

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	The staffs of this hospital will honestly inform me about the result of diagnosis.	1	2	3	4	5	6
2	The staffs of this hospital will honor the agreement made with me.	1	2	3	4	5	6
3	My medical issues are well handled by the staffs of this hospital.	1	2	3	4	5	6
4	I can trust this hospital staffs' judgment based on my sickness.	1	2	3	4	5	6
5	I can rely on the staffs of this hospital to solve my medical issues.	1	2	3	4	5	6

Patient Satisfaction

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	I am satisfied with my decision to use the service at this hospital.	1	2	3	4	5	6
2	My choice to come to this hospital is a wise decision.	1	2	3	4	5	6
3	My experience at this hospital is satisfactory.	1	2	3	4	5	6
4	I am not disappointed to use this hospital's service.	1	2	3	4	5	6

Behavioural Intention

No	Statements	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1	I will recommend that other people to use this hospital.	1	2	3	4	5	6
2	If I need medical services in the future outside my country of residence, I would consider this hospital as my first choice.	1	2	3	4	5	6
3	I will tell other people good things about this hospital.	1	2	3	4	5	6

Thank you for your time, cooperation, and participation in this research study.
All responses will be kept private and confidential.
----------*Enjoy your stay in Malaysia, Truly Asia* ----------

Appendix 2: Survey Questionnaire (Bahasa Indonesia Version)

Salam dan Selamat Datang Di Malaysia

Untuk Responden,

Saya adalah seorang siswa yang sedang menempuh gelar Doktor di Universitas Tunku Abdul Rahman (UTAR), Malaysia. Saya sedang melakukan studi penelitian dengan topik mengenai citra merek dan kualitas layanan rumah sakit dalam konteks pariwisata medis. Penelitian ini dilakukan untuk memenuhi persyaratan dalam menyelesaikan gelar Doktor saya. Saya sangat menghargai waktu yang anda berikan untuk mengambil bagian dalam penelitian ini. Partisipasi anda sangat dibutuhkan untuk meningkatkan pemahaman terhadap kualitas layanan dan kepuasan pasien terhadap rumah sakit yang ada di Malaysia.

Terlampir kuesioner singkat untuk dijawab oleh anda. Instruksi untuk mengisi kuesioner dapat ditemukan di dalam setiap bagiannya. Saya sangat berterima kasih jika anda dapat menyelesaikan kuesioner dan mengembalikannya sesegera mungkin. Setidaknya anda akan membutuhkan 15 menit untuk menyelesaikan kuesioner yang terlampir.

Mohon jangan menuliskan nama anda di formulir kuesioner. Semua jawaban anda tidak akan mengacu terhadap anda secara personal, dan semua informasi yang diberikan oleh anda akan dijaga privasinya juga dirahasiakan. Partisipasi anda dalam survei ini adalah berdasarkan keinginan sendiri. Jika anda mempunyai pertanyaan dan pemikiran tertentu, anda dapat menghubungi nomor saya di +6012-5825266 atau melalui email di jaysoncham@gmail.com.

Terima kasih atas waktu dan kerjasama anda; partisipasi anda dalam survei ini sangat saya hargai.

Salam Hormat,

Cham Tat Huei

Bagian A : Informasi Umum

Silahkan beri tanda cek (✓) pada kolom yang disediakan atau isilah pertanyaan yang diberikan di bawah dengan jawaban.

1. Apakah jenis kelamin anda?

( ) Pria ( ) Wanita

2. Apakah status pernikahan anda?

( ) Sendiri
( ) Sudah Menikah
( ) Bercerai
( ) Janda / Duda
( ) Lain-lain *(mohon dirincikan)* _____

3. Apakah golongan umur anda?

( ) 25 tahun dan di bawahnya
( ) 26 – 35 tahun
( ) 36 – 45 tahun
( ) 46 – 55 tahun
( ) 56 – 65 tahun
( ) di atas 65 tahun

4. Apakah pendidikan terakhir anda?

( ) SMA atau di bawahnya
( ) Sertifikat atau Diploma
( ) Sertifikat Profesional
( ) S1 – Strata 1
( ) S2 – Strata 2 dan di atasnya
( ) Lain-lain (*mohon dirincikan*) _____

5. Yang mana di antara berikut yang paling sesuai sebagai pekerjaan anda?

( ) Posisi Profesional
( ) Produksi/Posisi di bidang industri
( ) Pemilik Usaha/Wirausahawan
( ) Tidak Bekerja
( ) Eksekutif/Posisi Manager
( ) Tata-Usaha/Administrasi/Sekretaris
( ) Pensiunan/Tidak dalam usia bekerja
( ) Lain-lain (mohon dirincikan) _____

6. Sudah berapa kali anda melakukan perjalanan ke Malaysia untuk keperluan kesehatan termasuk perjalanan kali ini?

( ) Pertama kali
( ) 2 kali
( ) 3 kali
( ) 4 kali
( ) lebih dari 4 kali (mohon dirincikan) _____

7. Sudah berapa kali anda mengunjungi rumah sakit ini untuk keperluan layanan kesehatan termasuk yang sekarang?

( ) Pertama kali
( ) 2 kali
( ) 3 kali
( ) 4 kali
( ) lebih dari 4 kali (mohon dirincikan) _____

8. Bagaimana cara anda mengatur perjalanan medis kali ini?

( ) Langsung dengan pihak rumah sakit
( ) Melalui situs pariwisata medis (seperti mhtc.org.my, myMEDholiday.com, malaysiahealthtour.com, dan lain-lain)
( ) Melalui agensi perjalanan yang ada di Negara anda
( ) Lain-lain (*mohon dirincikan*) _____

9. Jenis pengobatan apakah yang sedang anda cari untuk perjalanan kali ini?

( ) Ortopedi (contoh: persendian, tulang belakang)
( ) Pengobatan Penglihatan / Lasik
( ) Perawatan Kesuburan
( ) Pemeriksaan Kesehatan Menyeluruh
( ) Kosmetik/plastik/ operasi rekonstruks
( ) Pengobatan dan Operasi Jantung
( ) Onkologi (Pengobatan Kanker)
( ) Lain-lain (*mohon dirincikan*) _____

10. Selama 3 tahun, berapa banyak yang telah anda gunakan untuk semua pengobatan di Malaysia?

( ) Kurang dari RM 10,000
( ) RM 10,001 – RM 20,000
( ) RM 20,001 – RM 30,000
( ) RM 30,001 – RM 40,000
( ) RM 40,001 – RM 50,000
( ) RM 50,001 – RM 60,000
( ) RM 60,001 – RM 70,000
( ) RM 70,001 – RM 80,000
( ) RM 80,001 – RM 90,000
( ) RM 90,001 – RM 100,000
( ) Lebih dari RM 100,001

Bagian B: Persepsi terhadap Rumah Sakit

Bagian berikut berhubungan dengan persepsi anda terhadap rumah sakit yang sedang anda kunjungi saat ini. Untuk setiap pernyataan yang terdapat di bawah, mohon berikan penilaian tentang seberapa banyak anda setuju atau tidak setuju dengan memberi bulatan pada angka yang sesuai dengan pendapat anda.

Media Komunikasi Sosial yang Dibuat Oleh Rumah Sakit
(*Mengacu pada Media Seperti: Facebook, Blog, YouTube, Instagram, Twitter, MySpace, dan lain-lain*)

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Tingkat media komunikasi sosial rumah sakit ini untuk mereknya sesuai dengan harapan saya.	1	2	3	4	5	6
2	Dibandingkan dengan media komunikasi sosial yang sangat baik oleh rumah sakit saingan, media komunikasi sosial rumah sakit ini tampil baik untuk mereknya.	1	2	3	4	5	6
3	Saya merasa puas dengan media komunikasi sosial milik rumah sakit ini untuk mereknya.	1	2	3	4	5	6

Komunikasi dari Mulut ke Mulut

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Keluarga saya/teman mempengaruhi sikap saya terhadap merek rumah sakit ini.	1	2	3	4	5	6
2	Keluarga saya/teman menyebutkan sesuatu yang belum pernah saya pikirkan tentang merek rumah sakit ini.	1	2	3	4	5	6
3	Keluarga saya/teman memberikan beberapa pendapat berbeda tentang merek rumah sakit.	1	2	3	4	5	6
4	Keluarga saya/teman mempengaruhi penilaian saya terhadap merek rumah sakit ini.	1	2	3	4	5	6
5	Keluarga saya/teman membantu saya membuat keputusan dalam memilih merek rumah sakit ini.	1	2	3	4	5	6

Media Komunikasi Sosial yang Dibuat oleh Pengguna

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Tingkat respons media komunikasi sosial yang diberikan oleh pengguna lain mengenai merek rumah sakit ini sesuai dengan harapan saya.	1	2	3	4	5	6
2	Dibandingkan dengan respons media komunikasi sosial yang sangat bagus oleh pengguna lain mengenai merek rumah sakit pesaing, respons media komunikasi sosia rumah sakit ini tampil baik untuk mereknya.	1	2	3	4	5	6
3	Saya merasa puas dengan respons media komunikasi sosial yang diberikan oleh pengguna lainnya mengenai merek rumah sakit ini.	1	2	3	4	5	6

Citra Merek Rumah Sakit

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Merek rumah sakit ini mempunyai fungsi praktek yang lengkap (layanan kesehatan dan fasilitas kesehatan yang memadai).	1	2	3	4	5	6
2	Merek rumah sakit ini mempunyai arti simbolis yang positif (reputasi baik, kredibilitas dan citra positif).	1	2	3	4	5	6
3	Saya merasa bahwa merek rumah sakit ini menyediakan pengalaman layanan yang menyenangkan.	1	2	3	4	5	6

Kualitas Layanan

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
	Tangible (*Bukti Fisik)*						
1	Rumah sakit ini mempunyai peralatan terbaru.	1	2	3	4	5	6
2	Fasilitas fisik milik rumah sakit ini terlihat menarik.	1	2	3	4	5	6
3	Staf rumah sakit ini memiliki penampilan rapi.	1	2	3	4	5	6
4	Materi yang berhubungan dengan rumah sakit ini menarik secara visual.	1	2	3	4	5	6
	Reliability (*Keandalan*)						
1	Staf rumah sakit ini memberikan layanan kesehatan yang benar untuk pertama kali.	1	2	3	4	5	6
2	Staf rumah sakit ini memberikan layanan yang dapat diandalkan sesuai dengan yang dijanjikan.	1	2	3	4	5	6
3	Staf rumah sakit ini memiliki ketulusan hati untuk menyelesaikan masalah saya.	1	2	3	4	5	6
4	Staf rumah sakit ini memberikan layanan sesuai dengan waktu yang diberikan.	1	2	3	4	5	6
5	Rumah sakit ini menyimpan catatan kesehatan yang akurat.	1	2	3	4	5	6
	Assurance (*Jaminan*)						
1	Staf rumah sakit ini dapat dipercaya.	1	2	3	4	5	6
2	Saya merasa aman dalam menerima pelayanan dari staf di rumah sakit ini.	1	2	3	4	5	6
3	Staf rumah sakit ini selalu sopan terhadap saya.	1	2	3	4	5	6
4	Staf rumah sakit ini memiliki pengetahuan untuk menjawab pertanyaan saya.	1	2	3	4	5	6
	Empathy (*Empati*)						
1	Staf rumah sakit ini memberikan perhatian individual terhadap saya.	1	2	3	4	5	6
2	Rumah sakit ini memiliki jam operasional yang sesuai dengan kebutuhan saya.	1	2	3	4	5	6
3	Rumah sakit ini mendapat tempat di hati saya.	1	2	3	4	5	6
4	Staf rumah sakit ini mengerti akan kebutuhan khusus saya.	1	2	3	4	5	6
5	Staf rumah sakit ini memberikan perhatian pribadi kepada saya.	1	2	3	4	5	6
	Responsiveness (*Daya tanggap*)						
1	Staf rumah sakit ini tidak pernah terlalu sibuk untuk merespons permintaan saya.	1	2	3	4	5	6
2	Staf rumah sakit ini menginformasi saya tentang kapan layanan akan diberikan.	1	2	3	4	5	6
3	Staf rumah sakit ini selalu ingin membantu saya.	1	2	3	4	5	6
4	Saya mendapatkan layanan cepat dari staf di rumah sakit ini.	1	2	3	4	5	6

Nilai Persepsi

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Usaha yang terlibat dalam memilih layanan pengobatan ini tidaklah sia-sia.	1	2	3	4	5	6
2	Waktu yang saya gunakan untuk datang ke Negara ini demi layanan pengobatan tidaklah sia-sia.	1	2	3	4	5	6
3	Layanan yang diberikan oleh rumah sakit ini adalah bagus sesuai dengan biaya yang saya keluarkan.	1	2	3	4	5	6
4	Uang yang saya gunakan untuk biaya pengobatan di rumah sakit ini bermanfaat.	1	2	3	4	5	6

Nilai Kepercayaan

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Staf rumah sakit ini akan menginfomasikan saya dengan jujur mengenai hasil diagnosa.	1	2	3	4	5	6
2	Staf rumah sakit ini akan menghormati keputusan yang dibuat bersama saya.	1	2	3	4	5	6
3	Masalah kesehatan saya ditangani dengan baik oleh staf rumah sakit ini.	1	2	3	4	5	6
4	Saya dapat mempercayakan keputusan staf rumah sakit ini menyangkut penyakit saya.	1	2	3	4	5	6
5	Saya dapat bergantung kepada staf rumah sakit ini untuk memberikan solusi mengenai penyakit saya.	1	2	3	4	5	6

Kepuasan Pasien

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Saya puas dengan keputusan saya untuk menggunakan jasa pengobatan rumah sakit ini.	1	2	3	4	5	6
2	Keputusan saya untuk datang ke rumah sakit ini adalah bijaksana.	1	2	3	4	5	6
3	Pengalaman yang saya dapatkan di rumah sakit ini adalah memuaskan.	1	2	3	4	5	6
4	Saya tidak merasa kecewa terhadap layanan rumah sakit ini.	1	2	3	4	5	6

Niat dan Perilaku

No	Pernyataan	Sangat Tidak Setuju	Tidak Setuju	Kurang Setuju	Cukup Setuju	Setuju	Sangat Setuju
1	Saya akan merekomendasikan kepada orang lain untuk memilih rumah sakit ini.	1	2	3	4	5	6
2	Jika saya membutuhkan layanan kesehatan luar negeri di masa depan, saya akan memilih rumah sakit ini sebagai pilihan utama.	1	2	3	4	5	6
3	Saya akan memberitahu hal baik tentang rumah sakit ini kepada orang lain.	1	2	3	4	5	6

Terima kasih untuk waktu, kerjasama, dan partisipasi anda di dalam studi penelitian ini.
Semua jawaban akan dijaga privasi dan kerahasiaannya.
----------*Nikmati Waktu Anda di Malaysia, Asia Sebenarnya* ----------

Appendix 3: Detecting Outliers

Observation number	Mahalanobis d-squared	p1	p2
127	128.879	.000	.000
200	119.170	.001	.000
260	110.905	.008	.000
265	105.907	.016	.000
233	98.147	.027	.000
163	97.646	.032	.000
287	90.991	.038	.000
258	90.226	.041	.000
365	83.000	.043	.000
43	81.804	.044	.000
197	80.238	.046	.000
54	70.144	.047	.000
283	79.150	.048	.000
72	77.450	.049	.000
322	64.984	.051	.000
103	64.895	.061	.000
277	64.766	.064	.000
140	64.658	.067	.000
148	63.632	.068	.000
29	63.565	.071	.000
288	63.364	.073	.000
134	63.122	.074	.000
293	63.105	.075	.000
77	62.851	.077	.000
310	62.467	.080	.000
216	62.212	.083	.000
63	62.189	.084	.000
384	61.773	.092	.000
152	61.603	.092	.000
106	61.550	.093	.000
338	61.244	.097	.000
371	61.200	.097	.000
7	61.193	.099	.000
330	61.104	.100	.000
248	60.813	.107	.000
38	60.729	.108	.000
46	60.698	.115	.000
13	60.501	.123	.000
298	59.966	.130	.000
263	59.707	.140	.000
256	58.619	.145	.000

377	58.330	.147	.000
250	58.016	.151	.000
351	47.947	.152	.000
274	47.696	.160	.000
214	47.529	.164	.000
340	47.371	.171	.000
334	47.353	.172	.000

Appendix 4: Detecting Multicollinearity

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	-.627	.320		-1.961	.051		
	HC	-.008	.032	-.010	-.239	.812	.698	1.432
	WOM	.113	.025	.171	4.436	.000	.873	1.145
	UC	-.033	.040	-.037	-.835	.405	.654	1.529
	BI	.134	.049	.114	2.733	.007	.751	1.332
	P.TRUST	-.009	.059	-.007	-.145	.885	.644	1.554
	P.VALUE	.227	.045	.218	5.059	.000	.700	1.429
	P.SATISFACTION	.450	.054	.372	8.337	.000	.653	1.532
	PSQ	.271	.072	.172	3.783	.000	.628	1.591

a. Dependent Variable: INTENT

Correlations

		HC	WOM	UC	BI	P.TRUST	P.VALUE	P.SATISFACTION	INTENT	PSQ
HC	Pearson Correlation	1	.106*	.530**	.202**	.120*	.066	.102*	.072	.058
	Sig. (2-tailed)		.037	.000	.000	.018	.197	.046	.155	.255
	N	386	386	386	386	386	386	386	386	386
WOM	Pearson Correlation	.106*	1	.265**	.212**	.171**	.201**	.224**	.341**	.173**
	Sig. (2-tailed)	.037		.000	.000	.001	.000	.000	.000	.001
	N	386	386	386	386	386	386	386	386	386
UC	Pearson Correlation	.530**	.265**	1	.172**	.160**	.217**	.161**	.150**	.127*
	Sig. (2-tailed)	.000	.000		.001	.002	.000	.001	.003	.012
	N	386	386	386	386	386	386	386	386	386
BI	Pearson Correlation	.202**	.212**	.172**	1	.363**	.160**	.375**	.376**	.361**
	Sig. (2-tailed)	.000	.000	.001		.000	.002	.000	.000	.000
	N	386	386	386	386	386	386	386	386	386
P.TRUST	Pearson Correlation	.120*	.171**	.160**	.363**	1	.420**	.463**	.403**	.476**
	Sig. (2-tailed)	.018	.001	.002	.000		.000	.000	.000	.000
	N	386	386	386	386	386	386	386	386	386
P.VALUE	Pearson Correlation	.066	.201**	.217**	.160**	.420**	1	.382**	.477**	.440**
	Sig. (2-tailed)	.197	.000	.000	.002	.000		.000	.000	.000
	N	386	386	386	386	386	386	386	386	386
P.SATISFACTION	Pearson Correlation	.102*	.224**	.161**	.375**	.463**	.382**	1	.408**	.472**
	Sig. (2-tailed)	.046	.000	.001	.000	.000	.000		.000	.000
	N	386	386	386	386	386	386	386	386	386
INTENT	Pearson Correlation	.072	.341**	.150**	.376**	.403**	.477**	.408**	1	.406**
	Sig. (2-tailed)	.155	.000	.003	.000	.000	.000	.000		.000
	N	386	386	386	386	386	386	386	386	386
PSQ	Pearson Correlation	.058	.173**	.127*	.361**	.476**	.440**	.472**	.406**	1
	Sig. (2-tailed)	.255	.001	.012	.000	.000	.000	.000	.000	
	N	386	386	386	386	386	386	386	386	386

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Appendix 5: Assessment of Normality

Variables	Min	Max	Skewness	Kurtosis
HC1	1	6	-1.147	2.532
HC2	1	6	-1.236	2.172
HC3	1	6	-1.215	2.297
WOM1	1	6	-1.336	2.040
WOM2	1	6	-1.018	1.028
WOM3	1	6	-1.039	1.593
WOM4	1	6	-1.178	1.434
WOM5	1	6	-1.289	1.776
UC1	1	6	-1.198	2.943
UC2	1	6	-1.087	2.564
UC3	1	6	-1.273	3.156
BI1	1	6	-.117	.071
BI2	1	6	-.241	.499
BI3	1	6	-.350	.881
T1	1	6	-.660	2.172
T2	1	6	-.403	.768
T3	1	6	-.521	1.269
T4	1	6	-.115	-.329
RELIA1	1	6	-.408	.898
RELIA2	1	6	-.414	1.264
RELIA3	1	6	-.389	.863
RELIA4	1	6	-.698	1.414
RELIA5	1	6	-.325	.267
A1	1	6	-.370	.580
A2	1	6	-.285	.628
A3	1	6	-.672	2.471
A4	1	6	-.565	1.486
E1	1	6	-1.040	1.984
E2	1	6	-.568	1.456
E3	1	6	-.724	1.087
E4	1	6	-.888	1.368
E5	1	6	-.808	1.209
RES1	1	6	-.700	1.724
RES2	1	6	-.766	1.609
RES3	1	6	-.224	.382
RES4	1	6	-.655	2.487
PV1	1	6	-.219	.282
PV2	1	6	-.467	.968
PV3	1	6	-.696	1.978
PV4	1	6	-.792	1.871
PT1	1	6	-.287	.280
PT2	1	6	-.078	-.256
PT3	1	6	-.022	-.358
PT4	1	6	-.012	-.223
PT5	1	6	-.022	-.238
PS1	1	6	-.289	.489
PS2	1	6	-.355	.891
PS3	1	6	.059	.042
PS4	1	6	-.060	.153
INTENTION1	1	6	-.479	1.920
INTENTION2	1	6	-1.001	3.191
INTENTION3	1	6	-.410	1.141

Appendix 6: Accessing Mediating Effect of Perceived Value

```
Run MATRIX procedure:

***************************************************************************

Preacher and Hayes (2004) SPSS Macro for Simple Mediation

Written by Andrew F. Hayes, The Ohio State University

http://www.comm.ohio-state.edu/ahayes/

For details, see Preacher, K. J., & Hayes, A. F. (2004). SPSS and SAS

procedures for estimating indirect effects in simple mediation models

Behavior Research Methods, Instruments, and Computers, 36, 717-731.

VARIABLES IN SIMPLE MEDIATION MODEL
 Y        P.SATISF
 X        PSQ
 M        P.VALUE

DESCRIPTIVES STATISTICS AND PEARSON CORRELATIONS
              Mean        SD  P.SATISF       PSQ   P.VALUE
P.SATISF    4.6528     .5518    1.0000     .4720     .3822
PSQ         4.6056     .4236     .4720    1.0000     .4399
P.VALUE     4.5725     .6408     .3822     .4399    1.0000

SAMPLE SIZE
      386

DIRECT AND TOTAL EFFECTS
            Coeff      s.e.         t  Sig(two)
b(YX)       .6149     .0586   10.4917     .0000
b(MX)       .6655     .0693    9.5978     .0000
b(YM.X)     .1864     .0421    4.4245     .0000
b(YX.M)     .4909     .0637    7.7013     .0000

INDIRECT EFFECT AND SIGNIFICANCE USING NORMAL DISTRIBUTION
           Value      s.e.  LL 95 CI  UL 95 CI         Z  Sig(two)
Effect     .1241     .0310     .0633     .1848    4.0002     .0001

BOOTSTRAP RESULTS FOR INDIRECT EFFECT
            Data      Mean      s.e.  LL 95 CI  UL 95 CI  LL 99 CI  UL 99 CI
Effect     .1241     .1236     .0345     .0576     .1935     .0447     .2162

NUMBER OF BOOTSTRAP RESAMPLES
     1000

****************************** NOTES *********************************

------ END MATRIX -----
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Appendix 7: Accessing Mediating Effect of Perceived Trust

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Run MATRIX procedure:

***************************************************************************

Preacher and Hayes (2004) SPSS Macro for Simple Mediation

Written by Andrew F. Hayes, The Ohio State University

http://www.comm.ohio-state.edu/ahayes/

For details, see Preacher, K. J., & Hayes, A. F. (2004). SPSS and SAS

procedures for estimating indirect effects in simple mediation models

Behavior Research Methods, Instruments, and Computers, 36, 717-731.

VARIABLES IN SIMPLE MEDIATION MODEL
 Y        P.SATISF
 X        PSQ
 M        P.TRUST

DESCRIPTIVES STATISTICS AND PEARSON CORRELATIONS
              Mean        SD  P.SATISF       PSQ   P.TRUST
P.SATISF    4.6528     .5518    1.0000     .4720     .4626
PSQ         4.6056     .4236     .4720    1.0000     .4757
P.TRUST     4.7819     .5059     .4626     .4757    1.0000

SAMPLE SIZE
      386

DIRECT AND TOTAL EFFECTS
           Coeff      s.e.         t  Sig(two)
b(YX)       .6149     .0586   10.4917     .0000
b(MX)       .5683     .0536   10.5983     .0000
b(YM.X)     .3355     .0532    6.3118     .0000
b(YX.M)     .4243     .0635    6.6813     .0000

INDIRECT EFFECT AND SIGNIFICANCE USING NORMAL DISTRIBUTION
          Value      s.e.  LL 95 CI  UL 95 CI         Z  Sig(two)
Effect     .1907     .0353     .1215     .2598    5.4052     .0000

BOOTSTRAP RESULTS FOR INDIRECT EFFECT
            Data      Mean      s.e.  LL 95 CI  UL 95 CI  LL 99 CI  UL 99 CI
Effect     .1907     .1913     .0418     .1173     .2809     .0828     .3075

NUMBER OF BOOTSTRAP RESAMPLES
     1000

****************************** NOTES *********************************

------ END MATRIX -----
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PUBLICATION

Publications Arising From the Thesis:

Cham, T. H., Lim, Y.M., & Aik, N.C. (2015). A Study of Brand Image, Perceived Service Quality, Patient Satisfaction and Behavioral Intention among the Medical Tourists. *Global Journal of Business and Social Science Review, 2*(1), 14-26

Cham, T. H., Lim, Y. M., Aik, N. C., & Alexander, T. G. M. Antecedents of Hospital Brand Image and the Relationships with Medical Tourists' Behavioural Intention. *International Journal of Pharmaceutical and Healthcare Marketing*. (Under Review)

Cham, T. H., Lim, Y. M., Aik, N. C., & Alexander, T. G. M. Factors Influencing Patients' Satisfaction and the Mediating Role of Perceived Value and Trust: A Study of Medical Tourists in Malaysia. *Journal of Hospitality Marketing & Management*. (Under Review)

Conference Presentations:

Cham, T. H., & Lim Y. M (2015). An Integrated Framework for Brand Image, Healthcare Service Quality, Patient Trust, Perceived Value, Patient Satisfaction and Behavioral Intention: Evidence from Medical Tourism of Malaysia. Paper presented at the 2nd Colloquium on Business, Economics and Accounting, January 23, HELP University, Kuala Lumpur.

Cham, T. H., & Lim Y. M (2013). An Integrated Framework for Brand Image, Healthcare Service Quality, Patient Trust, Perceived Value, Patient Satisfaction and Behavioral Intention: Evidence from Medical Tourism of Malaysia. Paper presented at the Researchers and Stakeholders' Seminar on Current Issues in Medical Tourism, October 13, University of Malaya, Malaysia.