DESTINATION BRANDING IN INDIAN MEDICAL TOURISM –AN EMPIRICAL STUDY

Thesis

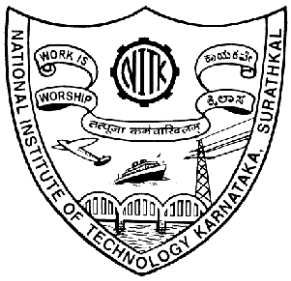
Submitted in partial fulfilment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

by

SUDHEER MUHAMMED K M

Register No: 138001HM13F08



SCHOOL OF MANAGEMENT

NATIONAL INSTITUTE OF TECHNOLOGY KARNATAKA,

SURATHKAL, MANGALORE - 575025

May, 2018

DECLARATION

(By the PhD Research Scholar)

I hereby *declare* that the Research Thesis entitled, '**Destination Branding in Indian Medical Tourism – An Empirical Study'** which is being submitted to the **National Institute of Technology Karnataka, Surathkal**, in partial fulfilment of the requirements for the award of the Degree of **Doctor of Philosophy** in Management, *is a bonafide report of the research work carried out by me*. The material contained in this Research Thesis has not been submitted to any University or Institution for the award of any degree.

138001HM13F08 Sudheer Muhammed KM

(Register Number, Name & Signature of the Research Scholar)

SCHOOL OF MANAGEMENT

Place: NITK, SURATHKAL

Date: 04-05-2018

CERTIFICATE

This is to *certify* that the Research Thesis entitled, " **Destination Branding in Indian Medical Tourism – An Empirical Study** " submitted by **Sudheer Muhammed K M**, (**Register Number: 138001HM13F08**), as the record of the research work carried out by him, is *accepted* as *the Research Thesis submission* in partial fulfilment of the requirements for the award of the degree of DOCTOR OF PHILOSOPHY in Management.

Research Guide

Prof. K. B. Kiran

Chairman - DRPC

(Signature with Date and Seal)

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The academic travel of the last four years was what I thought would be the most challenging part of my Doctoral studies. But now it gets revealed to me the complexities of acknowledging the contributions of every person directly or indirectly associated with my work and apologise for any inadvertent omissions.

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ABSTRACT

Destination branding has been critically viewed as the success formula of medical tourism business with firms realising that acquiring new customers is far more expensive than maintaining the existing ones. It focuses on keeping the medical customers loyal, though, there is little in agreement on which antecedents could be used to achieve this aim. In response, this thesis develops a model of destination branding based on a review of the literature to empirically investigate in one single model: (1) the effect of destination source credibility on place attachment and perceived value; (2) medical tourism service quality on place attachment and perceived value; (3) destination image on place attachment and perceived value; (4) the ultimate effect of both place attachment and perceived value on customer loyalty. In particular, this thesis seeks to investigate the moderating role of the perceived price reasonableness variable on study constructs (destination image, medical tourism service quality, destination source credibility, perceived value and place attachment). Furthermore, it presents and discusses empirical findings from a survey of 1205 medical tourists at various hospitals examined from their perspectives as end users using structural equation modelling (AMOS 23.0). The findings of this thesis largely support the hypothesised relationships proposed in the theoretical model. Specifically, the results revealed that destination image, medical tourism service quality and destination source credibility are crucial in affecting perceived value and place attachments. The results also provide substantial evidence of the relationship between perceived value and place attachments, which, in turn, are crucial determinants of customer loyalty. This study contributes significantly to the very limited literature available by arriving at medical travellers' price-dependent decisions in the international medical tourism industry. This thesis contributes to theoretical and practical knowledge by providing for the first-time evidence about relationships between destination images, medical tourism service quality, destination source credibility, and analysing how perceived value and place attachments can be associated. The inclusion of a perceived price reasonableness construct is suggested to contribute additionally to the body of medical tourism destination branding literature and provide a complete model within a medical service provider context. Findings imply the need for service firms in general, and medical service providers in particular, to strategically lever on the key antecedents of customer loyalty including perceived value and place attachments, in pursuit of a more competitive advantage, and long-term profit.

Keywords: *Medical Tourism, Destination Branding, India.*

LIST OF ABBREVIATIONS

AMOS	Analysis of Moment Structure
AGFI	Adjusted Goodness-of-Fit
ASQ	Administrative Staff Quality
AVE	Average Variance Extracted
DBLY	Brand Loyalty
CFA	Confirmatory Factor Analysis
CFI	Comparative Fit Index
CR	Composite Reliability
CR	Critical Ratio
DIMG	Destination Image
DSCR	Destination Source Credibility
DF	Degree of Freedom
EFA	Exploratory Factor Analysis
ML	Maximum Likelihood
MTSQ	Medical Tourism Service Quality
MSQ	Medical Service Quality
NFI	Normed Fit Index
GFI	Goodness-of-Fit Index
DATT	Place Attachment
PPR	Perceived Price Reasonableness
PVAL	Perceived Value
RMSEA	Root Mean Square Error of Approximation
SEM	Structural Equation Modelling
SD	Standard Deviation
SE	Standard Error
SPSS	Statistical Package for Social Science
SSQ	Supportive Staff Quality
TLI	Tuker-Lewis Index

CONTENTS

CHAPTER - 1

INTRODUCTION

CHAPTER 1

INTRODUCTION

1.1 INTRODUCTION

Medical Tourism is a new adjunct to the tourism sector having an impressive universal appeal and proliferating post globalisation of healthcare industry. Many countries are warming up to this sector by drawing practical frameworks within the social structure and the legal ambit of respective nations. Developing countries mainly are in the forefront offering state-of-the-art medical facilities and services to overseas customers. Medical tourism put plainly means clubbing leisure, fun, and recreational activities with wellness and healthcare services. Succinctly put, a medical tourist is one who is looking for high-end healthcare services in internationally accredited facilities at competitive prices.

This chapter provides an overview of the scope of this study. It gets divided into six sections. Section (1.2) presents issues related to the research background, followed by section (1.3) which specifies the research problem. Section (1.4) identifies the research questions formulated to achieve the objectives of this research while section (1.5) describes its significance. Section (1.6) indicates the methodology to attain the aims of this study, while section (1.7) outlines the overall structure of the study.

1.2 RESEARCH BACKGROUND

Medical tourism and its related businesses have been expanding exponentially. Moreover, this sector is most lucrative for the destination countries, predominantly developing ones like India (Cision 2017; Han 2013; Heung, Kucukusta, and Song 2011; Suki et al. 2015; Connell 2013; Johnson and Kaye 2009). The increased digital adoption favours the Indian healthcare market. From the present worth of US$ 100 billion, it is expected to grow at a CAGR of 23 percent to US$ 280 billion by 2020 (IBEF 2017). April 2017 saw a 22-25 percent growth in this industry and is expected to double from US$ 3 billion to US$ 6

billion by 2018 (ETHealthWorld 2016; IBEF 2017). It is expected to contribute 5.2 percent of the gross domestic product and employ about 9 million people in 2016 (Healthcare Industry 2017; IBEF 2017). Medical tourist traffic to India increased to almost 50 percent touching 200,000 in 2016 from 130,000 in 2015 (IBEF 2017). The hospitals and diagnostic centres attracted Foreign Direct Investment (FDI) worth US$ 4.34 billion between April 2000 and March 2017 (IBEF 2017; The Hindu 2017). The ratio of doctors to patients at 60 per 100,000 people is also relatively high, although the quality of medical training varies (Gahlinger 2008; Gupta and Das 2012). Today, India competes globally by offering to use the most advanced equipment for doing delicate procedures like robotic surgery and cutting-edge radiosurgery cancer treatment for tumours under non-stationary therapy (India Brand Equity Foundation 2017; Indian healthcare tourism 2016; Singh 2014). Phenomenal success rates and reduced mortality at world class infrastructures surpassing global standards has pushed the edge in India's favour. Hence investing in this sector would in all certainty yield rich dividends, more foreign exchange earnings, improved services creating a more favourable balance of trade, and enhance the overall tourism industry.

1.3 RESEARCH PROBLEM

Nurturing destination brand loyalty is a critical medical tourism destination branding challenge in today's Medical tourism market. Product and service quality, familiarity, product image, perceived value, product attachment, and trust are critical concepts in explaining customer purchase behaviour. Researchers agree that these variables contribute to creating a favourable intention towards a firm and influencing retention and loyalty (Bowen and Chen 2001; Han and Hyun 2013; Wang et al. 2012). Recognizing the importance of such variables, every firm in the hospitality and tourism industry is becoming ever more concerned about successfully managing and improving trustworthy service quality. Hence, to ensure a higher level of brand loyalty and command confidence of customers in product/service performance on which the service providers receive regular queries, it is necessary to give more attention to these areas.

Price perception plays a vital role in customers' decision-making processes (Guido, Pino, and Frangipane 2011; Jiang and Rosenbloom 2005; Oh 2000). The empirical evidence supports the notion that customers' perceptions of a firm's price reasonableness in comparison to its competitors' prices are central in building favourable intentions and loyalty toward a firm (Han and Kim 2009; Oh 2000; Zeithaml 1988). Researchers agree that the levels of price reasonableness perceived by a customer are a critical factor affecting consumer decision-making (Oh 2000; Watchravesringkan, Yan, and Yurchisin 2008; Zeithaml 1988). Customers tend to utilise price information/reasonableness while evaluating their experiences with a product or service (Villarejo-Ramos and Sánchez-Franco 2005; Watcharavesringkan et al. 2010). Therefore, perceived price reasonableness is one of the most important reasons for a consumer remaining with a particular service provider or switch to another.

Despite the criticality of product/service quality, destination image, destination familiarity, and credibility, no medical tourism research in the past examined their associations with medical service provider’s perceived value and destination attachment nor had any investigation thrown light on the impact of such relationships on destination brand loyalty from medical tourism context. This study focuses on developing and testing a theoretical framework of destination branding, which extends the literature on destination source credibility, destination image, destination attachment, medical tourism service quality, perceived value and destination brand loyalty. This study attempts explicitly to fill the gaps in the literature in three ways. First, the study aims to incorporate the existing concepts of branding with destination source credibility, destination attachment, destination image, and destination brand loyalty studies. Second, the study brings a new focus on destination source credibility as a necessary antecedent of destination loyalty through a mechanism of the mediation effects of destination attachment. While destination source credibility is an essential factor influencing destination image and destination attachment, it is less recognised by destination branding scholars when compared with other factors. While the existing literature has revealed the importance of price reasonableness, there exist only limited studies on the moderating role of perceived price reasonableness in the hospitality

and tourism industry. Hence, the study attempts to shed light precisely on these areas. Finally, this research framework provides a practical insight into various medical tourism destinations. Therefore, the primary purpose of this study is to evaluate a theoretical model that incorporates the constructs of destination source credibility, destination image, medical tourism service quality, perceived value and destination attachment as antecedents of destination brand loyalty. The researcher has also examined the moderating effects of perceived price reasonableness of the relationships mentioned above in the medical tourism context.

Accordingly, the following questions set out the problem of this research:

1) How does destination source credibility influence the medical tourist's perceived value and destination attachment?
2) What will be the role of destination image in formulating medical tourist's perceived value and destination attachment?
3) What is the influence of Medical tourism service quality on medical tourist's perceived value and destination attachment?
4) What is the effect of medical tourist's perceived value on destination brand loyalty?
5) What is the effect of destination attachment on destination brand loyalty?
6) What is the moderating impact of perceived price reasonableness on proposed associations within the model?

1.4 AIMS OF RESEARCH

To answer the above research questions, the aims of this study are fourfold:

- To investigate the influence of destination source credibility on medical tourist's perceived value and destination attachment.
- To determine the influence of destination image on medical tourist's perceived value and destination attachment.
- To analyse the influence of medical tourism service quality on medical tourist's perceived value and destination attachment.

- To determine the effect of medical tourist's perceived value on destination brand loyalty.
- To estimate the impact of destination attachment on destination brand loyalty.
- To examine the moderating impact of perceived price reasonableness on proposed relationships within the model.

1.5 STATEMENT OF SIGNIFICANCE

The phenomenon called global medical tourism is growing north and for reasons beyond doubt India remains a much sought-after destination by creating a benchmark, hence holds the tag "The Medical Hub of Asia". Each year roughly 5,000 medical tourists from Oman travel mostly to India and the United Kingdom for medical treatments (Al-Hinai, Al-Busaidi, and Al-Busaidi 2011). An open heart bypass operation that costs USD 100,000 in the United States only costs USD 18,500 in Singapore, USD 11,000 in Thailand, and USD 10,000 in India (Lunt and Carrera 2010). The results and findings of this research study could guide leading hospitals in India to have clarity in understanding what medical tourists value most and what they seek while deciding to travel to India for medical check-ups and surgeries. This study could provide tier-two hospitals with valuable information on the various aspects of improving the international medical tourist's travel decisions. Furthermore, this research study will be beneficial to the Ministry of Tourism (MoT) as profound details would unfold to determine the core motivating factors attracting international patients to seek India as their primary healthcare destination. Since Medical tourism is a consumer-driven industry, the challenge is to meet with the consumer's objectives for its survival and success.

1.6 RESEARCH METHODOLOGY

Source of data for this study was through quantitative survey-based methodology. This approach was essential for ascertaining the causal relationships among the underlying theoretical constructs. Self-administered questionnaires were considered to be the most appropriate tool. Most importantly, this method is quick, inexpensive, efficient, and can be

administered to a more substantial sample (Babin et al. 2012; Churchill and Iacobucci 2005; Sekaran 2003).

The questionnaire was developed using 7-point Likert type scale, ranging from (1= strongly disagree) to (7 = strongly agree). English was the media used for the preparation of questionnaire. Except, the demographic questions, the instrument included a total of 59 items, reflecting the constructs of interest. Identification of these items was by the validity of the previously drawn scale. A pre-test was conducted to ensure that the questions were understood and there was no ambiguity among them.

The sample of the study consist of medical tourists around 27 hospitals in India. Since it is an unorganised sector, the study considered 108 hospitals mentioned in the Service Export Promotion Council website of India (SEPC 2015) which were Joint Commission International (JCI) or National Accreditation Board for Hospitals & Healthcare Providers (NABH) accredited. The questionnaire was given out to medical tourists by front desk staff during check-in, and completed questionnaires returned during the check-out. 1620 questionnaires distributed in twenty-seven hospitals, i.e., 60 questionnaires per hospital.

Descriptive analysis of the entire sample was performed using Statistical Package for the Social Sciences (SPSS, Ver. 23). SPSS was used to screen the collected data before performing Structural Equation Modelling (SEM). Structural Equation Modelling using Analysis of Moment Structures (AMOS Ver. 23.0) was applied to test the hypotheses of the study. SEM is a multivariate statistical technique often used to confirm the causal relationships among latent variables. SEM was conducted using the two-stage approach recommended by C. Anderson and Gerbing (1988). The aim of the first stage (Measurement model) is to specify the causal relationships between the observed variables (items) and the underlying theoretical constructs (Composite and Latent variables) then provide reliable and valid constructs. The second stage is to test the hypotheses that reflects the relationships between these theoretical constructs. The model fit was determined through goodness-of-fit indices and the significance of paths using coefficient parameter estimates.

1.7 STRUCTURE OF THE THESIS

This section provides a brief review of the structure of the study. *Chapter One* introduces the issues related to the topic under investigation with a brief discussion of the methodology used.

Chapter Two provides an overview of relationship destination branding theory. It critically reviews the relevant literature related to the constructs that form the proposed relationship marketing model. These constructs include perceived value, destination attachment, medical tourism service quality, destination image, destination credibility, and perceived price reasonableness.

Drawing from the literature in *Chapter Two, Chapter Three* discusses the conceptual framework of relationship marketing proposed in this study. It discusses the nine hypotheses to be tested and analysed. H_1, H_2, H_3, H_4, H_5 and H_6, relate to the influence of destination source credibility, destination image and medical tourism service quality on perceived value and destination attachment. H_7 and H_8 represent the influence of perceived value and destination attachment on destination brand loyalty while H_9 reflects the moderating impact of perceived price reasonableness on proposed relationships within the model.

In *Chapter Four,* the methodology used to examine the proposed model established is outlined in *Chapter Three*. The methodology covers the aspects of (1) an overview of the design, (2) the use of quantitative methods, (3) the scale items selected to measure the underlying constructs, (4) the instrument used to collect the data, (4) the pre-test and final survey, (5) the techniques used to analyze the collected data; (6) the reliability and validity of the constructs, (7) and finally the ethical considerations related to the conduct of this research.

Chapter Five reports the results of data analysed using the techniques justified in *Chapter Four* which includes results related to the sample profile and testing the underlying hypotheses using the two-stage approach of structural equation modelling. The aim in the

first stage was to have valid and reliable constructs to test the nine hypotheses presented in *Chapter Three* that represent the relationships among them.

Finally, *Chapter Six* interprets the results drawn from testing the nine hypotheses, aiming to answer the three research questions identified in *Chapter One*. Theoretical and managerial implications are drawn from the results reported in *Chapter Five*. Limitations of this study and avenues for further research are also discussed. Lastly, conclusions emanating from the research findings are set forth.

CHAPTER - 2

REVIEW OF LITERATURE

CHAPTER 2

REVIEW OF LITERATURE

2.1 INTRODUCTION

This chapter encases a panoramic view of Medical Tourism and its attributes. The physiognomies of this study attempt to review the theoretical and empirical literature related to the concepts of brand loyalty, brand image, medical tourism service quality, perceived value, destination source credibility and destination attachment. The next section (2.2) presents the overview of medical tourism to provide a background for the study. Section (2.3) presents the overview of destination branding theory to provide a background for discussing the constructs of interest. The following section (2.4) describes the antecedents of destination brand loyalty. Section (2.5) discusses the literature gaps related to present study. A summary of the chapter is presented in the last section (2.6).

2.2 MEDICAL TOURISM – AN OVERVIEW

Medical tourism and its related businesses have been regarded as one of the most lucrative hospitality sectors for many destination countries, mainly developing ones (Han and Kim 2009; Heung, Kucukusta, and Song 2011). The market is rapidly expanding (Connell 2009; Sasha Issenberg 2016), and competition in the international medical tourism marketplace is becoming intense. In such an increasingly competitive environment, the primary concern for the practitioners is attracting new medical travellers through marketing and motivating them to make repeat purchases through service efforts/strategies (Han 2013; Han and Hyun 2015). The success of many stakeholders in this industry has invited the attention of new entrants brewing novel techniques and latest medical advancements at their facility to remain competitive, financially viable and uncompromisingly closer or beyond a customer's expectation by providing ultimate quality (Han 2013). Consequently, to keep the customer's perception of value, trust and continued patronage, changing times entails innovative thinking (Heung et al. 2011).

The history of Medical tourism dates back to ancient times. Since its inception as an Industry, 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 (Horowitz and Rosensweig 2007; Marlowe and Sullivan 2007; Nath, Atkins, and Sligar 2007). Ever since Medical Tourism took shape as an industry, it started to get managed more professionally, the latest being the influence technological advancements hold in transforming patient care (Chapman, Kelly, and King 2009). It is just a click away to reveal a world of choices for the consumer detailing the accreditation, availability of facilities, testimonials of doctors and patient reviews to match specific requirements enabling faster decision making, thus triggering a north side shift of global consumers, especially the developed countries (Gupta and Das 2012). It was reported that the evolving progress of medical tourism resulted with at least 28 countries from different parts of the world taking part in this industry, with at least a million patients visiting hospitals that were outside their own country (Vivek Singh & Onkar Sumant 2016).

Developing nations have realised that this industry is a marathon and highly rewarding. So, each one is catering to this growing demand projecting themselves as a world-class medical tourism destination. 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 are vying with each other as potential fore-runners (Smith and Forgione 2014). Deloitte (2009) reported that the minor hubs for medical tourism destinations are Hungary, South Africa, and Costa Rica whereas the main hubs for medical tourism are mostly distributed in the Asian countries that include Malaysia, Singapore, Thailand, India and South Korea.

A significant shift in the global medical industry saw Asia attracting over one and a half million medical tourists annually valued at US$8.5 billion (Ward and Mabrey 2015). Studies were conducted to understand the motivation behind this shift beyond the national borders of the developed nations and the results narrowed down to the expensive treatment costs in their home country (Lunt, Mannion, and Exworthy 2013; Suki et al. 2015). For instance, the conventional treatments charges in the United States of America (USA) for

coronary artery surgery is $ 88,000, while this surgery is charged at $ 20,800 to $ 54,500 in most of the hospitals in South East Asian countries (Moghavvemi et al. 2017). Besides, hip replacement surgery in the USA would cost patients for $ 33,000, while it is only priced in the range of $12,500 to $ 21,400 in South East Asian countries (Vivek Singh & Onkar Sumant 2016). However, significant improvements in the healthcare sector with the use of state-of-art facilities, ease and affordability of international travel, lesser waiting time, and the growth of the internet users have contributed to this positive swing.

Thus, it can easily be inferred that exorbitant health care expenses in their native countries have compelled the medical tourists from Europe, North America, United Kingdom, Japan, and Middle East to travel to foreign lands in Asia and Africa to seek medical attention (Benur et al. 2014; Bookman and Bookman 2007a; Vivek Singh & Onkar Sumant 2016). Large populations anticipating medical attention, increasingly high expectations on healthcare, comparatively high wealth and lack of healthcare option available in their homeland are the other reasons for teeming medical tourists. As evinced, Japanese firms usually send their staffs to countries like Singapore and Thailand for a medical checkup and other treatments due to the high-quality medical services in these countries and cheaper medical fees (P. M. Connell 2013). Similarly, The United States is found to follow 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 time, lack of insurance coverage on certain treatments, and the expensive medical costs in their country (Bies and Zacharia 2007).

2.2.1 Definitions of Medical Tourism

Growing popularity of this Industry has encouraged increasing number of travellers to seek medical attention overseas augmenting revenue of these developing nations (Bookman and Bookman 2007a). The present researcher feels the need for a more comprehensive study of this topic since past studies fail to give even a universally agreed definition. Discrepancies over the nature of leisure and tourism, the different intention of medical tourists, amount of resources, time allocated for individual activities, and diverse socio-

economics are pointers which both scholars and researchers are unable to resolve. Jagyasi (2011) suggested that the terms medical and tourism should be defined first. In this case, medical aspect is referred to as any medical services about 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 countries visited, touring, hospitality, and vacationing. Fraternizing tourism with this industry was questioned by some scholars (Beerli, Meneses, and Gil 2007; Bigné, Sánchez, and Sánchez 2001; Kenkel 1990) but those like arguing against it reasoned that International patients travelling to their chosen destinations for medical care consumed services associated with their travel, such as logistics, hospitality, and lodging, which is part of the tourism package. The inclusion of a tourism aspect in medical tourism was also supported by the extant literature (Bookman and Bookman 2007b; P. M. Connell 2013; Heung et al. 2011; Jagyasi 2011).

Table 2.1 Definitions of Medical Tourism

Authors	Definition
Clift (1997, p119)	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.
Connell (2006, p.1094)	Popular mass- culture where people often travel 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 (2006, p.1)	Travel activity that involves a medical procedure or activities that promote the wellbeing of the tourist.
Yap. J. (2008)	Patients travel abroad to receive medical treatment, which may be cosmetic surgery or some special treatment or periodic health examination.

Carrera & Lunt (2010).	Medical tourism it refers to the travel of a person to a foreign country with the aim of receiving medical care; with an emphasis on 'clinical, surgical, and hospital provision'.
*Jagyasi (2011)	Set of activities in which a person often travels long distances or across the border, to avail medical services with direct or indirect engagement in leisure, business or other purposes.
Heung, Kucukusta, and Song (2011)	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 healthcare service.
(Lee, V.C., Balaban 2014)	According to the Centers disease control and prevention, medical tourism is the term used to describe people who travel abroad from their home country to receive medical treatment.

*Source: Literature Review, Note. *Definition adopted in the present study*

In addition to the above, Jagyasi (2011) defined medical tourism as a set of activities in which a person often travels long distances or across the border, to avail medical services with direct or indirect engagement in leisure, business or other purposes. According to Jagyasi (2011), the aspect of long engagement can be explained as the consumption of services (e.g. lodging facilities, transportation services) that are related to leisure, business, or other purposes by medical tourists. Henceforth, the definition by Jagyasi (2011) was found suitable for the nature of the present study, and so, was adopted for this study.

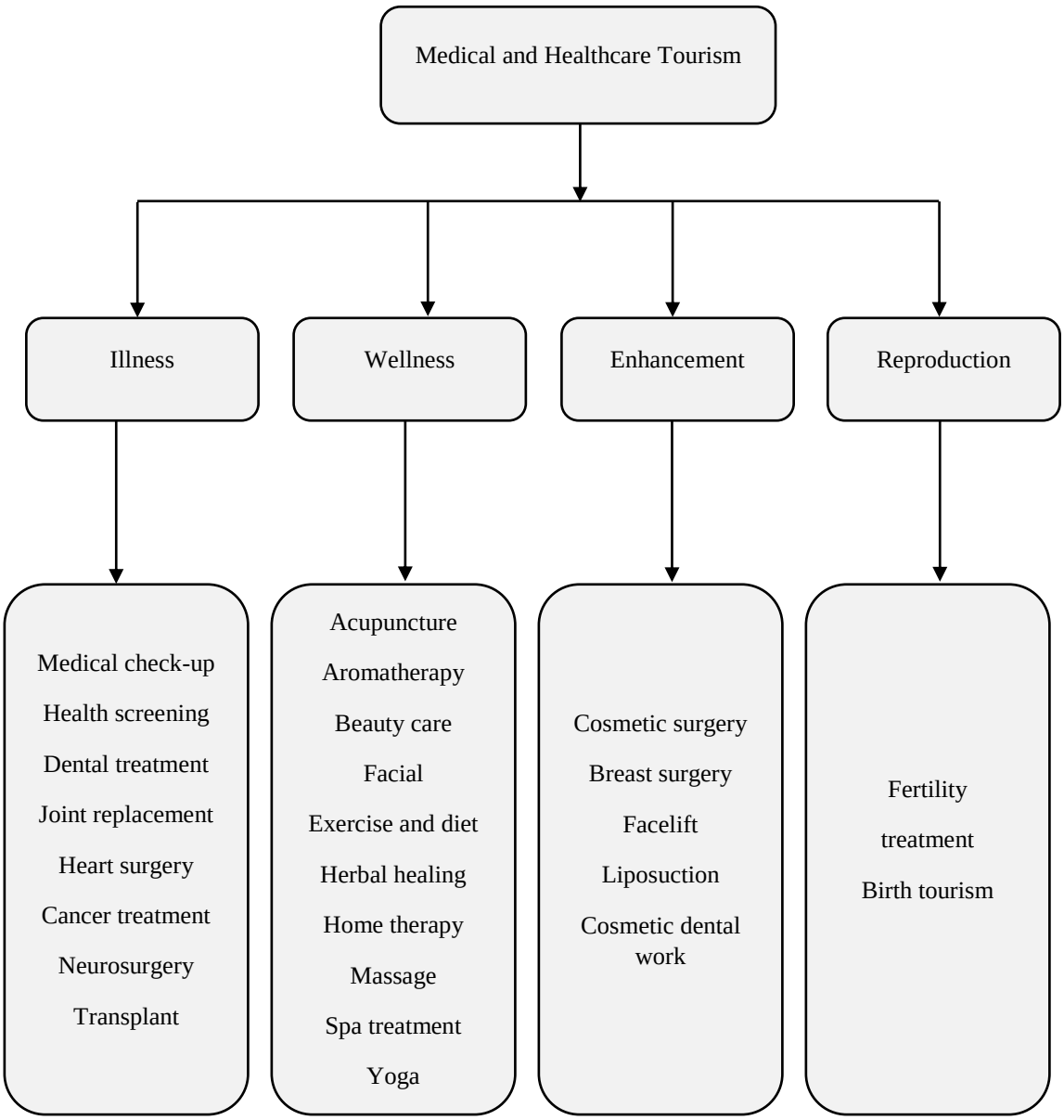
2.2.2 The Attributes of Medical Tourism

Medical tourism and health tourism were synonymous from its initiation although the elucidation for each was different. The attributes of both health tourism and medical tourism need to be understood in detail to avoid collision of the concepts. Carrera and Bridges (2006) reported that medical tourism and health tourism are interrelated but diverse in some context whereby conceptually, medical tourism is a part of the health tourism. To recognise medical tourism within health tourism, Cook (2008), explained that medical tourism implies diagnosis, surgical operations, and hospitalisation to restore or improve

health in the long run whereas health tourism includes treatments used to enhance health (by alternative treatments or health spa). An independent tourism consultancy firm based in London Tourism Research and Marketing (TRAM) coined medical and healthcare tourism as a new age healthcare and medical sector which is rightly the platform to different attributes between both medical tourism and health tourism They were the first to categorize it to in four namely; treatments of wellness, enhancement, reproduction, and illnesses (see Figure 2.1).

Lee and Spisto (2006), in their study, elaborated illness treatments as an extensive range of medical services requiring skilled medical intervention involving organ transplants, cancer treatment, heart surgery, dental treatment, comprehensive medical check-ups, neurosurgery, joint replacements, and so on. Specialized fertilisation procedures for reproduction treatments include in-Vivo and in -Vitro fertilisation treatments and other complicated procedures. Enhancement treatments are procedures that are cosmetic nature and designed for self-enhancement only. Treatments like cosmetic dental work, breast surgery, liposuction, facelifts, and other relevant cosmetic surgeries call for the services of a trained and highly skilled doctor's intervention.

Wellness treatments, on the other hand, are categorised as alternative healthcare services namely; beauty care, herbal healing, acupuncture, aromatherapy, massage, exercise and diet, spas, facials, and yoga which are performed by professionals who are accredited and recognised by health associations or organisations of international repute. Larocque et al. (2012), maintained that any treatment that requires certified medical doctors, physicians, and licensed facilities should be categorized under the term medical tourism. Consistent with this notion, previous studies also reported that medical procedures that are involved with medical tourism must involve licensed physicians in performing medical treatments (Bookman and Bookman 2007a; J. Connell 2013). Assuming that the nature of medical tourism and its attributes are now unambiguous, the theory for this study needs to be deliberated further.



Source: Review of Literature

Figure 2.1: Medical and Healthcare Tourism and Components

2.2.3 Medical Tourism in India

As per 2017 survey (Medgadget 2017), Asia is the fastest growing market for medical tourism with Thailand, India and Singapore accounting for almost ninety percent of the

total market share. Studies projected Asia Medical Tourism Market Analysis and Forecasts to 2022 - Market is anticipated to Cross US$ 14 Billion (Cision 2017). Undoubtedly, India emerges as the most sought-after medical tourist destination the world over for obvious reasons like internationally accredited hospitals, highly professional and highly qualified doctors and nurses, low-cost medical treatment cost, high-quality standard of services, and excellent hospitality services topped with lesser waiting time for getting treatment (Schult 2006). Since the start of the economic boom in 1990, India became the choice destination not only for Information Technology (IT) but also for medical treatment with nascent anticipation for the future (Gupta and Das 2012). The current situation, however, emboldens India to think of itself as an Asian Medical hub (Stolley and Watson 2012).

India, Malaysia, Singapore, and Thailand attract medical tourists seeking cardiac and orthopaedic surgery (Aishwarya Venkates 2015). Moreover, India offers world-class treatments for a variety of ailments including cosmetic surgery, neurological and orthopaedic procedures, cardiac care, and joint replacements (Indian healthcare tourism 2016). An American medical tourist opting for Elective procedures in India would be paying only a modest twenty percent of his or her medical costs incurred in their home country (Deloitte 2009). The industry is becoming more business savvy and is customizing it's medical facilities in tune with the growing Muslim patients travelling from South Asia, Africa and Middle East by projecting its first Halal Friendly Medical Tourism Hospital established at the Global Health City, Chennai in 2012, certified by Halal India and International Halal Integrity Alliance Malaysia; which is a partner of Islamic Chamber of Commerce and Industry, Saudi-Arabia, providing customized medical treatment to foreign Muslim patients along with halal-certified food, medicine, and prayer-rooms (Connell 2010).

Governments of developing Asian countries have realised the potential of medical tourism; especially the Indian Government which is working pro-actively to promote India as the leading Global medical tourism destination (Jagyasi 2011). Since the early 1990s, when the medical tourism market began to migrate to Asia, India remained the second most sought-after place one step behind Thailand (Reddy 2013). Taking a cue from the market

potential, India became the first country to promote medical tourism as an export industry by offering special tax incentives to medical tourism service providers (Indian healthcare tourism 2016; Jadhav, Yeravdekar, and Kulkarni 2014). Gupta and Das's (2012) study quotes India's 2002 National Health Policy "*To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment. The rendering of such services on payment in foreign exchange will be treated as 'deemed exports' and will be made eligible for all fiscal incentives extended to export earnings*". Indian government introduced a liberal "Medical Visa", unlike a regular visa which allows foreign patients to get a visa for the duration of their treatment and extend it up to a year (Indian healthcare tourism 2016).

Fundamental to India's popularity as a medical tourism destination is the internationally trained and experienced medical care providers, its vast network of private hospitals, and its pharmaceutical industry. A long history of subsidised medical education attracts nearly 30,000 graduate nurses and physicians every year (Gupta and Das 2012). Another factor significant to India's popularity as a medical tourism destination is its pharmaceutical industry, one of the largest in the world. It is highly self-sufficient and also exports drugs for a fraction of the cost to countries all around the world. It is ranked fourth in the world, accounting for 8 percent of the world's pharmaceuticals production (India Brand Equity Foundation 2017).

India turns out to be a prized medical tourist destination owing to its currency exchange rates (Bookman and Bookman 2007a; Cooper, Vafadari, and Hieda 2015). A medical tourist travelling from a country using higher priced currency spends a fraction for world-class medical care, medicines and infrastructure; thus, the adage 'First World treatment at Third World prices' holds good (Lunt, Horsfall, and Hanefeld 2015; Sasha Issenberg 2016). India also boasts of a range of alternative holistic systems of medicine such as Ayurveda, Unani, Siddha, Naturopathy, Yoga and Meditation in addition to modern medicines like Allopathic – surgery, plastic surgery, dental treatment and eye care treatment (Jyothis and Janardhanan 2009; Prem Jagyasi 2015).

Private sector players sensed the potential of medical tourism and started with infrastructure development matching world-class facilities which were not available a decade back. Apollo Hospitals went on to build the biggest hospital chains in the world most of which are for profit-hospitals, and not many could afford it locally (Hall 2013; Prem Jagyasi 2015). Presently, politically and economically stable scenario coupled with overseas trained doctors working with the state of art facilities seems to be the right remedy for the upsurge that this sector finds today, especially in India.

The influx of western medical tourists to Asian countries like India was a financially sound move mutually and has had a cascading effect in alleviating the overburdened healthcare systems of industrialized nations especially for those with no medical insurance, inadequate coverage and those who are not eligible for Medicare and thus, saved the United States from going into bankruptcy while meeting with the overwhelming health-related expenses of over 46.6 million people on a serpentine waiting period for getting their much desired cosmetic surgeries and dental reconstruction procedures (DeMicco 2012; Hodges, Turner, and Kimball 2012; Schult 2016; Sung and Ozuem 2017.).

Apparently, the legal, ethical and cultural reasons prevent the Industrialized countries from undertaking some specializations like stem cell therapy, infertility and organ transplant opening the way to 'Transplant tourism' which refers to a tourist seeking specialized organ transplant treatment away from his/her native country primarily resulting from a short supply of human organs locally, forcing patients to choose Asian countries as their treatment destination (Cohen 2016; Sasha Issenberg 2016). Apart from the exotic backdrop and reasonable personalised nursing care for the Medical tourists travelling to India the most prominent advantage may well be the anonymity attached to treatments like plastic surgery, drug rehabilitation and infertility (Prem Jagyasi 2015). It led several high-profile companies to evaluate the feasibility of outsourcing expensive medical procedures to offshore healthcare destinations to moderate the employee health care liabilities.

The health insurance companies, especially the overseas ones, see a potentially thriving market for the burgeoning medical tourism compelling the insurance provider networks to

empanel doctors across the globe opening to the fact that future health plans of major employers would inevitably include offshore facilities (Mandler, Won and Kim 2017). The offset to the meteoric growth of medical tourism in India for the medical insurance companies could be that lower premium could be offered for policyholders opting for medical attention in Asian countries due to obvious lesser treatment costs and hence, health care financing could be better calibrated considering the patient's financial status (Vivek Singh & Onkar Sumant 2016).

2.3 DESTINATION BRANDING

Tourism, though has been known to be prevalent since ages, a systematic study on destination branding began as recently as the late 1990s (Bianchi and Pike 2011; Pike 2005; Pike et al. 2010). A lack of consensus among the scholars has squarely left it with no definition although the backdrop of 'brand' and 'brand loyalty' could well provide the basis for it to arrive at a possible one for destination branding. Thus, destination branding goes beyond the realms of geographical, political or social scale to market the attributes of destination. The definition is given by Ritchie and Ritchie (1998) happens to be the most cited one discussing the importance of destination branding, and it suggests a more rounded definition that specifically identifies the unique nature of tourism marketing and destination management. Thus, based on Aaker and Keller's (1990) definition of a brand, Ritchie and Ritchie (1998) defined a destination brand as:

"A name symbol, logo, wordmark or other graphics that both identifies and differentiates the destination; furthermore, it conveys the promise of a memorable travel experience that is uniquely associated with the destination; it also serves to consolidate and reinforce the recollection of pleasurable memories of the destination experience."(Ritchie and Ritchie 1998)

Their definition addressed what a destination brand is and what it does about Aaker's (1991) core branding concepts (identification and differentiation) but failed to explain the process of using or implementing the brand. Anholt (2010) eloquently describes destination brand as the characteristic of a place that is attractive to visit and carries a "sense of place"

from the start by creating an emotional connect with its visitor, similar to telling a story that provides an insight into the place, its people, history, the way it views the world and how it relates to its environment. It is really about bringing the place to life and making it relevant to people today (Anholt 2010b).

The crux of destination branding is the positive image that gets reflected among the combination of similar brands as described by Cai (2002) that, "perceptions about the place as reflected by the associations held in tourist memory". Tasci and Kozak (2006) argue that destination branding is a selection and strategic combination of a consistent mix of brand elements to identify and distinguish a destination through positive image development. They further assert that the current empirical studies on branding in the tourism destination context are usually conceptualized at smaller levels, especially at resort, city and country levels.

Destination branding promises quality assurance which truly benefits choosy customers who are already aware of International hospital chains and expect high quality customer services, and especially those holding premium membership face minimal risk, reduced search costs, high value and awareness of destination brands which provides them with the detailed information destination source (Chen and Phou 2013; Lee and Lockshin 2011). Differentiation of destination, a variety of aspects of destination characteristics such as cultural, historical with believable, sustainable is positive attributes for attracting tourists.

Destination branding is the fundamental link which many previous researchers have missed and instead focused on destination image which could be summarized as a product of destination branding. For the success of a brand or product, the success of destination and consistent management of products by destination is crucial (Aaker 2011; Boo, Busser, and Baloglu 2009; Erdem and Swait 2004; Kurgun 2010; Veasna, Wu, and Huang 2013a). The many challenges that destination need to overcome and succeed are enumerated below:

1. The destination is a combination of sophisticated products services and not a specific product.

2. Markets of destination have little hold over the components that they are branding.

3. A diverse and wide range of corporations and organisations are involved in creating a brand.

4. Occasionally dearth of funds figures prominently.

5. Localized factors like political climate have definite repercussions on destinations.

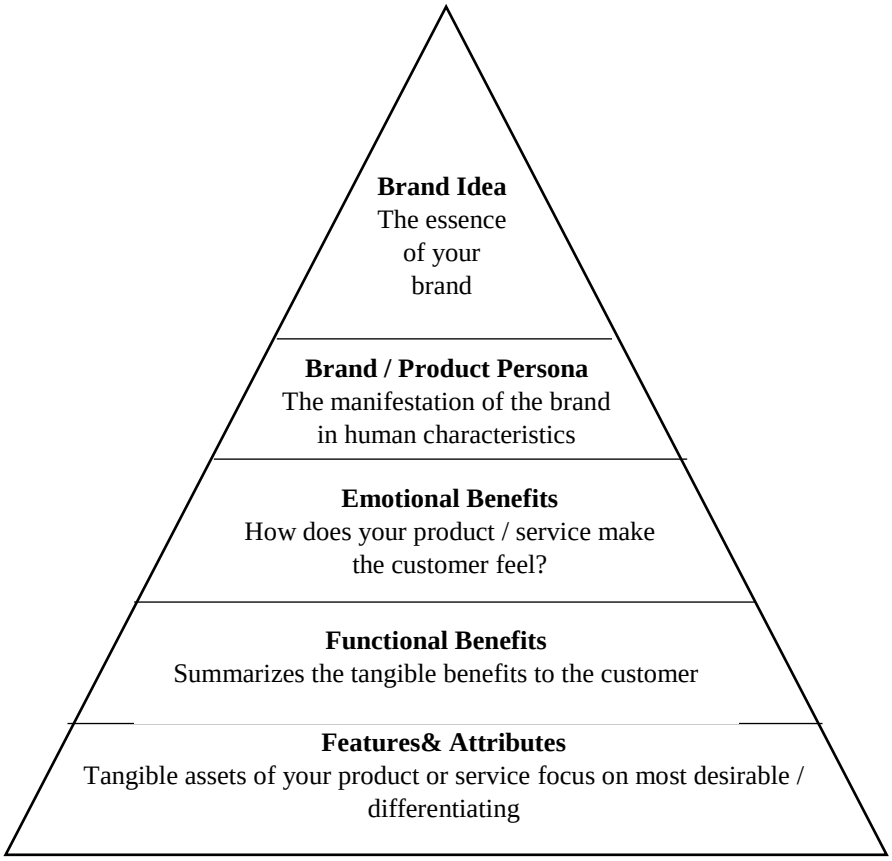


Figure 2.2 Brand Development Benefits Pyramid

Source: https://i.pinimg.com

For creating a dominant destination according to Morgan, Pritchard, and Piggott (2002) branding must be built by following these means:

1. Exude credibility.

2. Deliver on the publicised assurance to the public.

3. Be distinctive from competing service providers.

4. Project novel ideas.

5. Be equitable for both visitors and stakeholders.

Nigel Morgan, Annette Pritchard (2002) developed five phases for destination branding: Phase 1 is the analysis of recommendation and investigation of the market. Phase 2 is the development of brand identity. Phase 3 is introducing the brand and launching the brand. Phase 4 is the implementation of brand and final phase is reviewing and evaluating the brand. For developing the identity of the brand, planning a benefit pyramid is essential for the architecture and drivers of the brand.

2.3.1 Brand Loyalty and Destination Branding

In simple terms, brand loyalty confirms to repeated use of the same brand. This view has been upheld by several marketing managers who maintain loyalty as a suitable tool in attracting new customers even while retaining old ones. The tourism sector struck success with destination brand loyalty and could become the indicator for measuring the success of this sector. Research conducted in the past (Lee and Shen 2013; Sun, Geng-Qing Chi, and Xu 2013) decidedly conclude that it is hard for a brand to survive without loyalty. Loyalty implies remaining steadfast to a brand now and in the future for self even while recommending it to others.

Brand loyalty and brand equity are famously interwoven as essential revenue generators for the brand (Campón-Cerro, Hernández-Mogollón, and Alves 2015; Kim and Kim 2005; Villarejo-Ramos and Sánchez-Franco 2005; Wong and Teoh 2015). Enhancing consumer loyalty and developing brand added the much-needed profit for destination and loyal customers who thus show a high probability to pay more for premium memberships (Dogerlioglu-Demir et al. 2017; Wang et al. 2012a). Positive tourism strategies work to

create behavioural loyalty in destination choice. Oppermann (2000) hinted that destination loyalty should be thoroughly investigated and is heavily reliant on tourists repeating a specific destination. Although many researchers have investigated the factors leading to tourists returning to the same destination, a comprehensive work was done by Gitelson and Crompton (1984) on repeat tourists reveals four factors:

1. Reduced risk

2. The assurance of being in well-known company in a foreign territory.

3. Emotional and behavioural attachment to the destination

4. To experience innovative ways and methods in the destination that were absent during previous trips

Most studies done hitherto point to satisfaction or a sense of accomplishment as the reason for the tourist's return decisions though some studies conclude antithetically (Han and Hyun 2015; Kim and Jamal 2007; Levy and Hassay 2005; Oliva, Oliver, and Macmillan 1992; Oppermann 1999; Prayag and Ryan 2012; Wickens, Gordon, and Liu 2004). Customer behaviour loyalty is brand-centric, explicating the customers repeat purchase decisions. However, tourism research focused on tourism destination loyalty and used familiarity with a destination, propensity to visit, and satisfaction as the core antecedents behind an individual's revisit intention (Bowen and Chen 2001; Glover 2009; Milman and Pizam 1995).

Several researchers validate that studying loyalty from the tourism perspective is a real challenge. Chen (2013); Gitelson and Crompton (1984); Jago and Shaw (2000); Lee, Jin, and Lee (2014); Oppermann (1999); Zhang et al. (2014) conclude that studying loyalty and novelty, both being antipodal from a tourist's angle, could be self-defeating. Situational and external elements such as weather, logistics, time and companions influence a tourist's decision. Lin et al. (2007) narrowed down to a dynamic model including tangible (i.e., money) and intangible resources (i.e., gratitude, social recognition, status, love, self-

esteem, and symbolic interaction) as valuable assets to be mutually exchanged among people to increase loyalty in the tourism context.

2.3.2 Involvement in Destination Brand Loyalty

An in-depth analysis of involvement has been described using concepts of marketing from multiple studies. Houston and L. Rothschild (1978) explained the notions of involvement both enduring and responsive. Finn (1983) discovered three aspects of involvement viz; response, subject and product. Park and Young (1986) placed involvement into cognitive and affective areas. Shavitt and Laaksonen (1996) identified the three ways of creating involvement: individual state, cognitive, and response methods. Though no single definition for involvement has been coined, Gursoy and Gavcar (2003) studied three topics of tourism involvement: pleasure value of a trip, the probability of risk regarding a vacation, importance of risks which are related to that vacation or trip having a significant impact on the destination for tourists.

The researchers narrowed down to the importance of pleasure and emotions that are significantly linked to gender, level of education and married couples while the value of sign was related to age. Zalatan (1998) researched the wives' involvement in the decision process in tourism destinations, revealing women to be proactive than their husbands in the decision-making process for vacation, such as selecting the destination itself, restaurants and resorts, and budgeting for the entire trip. The link between involvements with several tourism challenges revealed that a segment of tourists who were more involved in the process of tourism plans were potentially decision makers collecting travel data sources using nature-based routes and were inclined to share their experience after the travels. Clements and Josiam (1995) concluded that during tourism decision process, individuals were likely to travel more and choose destinations overseas. Hwang, Lee, and Chen (2005) mention that tourist's perception about attachment to certain places had greatly influenced the involvement of tourists. Exclusive bird watching tourists developed a behaviour to go bird watching more often, spent money on equipment and applied for premium

memberships of bird organisations. Highly involved tourist groups preferred to acknowledge previous experience and recommendations of other tourists.

2.4 FORERUNNERS OF DESTINATION BRAND LOYALTY

Consumer behaviour research during the past decade has validated the adequate focus shown on tourism marketing decisions and strategies (Verhallen and Fred van Raaij 1986). Most travel and leisure literature studies have done an in-depth analysis of satisfaction, travel motivation and destination image and arrived at many competing theories (Tasci, Gartner, and Tamer Cavusgil 2007). However, literature development of these concepts has sadly remained owing to a lack of consensus on the theoretical framework (Bigné et al. 2001). Newer sophisticated data analytic tools will help in consolidating knowledge and theory testing and thus enhance further research.

Though Copeland's (1923) study of ‘‘brand insistence,’’ pioneered the examination of loyalty, it remains as one of the most frequently examined topics. Marketing and tourism literature recognise brand loyalty as a major driving force and one of the most important success indicators (Sun, Geng-Qing Chi, and Xu 2013; Yoon and Uysal 2005). As suggested by Sun, Geng-Qing Chi, and Xu (2013), ‘‘success depends not on the first purchase but the repurchase. It is unlikely that any brand can survive over time without some degree of loyalty.’’ Several studies also suggested that brand loyalty results in reduced customer recruitment costs, customer price sensitivity and servicing costs (Allenby and Lenk 1995; Krishnamurthi and Raj 1991). Therefore, during the last decade, loyalty concept has received increasing attention from tourism researchers. Table (Appendix-C) presents a summary of the literature that studied destination loyalty and tourists’ behavioural intentions for the past decade. As mentioned before, this table reveals a lack of research effort on Indian tourists’ behaviour.

Tourist loyalty based on the impact of destination image and perceived value has been liberally studied by (Alhemoud and Armstrong 1996; Baloglu and McCleary 1999; Beerli and Martín 2004; Bianchi and Pike 2011; Chen and Tsai 2007; Faullant, Matzler, and Füller 2008; Kerstetter and Cho 2004; Lee, Yoon, and Lee 2007; Patterson and Spreng 1997; Pike

2005; Tasci et al. 2007; Um, Chon, and Ro 2006; Yangzhou Hu and Ritchie 1993; Yoon and Uysal 2005) and thus have convincingly concluded the two key elements to be instrumental in motivating revisit and recommending to new customers. The destination image formation, its attractiveness and credibility are considered vital to the tourists' overall attitudes and behavioural intent towards a specific destination (Tasci et al. 2007).

The previous studies show that the antecedents or causes of loyalty / behavioural intentions are inclusive of, but are not limited to, tourists' motivation, satisfaction, service quality, perceived value, destination image, destination knowledge, involvement, information search behaviour and their previous visits and experiences with the destination. For example, Chi and Qu (2008) found that destination image and tourist satisfaction are likely to have direct and positive impacts on destination loyalty. Similar findings were also reported by Campón-Cerro, Hernández-Mogollón, and Alves (2015); Gallarza and Saura (2006); Gursoy, Chen, and Chi (2014); Nguyen, Barrett, and Miller (2011); Yoon and Uysal (2005); Zhang et al. (2014) discovered significant effects of value dimensions and satisfaction on loyalty. Chi and Qu (2008); Chih-Chung, Chang, and Lin (2012); Huei, Mee, and Chiek (2015) stated that while satisfaction tends to play a significant role in destination loyalty formation for both first time and repeat tourists, the effect is more significant for first-timers than for repeaters.

The present study proposes a theoretical model for destination loyalty formation that builds on findings of previous studies by integrating the influences of tourists' level of destination credibility into the model. The model is tested among Indian medical, domestic tourists, a largely understudied group. The model which proposes that tourists' level of trust with a destination is likely to have significant impacts on their destination loyalty formation which in turn influences tourists' perception of value and their attachment with the destination. Further, the model suggests that both perceived value and destination attachment are likely to play significant roles in their destination loyalty formation.

2.4.1 Destination Source Credibility

Credibility fundamentally has two components namely; trustworthiness and expertise. Brand credibility is defined as the believability of the product information contained in a brand, which requires that consumers perceive that the brand has the ability (i.e., expertise) and willingness (i.e., trustworthiness) to deliver what has been promised continuously. Both the expertise and trustworthiness of a brand reflect the cumulative impacts of associated past and present marketing strategies and activities. The credibility of a brand has been shown to be higher for brands with higher marketing mix consistency over time and higher brand investments, ceteris paribus (Erdem and Swait 1998). Consistency refers to the degree of harmony and convergence among the marketing mix elements and the stability of marketing mix strategies and attribute levels over time. The consistency of attribute levels over time, for example, consistency in quality levels implies low "inherent product variability" (Veasna et al. 2013a) which can be achieved by a dedication to quality standardisation. However, the consistency to which we refer is that of the brand positioning in general. Brand investments, on the other hand, are resources that firms spend on brands to (1) assure consumers that brand promises will be kept and (2) demonstrate a longer-term commitment to brands (Veasna, Wu, and Huang 2013b). It has also been shown that the clarity (i.e., lack of ambiguity) of the product information contained in a brand is an antecedent to brand credibility (Erdem and Swait 1998). As also suggested by Aaker and Keller (1990), higher perceived (or expected) quality, lower information costs and risk associated with credible brands may increase consumer evaluations of brands. Indeed, Erdem and Swait (1998) have shown, using structural equation models, that expected utility is increasing in perceived quality and decreasing in perceived risk and information costs.

Brand positioning characteristically is determined by its credibility. Credibility springs from "source credibility" literature. For instance, Ohanian (1990) develops a source credibility scale for celebrity endorsers. When source credibility relates to brands, or when we refer to brands as our sources, the credibility concept denotes brand credibility. Prior studies have suggested three components of credibility: trustworthiness, expertise, and

attractiveness/likeableness (Erdem and Swait 2004; Keller and Keller 2001). Brand credibility represents the cumulative effects of a firm's past marketing activities and can influence consumers' future brand consideration, which is important in consumer behaviour research (Erdem, Swait, and Louviere 2002). Brand image and brand awareness are found to positively moderate the relationship between brand credibility and consumers' brand purchase intention (Wang and Yang 2010).

Scant studies have examined the relationship between brand credibility and consumers' brand purchase intention but the probability of including the brand in the consideration set always weighs high due to brand credibility (Wang et al. 2012b; Wang and Yang 2010). Since previous studies only focused on trustworthiness and expertise, they were considered incomplete as they missed out on traits such as attractiveness/likeableness, thus failed to reflect the effect of brand credibility on consumers' brand consideration. Thus, the current research focusses on exploring and assessing the relationships among these constructs in the brand loyalty model.

2.4.2 Destination Image

Tourism literature incorporates Tourism destination image as an utmost important study area with references on the subject dating back to the 1970s and 1980s which opened considerable scope of research focus on the subject (Agapito, Valle, and Mendes 2013; Gómez, Lopez, and Molina 2015; Huei et al. 2015; Stepchenkova et al. 2015). Some previous studies have contributed to the definition of destination image (Campo-Martínez, Garau-Vadell, and Martínez-Ruiz 2010; Chen and Kerstetter 1999; Chi and Qu 2008; Huei et al. 2015). According to Bandyopadhyay and Kerstetter (2003) and Sergio and Lopes (2011), destination image put forward an expression of objective knowledge, impressions and emotional thoughts a person might have a specific place.

Destination image has also been defined as potential visitors' perceptions towards an area (Phelps 1986). It has also been stated as the sum of beliefs, ideas and impressions that people have of a place (Kotler 1988). After decades of further research, Ekinci (2003) extended definitions by defining destination image as a set of beliefs, impressions and ideas

that a tourist holds for a particular place. More recently, destination image has been defined as all the impressions and ideas, beliefs and feelings accumulated over time about a place (Sancho Esper and Álvarez Rateike 2010). These definitions indicate that the image of a destination is comprised of an individual's feelings and ideas about a destination or a place.

Anholt (2010) extended his imagination and research about destination image at the 'nation' level. According to Anholt (2010), nation branding or image is a process by which a nation's image can be created or altered, monitored, evaluated and proactively managed to enhance the country's reputation among an international target audience. Anholt (2010) discusses how in this crowded global marketplace, most people and organisations do not have time to learn much about other places. Consequently, nation branding or image becomes an important vital requirement for places that wish to compete globally. Dinnie (2004), another key thinker in a particular area of country or nation branding, offers a position along similar lines. Destination image can have a significant impact on how competitive a destination's position is in the tourism market. Knowledge and shaping the destination image contributes to improving the attractiveness of a destination and strengthens its ability to compete colouring the decision-making in tourism or travel (Sancho Esper and Álvarez Rateike 2010). With little idea about a place, the picture given by tourists visiting these places shows a significant impact on destination selection (Govers and Schoormans 2005). Getting a genuine and positive image of the destination gives it a higher chance to be selected as a tourist destination because tourists prefer to choose the place that has a positive image in their minds.

Furthermore, destination image plays a significant role in the success of the destination brand and the strength of the destination brand depends on a positive destination image (Kurgun 2010). Furthermore, the brand image of the destination forms the determinant developing the destination brand (Tasci and Kozak 2006). It is thus evident the destination brand, and a positive image in tandem contribute to the increased attractiveness of the destination and thus enhance tourists' loyalty (Lee et al. 2010).

Destination image measurements sought the attention of stakeholders, marketers and tourism researchers equally both on a temporal and spatial scale. Unequivocally every research points at tourist expectation matching with a successful marketing strategy to be the guiding force. Several researchers in the past like Wee (1986) recommended taking into account the importance of the image while developing marketing strategies, recent studies by Abe-Ouchi (2012) conclude that image is based on the tourist's expected benefits, psychological characteristics, and meanings. Furthermore, the most influential study in this field was published by Echtner and Ritchie (2003) which highlighted the strengths and deficiencies of the methods used to define and measure destination image resulting in the suggestion of a combination of structured and unstructured methodologies to measure destination image.

Vibrant information technology with robust internet connectivity makes it easy for a potential medical tourist to have not just a three-dimensional image of their chosen destination but also help get an inside view of the facilities offered including the reviews of past customers suggesting an easy measure of the destination image. Widespread use of travel blogs appears to be a right tool in attracting western tourists.

2.4.3 Medical Tourism Service Quality

Medical tourism separately and in combination prodigiously rests on service as a keyword. Previous studies vehemently highlighted its importance, more so in the recent past, with growing competition in this sector, service quality emerges to be the lifeline of this industry. The service providers in this sector realise the enormity of continually providing improved services to woo old customers and squarely depend on the time-tested word of mouth broadcast to attract new customers. Parasuraman, Zeithaml, and Berry (1988) define Service Quality (SQ) as the difference between customer expectations of the service to be received and perceptions of the actual service received. Based on this conceptualisation, Parasuraman, Zeithaml, and Berry (1988) developed a service measurement scale (i.e., SERVQUAL) on a five-quality dimension - (reliability, responsiveness, assurance, empathy, and tangibles). SERVQUAL has been widely accepted by scholars but also

criticised for its weaknesses and practical application (Cronin and Taylor 1992). In the tourism/hospitality literature, scholars have developed several domain-specific service quality scales such as LODGSERV (Knutson et al. 1990; Patton, Stevens, and Knutson 1994), HOLSERV (Wong Ooi Mei, Dean, and White 1999), Lodging Quality Index (Getty and Getty 2003), and others (Akbaba 2006; Albacete-Sáez, Fuentes-Fuentes, and Javier Llorens-Montes 2007; Ekinci, Riley, and Fife-Schaw 1998; Tsang and Qu 2000; Wilkins, Merrilees, and Herington 2010). Hence the focus shifts fundamentally on educating the traveller to the medical services like cardiac, cosmetic, dental care, and also weight-loss surgery provided at the property along with the potential tourism attraction adjoining the destination.

Medical services' quality and price are among the key motives for medical tourists to pursuit for treatments overseas (Zailani et al. 2016; Zhang, Seo, and Lee 2013). Zailani et al. (2016) specified that highly skilled physicians are the key factor which affects medical tourist satisfaction. The Council of European Dentist. (2007) Found that treatment quality, professionalism, and innovative technology are the top three significant travel motivations. Other researchers found physicians' compassion, humbleness, speed, comfortable and friendly environment and special treatments are important motivations (Kovacs and Szocska 2013; Österle, Balázs, and Delgado 2009). There have been developments in medical care standards abroad including treatment convenience in which some patients were satisfied with the medical care quality received abroad and spread good reviews by word-of-mouth to others (Barrowman, Grubor, and Chandu 2010). Medical care standards relate to having qualified and experienced medical professionals as required by licensing and accreditation, regulation of medical clinics, quality of medical care education, training of assistants, selection of equipment and supplies, and treating patients based on specific needs or personalised care (Turner, 2009).

2.4.4 Destination Attachment

A concept pioneered in environmental psychology, namely: place attachment, representing an emotional or affective bond between a person and a particular place, has been used as a

construct to investigate tourists' emotional, functional, affective, and social attachments to certain tourist destinations and/or tourism products (Lee 2011; Ramkissoon, Smith, and Weiler 2013; Yuksel, Yuksel, and Bilim 2010). This tourist-place bonding and interaction that develops is multi-faceted and encompasses various dimensions, such as place identity, place dependence, affective attachment, and social bonding (Ramkissoon et al. 2013; Smith and Forgione 2014). Among these dimensions, place identity represents personal cognitive identity affiliated with the physical environment and can be regarded a symbolic or affective attachment to a particular place (Kyle, Absher, and Graefe 2003). Place dependence refers explicitly to a functional attachment to a particular place (Gross and Brown 2008), showing the importance of having the social and Physical resources necessary for desired activities (Kyle, Graefe, and Manning 2005). Affective attachment refers to the affective relationship between an individual and a place that goes beyond cognition, preferences, or judgments (Jorgensen & Stedman 2001). Finally, social bonding refers to social relationships between individuals and other individuals, communities, and cultures (Kyle et al. 2005).

The process by which humans develop emotional bonds with places is known as place attachment. In other words, the sense of physically being and feeling ‘in place’ or ‘at home’ can be considered as a sign that an individual has created emotional sync to a place. This concept has been used by recreation researchers and managers to explain different behaviour of leisure, such as recreationists’ setting preferences, management preferences and activity participation (Kyle, Mowen, and Tarrant 2004). Destination attachment can be defined as the affective bond, an emotional linkage of an individual to a particular environment (Hidalgo & Hernandez 2001; Low and Altman 1992). In other words, place attachment includes a state of psychological well-being resulting from accessibility to a place or a state of distress upon separation or ‘remoteness’ from a place; an emotional investment with a place (M. Hummon 1992) and ‘‘the extent to which an individual values and identifies with a particular environmental setting’’ (Moore and Casper 2006).

The emotional bond a person develops to a particular place has to do with the ambience, which is mostly influenced by personal experience and social interaction being the

fundamental dimension for attaching meaning of space in line with one's identity. Although this starts to develop after one or more visit, the possibility of developing a strong feeling for places one has never visited cannot be pushed aside in totality (Yoo, Donthu, and Lee 2000). Halpenny (2010), argues that even for the first-time visitors, a sense of destination attachment may have developed before their actual visit that could be based on stories and references about the destination from friends and family or mass media. Contextual and cultural issues have been reported to influence ascription of meaning to a place (Kyle et al. 2005).

Cresswell (2004) opines that attachments are formed between people and buildings, environments, homes, objects, landscapes, neighbourhoods, towns and cities. They are developed with existent places as well as with a mythical or hypothetical destination, and they may vary in scale and specificity, from microscopic scales to nations, to the distant planets or to the universe itself (Low and Altman 1992). Destination attachment, like the sense of place, ''involves an interplay of affect and emotions, knowledge and beliefs, and behaviours and actions about a place'' (Low and Altman 1992, p.5). Destination attachment is defined as an emotional, cognitive and functional bond with a place (Halpenny 2010) in the present study.

2.4.5 Perceived Value

Rudimentary to a product or service, undoubtedly, is its perceived value which provides an insight into a consumer's mind and guides the manufacturer or service provider to customise in line with a customer's choice. Each customer would have their perception of the valuation of benefits and costs before zeroing down to a service or product, notwithstanding flexibility towards time, location and circumstance. The preference for certain features of the same object can be changed, with the alteration of one set of circumstances from moment to moment (ice-cream in summer vs ice-cream in winter) or from place to place (at sea vs at home) (Holbrook 1999; Woodruff and Gardial 1996). A one-dimensional or single variable approach to perceived value defines value as (1) low price, (2) whatever the consumer wants in a product, (3) the quality the consumer gets for

the price paid, and (4) what a consumer gets for what a consumer gives. Contrarily, a multidimensional or multiple variable approaches to perceived value represents the sum of the different dimensions of value, which have different effects in different situations. Majority of marketing researchers have accepted the definition of perceived value as consumer's assessments of the trade-offs between the benefits and sacrifices realized in selecting a given product from those options available in the market (Chen and Dubinsky 2003; Lapierre 2000; M. Hummon 1992; McDougall and Levesque 2000; Rust and Oliver 1994; Zeithaml 1988). Perceived benefits that the consumers feel they have received from a product or service include perceived quality, internal and external features of the product, and other psychological benefits (Zeithaml 1988). Perceived sacrifices are primarily associated with price as monetary cost. Nevertheless, it is necessary to include non-monetary costs such as the cost of the time, physical effort, mental effort, and lifestyle changes associated with consuming said product (Snoj, Pisnik Korda, and Mumel 2004). Thus, a closer understanding of perceived value concludes that the benefits have a positive impact on perceived value and the costs have a negative impact. Monetary cost influences consumer choice in two distinct ways: as an amount of money the consumer must give up in exchange for the purchase and use of the product and as a quality indicator, implying that the product is of higher quality if the price is higher than similar products. These two components of monetary cost have different impacts on perceived value in the sense that the amount of money paid has a negative impact on perceived value while having a positive impact as an indicator of quality (Oh 2000). However, some studies have shown (J. Joseph Cronin, Michael K. Brady 2000; Oh 2000; Piri Rajh and Rajh 2006; Sweeney, Soutar, and Johnson 1999) that the negative impact of price on perceived value is greater than its positive impact on the perception of quality.

In analysing the relationship between the dimensions of perceived benefits and perceived sacrifices, it can be seen that improved perceptions of quality result in increased value, while higher levels of perceived sacrifice lead to reduced perceptions of value (J. Joseph Cronin, Michael K. Brady 2000; Piri Rajh and Rajh 2006). A company can, therefore, increase the perceived value of its offerings by providing additional benefits to consumers

or by reducing purchasing costs. According to Kotler and Keller (2006), increased customer value can be achieved through a combination of increase to the functional or emotional benefits and reductions to one or more of the costs. Perceived benefits and sacrifices can thus be understood as two interdependent elements, since increasing the benefits should lead directly to lower the perceived costs (Ravald and Grönroos 1996). Despite high quality and decided benefits, if the price is very high and the customer is not willing to pay, then the product holds no value to that individual (Ashton, Gerrard, and Hudson 2011).

2.4.6 Perceived Price Reasonableness

The concept of medical tourism started because of price considerations; hence like any other, business price remains the prime criteria in tourism and hospitality industry. Price fairness decidedly affects a consumer's product/service-choice behaviour and forms their attitude towards the provider. A customer's negative feedback (word of mouth broadcast) about the price being reasonable or unreasonable is critical to a firm's growth, escalating the price sensitivity (Oliver and Swan 1989). Zeithaml (1988) describes 'price' as having both monetary and non-monetary elements to it where monetary facet is the objective, price (i.e., actual price) of a product or service, while the non-monetary facet is the price as perceived by consumers (i.e., encoded price). Chen, Gupta, and Rom (1994) and Han and Kim (2009) elaborated this encoded price as an individual's comparative evaluation of the adequateness/reasonableness of the price for a product or service with its competitors, also referred to as reference price. Numerous researchers identified complexities in pricing to synergy in the medical tourism industry. A medical facility utilises the hospitality services (a wide range of foods and beverages, rooms of various sizes or types, room service, concierge service) along with medical, healthcare and other aesthetic health products. Here the perceived adequateness of price rather than actual price may be more suitable for determining the customer decision formation. According to Oh (2000) and Zeithaml (1988), customers tend to remember the encoded/perceived price rather than the actual price after subjectively assessing price reasonableness compared to reference prices offered by competitors.

Reams of literature have been inked bringing to light price reasonableness as the one motivating factor in consumer's decision making to engage in the repeated purchase or the use of services and thus spread positive goodwill about the firm to peer groups. All the researchers agree on price reasonableness consistently influencing a customer's choice of continuing with the current provider or switch to new one.

Price reasonableness plays a dominant role in a health tourist's choice decisions especially that of an International one because of performance uncertainty wherein a prospective client cannot pre-check the products or services. Hence, price narrows down to be the only reliable cue in their post-purchase decision-making processes. Attesting to this view of price disparities while providing specialised treatments (e.g., dental care, cosmetic surgery) between home and destination nations an increasing international tourists traffic particularly from the developed nations touring to less developed, equally developed nations has been observed (Crozier and Baylis 2010). U.S customers travelling abroad for less costly healthcare; Japanese decision for international Medicare being more affordable and Chinese going overseas for high-quality medical care at reasonable prices are just a few instances. Ryu and Han (2010) indicated that, in a hospitality context, patrons' assessment of product and service quality are likely to cause greater satisfaction and results in more favourable decisions for a firm when their subjective evaluation suggests the price is reasonable. Price reasonableness perceptions can lead to one of two decisions: to equally high prices with high quality or to dissuade them from the repurchase of a product/service either of which may have a positive and negative role in their decision-making processes. Customers' decision-making processes heavily depend on their perceptions of price reasonableness, playing either a positive (the price level is positively associated with product/service performance) or negative (price level inconsonant with product/service performance repels customers from repurchasing) role (Watcharavesringkan et al. 2010).

2.4.7 Destination Brand Loyalty

Brand loyalty is defined as "a deeply held predisposition to re-patronise a preferred brand or service consistently in the future, causing repetitive same brand purchasing, despite

situational influences and marketing efforts having the potential to cause switching behaviour" (Oliver 1999, p 34). Aaker (1991) views loyalty as "the attachment that a customer has to a brand" (p. 39). Brand loyalty is at the pinnacle of the Customer-Based Brand Equity (CBBE) hierarchies proposed in the work of Aaker and Keller, and as such, we have adopted destination brand loyalty as the dependent variable in the measurement of destination brand equity.

Brand loyalty on medical tourism was never focused nor tested but changing times draw increased interest from researchers (Bowen and Chen 2001; Chitty, Ward, and Chua 2007; Mechinda, Serirat, and Gulid 2009; Oppermann 2000) showing a keen interest in considering its positioning with branding. These studies assert that the measurement of destination loyalty, especially in a long-haul travel context is difficult since the purchase of a tourism product is often infrequent, or even once in a lifetime, and part of multi-destination travel experience (Oppermann 1999; Woodside, Sood, and Miller 2008). Thus, measuring attitudinal elements of loyalty is more suited for long-haul travellers. Previous research suggests two-dimensions of loyalty construct behavioral loyalty and attitudinal loyalty where behavioral loyalty refers to the frequency of repeat purchase or relative volume of same brand purchase while attitudinal loyalty refers to the dispositional commitment or attitude a consumer-traveler has toward a destination measured by intent to visit and positive word-of-mouth recommendations (Jones and Taylor 2007). Attitudinal loyalty is considered as the dependent variable in this study since it is a measure of future travel preference or intent to visit.

Undoubtedly, loyalty finds itself in the hierarchy playing a critical role in the survival and success of businesses (Stepchenkova and Mills 2010). Customer relationship unambiguously plays a vital role in the growth of the company with previous studies optimistically suggesting the cost benefits of retaining an existing customer compared to acquiring new ones (Gursoy and Gavcar 2003). Some studies further conclude that a small decrease in customer retention cost is likely to cause a significant increase in profits (Reichheld and Sasser 1990) which proves the seriousness companies attach to customer relationship which ultimately helps forge a mutually beneficial lasting relationship. A

company needs to reach out to the customer by providing them unique experiences exceeding their expectations, giving utmost priority to their opinions and feedbacks, minimising the post-purchase hassles converts a regular customer to a loyal one. Peppers and Rogers (1997) importantly argue that giving customised services helps in gaining customer loyalty. Thus, developing and implementing an effective and efficient marketing strategy that centres on loyalty requires a clear understanding of the critical importance of the relationship between individuals buying preferences and their product loyalty (Chen and Gursoy 2001).

While studying the antecedents of tourist loyalty in the hospitality and tourism sector, various strategies were considered as a solution. Different researchers suggested diverse approaches to define tourist loyalty. While some focused on utilising attitudinal or behavioural conceptual perspectives, others utilised an alternative conceptualisation that combines both attitudinal (attitude or attraction towards a destination) and behavioural perspectives (repeat visitation). As argued by Chen and Gursoy (2001), a combination of both attitudinal and behavioural perspectives provides the most accurate representation of tourist loyalty because only considering a tourist's purchasing behaviour such as repeat visits may not truly reflect a tourist's loyalty. There is no question that loyal customers tend to purchase the same product repeatedly; however, this may not be necessarily true for tourism destinations (Chen and Gursoy 2001). As argued in tourists' two-dimensional motivation theory (Iso-Ahola 1982), individuals travel either to escape from their daily routine or to seek something new. If a tourist travels with a purpose of seeking something new, there is little possibility that the tourist will visit a destination he or she had already visited, even if that tourist had an outstanding tourism experience at that destination. Therefore, destination loyalty may not require an individual to visit the same destination repeatedly.

Past recreation and leisure literature elaborate loyalty with considerable attention by using activity destination image, destination credibility, service quality, perceived value and destination attachment as precedent variables for loyalty which encompasses behavioural, attitudinal, and composite approach-related concepts in it. The sequential purchasing of a

brand or product over a specific period denotes behavioural approach to loyalty, while attitudinal loyalty is thought to originate from a consumer's attitude and behavioural intentions, which psychologically contributes to repeat purchases. However, simultaneous assessment of how destination image, service quality, destination attachment, and destination loyalty are related has rarely been researched. The following section opens up to a tourists' destination loyalty formation model based on literature about credibility, destination image, perceived value, medical tourism service quality, destination attachment, and loyalty. The likely antecedents as revealed in this study hints at perceived value, destination credibility, medical tourism service quality, destination attachment and destination image from the perspective of an Indian medical tourists' destination loyalty.

In the following chapter (chapter III), a tourists' destination loyalty formation model is developed based on the literature on familiarity, destination credibility, destination image, perceived value, destination attachment, medical tourism service quality and loyalty; and the hypotheses that specify the directions of relationships among the constructs have been proposed. The model suggests that perceived value, satisfaction, image, familiarity are likely to be the antecedents of Indian tourists' destination loyalty.

2.5 HIGHLIGHTS OF REVIEW OF LITERATURE AND RESEARCH GAPS

- Building emotional destination attachment is the primary concern for tourism destination branding today. More recently, source credibility in customer behavior literature regarding brand credibility (e.g., Erdem & Swait, 2004; Spry, Pappu, & Cornwell, 2011), store or brand image (e.g., Bian & Moutinho, 2011; Lee, Lee, & Wu, 2011; Martenson, 2007; Wu, 2011), brand attachment (e.g., Bloemer & De Ruyter, 1998; Malär, Krohmer, Hoyer, & Nyffenegger, 2011; Thomson, MacInnis, & Park, 2005), and brand satisfaction (e.g., Kocyigit & Ringle, 2011; Ladhari, Souiden, & Ladhari, 2011; Lovelock & Wirthz, 2007), have been well-examined and defined in regard to customer perceptions of a variety of product/service branding contexts. However, it has largely been ignored in the tourism management

literature (Hwang, Lee, & Chen, 2005; Spry et al., 2011; Yuksel, Yuksel, & Bilim, 2010).

- Despite the criticality of product/service quality, destination image, destination familiarity and credibility, no previous medical tourism research has yet examined their associations with medical and service perceived value and destination attachment, nor investigated the impact of such relationships on brand loyalty in a medical tourism context (Han & Hyun, 2015; Im, Kim, Elliot, & Han, 2012; Manaf, Hussin, Kassim, Alavi, & Dahari, 2015; Shahijan, Rezaei, Preece, & Ismail, 2015).
- Also, while price and its importance have been repeatedly emphasised in the existing literature, little research has been conducted to date on the moderating role of perceived price reasonableness in the hospitality and tourism industry. The present study was designed to shed light on these issues (Han & Hyun, 2015).
- Medical tourism justifies better quality or a better quality/price ratio in treatment than the native country. Acceptable service quality remains a priority leaving behind price as a good reason to attract consumers to the hospital, clinic or even a county. Perceived value as well as a powerful predictor of the purchase and loyalty intentions. Hallem and Barth (2015), Choi et al. (2004) are among the few who have studied patient care for the perceived value of the medical tourism experience in developing countries. The present study attempts to verify a comprehensive model is integrating these variables into medical tourism in India and blend price perceptions; service quality; value and satisfaction as predictors to attitudinal loyalty.
- India has in the past few decades seen tourism both in terms of domestic as well as inbound/outbound tourist, grow exponentially. Despite being one of the world's most-watched tourist markets, empirical studies, especially on Indian tourists' loyalty behaviour, have seldom been examined. Since the majority of the destination loyalty and tourist's behavioural intention studies were conducted in the Western countries (Appendix-Table 6) the findings of those studies may or may not apply to India. This study envisages to fill these lacunae to help enrich the medical

tourism and hospitality literature by examining factors that will lead to Indian medical tourists' destination loyalty, using the data collected from popular tourist destinations across India.

- Finally, this research framework provides a pragmatic perception of various medical tourism destinations. A theoretical model integrating destination source credibility, destination image and destination attachment as antecedents of destination loyalty; arbitrating the effects of destination attachment and perceived value for the relationships mentioned above remains the focus of this study.

2.6 SUMMARY

Medical tourism has survived the metamorphosis in successive civilisations and after several calibrations have finally found its newfound charm and position as a contribution to the national exchequer by generating revenue and thus promote this significant industry. Indeed, global competition exists but major competitors are from Asia with India thus, making the country a major player for obvious reasons like highly skilled doctors and paramedics working in hi-tech hospitals equipped with world-class facilities, even while remaining cost-effective compared to world standards. These facilities boast of having the accreditation matching world standards by getting robust support with the active participation of government and private agencies.

This chapter defines the boundaries of the study by discussing the constructs that are to be empirically examined within the proposed medical tourism brand loyalty model. The model incorporates the constructs of the destination image, medical tourism service quality, destination credibility, perceived value, destination attachment, perceived price reasonableness and loyalty.

In reviewing the relevant literature, it is noted that the constructs used in this research have not previously been presented in one single model (this is further discussed in chapter three). Further, the inclusion of medical tourism service quality as an essential variable in the proposed model provides a better understanding of the relationship development between customers and service providers within the hospitality context of this study.

Although there could be constructs other than those incorporated in the proposed model above, it is believed that this research has included the constructs that are most suited to answer the research questions posed in Chapter One.

To provide a basis for identifying the above-proposed model, some issues of destination branding assumed to be relevant to this study, are discussed that is followed by four sections, which reviewed each construct, providing a better understanding of the role that they play in the proposed theoretical model. For this reason, it has been necessary to review the literature on marketing with a particular focus on destination branding. This discussion is also supported by reviewing the relevant literature specific to the context of the tourism industry.

In the next chapter, the hypotheses established by the theoretical model to be empirically tested, are discussed. These hypotheses represent the relationships between the underlying constructs discussed in this chapter: source credibility, destination image, medical tourism service quality, perceived value, destination attachment, perceived price reasonableness and brand loyalty.

CHAPTER - 3

CONCEPTUAL FRAMEWORK

CHAPTER 3

CONCEPTUAL FRAMEWORK

3.1 INTRODUCTION

Chapter Two discussed the theoretical foundation for the study. Chapter Three discusses the development of the proposed model to be analysed and the hypotheses to be tested. It will help enrich the tourism and hospitality literature by examining factors that will lead to Indian tourists' destination loyalty, using data collected from popular medical tourist destinations in India. This chapter is organised into six sections. The following section (3.2) provides an overview of the proposed model, which has been developed to examine the research questions. The research hypotheses specifying the relationships between the underlying constructs are then discussed. Section (3.3) discusses the consequences of destination source credibility. Section (3.4) discusses the consequences of Destination Image, and section (3.5) discusses the consequences of medical tourism service quality. Section (3.6) discusses the consequences of perceived value, and section (3.7) discusses the effect of destination attachments. Section (3.8) discusses the effect of Perceived price reasonableness among the study constructs. Section (3.9) discusses the operational definitions of the study constructs. The final section (3.10) presents a chapter summary.

3.2 THEORETICAL FRAMEWORK AND HYPOTHESES DEVELOPMENT

As explained in the Chapters One and Two, the research is concerned with the advancement of our understanding of the medical tourism destination preference of medical tourists and their loyalty. Furthermore, for the first-time linkages between destination image, destination credibility, medical tourism service quality, destination attachment, perceived value and brand loyalty have been integrated into one model, which addresses a gap in the literature by providing a complete model within the context of destination branding that is consistent with Chen and Phou (2013), who argue that even though many scholars have attempted to explain the development of destination branding, few have paid explicit

attention to the role played by perceived price reasonableness in this process. The study conducted by Anderson and Kumar (2006), makes it clear that the integration of perceived price reasonableness is an essential component in medical tourism brand loyalty development.

Based on the preceding literature review (see Chapter Two), the conceptual framework of the present research, shown in Figure 3.1, includes nine main hypotheses, which will be tested. Hypotheses ($H_1$and H_2), (H_3 and H_4) and (H_5 and H_6) reflect the influence of destination image, destination credibility and medical tourism service quality - on perceived value and destination attachment, respectively. Hypotheses ($H_7$and H_8) reflect the influence of perceived value and destination attachment on brand loyalty, whereas hypothesis H_9 proposes the perceived price reasonableness moderates the relationships among study constructs

In order to provide a complete understanding of the cause and effect of these hypotheses, this chapter explains the consequences of the destination image, destination credibility, medical tourism service quality, perceived value and destination attachment. However, there is no hypothesised consequence of loyalty, as it is the final predicted construct in the proposed model. In this model, destination image, destination credibility and medical tourism service quality have been treated as exogenous constructs, while perceived value, destination attachment and loyalty have been treated as endogenous constructs. As was discussed in section (2.6), this is because destination image, destination credibility, medical tourism service quality represents the foundation upon which customers base their evaluation of the loyalty they have with their service provider (i.e., a medical service provider in the case of this study).

3.2.1 The Effects of Destination Source Credibility

Destination source credibility studies done in the past allude a sense of delivering on the promises related to a specific destination. Studies done in Marketing and Communication in the past few decades find widespread mention on Source Credibility (Biddix et al. 2011; Veasna et al. 2013; Kani et al. 2017). The key word in source credibility is trustworthiness

which unequivocally influences the consumer opinion. Hence, recent researches on consumer perception of brands have laid considerable focus on source credibility, which has mostly been ignored about an exploration of tourism destinations (Derbyshire and Giovannetti 2017; Kani et al. 2017).

Brand source credibility is the highway that guides a consumer through the credibility and trustworthiness of a brand (Erdem and Swait 1998). Past research study suggests brand credibility affecting a positive brand purchase intention through perceived quality, perceived risk and the information costs saved. Perceived quality refers to the consumer's judgment about the superiority or excellence of a product or service (Herbig and Milewicz 2013; Ayeh 2015; Shan 2016). The uncertainty consumer faces while making a purchase even while being unaware of the consequences of their purchase decisions elaborates perceived risk (Jiillian C. Sweeney et al. 1999). Information costs saved can be conceptualised by lowering information gathering and processing costs, which include the expenditure of time and money. Higher perceived quality, lower information costs, and lower risks associated with credible brands can increase consumer evaluations of brand credibility which inevitably reduces the cost of information-gathering and information-processing and will reduce perceived risk.

Hypothesis 1: Brand credibility will positively affect the perceived value.

According to the theory of self-congruity, the higher the self-concept and destination source credibility, the greater is its power to create a kind of self-image toward the destination (Veasna et al. 2013; Yoshihara et al. 2016; Kani et al. 2017). The destination image matching with the tourist's self-image has a decided role in building tourists' feelings and attitudes toward destination source credibility (Hwang et al. 2005). Therefore, credible tourist information turns out to have an important influence on the selection of destinations (Bayoglu et al. 2017). Taking an analogy from psychology and marketing literature, the former considers attachment as an emotional linkage between a person and a specific object while the latter deliberates that customers can build emotionally charged relationships with brands. Therefore, destination attachment is defined as a set of positive

beliefs and emotional linkages of an individual to a specific tourism destination (Veasna et al. 2013; Kani et al. 2017). Reliability and credibility, thus, becomes the tourists' binding factor to a specific destination. Credible destination sources are associated with tourists' beliefs and attitudes toward the decision-making processes related to choosing a specific destination (Johnson and Kaye 2009; Ayeh 2015). Destination source credibility and destination image could indeed affect tourist perceptions of destination satisfaction as well as the destination attachment. Thus, the following hypothesis has been proposed:

Hypothesis 2: Destination source credibility has a positive influence on Destination attachment.

3.2.2 The Effects of Destination Image

An individual or group carry a destination image of a particular object or Destination through the awareness, different impressions, prejudices and emotional thoughts of it. (A. D. A. Tasci et al. 2007; Ramseook-Munhurrun et al. 2015; Alcántara-Pilar et al. 2017; Kani et al. 2017). Destination image plays substantial roles in destination choice while surfing for lodging, attractions to visit, activities to participate in, Destination image gets influenced by a post-trip appraisal of perceived value, satisfaction and future travel intentions (Baloglu and Brinberg 1997; Bigné et al. 2001; Asli D. A. Tasci and Kozak 2006; Sun et al. 2013; Kani et al. 2017). Past studies have suggested that destination image formation is influenced by both stimulus factors and individual tourists' characteristics Chen and Kerstetter 1999; Bigné et al. 2001; Anholt 2010).

An in-depth study in the past revealed the coalition factors of destination image, perceived quality, satisfaction, intention to return and willingness to recommend the destination affecting a tourist's travel decisions (Baloglu and Brinberg 1997; Konecnik and Gartner 2007; Tasci et al. 2007; Kani et al. 2017). Perceived value, satisfaction and loyalty has an essential bearing on the image, bolstering the existence of a positive relationship between destination image, perceived value and satisfaction (Asli and Kozak 2006; Konecnik and Gartner 2007). Another study found that destination image directly affects tourists' idea of perceived value and indirectly affects their future behaviour (Kani et al. 2017; Pike 2017).

Hence, the preceding empirical and theoretical discussions lead to the following hypothesis:

Hypothesis 3: There is a significant relationship between destination image and perceived value.

Destination image invariably turns out to be a key factor in understanding tourists' destination selection processes, a subjective interpretation facilitated by tourists' feelings and beliefs toward a specific destination identifies itself as an important element in travel decisions; arguably, destination image could be assisted by the strengths of a destination in the eyes of potential visitors and could be designated as a forerunner to destination attachment (Alcántara-pilar et al. 2017; Kani et al. 2017; Pike 2017). Destination image holds vital roles in destination choice, decision progression and in the selection of on-site activities such as lodging, attractions to visit and the events to participate in,. (Baloglu and Brinberg 1997; Prentice 2004). Destination image invariably has a significant post trip influence on factors like perceived value, satisfaction and future intentions (intention to revisit and willingness to recommend (Anholt 2010; Kamalipour et al. 2012; Larocque et al. 2012). Hence, expectedly the most favourable destination image would lead to a stronger cognitive attachment to a particular destination. Depending on this rationale, the following hypothesis is proposed:

Hypothesis 4. Destination image has a positive influence on Destination attachment.

3.2.3 The Effects of Medical Tourism Service Quality

The modern-day consumer is very much market savvy and does a detailed check on the product or service, and service quality weighs heavily on their minds before confirming their choice (Huei et al. 2015; Manaf et al. 2015). Service quality thus, means merely delivering on the customer expectations consistently, wherein the image rather than the physical quality of the product or service becomes essential in customer retention which is cemented by a matrix of healthy customer relationship and service awareness (Parasuraman et al. 1988).

Attributes like money, quality, benefit, and social psychology are known to have a direct impact on customer's perceived value. Value generation from monetary perception is a state of satisfaction when less is paid for the goods (Gotlieb et al. 1994; Hallem and Barth 2011). While considering the quality angle for a product, the deciding factor would obviously be the price which determines the quality (Ravald and Grönroos 1996). It turns out that when a high-quality product is charged less, it creates positive perceived value. The benefit aspect indicates the customer's perceived value during the overall evaluation of the utility of perceived benefits and perceived sacrifices (Parasuraman et al. 1988). Purchasing certain goods adds to the generation of value among the buyer's community itself contributing to the social psychology viewpoint (Woodside et al. 1989). In short, it explains that merchandises carry particular meanings (such as social, economic status and social culture) and can amplify the effect of social self-concept (Jillian C Sweeney and Soutar 2001; Z. Wang, A. C. Bovik, H. R. Sheikh and E. P. Simoncelli 2004). The study focused on a customer's perceived value while evaluating the benefits of a product or a service based on their advance sacrifices and exposit the perceived performance when they use something like mobile value-added services.

While exploring the relationships between service quality and customer's perceived value in the tourism marketing sector, most empirical studies in the past pointed out that service quality would positively influence perceived value (Kuo et al. 2009). The studies are done on the product and service industry, Z. Wang, A. C. Bovik, H. R. Sheikh and E. P. Simoncelli (2004) and Jillian C Sweeney and Soutar (2001), separately investigated the tourism sector in China and Canada and found out that service quality is positively related to perceived value. Accordingly, Hypothesis is proposed as under:

Hypothesis 5: Medical Tourism Service Quality has a positive influence on Perceived Value.

The extant literature indicates that high service quality evaluations are associated with higher destination attachment levels which lead to loyalty (Woodside et al. 1989; Lertwannawit and Gulid 2011; S. Lee et al. 2014). It implies that favourable service

quality evaluations would be associated with high functional and emotional bonds to a Destination which can subsequently lead to loyalty development. While exploring the relationship between service quality, destination attachment and destination loyalty can help to guide destination managers' focus on paramount factors leading to customer retention, an examination of this relationship remains rare in destination studies.

Service quality, therefore, is the discerning factor that gives the strategic edge from a competitor and is a key determinant of, product attachment, thus proving to be the forerunner to customer retention and loyalty. Incidentally, the tourism sector promoted a customised, enduring and committed connect with the customer portraying the significance of brand attachment to a given destination which needs to be emulated by other service sector brands to remain a favourite. Based on this rationale, the following hypothesis is proposed:

Hypothesis 6: Medical Tourism Service Quality has a positive influence on Destination attachment.

3.2.4 The Effects of Perceived Value

A customer's subjective evaluation of a products quality concerning its "superiority or excellence" of a product or service is defined as perceived value. Alternately it can also be defined as an appraisal variable that is likely to be models explaining behavioural intentions (Hallem and Barth 2011; S. Lee et al. 2014; Dogerlioglu-Demir et al. 2017). The dynamics of customer retention remains undoubtedly an overtime challenge requiring clarity in perception influences forming quality perceptions and its progression. Past studies revealed perceived value is similar to an individual's attitude (Parasuraman et al. 1988; Hui et al. 2007; Kwenye and Freimund 2016). It conclusively proves perceived value factor being weighed heavily by the customer while assessing a product. This view is upheld in a recent article by Kani et al. (2017) inarguably concluding that in the short run higher quality perceptions positively lead to increased profits due to premium prices. While in the long run effective business growth leads to both market expansion and market share gains. Several studies posited positive relationships between perceived quality and brand loyalty,

brand awareness and perceived quality, apart from other allied relationships like broadcasting attitudes and brand awareness, distribution intensity and brand awareness among emerging markets like India and Thailand (Zailani et al. 2016; Kani et al. 2017; Mandler et al. 2017). The perceived value of customers focuses on their actual buying behaviour, especially brand loyalty, generating considerable experimental interest. Consequently, this study posits the following hypothesis:

Hypothesis 7: Perceived Value is positively related to brand loyalty.

3.2.5 The Effects of Destination Attachment

Brand attachment simply refers to " the strength of the cognitive and affective bond connecting the brand with self " within a symbolic framework (Kamalipour et al. 2012; T. H. Lee and Shen 2013; Ramkissoon et al. 2013). Fournier (1998) proposed brand attachment as one of the six dimensions appropriate to a consumer-brand relationship. Brand attachment is a key determinant of consumer consumption behaviour, and it finds endorsed by several attributes inherent to the concept. Attachment articulates an emotional bond which is persistent, resistant to change, impact cognition, and predict behaviour (Kamalipour et al. 2012; Kani et al. 2017). Persistence mirrors the degree to which an individual's attachment concerning an object remains unchanged over time. While resistance, on the other hand, symbolises an individual's ability to refuse to shift to competitive products (Baggett et al. 2009). A stronger bonding contributes to a consumer's resistance to change and capacitates a brand to withstand bad performance (Keller et al. 2008). (Park et al. 2010), expounds brand attachment as more than an attitudinal construct and accounts for higher-order consumer behaviour associated with commitment to a lasting relationship. Therefore, brand attachment signifies the relationship between a consumer and a brand leading to "automatic retrieval of thoughts and feelings about the brand". Recent times have seen an affective reaction to brands assisting in the easy prediction of brand loyalty. Empirical studies show that brand affect influences purchase and attitudinal loyalty (Krishnamurthi and Raj 1991; Horng et al. 2012; Wong and Teoh 2015), Therefore, the study expects that:

Hypothesis 8: Destination attachment is positively related to overall brand loyalty

3.2.6 The Effects of Perceived Price Reasonableness

The monetary and non-monetary facet of any commerce rests critically on the price a product carries. Objective price (i.e., actual price) of a product or service essentially hints at the monetary facet, while the non-monetary facet (i.e., encoded price) is the price as perceived by consumers (Godey et al. 2016). Therefore, it becomes important to know how customers perceive prices and whether price changes are adequate or inadequate. Thus, price fairness reflects the attitudinal shift of a customer towards a product or service appraising its reasonableness with the competitors (Giovanis and Athanasopoulou 2016). Medical tourists' differ from other industries due to the associated overheads included with it like medical/healthcare/aesthetic product, the hospitality services like a wide range of foods and beverages, selecting rooms of various sizes or types, room service and concierge services (Rubio et al. 2017). Oh (2000), and Parasuraman et al. (1988) in their study have concluded that the customers tend to remember only the encoded/perceived price rather than the actual price while subjectively assessing price reasonableness in comparison to the reference prices offered by competitors.

A cross-section of past researchers has identified perceived price reasonableness weighing heavily on the consumer's choice of being steadfast with a brand (Eng et al. 2016). Reasonable price makes guarantee repeat purchases and helps spread positive vibes about the company through the word of mouth broadcasting (J. Sweeney and Swait 2008). Momentousness of price is the justification for the influx of medical tourists to Asian countries and the validation to this effect has been that in spite of the uncertainty of prior checking or examining of the product or services offered by a hospital or clinic, purchases are made (J. Sweeney and Swait 2008; T. H. Lee and Shen 2013). In such cases, perceptions of price fairness/reasonableness become a reliable and dominant clue in their post-purchase decision-making processes.

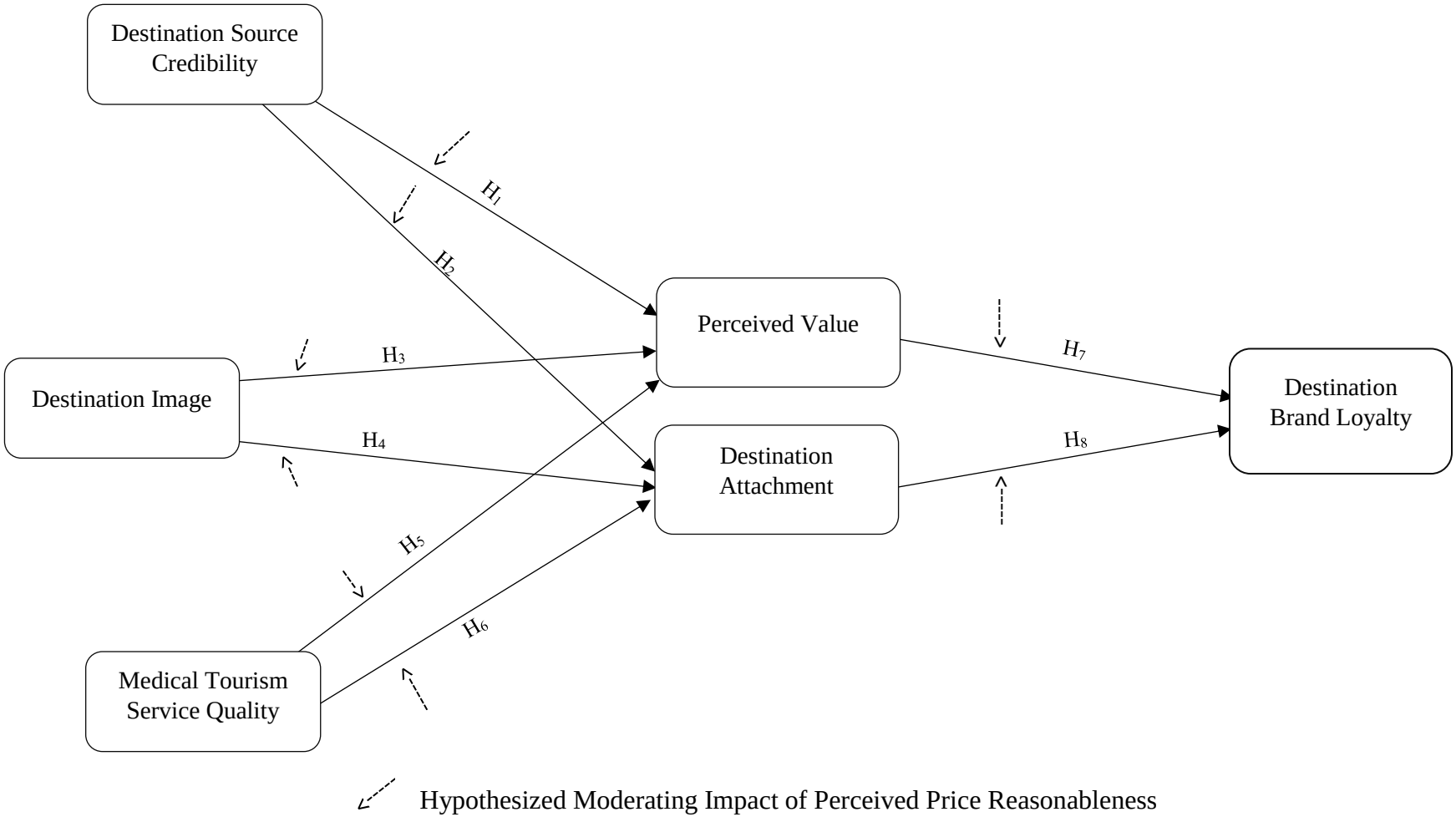


Figure 3.1. Medical Tourism Customer Based Brand Loyalty Model

Source: Review of Literature

International medical tourists travel decisions sprout primarily due to the cost disparities between home and destination countries (Qiu, H. Z., & Zhang 2008). Price reasonableness thus remains vital decision-making criteria creating a positive or negative impact in the patrons' mind who equate high prices with high quality or may be dissuaded from the repurchase of a product/service due to inconsonant pricing. Price perceptions importantly enough cause international customers who experience a higher level of price reasonableness to form stronger behavioural intentions than among those who find prices to be less appropriate to the medical product's performance, satisfaction, or reliability.

Hypothesis 9: Perceived price reasonableness significantly moderates the relationships among study constructs (i.e., destination source credibility, Destination attachment, destination image, medical tourism service quality, perceived value and destination brand loyalty of medical tourist) within the proposed conceptual model.

3.3 OPERATIONAL DEFINITIONS

The operational definitions used to measure the constructs are presented in Table 3.1.

Table 3.1 Operational Definitions of Constructs

Construct	Operational Definition
Destination Source Credibility	Destination source credibility as the believability that the destination management is willing and capable of delivering on its promises related to India.
Destination Image	Destination image as the expression of all knowledge, impressions, prejudices and emotional thoughts an individual or group about India.
Medical Tourism Service Quality	Medical tourism Service quality as the measure of how well the service level delivered matches customer expectations, while a firm delivering quality service means conforming to customer expectations on a consistent basis
Perceived Value	Perceived value as consumer's judgment about the "superiority or excellence" of the medical product or service.
Destination Attachment	Destination attachment refers to "the strength of the cognitive and affective bond connecting the destination brand with the self."

Perceived Price Reasonableness	Perceived price reasonableness as the customers' perceptions of the appropriateness of a price for a medical product or service in comparison to competitors.
Brand Loyalty	Brand loyalty is a deeply held commitment to re-buy or re-patronise a preferred medical product/service consistently in the future.

3.4 SUMMARY

As deliberated before this study objectively examine the proposed model of customer brand loyalty from medical tourist's standpoint providing a profound understanding of this growing relationship within the tourism realm. Focused at achieving this goal, the model proposed in this study examines the association between the constructs of the destination image, destination source credibility, medical tourism brand loyalty, perceived value, destination attachment, perceived price reasonableness and brand loyalty (as conceptualised in Chapter Two) within a single framework. Nine hypotheses (H_1, H_2, H_3, H_4, H_5, H_6, H_7, H_8 and H_9) have been formulated to reflect the causal relationships between these underlying constructs in which destination image, destination source credibility and medical tourism service quality have been considered as exogenous constructs, while the remaining as endogenous constructs.

Inconsistent with the relevant literature, perceived price reasonableness and loyalty construct have been incorporated into the proposed theoretical model, as this construct is increasingly being recognised as fundamental to buyer-seller relationships (J. Sweeney and Swait 2008; Choi 2017; Kani et al. 2017). This addition allows the present model to fill the existing gap within the literature by incorporating a link between each type of destination image, destination source credibility and medical tourism service quality (H_1, H_2, H_3, respectively) and later between perceived value and destination attachment.

The methodology adopted to test the underlying nine hypotheses is discussed in the following chapter. It includes an overview of the methodology used, measurement development, data collection tool, sampling design, data collection procedures, analytical techniques, and finally issues related to reliability and validity.

CHAPTER - 4

RESEARCH METHODOLOGY

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The header to this chapter is self-suggestive by broadly entailing methodology to empirically examine the theoretical model established in Chapter Three and to address the research questions discussed in chapter one. Methodology finds mentioned second (4.2) to Introduction out of the eleven major sections in this thesis. The general scheme and justification of picking quantitative survey methodology in this research are elaborated in section (4.3) while Section (4.4) develops and discusses the scale items used to determine constructs to form the proposed model. Section (4.5) describes the instrument used to collect data while section (4.6) discusses the pre-test phase before the final survey followed by the final survey in section (4.7), including the sampling frame and procedures used to collect the data. Section (4.8) details the statistical techniques used in this thesis, including preliminary and structural equation modelling while Section (4.9) discusses issues regarding the reliability and validity of the instrument. The next Section (4.10) outlines ethical considerations related to this research and finally followed by summarisation of the chapter section (4.11).

4.2 METHODOLOGICAL OVERVIEW

This chapter reflects the general mood of this thesis and details the answers to the research questions in chapter one followed by testing the hypotheses in chapter two which summarises each of the steps in Figure 4.1. A self-administered questionnaire remains the basis for data collection highlighting demographic questions, medical tourism related information and questions measuring the intended constructs during quantitative survey methodology reflecting on the proposed theoretical models based on multi-item measures using 7-point Likert scales adopted from previously tested scales were used.

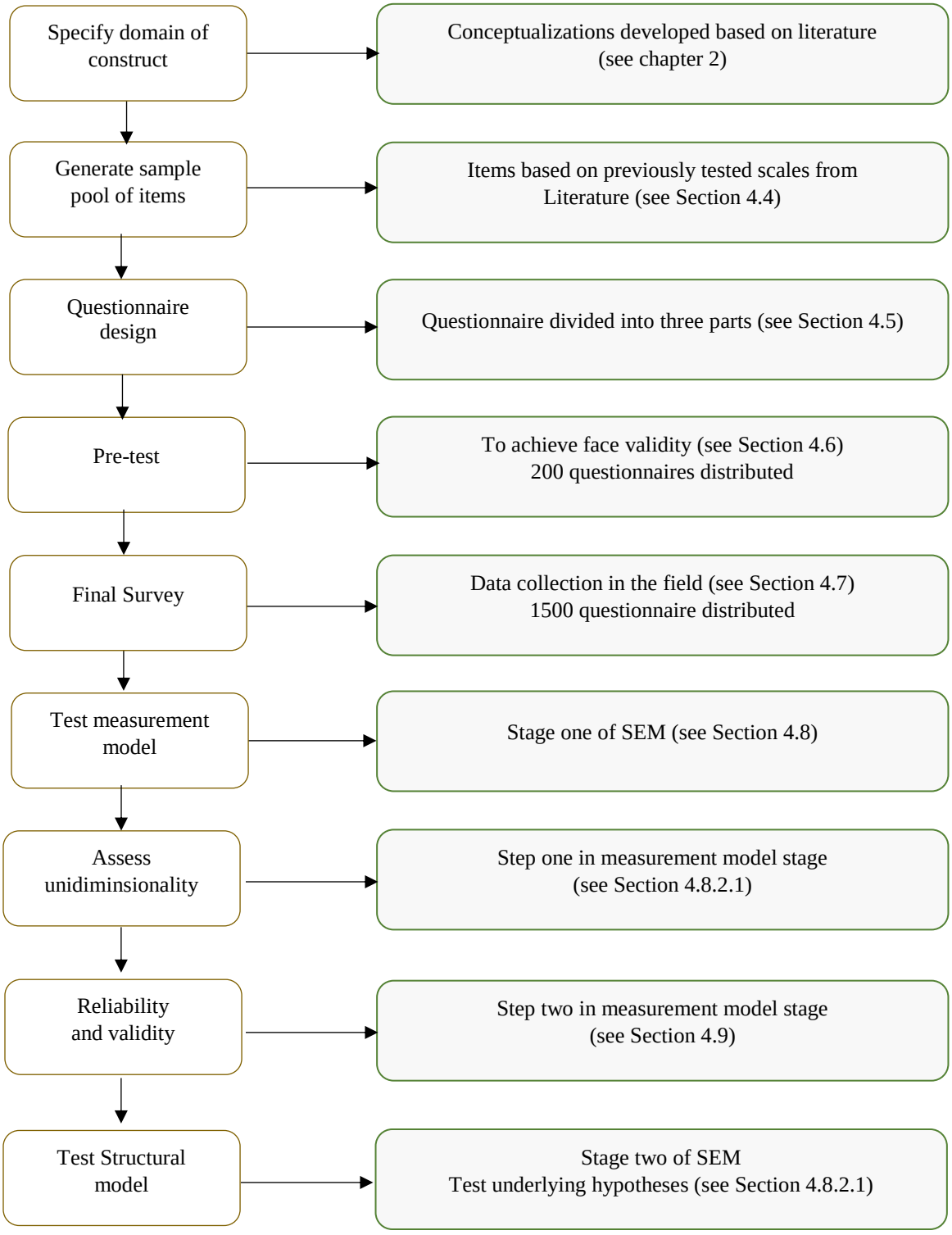


Figure 4.1: Overview of Methodology

A pre-test was mandatorily done to calibrate the discrepancies in the questionnaire and rationalise it before the final survey which extended to medical tourists from twenty-seven hospitals in India between the years June 2015 to December 2016. These medical tourists, classified as a 'traveller seeking any form of medical treatment away from their native country' forming the sample examined in this study, were given a questionnaire each while they checked in and instructed to return it to the nursing staff while leaving. Only 1204 of 1620 questionnaires came back from which only 1025 were included in the final data analysis.

Data analysis adopted two statistical techniques. Statistical Package for the Social Sciences (SPSS) version 23 was used to analyse the preliminary data and provide descriptive analyses such as means, standard deviations, and frequencies while Structural Equation Modelling (SEM using AMOS 23.0) with Confirmatory Factor Analysis (CFA) was used to test the measurement model. SEM was conducted using two-stage approach recommended by C. Anderson and Gerbing (1988). Stage one or the measurement model used CFA, done in two steps - assessment of unidimensionality followed by reliability where the internal consistency of measures was assessed using Cronbach's alpha and validity studies where construct (including convergent and discriminant) and external validity was included. Stage two assessed the structural model after the scale was developed in stage one where the hypotheses discussed in Chapter two are put to the test in stage two to measure the structural model.

4.2.1 Research Paradigm

Social reality can be understood in multiple ways and there are different research approaches to choose from. These approaches are based on particular ideas about the world and nature of the knowledge. A research paradigm refers to 'the set of common beliefs and agreements shared between scientists about how problems should be understood and addressed' (Kuhn 1962). It can also be referred to 'the net that contains the researcher's ontological, epistemological and methodological premises' (Guba 1990, p. 17). Ontology is concerned with the nature of reality and existence. Epistemology refers to the theory and

nature of the knowledge. Methodology is all about how to understand the world or how to gain knowledge. There are many paradigms such as the conventional positivism, constructivism or interpretivism, pragmatism, and recent subjectivism and critical realism. Most of the research in social science belongs to either positivism or interpretivism although critical realism (CR) as a research paradigm is also gaining popularity in recent times. This section elaborates on the two major paradigms which are being used in the study of medical tourism destination branding.

The Positivism Paradigm

Positivism paradigm which has represented the traditional form of research, is historically associated with the French philosopher Auguste Comte who espoused that observation and reason as means to understand human behaviour. According to positivists, there is only a single objective reality which can be sensed and explained in the same way as done in the natural world. In this traditional approach, it is assumed that the social world is similar to the natural world which adheres to the universal laws and is committed to objectivity and neutrality. Positivists argue that the real events can be observed empirically through sensory perceptions and explained in logical manner and therefore rejects metaphysics, opinion and beliefs. Positivism or post-positivism reflects a deterministic philosophy where the causes probably lead to effects or outcomes (Creswell 2014). According to positivists, the world can be known from the science and technology, can be predicted through the laws, theories, maxims and assumptions about the world and is singular in truth and reality (O'leary 2004). Positivist ontology takes an atomistic world view where the world is external and events can be observed and determined in a regular manner (Crotty 1998). Epistemologically, the relationship between the researcher and the subject remains detached where the role of social scientists is of analyst or interpreter of the subject matter (Cohen, Manion, and Morrison 2013). As far as methodology is concerned, positivism relies heavily on quantitative form of data and often uses experimental designs, survey methods, mathematical models and statistical techniques to generate data. The positivist approach often follows a deductive approach where from a general theory specific hypothesis are made and then tested. From this perspective it is a reductionist approach

where life experiences can be measured by breaking down to discrete units for analysis (Creswell 2014). However, recently the focus has shifted to post-positivism. Like positivists, post-positivists are also realists, the difference being they are critical realists. Knowledge is provisional and can be modified or upgraded or refuted in course of time. The research findings in the social world generated through scientific methods are neither totally objective nor unquestionably certain (Crotty 1998). According to Ryan (2006), "post-positivist research principles emphasise meaning and creation of new-knowledge, and are able to support committed social movements, that is, movements that aspire to change the world and contribute towards social justice". According to Guba (1990), ontologically, post-positivists belief in critical realism which concludes that reality can never be fully comprehended, and the researcher is a modified objectivist and methodology includes modified or manipulated experimental designs emphasizing on critical multiplism and use of more qualitative methods.

4.3 QUANTITATIVE APPROACH

A quantitative approach and the survey methodology using self-administered questionnaires being justifiably appropriate for collecting data from sample medical tourists at various accredited hospitals are elaborated hereunder.

Medical tourism brand loyalty literature grounded the development of a theoretical model to test the research questions and the hypotheses which were reconfirmed by past few studies (Amaratunga et al. 2002; Neuman 2006; Punch 1998). Thus, the hypotheses resolving around this research question were tested by measuring the underlying variables in the theoretical framework; which is an integral part and an essential aspect of quantitative research design by providing strong reliability and validity (Neuman 2006). This methodology has found much success with buyer-seller relationships, especially those from hospitality sector which is appropriately analogous to the fundamental objective of arriving at a paradigm in this research.

4.3.1 Survey-Based Research

The five good reasons for evaluating the proposed theoretical model among the sample of medical tourists around hospitals in India were that ultimately these revealed large samples of data which was found to be an appropriate tool in a survey research method. The format starts to deal more directly with the nature of respondents' thoughts, opinions and feelings and collect information on belief, attitudes and motives (Shaughnessy, Zechmeister, and Zechmeister 2000; Wickens, Gordon, and Liu 2004). With little or no control required on the part of the investigator over behavioural events, it stands out second (Babin et al. 2012). Data processing in the next stage enables the researcher to draw generalised scientific conclusions from a larger sample of responses (John W. Creswell 2016; Martin, Rosenbaum, and Ham 2015). Fourth, it is more concerned about causal research situations (Hair et al. 2010), and finally, it is considered useful because it is quick, inexpensive, efficient, and can be administered to a large sample (Churchill and Iacobucci 2005; Hair et al. 2010; McClelland 1994).

The five reasons for survey method mentioned above are indeed healthy and merit their use here. However, over-reliance on self-report data is looked with scepticism, mainly when both the independent and dependent variables are assessed within the same instrument (Campbell 1982; Spector 1992). It raises questions about the conclusions drawn from systematic response distortion and the reliability and validity of the measures used in the instrument (Hair et al. 2010). The absence of control over timeliness, difficulty invalidation of selected respondents statements, and inadequate penetration to information by the researcher is seen as associated problems with survey methods. Hair et al. (2010) guidelines were used to ensure precision, and circumvent drawbacks with the survey methods which were addressed by using previously tested reliable and valid scales to measure the underlying constructs followed by designing a questionnaire that was easy for the respondents to understand and free from response bias (see Section 4.5) and address the systematic response distortion. Research control like any research method would carry, was construed as an obvious limitation in this study. The type of survey method used finds elaborated next.

4.3.2 Self-Administered Questionnaire

Personal interviews, telephone interview, and self-administered questionnaires form part of a range of data collection techniques. The third option used here allows the respondent to read the survey questions and record his or her responses without the presence of a trained interviewer the only challenge being clarity of the written words than the skill of interviewers (Babin et al. 2012; Hair 2009).This method in comparison to the other two comes with the following three advantages. The first being that a large number of respondents could be used to survey quickly and economically. Second, the questionnaire, being not time-bound, gives the respondents the luxury of time and lastly a wider geographical area is covered more economically. Furthermore, studies relevant to this thesis (in the domain of destination branding) in the past have successfully utilised self-administered questionnaires (Babin et al. 2012; Hair et al. 2010; Mechinda et al. 2010; Oppermann 2000).

The form used in this survey is called drop-off survey. Here the researcher and a representative (i.e., front-desk staff in this research) travel to the respondents' location, hand deliver the survey questionnaires, which, after filling, are picked up by the representative (Babin et al. 2012; Hair et al. 2010). The merits of this methods being the availability of a person to answer questions (i.e., medical tourists staying at each hospital approached) and the ability to generate interest in the completion of questionnaires (i.e., staff can encourage medical tourist to complete questionnaires through direct interaction). Hospitals were reticent to provide patient's personal information over E-mail, web-based survey or even telephone.

4.4 SCALE DEVELOPMENT

This study explored relevant literature review for the development of scales, and a total of fifty-six scale items were selected to measure the constructs like destination source credibility, medical tourism service quality, destination image, perceived value, destination attachment, perceived price reasonableness and brand loyalty. Selecting the precise items required methodical deliberations starting with items that measure the content of each

construct in this research, and determine the extent to which they represent definitions and dimensions that represent a business-to-customer market representative of consumers' perceptions as end users of buyer-seller brand loyalty relationships rather than being business-to-business; consistent with Churchill and Iacobucci (2005), p.68) recommendation that "the researcher probably would want to include items with slightly different shades of meaning because the original list will be refined to produce the final measure". All scales used have been adopted from past studies with valid and reliable measures of similar constructs. New scales were developed using items from various scales in these previous studies, validity and reliability were examined to ensure the new scales were acceptable. Table 4.1 shows a summary of the number and source of the items used to test each construct. These items are further discussed later in this section.

Constructs have been operationalised using 7-point Likert scale which are highly desirable in numerically ordering respondents, particularly, an attitude scale widely used in marketing research, ranging from (1= strongly disagree) to (7 = strongly agree), with exception of the emotions construct, which was assessed on a scale ranging from (1 = never) to (7= very often). The Likert-scales were selected because they take less time, and are easy to answer (Churchill and Iacobucci 2005; McClelland 1994) while its most serious drawback being lack of reproducibility (Oppermann 1999), and yet outmatching others (such as 5-point Likert scales), as it allows greater discrimination and finer differences between people.

Churchill and Iacobucci (2005) attributed single-item scales to lack sufficient correlation while measuring the attribute especially those closely related to one another. They have restricted variance of scale and unreliable responses. Hence, a useful measurement of complex factorial constructs as recommended by (Churchill and Iacobucci 2005; Nunnally 1978) and Han 2017) demands multi-item scales to provide a comprehensive evaluation and tide over the limitations of single-item measure.

Table 4.1: Total of Scale Items Used in the Study

Constructs	Number of Items	Sources
Destination Source Credibility	**6**	(Erdem and Swait 2004a)
Expertise	3	
Trustworthiness	3	
Destination Image	**5**	(Lee and Lockshin 2011)
Medical Tourism Service Quality	**22**	(Manaf et al. 2015)
Medical Staff Quality	12	
Supporting Services Quality	6	
Administrative Services Quality	4	
Perceived Value	**5**	(Lee et al. 2010)
Destination Attachment	**8**	(Kyle, Graefe, and Manning 2005; Williams and Vaske 2003)
Destination Brand Loyalty	**4**	(Yoo, Donthu, and Lee 2000)
Perceived Price Reasonableness	**6**	(Han and Kim 2009; Oh 1999)

Source: Review of Literature.

The original and modified questionnaire items of each construct are listed in table 4.2 - 4.8. Scale items were revised and validated by conducting pre-test procedures discussed in section 4.6.2 to better reflect customers' perspectives in a medical tourism context elaborating on the items used to measure and the underlying constructs in the proposed theoretical model.

4.4.1 Destination Source Credibility

Brand credibility or believability of a product strews the belief that a brand is capable and willing to deliver on the promises made about the firm's product quality using elements like charging higher prices, offering extended warranties or distribution via high-end channels. Scales used by (Erdem and Swait 2004b), were used to measure the aspects of expertise and trustworthiness.

Table 4.2: Destination Source Credibility Scale Items

Original Scale Items	Modified Items
Information claims from (X)/(Y) are believable.	Medical treatment claims from India are believable
Over time, my experiences with (X)/(Y) led me to expect it to keep its promises.	Over time, my experiences with Indian medical tourism led me to expect it to keep its promises.
This brand reminds me of someone who's competent and who knows what he/she is doing	Medical treatment in India reminds me of someone who's competent and who knows what he/she is doing.
(X)/(Y) has a name you can trust.	Indian medical tourism has a name you can trust
(X)/(Y) has the ability to deliver what it promises.	Medical tourism in India delivers (or would deliver) what it promises
This brand does not pretend to be something it is not	Hospitals in India does not pretend to be something it is not

Source: Review of Literature Note: These items were adapted from (Erdem and Swait 2004a).

4.4.2 Destination Image

Product attribute measures employed by (Lee and Lockshin 2011) based the forming of a 5-item scale measuring product image. Four items were selected reflecting on the consumer's affective evaluations of a 'country's behaviour', including the socio-political values. Besides the international policy; relationships with other countries were found consistent with the proposed operational definitions of affective country image in this

study. The potential affective country image measures developed in different disciplines (e.g., clinical and environmental psychology) (Roth and Diamantopoulos 2009), scales based on Russell (1980) reflecting two affective dimensions (pleasant/unpleasant, arousal/ sleepy) of travel destinations (Baloglu and McCleary 1999; Lin et al. 2007; Walmsley and Young 1998) and previous country-of-origin studies attempting to measure the affective component of country image by focusing on the 'people facet' (Laroche et al. 2005; Papadopoulos, Heslop, and Bamossy 1990; Parameswaran and Pisharodi 1994) all of whom considered measures such as competence, creativity, standard of living, training and labor inclined to report on cognitive perceptions rather than affective evaluations and were all found to be inconsistent with this study.

Table 4.3: Destination Image Scale Items

Original Scale Items	Modified items
The country is safe and secure	India is safe and secure
The country offers exciting and interesting places to visit	India offers exciting and interesting medical treatments
The country has beautiful scenery and natural attractions	India has beautiful scenery and natural attractions
The country has a pleasant climate	India has a pleasant climate
As a tourism destination, Country offers good value for money	As a tourism destination, India offers good value for money

Source: Review of Literature Note: These items were adapted from (Lee and Lockshin 2011).

4.4.3 Medical Tourism Service Quality

Medical tourism service quality essentially adopted measuring twenty-two items under three minor constructs highlighting the services of physicians and medical staff, especially 'short waiting time for medical examination' being labelled as 'medical staff quality' followed by 'supporting services' which included 'Internet access and hospital amenities',

trailed next by ‘package pricing, logistics and monetary attributes’ labelled as ‘administrative services quality’. Scales used by Manaf et al. (2015), were used to measure the aspects of medical tourism service quality.

Table 4.4: Medical Tourism Service Quality Scale Items

Original Scale Items	Modified Items
Medical Staff Quality	
The physicians allowed me to ask many questions, enough to clarify everything	The physicians allowed me to ask many questions, enough to clarify everything
The physicians adequately explained my condition, examination results and medical process	The physicians adequately explained my condition, examination results and medical process
Ease of assembling and transmitting of medical record/information	Ease of assembling and transmitting of medical record/information
Medical staff was polite and friendly	Medical staff was polite and friendly
The process for setting up the medical procedure appointment was simple and easy	The process for setting up the medical procedure appointment was simple and easy
The physicians paid enough attention to my concerns in deciding on a medical procedure	The physicians paid enough attention to my concerns in deciding on a medical procedure
The hospital has adequate grievance channel for patients	The hospital has adequate grievance channel for patients
The hospital has acceptable protection against medical malpractice and liability	The hospital has acceptable protection against medical malpractice and liability
The medical staff has good communication skill	The medical staff has good communication skill
Arrangement for language interpretation service	Arrangement for language interpretation service

Availability of physicians and nurses who can speak my language	Availability of physicians and nurses who can speak my language
Short waiting time for the medical examination from the physicians	Short waiting time for the medical examination from the physicians
Supporting Services Quality	
The hospital amenities (cafeteria, Wi-Fi and public telephone) were conveniently located.	The hospital amenities (cafeteria, Wi-Fi and public telephone) were conveniently located.
Hospital care facilities (laboratory and doctors' office) were easy to find	Hospital care facilities (laboratory and doctors' office) were easy to find
The hospital's attention to patients' privacy, confidentiality and disclosure	The hospital's attention to patients' privacy, confidentiality and disclosure
The hospital has state-of-the-art facilities and equipment	The hospital has state-of-the-art facilities and equipment
The hospital provides free Internet access	The hospital provides free Internet access
The payment procedure was quick and simple	The payment procedure was quick and simple
Administrative Services Quality	
Package pricing with price transparency.	Package pricing with price transparency.
Coordination of arrangements between the patient, hospital, third party insurance companies, Embassies and other Businesses	Coordination of arrangements between the patient, hospital, third party insurance companies, embassies and other businesses
Convenient hospital transportation arrangement	Convenient hospital transportation arrangement
Assistance with financial arrangements including advance estimates for fees, deposits and payments	Assistance with financial arrangements including advance estimates for fees, deposits and payments

Source: Review of Literature *Note: These items were adapted from* (Manaf et al. 2015b).

4.4.4 Perceived Value

Measurement of perceived value on medical travel which, fundamentally, is a multidimensional phenomenon is upsetting because of intangible nature of value, admittedly a vital characteristic and lack of unanimity in the number or nature of dimensions used to model. Following five items are adopted in this study. Scales used by Lee et al. (2010) were used to measure the aspects of perceived value.

Table 4.5: Perceived Value Scale Items

Original Scale Items	Modified Items
Based on my experience, the medical service skills in Taiwan offer me good values	Based on my experience, the medical doctor's skills in India offer me good values
Based on my experience, the medical tourism service in Taiwan offers good value for money.	Based on my experience, the medical tourism service in India offers excellent value for money.
Based on my experience, the price charged for medical tourism to Taiwan is reasonable.	Based on my knowledge, the price charged for medical tourism to India is reasonable.
Based on my experience, the medical tourism service in Taiwan offers good quality/benefits.	Based on my experience, the medical tourism service in India offers excellent quality/benefits.
Based on my experience, I feel that this medical travel is worthwhile.	Based on my knowledge, I feel that this medical travel is worthwhile

Source: Review of Literature Note: These items were adapted from (Lee et al. 2010).

4.4.5 Destination Attachment

Destination attachment, the most famous term in the tourism industry, is an emotional bond between an individual and a particular spatial setting which is measured using eight items to represent place identity and place dependence. Scales used by Williams and Vaske (2003); Kyle et al. (2005) were used to measure the aspects of destination attachment.

Table 4.6: Destination Attachment Scale Items

Original Scale Items	Modified Items
(X)/(Y) is a very special destination to me.	India is a very special destination to me.
I identify strongly with this destination.	I identify strongly with this destination.
No other place can provide the same holiday experience as (X)/(Y).	No other place can provide the same holiday experience as India.
Holidaying in (X)/(Y) means a lot to me.	Holidaying in India means a lot to me.
I am very attached to this holiday destination.	I am very attached to this holiday destination.
(X)/(Y) is the best place for what I like to do on holidays.	India is the best place for what I like to do on holidays.
Holidaying here is more important to me than holidaying in other places.	Holidaying here is more important to me than holidaying in other places.
I would not substitute any other destination for the types of things that I did during my holidays in (X)/(Y).	I would not substitute any other destination for the types of things that I did during my holidays in India.

Source: Review of Literature Note: These items were adapted from (Kyle et al. 2005; Williams and Vaske 2003).

4.4.6 Perceived Price Reasonableness

"Price" has two facets: monetary objective price (i.e., actual price) of a product or service and non-monetary facet is the price as perceived by consumers (i.e., encoded price) to it. Three items each from Han & Kim, (2009) and H. Oh, (2000), were used to measure perceived price reasonableness.

Table 4.7: Perceived Price Reasonableness Scale Items

Original Scale Items	Modified Items
The menu prices at this restaurant are reasonable.	The menu prices at this hospital are reasonable.
The menu prices charged by this restaurant are inexpensive.	The menu prices charged by this hospital are inexpensive.
The menu prices charged by this restaurant are appropriate.	The menu prices charged by this hospital are appropriate.
The menu prices charged by this seller are a real rip-off.	The menu prices charged by this hospital are a real rip-off.
The menu prices charged by this seller are Very low	The menu prices charged by this hospital are Very low
The menu prices charged by this seller are Not pricey at all	The menu prices charged by this hospital are Not pricey at all

Source: Review of Literature Note: These items were adapted from (Lee et al. 2010; Oh 2000).

4.4.7 Destination Brand Loyalty

Destination branding intends to build and develop a continuing loyalty (Pike 2005). Consequent to providing high levels of service quality importantly is loyalty. Customarily, loyalty research worked up various behavioural measures and viewed loyalty based on purchase (Dick and Basu 1994). These behavioural measures include repeat purchases, the proportion of purchases (Cunningham 1956), purchase sequence (Kahn, Kalwani, and Morrison 1986), and the probability of purchase (Wagner and Taudes 1987).

Table 4.8: Destination Brand Loyalty Scale Items

Original Scale Items	Modified Items
I would recommend others to visit xxx.	I would recommend others to visit Indian hospital and India for medical treatment.
I will visit xxx in the future.	I will visit India in the future.
xxx is my first choice among destinations.	India is my first choice among medical tourism destinations.
I will say positive things about Taiwan.	I will say positive things about Indian hospital and India.

Source: Review of Literature Note: These items were adapted from (Bitner 1990; Dick and Basu 1994).

However, Jacoby and Olson (1976) were critical with these behavioural measures to devoid of any conceptual basis and capturing only the static outcome of a dynamic process. As such, the frequency of repeated purchases may be caused by orientations such as subjective norms and situational factors. Dick and Basu (1994) went further to conceptualise loyalty as a relationship between the relative attitude toward an entity (brand/service/store/vendor) and its repeat patronage. Both a highly promising attitude compared to potential alternatives and repeat patronage are hence required for unceasing loyalty. In this research, loyalty to the service provider is conceptualised regarding repeat patronage, switching behaviour, word-of-mouth recommendations and complaints. This scale consisted of 4 items operationalised from definitions of consumer loyalty and service loyalty found in research by Bitner (1990) and Dick and Basu (1994).

4.5 QUESTIONNAIRE

The questionnaire mainly is a data collection tool in a written form which syncs with the variables to be measured within a pre-defined alternative and helps in efficiently gathering data from large samples (Clarke and Dawson 1999; McClelland 1994). This questionnaire

has been driven into three parts (see Appendix B) namely demographics, medical tourism related information, and finally the postulates of the proposed theoretical model (discussed in section 4.4) being the order of reference which is catalogued below:

The questionnaire begins by explicitly asking the respondent the fundamental concepts followed here using a 7-point Likert type scale ranging from (1= strongly disagree) to (7 = strongly agree). The second part includes general information about medical tourism and follows under eight items explicitly reflecting information related to medical tourism in India (comprising a frequency of visit, duration of treatment, insurance coverage of medical tourists). The third part includes their gender, age, nationality, number of nights spent, the purpose of visit, educational qualification, job, and income.

The third part covers Demographic or sensitive questions like age or income which may prove too intrusive to potential respondents resulting in a passive response. Hence, to get an enthusiastic riposte the most critical questions were focused from the beginning (Malhotra, Baalbaki, and Nasr 2013).

Although the length of a questionnaire is often disputed, this work inclusive of the covering letter abides by the general rule of thumb for questionnaires by not exceeding six pages printed on both sides of the paper to reduce further the impression of the survey being long (Babin et al. 2012). It was systematically designed to achieve the goal of the research by sequentially arranging the questions covering every topic in detail, minimising biases of response, neatly organised and conveniently spaced to minimise eyestrain (Malhotra and Birks 2003; Tull and Hawkins 1976). The phrasing in this questionnaire remained uncomplicated, clear, answerable, unbiased, and aligned with the context for every segment of respondents being able to read and comprehend besides being enthused to complete it (Fowler 1992; Frazer and Lawley 2000; Janes 1999).

Experts in the field were roped in for eliminating ambiguity or lexes in the instrument draft (see next section of pre-test) before ratifying it and establish validity and reliability (Janes 1999; Frazer and Lawley 2000; Churchill and Iacobucci 2005; Sánchez-Fernández et al. 2009) with minimised measurement errors (Sanchez 1992).

A covering letter introducing the study and its aims encouraging respondents to complete and return the questionnaire find enclosed on the first page of the instrument (see Appendix A.1) which assures confidentiality and anonymity of the respondents, besides the researcher's contact details (Churchill 1979).

4.6 PRE-TEST

The researcher, as Shelby D. Hunt et al. (1982, p.270) points out, starts to ask: "Will the instrument provide data of sufficient quality and quantity to satisfy the objectives of my research?" and reaches at a wide agreement that pre-testing remains integral to questionnaire development process seconded by marketing scholars like Reynolds and Diamantopoulos (1998). The discussion starts with the pre-test or "a trial run with a group of respondents used to screen out problems in the instructions or design of a questionnaire" (Zikmund 2000, p.229) methods, their justification, sampling frame and procedures followed in this study whose benefits before the main survey has been supported by numerous researchers (Babin et al. 2012; Churchill and Iacobucci 2005; Reynolds and Diamantopoulos 1998; Shelby D. Hunt et al. 1982).

Blair, J., & Presser (1992) found real differences between pre-test methods which were confirmed by Reynolds and Diamantopoulos (1998), who noted several disagreements among scholars about the best method for pre-test administration. Overall, the methodological literature has been found to distinguish between three types of pre-test methods (Babin et al. 2012; Blair, J., & Presser 1992; Churchill and Iacobucci 2005; Reynolds and Diamantopoulos 1998), including planned field survey, personal interviews (face-to-face), and an expert panel. The first is planned field survey employing small sample referred to as 'pre-testing', then personal interview, where the interviewer is required to identify any obstacles, difficulties, or incomprehensible questions impeding respondents' ability to provide accurate answers, following which an expert panel is asked to critically judge the instrument (Zikmund 2000).

Reynolds and Diamantopoulos (1998) critically analysed the three methods concluding that a broadly covered planned field survey is seldom affected by the interaction between the

respondents and interviewer since people not targeted might not complete the questionnaire. Hence, personal interview remains the most effective means of conducting a pre-test, due to accuracy and completeness of the information generated. The questionnaire has been filtered by the expert panel to avoid erroneous results arising out of the biased questionnaire. (See pre-test procedures).

4.6.1 Pre-Test Sampling Frame

Shelby D. Hunt et al. (1982) posed two central questions in discussing the sampling frame for a pre-test. First "who should be the subjects in the pre-test?" - it was necessary to include subjects similar to those approached in the actual survey (Churchill and Iacobucci 2005; Tull and Hawkins 1976) a small number of respondents with certain characteristics were deemed more efficient in exploring errors in the survey instrument than respondents chosen randomly from the population of interest and "how large a sample is needed for the pre-test" (Reynolds and Diamantopoulos 1998).

The sampling frame for a pre-test consists of medical tourists at three hospitals in Kerala (Baby Memorial Hospital, Kozhikode, Aster Medcity Cochin and Craft Hospital & Research Centre, Thrissur) corresponding to the population studied from the population of interest in the purposive sampling generated from the hospitals as mentioned in government website (http://www.indiahealthcaretourism.com/).

The pre-test sampling size (the second question) has little in agreement with the literature (Shelby D. Hunt et al. 1982). Zikmund (2000) did not specify size, merely recommending a 'small' sample while Wrenn et al. (2002) indicated that a sample of 20 is adequate, Malär et al. (2011) confirms 50 respondents for running of proper statistical testing procedures. Accordingly, 200 questionnaires were distributed to medical tourists at these hospitals, aimed at targeting 50 respondents.

4.6.2 Pre-Test Procedures

Pre-test methods have their limitations hence past researchers suggest the use of different combination approaches (Blair, J., & Presser 1992; Gilbert A. Churchill and Iacobucci

2005; Malhotra et al. 2013) to dwarf it. This study included expert panel, interviews, and planned field survey methods in its pre-test questionnaire to glide over the shortcomings of using only one method (see Table 4.8).

Table 4.8: Procedures Used in Pre-test

Procedures	Target	Reasons this Procedure Used
1.Panel of experts	Two professors in the area of marketing + two experts in Hospitality Industry	To: 1) Assess the relevance of its conceptualisation of marketing research operation; 2) Appraise the suitability of the terminology to the hospital context; 3) Make further suggestions, criticism and comments on the questionnaire and its facets; and 4) Validate the questionnaire
2. Personal interviews	Five personal interviews with Medical tourist in various hospitals	To: 1) Ask Medical tourists to give their comments and identify any problems regarding the questionnaire; and 2) Interviews results used in pre-testing
3.Planned survey (data collection)	200 questionnaires distributed to Medical tourists	To: 1) Modify and refine the questionnaire before the final survey; and 2) Perform proper analysis

Initially the draft was distributed to a panel of four experts consisting of two professors from marketing at Indian Institutes of Management (IIM) Kozhikode in Kerala, India and two senior doctors from Kerala; one working at KIMS Hospital whilst the other at EMS Hospital in Perinthalmanna and were asked to evaluate the questionnaire 1) assess the relevance of conceptualization of marketing research operation; 2) appraise the suitability of terminology with medical tourism context; and 3) make further suggestions, criticism and comments on the questionnaire and its facets.

The experts after evaluating the questionnaire identified one item (or question) related to perceived Price Reasonableness and three related to Destination image needing rephrasing to the medical tourism context. Several demographic questions relating to the guest's itinerary like a few days stay in the hospital, the purpose of visit, and nationality were made to the instrument to ensure its relevance to the domain of this study and to achieve face validity.

Malhotra et al. (2013) suggest conducting five personal interviews, which was done with the approval of concerned hospitals to identify lacunas in questionnaire format, phrasing or design and redress every comment or suggestions. In the questionnaire two suggestions a) providing more space between each group of questions within the same part making the questionnaire easier to read, b) when asked to express their opinion about the image of India as medical tourism destination two out of five respondents failed to understand the question, were redrafted and incorporated in the pre-test.

Finally, formal letters of invitation to the amended questionnaires for patients were mailed to the medical tourism service providers (see Appendix A.2). Two sittings one with academics (procedure one) and another with hospital administrators (procedure two) discussed the best way to approach the medical tourists to fill in the questionnaires; and realising that the most appropriate way was to distribute the questionnaires when patients checked in and collect them during checking out, giving them enough time fill. 200 questionnaires were distributed to medical tourists by front desk staff at each of the hospitals mentioned above between June 2015 and Dec 2015. Sixty-five usable

questionnaires were received (33 % response rate). The reliability of the measures was assessed by using Cronbach's coefficient alpha, as a result of which it was found that all scale items had high alpha scores exceeding .70. Following the reliability assessment, convergent and discriminant validity of items were assessed by using confirmatory factor analysis which became difficult due to the small sample size (N=64). Hence, validity assessment was conducted after the final data collection and discussed as part of SEM in the next chapter.

Beyond the above empirical results, respondents' answers identified a need for additional modifications. Questions related to job title were deleted as most respondents overlooked it, so the income categories were modified to suit the context. The pre-test also confirmed that giving questionnaires to front desk staff at targeted hospitals is the most appropriate way to approach potential respondents.

The four pre-test procedures went through minor changes in statement, wording and layout of the instrument ensuring that questions could be easily understood by all respondents (Zikmund 2000). Since the instrument required no significant modifications, another pre-test was considered unnecessary. A copy of the final survey instrument used in this study is provided in Appendix B.

4.7 FINAL SURVEY

Following the pre-test, the final survey with 56 items of the questionnaire was designed for the final fieldwork. This section began with a discussion of the sampling frame related to the final survey followed by detailed descriptions of the protocols undertaken to manage data collection.

4.7.1 Final Survey Sampling Frame

This study attempts to evaluate the proposed theoretical model determining the brand loyalty of medical tourists with one destination over others and how their loyalty is developed, especially towards, India. Consistent image-building efforts influence destination preference and post-visit loyalty; this critical "missing link" in previous

researches led to the development of a conceptual framework to delineate the relationship between image, and another construct on destination loyalty formation. Image building is a natural process in marketing, destination planning and management. Ultimately this study aims to be a practical guide to establish a positive image and create loyalty among inbound tourists providing new insight into how medical tourists are determining brand loyalty towards India as a medical tourism destination, which has not been hitherto investigated.

Indian medical tourism industry, though nascent, possesses enormous futuristic potential and incumbent government opening to this realisation is aggressively promoting India as a global healthcare destination by listing 108 hospitals on the government website (http://www.indiahealthcaretourism.com) with JCI and NABH accreditation which are actively engaged in medical tourism services providing a further boost to the sector.

Table.4.9. List of Region Wise Hospitals

Region	States	No of Hospitals	Total	Proportion (1:4)
East India	West Bengal	**3**	**4**	**1**
	Odisha	**1**		
	Jharkhand	---		
	Andaman and Nicobar Islands	---		
Northeast India	Arunachal Pradesh	---	**0**	**0**
	Assam	---		
	Manipur	---		
	Meghalaya	---		
	Mizoram	---		
	Nagaland	---		
	Sikkim	---		
	Tripura	----		
South India	Andhra Pradesh	**3**	**52**	**13**
	Karnataka	**13**		

	Kerala	**12**		
	Tamil Nadu	**13**		
	Telangana	**11**		
Western India	Gujarat	**8**	**21**	**5**
	Maharashtra	**12**		
	Goa	**1**		
	Daman and Diu	**--**		
	Dadra and Nagar Haveli	**--**		
North India	Jammu and Kashmir	**--**	**31**	**8**
	Himachal Pradesh	**--**		
	Punjab	**2**		
	Chandigarh	**1**		
	Uttarakhand	**--**		
	Haryana	**8**		
	Delhi	**14**		
	Uttar Pradesh	**3**		
	Rajasthan	**3**		
		Total	**108**	**27**

Hospital list (Services Export Promotion Council, 2015) Region classification based on Ministry of Home Affairs (http://www.mha.nic.in/uniquepage.asp?ID_PK=470)

4.7.2 Sampling Technique

Mixed sampling envisages the use of two or more primary methods of sampling (Donald Cooper 2013). This study combines both probability and nonprobability sampling methods ensuring generalisation of the main findings with the population under study.

First phase sampling of selecting hospitals through simple random sampling one of the primary applications of probability sampling has been applied by using a random number table which is typically used when a complete frame of reference is available. Initially, the hospitals are classified on their geographical location (East India, Northeast India, South

India, Western India and North India) (Table 4.9), then in proportion to the numbers in each region, hospitals were randomly selected. The researcher for the present study has selected 27 hospitals based on their geographical location (Table 4.10). In the second phase of sampling, convenience sampling was used, and patient intercept surveys are used to carry out to collect data from the final consumer of selected hospitals.

Table 4.10 List of Hospitals

No.	Name of the Hospital	Filled Questionnaire Received	Region wise Response Rate
1	NH Rabindranath Tagore International Institute of Cardiac Science, Kolkata	50	East India (83.33%)
2	Sentini Hospitals (P) Ltd, Vijayawada	23	South India (88.20%)
3	Bangalore Baptist Hospital, Bangalore	60	
4	Columbia Asia Hospitals, Bangalore	60	
5	M. S. Ramaiah Memorial Hospital, Bangalore	60	
6	Baby Memorial Hospital, Kozhikode	60	
7	Aster Medcity, Cochin	60	
8	Craft Hospital & Research Centre, Thrissur	60	
9	Dr. Kamakshi Memorial Hospital, Chennai	28	
10	Frontier Lifeline Hospital, Chennai	45	
11	Kovai Medical Centre & Hospital, Coimbatore	60	
12	Continental Hospitals, Hyderabad	58	
13	Aware Global Hospitals, Hyderabad	56	
14	Care Hospitals, Hyderabad	58	

15	Wockhart hospital, Surat	40	Western India (69.66%)
16	Shri Mahavir Health & Medical Relief Society, Surat	45	
17	Asian Heart Institute, Mumbai	30	
18	Jaslok Hospital & Research Centre, Mumbai	58	
19	Seven Hills Healthcare, Mumbai	36	
20	Bhandari Hospital & Research Centre, Jaipur	45	North India (53.54%)
21	Heritage Hospitals, Varanasi	28	
22	Indian Spinal Injuries Centre, Delhi	36	
23	ISIS Hospital IVF & Multi Speciality Centre, Delhi	28	
24	Max Super Speciality Hospitals, Delhi	40	
25	Primus Super Speciality Hospital, Delhi	39	
26	Alchemist Hospital, Gurgaon	22	
27	Medanta - The Medicity, Gurgaon	19	

Hospitals are selected from SEPC Website: (http://www.indiahealthcaretourism.com/)
* Researcher has distributed 60 questionnaires in each hospital

4.7.3 Final Survey Procedures

After finalising the instrument and confirming its appropriateness, a pre-test was conducted followed by sequencing the steps to final survey and research data collection. In line with the pre-test a letter seeking permission (see Appendix A2) to do research in twenty-seven hospitals was mailed with the instrument detailing briefly the aims of the study, its significance to them, intended use of data, time, and issues related to confidentiality and their voluntary participation with an epilog ensuring them with a critical feedback report in the end.

The hospitals consented to participate proactively in the survey pushing the fieldwork in India from Jan 2015 and Dec 2016 which, though brief, generated sufficient responses (1205 responses), encouraging the researcher to extend the phase for another month.

Extensive deliberations with hospital administrators (from Baby Hospital and Aster Medicity hospitals) and academia (from National Institute of Technology Karnataka, Mangalore University, IIM Kozhikode) concurrent to the literature steered the suitable approach to medical tourists. Though the questionnaire was self-administered, front desk managers of these hospitals were educated to answer the prospective query by the medical tourists.

The researcher travelled to the respondent's locations using drop-off method questionnaires in English through the front desk staff at each participating hospitals during checking in by each medical tourist and picked them up after they finished leisurely during their stay (see section 4.3.2 for further discussion about this method) (Zikmund 2000).The researcher made dedicated efforts with the front desk staff of each hospital to get an enthused response.

To reverse a rather pedestrian response to drop-off method use of other ingenious methods in discussion with the front desk staff and in alignment with follow-up procedures as recommended by methodological authors G A Churchill (1979); Zikmund (2000) additional locations like eateries, rooms and laboratories were targeted with a gentle reminder in the questionnaires to encourage the medical tourists to complete them. Historically this procedure is widely recommended by scholars for its positive responses (Frazer and Lawley 2000; Zikmund 2000). Animated discussions with administrators such as medical superintendent, senior doctors, surgeons, nurses, and front desk staff were resorted to entail more active participation on their side with some hospitals even offering soft drinks for completing the questionnaire yielding the much-desired results.

In total, the researcher distributed 60 questionnaires to each of the 27 hospitals, 1620 questionnaires overall. The objective was to obtain a maximum sample for the study, which

is appropriate for running structural equation modelling (Hair et al. 2010; Wolf et al. 2013). The distribution procedures utilised resulted in 1205 being returned.

4.8 METHODS OF DATA ANALYSIS

Cooley (1978, P.13) hints at "the purpose of the statistical procedures is to assist in establishing the plausibility of the theoretical model and to estimate the degree to which the various explanatory variables seem to be influencing the dependent variable". Statistical Package for Social Sciences (SPSS) version 23 analyses the preliminary data and Structural Equation Modelling (SEM) using Confirmatory Factor Analysis tests the hypothesised model discussed in Chapter Three describing and justifying the use of these statistical techniques.

4.8.1 Preliminary Data Analysis

Statistical Package for Social Sciences (SPSS) version 23 a widely used and accepted by researchers as a data analysis technique (Zikmund 2000) analyzed the quantitative data gathered from questionnaires, screening the data in terms of coding, missing data (i.e., using t-test), outliers (i.e., using Box and Whisker, normal probability plot), and normality (i.e., using skewness and kurtosis) which finds elaborately defined and described in section 5.3. The software helped in preliminary data analysis including frequencies, mean, and standard deviation for each of the variables to gain preliminary information about the sample giving the reader a 'snapshot' of the data collected and used in the research.

4.8.2 Structural Equation Modeling (SEM)

Structural Equation Modeling (SEM) is "a collection of statistical techniques that allow a set of relationships between one or more independent variables, either continuous or discrete, and one or more dependent variables, either continuous or discrete, to be examined" (Tabachnick and Fidell 1996). SEM has become an essential tool for analysis that is widely used in academic research (Brown 2006; C. Anderson and Gerbing 1988; Hair 2009; Hair, Bush, and Ortinau 2005).

SEM explains the pattern of successive inter-related dependence relationships simultaneously between a set of latent or unobserved constructs, each measured by one or more observed variables (Hair et al. 2005). SEM rests on the assumption of causal relationships where a change in one variable (x1) is supposed to result in a change in another variable (y1), in which y1 affects x1. Not only does SEM aim to analyse latent constructs, particularly the analysis of causal links between latent constructs, but also it is effective for other types of analyses including estimating variance and covariance, test hypotheses, standard linear regression, and confirmatory factor analysis (Zikmund 2000). According to C. Anderson and Gerbing (1988), SEM "a comprehensive means for assessing and modifying theoretical models" is a confirmatory method endorsed by researchers as an appropriate technique to examine hypothesized models (see (Babin et al. 2012; Brown 2006; C. Anderson and Gerbing 1988; Hair et al. 2010; Zikmund 2000).

SEM not only assesses the unidimensionality, and reliability and validity of each construct (C. Anderson and Gerbing 1988; Hair et al. 2010) but also provides an overall test of model fit, confirmatory factor analysis, and individual parameter estimate tests, thus, providing adequate best model fits the data.

Hall et al. (2012) structural equation modelling software AMOS 23.0 (Analysis of Moment Structures) was used to explore statistical relationships among the items of each factor and between the factors of independent (i.e., destination image, medical tourism service quality and destination credibility) and dependent variable (i.e., loyalty). Further, the researcher can specify, estimate, assess, and present the model in a causal path diagram to show hypothesised relationships among variables. The empirical model can be tested against the hypothesised model for goodness of fit. Any causal path that does not fit with the original model can be modified or removed.

4.8.2.1 Two-Stage Structural Equation Modeling

SEM is performed in one-stage and two-stage approach. The one-stage approach aims to process the analysis simultaneously by estimating both structural and measurement models (called single-stage approach). The two-stage approach aims to process the measurement

model first and then fix this measurement model in the second stage when the structural model is estimated (called two-stage approach). The two reasons to adopt the two-stage approach for this study as recommended by C. Anderson and Gerbing (1988) are (1), it is widely accepted and used in marketing research (Hair et al. 2010), particularly in similar studies of destination branding (i.e., (Cormany and Baloglu 2011; Ekinci 2003; Mohd Yasin, Nasser Noor, and Mohamad 2007; You and O'Leary 2014) and (2), to avoid any interaction between the measurement and structural models, the two stage approach helps to ensure the accurate representation of the reliability of the items of each construct (Hair et al. 2010). Analyzing the causal relationships in the structural model requires performing the measurement model first (these stages been further explained next), due to the latter representing a condition that must be satisfied as a matter of logical necessity (Bagozzi and Yi 1988; C. Anderson and Gerbing 1988).

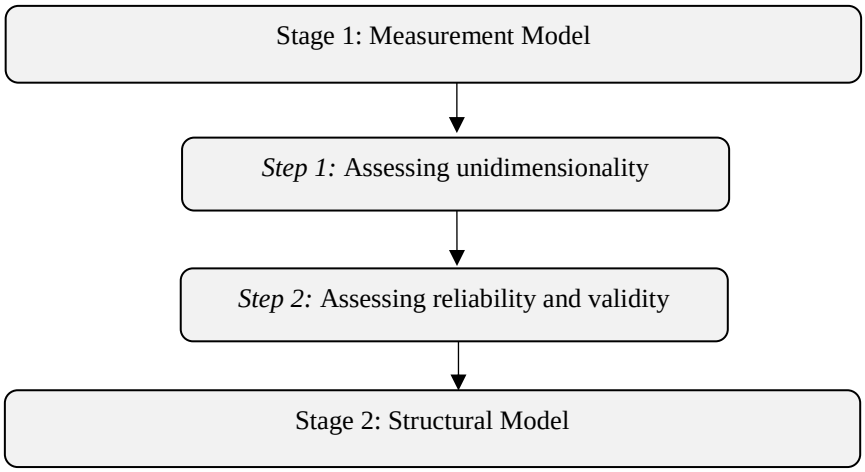


Figure 4.2: Two-Stage Structural Model Used in this Thesis

As shown in Figure 4.2, the first (measurement model) stage of the analysis was conducted by specifying the causal relationships between the observed variables (items) and the underlying theoretical constructs (composite and latent variables). The purpose of this stage was to verify the unidimensionality of the composite and latent constructs in the first step. Unidimensionality has been defined as "an assumption underlying the calculation of reliability and is demonstrated when the indicators of a construct have acceptable fit on a

single-factor (one dimensional) model" (Hair et al., 1995, p. 641). Anderson and Gerbing (1988) argued that unidimensional measurement models are more useful because they offer more precise tests of the convergent and discriminant validity of factor measurement. Therefore, the purpose of the first step is to ensure that a set of items empirically measures a single dimension. In accordance with findings of Anderson and Gerbing (1982), Dunn et al. (1994), and Hair et al. (1995), unidimensionality assessment was conducted prior to testing the reliability and validity of each construct.

In assessing unidimensionality, exploratory factor analysis (EFA) has widely been suggested as the appropriate tool when a theory is absent, or new scales are being developed (C. Anderson and Gerbing 1988; Hair 2009). C. Anderson and Gerbing (1988) have also argued that exploratory factor analysis cannot assess unidimensionality directly, but aims to assess the factor structure of a scale. Therefore, confirmatory factor analysis (CFA) is a better method for use in research study like this where hypotheses about the grounded theoretical models exist (Bollen 1989). CFA thus is considered a more powerful (C. Anderson and Gerbing 1988; Hair et al. 2005), and more flexible technique than exploratory factor analysis for such assessment. Zikmund (2000) maintains there is evidence that the factor structure identified in EFA may turn out to have poor fit to the same data when evaluated with CFA.

Use of confirmatory factor analysis in this study stands justified, especially so as scales' items have been adopted based on previous literature which were well grounded in theory (see Section 4.4) while the underlying constructs of destination image, destination credibility, medical tourism service quality, perceived value, place attachment and loyalty have already been demonstrated empirically to be valid in the literature. CFA was used to determine whether the number of factors and the loadings of measured indicators (items) had conformed to what was expected, based on re-established research and theory. Weakly loaded items on the hypothesised factors were removed from the scale resulting in a uni-dimensional scale (Zikmund 2000). CFA, a factor loading of 0.50 and above on a specified factor has been considered acceptable and remains the benchmark of this study (Hair 2009).

Once unidimensionality of constructs is achieved, reliability and validity (see Figure 4.2) of these constructs is demonstrated (see Section 4.9 for further discussion on reliability and validity) by confirmatory factor analysis using maximum likelihood estimate (Babin et al. 2012; C. Anderson and Gerbing 1988). The paths or causal relationships between the underlying theoretical latent constructs were specified in the structural model (second stage); details of which are discussed subsequently.

4.8.2.2 SEM Assumptions

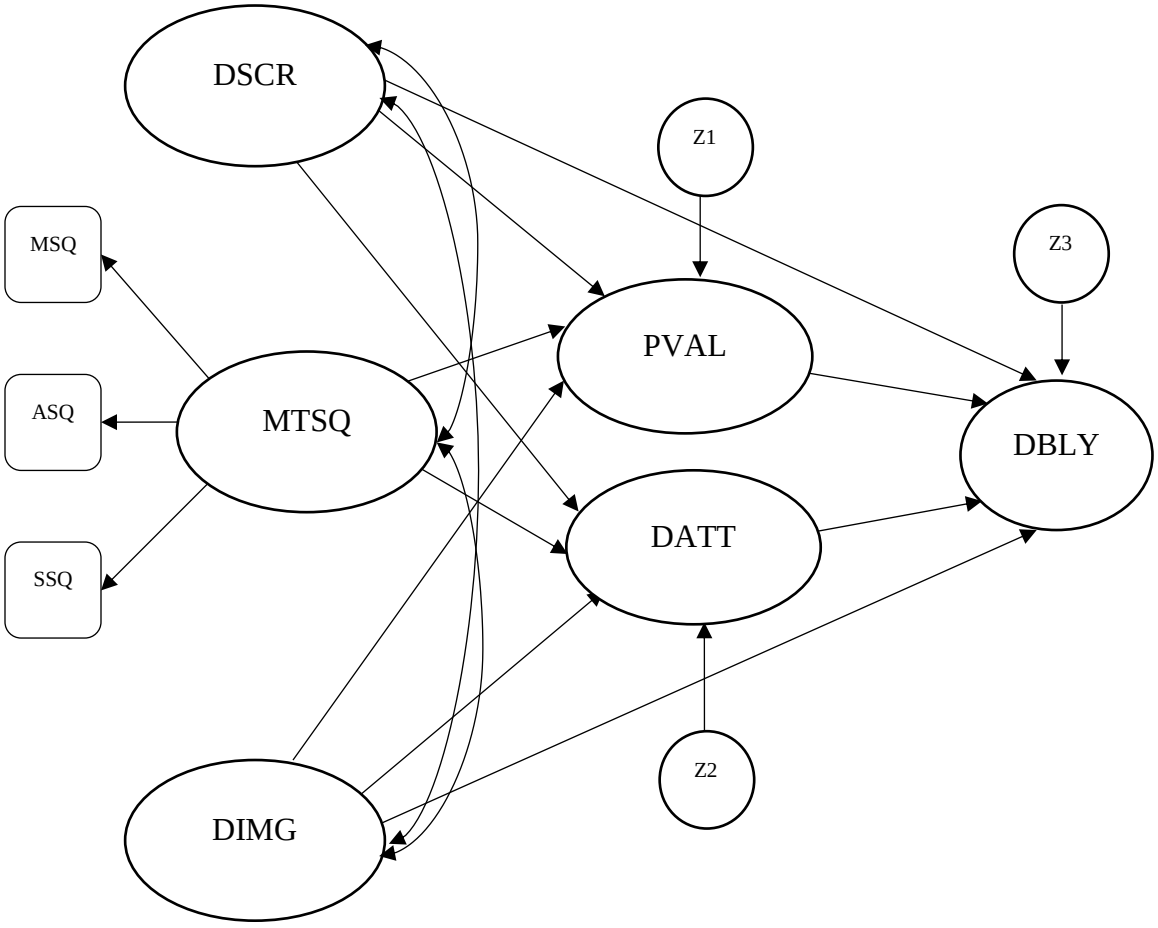
Every statistical method needs to comply with some assumptions before conducting SEM which requires adequate sample size as covariance and correlations are less stable when estimated using small sample sizes (Tabachnick and Fidell 1996). Some authors argue SEM being useful for sample sizes as small as fifty (C. Anderson and Gerbing 1988) but the consensus is hundred as the minimum sample size to ensure appropriate use of maximum likelihood estimation (MLE) (Hair et al. 2005). Boomsma (1983) however suggests that the estimation of SEM by using maximum likelihood methods can be used only when the sample size is at least 200. Zikmund (2000) suggested that instead of thinking about some participants per measured variable, it is worthwhile to think about the number of subjects per estimated parameter. Tabachnick and Fidell (1996) suggest that fewer than ten subjects per estimated parameter may be adequate if the estimated size of the effect is large and the measured variables normally distributed. A sample of 400 and more is considered undesirable (Hair et al. 2005) because the methods become too sensitive and goodness-of-fit measures will indicate a poor fit. Though scholars agree to disagree about sample size J. F. Hair et al. (2010) considered 200 as an ideal number. A sample size of 271 for this study is considered appropriate to use SEM.

Apart from sample size, essential assumptions for using SEM include the normal distribution of the data as well as the effect of missing data and outliers. These issues have been discussed in the next chapter under Data Screening (see Section 5.3).

4.8.2.3 Path Diagram

In SEM, the hypothesised or causal relationships can be presented in the form of a path diagram. The SEM diagram Figure 4.3 in this study consists of the constructs as unobserved variables, measured variables (composite variables), measurement errors, and arrows representing relationships between the variables. Constructs such as destination image, destination source credibility, medical tourism service quality, perceived value, destination attachment, and loyalty are presented as ovals (unobserved variables). Measured or composite variables such as Medical service quality (MSQ), Supporting staff quality (SSQ), Administrative staff quality (ASQ) expertise are presented as rectangles.

Single-headed arrows in the diagram represent linear dependencies indicating the extent to which one variable (construct) is dependent on the other (causal paths or relationships). In the diagram, correlations or covariance between the variables are represented as double-headed arrows, as seen in the relationship between destination image, destination credibility and medical tourism service quality. It is where a relationship between the variables are assumed, but no causal path is hypothesised. The model includes measurement error represented as (e) and enclosed in small circles, associated with the composite variables and residual error represented as (z) in small circles associated with the latent variables.



DSCR: Destination Source Credibility, DIMG: Destination Image, MSQ: Medical staff quality, SSQ: Supportive staff quality, ASQ: Administrative services quality DATT: Destination Attachment, PVAL: Perceived Value, DLOY: Destination Brand Loyalty, MTSQ: Medical tourism service quality.

Figure 4.3: The Path Diagram of the Study

4.8.2.4 Evaluating the Fit of the Model

SEM, integrates series of goodness-of-fit indices, ascertaining if the model fits the data or not. Though SEM provides many indices, scholars failed to reach a consensus about which fit indices to report. C. Anderson and Gerbing (1988) suggest that researcher might assess how well a specified model accounts for data with one or more overall goodness-of-fit indices. Kline (2005) recommends at least four such as GFI, NFI or CFI, NNFI and SRMR. Reflecting diverse criteria and the best overall picture of the model fit, Gilbert A. Churchill

and Iacobucci (2005); J. F. Hair et al. (2005); Donald Cooper (2013); De Vaus (2017) recommend the use of at least three fit indices by including one in each of the categories of model fit: absolute; incremental; and parsimonious (as discussed below). The measures most commonly used in marketing research to evaluate models where the three categories are reflected is adopted in this study are detailed below in Table 4.12, the first category of absolute values includes chi-square (x^2), GFI, and RMSEA; the second category (incremental) includes AGFI, NFI, CFI, TLI; and the third category (parsimonious) includes x^2 /df.

Table 4.12: Summary of Goodness-of-Fit Indices

Name of the Index	Level of Acceptance	Comments
Absolute fit indices		
Chi-square (χ^2)	P > 0.05	This measure is sensitive to large sample sizes
Goodness-of-Fit (GFI)	.90 or greater	A value close to 0 indicates a poor fit, while a value close to 1 indicates a perfect fit
Root Mean Square Error of Approximation (RMSEA)	Between .050 and .080	Value up to 1.0 and less than .05 is considered acceptable
Incremental fit indices		
Comparative Fit Index (CFI)	90 or greater	A value close to 0 indicates a poor fit, while a value close to 1 indicates a perfect fit
Adjusted Goodness-of-Fit (AGFI)		
Tuker-Lewis Index (TLI)		
Normed Fit Index (NFI)		
Parsimonious fit indices		
Normed Chi-square (χ^2 /df)	$1.0 \leq x^2/df \leq 5$	Lower limit is 1.0, upper limit is 3.0 or as high as 5

The chi-square (χ^2) considered the most fundamental measure of overall fit is a test of whether the matrix of implied variance and covariance (Σ) is significantly different to the matrix of empirical sample variance and covariance (S). It is calculated to determine the discrepancy between Σ and S. When the probability (P) becomes higher than 0.05 it indicates that the discrepancy between Σ and S is trivial. It transpires that the actual and predicted input matrices are statistically compatible. Despite being a significant statistical index to evaluate the fit of a model, it turns sensitive to sample size (Fornell and Larcker 1981; Marsh and Balla 1994), especially when it crosses 200 (Bagozzi and Yi 1988; Hair et al. 2005). Marketing researchers use it in conjunction with other indices to evaluate overall fit before rejecting or accepting their models (Bagozzi and Yi 1988; Neuman 2006).

Subsequently, this study uses Goodness-of-Fit Index (GFI) proposed by Jöreskog and Sörbom (1984) to measure of the absolute fit index. GFI indicates the relative amount of variance and covariance together explained by the model (Brown 2006) which is calculated by comparing the discrepancy value for the model under test to the discrepancy value for a saturated version of the model. This therefore is counted as representing a 100% fit (or 1.0) although this measure is not adjusted for degrees of freedom (Clifton and Ahmad 2009; Hair et al. 2005), ranging from 0 (indicating a poor fit) to 1 (indicating a perfect fit), where a recommended level of acceptance is .90 (Hair et al. 2010).

Root Mean Square Error of Approximation (RMSEA) is the next level measure of absolute fit index aiding in correcting the tendency of chi-square to reject specified models by considering errors of approximation in the population under study taking away stringent requirements on the population demanded by the model. The study reveals a value ranging from .05 to .08 is commonly acceptable (Hair et al. 2010) even while Burns et al. (2017) recommend that RMSEA should be less than 0.05, MacCallum and Browne (1993) suggest a value of up to 1.0 is reasonable.

Incremental Fit Indices

Incremental fit measures contrast between the proposed model and the null model.1 Adjusted Goodness-of-Fit Index (AGFI) a critical incremental index is espoused in this study since contrary to GFI from the absolute fit indices category AGFI allows adjustment for degrees of freedom (Hair et al. 2005; Marsh and Balla 1994). The quantity 1-GFI is multiplied by the ratio of the model's degree of freedom divided by degree of freedom for the baseline model, the AGFI is one subtracted to this result. Similar to GFI, this measure range from 0 (indicating a poor fit) to 1 (indicating a perfect fit), where a recommended level of acceptance is 0.90 (Hair et al. 2010).

Adding to AGFI, Normed Fit Index (NFI) is one of the most popular incremental measures (Brown 2006; Hair et al. 2005). NFI reflects the proportion to which the researchers' model fit compared to the null model. For example, NFI = 0.50 means the researcher's model improves the fit by 50 percent. However, this index does not control for degrees of freedom (Cronin and Taylor 1992) and to overcome this shortcoming. Henseler et al. (2015) have used it with the Comparative Fit Index (CFI) which compares the covariance matrix predicted by the model to the observed covariance matrix. This study details both NFI and CFI which range from 0 (poor fit) to 1 (perfect fit) having a commonly recommended level of 0.90 or greater (Hair et al. 2010). Another important incremental measure used in this study is the Tucker-Lewis Index (TLI) recognised as a non-normed fit index (NNFI) (Hair et al. 2010; Marsh and Balla 1994). TLI combines a measure of parsimonious into a relative index between the proposed or hypothesised and null models, resulting in values ranging from 0 (not fit at all) to 1 (perfect fit). Similar to NFI and CFI, the commonly recommended level is 0.90 or greater (Hair et al. 2010) which finds adopted in this study due to its ability to provide an unbiased indication of model fit at all sample sizes (Cronin and Taylor 1992).

Parsimonious Fit Indices

The third category of parsimonious fit indices tests the parsimony of the proposed model by evaluating the fit of the model to the number of projected coefficient required to achieve the level of fit (Hair et al. 2010). Under this group, the normed chi-square (χ^2 /df) is the

most popular parsimonious fit index employed to evaluate the appropriateness of the model (Hair et al. 2005). In this measure, a range of acceptable values for the χ^2 /df ratio have been suggested, ranging from less than 2.0 (C. Anderson and Gerbing 1988; Hair et al. 2005), though less than 3.0 (Marsh and Balla 1994), to more liberal limits of less than 5.0 (Tabachnick and Fidell 1996). Since χ^2 is the main component of this measure, χ^2 /df is also sensitive to the sample size. Therefore, this study has used this measure as an indicator of overall fit (in conjunction with other measures), not as a basis for rejecting or accepting the model.

4.9 Reliability and Validity

As discussed earlier, upon establishing the unidimensionality, the underlying constructs of this study can be assessed for reliability and validity (C. Anderson and Gerbing 1988; Hair et al. 2010; Peter 1979), which are closely related concepts even while remaining separate (Bollen 1989). A measure could be consistent (reliable) though not accurate (valid) or even inversely true (Howard 2013). Hence, an instrument is valid if it measures what is supposed to and reliable if it is consistent and stable (Sekaran 2003). Validity and reliability assessment ensures the quality of findings and conclusions of this study. Cronbach (1951) coefficient alpha, Construct Reliability (CR), and Average Variance Extracted (AVE) are computed to assess reliability, while content, construct, criterion and external validity are examined for validity. Reliability and validity assessments find detailed below.

4.9.1 Reliability

Zikmund (2000, p. 330) defines reliability as "the degree to which measures are free from random error and therefore yield consistent results". Therefore, reliability refers to the degree to which a scale produces consistent results when repeated measurements are made on the variables of concern (Malhotra and Birks 2003). Reliability and error are inversely related, therefore, larger the reliability smaller the error (Punch 1998) which remains the prime objective of any research (Coakes 2013).

Reliability is assessed mainly by 1) repeatability and 2) internal consistency (Zikmund 2000). Repeatability uses two methods - test-retest, and alternatives. Test-retest method entails the administration of the same instrument on two different occasions to the same sample of respondents, taking into account the equivalent conditions. Here, a correlation coefficient is computed to confirm the degree of similarity between the two tests. However, two main drawbacks proposed by Kinnear and Taylor (1996), Malhotra et al. (2013), accompany making it unsuitable for this study. The initial test influences respondents' to change their attitude toward the following responses. Second, respondents may change their attitude due to the time factor; the longer time between the two tests may contribute to changing attitudes, and so long the time interval between the tests, lower the reliability.

Alternative-form method "is used when two alternative instruments are designed to be as equivalent as possible" (Zikmund 2000, p.331). In this case, these two measurement scales are administered to the same group of respondents. When the correlation between the two forms is high, that means the scale is reliable (Babin et al. 2012). However, it remains difficult in all cases to construct two equivalent forms of the same instrument.

The methods mentioned above were inappropriate for this study due to their shortcomings and so the second dimension of reliability - internal consistency is "used to assess the reliability of summated scale where several items are summed to form of the total score" (Malhotra and Birks 2003, p. 305). If reliable, the items would show consistency while an indication of the concept is being measured. The basic measure of internal consistency is split-half reliability involving dividing a multi-items measurement into two halves and thus checking the results obtained from the first half of the scale items against the results from the other half. While this method has been widely used in the literature, a major limitation is that results rely on how the items are divided and Cronbach's (1951) coefficient alpha, one of the most common methods in gauging reliability is considered appropriate (Nunnally 1978; Peter 1979; Sekaran 2003). This technique estimates the degree to which the items in the scale are representative of the domain of the construct being measured which is the internal consistency of a set of items, and is considered 'absolutely the first measure' one should use to assess the reliability of a measurement scale (Churchill 1979;

Nunnally 1978). Cronbach's coefficient is essential in measuring multi-point scale items (i.e., 7-point Likert scale used in this thesis) (Sekaran 2003) in which internal consistency has been adopted to assess the reliability of the measures in this study.

This study employed multi-items scales where Cronbach's alpha estimate has been used as a verification of the reliability of the composite items comprising each scale for each construct like the constructs of destination image, destination credibility, medical tourism service quality, perceived value, place attachment, perceived price reasonableness and loyalty were subject to such assessment (see Section 5.7.2). While assessing reliability through Cronbach's alpha, authors suggest different levels of acceptance. Nunnally (1978) recommended that an acceptable alpha is between 0.50 and 0.60 which was raised to 0.70 for internal consistency in the second edition by (Nunnally 1978) titled Psychometric Theory. Nunnally and Bernstein (1994) suggest a rule of thumb level of higher than .70, with level as low as 0.60 is acceptable for new scales while some authors like Carmines and Zeller (2017) indicate that at least 0.80 is required to establish internal consistency. Different schools of thoughts exist on levels of acceptance which agree on an alpha of .70 and over as acceptable. This study considered using this cut-off point (0.70) as the minimum for determining the internal consistency of scales.

Traditionally, marketing researchers adopted the procedures recommended by G A Churchill (1979) and Peter (1979) to develop their customised scales. This procedure attempts item purification using Cronbach's coefficient alpha and exploratory factor analysis. However, C. Anderson and Gerbing (1988) expanded the scale development procedure by including Confirmatory Factor Analysis (CFA) as coefficient alpha is not a sufficient condition to assess unidimensionality, seconded by other authors such as Steenkamp and van Trijp (1991) who maintain that CFA provides a better estimate of reliability than coefficient alpha. Hinkin (1995) maintains that the CFA approach can examine the stability of the factor structure in scale construction. To assess and ensure reliability in this study CFA is made use of providing the researcher with greater confidence about individual items being consistent with their measurements (Hair 2009).

Generally researchers report at least one of the three model-based estimates of reliability (Bollen 1989), internal consistency in this study is assessed using confirmatory factor analysis (CFA) which also assessed reliability using the approach suggested by Fornell and Larcker (1981), evidently common and widely used in marketing research, particularly in relationship marketing (Wulf et al. 2001; Hsieh and Hiang 2004; Bove and Johnson 2006). CR measures the internal consistency of a set of measures rather than the reliability of a single variable to capture the degree to which a set of measures indicates the common latent construct (Howard 2013). The main advantage is that CR is based on estimates of model parameters and has more extensive applicability. AVE estimate, on the other hand, is a more conservative indicator of the shared variance in a set of measures than construct reliability. The variance-extracted estimate reflects the overall amount of variance in the items accounted for by the latent construct. In this study CR and AVE have been calculated separately for each multiple items construct because AMOS does not compute these two measures directly (Hair et al. 2010). Bagozzi and Yi (1988) recommended that CR should be equal to or greater than 0.60, and AVE should be equal to or greater than 0.50 which is the widely accepted threshold and finds used in this study.

This study determined Cronbach's alpha, CR, and AVE to ensure that the specified items are sufficient in their representation of the underlying constructs, including destination credibility, medical tourism service quality, perceived value, place attachment and loyalty. The results related to these assessments are reported in section 5.7.2.

4.9.2 Validity

To consider an instrument as adequate reliability alone remains insufficient (C. Anderson and Gerbing 1988; Churchill 1979; Hair et al. 2010). Hence, validity which represents the relationship between the construct and its indicators (Punch 1998), is required to validate the constructs of this study. According to Zikmund (2000, p.331), validity means "the ability of a scale to measure what is intended to be measured". Neuman (2006) points out that the better the fit between the conceptual and operational definitions, the greater the measurement validity.

Nunnally and Bernstein (1994) suggest three critical aspects of a valid construct. First, the construct should be seen as a good representation of the observable domain related to the construct. Second, the construct should well represent the alternative measures. Finally, the construct should be well related to other constructs of interest. Weighing these considerations, three types of validity like content, construct (convergent and discriminant validity) and criterion have been examined in this study which relates to the internal validity of the scales and their respective items. Generalizability of this research findings investigated external validity.

4.9.2.1 Content Validity

Content or face validityy is a subjective but systematic assessment of the extent the content of a scale measures a construct (Malhotra and Birks 2003). Experts while measuring show adequate coverage of the concept conclude the measure as having face validity (Zikmund 2000). To obtain content validity the recommended procedures of Donald Cooper (2013) are followed by identifying the existing scales from the literature and conducting interviews in line with the pre-test methods discussed earlier using a panel of experts (academicians and industry representatives), then seek their comments on the instrument. Content validity, being subjective, doesn't sufficiently provide a rigorous empirical test (Zikmund 2000) therefore, other measures of validity was mandatory before the final survey.

4.9.2.2 Construct Validity

Construct validity depends primarily on the actual measurement of the instrument (Churchill and Iacobucci 2005) wherein the measure fitting the theories around the designed tests reveal detailed results. The use of theoretical questions on the working of scales and their deductions have been emphasised earlier Malhotra et al. (2013). Validity measure typically refers to developing correct and adequate operational measures for the concept being tested (Malhotra et al. 2013).Discounting construct validity which (Nunnally 1978) cannot measure "internal consistency", which can be done only by reliability and content validity sets of measurement items.

Both the convergent validity analysed the construct validity which examines the measures of the same construct as being highly correlated while the discriminant validity measures the construct to have not correlated too highly with other constructs (Sekaran 2003).

This study focused on CFA a part of SEM in place of several advanced procedures like factor analysis, correlation to assess convergent and discriminant validity. While demonstrating convergent validity, the magnitude of the direct structural relationship between the item and latent construct (or factor) should be statistically different from zero (Howard 2013). Other words, the final items (not including deleted items) should be loaded highly on one factor (C. Anderson and Gerbing 1988), with a factor loading of 0.50 or greater (Hair et al. 2010). AVE was used as an indicator for supporting convergent validity (Fornell and Larcker 1981).

This study employs two methods of discriminant validity. The first method is consistent with the discriminant validity definition of Sekaran (2003) checking the estimated correlations between the factors, wherein if the two factors are highly correlated (greater than 0.85), redundant items showing lack of discriminant validity gets deleted (Kline 2005). The second method examines pattern structure coefficient, the standardised factor loading derived from AMOS analysis determines whether factors in measurement models are empirically distinguishable (Thompson 1997). Moving away from restrictive assessments of convergent and discriminant validity, construct validity in this study was enhanced by assuring that the model (through goodness-of-fit results obtained from CFA) fits the data adequately (Hsieh and Hiang 2004) the results of which find reported in section 5.7.2.

4.9.2.3 Criterion Validity

Criterion validity is the third measure of validity demonstrated in this study referred to as the ability of measures to correlate with another standard measure of the same construct (Zikmund 2000). Depending on the time sequence in which the new measurement scale and the criterion measure are correlated it is classified as concurrent validity when a new measure is taken at the same time as a criterion and is shown to be valid or predictive

validity when a new measure predicts a future event (Sekaran 2003). Criterion validity goes outdated with increased use of construct validity which is synonymous with convergent validity that has been the measure in this study and therefore assumed that criterion validity is also accounted for.

4.9.2.4 External Validity

External validity, in contrast to internal validity which is restricted to the scales and their respective items of this research, establishes the extent to which this study findings can be generalised to other subjects or sectors like medical service providers or other service industries using a real-world setting of 27 medical tourism service providers chains in India as representative sample.

Valid constructs provide conclusions that help generalise the results of any thesis. This study utilised following four types of validity of constructs namely content, construct, criterion and external before testing the underlying hypotheses

4.10 ETHICAL CONSIDERATIONS

Fair ethical consideration is demanded of every researcher, and National Institute of Technology Karnataka (NITK) stipulates approval from the Research Progress Assessment Committee before conducting the fieldwork, especially involving human subjects, which was scrupulously followed by taking formal prior consents, so to avoid the undesirable effect on any individual. The ethics application specified the aims, procedures involved and the nature of the project elaborating upon zero potential risks associated with this project. The participating hospitals were mailed with a letter of prior permission to conduct the pre-test and final survey along with the formal invitation and the instrument; informing them about the aims of this study, time frame of data collection, intended use of data, issues related to their voluntary participation, assuring confidentiality and importantly highlighting its merit to them. Individuals wanting more information before participating in the research were additionally given the option to contact this researcher or his

representative to provide further details about this project. Finally, to ensure confidentiality the researcher in principle followed the succeeding criteria diligently:

• Personal information has been totally withheld

• Use of raw data explicitly restricted to research.

• Data to be safely kept in the principal investigator's office in a locked cabinet.

The Doctoral Research Assessment Committee at NITK approved to conduct this research after being convinced about the above measures.

4.11 SUMMARY

The use of quantitative analysis in answering the research questions besides testing the hypotheses finds justified in this chapter. The intended measurement scales for each of the constructs in the proposed model using previously tested scales; instruments and the methods used to collect data in the pre-test and final survey; the population, sampling and procedures used; the statistical techniques used to empirically test the research hypotheses of the proposed model; the issues related to the reliability and validity and ethical considerations to this research have all been detailed here.

Chapter five discusses data screening and preliminary data analysis, including descriptive statistics and sample characteristics. The hypothesised model of medical tourism brand loyalty is then tested under two stages 1) testing the measurement model besides 2) testing the structural model; examining the association between the underlying constructs of destination source credibility, medical tourism service quality, destination image, perceived value, destination attachment, perceived price reasonableness and brand loyalty.

CHAPTER - 5

DATA ANALYSIS AND INTERPRETATIONS

CHAPTER 5

DATA ANALYSIS AND RESULTS

5.1 INTRODUCTION

The preceding chapter detailed the research methodology adopted to test the proposed theoretical model and answer the research questions of the study. This chapter elaborates the results of the data analysis and tests the hypotheses. The Sub-section (5.2) deals with the preparation of the data, including editing and coding, followed by a discussion as embodied under section (5.3) about the procedures followed for screening the data. The fourth section (5.4) discusses the response rate, and the fifth section (5.5) describes sample characteristics. Next in line is section six (5.6) which reports the results of Structural Equation Modelling (SEM) used to test the hypotheses arising from the model. The next two sections (5.7 and 5.8) discuss the two-stage structural model used in analysing the data. The first stage of the measurement model is presented in section seven (5.7) while section (5.8) presents the structural model. Section nine (5.9) presents the final results related to the testing of the hypotheses. Section ten and eleven (5.10 and 5.11) present test for metric invariance for testing the moderating impact of perceived price reasonableness on study constructs and their results, and a conclusion is presented in section (5.12).

5.2 DATA EDITING AND CODING

After collecting data from the medical tourists (see Section 4.7.2 for the description) it was put to editing to ensure that there were no omissions, incompleteness or inconsistency with the data. Editing is considered to be a part of the data processing at the analysis stage (Zikmund 2000). Following the recommendation of Sekaran (2003), this study included all respondents in the analysis who completed at least 75 Percentage of questionnaire answers, while those with more than 25 Percentage unanswered questions were excluded (i.e. 25 surveys were excluded). Every missing data has been considered as missing values (Kinnear and Taylor 1996; Sekaran 2003) as discussed below.

Coding was used to assign numbers to each answer (Malhotra and Birks 2003) and to allows the transference of data from the questionnaire to SPSS. These procedures are undertaken either before (pre-coding) or after the questionnaire is answered (post-coding). In this study, the coding procedure was performed by establishing a data file in SPSS, and all the question items were all pre-coded with numerical values (see questionnaire in Appendix B). Data editing procedures commenced after meticulous data entry in the data file to plug any error during data entry. Out-of-range values in the data file were corrected by referring to the original questionnaire.

5.3 DATA SCREENING

During the first stage of data analysis, screening was done to trace the missing data, outliers, and abnormality were conducted. Data screening facilitates cross-checking to ensure the correctness of the data entered and to satisfy that the distribution of variables used in the analysis is in order.

5.3.1 Treatment of Missing Data

It is uncommon to obtain data sets without some missing data (Coakes 2013; Hair et al. 2010). Missing data is the outcome of a respondent failing to answer one or more survey questions. Two ways have been recommended by Tabachnick and Fidell (1996) to evaluate the degree of these missing data. The first is to evaluate the quantum of missing data, and the second is to pick the pattern of missing data. However, Tabachnick and Fidell (1996) argue that though the former is still necessary, assessing the pattern of missing data may be more important; because checking the pattern of missing data has an advantage in determining whether or not missing data occur randomly or relate to specific items. It means that the pattern of missing data should be randomly distributed among the questionnaires or else the missing data will lead to biased estimates of results (Tabachnick and Fidell 1996).

SPSS screening of the data indicated that no variable had more than 5% of missing data and since less than 5 Percentage of missing data is considered acceptable (Churchill and Iacobucci 2005) there was no requirement to assess the pattern of missing data. Nonetheless, to ensure that there was no systematic error (the missing data were randomly distributed) in the responses, the randomness of missing data was assessed

(Hair et al. 2010). An analysis of the pattern of missing data using SPSS missing data analysis indicated only random occurrences. This study is in sync with Tabachnick and Fidell (1996) principles meaning that there is no problem with the data and thus it can be analysed further.

As there was minimal missing data and the missing data were distributed randomly, it was decided to replace missing responses of each variable with the variable mean responses. This method was deemed to be most appropriate for the following two reasons. First, it is one of the more widely used methods since it is based on valid responses that make the mean the best single replacement of missing data (Hair et al. 2010). Second, because variables in the thesis are going to be grouped in factors, listwise deletion of variables with missing data would result in substantial loss of the overall sample size (Tabachnick and Fidell 1996).

It was essential to ensure that replacing missing values with the variable mean would not significantly alter the means and distribution of variables (pre-and post-replacement). A paired sample t-test was conducted to examine if there were any mean differences between original and adjusted variables. A Wilcoxon signed-rank1 was also used to test all pairs of variables to identify as to whether significant differences in the distribution of pre- and post-replacement existed. Hence, it can be confidently deduced that mean replacement did not alter the overall mean and distribution of variables.

5.3.2 Assessment of the Normality

Following the replacement of missing data with variable means (Coakes 2013), the scale data were assessed to determine normality of distribution. Since the assumption that factor analysis and structural equation modelling both require variables to be normally distributed, it was necessary to check the distribution of variables to be used in the analysis (Hair et al. 2010; Kline 2005; Tabachnick and Fidell 1996).

The first step is to dragonize the distribution of the variables used Box and Whisker and steam and leaf plots to check for outliers. Outliers refer to “observations with a unique combination of characteristics identifiable as distinctly different from the other observations” (Hair et al. 2010, p.57). These outliers might carry very high or very low scores (extreme values), and could result in non-normality data and distorted statistics

(Hair et al. 2010; Tabachnick and Fidell 1996). Given that extreme values represented less than 5 Percentage of the data, the method of changing scores was used as recommended by Tabachnick and Fidell (1996). Extreme values, in this case, were recorded (changed) to their closest values (up or down).

In order to check any actual deviation from normality, some methods can be made use of. One such method is the use of skewness and kurtosis. By using this method, values for skewness and kurtosis should not be significant if the observed distribution is exactly normal. For large sample sizes, 200 and over (Hair et al. 2010), even small deviations from normality can be significant but not substantial. Tabachnick and Fidell (1996, p.74) maintains that "in a large sample, a variable with statistically significant skewness and kurtosis often does not deviate enough from normality to make a substantiated difference in the analysis". Although this method is more applicable to small sample sizes, it was necessary to check the absolute values of skewness and kurtosis. If a variable with an absolute value of kurtosis index is found to be greater than 10.0, it may suggest the existence of a problem, and if the values are greater than 20.0, it may indicate a much more serious one (Kline 2005). Therefore, it was recommended that absolute value of skewness and kurtosis should not be greater than three and ten. An inspection of both skewness and kurtosis by using SPSS indicated that the absolute values were within the recommended levels (see Table 5.1) which indicates univariate normality. Table 5.1 also presents the final descriptive statistics for the items used in the study.

While the inspection of skewness and kurtosis values was important, it is recommended that visually assessing normal probability plots 2 is more appropriate for larger sample sizes (Hair et al. 2010). Looking for values clustered around the straight line, the assessment of these probability plots indicated that there was no severe deviation from normality. Since these variables did not deviate from normality, it was not necessary to make any further adjustments like the transformation of the data (Tabachnick and Fidell 1996).

Table 5.1: Measures of the Constructs and Descriptive Statistics

Items	Mean	SD	Skewness	Kurtosis
Destination Source Credibility				
Medical treatment claims from India are believable	4.94	1.74	.811	.341
Over time, my experiences with Indian medical tourism led me to expect it to keep its promises.	4.67	1.68	-.526	-.524
Medical treatment in India reminds me of someone who's competent and knows what he/she is doing.	5.00	1.70	-.766	-.334
Indian medical tourism has a name you can trust	4.97	1.62.	-.800	-.129
Medical tourism in India delivers (or would deliver) what it promises	5.02	1.58	-.758	-.154
Hospitals in India doesn't pretend to be something it isn't	5.07	1.61	-.764	-.162
Destination Image				
India is safe and secure	4.82	1.62	-.641	-.330
India offers exciting and interesting medical treatments	5.26	1.35	-.685	.018
India has beautiful scenery and natural attractions	5.19	1.53	-.871	-.022
India has a pleasant climate	5.05	1.57	-.673	-.258
As a tourism destination, India offers good value for money	5.04	1.64	-.760	-.209
Medical Tourism Service Quality				
Medical staff quality				
The physicians allowed me to ask many questions, enough to clarify everything	5.20	1.46	-.789	.388
The physicians adequately explained my condition, examination results and medical process	5.11	1.63	-.828	-.043
Ease of assembling and transmitting of medical record/information	4.97	1.55	. -560	-.440
Medical staff was polite and friendly	*5.01*	*1.54*	*-.604*	*-.366*
The process for setting up the medical procedure appointment was simple and easy	*4.84*	*1.53*	*-.484*	*-.577*
The physicians paid enough attention to my concerns in deciding on a medical procedure	*5.08*	*1.51*	*-.765*	*.233*

Items	Mean	SD	Skewness	Kurtosis
The hospital has adequate grievance channel for patients	*5.22*	*1.70*	*-0.906*	*-0.169*
The hospital has acceptable protection against medical malpractice and liability	*5.60*	*1.50*	*-1.126*	*0.558*
The medical staff has good communication skill	*5.10*	*1.76*	*-.689*	*.338*
Arrangement for language interpretation service	*5.11*	*1.63*	*-.828*	*-.043*
Availability of physicians and nurses who can speak my language	*4.92*	*1.51*	*. -569*	*-.449*
Short waiting time for the medical examination from the physician's	*4.97*	*1.55*	*. -560*	*-.440*
Supporting services quality				
The hospital amenities (cafeteria, Wi-Fi and public telephone) were conveniently located.	*5.22*	*1.70*	*-.906*	*-.169*
Hospital care facilities (laboratory and doctors' office) were easy to find	*5.10*	*1.76*	*-.689*	*.338*
The hospital's attention to patients' privacy, confidentiality and disclosure	*4.92*	*1.51*	*. -569*	*-.449*
The hospital has state-of-the-art facilities and equipment	*5.10*	*1.76*	*-.689*	*.338*
The hospital provides free Internet access	*4.84*	*1.53*	*-.484*	*-.577*
The payment procedure was quick and simple	*5.60*	*1.50*	*-1.126*	*.558*
Administrative services quality				
Package pricing with price transparency.	*5.60*	*1.50*	*-1.126*	*.558*
Coordination of arrangements between the patient, hospital, third party insurance companies, embassies and other businesses	*5.10*	*1.76*	*-.689*	*.338*
Convenient hospital transportation arrangement	*4.92*	*1.51*	*. -569*	*-.449*
Assistance with financial arrangements including advance estimates for fees, deposits and payments	*4.84*	*1.53*	*-.484*	*-.577*
Perceived Value				
Based on my experience, the medical service skills in India offer me good values	*4.94*	*1.50*	*-.788*	*-.184*
Based on my experience, the medical tourism service in India offers excellent value for money.	*5.25*	*1.46*	*-.715*	*-.051*
Based on my knowledge, the price charged for medical tourism to India is reasonable.	*5.50*	*1.23*	*-.628*	*-.109*

Items	Mean	SD	Skewness	Kurtosis
Based on my experience, the medical tourism service in India offers				
excellent quality/benefits.	*5.53*	*1.39*	*-.796*	*0.391*
Based on my knowledge, I feel that this medical travel is worthwhile	*5.30*	*1.40*	*-.729*	*.068*
Destination Attachment				
India is a very special destination to me	*5.45*	*1.32*	*1.589*	*2.505*
I identify strongly with this destination	*5.56*	*1.53*	*-1.068*	*.881*
No other place can provide the same holiday experience as India	*5.57*	*1.37*	*-1.305*	*1.273*
Holidaying in India means a lot to me	*5.62*	*1.47*	*-1.167*	*1.141*
I am very attached to this holiday destination	*5.43*	*1.57*	*-1.195*	*.996*
India is the best place for what I like to do on holidays	*5.36*	*1.38*	*-1.061*	*.372*
Holidaying here is more important to me than holidaying in other places	*5.40*	*1.35*	*-1.077*	*.871*
I would not substitute any other destination for the types of things				
that I did during my holidays in India	*5.45*	*1.60*	*-.642*	*-.044*
Perceived Price Reasonableness				
The menu prices at this hospital are reasonable.	*5.38*	*1.42*	*-.854*	*-.048*
The menu prices charged by this hospital are inexpensive.	*5.25*	*1.51*	*-1.064*	*.673*
The menu prices charged by this hospital are appropriate.	*5.00*	*1.42*	*-.931*	*.532*
The menu prices charged by this hospital are a real rip-off.	*5.02*	*1.46*	*-750*	*.059*
The menu prices charged by this hospital are Very low	*5.38*	*1.42*	*-.879*	*.207*
The menu prices charged by this hospital are Not pricey at all	*5.25*	*1.51*	*-1.366*	*1.411*
Destination Brand Loyalty				
I will not use any other Medical tourism destination if this treatment				
is available in India.	*5.56*	*1.32*	*-.859*	*.181*
This Medical tourism destination would be my first choice.	*5.65*	*1.39*	*-.785*	*-.143*
I will tell other people positive things about it.	*5.67*	*1.53*	*-.986*	*.310*
I consider myself to be loyal to this Medical tourism destination.	*5.75*	*1.39*	*-.789*	*-.144*

Note: N = 1025 for all items. All items were measured using 7-point Likert scale. SD = standard deviation.

5.4 RESPONSE RATE

As discussed in the Methodology Chapter (section 4.7.2), the data used in this study was gathered from various hospitals in India. The process of data collection commenced in June 2015 ended in December 2016. A total of twenty-seven hospital chains participated in this survey. Necessity of participation of respondents from a cross-section of hospitals was found to be inevitable to ensure that the sample was the product derived from the representation of the medical tourists in India. The survey conducted was distributed among one thousand and six hundred and twenty (1620) tourists in participant hospitals (60 questionnaires in each hospital). Out of 1620 questionnaires,1204 were returned duly completed. Having found around Twenty five percent of the items in the questionnaire stood unanswered by one hundred Twenty-five participants, the effective responses that could be accounted for were found to be 1079. It represented an effective response rate of 71.93%. Of the 1079 questionnaires, a final sample of 1025 was identified as representing medical tourists (the focus of this thesis) comprising 94.99 % of the usable completed questionnaires (or 68.33% of the overall surveys distributed). As this study focuses only on medical tourists, the remaining 208 surveys (14.86%) were not used for the analysis.

The response rate of this study is considered appropriate for two reasons. First, it is similar to the study of Shanmugam (2013), which has reported a response rate of 68.8%. The response rate here is, however, higher than the one reported by Reddy (2013), who collected data from medical tourists using a mail survey and reported a response rate of 69.45%. Secondly, the sample is large enough to conduct SEM analysis, which is used in this study.

5.5 SAMPLE CHARACTERISTICS

Table. 5.2 represents a graphic profile of the overall sample. A closer look at the actual visitors' demographics reveal that, (as in their order of hierarchy), the majority respondents were from the Middle East (48.1%), followed by Africa (28.8%), South Asia (11.5%), Westerners (9.6%) and East Asia (1.9%), respectively. Male respondents outnumbered females by a ratio of 73.1% to 26.9%.

The age bracket of the respondents ranges between 56 and above (42.3%), 46-55 years (32.7%), 36-45 years (19.2%), 26-35 years (3.8%) and below 25 Years (1.0%). A total of 82.7% respondents were married, while 9.6% were either widowed/separated/divorced and the remaining 7.7% belonged to the categories of bachelor's and Spinsters. 55.8% of total respondents were unemployed while 44.2% were employed. Amongst the employed categories, 48.2% were in the public sector, 34.4% worked with the private sector, and the remaining 17.4% were self-employed.

The Income bracket of the respondents (all figures in US$) comprising 38.5% is in the order of 30,000 and below, while the rest of the respondents falling within the ranges 40.5%, 12%, 10% respectively are the recipients of the income of 30,001 – 60,000, 60,001 – 1,00,000, and 1,00,000 and above.

The educational qualifications of the respondents revealed that 08.4% did not attend school at all. The remaining respondents are categorised into four grades namely, 10^{th} grade and below, graduated from high schools, graduated from colleges and Postgraduates (master's Degree / PhD) respectively covering a population size of 16.8%, 35.2%, 25.2% and 15.4%.

An inquiry into the frequency of visits revealed that 65.2% of the respondents were first-timers while the remaining 34.8% of them were repeaters. It also revealed that only 5.2% of the respondents had come on their own while 80.5% of the visitors accompanied by their families. The remaining 14.0% were accompanied by their friends.

With the objective of generating a fair idea, although not accurate, the researcher thought it appropriate to find out the stay duration of these visitors in India. Accordingly, the stay duration was divided into four stages namely, 16-30 days, 31-45 days, 46-60 days and 61 days and more. In the chronological order of these stages, the size of the respondents was found to be 30.2%, 34.6%, 32.8% and 03.5%.

In an average, 30.8% of the respondents visited India for Sight treatment / Lasik. The other areas of speciality chosen by the respondents were Dental surgery/ Treatment, Cosmetic/ Plastic surgery, Heart surgery, Comprehensive medical checkup, Infertility

treatment and Obesity Surgery which respectively accounted for a population strength of 6.8%,4.8%, 29.8%, 7.7%, 15.4% and 9.6%.

The other question forced to the respondents was the insurance coverage aspects, the response to this quarry revealed that meager 05.5% of the medical tourists had availed of the insurance coverage extended by the Insurance companies in India, while 85.5% of inmates were stated to have been availed of these facilities from the countries of the origin. The need to improve or modernise the insurance schemes in India is conspicuous.

The graphic profile of the final sample is that agencies through which visits were got facilitated and the extent of involvement of such agencies. From the revelation of the respondents, it has been ascertained that majority of them (70.8%) had arranged their visits through direct contacts with the respective hospitals. The remaining 29.2% of them made their visits possible through medical travel intermediaries websites in India.

TABLE 5.2 Demographic Profile of Respondents

Profile	Category	Percentage (%)
Region of Origin	East Asia	1.9
	South Asia	11.5
	Africa	28.8
	Westerners	9.6
	Middle Easters	48.1
Gender of the Respondent	Male	73.1
	Female	26.9
Age of the Respondent	Under 25 years old	1.0
	26-35 years old	3.8
	36-45 years old	19.2
	46-55 years old	32.7
	56years or older	42.3
Marital status of the Respondent	Bachelors and Spinsters	7.7
	Married	82.7
	Divorced/Widowed/Separated	9.6
Occupation of the Respondent	Employed	44.2
	Unemployed	55.8
Employment Status of the	Private Sector	34.4
Respondent	Public sector	48.2
	Self-Employed	17.4
Annual Income of the Respondent	30,000 and below	38.5
In USD	30,001-60,000	40.5
	60,001-100,000	12
	Above 1,00,000	10
Highest level of education of the	Did not attend school	08.4
Respondent	Up to 10th grade	16.8

Profile	Category	Percentage (%)
	Graduated from high School	35.2
	Graduated from College	25.2
	Postgraduate (Master's Degree/PhD)	15.4
Frequency of visit	First visit	65.2
	Revisit	34.8
Companion with the Respondent	On your own	5.2
	With family	80.5
	With friends	14.0
Stay duration of the Respondent	16-30 Days	30.2
in India	31-45 Days	34.6
	46-60 days	32.8
	More than 60 Days	03.5
Treatments sought by Respondent	Dental surgery/ Treatment	6.8
	Cosmetic/ Plastic surgery	4.8
	Sight treatment/ Lasik	30.8
	Heart surgery	29.8
	Comprehensive medical checkup	7.7
	Infertility treatment	15.4
	Obesity Surgery	9.6
Medical insurance coverage	Yes	05.5
in India	No	94.5
Medical insurance coverage	Yes	85.5
in home country	No	14.5
Arrangement of medical	directly with the hospital	70.8
	Through medical travel Intermediaries' websites in India	29.2

5.6 ANALYSIS OF THE STRUCTURAL EQUATION MODELING

As discussed in section 4.8, structural equation modeling (SEM) is used to test the hypotheses arising from the theoretical model. In order to perform the SEM analysis, the two-stage approach recommended by C. Anderson and Gerbing (1988) was adopted. The rational for using this approach was discussed in section 4.8.2.1.

In the first stage (measurement model), the analysis was conducted by specifying the causal relationships between the observed variables (items) and the underlying theoretical constructs. For this purpose, confirmatory factor analysis using AMOS 23.0 was performed. Following this, the paths or causal relationships between the underlying exogenous and endogenous constructs were specified in the structural model (second stage). Exogenous constructs included destination source credibility, medical tourism service quality and destination image whereas endogenous constructs included perceived value, destination attachment and loyalty. Analysis and results related to these two stages are discussed in the following sections.

5.7 STAGE ONE: MEASUREMENT MODEL

The measurement model is "the portion of the model that specifies how the observed variables depend on the unobserved, composite, or latent variables" (Arbuckle 2005,p89). In this sense, the measurement model aims to specify which items correspond to each latent variable. Accordingly, the measurement model in this thesis specifies the pattern by which each measure is loaded onto a particular variable (composite or latent variables) (Byrne 1989). Each one of the constructs under consideration including destination source credibility, destination image, medical tourism service quality, perceived value, destination attachment and loyalty was separately analysed in a separate measurement model. If the results are not consistent with a priori specified measurement model, then the measurement model should be rectified and reanalysed (Bollen 1989; C. Anderson and Gerbing 1988; Hair et al. 2010; Kline 2005; Tabachnick and Fidell 1996). Thus, the measurement model in this stage has been evaluated in two steps. The first step assesses the unidimensionality for each factor, and the second step aims to assess the reliability and validity of each construct. These two steps are discussed in detail below.

5.7.1 Assessing the Unidimensionality (Step 1)

The specification of the measurement model for each underlying construct with a discussion of the path diagram is highlighted in this section. The use of multi-item scales to measure each factor in the measurement model is discussed followed by a description of the procedures that were conducted to modify the measurement model.

The constructs in the proposed model are destination source credibility, destination image, medical tourism service quality, perceived value, destination attachment, perceived price reasonableness and loyalty each of which were assessed for unidimensionality. Each one of these constructs was then examined in a separate measurement model. As shown in Figures 5.1 to 5.6, previously developed items are observed variables and appear as rectangles. Single-headed arrows are linking the factors (also called latent variables) to their items (indicators), and single-headed arrows linking the error terms to their respective indicators. No single-headed arrows are linking the factors because there are no theoretical relationships that point to one of these factors causing the other. Instead, double-headed arrows show correlations between these factors. These figures also provide the standardised parameter estimates (also called factor loadings) on the arrows connecting factors with their items. The values appearing next to the edge of the items are squared multiple correlations, and values next to the curved double-headed arrows show correlations between the latent variables (factors).

In each measurement model, multiple items have been used to measure each factor (C. Anderson and Gerbing 1988; Hair et al. 2010; Kline 2005) to allow the most unambiguous assignment of meaning to the estimated constructs (Hair et al. 2010). It maintains that "if a standard CFA model with a single factor has at least three indicators, the model is identified. If a standard model with two or more factors has at least two indicators per factor, the model is identified."

Other researchers such as Bentler and Chou (1987) also suggest the necessary number of items per construct. They suggest that a measurement model should contain at most 20 variables measuring no more than five to six constructs (three to four indicators measure each construct). It is because the interpretation of results and their statistical

significance becomes difficult when the number of concepts becomes too large (Yang-wallentin 2007). At the starting point in the measurement model, each factor of the underlying constructs has the appropriate number of items or indicators (see Table 4.1). In confirming each measurement model, it may be the case that some items in the scales become redundant, and as such the measurement model needs to be recalibrated by removing these redundant items (Hair et al. 2010; Kline 2005). This way, parsimonious unidimensional constructs are obtained (C. Anderson and Gerbing 1988).

The rationale for the above process includes two main considerations as recommended by (Kline 2005). First, the indicators specified to measure a proposed underlying factor should have relatively high-standardised loadings on that factor. As discussed in section 4.8.2.1, this is typically 0.50 or greater (Hair et al. 2010). Second, the estimated correlations between the factors should not be greater than .85 (Kline 2005). To be precise, if the estimated correlation between the Administrative Staff Quality (ASQ), Supporting services quality (SSQ) and Medical staff quality (MSQ) (as is estimated at 0.95 in the measurement model of figure 5.1), the items may not be measuring two different factors. In other words, there is overlap between these two factors, and thus they are empirically not distinguishable. These two considerations are made in conjunction with the overall goodness-of-fit indices to suggest acceptance of unidimensionality for each model.

A more detailed evaluation of model fit can also be obtained by an inspection of the normalised residual and modification indices (Donald Cooper 2013; Hair et al. 2010). Here, the normal residual (also called standardised residual) refers to the difference between observed correlation/covariance and the estimated correlation/covariance matrix. The Modification indices refer to the calculation of each non-estimated relationship in the specified model. Residuals more than ± 2.58 are indicative of a specification error in the model, whereas a modification index value of greater than 3.84 shows that the chi-square would be significantly reduced when the corresponding parameter is estimated (Hair et al. 2010). In this thesis, the evaluation of the measurement model is not only based on statistical principles, but also on a theoretical justification (C. Anderson and Gerbing 1988; Hair 2009; Kline 2005). That is, the ultimate aim of this statistical inspection is to find a model that is both substantively

meaningful and statistically well-fitting for the data and theory (Kahn, Kalwani, and Morrison 1986). It is consistent also with Holmes-Smith et al. (2006, p.15), who maintain that "the researcher should guard against making changes solely based on data-driven grounds in an attempt to get a model that fits the data better."

A final consideration in confirming each measurement model is the choice of parameter estimates intended to be used. These include Maximum Likelihood Estimators (MLE), Instrumental Variables (IV), Unweighted Least Squares (ULS), and Generalized Least Squares (GLS). Since the sample size in this thesis being 1025 respondents, MLE was used as the parameter estimation method for the following reasons. First, according to Howard (2013), MLE is considered to be a most appropriate measurement model on the assumption that it is a multivariable normal distribution model, especially so when the sample is huge. Second, C. Anderson and Gerbing (1988) emphasise that the properties of MLE are unbiased, consistent and efficient when it comes to the question of desirable asymptotic, or large-sample. Finally**,** MLE is suited to theory testing and development remains a desirable tool for statistical testing which has been adopted by some authors such as Yang-wallentin (2007).

The development of each measurement model is now discussed. The results of testing the unidimensionality of each construct- destination source credibility, destination image, medical tourism service quality, perceived value, destination attachment and loyalty, are presented in AMOS 23.0.

5.7.1.1 Medical Tourism Service Quality

Medical Tourism Service Quality was measured using three separate factors: Medical staff quality, Supporting services quality and Administrative services quality. Each of these factors has been measured by some questionnaire items (i.e., indicators). In total, 22-items were used to measure the Medical Tourism Service Quality construct. As is made clear in Table 5.3, medical staff quality (MSQ) was measured by 12 questionnaire items labeled from MSQ1, MSQ 2, MSQ 3, and MSQ 4 …. MSQ12 whereas Supporting services quality (SSQ) was measured through six questionnaire item distinguished described as SSQ13, SSQ 14, SSQ15, SSQ16, SSQ17 and SSQ18. The final factor viz the Administrative services quality (ASQ) was measured using four

questionnaire items catalogued as ASQ19, ASQ20, ASQ21 andASQ22. Given that these constructs were considered as exogenous variables, the statistical SEM model specifies that they are inter-correlated.

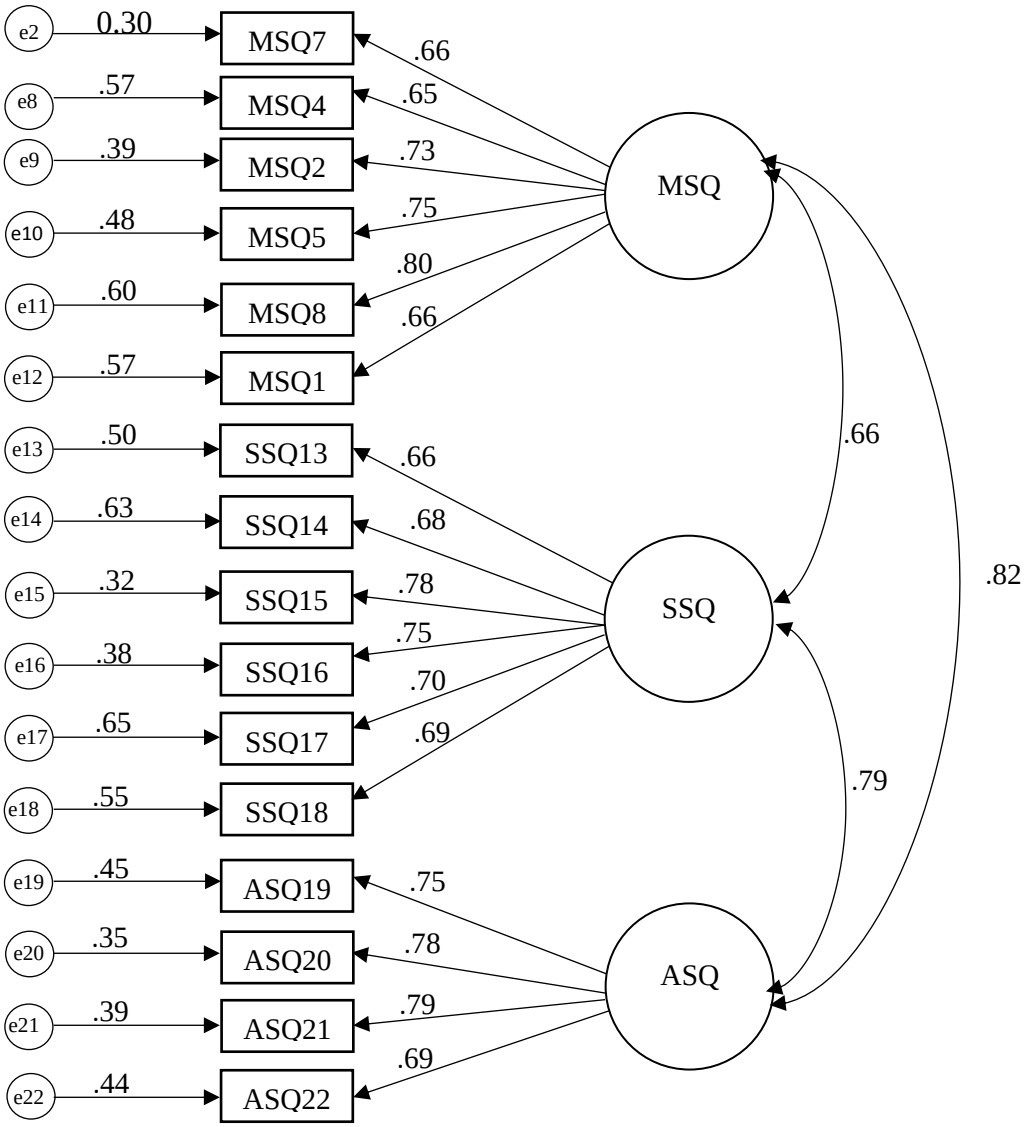
Although the standardised parameter estimates were all significant (P<0.001), results of the CFA indicated that the initial measurement model required recalibration. The chi-square was significant (χ^2 = 5171.809, df =206, P = .000). The GFI was .461, AGFI = .457, RMSEA = .252, NFI = 0.797, CFI = 0.803, TLI = .779, and χ^2 /df =25.106). Furthermore, CFA results also indicate that the inter-correlations among Medical staff quality, supporting services quality and Administrative services quality factors were higher than 0.85, demonstrating a lack of discriminant validity. Discriminant validity is further discussed in section 4.9.2.2. Given the fact that the Medical staff quality factors were highly intercorrelated and some of above indices (i.e., χ^2, GFI, AGFI) were not within the acceptable level, further detailed assessment (re-specification) was conducted. Discriminant validity was improved as follows (Kline 2005).

Examination of standardised residuals indicated that all residual values were within the threshold recommended by Hair et al. (2010) (less than m 2.58). However, modification indices indicated that the indicators (Medical staff quality), MSQ12, MSQ1, MSQ10 and MSQ6 had unacceptably high values (42.57, 34.9, 42.5, and 12.35, respectively). After iteratively removing these redundant items, three additional items measuring Medical staff quality (MSQ9 and MSQ3) were found to be lacking in discriminant validity and were further removed. The purpose of repeating the filtering process was to remove a few items as possible, taking into account the need for deriving a more parsimonious model. In total, six Medical staff quality items were removed prior to further analysis.

Although the value of some deleted items was relatively high compared with the total, their removal did not significantly change the content of the construct as it was conceptualised. It is because the remaining items for Medical staff quality had the highest initial loadings, and thus the meaning of the factors had been preserved by these items.

Table 5.3: Medical Tourism Service Quality Items and their Description

Original Item	Item Label	Item Deleted
Medical staff quality (MSQ)		
The physicians allowed me to ask many questions, enough to clarify everything	MSQ1	*Deleted*
The physicians adequately explained my condition, examination results and medical process	MSQ2	
Ease of assembling and transmitting of medical record/information	MSQ3	*Deleted*
Medical staff was polite and friendly	MSQ4	
The process for setting up the medical procedure appointment was simple and easy	MSQ5	*Deleted*
The physicians paid enough attention to my concerns in deciding on a medical procedure	MSQ6	
The hospital has adequate grievance channel for patients	MSQ7	
The hospital has acceptable protection against medical malpractice and liability	MSQ8	
The medical staff has good communication skill	MSQ9	*Deleted*
Arrangement for language interpretation service	MSQ10	*Deleted*
Availability of physicians and nurses who can speak my language	MSQ11	
Short waiting time for the medical examination from the physicians	MSQ12	*Deleted*
Supporting services quality (SSQ)		
The hospital amenities (cafeteria, Wi-Fi and public telephone) were conveniently located.	SSQ13	
Hospital care facilities (laboratory and doctors' office) were easy to find	SSQ14	
The hospital's attention to patient s' privacy, confidentiality and disclosure	SSQ15	
The hospital has state-of-the-art facilities and equipment	SSQ16	
The hospital provides free Internet access	SSQ17	
The payment procedure was quick and simple	SSQ18	
Administrative services quality (ASQ)		
Package pricing with price transparency.	ASQ19	
Coordination of arrangements between the patient, hospital,		
Third-Party insurance companies, embassies and other businesses	ASQ20	
Convenient hospital transportation arrangement	ASQ21	
Assistance with financial arrangements including advance estimates for fees, deposits and payments	ASQ22	



Note: MSQ: Medical staff quality, SSQ: Supportive staff quality, ASQ: Administrative services quality

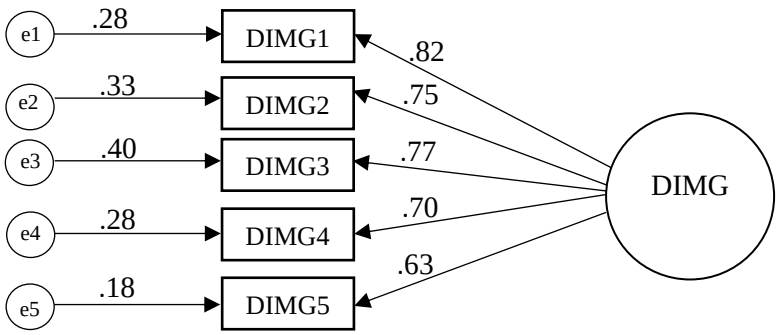
Figure 5.1: A CFA Measurement Model of Medical Tourism Service Quality

Following the process described above, CFA has performed again with the six redundant items removed. As goodness of fit indices was improved, the modified model showed a better fit to the data (χ^2 = 151.373, df = 89, P = .001). The GFI was 0.955, AGFI = 0.931, NFI = 0.990, CFI = 0.996, TLI = .994, RMSEA = 0.043, and χ^2 /df = 1.7). Even though the chi-square is still significant, these values suggest that this model fits adequately into the data. As discussed before, it is commonly accepted that the chi-square estimate would potentially reject valid models in large sample size (Bagozzi and

Yi 1988). Given that the model fits the data adequately and the correlations between the underlying factors are less than .85 (see the values on the double-headed arrows in Figure 5.1), no further adjustments were required. As shown in Figure 5.1, the modified model was tested with six indicators to measure Medical staff quality (MSQ7, MSQ4, MSQ2, MSQ5, MSQ8 and MSQ1), and six indicators to measure Supporting services quality (SSQ13, SSQ14, SSQ15, SSQ16, SSQ17 and SSQ 18), and finally by four indicators to measure Administrative services quality (ASQ19, ASQ20, ASQ21, and ASQ22). The standardised factor loadings for these measures were all higher than the recommended level of .50 (see Table 5.10). It indicates that standardised parameter estimates for these measures were deemed to be statistically significant (P<0.001), providing unidimensional scales for each of the three factors.

5.7.1.2 Destination Image

As presented in Table (5.4), five items (DIMG1-DIMG5) were used to measure the model of the destination image. The results of CFA provided adequate proof for accepting this model. A glance into the figure 5.2 makes it abundantly clear that based on slandered parameters estimates, all indicators are statistically significant (P<0.001) and each item was loaded to ascertain the destination image (see Table 5.10). CFA results also showed that the chi-square was significant (χ^2 = 6.863, df = 4, P = 0.143). The GFI was .993, AGFI = .972, NFI = .996, CFI = .998, TLI = .995, RSMEA = .04, and χ^2 /df = 1.715. These values suggest an adequate fit to the model, so no further adjustments were required.



Note: DIMG: destination Image

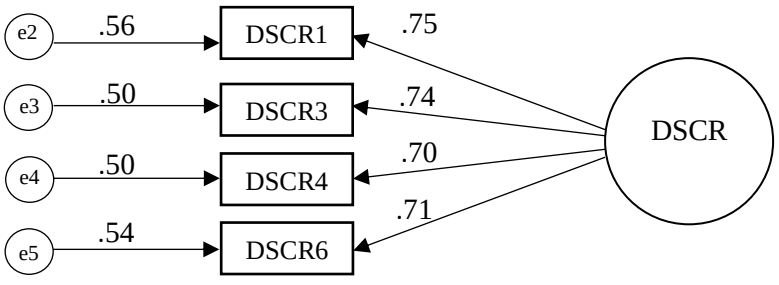
Figure 5.2: A CFA Measurement Model of Destination Image

Table 5.4: Destination Image Items and their Description

Original Item	Item Label
Destination Image	
The Indian conditions are good for engaging in medical tourism	DIMG1
India offers good medical tourism experiences.	DIMG2
India reflects an authentic medical environment.	DIMG3
India offers possibilities to find out and learn things about medical environments.	DIMG4
India offers unique experiences in a medical environment.	DIMG5

5.7.1.3 Destination Source Credibility

As shown in Table 5.5, six indicators were used to measure one-factor model of destination source credibility (DSCR1-DSCR6). Although standardised parameter estimates were all significant (P<0.001), results of the CFA (Figure 5.3) indicated that the initial measurement model required respecification. The chi-square was significant (χ^2 = 56.710, df =7, P = 0.000). The GFI was .956, AGFI = .869, RMSEA = .137, NFI = .989, CFI = .990, TLI = .979, and χ^2 /df =8.101. Examination of standardised residuals indicated that all residual values were within the threshold recommended by Hair et al. (2010) (less than m 2.58). However, modification indices indicated that the indicators DSCR2 and DSCR5 had unacceptably high values (55.5 and 22.3, respectively).



DSCR-Destination Source Credibility

Figure 5.3: A CFA Measurement Model of Destination Source Credibility

Table 5.5: Destination Source Credibility Items and their Description

Original Item	Item Label	Item Deleted
Trustworthiness		
Medical tourism in India delivers (or would deliver) what it promises	DSCR1	
Medical treatment claims from India are believable	DSCR2	*Deleted*
Indian medical tourism has a name you can trust	DSCR3	
Expertise		
Medical treatment in India reminds me of someone who's competent and knows what he/she is doing.	DSCR4	
Hospitals in India does not pretend to be something it is not DSCR5	*Deleted*	
Indian hospitals are the forefront of using technology to deliver a better service	DSCR6	

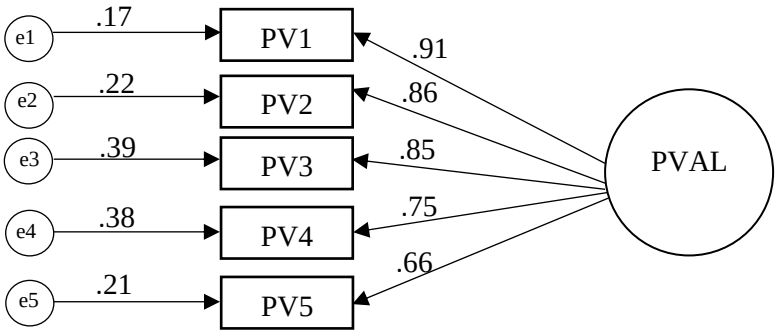
Following the process, as described above, CFA has performed again with the two redundant items removed. As goodness of fit indices was improved, the modified model showed a better fit to the data (χ^2 = 4.302, df = 2, P = .116). The GFI was .994, AGFI = .971, NFI = .991, CFI = .995, TLI = 0.986, RMSEA = .055, and χ^2 /df = 2.151. These values suggest that the model fits adequately to the data and no further adjustments were required.

5.7.1.4 Perceived Value

As shown in Table 5.6, five indicators were used to measure the one-factor model of Perceived Value (PVAL1-PVAL5). The results of CFA shown in Figure 5.4 indicate that the standardised parameter estimates for all indicators were statistically significant (P <0.001) and each of the five-item was loaded under the factor (see Table 5.10). Results also indicate that this model fits the data adequately. As was expected, the chi-square goodness-of-fit was statistically insignificant (χ^2 = 8.851, df = 3, P = .031). The GFI was .991, AGFI = .956 NFI = .995, CFI = .997, TLI = .989, and RSMEA = .052, and χ^2 /df = 2.401.

Table 5.6: Perceived Value Items and their Description

Original Item	Item Label
Perceived Value	
Based on my experience, the medical service skills in India offer me good values	PVAL1
Based on my experience, the medical tourism service in India offers good value for money.	PVAL2
Based on my experience, the price charged for medical tourism to India is reasonable.	PVAL3
Based on my experience, the medical tourism service in India offers good quality/benefits.	PVAL4
Based on my experience, I feel that this medical travel is worthwhile	PVAL5



Note: PVAL-Perceived Value

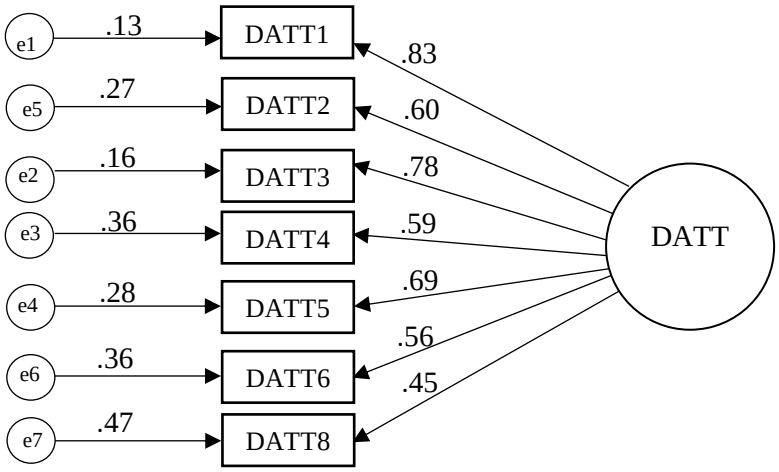
Figure 5.4: A CFA Measurement Model of Perceived Value

5.7.1.5 Destination Attachment

As shown in Table 5.7, eight indicators were used to measure one-factor model of destination attachment (DATT1-DATT8). Although standardised parameter estimates were all significant (P<0.001), results of the CFA (figure 5.5) indicated that the initial measurement model demanded re-specification. The chi-square was significant (χ^2 = 158.199, df =10, P = .000). The GFI was .910, AGFI = .877, RMSEA = .077, NFI = .957, CFI = .960, TLI = .887, and χ^2 /df =15.821. Examination of standardised residuals indicated that all residual values were within the threshold recommended by Hair et al. (1995) (less than m 2.58). However, modification indices indicated that the indicators DATT7 had unacceptably high values (55.5 respectively).

Following the process described above, CFA has performed again with the one redundant item (DATT7) removed. As goodness of fit indices was improved, the modified model showed a better fit to the data (χ^2 = 7.744, df = 5, P = .171). The GFI

was .994, AGFI = .968, NFI = .997, CFI = .999, TLI = .996, RMSEA = .035, and χ^2 /df = 1.541. These values suggested that this model fits adequately into the data, and no further adjustments were required.



Note: DATT-Destination Attachment

Figure 5.5: A CFA Measurement Model of Destination Attachment

Table 5.7: Destination Attachment Items and their Description

Original Item	Item Label	Item Deleted
India is a very special destination to me	DATT1	
I identify strongly with this destination	DATT2	
No other place can provide the same holiday experience as India	DATT3	
Holidaying in India means a lot to me	DATT4	
I am very attached to this holiday destination	DATT5	
India is the best place for what I like to do on holidays	DATT6	
Holidaying here is more important to me than holidaying in other places	DATT7	*Deleted*
I would not substitute any other destination for the types of things that I did during my holidays in India	DATT8	

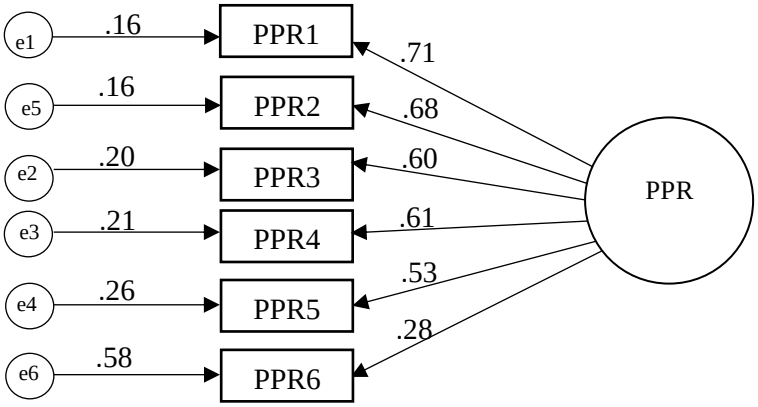
5.7.1.6 Perceived Price Reasonableness

As shown in Table 5.8, six indicators were used to measure the one-factor model of Perceived price reasonableness (PPR1-PPR6). The results of CFA shown in Figure 5.6

indicate that the standardised parameter estimates for all indicators were statistically significant (P <0.001) and loaded under this factor (see Table 5.10). Results also indicate that this model fits the data adequately. As was expected, the chi-square goodness-of-fit was statistically insignificant (χ^2 = 13.417, df = 7, P = .063). The GFI was .998, AGFI = .965 NFI = .990, CFI = .995, TLI = .990, and RSMEA = .049, and χ^2 /df = 1.917.

Table 5.8: Perceived Price Reasonableness Items and their Description

Original Item	Item Label
The menu prices at this hospital are reasonable.	PPR1
The menu prices charged by this hospital are inexpensive.	PPR2
The menu prices charged by this hospital are appropriate.	PPR3
The menu prices charged by this hospital are a real rip-off.	PPR4
The menu prices charged by this hospital are Very low	PPR5
The menu prices charged by this hospital are Not pricey at all	PPR6



Note: PPR- Perceived price reasonableness

Figure 5.6: A CFA Measurement Model of Perceived Price Reasonableness

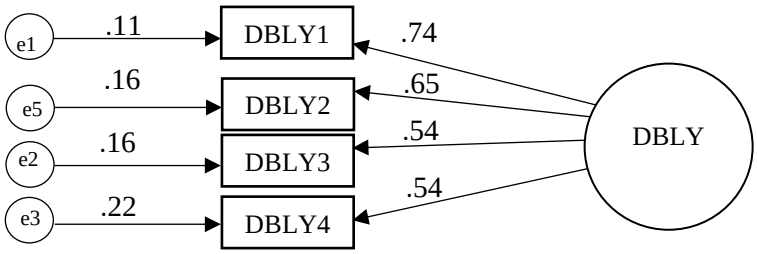
5.7.1.7 Destination Brand Loyalty

As presented in Table (5.9), four items (DBLY1 to DBLY4) were used to measure the one-factor model of brand loyalty. The results of CFA evidently paved the way for the acceptance of this model. As could be seen from the figure 5.7, all indicators are statistically significant (P<0.001) based on the standardised parameters estimates arrived at on loading all the items (Table 5.10). CFA results also showed that the chi-

square was significant (χ^2 = 0.75, df = 2, P = 0.963). The GFI was 1.00, AGFI = 1.00, NFI = 1.00, CFI = 1.00, TLI = 1.00, RSMEA = .000, and χ^2 /df = 0.37). These values suggest an adequate fit to the model.

Table 5.9: Destination Brand Loyalty Items and their Description

Original Item	Item Label
I consider myself to be loyal to this Medical tourism destination.	DBLY1
This Medical tourism destination would be my first choice.	DBLY 2
I will not use other Medical tourism destination if this treatment is available in India.	DBLY 3
I will tell other people positive things about it.	DBLY 4



Note: DBLY- Destination Brand Loyalty

Figure 5.7: A CFA Measurement Model of Destination Brand Loyalty

5.7.2 Reliability and Validity of the Constructs (Step 2)

Consequent to the establishment of the unidimensionality (discussed in Section 5.7.1) but before testing the hypotheses in the structural model (stage two), the reliability and validity of the underlying constructs were assessed (Wulf, Odekerken-Schröder, and Iacobucci 2001). As discussed in Step one, The Reality of the constructs was assessed by using Cronbach's Alpha, Construct Reliability (CR), and Average Variance Extracted (AVE), while the validity of the constructs was evaluated by using convergent and discriminant (these issues have been elaborately discussed in Section 4.9).

The Reliability of the measures was formally assessed using Cronbach's (1951) coefficient alpha and after that by using Confirmatory Factor Analysis (CFA) (Section 4.9.1). As shown in Table 5.10, the Cronbach's coefficient alpha score of all the constructs exceeded the suggested level of .70 (Nunnally 1978). Construct Reliability

(CR), and the Average Variance Extracted (AVE) were evaluated by using the formula given by Fornell and Larcker (1981). Bagozzi and Yi (1988) recommended that CR and AVE should respectively be equal or greater than 0.60 and 0.50. The results show that the measures used in this study for evaluating the reliability of the constructs were found to be within the acceptable level (Table 5.10).

In the case of validity, confirmatory factor analysis has also been used to assess construct, convergent and discriminant validity (Section 4.9.2). Empirically, construct validity exists when the measure is a good representation of the variable the researcher intended to measure. As Bagozzi and Yi (1988) argued, construct validity is a necessary prerequisite for theory testing. The results obtained from goodness-of-fit indices confirmed construct validity in this study (Hsieh, Chiu, and Chiang 2005).

As for convergent validity, evidence has been found in which all factor loadings for items measuring the same construct are statistically significant (C. Anderson and Gerbing 1988). As indicated in Table 5.10, all factors included high loadings (higher than .50) and were statistically significant ($P<0.001$). The results of AVE presented in Table 5.10 provide additional support for convergent validity. Finally, discriminant validity was assessed using two methods. Initially, as suggested by Kline (2005), it was ensured that the estimated correlations between the factors are not higher than .85 by keeping each measurement model in line with this assessment. To suit this requirement redundant items that caused high correlations among factors were deleted which revealed the existence of discriminant validity (Results achieved by testing the measurement models as explained in the previous sections are relevant).

Finally, discriminant validity was assessed by examining the pattern structure coefficient to determine whether factors in measurement model are empirically distinguishable (Thompson 1997). On the basis of this restrictive test, substantial evidence was found for discriminant validity between each possible pair of factors.

Table 5.10: Measurement Model Evaluation

Construct	Items	Standardized Loading	Cronbach's alpha (α)	CR	AVE
Medical Tourism Service Quality			**.90**	**.83**	**.735**
Medical staff quality					
	MSQ2	.980			
	MSQ5	.978			
	MSQ11	.966			
	MSQ8	.965			
	MSQ7	.909			
	MSQ4	.900			
Supporting services quality					
	SSQ13	.976			
	SSQ14	.990			
	SSQ15	.988			
	SSQ16	.915			
	SSQ17	.941			
	SSQ18	.981			
Administrative services quality					
	ASQ19	.961			
	ASQ20	.959			
	ASQ21	.952			
	ASQ22	.955			
Destination Image			**.89**	**.87**	**.72**
	DIMG3	.916			
	DIMG4	.897			
	DIMG5	.892			
	DIMG2	.885			
	DIMG1	.856			
Destination Source Credibility			**.81**	**.85**	**.52**
	DSCR6	.815			
	DSCR1	.808			

Construct	Items	Standardized Loading	Cronbach's alpha (α)	CR	AVE
	DSCR3	.795			
	DSCR4	.793			
Perceived Value			**.94**	**.93**	**.75**
	PVAL4	.932			
	PVAL3	.920			
	PVAL2	.917			
	PVAL5	.876			
	PVAL1	.871			
Destination Attachment			**.96**	**.92**	**.65**
	DATT4	.882			
	DATT2	.879			
	DATT8	.874			
	DATT3	.862			
	DATT6	.855			
	DATT5	.852			
	DATT1	.790			
Perceived Price Reasonableness			**.88**	**.85**	**.56**
	PPR2	.885			
	PPR4	.852			
	PPR1	.848			
	PPR3	.833			
	PPR5	.778			
	PPR6	.608			
Destination Brand Loyalty			**.86**	**.85**	**.61**
	DBLY1	.882			
	DBLY4	.858			
	DBLY3	.817			
	DBLY2	.815			

Note: CR = composite reliability; AVE = Average Variance Extraction. DSCR: Destination Source Credibility, DIMG: Destination Image, MSQ: Medical staff quality, SSQ: Supportive staff quality, ASQ: Administrative services quality DATT: Destination Attachment, PVAL: Perceived Value, DBLY: Destination Brand Loyalty, PRR: Perceived Price Reasonableness

5.7.3 Review of Measurement Model (Stage One)

As shown earlier, each construct or latent variable in the first stage has its measurement model, in which the observed variables (items or indicators) define each construct. Each measurement model examined in this study was assessed through two steps. Assessing the unidimensionality was first, and reliability and validity were second. This assessment process was carried out using CFA. In the first step, each measurement model was assessed strictly in the fully specified manner by determining the relationships between the factors and their items. Results indicated that the fully specified measurement model needed to be respecified in order to provide a more parsimonious model. The respecification of the model was needed because the factor had highly correlated (i.e.,>.85) leading to lack of discriminant validity owing to the facts that the items were not highly loaded on the respective hypothesized factor (by investigating significance of standardized parameter estimates), model was not adequate to fit the data (through goodness-of-fit indices) and the factor had the large presence number of residuals and modification indices. This specification was conducted in conjunction with the theory. The resulting modified model was then assessed for an acceptable fit to proceed with further analysis.

As a second step, Further analyses were carried out to evaluate the reliability and validity of each construct in the modified model. Internal consistency was assessed using Cronbach's alpha, CR and AVE. As indicated in Table 5.10, these measures identified values above the recommended levels needed for this study (i.e., .70 for Cronbach's alpha, .60 for CR, and .50 for AVE), indicating acceptable levels for the reliability of constructs. In the case of validity, convergent validity was supported by all items being statistically significant (P<0.001), and the loading was done strictly in accordance with the specified factors. Convergent validity level was also found to be most appropriate being in conformity with the AVE .50 and above. Furthermore, the fit of the model by using goodness-of-fit indices has confirmed the construct validity. In order to overcome the high correlation aspect which stood in the way of achieving the discriminant validity, the redundant items were deleted. The results of pattern strictures and coefficients which shows that each factor in each measurement model was empirically distinguishable also helped to achieve this objective. Having analysed the

measurement models for unidimensionality, reliability, construct validity, convergent validity and discriminant validity, the next stage is to perform the analysis of the structural model.

5.8 STAGE-II: STRUCTURAL MODEL (TESTING OF HYPOTHESIS)

Once all constructs in the measurement model (stage one) were validated and satisfactory fit achieved (C. Anderson and Gerbing 1988; Hair et al. 2010; Kline 2005), a structural model can then be tested and after that set the second stage for main analysis. The structural model has been defined as "the portion of the model that specifies how the latent variables are related to each other" (Arbuckle 2005). The structural model aims to specify which latent constructs directly or indirectly influence the values of other latent constructs in the model (Byrne 1989).

As presented in Table 5.11, these hypotheses were represented in eight causal paths (H1, H2, H3, H4, H5, H6, H7, and H8). As detailed in section (5.10), H9a to H9h relate to moderation testing to determine the relationship between the constructs under consideration. In the proposed theoretical model discussed in Chapter Three, the underlying constructs were classified into two classes, including exogenous constructs (destination source credibility, destination image and medical tourism service quality) and endogenous constructs (perceived value, destination attachment, and loyalty).

Table 5.11: Underlying Hypotheses

Hypotheses	Hypotheses
H_1: DSCR→ PVAL	Destination Source Credibility significantly affects perceived value.
H2: DSCR→ DATT	Destination Source Credibility significantly affects destination attachment
H3: DIMG→ PVAL	Destination Image significantly affects the perceived value of medical tourism.
H4: DIMG→ DATT	Destination Image significantly affects Destination Attachment.
H5: MTSQ→ PVAL	Medical tourism service quality significantly affects perceived value.
H6: MTSQ→ DATT	Medical tourism service quality significantly affects destination attachment
H7: PVAL→ BLOY	Medical tourist's perceived value significantly affects overall brand loyalty.
H8: DATT→BLOY	Destination attachment significantly affects brand loyalty.
H9a-11h:	Perceived price reasonableness significantly moderates the relationships among study constructs (Destination source credibility, destination attachment, medical tourism service quality, perceived value, destination attachment, and brand loyalty of medical tourist) within the proposed conceptual model.

Goodness-of-fit indices were put to the test with a view to ensure that hypothesised structural model fits the data. If it does not fit the data, the model will have to be re-specified until the acceptable statistical fitness, and the theoretically meaningful representation of the observed data are achieved (C. Anderson and Gerbing 1988; Hair et al. 2010; Kline 2005; Tabachnick and Fidell 1996).

Having met the object of structural equation modelling (see Section 4.8.2.2), the coefficient parameter estimates were examined along with the overall model fit indices to test hypotheses H1 to H8. Parameter estimates are fundamental to SEM analysis because they are used to generate the estimated population covariance matrix for the model (Tabachnick and Fidell 1996). Coefficients' values are obtained by dividing the variance estimate by its Standard Error (S.E). That is, when the Critical Ratio (C.R.) (called z-value in Tables 5.12,) is higher than 1.96 for a regression weight (or standardised estimates), the parameter is statistically significant at the .05 levels. To be precise, the first hypothesised path between destination source credibility and perceived value (see Table 5.12) indicates a CR of 4.345, which exceed the value of 1.96 required for statistical significance. That means the regression weight of destination source credibility in the prediction of perceived value at the $P < 0.05$ level is significantly close to zero ($P = .000$).

In the path diagram shown in Figures 5.8, the values for the paths connecting constructs with a single-headed arrow represent standardised regression beta weights. As in the measurement model, the values appearing on the edge of the boxes are variance estimates in which latent variables or factors explain the amount of variance in the observed variables, and values next to the double-headed arrows show correlations. The evaluation of the structural model of this thesis is discussed below.

5.8.1 Structural Model One (The Hypothesized Model)

The analyses of the hypothesised structural model were conducted by testing the hypothesised model, through the application of eight casual relationships as specified in Table 5.11. In the path diagram presented in Figure 5.8, exogenous constructs destination source credibility, destination image and medical tourism service quality have a no-single headed arrow pointing toward them. A necessary assumption of SEM

is that the exogenous constructs are assumed to be correlated. It is because correlations between each pair of exogenous constructs must be estimated, even though no correlations are hypothesised (Hair et al. 2010; Kline 2005).

Table 5.12: Testing Hypotheses Using Standardized Estimates (Hypothesized Model)

Hypothesized path	Standardised estimate	z-value	Supported
H_1: DSCR→ PVAL	**.324**	**4.345*** **	**supported**
H2: DSCR→ DATT	**.386**	**4.40*** **	**supported**
H4: DIMG→ PVAL	**.126**	**9.097*** **	**supported**
H5: DIMG→ DATT	**.249**	**9. 98*** **	**supported**
H7: MTSQ→ PVAL	**.237**	**8.449*** **	**supported**
H8: MTSQ→ DATT	**.204**	**7.467*** **	**supported**
H10: PVAL→ DBLY	**.180**	**7.202*** **	**supported**
H11: DATT→BLOY	**.145**	**5.660*** **	**supported**
DSCR→ BLOY	**.423**	**5.335*** **	**supported**
DIMG→ BLOY	**.251**	**7.047*** **	**supported**
MTSQ→ DATT	**.367**	**6.447*** **	**supported**
Indirect effect			
	DBLY<---PVAL<---MTSQ	**.041*** **	**supported**
	DBLY<---DATT<---MTSQ	**.031*** **	**supported**
	DBLY<---PVAL<---DIMG	**.022*** **	**supported**
	DBLY<---DATT<---DIMG	**.037*** **	**supported**
	DBLY<--DATT<---DSCR	**.007 ** **	**supported**
	DBLY<--PVAL<---DSCR	**.013** **	**supported**

DSCR: Destination Source Credibility, DIMG: Destination Image, MTSQ: Medical Tourism Service Quality, DATT: Destination Attachment, PVAL: Perceived Value, DBLY: Destination Brand Loyalty,

χ^2/df (379.722/231) = 1.644; GFI = .927; AGFI = .905; NFI = .962; CFI = .985; RMR = .031; RMSEA = .040.
Note: ***p < .001 and they were significant at -value >1.96. A regression weight was fixed at 1.

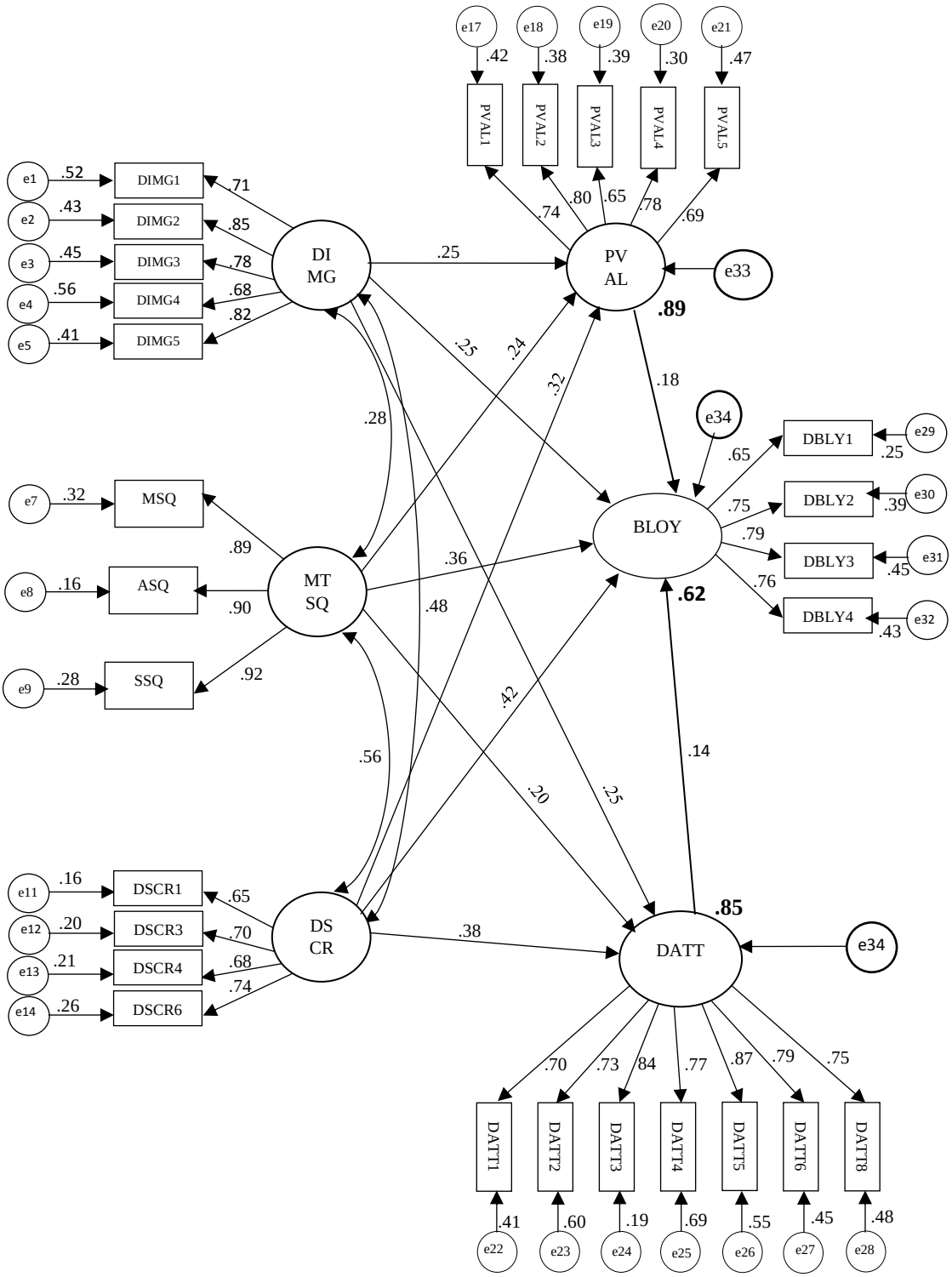


Figure 5.8: Hypothesised Structural Model

Endogenous constructs (relationships perceived values, destination attachment and loyalty) have at least one single-headed arrow leading to them. Straight arrows (or single-headed arrow) indicate causal relationships or paths, while the absence of arrows linking constructs implies that no causal relationship has been hypothesised. The error terms (e) represent random error due to the measurement of the constructs they indicate. The parameter (z) represents the residual errors in the structural model resulting from random error and systematic influences, which have not been explicitly modelled.

The results presented in Table 5.12 on testing the hypothesised model indicate that the hypotheses H1, H2, H3, H4, H5, H6, H7, H8 were statistically significant and in the hypothesised direction. The standardized estimates for these hypotheses were all significant (ß =.324, .386, .126, .249, .237, .204, .180, .145, respectively). Thus, these hypotheses were supported by the standardised estimates. The indices for goodness-of-fit demonstrate that this model fits the data adequately, even though chi-square was significant (χ^2/df (379.722/231) = 1.644; GFI = .927; AGFI = .905; NFI = .962; CFI = .985; RMR = .031; RMSEA = .040). The model, however, also demonstrates that all the eight paths were statistically significant (P<0.05). Figure 5.8 summarises the results obtained for each hypothesised path. The structural model was therefore accepted as the final model. On a theoretical basis, the final model is consistent with previous studies in destination branding, which have only examined the impact of destination source credibility, medical tourism service quality, perceived value, destination attachment and brand loyalty (Section 2.3.3).

5.9 RESULTS OF TESTING THE HYPOTHESES

However, the researcher in this study has made earnest attempt to scrupulously examine nine hypothesised relationship with the topic medical tourism branding in India (Refer Table 5.10). The implications of these results have been further discussed in Chapter Six.

5.9.1 Destination Source Credibility and Perceived Value

The relationship between the exogenous variables (destination source credibility) and endogenous variable (perceived value) in relation to the hypothesis H1 as shown earlier stood explicitly explained. As outlined in Table 5.12, the hypothesized relationships

were found to be significant (ß = .324, z-value = 4.345). It adequately supported the hypothesis representing the relationship between in the destination source credibility and perceived value (H1).

5.9.2 Destination Source Credibility and Destination Attachment

The hypothesis H2 explains the relationship between Destination source credibility as an exogenous variable and Destination attachment as an endogenous variable. Results in Table 5.12 indicate that the hypothesis is statistically significant. The paths from Destination source credibility to Destination attachment (H2) was significant (ß = .386, z-value = 4.40). Thus, the hypothesis stood supported.

5.9.3 Destination Image and Perceived Value

The hypothesis H3 explained the relationship between Destination Image as exogenous variable Perceived Value as an endogenous variable. Results in Table 5.12 indicate that the hypothesis is statistically significant. The paths from Destination Image to Perceived Value (H2) was significant (ß = .126, z-value = 9.097). Thus, the hypothesis gets adequately supported.

5.9.4 Destination Image and Destination Attachment

Hypothesis H4 represents the relationship between Destination Image (exogenous variables) and Destination attachment (endogenous variable). According to the results presented in Table 5.12, it has been found that this hypothesis was statistically significant (ß = .249, z-value = 9.98), and hence acceptable safely.

5.9.5 Medical Tourism Service Quality and Perceived Value

The hypothesis H5 represents the relationship between Medical tourism service quality (exogenous variables) and Perceived Value (endogenous variable). This hypothesised relationship was found to be significant (ß = .237, z-value = 8.44) and it supports this hypothesis.

5.9.6 Medical Tourism Service Quality and Destination Attachment

As discussed earlier, the hypothesis H6 explains the relationship between the exogenous variables (Medical tourism service quality) and endogenous variable

(Destination attachment). As outlined in Table 5.12, the hypothesized relationships were found to be significant (ß = .204, z-value = 7.46). Thus, the hypothesis representing the relationship between Medical tourism service quality and Destination attachment gets logical supported.

5.9.7 Perceived Value and Destination Brand Loyalty

Hypothesis H7 represents the relationship between the two endogenous variables, Perceived Value and Brand Loyalty. According to the results presented in Table 5.12, it has been found that this hypothesis was statistically significant (ß = .180, z-value = 7.20), and is an acceptable level.

5.9.8 Destination Attachment and Destination Brand Loyalty

The hypothesis represents the relationship between Destination attachment and Brand Loyalty (H8). This hypothesised relationship was found to be significant (ß = .14, z-value = 5.66) which supports the hypothesis.

5.9.9 The mediating effect of Perceived Value and Destination Attachment

Subsequently, the indirect impact of study variables was examined. The results revealed that destination image and perceived value significantly and indirectly supported brand loyalty (DBLY<---PVAL<---DIMG = .022***) as Indicated in Table 5.2. The destination image and destination attachment significantly and indirectly affected brand loyalty (DBLY<---DATT<---DIMG =.037***). The results also revealed that medical tourism service quality and perceived value significantly and indirectly supported brand loyalty (DBLY<---PVAL<---MTSQ =.041***). The medical tourism service quality significantly and indirectly supported brand loyalty (DBLY<---DATT<---MTSQ =-.031***). Results revealed that destination source credibility and perceived value significantly and indirectly supported brand loyalty (DBLY<---PVAL<---DSCR=.013***). The destination source credibility significantly and indirectly supported brand loyalty (DBLY<---DATT<---DSCR =-.007***).

5.10 TEST FOR METRIC INVARIANCE

A test for metric invariance with a series of modelling comparisons was conducted to test the moderating impact of perceived price reasonableness. Based on Steenkamp and

Baumgartner (1998) suggestions, both measurement and structural invariance models were also evaluated. To evaluate measurement invariance, a non-restricted model was initially generated after separating respondents into high (456 cases) and low (483 cases) groups of perceived price reasonableness, employing a K-means cluster analysis. Results showed that this freely-estimated model had an excellent fit to the data (χ^2 =498.451, df = 265, p < .001, RMSEA = .041, CFI = .955, NFI = .899). This model was compared to the full-metric invariance model in which all factor loadings were constrained to be equivalent across groups (χ^2 = 595.451, df = 285, p < .001, RMSEA =.054, CFI = .948, NFI = .896). As shown in Table 5.13, the resulting insignificant invariance model ($\Delta\chi^2$ (12) = 18.07, p > .01) supported full-metric invariance for the high and low groups of perceived price reasonableness. Accordingly, this full-metric invariance model adopted for subsequent analysis.

5.11 RESULTS OF INVARIANCE TEST

A baseline model rooted in the full-metric invariance model was generated by adding the proposed links among study variables in both groups. Results indicated that the baseline model satisfactorily fitted the data (χ^2 = 628.714, df = 298, p < .001, RMSEA = .054, CFI = .972, NFI = .883). Consequently, this model was compared with a series of nested models in which a particular path was constrained to be equal between high and low groups. In line with the hypothesis connected to this research study, these modeling comparisons showed that the links from destination image to perceived value ($\Delta\chi^2$ (1) = 6.224, p < .01), from destination image to destination attachment ($\Delta\chi^2$ (1) = 5.043, p < .01), from medical tourism service quality to perceived value ($\Delta\chi^2$ (1) = 4.624, p < .02), from medical tourism service quality to destination attachment ($\Delta\chi^2$ (1) = 11.021, p < .01), and perceived value to brand loyalty ($\Delta\chi^2$ (1) = 4.624, p < .05), from destination attachment to brand loyalty were ($\Delta\chi^2$ (1) = 8.513, p < .01) were significantly different between groups.

These results supported Hypotheses 9a, 9b, 9c, 9d, 9g and 9h. However, there were no significant differences on the paths from destination source credibility to perceived value ($\Delta\chi^2$ (1) = .046, p > .05), and from destination source credibility to destination attachment ($\Delta\chi^2$ (1) = .764, p > .05). Hence, Hypotheses 9e and 9f had no supporting base. The finding from the structural invariance test presented in Figure 5.9, Table 5.9.

Table 5.9

Invariance Tests for the Measurement and Structural Models.

Groups			Models	χ2	df	RMSEA	CFI	NFI	Δχ2	Full-metric invariance
High and low groups for perceived price reasonableness			Non-restricted model	498.451	265	.041	.955	.899	Δχ2 (12) = 18.07	Supported
			Full-metric invariance	598.451	285	.054	.948	.896	p>.01 (insignificant)	
paths	High		Low		Baseline model (Freely estimated)			Nested model (Constrained to be equal)		
	Coefficients	t-values	Coefficients	t-values						
DIMG→ PVAL	.525	5.235**	.354	2.674**	χ2 (298) =628.714			χ2 (299) =639.445		
DIMG→ DATT	.355	2.455**	.245	2.954**	χ2 (298) =628.714			χ2 (299) =635.658		
MTSQ→ PVAL	.745	9.731**	.601	5.654**	χ2 (298) =628.714			χ2 (299) =637.789		
MTSQ→ DATT	.784	9.637**	.645	6.958**	χ2 (298) =628.714			χ2 (299) =636.274		
DSCR→ PVAL	.525	5.754**	.112	1.685	χ2 (298) =628.714			χ2 (299) =629.171		
DSCR→DATT	.643	6.954**	.099	3.746	χ2 (298) =628.714			χ2 (299) =628.953		
PVAL→ DBLY	.327	2.262**	.185	1.458**	χ2 (298) =628.714			χ2 (299) =634.251		
DATT→ DBLY	.583	5.624**	.322	2.847**	χ2 (298) =628.714			χ2 (299) =638.753		

Note 1. DIMG- Destination Image, MTSQ- Medical tourism service quality, DSCR- Destination source credibility, PVAL- Perceived Value, DATT- Destination attachment, DBLY- Brand Loyalty

Note 2. Other goodness-of-fit indices of the baseline model for two groups: RMSEA = .054; CFI = .972; NFI = .883.

**p < .01.

Chi-square difference test:

a Δχ2 (1) = 6.224, p < .01 (significant; H9a - supported).

b Δχ2 (1) = 5.422, p > .01 (significant; H9b - supported).

c Δχ2 (1) = 4.624, p < .05 (significant; H9c - supported).

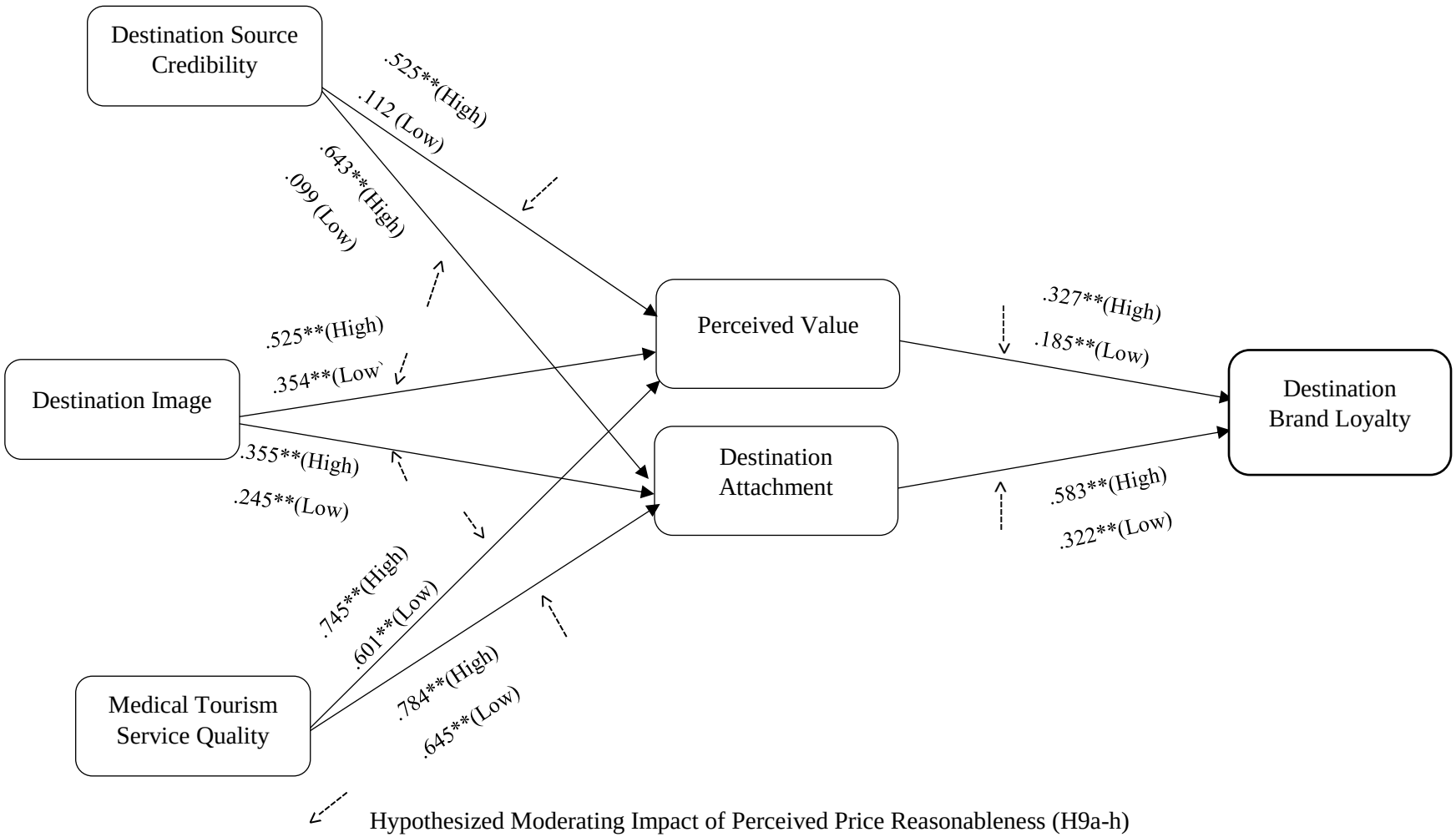
d Δχ2 (1) = 11.021, p > .01 (significant; H9d - supported).

e Δχ2 (1) = .046, p < .05 (insignificant; H9e - not supported).

f Δχ2 (1) = .764, p < .05 (insignificant; H9f – not supported).

g Δχ2 (1) = 4 .624, p > .05 (insignificant; H9g - supported).

h Δχ2 (1) = 8.513, p < .01 (significant; H9h - supported).



**p<.01, Goodness of fit statistics: $\chi 2$= 628.714, (df= 298, p<.001, RMSEA = .054 CFI = .972; NFI = .883.

Figure 5.9. Results of The Structural Invariance Model

5.12 SUMMARY

The first part of data analysis in this thesis has been the editing of data from collected questionnaires and the coding of question items. Data screening was then performed prior to conducting SEM, as the latter is susceptible to missing data, normality, and sample size. Following this, the number of respondents was analysed. Respondents who met the criterion of medical tourist to hospitals were 1025, representing the final sample of 71.93%. Demographic characteristics of this sample have been described.

The second part of data analysis is the use of SEM, which was conducted in two stages: the measurement model and the structural model. In the first stage, the fit of each measurement model was assessed by using a CFA of the constructs of interest to make sure that each one was unidimensional. At this stage the assessment of the measurement model was made with reference to the following pattern of results: (1) indicators specified to measure a proposed underlying factor all have relatively high standardized loadings (i.e., >.50) on that factor; (2) estimated correlations between the factors were not higher than .85; and (3) the overall goodness-of-fit indices suggest acceptance of the model. These assessments have also been undertaken in addition to examining normalised residual and modification indices.

Accordingly, initial results indicated that the measurement model of this thesis provided an adequate fit to the data, and all indicators were highly loaded on their specified factors. Each factor construct was then tested for reliability and validity. As regards to reliability, Cronbach alpha and CR were examined jointly with AVE. Results obtained indicated that all constructs were reliable. Also, in order to confirm the validity for each construct, convergent, construct, and discriminant validity was also assessed. Substantial evidence was found for considering the constructs in this thesis as valid and adequate for use in the next stage (structural model) to test the hypotheses.

The hypothesised structural model to be tested was specified by including the constructs after validation in the measurement model. The hypothesised model (original structural model) was tested in the second stage, including nine paths representing the hypotheses

(H1, H2. H3, H4, H5, H6, H7, and H8). All the eight hypotheses were found statistically significant.

While invariance test results did not support the hypothesised (H9) moderating impact of price reasonableness on the link between destination source credibility and the perceived value, the path was interestingly significant only in the high group (high group: .525, $p > .01$ vs low group: .112, $p > .05$). Similarly, although the path from destination source credibility to destination attachment differed significantly across the high and low groups, the link was not significant in the low group (high group: .643, $p > .01$ low group:.099, $p > .05$). The other hypothesis (9a, 9b, 9c, 9d, 9g and 9h), support the hypothesised moderating impact of price reasonableness

The next chapter discusses the above results in detail in order to answer the research questions outlined in Chapter One. Further, it draws the implications for both practice and theory, discusses the limitations of this thesis, describes the directions for further research, and identifies the conclusions.

CHAPTER - 6

DISCUSSION AND CONCLUSIONS

CHAPTER 6

DISCUSSION AND CONCLUSION

6.1 INTRODUCTION

In continuation of the hypothesis examined in the third chapter, the fifth chapter further scrutinised the results clearing the ways for final interpretations to be made in this concluding chapter highlighting the aims and objectives of this study (see Section 1.3) by answering the following six fundamental research questions formulated in Chapter One. These are (1) How significant is the influence of destination source credibility, destination image, medical tourism service quality on customer perceived value and destination attachment for medical tourist of Indian hospitals? (2) Do perceived value and destination attachment subscribe as important factors in determining the depth of loyalty that the medical tourists owe to the service provider at hospitals? Moreover, (3) Does customer's perceived price reasonableness of medical tourism influence the study constructs?

This chapter is broadly divided into thirteen sections. Each of the subsequent sections (6.2 to 6.13) deals with the issues as reflected here-in-below: -

- Section 6.2 summarises the results obtained from testing the hypotheses.
- Section 6.3 explains the influence of destination source credibility on perceived value and destination attachment.
- Section 6.4 focuses on the effect of destination image on perceived value and destination attachment.
- Section 6.5 deliberates how medical tourism service quality inspired on perceived value and destination attachment.
- Section 6.6 establishes the impact of perceived value on loyalty.
- Section 6.7 subscribes the impact of destination attachment on loyalty

- Section 6.8 explains the moderating influence of perceived price reasonableness on study constructs.
- Section 6.9 ponderes over the mediating influence of perceived value and destination attachment.
- Section 6.10 relates to the theoretical and managerial implications of the study.
- Section 6.11 here, the limitations of this study is put forth.
- Section 6.12 focuses on directions for further research.
- Section 6.13 arrives at conclusions based on discussion of the research findings.

6.2 SUMMARY OF THE RESULTS

The thesis developed and empirically tested a model that leads to a better understanding of the relationships between service providers and medical tourist in various hospitals. In order to answer the research questions, this model extends destination branding research by investigating the effect of destination source credibility, destination image, medical tourism service quality on customer perceived value, and destination attachment.

Further, it examines the influence of perceived value and destination attachment on brand loyalty, and finally, the moderating influence of perceived price reasonableness on study constructs. As discussed in Chapter Two, the underlying constructs were used to examine the proposed theoretical model conceptualised following a literature review. Reliable and valid measures were used to measure these constructs based on the model developed in pursuance of the literature review.

The results of the hypothesised relationships are in concurrence with the theoretical model proposed in this study. In particular, the results suggest that perceived value and destination attachment are positively influenced by destination image, destination source credibility, and medical tourism service quality. Also, it has been found that the construct of perceived value and destination attachment is an important determinant factor of brand loyalty. These results demonstrate that in eliciting customer loyalty, it is not only necessary for service providers to develop the value of relationships with the customers, but also to consider

customers attachment towards the place. The results are discussed in more details in the following sections.

6.3 THE CONSEQUENCES OF DESTINATION SOURCE CREDIBILITY

The results of testing the hypotheses are described here for which extensive study for ascertaining the relationship between destination source credibility as core point and perceived value and destination attachment as two different linkages to answer the first research question was necessarily needed.

Q1: How does destination source credibility influence medical tourist's perceived value and destination attachment?

6.3.1 Destination Source Credibility and Perceived Value

In the course of designing the model, the researcher hypothesised that the development of destination source credibility influences the perceived value. Therefore, hypothesis (H1) was earmarked to represent the influence of destination source credibility in relation to perceived value.

The study found that Brand source credibility is an essential aspect of medical tourism since trustworthiness and credibility of the brand are essential components. Conceptually, the empirical testing of these relationships have mostly been ignored, and hence this study may be disappointing on evidence for reconfirmation. These findings suggest that medical tourists possibly rely more on credible source information, corporate hospital credibility, country credibility while selecting medical tourism destination. It will reduce the cost of information-gathering and information-processing and will reduce perceived risk. These results corroborate with (Erdem and Swait 1998; Guido, Pino, and Frangipane 2011; Metzger et al. 2003; Veasna, Wu, and Huang 2013).

The results of this study are in harmony with only a few empirical studies. For example, Prayag and Ryan 2012; Veasna et al. 2013 reported that destination source credibility had a positive effect on international tourists' destination attachment, and this has also been confirmed by domestic tourists visiting a cultural site in Taiwan (Lin et al. 2007). Further,

the mediating effect of perceived value between destination source credibility and brand loyalty stands confirmed through this study which is in line with a few empirical studies (e.g., Fleury-Bahi et al., 2008; Lee et al., 2007; Prayag & Ryan, 2011; Yuksel et al., 2010). The current findings validate the literature on brand credibility and perceived value. Furthermore, it can be deduced that the relationship between destination source credibility and brand loyalty can be entirely mediated by perceived value. The findings of this study remain unique by endorsing these relationships which until now have mostly been ignored.

6.3.2 Destination Source Credibility and Destination Attachment

One of the objectives of this study is to determine whether Destination source credibility positively affects destination attachment. A reading into past literature brings the obviousness in focus and identifies an absolute lack of knowledge of this linkage which could be narrowed down to some extent by this study. Therefore, H2 was designed to measure the relationship between Destination source credibility and destination attachment.

As in the case of first hypothesised relationship (H1) between the destination source credibility and perceived value discussed in section (6.3.1), the results of this study demonstrate that destination source credibility is influenced by perceived value. In this study, the literature on brand credibility strongly advocated and finally confirmed the fitness of relationship between perceived value and attachment. Therefore, the researcher has no reservation to suggest application of this finding in an integrated research framework in the context of tourism branding and destination attachment. It is suggested that brand signal theory can be applied for developing a theoretical model of destination source credibility and destination branding which will establish a positive and strong destination concept to attract potential tourists to visit or revisit a destination. Intuitively, if a tourist has a more emotional attachment to a destination, he or she should derive more attachment from the destination experience all by themselves.

In addition, the relationship between destination source credibility and brand loyalty can be fully mediated by destination attachment. Furthermore, destination source credibility,

attachment, and perceived value are considered to be critical antecedents of destination loyalty. The results of this study are in agreement with previous researchers (Kamalipour, Yeganeh, and Alalhesabi 2012; Kyle, Graefe, and Manning 2005), who found support for the link between credibility and attachment. This study took a pioneering step to provide empirical insight into the role of credibility (trustworthiness and expertise) as being an important consequence of destination attachment. Credible tourist information has been shown to have an essential influence on the selection of destinations (Molina & Esteban, 2006).

In line with the objective as outlined in section 1.3, it was inevitable to find an answer to the above research questions for which the researcher had to expand his study on aspects of brand loyalty to show that both perceived value and destination attachment closely depend upon the destination source credibility. Accordingly, this study makes a valuable contribution to destination branding theory by demonstrating a positive linkage between credibility, perceived value and attachment.

6.4 THE CONSEQUENCES OF DESTINATION IMAGE

This section explains the results of testing the hypotheses related to the linkage between destination image and perceived value, and between destination image and destination attachment. These two linkages aimed to answer the second research question.

Q2: What are the role of destination image in medical tourist's perceived value and destination attachment?

6.4.1 Destination Image and Perceived Value

The researcher has made use of every resource to examine the positive influence of destination image and perceived value. A study on the relevant literature revealed that only limited efforts were taken in the past to establish the relationship between the destination image and perceived value. Hence, the researcher here ventured to represent both the perceived value construct (combined with perceived risk and perceived benefits) and destination image in one single model, which has provided us with a deeper understanding

of the relationship between the customers and service providers (Refer to section 3.4) than that arrived at through previous studies. For this purpose, hypothesis H3 was found to be an idle tool.

Consistent with expectations, this study provides strong support to the notion that destination image directly affects perceived value (H3) and leads to loyalty, while only perceived value directly affects loyalty. Chen & Tsai (2007) found a relationship between destination image and perceived value which has been confirmed by this study. However, the current study shows that destination image indirectly influences loyalty through perceived value. This finding is in line with the arguments advanced the in previous studies (Echtner and Ritchie 2003; Hankinson 2005; Költringer and Dickinger 2015; Lee 2009, 2009; Prayag and Ryan 2012). It also has a positive impact on the loyalty of the medical tourists' perceived value to the service provider.

6.4.2 Destination Image and Destination Attachment

The researcher resorted to investigating the influence of destination image to destination attachment; he had framed a hypothesis to ascertain the relationship between destination image and destination attachment. Therefore, hypothesis (H4) was formulated to examine this relationship.

As hypothesised, the results discussed in section 5.9 support the theory that destination image influences customers' destination attachment (H4). That is, medical tourists are more likely to get attracted towards Indian medical tourism, based on their assessment of Indian hospital industry and India. In short, what is needed to promote medical tourism in India is to create a positive environment consistent with destination image and destination attachment.

This theory supports the previous research in which destination image was found to be crucial in predicting destination attachment. The results of this study are also in line with a good number of past empirical studies. Prayag and Ryan (2011) reported that destination image had a positive effect on international tourists' destination attachment to Mauritius

Island, and this has also been confirmed among domestic tourists visiting a cultural site in Taiwan (Hou, Lin, & Morais, 2005).

This study provides strong evidence to support the notion that destination image directly affects destination attachment (H4) and leads to loyalty, while only perceived value directly affects loyalty. Since previous studies have mostly ignored these relationships, the findings of this study are unique. It can be applied to an integrated research framework on tourism branding and in destination context.

6.5 THE CONSEQUENCES OF MEDICAL TOURISM SERVICE QUALITY

This section provides enough space to explain the results of testing the hypotheses related to the linkage between medical tourism service quality and perceived value and also between medical tourism service quality and destination attachment. These two linkages aimed to answer the second research question.

Q3: What is the role of Medical tourism service quality in medical tourist's perceived value and destination attachment?

6.5.1 Medical Tourism Service Quality and Perceived Value

In the proposed model, this study hypothesized that the development of Medical tourism service quality influences Perceived value. Therefore, hypothesis (H5) was proposed to represent the influence of Medical tourism service quality on Perceived value.

Consistent with the expectations, the results of this study demonstrated that the medical tourism service quality construct is an important variable in predicting perceived value, which evidently supported the hypothesis (H5). To be precise, these results demonstrate that service quality of Indian hospitals is the major predictors of medical tourist's perceived value. This phenomenon has a direct influence on medical tourists' behavioural intentions

The findings prove that medical tourists are value-oriented customers. Perception of value contributes more towards loyalty with the service provider, in consonance with the service quality they received. Similar relationships between service quality, perceived value and

revisit intentions have also been found in other tourism sectors, such as airlines (Chen, 2008) and hotels (Hu et al.,2009). What is learned from this study is that it is imperative on the part of the medical service providers to facilitate high-quality service to that customer aiming to build a strong brand, essentially securing high consumer loyalty.

6.5.2 Medical Tourism Service Quality and Destination Attachment

One of the objectives of this study is to determine whether medical tourism service quality will positively have any bearing in as much as the attachment towards the destination (place) of the service providers is concerned. This study identifies that there is an absolute dearth of previous knowledge about this linkage in any literature and therefore, the present investigation will, undoubtedly, provide a meaningful contribution to the existing literature. Hypothesis (H6) was posited to represent the relationship between medical tourism service quality and destination attachment, keeping an eye on these aspects.

As in the case of Hypothesized relationships between the Medical tourism service quality and destination attachment discussed above, the results of this study demonstrated that customer attachment towards a place is definitely influenced by Medical tourism service quality. The results provided enough evidence to support H6. Every medical tourist would expect a certain level of medical service quality while selecting a destination. This finding is in line with the conclusions arrived at in the past studies which postulate that medical tourism service quality is a dominant psychological driver of destination attachment (Lee & Shen, 2013; Tsai, 2012). Tourist loyalty mostly depends on the service quality linked to destination attachment. Researchers such as Lovelock, Patterson, and Walker (1998) suggest that service quality is, at least partly, a nonexperience-dependent perception. The fact that service quality can be formed before tourists experience a destination attachment suggests that it only serves as an incentive for visiting. Loyalty, however, is only established after tourists have their experience and form their opinion of a destination. The results of this study show that service quality is just one of the way to create destination attachment. Future study can examine other factors such as destination personality (Yeh,

Liu & Yeh, 2010), the uniqueness of destination (Davenport & Anderson, 2005; Twigger-Ross & Uzzell, 1996), emotions (Williams & Vaske, 2003), and so on.

6.6 THE CONSEQUENCES OF PERCEIVED VALUE

This section explains the results of testing the hypotheses related to the relationships between perceived value and brand loyalty. The linkage has aimed to answer the first research question.

Q4: What is the effect of medical tourist's perceived value on brand loyalty?

6.6.1 Perceived Value and Destination Brand Loyalty

The relationships between the perceived value and brand loyalty have been elaborately discussed earlier in this thesis. It has helped to prove that the influence of brand loyalty and perceived value. Thus, these results support H7.

Over the years, there are well-recognized researchers in marketing literature whose study confirms the link between the constructs of perceived value and loyalty (Guido et al. 2011; Hallem and Barth 2011; Prajitmutita, Perényi, and Prentice 2016; Snoj, Pisnik Korda, and Mumel 2004; Sweeney and Soutar 2001). The perceived value-loyalty link is also consistent with Reichheld's (Reichheld and Sasser n.d.) research on loyalty. McDougall and Levesque (2000) suggested that the influence of perceived value on loyalty needs in-depth empirical research. In the research about the online selling of retail goods conducted by the two websites- books.com and flights.com, a strong and positive association between perceived value and loyalty were established (Milliman et al. 1999). Their study also found that service quality exerts indirect influence on loyalty, while perceived value exhibits both direct and indirect associations with loyalty.

Thus, the role of perceived value needs further attention, more specifically in medical service sectors aiming to make sure that customers feel satisfied with the treatment and stay during their visit and leave the hospitals with a sense of worthiness in their decision making. This would encourage customers to re-purchase their services.

6.7 THE CONSEQUENCES OF DESTINATION ATTACHMENT

The result of testing the hypothesis related to the relationship between destination attachment and brand loyalty is intended to be conveyed through this section. The linkage has aimed to answer the first research question.

Q5: What is the effect of destination attachment on brand loyalty?

6.7.1 Destination attachment and Destination brand loyalty

In the model designed for this study, it was hypothesised that destination attachment influences brand loyalty. Therefore, the hypothesis (H8) was proposed, to represent the influence of destination attachment and brand loyalty.

As discussed in section 5.9, the test results based on the hypothesis (H8) makes it clear that the destination attachment influences brand loyalty. The study made by this researcher in the empirical context has proved that brand loyalty arises when buyers first develop a feeling of attachment to the destination. These findings are in total agreement with the results of the previous research studies (Kressmann et al., 2006; Matzler et al., 2011). Hence, this study makes a significant contribution to the results achieved by the previous researchers.

Creating an emotional bond between medical tourist and service providers is an important marketing challenge for any firm because strong brand-customer bonds are assumed to generate medical tourism brand loyalty. In service marketing, the service provider's ability to create emotional bonds between the service brand and their medical tourists have been suggested to be the key challenges that marketers have to face in maintaining long-term customer relationships (Han & Sung, 2008). In the same vein, marketers encourage close consumer service relationships because such relationships are believed to positively affect brand loyalty (Kressmann et al., 2006; Matzler et al., 2011).

6.8 THE MODERATING EFFECT OF PERCEIVED PRICE REASONABLENESS

The results of testing the hypothesis in the context of moderating relationships between perceived price reasonableness and study constructs are intended to be broadly discussed in this section. The linkage is aimed to answer the first research question.

Q6: What is the moderating impact of perceived price reasonableness on proposed associations within the model?

The moderating relationships between perceived price reasonableness in relation to other designed constructs in the model such as destination image and perceived value, destination image and destination attachment, medical tourism service quality and perceived value, medical tourism service quality and destination attachment, perceived value and brand loyalty, destination attachment and brand loyalty are of paramount importance.

As in the hypothesis, the moderating relationships between perceived price reasonableness on proposed associations within the model, particularly the perceived price reasonableness between destination image and perceived value, destination image and destination attachment, medical tourism service quality and perceived value, medical tourism service quality and destination attachment, perceived value and brand loyalty, destination attachment and brand loyalty are of paramount importance.

The present study successfully designed the proposed model by including medical travellers' perceptions of price reasonableness and identification of the fundamental moderating impact of this variable. In general, our proposition that the linkages within the proposed conceptual model would be moderated by perceived price reasonableness was supported. As presented in Figure 5.9 and Table 5.13, relationships were significantly stronger in the high group than in the low group concerning price reasonableness. The results imply that (1) at similar levels of medical quality, patient customers with high perceptions of price appropriateness are more likely to be perceived or attached once these customers attain an adequate level of perceived value and destination attachment; (2) they are likely to have a stronger level of brand loyalty with the medical professionals or

employees at the clinic; (4) and they will be more likely to return to the clinic and destination country. Those at a similar level of destination credibility are more likely to build an active perceived value than customers with a relatively lower level of price reasonableness. Moreover, those at a similar level of destination credibility are more likely to build an active destination attachment than customers with a relatively lower level of price reasonableness.

As such drawing parallels to the results of previous research (Calisir, Basak, and Calisir 2016; Chua et al. 2015; Han and Hyun 2015) will be of no avail. However, no effort was made during the previous studies to test the moderating role of perceived price reasonableness in medical tourism destination branding. Based on the notion that each medical tourist has different perceived price reasonableness level (Han et al., 2001), this study highlighted that medical tourists' response to treatment experience would vary depending on their price reasonableness level.

6.9 THE MEDIATING EFFECT OF PERCEIVED VALUE AND DESTINATION ATTACHMENT

Moving a little farther from the targeted sphere of this study, the researcher thought it fit and proper to examine how far the mediating effect of perceived value and destination attachment will have an impact on brand loyalty. In the theoretical model medical travellers' perceived value and destination attachment components where found to have a significant mediating role. To be more precise, perceived value and destination attachment play an important mediating role between destination source credibility, destination image, medical tourism service quality and brand loyalty. This finding is conformity with the results from the previous studies (Han & Kim, 2009; Morgan & Hunt,1994; Oliver,1993). Thus, it is indirectly for medical tourism researchers to understand the mediating nature of perceived value and destination attachment when developing a model for theory.

6.10 IMPLICATIONS

This study focused on destination branding in the medical tourism sector in the context of harmonious relationships between the service providers and the customers. Therefore, the findings of this study establish critical theoretical implications for managing and improving the effectiveness of destination branding in these contexts.

6.10.1 Theoretical Implications

Despite the phenomenal growth in medical tourism, little is known about the role of medical tourism service quality, destination source credibility, destination image, perceived value and destination attachment in explaining international patient-travellers' loyalty. In the present study, special attention has been given while examining the depth of association amongst these constructs (medical tourism service quality, destination source credibility, destination image, perceived value, destination attachment, brand loyalty and price reasonableness, more particularly the moderating role perceived price reasonableness and the relative importance among study variables, which shall have a positive impact in the formation of loyalty of the customers on the question of revisit to the destination hospital and country for medical care

Theoretically, attracting new customers through destination branding costs organisations more than what is required to keep steadily the loyalty of the existing customers. From the medical service perspective it has been the focus in this study, that the researchers in the past had erred in concluding that a small increase in the number of loyal medical tourists will result in substantial increase in profitability of the service providers (Bowen and Shoemaker, 1998; Tepeci, 1999; Kim and Cha, 2002). However, developing and sustaining loyalty is becoming increasingly challenging (Liang and Wang, 2005). Hence, the study has attempted to provide a medical tourism destination branding model that can be efficiently used in securing customer loyalty to medical service providers. Furthermore, this study has extended the research on destination image, medical tourism service quality and destination source credibility through investigating their influence on perceived value. This linkage reflects that the three constructs shown above enhance the perceived value of

medical tourists towards medical tourism destination. The results of this study, therefore, demonstrate that perceived value between customers and service providers can be achieved by improving medical tourism service quality, medical tourism destination image and also by providing credible information about what Indian medical tourism promises. Although the relationship between these three constructs and perceived value has been investigated in to in the previous occasion, evidence achieved through this study on its linkage within the framework of the medical tourism industry is the novelty of this study.

In the course of this study, the researcher was able to establish the relationships between medical tourism destination and the customers, while examining the influence of destination image, medical tourism service quality and destination source credibility on destination attachment. As a result of a detailed probe of customers, emotional attachment towards medical tourism destination variables like destination image, medical tourism service quality and destination source credibility was found to be crucial. It suggests that the inclusion of destination attachment as consequences of the destination image, medical tourism service quality and destination source credibility in the proposed model has made a significant contribution to the destination branding theory. Although the importance of destination attachment as a critical variable in the destination image, medical tourism service quality and destination service credibility had been widely acknowledged, these construct remained under focused in the past studies, the adverse effect of which is evidently clear through the present study.

The researcher in this study has made an earnest attempt to analyse the reasons behind the customers becoming loyal to medical firms by profusely contributing to the theory of destination branding and demonstrating that the construct of destination attachment is vital in determining the destination brand loyalty. Also, the results speak its self of the facts the perceived value and destination attachment will work well together in evoking customer loyalty towards destination branding. Although this linkage is not unusual, this study improves the literature further by investigating the two constructs in a single model.

Also, the highlight of the present study is a theoretical framework on medical travellers' perceived value and destination attachment components which were found to have a significant mediating role. In particular, destination attachment significantly mediated the impact of destination image, destination source credibility and medical tourism service quality on its outcome variables and perceived value significantly mediated the impact of destination image, destination source credibility and medical tourism service quality on its outcome variables; These findings are in conformity with the results of the previous studies (e.g., Han & Kim, 2009; Morgan & Hunt,1994; Oliver,1993). Medical tourism researchers should keep in mind the mediating nature of perceived value and destination attachment when developing a model or theory.

In the process of the present study, the researcher successfully loaded the proposed model with additional construct- medical travellers' perceptions of price reasonableness- to arrive at the level of major moderating impact of this variable. Although it cannot be said with certainty that this conceptual model is most reliable, it (the model) however, satisfactorily demonstrated how easily international medical travellers' loyalty could be formed. The variables in the present theoretical model have strong explanatory power to predict brand loyalty towards the Indian medical tourism destination (R^2 = .620). Our investigation brought to light the structural relationships amongst study variables that will provide marketers with valuable information for developing customer-retention strategies or strengthening existing strategies. It will help researchers gain a deeper understanding of overseas patient-travellers' decision formation for medical care.

The fact, that this study has provided a more accurate methodological process by which each of the underlying constructs has been defined tends to give many dividends to the researcher for perusing this research work with dedication. To make it various possible items were combined to measure each of the constructs. The assessments of reliabilities and validities of each construct were made through the laid down CFA procedures, and the results thereof were found to conform with the correspondence rules between both empirical and theoretical concepts (Bagozzi, 1984, Han, 1991). Therefore, combining these methodologies with the most systematically accurate measurement items of this study

provides a useful and reliable direction for future empirical research into destination branding.

6.10.2 Managerial Implications

The results of the current study may encourage medical tourism marketing managers to invest in marketing communications and advertisements that are culturally and emotionally appealing in a medium that enjoys credibility with the targeted medical tourists. However, according to Pike (2017), marketers' attempts to stimulate induced images about a destination cannot change people's minds, immediately. Therefore, "what is required then is to identify of those attributes that are important to travellers at the given destination, where its perceived value is higher than that of the similarly placed destinations. Such attributes are representative of strengths, which should be emphasised in marketing communications." (Pike, 2017 p. 128). Therefore, destination managers/ marketers can focus on the promotion of destination source credibility as an effective tool to attract the medical tourists to a tourism destination. The study results also got to suggest that both tourism and destination managers should provide more accurate electronic information about destinations so that the international medical tourists to plan their travel strategies to a given destination more efficiently.

The results also are of paramount importance for the service providers to contribute greatly to raise the level of its credibility and do everything possible to improve the image of the destination to tempt the medical tourists to opt for a given destination. The other areas where the service providers shall regularly focus are of image building, customer perceived value and loyalty level index. It will help to attract the previous visitors again. In the case of new visitors, the affordability is a useful measure to be adopted. In this modern era of development, service providers could easily rich out to consumers by using modern advertising techniques through the user-friendly websites and social media. It will prove to be fruitful, no matter a premium priced will have to be paid for it. Rather than adopting a haphazard occasional marketing campaign, the corner strategy communicating maximum

relevant information to the customers through a meaningful network of knowledge will prove to be an effective tool to attract the medical tourists.

Medical tourism service quality has to be the most critical variables requiring adequate attention on the part of the medical service chain. It could be ensured by employing efficient, dedicated and specialised physicians and supporting staff in the hospital. The price tag should also be reasonable and affordable. Overall, the medical care service shall be exemplary while the service cost will be tremendously low and below the price level of the similarly priced international service providers. The medical service provider can gain a positive word of mouth from the consumers when their comfort level, both regarding medical facilities and environmental niceties, is equitable or higher to the price they have paid. Since perceived value, destination attachment and brand loyalty are the most critical antecedents that will help to command the loyalty of the customers. Both the service providers as well as the designated country as a matter of economic policy aiming to attract tourists should widely communicate in depth and breadth of those values through websites and social media.

The outcome of the study revealed that (1) as compared to perceived value, the impact of destination source credibility on destination attachment and loyalty was less (2) the impact of destination image on place attachment and loyalty was greater than that of perceived value (3) the effect of medical tourism service quality on place attachment and loyalty was of lesser consequences (4) credible information about the destination and medical tourism service quality will enhance the perceived value of medical tourism in comparison to the place attachment (5) destination image will boost the level of place attachment towards medical tourism destination unlike the perceived value and (6) the medical tourism service quality, destination image and destination source credibility components are vital to tourists' decision formation. As repeatedly emphasised in numerous studies of marketing and consumer behaviour, efficiently dealing with this variable can be the key to successful customer retention for both the clinic and the destination country.

This study contributes in good measure to the insufficient literature available on medical travellers' price-related decision formation in the international medical tourism industry. Marketers at medical clinics and destination countries must recognise the intricacies in developing and improving customer image and hence employ novel ideas to ensure the loyalty of the existing customers and attract new tourists, whereby the service providers can maximise their revenues. Where a customer transacts business with a medical firm, the price reasonableness is likely to be decided by him/ her regarding the level of advantage (Ryu & Han, 2010). The more the benefits, the satisfactorily level of customers on perceived price reasonableness will also be known (Han & Kim, 2009). The other way to boost the image of the customers is to introduce various benefits like complimentary aesthetic services to non-aesthetic repeaters in the form of skincare evaluation, chemical peels for increasing skin glow, facial cleanses and also by providing gift vouchers for local restaurants, local souvenirs).

In addition, market segmentation is recommended. For instance, while a majority of patient customers from some developed countries prefer cheap; but proper medical care when choosing a medical-tourism destination (Crozier & Baylis, 2010), upper-class individuals from developing and developed countries travel abroad for high-quality and safe medical care. They seek posh star hotel facilities in clinics to avoid the nuisance of a stay in a crowded place and wasting their times due to traffic jams (Bernstein, 2012; Han, 2013). Comprehensive details about service facilities and pricing strategies aiming to target customers of these categories could be planned and facilitates to reach the messages to them through electronic media. This strategy, if employed, the success rate and the yield thereof will be tremendously high.

There is every reason for the service providers and government of India to be extremely happy by the findings arrived at with empirical evidence on the fact the trust and loyalty of the international tourists will rise to high magnitude, when they (tourists) peruse high price reasonableness which will depend upon the country’s ability to contain inflation. It will argument the income from tourism to both the service providers and the exchequer.

6.11 THESIS LIMITATIONS

It is a common phenomenon that a part of the thesis of a research project is kept apart to examine carefully its limitations (Dolen and Lemmink, 2004). While this study contributes to the body of destination branding literature, it has several limitations that need to be identified. These are discussed briefly in the succeeding paragraphs in the context of what had been stood in the way of arriving at a harmonious conclusion in every aspects of the research work such as sample size, constructs measure, analytical techniques (Structural Equation Modelling), to name a few.

It is not out of place to look into the theory established by Sheth and Partivayar (1995) and Arnold and Bianchi (2001) in that the customers by enlarging tend to view relationships from the context of the different cultural environment. Therefore, caution about generalising the results of this thesis might be taken, as they reflect the loyalty of medical tourists towards India.

The next problem had arisen owing to use of English language in scripting the questionnaire. It probably had led to some confusion in the minds of the tourists while expressing their opinion on account of the language barrier.

The scale used for measuring destination source credibility (DSC) needed to be manipulated by a specific credible source context (i.e., e-destination source credibility), which is designated by tourist agents or tourism/destination managers. This study treated DSC as a single factor, in line with the one adopted by Erdem and Swait (2004), notwithstanding the fact that another researcher Spry et al. (2011) used two sub-dimensions (i.e., trustworthiness and expertise). Thus, this study only validated the measurement scales of DSC as developed by Erdem and Swait (2004).

Admittedly, the affective component of destination image was not measured. It is left to the future researchers to meticulously measure linkage between destination source credibility, attachment, loyalty and other study constructs.

Finally, the researcher admits the fact that the proposed conceptual model was not designed to include all possible influences on international patient customers' loyalty. The scope was limited to incorporated variables in the proposed theoretical framework. While such variables, as expected, effectively accounted for total variance identifying additional constructs is considered to be crucial in the spectrum of international medical tourism concept. For instance, Ajzen (1991) and Ajzen and Fishbein (1980) in their rational choice models (i.e., the theory of reasoned action and the theory of planned behavior) indicated that volitional (i.e., attitudes and subjective norm) and non-volitional (i.e., perceived behavioral control) factors have important roles in explaining one's decision-making process or behavior. Integrating such constructs into the proposed model will further strengthen the proposed theoretical framework, providing more comprehensive explanations of intention formation.

6.12 DIRECTIONS FOR FURTHER RESEARCH

Although this thesis has developed a model that provides an effective destination branding program, several profitable areas for future research remain. For example, given that the results of this thesis are limited to Indian medical tourist’s perspectives, findings could be different when other cultural groups are integrated into. It suggests a need for more cross-cultural research to identify whether premium consumers behave in the same way, or there is something unique about Indian medical tourists. The works of Sheth and Partivayar (1995), and Arnold and Bianchi (2001) suggest that culture is an essential issue in consumer-business relationships. This suggestion is also important for global services sectors, which target a diverse range of customers. Furthermore, it would pave the way for an informative study which will help to judge the diverse situations in different scenario set up by the international medical service providers the differences between multinational medical service providers. De Wulf et al. (2001) argued that the degree of social exchange and the possibilities for interpersonal communications in retail settings is greater in smaller stores than bigger ones. If this argument is adapted in the context of medical tourism in the days to come it would establish as to whether customers in small hospital chains (i.e., 3-star) perceive more interpersonal relationships than they do in big hospital chains.

Future researchers can validate the mindset of tourists highly from nations all over the continents and judge how differently they conceive the relationships between destination source credibility, destination image and attachment in the background of their cultural settings (Baek et al., 2010).

Elaborate research works are needed for furthering the knowledge about the constructs used for this study by employing new techniques. The researchers can explore the role of destination source credibility in other service settings to see, if, indeed, the results are generalizable across other premium medical services. A comparative study can be undertaken to unearth the differences between premium and other services, as perceived value based on the purchasing power of the visitors is of paramount importance, the price being an integral part of decision making. No doubt, the derailment of perceived importance of destination image and medical tourism service quality will also have an adverse effect on the loyalty of the patients. Again, it is equally important for the future researchers to analyse the relative difference of influence on destination image and destination source credibility among the varying category of customers coming under the ambit of less loyalty and higher loyalty.

6.13 CONCLUSION

When the customers enjoy the benefits, which include low pricing policy, clean and healthy environment, destination branding theory and practice come to reality. Aiming customer loyalty towards service providers and the nation, it is imperative for the hosts to build the strong relationships with the guests. The tasks to be deployed to achieve this objective is an extremely difficult one. In a way, it could be said with certainty that this study will make a significant contribution to the destination branding literature by designing model that empirically investigates medical tourists' perspectives of their relationships with medical service providers. This single model provides a more in-depth understanding for the relationships between service providers and their customers by examining the association between destination image, destination source credibility, medical tourism service quality, perceived value, place attachment and loyalty. Although there could be much more reliable

constructs other than those incorporated in this model, constructs framed for this study successfully developed destination branding programme. This study has highlighted the importance of destination image, destination source credibility, medical tourism service quality by investigating their impact on perceived value and place attachment.

The past research on this topic had established a strong relationship between place attachment and loyalty; but this researcher has created an edge by enlarging the scope of destination branding literature by way of demonstrating the significant effects and relationships between place attachment and loyalty opening the doors for service managers to put optimum effort to develop a positive attachment to broaden the level of loyalty.

With due regard to the theory that marketing practitioners are keen to know the significant role of perceived value in the course of destination branding as put forward by Anderson and Kumar's (2006), the researcher here sincerely and unassumingly states that for the first time he could contribute immensely to the literature by bringing to light the invisible value of relationship between the perceived value (combining perceived cost and benefits) and loyalty. It corroborates the finding of the (i.e., Barnes, 1997; Liljander and Strandvik, 1997; Anderson and Kumar, 2006), which among other things state that customer perceived value (positive and negative) is crucial in shaping the relationships between the medical tourists and medical service providers. This work has provided a good measure of satisfaction to the researcher in that the probe to measure the perceived value of every construct embodied in the investigation process have vehemently and positively supported the hypothesis designed for the purpose, the result of which will be useful for both academics and medical tourism practitioners.

The perceived price reasonableness and study construct proposed have not only been found to be important in moderating the consequences of study constructs but also been served as essential determinants of customer loyalty. In this context, it has been found that when medical tourists conceive the reality of perceived price reasonableness based on the higher credibility of the country and service providers and prevalence of higher medical tourism service quality and experience positive destination image, the medical tourism in India is,

undoubtedly, bound to grow without metes and bounds, provided the fabric of loyalty is carefully knitted.

In conclusion, the researcher takes the liberty to declare that the laborious task undertaken for providing a practical and durable brand image, keeping the interest of the service providers and more importantly ensuring the systematic growth of medical tourism in India, which will give tremendous boost in the economy of the nation.

APPENDICES

APPENDICES

Appendix A

1. Cover Letter to Medical Tourists Participating in the Survey

Dear Sir/Madam

I am pursuing PhD at National Institute of Technology Karnataka, Surathkal, under the guidance of Dr. Sunil C D'Souza on the topic 'Destination Branding in Indian Medical Tourism –An Empirical Study'. The study aims to develop an integrated model of medical tourism destination branding in the context of medical tourists' perceptions of various hospitals. It is a significant study in that it will extend both destination branding and consumer behavior theory and practice.

On the following pages, you will be presented with a series of questions about your relationship with this Hospital (in India). Please note that the questions are on both sides of the paper. Your answers will, of course, remain entirely confidential. Please answer each question as honestly as you can, and note that there are no right or wrong answers. A quick response is generally the most useful. The questionnaire should not take you more than about 20 minutes to complete. The survey data will be used for analysis only, and the final overall results will be used for academic research purposes.

Once you have completed the questionnaire, please give it back to the front desk inside the envelope provided.

Thank you very much

With regards
Sudheer Muhammed KM
Research Scholar
National Institute of Technology Karnataka
Surathkal, Mangalore
Email: sudheerkkm@gmail.com

2. Invitation to Hospitals Requesting Participation in Final survey

Dear Sir / Madam

As part of my research for PhD programme at National Institute of Technology-Karnataka, Surathkal, titled "Medical Tourism: Demand, Supply and Opportunities", I am conducting a survey of medical tourists in India. This letter is to request permission from your hospital to allow me to conduct brief interviews/surveys with any willing medical tourist in your hospital.

Medical tourism has become a significant phenomenon in health care. By interviewing tourists who come to India for medical treatment, a better picture can be gained to what the thinking and reasons behind medical tourism are. As of today, there are very few scholarly publications that have been the direct result of interviewing medical tourists. This research will add to the nascent literature of medical tourism and will also give medical tourism more prominence in the academic world.

I have chosen various hospitals around India based on the information on the hospitals' website. I have chosen your hospital as one among my study samples because of the excellent quality of health care in your hospital and also your promotion of medical tourism. I would like to interview foreign patients informally for approximately 20 minutes per person. The survey has been planned under the scrutiny of my institute, and the questionnaire I will be using has been approved by the concerned faculty. Patients' participation in the survey is strictly voluntary, and I will interview a patient only if he/she gives me their permission to do so. No patient will be forced or convinced to take this interview. In my thesis write-up, I will only mention the names of the hospitals where I conduct my interviews for my study areas. My research has nothing to do with critiquing any facilities, etc. My only objective is to interview medical tourists to find out what their thinking is in order to make a decision to become a medical tourist.

I am also including a copy of the letter of approval from the Institution. A copy of the questionnaire to be used in the survey will be provided prior to it. I will strictly adhere to the format of questions listed. If you feel that any of my questions are inappropriate, I shall consider removing them from

the survey at your hospital. I shall also address any more questions/concerns you might have regarding the interviewing process.

Thank you very much for your time and consideration, and I hope that you will grant me permission to interview foreign patients at your hospital. Please do not hesitate to contact me if you have any questions whatsoever.

Yours faithfully

Sudheer Muhammed KM
Full Time Research Scholar
Department of HSSM, NITK, Surathkal
Srinivasanagar P.O Mangalore - 575025
Karnataka, India
Email: sudheerkkm@gmail.com

Appendix B

1. Questionnaire

Questionnaire # _____

Section III Perceptions of India and Medical Tourism in India

Please mark (✓) in the answer column for each statement that best indicate your reasons by using the scale below.

(1 – Strongly Disagree (SD), 2 – Disagree (D), 3 - Somewhat disagree (SWD), 4 - Neither agree or disagree (NA), 5 – Somewhat agree (SWA), 6-Agree (A), 7-Strongly agree (SA)

When it comes to medical treatment, the credibility of Indian medical tourism		1	2	3	4	5	6	7
1	Medical tourism in India delivers (or would deliver) what it promises							
2	Medical treatment claims from India are believable							
3	Indian medical tourism has a name you can trust							
4	Medical treatment in India reminds me of someone who's competent and knows what he/she is doing							
5	Hospitals in India doesn't pretend to be something it isn't							
6	Indian hospitals are the forefront of using technology to deliver a better service							
When it comes to medical treatment, the image of Indian Medical tourism								
7	India is safe and secure							
8	India offers exciting and interesting medical treatments							
9	India has beautiful scenery and natural attractions							
10	India has a pleasant climate							
11	As a tourism destination, India offers good value for money							
When it comes to medical treatment, Service quality of Indian medical tourism								
Medical staff quality								
12	The physicians allowed me to ask many questions, enough to clarify everything							
13	The physicians adequately explained my condition, examination results and medical process							
14	Ease of assembling and transmitting of medical record/information							

15	Medical staff was polite and friendly							
16	The process for setting up the medical procedure appointment was simple and easy							
17	The physicians paid enough attention to my concerns in deciding on a medical procedure							
18	The hospital has adequate grievance channel for patients							
19	The hospital has acceptable protection against medical malpractice and liability							
20	The medical staff has good communication skill							
21	Arrangement for language interpretation service							
22	Availability of physicians and nurses who can speak my language							
23	Short waiting time for the medical examination from the physicians							
	Supporting services quality							
24	The hospital amenities (cafeteria, Wi-Fi and public telephone) were conveniently located.							
25	Hospital care facilities (laboratory and doctors' office) were easy to find							
26	The hospital's attention to patient s' privacy, confidentiality and disclosure							
27	The hospital has state-of-the-art facilities and equipment							
28	The hospital provides free Internet access							
29	The payment procedure was quick and simple							
	Administrative services quality							
30	Package pricing with price transparency.							
31	Coordination of arrangements between the patient, hospital, third party insurance companies, embassies and other businesses							
32	Convenient hospital transportation arrangement							
33	Assistance with financial arrangements including advance estimates for fees, deposits and payments							
When it comes to medical treatment, I perceive Indian medical tourism								
34	Based on my experience, the medical doctor's skills in India offer me good values							
35	Based on my experience, the medical tourism service in India offers good value for money.							

36	Based on my experience, the price charged for medical tourism to India is reasonable.							
37	Based on my experience, the medical tourism service in India offers good quality/benefits.							
38	Based on my experience, I feel that this medical travel is worthwhile							
When it comes to India, Attachment with Indian Medical tourism								
39	India is a very special destination for me							
40	I identify strongly with this destination							
41	No other place can provide the same medical experience as India							
42	Medical treatment in India means a lot to me							
43	I am very attached to this medical tourism destination							
44	India is the best place for what I like to do on medical treatment							
45	Undergoing treatment in India is more important to me than Undergoing treatment in other places							
46	I would not substitute any other destination for medical treatment							
When it comes to India, brand loyalty with Indian Medical tourism								
47	I would recommend others to visit Indian hospital and India for medical treatment							
48	I will visit India in the future							
49	India is my first choice among medical tourism destinations							
50	I will say positive things about Indian hospital and India							
When it comes to India price reasonableness with Indian Medical tourism								
51	The menu prices at this hospital are reasonable							
52	The menu prices charged by this hospital are inexpensive.							
53	The menu prices charged by this hospital are appropriate.							
54	The menu prices charged by this hospital are a real rip-off.							
55	The menu prices charged by this hospital are Very low							
56	The menu prices charged by this hospital are Not pricey at all							

Section II Medical Tourism Related Information

1. Frequency of visit

   ☐ First visit ☐ Revisit

2. Companionship

   ☐ On your own ☐ With family ☐ With friends

3. Planned duration of stay in India:

Less than 15 Days		46-60 days	
16-30 Days		More than 60 Days	
31-45 Days			

4. How did you know about this hospital?
   - Friends/relatives visited India
   - Travel agents
   - Travel guidebooks
   - Tourism India collaterals
   - Travel Magazine
   - Internet
   - Newspaper
   - Business

5. Indicate the type of treatments sought by you:

Dental surgery/treatment	
Cosmetic/plastic/reconstructive surgery	
Sight treatment/Lasik	
Heart surgery	
Comprehensive medical checkup	
Infertility treatment	
General Surgery	
Obesity Surgery	
Brain Surgery	
Other: Please Specify:……..	

6. Do you have any health or medical insurance coverage for this type of medical treatment?
   a. In your country ☐ Yes ☐ No ☐ Don't know
   b. In India ☐ Yes ☐ No ☐ Don't know

7. How did you arrange for this medical treatment?
   - Directly with the hospital
   - Through medical travel intermediaries' websites
   - Other (please specify) …….

8. Which of the following is the most prominent reason for choosing India for your treatment? Please mark (✓) in the answer the column for each statement.

Quality of the treatment	
The high success rate in special surgeries	
Better treatment in every medical division	
Cost of the treatment	
Post-operative vacation	
Customized services	
Location of the Hospital	
Minimal waiting time in India	
Others, please specify:	

Section III General Information

1. Country of Residence: ☐
2. Gender: ☐ Male ☐ Female
3. Age Group ☐ Under 25 years old ☐ 35-45 years old ☐ 55years or older ☐ 25-35 years old ☐ 45-55 years old
4. Marital Status: ☐ Single ☐ Married ☐ Divorced/Widowed/Separated ☐ Others
5. Occupation: ☐ Employed ☐ Un Employed
6. If Employed, ☐ Private Sector ☐ Public sector ☐ Self Employed
7. Annual Income (in USD)
   ☐ 30,000 and below ☐ 30,001-60,000
   ☐ 60,001-100,000 ☐ 100,001-200,000
   ☐ More than 200,001
8. What is your highest level of education?
   - Did not attend school
   - Up to 10th grade
   - Graduated from High School
   - Graduated from College
   - Postgraduate (Masters Degree/PhD)

Appendix C. Summary of Literature on Destination Loyalty / Behavioral Intentions

Authors / Year / Journal	Survey Procedure / Location / Sample Size	Statistical Methods	Operationalization of Destination Loyalty / Behavioral Intentions	Antecedents of Loyalty / Intention	Study Findings
Bigne´ et al. (2001) *Tourism Management*	On site survey of two Spanish tourist resorts; convenience sampling; 251-surveys in Peniscola and 263 in Torrevieja	Path analysis	Intention to return Intention to recommend	image, quality, satisfaction	Image --> Quality; Quality --> Satisfaction Image--> Satisfaction; Quality --> Return Image --> Recommendation; Image –
Chen and Gursoy (2001),*International Journal of Contemporary Hospitality Management*	On-site survey of Korean outbound travelers in Seoul International Airport; 265 useful questionnaires	Multiple regression, path analysis, Chi-squire	measured by a single item— ‘‘it is a recommendable place’’(5-point Likert scale)	Destination safety, cultural differences, Past experience (indirect effect)	Regression: cultural difference (b = 0.18), safety (b = 0.161), convenience (b = .145) relate to DL; Path analysis: Safety (b = 0.11) and cultural difference (b = 0.235) directly affect DL; safety mediates Between past experience and DL; Past experience affects safety (b = 0.125)
Lento, O’Leary, and Morrison (2004) *Annals of Tourism Research*	Survey on flights of over 55 US and foreign airline carriers; two-stage stratified sampling, sample size 2,284—all are repeat visitors	EFA, SEM			Prior visit influences activity involvement & economic involvement. Most frequent tourists have the narrowest activity choices; expenditure of repeat tourists are more than first time visitors
Yoon and Uysal (2005) *Tourism Management*	500 self-administered questionnaires to tourists staying in well-known hotels nearby Mediterranean Sea	EFA, CFA, SEM	(1) How likely you will revisit xxx? (2) describe your overall feelings about your visit; (3) will you suggest xxx to friends or relatives?	Push & pull motivation, travel Satisfaction	Destination loyalty (DL) is positively affected by tourist satisfaction (b = 0.79) and push motivation (b = 0.41); Satisfaction is negatively affected by pull motivation (b = 0.54)
Alegre and Cladera (2006) *Journal of Travel Research*	Tourist Expenditure Survey conducted by the Balearic Island (Spain) Regional Government for the year 2002-2003; sample size: 7,564	ordinal regression (ordered logit model), logarithm of the probability ratio	whether you intend to spend another holiday in xxx (Yes/no)	Numbers of visits, overall satisfaction, tourist characteristics	Repeat visitors are more likely to return than first time visitors; The major determinant of intention to return is high satisfaction levels; numbers of visits have a small effect on overall satisfaction; for repeat visitors, dissatisfaction has smaller negative effect on return intention than first time visitors
Galarza and Saura (2006) *Tourism Management*	Survey students from private universities in Valencia & Madrid (Spain) who travel in groups; 274 useful responses	SEM	(1) whether to visit the same destination; (2) positive word of mouth	Value dimensions (efficiency & service quality); Satisfaction	Value dimensions (efficiency & service quality) and satisfaction directly and positively affect DL; Confirm the ‘‘quality --> value --> satisfaction --> loyalty’’ chain

Oom do Valle, Silva, Mendes, and Guerreiro (2006) *International Journal of Business Science and Applied Management*	486 personal interviews; Structured questionnaire; Portuguese & foreign tourists to Arade (Portugal); quota sampling,	SEM,Categoric al principal components analysis (CATPCA), cluster analysis	(1) Intention to return; (2) Willingness to recommend	Tourist satisfaction	Satisfaction --> DL (0.79) --> revisit (0.53)/willing to recommend (0.84); Two clusters (1: satisfied & 2: unsatisfied); High satisfaction affects willingness to recommend more than return intention; Two clusters are not socio-demographically different; Cluster 1: more foreigners vs. Cluster 2: more native Portuguese
Um et al. (2006) *Annals of Tourism Research*	Multistage cluster sampling design with stratification, 812 useful interviews in the departure lounge area of the Hong Kong International airport; Omnibus survey delivered: longitudinal data - 740 samples in 2001, 681 in 2002, 450 in 2003	Path analysis, conventional linear regression	How likely would you return to Hong Kong for pleasure travel? (7-point scale)	Perceived attractiveness, satisfaction, service quality & perceived value for money	Perceived attractiveness, satisfaction and perceived value for money all have directly and positively affect revisit intention; Satisfaction is positively affected by perceived attractiveness, quality of service, & value for money; Perceived attractiveness is the most important indicator of DL
Chen and Tsai (2007) *Tourism Management*	Convenience sampling in Kengtin, Taiwan; 393 usable surveys obtained	EFA, SEM	Likeliness to revisit Willingness to recommend	Destination image, trip quality, perceived value, satisfaction	Destination image --> trip quality (0.91); trip quality --> perceived value (0.83); perceived value --> satisfaction (0.75); Satisfaction --> behavioral intention (0.54)
Hui, Wan, and Ho (2007) *Tourism Management*	Tourists departing Singapore Changi airport, systematic sampling, 424 useable responses (including European, Asian, Oceania & North American tourists)	Multivariate technique - Hotelling T2, stepwise approach, simple regression	Likelihood of recommendation/revisiting	Expectation, perceptions experiences, disconfirmation, overall satisfaction	Likelihood of recommendation/ revisiting is affected by overall satisfaction; tourists expectation/ perceptions are different in groups (geographically); For all groups: Overall convenience & commodities are important to satisfaction; ‘‘price’’ is non- significant in shaping satisfaction, ‘‘accommodations and food’’ is significant for North Americans; ‘‘Attractions’’ is significant for European and Asian tourists, ‘‘Culture’’ is important for Oceania tourists
Jang and Feng (2007) *Tourism Management*	Data from the Pleasure Travel Markets Survey in France, total of 1,221 personal interviews, subsample of 163 respondents was drawn from the dataset	SEM	intention to revisit within the next 12 months (short-term revisit intention); mid-term: revisit within the next three years, long-term: revisit within the next five years	Destination satisfaction, novelty seeking	Satisfaction is a direct antecedent of short-term revisit intention (0.26); novelty seeking is a significant antecedent of mid- term revisit intention (0.12); short-term --> mid-term --> long-term revisit intention
Lee et al. (2007) *Leisure Science*	Survey data collected from Umpqua National Forest (USA), stratified sampling, 359 useful responses	SEM, CFA	Attitudinal loyalty; behavior loyalty, conative loyalty	activity involvement, satisfaction, service quality	Direct: Service quality positively affects activity involvement and satisfaction; Activity involvement positively affects attitudinal DL (b = 0.5) and behavioral DL (b = 0.4); Satisfaction positively affects attitudinal DL (b = 0.29) and

					conative DL (b = 0.53); Indirect: Service quality indirectly affects attitudinal DL & behavioral DL through activity involvement and affects attitudinal DL & conative DL through satisfaction; attitudinal DL --> conative DL (0.42) --> behavioral DL (0.74)
Chi and Qu (2008) *Tourism Management*	Cross-sectional survey conducted at Southern USA; Two-stage sampling approach; 345 questionnaires returned	EFA, CFA, SEM	repeat purchase intentions and WOM recommendations	Overall satisfaction, attribute satisfaction Destination image	Attribute satisfaction (b = 0.12) and overall satisfaction (b = 0.67) positively affect DL; Destination image positively affects attribute satisfaction (b = 0.71) and overall satisfaction (b = 0.29); Attribute satisfaction positively affects overall satisfaction (b = 0.20)
Faullant et al. (2008) *Managing Service Quality*	Data from ‘‘TQC’’ study (annual online survey), 6,172 customers completed survey	SEM, Image-satisfaction-grid; Multiple-group analysis	revisiting intention and word- of-mouth (WOM)	Satisfaction, image	Highest DL: highest image and satisfaction score; Image is more important than satisfaction for repeat visitors; Image is less likely to change and more pronounced for repeat visitors;
Kim (2008) *Journal of Travel & Tourism Marketing*	Web-based questionnaire sent to college student at Michigan State University (USA), 1st survey 2,437 useful responses, 2nd survey 591 useful responses	SEM; CFA	(Push and pull motivations,	Push and pull motivations, satisfaction, cognitive involvement, affective involvement	Push motivations --> Pull motivations (0.57); Pull motivations --> Cognitive involvement (0.13); Cognitive involvement --> affective involvement (0.62); Cognitive involvement --> satisfaction (0.27) -->DL; Affective involvement --> satisfaction (0.67) --> DL
Li and Patrick (2008) *Journal of Travel Research*	Online panel survey, Useful sample 554, active cruisers	SEM, Multiple regression, correlation analysis	Attitudinal loyalty, behavioral loyalty	Satisfaction, quality of alternatives, & investment size	Among 3 variables: satisfaction mostly predict attitudinal DL; satisfaction (0.55) & investment size (0.34) positively affect attitudinal DL; quality of alternatives (-0.22) negatively affects attitudinal DL; attitudinal DL --> behavioral DL
Correia Loureiro and Miranda Gonza´lez (2008) *Journal of Travel & Tourism Marketing*	Face-to-face interviews in Extremadura (Spain) & Alentejo (Portugal), and online questionnaire (total sample size = 500)	Factor analysis, ANOVA, SEM	behavior and attitude loyalty	Satisfaction, perceived quality, image, trust	Satisfaction, perceived quality, image, & trust all positively affect DL; Image is a direct antecedent of all other constructs; quality positively affects satisfaction & DL; satisfaction positively affects trust
Alegre and Cladera (2009) *European Journal of Marketing*	Data from survey on Tourist Expenditure in the Balearic Islands (Spain), by regional government and University of Balearic Islands, 6,848	SEM	Ask visitors whether they plan to revisit	Overall satisfaction, number of prior visits	Overall satisfaction is a major determinant of DL, stronger than number of past visits; Past visits positively affect overall satisfaction; satisfaction with basic components of the sun and sand product is crucial to overall satisfaction

Lee (2009) *Leisure Sciences*	On-site survey in three wetlands in Taiwan (Sihcao, Cigu,& Haomeiliao), systematic sampling among tourists departing via the exit area, 1,244 usable responses	EFA, SEM, path analysis	willingness to revisit, willingness to recommend, and positive WOM	Destination image, tourist attitude, amp; motivation (all indirect effect); satisfaction (direct)	Destination image, tourist attitude, & motivation indirectly affect future behavior; They are all directly related to satisfaction (! = 0.27, 0.41, & 0.33); Satisfaction directly affects future behavior (b = 0.67) and mediates the relation between the three variables and future behavior
Mechinda et al. (2009) *Journal of Vacation Marketing*	Survey distributed to international and domestic repeat tourists in Chiangmai, Thailand; sample size 400, quota sampling	EFA, Chi-square	Attitudinal and behavioral loyalty	attachment, familiarity, perceived value, pull & push motivation, gender, have children or not	Attitudinal DL: mainly driven by attachment, familiarity, and perceived value, pull motivation positively affects both international/domestic tourists; Behavioral DL: negatively affected by push motivation; Gender positively affects attitudinal and behavioral DL among international/domestic tourists
Campo-Mart´ınez, Garau-Vadell, and Mart´ınez- Ruiz c (2010) *Tourism Management*	A survey based on personal interviews with tourists leaving Palma Airport (Mallorca, Spain); Useful responses: 676	Means, Kruskal–Wallis one-way ANOVA, logistic regression analysis	Revisit intention	Satisfaction, global image, prior experience	For total sample: all 3 variables positively affects revisit intention (Satisfaction > Prior experience > Global image); For those with partner/friends: satisfaction /positive image/prior experience positively affect revisit intention; For those with family & children: satisfaction/prior experience positively affect revisit intention, For those travel alone: all hypotheses were rejected
Yuksel, Yuksel, and Bilim (2010) *Tourism Management*	Survey conducted at Didim hotels (Turkey), 224 useful responses	Outlier analysis, SEM	cognitive, affective and conative loyalty	Place attachment operationalized as place dependence (PD), affective attachment (AA), place identity(PI), and satisfaction	Direct: PD/AA/PI --> cognitive/ affective DL; PD/AA/ PI --> satisfaction; Satisfaction --> cognitive DL/ conative DL/affective DL; Cognitive DL --> Affective/ conative DL; Affective DL --> conative DL; Indirect: Place attachment (PD/AA/ PI) --> satisfaction --> DL
Bosnjak, Sirgy, Hellriegel, and Maurer (2011) *Journal of Travel Research*	Online survey, 973 German tourists were recruited with the aid of nonprobability methods	SEM	satisfaction, revisiting intentions, and positive word of mouth	Self-congruity, functional congruity, hedonic congruity, economic congruity, safety congruity, moral congruity, & leisure congruity	All 7 types of congruity positively affect post visit loyalty (top 3: self, functional, & hedonic congruity; bottom 2: economic & moral congruity)
Chi (2011) *Journal of Hospitality & Tourism Research*	Data collected at Arkansas (USA), 345 useful responses	Multi-sample structural equations analyses, (using SEM), equality/ invariance	tourists' intention to revisit xxx and their willingness to recommend xxx	Tourists' demographic characteristics such as age, gender, income, education	Tourists with different age and income have no sig difference in destination image perception, levels of satisfaction, or loyalty; Tourists in different gender and education perceive image differently but have similar satisfaction and loyalty; Holistic loyalty formation process is the same across different demographic groups

Lee et al. (2011) *Tourism Management*	Survey distributed to Chinese outbound tourists flying between the Beijing International Airport and Incheon Airport 513 completed surveys	Principal component factor analysis, CFA, SEM	Positive WOM, revisit intention, recommend intention	Tourist expectations, motivations tour quality, tourist satisfaction, tourist complaints	Tourist expectation (! = 0.084) & motivation (! = 0.122) --> tour quality; tour quality --> tourist satisfaction (b = 0.266); tourist satisfaction --> tourist complaint (b=-0.279); tourist complaint --> tourist loyalty (b = 0.320) Commitment & satisfaction --> DL
Velazquez et al. (2011) *Journal of Vacation Marketing*	Literature review			Commitment, satisfaction, variety seeking trait, demographic variables, service quality, perceived value	Commitment & satisfaction --> DL (attitudinal /behavioral), relation between satisfaction and DL is moderated by consumer variety seeking trait & demographic variables; Service quality & perceived value --> satisfaction
Chi (2012) *Journal of Hospitality & Tourism Research*	Data collected from visitors who stopped by the Eureka Springs (USA) Welcome Center, hotels, & motels, art galleries, etc. Proportionate stratified sampling & systematic random sampling, 345 useful responses	Multiple group analysis in SEM	Revisit and referral intention	Previous visits	Destination image leads to overall/ attribute satisfaction, this relation is similar between first-time & repeat visitors; satisfaction leads to DL— this relation is stronger for first-time visitors; repeat visitors have higher revisit intention than first-time visitors
Forgas-Coll, Palau-Saumell, Sa´nchez- Garc´ıa, and Callarisa-Fiol (2012) *Tourism Management*	Personal interviews; 927 questionnaires collected from adult tourists in Barcelona airport (Spain)	SEM (Multi-group analysis), CFA	Affective loyalty and cognitive loyalty	Satisfaction, perceived value	1. Perceived value --> affective loyalty (0.39) 2. Perceived value --> satisfaction (0.89) 3. Satisfaction --> affective loyalty (0.49) 4. Affective loyalty --> conative loyalty (0.84) The nationality of the tourists moderates all the above relations
Prayag and Ryan (2012) *Journal of Travel Research*	Quota sampling, self- completed questionnaire with the presence of the interviewers using hotel guests (adult) in Mauritius, effective sample size: 705	CFA; SEM	revisit and recommend intention	Destination image, personal involvement place attachment, overall satisfaction	1. Personal involvement --> Destination image (0.614); 2. Destination image --> Place attachment (0.166); 3. Destination image --> Overall satisfaction (0.514); 4. Place attachment --> Overall satisfaction (0.148); 5. Personal involvement --> Place attachment (0.790); 6. Overall satisfaction --> Revisit intentions (0.124); 7. Overall satisfaction --> Recommendation intentions (0.119); 8. Place attachment --> Revisit intentions (0.353); 9. Place attachment --> Recommendation Intentions (0.273)
Xiaoxia Sun Christina Geng-Qing Chi Honggang Xu (2013)	Data were collected) from tourists (640	CFA SEM	perceived value, satisfaction	behavioral intentions	perceived value→ loyalty (0.57) satisfaction→ loyalty (0.47)

Tsung and Yen Ling Shen (2012) Tourism management	convenience sampling 637	CFA SEM	Attitudinal and behavioral loyalty	Attraction, centrality, self-expression Place identity, place dependence	Place identity→Attitudinal loyalty (0.46) Place dependence→Attitudinal loyalty (0.43)
Hongmei Zhang*, Xiaoxiao Fu , Liping Cai b, Lin Lu (2014)	A total of 66 independent studies	meta-analysis	Intention to recommend Visit intention Revisit intention Behavioral intention	Destination Image	Destination image→ loyalty
Ching-Fu Che, Sambath Phou (2013)	Data were from surveys of 428 foreign tourists visiting the Angkor	CFA SEM	Behavioral Outcomes	Trust, Satisfaction, Attachment	Attachment→ loyalty (0.025) trust →loyalty (0.72) Satisfaction→loyalty (0.212)
Magnus Hultman , Dionysis Skarmeas Pejvak Oghazi HooshangM. *Beheshti (2015) Annals of tourism research Annie*	data collected from 490 Taiwanese consumers	CFA SEM	Revisit intentions (RV)	Satisfaction, identification, personality	satisfaction→RV (0.54), identification→RV (0.62), personality→RV (0.34)
Annie Chen Norman Peng Kuang-peng Hung (2015) *Journel of destination management*	data collected from 500 tourists'	CFA SEM	Brand loyalty	Self-congruence, Brand identification, Lifestyle congruence	Self-congruence→brand loyalty (0.45), brand identification →brand loyalty (0.52) Lifestyle congruence-→brand loyalty (0.25)
Zhenxiao Xu, JieZhang (2015) Journal of destination Marketing&Management	data collected from 200 Chinese domestic tourists	CFA SEM	destination loyalty.	Tourist Satisfaction, Place Attachment	Tourist satisfaction→loyalty (0.38) Place attachment-→loyalty (0.30)
Chih-Wen Wu (2015) *Journal of Business Research*	interview data from 475 foreign tourists.	CFA SEM	future behavioral intentions	destination image Customer experience, satisfaction	destination image→ loyalty (0.52) Customer experience, customer experience→loyalty (0.58) Satisfaction →loyalty (0.35)
Le Chi Cong (2016) *Journal of Hospitality and Tourism Management*	data collected from 912.respondents	CFA SEM	intention to revisit.	Quality, satisfaction	quality→ loyalty (0.67) satisfaction→loyalty (0.32)
Yueying Hazel Xu, Ip Kin Anthony Wong, Xiuchang Sherry Tan (2016)	800 were surveyed.	CFA SEM	behavior intention	Perceived value	perceived value → loyalty (0.56)

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BIO-DATA

SUDHEER MUHAMMED KM

Kodan kadan house,

Payyanadam P.O, Mannarghat

Palaghat District,

PIN – 678282, Kerala.

Phone: +91 9744550471

Mobile: +91 8904624162

E-Mail: sudheerkkm@gmail.com

ACADEMIC QUALIFICATION

M.Com.	Department of Commerce, Pondicherry University (**A Central University**), Karaikal Campus, with specialisation in **Business Finance** during the academic years 2011-2013 with **9.34 CGPA Points**.
B.com,	Islamiya College Thalikkulam, Trissur, Kerala under Calicut University, Calicut, Kerala during the academic years 2008- 2011 with **70 %** of marks.
INTERMEDIATE	Islamiya College Thalikkulam, Trissur, Kerala under Kerala State Higher Secondary Board, Kerala, during the Academic years 2006-2008 with **70%** of marks.
MATRICULATION	P.T.M.H.S Higher Secondary School, Kodiyathoor, Kozhikode, Kerala under Kerala State Board, Kerala, during the Academic years 2006 with **75 %** of marks.
UGC-NET	Qualified UGC – NET by University Grant Commission (UGC), New Delhi (December 2012).

PUBLICATION IN PRESENTATION PROCEEDINGS

- Muhammed Sudheer KM and D'Souza, Sunil.(2014), **"A Review of Preventive Health Information Seeking Behavior of Common People in Developing Countries",** paper accepted for presentation and Publication in the International conference in Marketing (MARCON 2014) at Indian Institute of Management Calcutta , December 18-20, 2014 .

- Muhammed Sudheer KM and D'Souza, Sunil. (2014), **"Medical Tourism and Market feasibility in emerging economy",** paper accepted for presentation and Publication in the Twelfth AIMS International Conference on Management at Indian Institute of Management Kozhikode , January 2-5, 2015.

- Muhammed Sudheer KM and D'Souza, Sunil. (2014), **"A conceptual Framework for Exploring the Policy Implications and Consumer Decision Components for Medical Tourism.",** paper accepted for presentation and Publication in the 1st IIMA International Conference on Advances in Healthcare Management Services at Indian Institute of Management Ahmedabad , June 6-7, 2015.

PUBLICATION IN JOURNALS

- Muhammed Sudheer KM and D'Souza, Sunil. (2017), "**Medical Tourist's Travel Motivations and Concerns Over Risk Towards India",** Asian-African Journal of Economics and Econometrics, Vol.17, No.1 (2017), ISSN : 0972-3986 (Indexed in ABDC & Scopus).

- Muhammed Sudheer KM and D'Souza, Sunil. (2017), "**Effective Governance through Quality in Healthcare Organizations: An Empirical Study",** International Journal of Economic Research, Vol.14 (2017), ISSN : 0972-7302 (Indexed in ABDC & Scopus).

WORKSHOPS ATTENDED

- Participated in a workshop conducted by RBI on **FEMA (Foreign Exchange Management Act).**
- Participated on National Level Seminar on **ETBI (Emerging Trends in Banking Industry)** Conducted by Department of Commerce, Pondicherry University.
- Participated in a National workshop conducted by NIT Calicut in **Multivariate data analysis using SPSS and MS Excel.**
- Participated in a **Faculty Development Programme (FDP) on Improving the Quality of Research *and making* Mid-Course Corrections** conducted by Indian Institute of Technology Madras.
- Participated in a **Faculty Development Programme (FDP) on Multivariate Data Analysis** conducted by Indian Institute of Management Kozhikode.
- Participated in a National workshop conducted by Pondicherry University in **Multivariate data analysis using SPSS and MS Excel.**
- Participated in a Faculty **Development Programme (FDP)** on **Research Skills and Data Analysis Using R** conducted by School of Management Studies (SMS), Cochin University of Science and Technology.
- Participated in a **Faculty Development Programme (FDP)** on **Multivariate Data Analysis using SPSS and AMOS – A Publication Focus** conducted by TAPMI, Manipal.
- Participated in a Faculty **Development Programme (FDP)** on National Workshop on **Data Science and Business Analytics** conducted by School of Management NIT Calicut.