The Role of Service Quality in Developing the Medical Tourism Sector in an Arabic Context: the Qatari Perspective

By

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DEDICATION

I dedicate this success to my dad who was and will remain my true inspiration by always believing and urging me to fulfil my dreams despite all the challenges. I am blessed to have a great dad who prepared us for the future challenges and I will always cherish his words as a guide to carry on during hard times.

I also dedicate this thesis to my husband who is very supportive and patient and for baring all the responsibilities with an open heart .

Consecrating this work to my older sister Haya and her husband for taking care of my kids during my journeys abroad visiting the University.

My lovely friend Nadeen Chaar,I thank you for all the support granted in being a part of taking care of my kids and for lifting my spirits high during hard times.

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ABSTRACT

Medical tourism is a growing niche market within the global tourism sector which has expanded significantly over the last two decades. Since the early 2000s, the Qatari Government has been proactively trying to move away from its economic dependence on oil and the finite hydrocarbon industries and to develop more sustainable industries. At the same time the culture of the country has meant that the government has always sought to provide world class healthcare for its people free at the point of use. Consolidating these aims in the Qatar National Vision 2030, the Qatari Government now seeks to develop a medical tourism industry, which would continue to provide world-class health care for its people, provide high status employment, and expand its sustainable economic base. The aim of this study was to develop an in-depth understanding of the complexity of medical tourism per se and in particular the complexity of medical tourism as a distinct niche market within the Qatari context. SERVQUAL theory was used as a tool to help develop this deep understanding of medical tourism within the Arabic context. In this study, a framework is developed to identify the critical service quality factors in that context using Hamad Medical Corporation (HMC) as a vehicle in Qatar.

A three-phase exploratory sequential mixed methods research design guided by a pragmatic research paradigm with HMC as the vehicle was implemented. Qualitative data was collected through semi-structured interviews with 6 Qatari government officials and 20 senior managers of HMC for the first two phases. For the third a questionnaire involving 350 users of HMC services was distributed to collect quantitative data. Thematic analysis was employed to analyse the interview data while the questionnaire data was analysed using SPSS. The data from all three studies was then triangulated to validate the results and identify key themes.

The key findings identified an essential need to revise current Qatari legislation in order to allow hospitals and other medical facilities to participate in the commercial delivery of medical tourism and to relax visa restrictions to allow for easier access to Qatar. They also revealed confusion with regard concept of medical tourism, identifying a much larger continuum of types than previously understood, and conflict between participants with regard to potential fears relating to the development of medical tourism. Finally, it was found that only 4 of the 5 service gaps usually identified in SERVQUAL models were applicable in the Qatari context from a theoretical perspective.

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LIST OF ABBREVIATIONS

AHF	Advanced Heart Failure
CAGR	Compound Annual Growth Rate
DFAT	Department of Foreign Affairs and Trade
EWOM	Electronic Word of Mouth
GCC	Gulf Cooperation Council
GDI	Gender Development Index
GSDP	General Secretariat of Development Planning
HMC	Hamad Medical Corporation
IMF	International Monetary Fund
JCI	Joint Commission International
MOF	Ministry of Finance
MOFA	Ministry of Foreign Affairs
MPH	Ministry of Public Health
PHCC	Primary Health Care Corporation
QF	Qatar Foundation
QHFMP	Qatar Health Facilities Master Plan
QTA	Qatar Tourism Authority
SCH	Supreme Council of Health
SERVQUAL	Service Quality
UAE	United Arab Emirates
UNWTO	United Nations World Tourism
WHO	World Health Organization
WISH	World Innovation Summit of Health
WOM	Word of Mouth

Chapter One

Introduction and Research Problem

1.1   Background

Medical tourism is a growing niche market within the tourism sector which has expanded significantly over the last two decades (Goyal, 2013). According to Hall (2013) and Connell (2011), medical tourism can generally be described as patients travelling out of their medical areas with the aim of general wellness, in order to obtain some critical or optional medical procedures. The expression, medical tourism, has evolved from the tradition of citizens from developed countries travelling to developing parts of the world to buy a range of cheaper, potentially better medical services than those they can obtain in their home countries.

Radzi *et al.*, (2014) shows that medical tourism is now frequently classified under three main categories from a country's perspective. The first category is inbound, which means foreign individuals visiting or coming into a particular country seeking medical help based on the origin of travel. The second one is outbound, which refers to natives of a country travelling to a different country outside their environment seeking medical help. The third category is known as intra-bound, which represents a developed form of domestic tourism whereby natives visit different regions or cities of their country. Connell (2011) identified financial cost of care provided, value of treatment, application of medical technology, faster treatment and confidentiality of the personal data of potential patients as key factors that affect the nature of medical tourism. However, Hodges *et al.,* (2012) noted that although medical tourism offers number of advantages for the travellers there are hazards involved with seeking medical help overseas. These include the varying standards of hospitals and physicians and the follow-up process after completing the medical process, as patients tend to leave soon after treatment to return to their home countries. Hall (2013) examples that many countries are currently creating pragmatic arrangements to service medical tourism. Haseltine (2013) concurred stating that

low cost transportation, advanced incomes, information and technology improvements, and high-quality services all support the concept of travel to far-away countries for medical treatments.

1.2   Qatar as a Potential Medical Tourism Destination

Qatar is a vast progressing country and has one of the most stable and flourishing of the global economies. With Qatar's political stability and saving rate being higher than that of other countries within the Middle East, it has adopted one of the greatest sustainable development plans in the Middle East region (Mallakh, 2015). From 2003, Qatar started to focus on national savings in order to achieve sustainable development. Consequently, investments that ensure a high level of economic change, enlarge integration capability and support private investments are widely encouraged by the Government of Qatar to assist in progressing the long-term aims of its economy (Al-Khouri and Dhade, 2014).

The two Qatari national health strategies for 2011-2016 and 2016-2022 (see Appendix III) aim to establish the pillars of the future of the State of Qatar. This is to be achieved by motivating sustainable development and renovation, empowering Qatari nationals to shape their future, establishing a citizens'-centred approach, encouraging partnerships to guarantee effectiveness, building on Qatar's wealthy history to achieve its goals and assisting in the story of Qatar's achievement (Ministry of Development Planning and Statistics, 2015). These plans require the development of a competitive and diversified economy, which can ensure a high -living standard for all people in Qatar now and in the future (International Monetary Fund (IMF), 2013). The plans focus on maintaining a prosperous society, building a caring society that is founded on high ethical standards and the ability to perform an important role in worldwide partnerships for development. Where a high-quality environment is achieved there is unison between economic development, social development and environmental safety (Brebbia, 2013; GSDP, 2014; Sillitoe, 2014).

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Since the beginning of the 21st century, as part of these Government plans, Qatar started transforming into an international centre for medical tourism with broad variety of health care centres providing a range of medical services (Smith and Puczko, 2014). For example, the opening of new rehabilitation and addiction management centres and offering wellness packages with special luxury programmes (Deloitte, 2015).

According to the Oxford Business Group (2014), by 2020 Qatar's healthcare market is expected to lead the region with an expected Compound Annual Growth Rate (CAGR) of 14.4% followed directly by UAE with approximately 14.1%. Ram (2014) stated that Qatar was the top developing healthcare market in the Gulf Cooperation Council (GCC) from 2008 to 2013 with a high CAGR of nearly 23% throughout that time. According to the International Business Publication (2012), Qatari hospitals provided world class treatment at 10% to 20% less than the cost of American hospitals. As a result, a rising number of patients are making Qatar their preferred medical destination (International Business Publication, 2012).

Furthermore, robotic surgery (complex surgery using microscopic robotic support) in Qatar has developed within the last five years with more doctors meeting the skills criteria to carry out robotic surgery besides performing more conventional surgery using the most up to date technologies (Wiseman *et al.,* 2014). As a result, more people are encouraged to come and visit Qatar in pursuit of high-quality medical services (Wittek *et al.,* 2013). Smith and Puczko (2014) noted that Qatar is listed as an elective medical tourism destination and is identified as a centre for cosmetic surgery for many travellers including obesity operations. With these huge investments into world class healthcare facilities and medical services that the Qatari government has invested for its people, it is now considering about how best to expand its nascent medical tourism industry as part of the government's plans to develop new, sustainable industries.

Most Qatari medical centres and hospitals are accredited by internationally recognised accrediting agencies. This is part of the Qatar's rules that hospitals must be accredited by both the Qatari Ministry of Health and at least one international accreditation body. Qatar's Ministry of Health informed all private hospitals and medical centres in Qatar that they must have this accreditation certificate by 2020 at the latest, as this document will represent the main condition for renewing their licences (Supreme Council of Health, 2015). The Joint Commission International (JCI) is the main accreditation agency with the authority to accredit medical centres outside the US. However, JCI has only given accreditation to the Hamad Medical Corporation (HMC) in Qatar, which includes all HMC hospitals. Other smaller hospitals are mostly accredited by international bodies such as The Canadian Health Certification (Supreme Council of Health, 2015).

1.3   Income Generation

In developing countries, medical tourism is rising as a profitable sector of the economy. A report published by Market Research Future (2018) about the Global Medical Tourism Market showed an impressive Compound Annual Growth Rate (CAGR) of 21.4 percent for the industry between 2018 and 2023. The forecast indicated that the Global Medical Tourism Market would reach US$ 226,762.70 million by end of 2023. Further, the Report showed that Asia Pacific accounted for a 43.7 percent global market share. Spine/orthopaedic treatments held the biggest share of the global market at 14.9 percent and was forecasted to reach US$ 27,902.80 million by end of 2023 (Market Research Future, 2018). Investment in this business field is a way of generating income, getting better services, creating foreign exchange, generating an extra stability of trade and improving tourism in general (Botterill, 2013). Although the medical tourism industry has been described as lacking "authoritative data on the number and flow of medical tourists between countries" (Mathijsen, 2019, p. 373), the International Healthcare Research Centre (IHRC, 2016) estimated that the global medical

tourist flow was about 11 million per year. According to Hall (2013) many countries have taken up the unique business opportunities that medical tourism offers. Countries such as the United Arab Emirates, India and Thailand are considered to be new centres in comparison to the UK and US which both are old centres in welcoming medical tourism (Stolley and Watson, 2012). An example of the rapidly developing medical tourism sector is India where in 2015 it was valued at about US$ 3 billion with projections of triple growth by 2020 to reach US$ 9 billion (International Medical Travel Journal (IMTJ), 2018a).

1.4   Service Quality

Service quality is connected to the conception of insights and anticipations (Radzi *et al.,* 2014). Clients check out service quality by judging what they expect against how a service supplier performs in reality. Thus, service quality can be characterised as the variation between clients' anticipations of service and their view of genuine service execution (Noe *et al.,* 2013). Service quality is used as a means to determine how well the service level delivered matches the expectations of the client. Achieving quality service means ensuring clients expectations are met consistently (Radzi *et al.,* 2014). SERVQUAL is one of the most popular models for evaluating service quality. This scale identifies service quality by finding out the gaps between anticipation and observations or insights in relation to the clients view point. It also involves the evaluation of the characteristics of service quality i.e. physical structure, trustworthiness, receptiveness, assertion, and understanding (Kong, 2005; Kachwala and Mukherjee, 2009; Zeithaml, 2010). Sohail (2003) stated that service quality has been explained by many researchers as a type of attitude, linked but not equal to fulfilment, which is reflected by eliminating any gap between anticipations of clients and service suppliers' achievement. Rodrigues (2013) described service quality as the capability to constantly meet external and internal clients' anticipation and desires including practical and personal accomplishments.

Seligman (2012) was more explicit and suggested that service providers are required to focus on the four features of services. The first feature is heterogeneity which implies that differing service achievements take place at different levels and that all consumers are different and so have different expectations. The second feature is intangibility, which means that consumers usually cannot use any of their five senses to check the service before they achieve a proper agreement with a provider. The third feature is inseparability, which means that consumers do not see the service provider and the service as separate entities. Instead, customers always look at them as one united structure and yet they have to seek the service. The final feature is perishability, which means service providers cannot store a service, therefore, if it is not used or sold the opportunity to provide the service is lost.

Although Qatar is a developing country, Cohen (2014) and Smith and Puczko (2014) argue that it is protected against many of the negative factors which most of the developing countries are suffering from. Such factors include inefficient power supply, lack of water, and infrastructure limitations all of which impact upon the potential for and image of medical tourism. This is because these factors influence both the quality of services offered and customers' satisfaction. However, there are some other factors, which might impact on the performance of the medical tourism sector in Qatar. These challenges include lack of coordination, concerns about possible complaints related to bad results of medical care, lack of strong and efficient human resource management, lack of staff training, complications within the customer services department and lack of effective marketing schemes (Todd, 2011). In a competitive market such as medical tourism, marketing is critical to the development of the sector. The application of the 7Ps of place, promotion, price, product, physical infrastructure, and process have been shown to complement the application of SERVQUAL in the medical tourism marketing mix (Das, 2017).

1.5   Research Questions

As discussed, a thriving medical tourism industry can be a powerful driving force for economic change, as was the case in Malaysia and India (Kijs *et al.,* 2016). It supports employment and investment and changes economic formation. Reflecting on the vision expressed in the Qatar National Vision 2030 (QNV) - i.e. the Qatari Government policy aimed at developing new and sustainable industries and is discussed in detail in section 2.1.2 - this thesis aims to investigate the potential for medical tourism in Qatar and to identify potential barriers which would need to be overcome to enable this sector to become a major sustainable contributor to the economic development of Qatar.

When focussing on service quality, several authors (including Frost and Kumar, 2000; Athina, 2011; Rebelo and Soares, 2012) state that the advantage of using the SERVQUAL model is the support it provides in understanding the qualified importance of assessing gaps between real and required performance and in measuring the performance of the health (or other service) sector. Moving beyond the gaps identified by the SERVQUAL model, this thesis is going to investigate service quality theory from a medical tourism perspective within the Qatari context. The problem that this thesis attempts to solve is the lack of clarity about the kind of medical tourism that Qatar should pursue and the gaps that would hinder the development and successful implementation of medical tourism in Qatar to ensure that the governmenr's development plans are effectively implemented.

SERVQUAL has been developed from others service quality theories and applied in America and other Western countries in different industries like banking, hospitality, and airlines. This research has been structured to investigate how these theories theory could be used to help medical tourism develop within Arabic countries/cultures using Qatar as the focus country. Lovelock *et al*., (2015) stated that marketing strategies are important aspects to be considered by the providers of medical tourism services and that most of these strategies are

based on Kotler's 7Ps of marketing. Similarly, Radzi *et al.,* (2014) argued that the marketing mixes of medical tourism services based on Kotler's 7Ps are:

1) Product which must offer world class services;

2) Price which must be a competitive price but still reflect the high quality of the product;

3) Place which needs to be accessible to all individuals interested in medical services worldwide;

4) Promotion which is the engine of the whole marketing strategy and can be undertaken via various approaches like social media;

5) People who are considered as the base around which all other mixes of the marketing strategy must be designed in order to achieve their satisfaction and better understanding for their demands, in addition to evaluating the patient's culture to help to develop a successful strategy;

6) Process which means accreditation by international bodies to show that the services provided by a particular medical centre are aligned to the international patients' expectations;

7) Physical evidence which means a high-quality service environment in the infrastructure with luxury spaces and outstanding facilities combined with advanced technologies to ensure trust within the global patient community resulting in development of the medical tourism sector.

Hence, following the 7Ps model, which is represented by good quality products, and identifying the gaps of the SERVQUAL model will be essential in determining the ways to enhance medical tourism in the Qatari context in this thesis. The research addresses the following research questions:

1) What is the complexity of the concept of medical tourism?

2) Who is the medical tourism customer in the Qatari and Arabic context?

3) What are the service quality barriers in Medical Tourism in Qatar?

1.6 Research Aim

To ensure better insight into the complexity of medical tourism and the complexity of medical tourism in term of being defined as a distinct niche market in the Qatari context and to critically analyse how service quality theory can be used to help enhance medical tourism within the Arabic context. A framework is developed to identify the critical service quality factors in that context using Hamad Medical Corporation as a vehicle in Qatar.

1.7 Research Objectives

The following are the research objectives of this research:

1) To undertake a critical literature review in relation to service quality and niche tourism with a focus on the medical tourism sector. This will identify current theoretical debates about medical tourism, service quality, medical tourists expectations of non-medical services and cultural issues. Achieving this objective will lead to a conceptual framework.

2) To identify and critically examine government and HMC management's (the case organisation) perceptions in relation to service quality theory by undertaking primary research with those employed in these areas using the SERVQUAL model. Achieving this objective will provide insights of the gaps in theory and how they affect the quality of the provision of non-medical services.

3) To critically examine the HMC service users (potential medical tourists) experiences of medical tourism in relation to service quality based on the SERVQUAL model.

4) To critically align internal and external beliefs: government, HMC Management and service users (medical tourists) perceptions and experiences of service quality in relation to medical tourism in order to identify gaps in knowledge and provision, establish critical service quality factors and to revise the conceptual framework.

5) To reflect on the adopted framework and make recoomendations to enable Qatar to become a leading medical tourism destination.

1.8   Position of the Researcher

My position as a researcher is based on two main aspects, which are my educational history and my job experience. Holding a master's degree in hospitality and having attended many training courses in management and leadership has provided me with the ability to perform research professionally. An exposure of 15 years of work experience within the Qatar Medical Sector in hospitality and support services has expanded my knowledge and brought me into daily contact with customers, employees, and services. These two aspects have helped to identify the research questions. I believe that the relationship between the understanding of medical tourism sector in Qatar has to be addressed to align its development with international requirements and perceived standards in order to match the changes taking place in the world.

In addition, being a professional working in one of the leading healthcare organisations in Qatar and having contacts with key decision makers created a solid base for me to undertake this thesis. This is especially because the employers have a significant interest in the potential for the development of medical tourism in Qatar from both the business perspective and in compliance with current government policy they were very supportive of the concept of the thesis and happy to provide access to very senior officials, which might not have been possible otherwise.

1.9   Structure of the Overall Thesis

This thesis contains nine chapters. The first chapter has provided the overall introduction into the research topic about medical tourism and service quality from a general perspective. Section two introduced more specific background information about medical tourism and service quality with particular emphasis towards the Arabic and Qatari context.,

The research aim and the five objectives proceeded the detailed structure outline of the thesis and the position of the researcher which completes this chapter.

In the second chapter, the purpose is to provide knowledge about the country of focus in this research, Qatar. Qatar's country context is provided with details about its geographical location, population, culture, political and economic status. The infrastructural and other development plans and the health facilities and healthcare facilities in Qatar are also featured as well as Qatar's tourism, its facilities and development.

The third chapter is the review of previous literature. The chapter contains 13 major sections besides the introduction and summary of literature review, which constitute the first and the last sections of the chapter. Tourism concepts and aims, medical tourism's historical background, and medical tourism theories and concepts appear in the second, third, and fourth sections of the third chapter. The focus then shifts to literature about the economic impact of medical tourism, the cultural requirements and obstacles associated with medical tourism, and medical tourism and health tourism typologies in the fourth to eighth sections. Literature about the main antecedents that influence the behavioural intentions of tourists, service quality, and the evolution of service quality theory and models are also covered in the third chapter. The review of the stakeholder theory, the concepts of hospitality and hospitableness, and the built-in environment in hospitality precede the discussion of the conceptual framework and the summary of the findings in literature.

In the fourth chapter, the research methodology is showcased. The first section is about the methodological perspectives and covers the epistemology and theoretical perspective, research approach and research purpose. The methods focusing on the exploratory sequential mixed methods approach are discussed in as are the data sources, collection, and analysis procedures. The ethical considerations that were relevant to this study also appear in the fifth section before discussions about validity, reliability, and methodological reflections.

The fifth chapter presents the results and discussions of the results obtained following the interviews with officials from government ministries. The trend is repeated in the sixth and seventh chapters where the results of the interviews conducted with senior managers at HMC and survey results obtained from the HMC services users are presented.

The eight chapter integrates the key findings. This entails the comparison and contrasting of the key findings that dominated the three previous chapters which informs the summarisation of the key findings. This is followed by linking the key finding to the conceptual framework.

The ninth chapter concludes this thesis drawing together the findings and discussions in accordance with the research objectives and questions. The chapter also highlights the practical and theoretical contributions made by this research. It also contains five practical recommendations and other recommendations to advance the theory, which would fast-track the achievement of successful implementation of medical tourism in Qatar. The ninth chapter also contains the suggestions for further research and the personal reflections of the researcher.

Chapter Two

Country Context, Qatar

2.1 Introduction

This chapter sheds light on the country context of Qatar. It begins with a brief description of the country's geographical location and population, political context, Qatar's current eco-financial status and future plans. It also includes information about managed development versus uncontrolled growth in Qatar, the extent and the quality of emigrant labour force and the development path. The section also contains information about the economy of Qatar, Qatar's National Vision, culture, health facilities master plan, growth in healthcare sector, state of health and internal medical tourism. Additionally, it discusses growth prospects for Qatar's healthcare market, key performance indicators of Qatari healthcare and infrastructure including different modes of transport. Since the research topic investigates medical tourism, this chapter concludes by highlighting tourism facilities available in Qatar, tourism development in Qatar, political stability and the potential safety of patients in Qatar.

2.1.1 Location and Population

The State of Qatar is a self-governing country located in the Middle East region. Its official name is Dawlat Qatar while Qatar and State of Qatar are the short and international long forms respectively (Nations Online, 2019). Qatar's geographical size is about 11,586 square kilometres and stretches approximately 200 kilometres into the Persian Gulf with a coastline of about 563 kilometres (The World Factbook, 2019), as shown in Figure 2.1.1a. Qatar comprises of many islands with Al-Asshat, Sharouh and Halul being among the largest. The southern border of Qatar is shared with Saudi Arabia while Bahrain, Iran and the United Arab Emirates share its marine border. Doha (Ad Dawhah) is the capital and other major cities include Al-Wakrah, Umm Şalāl Muḥammad, Dukhan, Ras Lafan, Ash Shīḥānīyah, Al-Khor, Musayʿīd, and Madīnat ash Shamāl (Ministry of Foreign Affairs (MOFA), 2019).

Figure 2.1.1a. *Detailed map of Qatar*

Source: Nations Online (2019)

As at the end of 2016, Qatar had an estimated population of 2.6 million (Nations Online, 2019). However, Qataris are only said to be about 11.6 percent of the entire population with non-Qataris making up the rest (The World Factbook, 2019). According to the Australian Department of Foreign Affairs and Trade (DFAT), non-Qataris mainly comprise of Pakistanis

or Indians followed by other Arabs and Iranians. There are more males (1,391,192) than

females (279,256) in Qatar and the biggest proportion of the population comprises of

individuals aged between 25 and 54 years (70.67 percent). The reason for this gender

discrepancy occurs because most of the non-Qatari population is male and frequently working

in male-orientated industries such as petrochemicals; this is also the most likely reason for the

high number of working age population. Individuals aged at least 65 years are the fewest at

1.06 percent, as shown in the population pyramid in Figure 2.1.1b below.

Figure 2.1.1b. *Qatar's population pyramid (2016)*
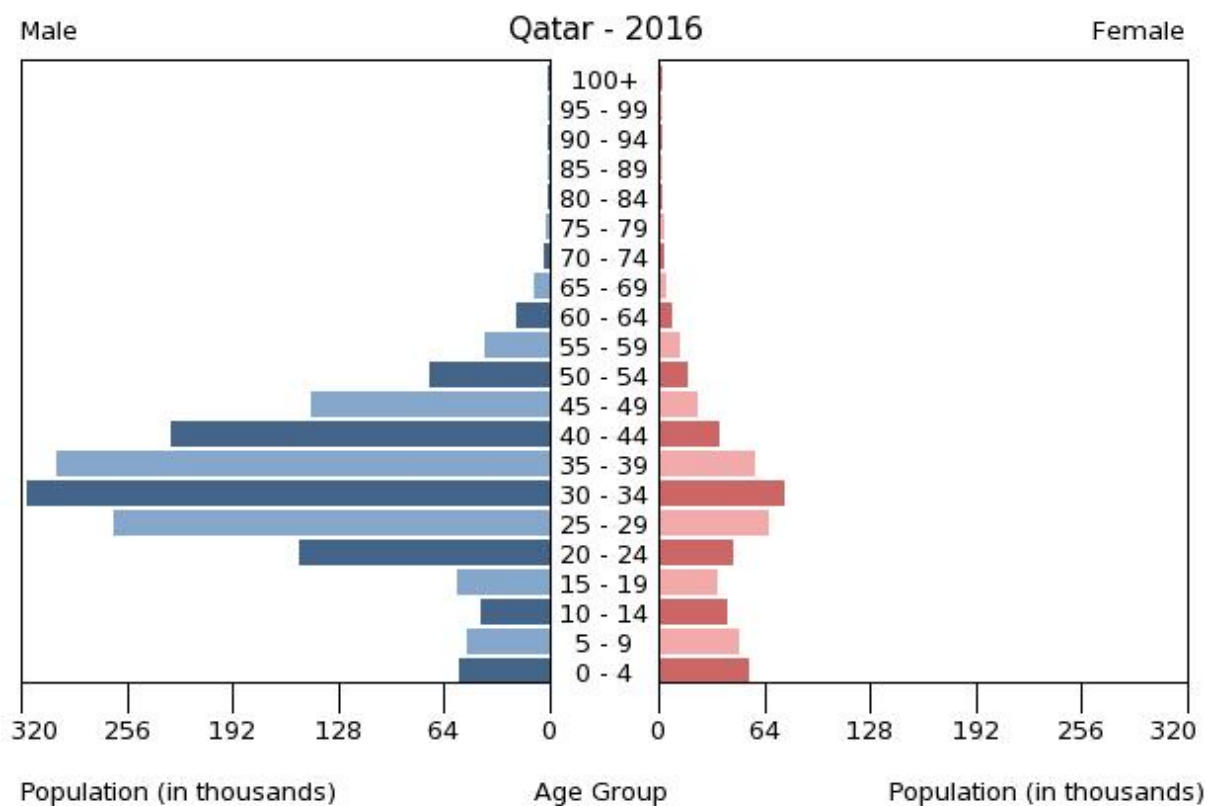
Source: Qatar Country Report (2015)

Although English is commonly used in Qatar, the official language is Arabic. The

common use of English is due to the high number of non-Qatari people living in the country

and as a result of Qatar's colonial links to Britain. Since its independence from Britain during

the previous century, Qatar has developed from a poor British city state recognised for pearling

to one of the most well-developed countries in the world for oil and gas production (Qatar Country Report, 2015).

2.1.2. Political Improvement

The reputation of Qatar has progressed internationally as many improvements have taken place within the political system, for example the way the country handles its agreements with other regions worldwide and having a strong affiliation with the United States (US) (Oxford Business Group, 2014). In addition, Qatari people enjoy freedom of speech and the right to vote in their parliament (Oxford Business Group, 2014). In 2004, the country's Permanent Constitution was approved and in June 2005 it came into force. The Constitution makes transparent the responsibilities of all authorities and the Qatari citizens' duties and rights (Orr, 2007). These sorts of arrangements are a part of a soft power concept, which has made Qatar's global image grow steadily. However, currently the Constitution is not explicit about the development of tourism or the establishment of the Qatar Tourism Authority (QTA), replaced by the National Tourism Council in 2018 following Emiri decree No 74 of 2018 by Sheikh Tamim bin Hamad bin Khalifa Al Thani, the Emir of Qatar.

2.1.2.1. Political Stability

There is a general view that a dependable political situation is an essential condition to achieve economic development (Kinninmont, 2015). The political steadiness of a country is considered as a highly positive feature which attracts businesses, tourism and other activities to participate in the economy of this particular country or region. However, political stability can be affected by number of factors, such as the degree of democracy, religion as a key cultural power which performs an imperative role in politics, population of the country, development rate, the region where this particular country is located, and various international issues like the country's position in international developments (Akongdit and Issam, 2013). The 2019 Fragile States Index (FSI) produced by The Fund For Peace showed that Qatar's political

stability worsened in 2018, but recorded an improvement of 2.7 points in 2019 to rank 141st out of 178 countries in overall fragility based on the FSI ranking. The increased fragility in 2018 is attributable to the ostracism it suffered with other GCC countries. On the other hand, the improvement in 2019 is attributed to the improved relations and the reestablishment of better political relations following the focus by Emir Tamim on domestic politics (Bertelsmann Stiftung's Transformation Index (BTI; 2018).

Political constancy plays an essential role in shaping economic growth in Middle Eastern economies. In particular, Qatar's brand image has been improved by its diplomatic triumphs, for example the state being involved in global peacekeeping as well as the hosting big international events (Darwich, 2011) including the 2022 Football World Cup. This involvement in building diplomatic relations means that Qatar is an important player in peace and stability frontiers especially in the Middle East region. These overt demonstrations of interest in peace and cohesion are likely to be a reassurance to medical tourists that Qatar is a peaceful and so safe place to visit.

2.1.3 Key Elements of Qatar's National The QNV

As stated by Qatar's General Secretariat for Development Planning (GSDP) (2014), the QNV is based on the primary standards of the Qatari Constitution and the policies designed by his Highnesses the Emir, the Heir Apparent, and Sheikha Mozah along with in-depth discussions with international and local experts and government institutions (Gulf Education International Conference, 2012). The National Vision is based on a culture that encourages equality, social cohesion, and justice. The Vision represents the values of the Permanent Constitution which:

- Upholds religious values, morals and traditions

- Protects personal and public freedoms

- Ensures stability, equal opportunities and security

QNV (See Appendix II) is based upon four principles, these are; (GSDP, 2011)

- Human Development –According to the HDI Report (Human Development Index) in 2008, Qatar's ranking was 35th out of 177 countries with a value of 0.88 out of a possible 1.00. The same report indicated that Qatar's rank for GDI (Gender Development Index) was 84 out of 93 nations with a score of 0.374. These two indices signal the ability of Qatar to provide quality services to its people. Qatar intends to develop an advanced educational system which is world class and offers first-class education to students, (Harber, 2014). This governmental initiative, "Qatarisation", will increase the number of Qatari employees in both public and private sectors. As a result, empowered and highly trained nationals will be expected to contribute to the future success of Qatar in both economic and educational industries so that, for example, half of the workforce in Qatar's Industry and Energy sector will be Qataris by 2030. However, the achievement of Qatarisation is not as easy as it the Vision puts it and some of the challenges that have been identified in previous research include weak educational outcomes, skills mismatch, and cultural barriers (Nejad, 2016).

- Social Growth - Qatar aims to progress and expand the social scopes of its nation by developing the Qatari national competency in flexibility and effective handling of the needs of the current era by safeguarding a coherent and strong family life that benefits from social and health care security. Women will be encouraged to take on important roles in every area of life, particularly by way of taking part in political and economic decisions. Yet, the strong traditions of the Qatari society that are deeply rooted in the conservative culture may still hamper women from playing this role. This complex conflict between Qatar's efforts in developing women's human capital and "traditional social norms and attitudes that prioritize domestic life" cannot be ignored (Mitchell *et al.,* 2015, p. 1). Qatar is reliant on education to build a community that is stable, safe

and secure. Within the framework of its Islamic and Arabic identity, Qatar will pursue inter-ethnic cohesion while guaranteeing more career opportunities. Qatar's constructive and important regional role will be improved, particularly in the Arab League structure, the Islamic Convention Organisation and the GCC (GSDP, 2011). On the other hand, significant projects have been and are being developed such as museums and libraries to preserve and promote social and historic heritage and culture (Niblock, 2015).

- Economic Growth – A proactive Qatari economy is considered to be a sound basis from which to build a prosperous economy and stable social development. Nourishing affluence for a long-term future needs efficient administration of exhaustible resources to make sure that future generations will still have sufficient resources to achieve their ambitions. Qatar's resources of hydrocarbon must be managed to produce realistic sustainable expansion. Shifting the economic emphasis away from hydrocarbon-based industrial development to service-based industries is considered to be a sustainable means for creating world-class infrastructure; creating effective methods of delivering services to the public; building a well-trained and constructive work force; and encouraging the growth of free enterprise and innovation abilities. If achieved, these accomplishments will give a broader stage for Qatar's changing economy and its placement as a local centre for know-how and great value service and industrial performances. However, achieving these ambitions should not be underestimated; an initial test will be to allow the private sector to have an important role in developing this sustainable growth.

- Environmental Growth- Environmental integrity is recognized as a key element to promote the inhabitants' health (Langlois *et al.,* 2012). Due to the remarkable growth in the petrochemical industry, the Qatari population has suffered from a high level of

respiratory diseases (asthma in particular) (Al-Marri and Dawoud, 2001) triggered by the decline in air quality. Qatar's carbon dioxide emissions have been reported to be 45.4 metric tons per capita, which is extremely high compared to a global average of 4.988 (World Bank Group, 2019). Yet, a clean/healthy environment is essential if a country is to try to develop a reputation and a high-quality health service provider. The country started to take action in 2008 when the dilemma was identified, becoming the first GCC country member in the Global Gas Flaring Reduction Program organised by the World Bank (Energy Information Administration, 2014). From the period of 1980 to 2011, the concentration of carbon in Qatar has declined from 1.059 to 0.537 (Energy Information Administration, 2014).

Protection of the environment and economic development are heavily interrelated to each other. Development trends may, and usually have, damaging consequences on the environment. Degradation of the environment may be lessened via investment in sophisticated equipment intended to reduce the harm produced by economic development. It may also be decreased by policies which limit unplanned or spontaneous development. However, it is not possible to prevent some damage to the environment despite the great efforts that are being undertaken by the Qatari government as the initial industrial development relied on the development of the gas, petrochemicals and oil industries. (Sillitoe,2014). In addition, Qatar's attempts to look after the environment are not always fully effective because Qatar's geographical and ecological system is influenced by the activities and practices of each country within the Gulf region. Thus, it is essential to educate and support all the Gulf States in relation to the need to care for and preserve the environment. Qatar's National Vision aims at simplifying the choices linked to social and economic development through more financial investments and focused efforts (Brady and Ebbag, 2013).

2.1.4 Qatar's current eco-financial status and future plans

Qatar is currently at a turning point. The country's plentiful wealth generates both frightening challenges and unimagined prospects, such as ensuring equilibrium in the labour market between Qatari citizen and foreigners and managing the water supply for an ever-increasing population (Oxford Business Group, 2014). The master plan of the QNV outlines developments for the future and indicates the ambitions, culture and aims of the people. Highlighting the vision of the future, it paints a picture of a socially cohesive Qatar where ethics and integrity are dominant and the country is an economic, political and social force globally and an international partner. The rationale for this futuristic view is also to motivate Qatari nationals to join in, own up, and support the realisation of the QNV.

Qatar is benefiting from an era of incomparable affluence, with outstanding financial growth being evidenced by a rising standard of living for most Qatari nationals (BTI, 2018). Data from the International Monetary Fund (IMF; 2019) World Economic Outlook shows that Qatar's Gross Domestic Product (GDP) per capita has been above that of advanced economies, emerging market and prospered economies, and the world average, as shown in Figure 2.1.4 below.

Figure 2.1.4. *Qatar's GDP per capita compared to the world standards and other economies*
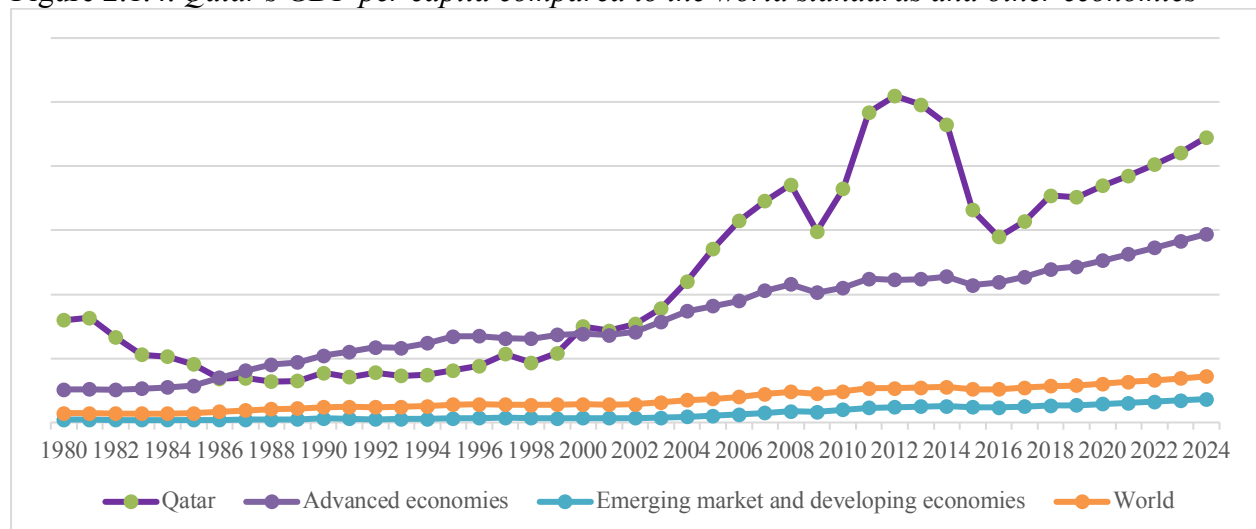
Source: Our World in Data (2019)

The country has one of the greatest incomes in the world due to oil and gas (Fromherz, 2012) and while there has been a rapid rise in non-energy projects, gas and oil remain accountable for over fifty per cent of the Gross Domestic Product. However, the country's flourishing economic market has led to a demand for a more professional workforce; this, along with increased infrastructure investment, has attracted many foreigners to live and work in Qatar. This foreign/immigrant labour has enabled organizations to choose the best employees from a wide international pool, including from bordering Arabic states (Oxford Business Group, 2014). The implication of this is that sectors such as healthcare have the benefit of experienced foreigners contributing to the achievement of the QNV.

2.2 Qatar's Opportunities and Challenges

Although Qatar strives to play a major and international role in the development of healthcare services, education and research there are limitations regarding the speed of the implementation. Pressures relating to economic disproportion and overheating may manifest through rapid increase in prices. Should this happen, it could lead to financial weaknesses, potential decline in the public services quality, inactive and low efficiency in labour, late project completion, potential damage to environmental degradation, and social damage to the Qatari society (Oxford Business Group, 2014; Sillitoe, 2014).

2.3 The Extent and Features of the Immigrant Employment Force and Development Path

One of the most significant opportunities and challenges Qatar is encountering is the great rates of expansion of the population among both, expat and nationals because of huge city developments and massive industrial development especially in the hydrocarbon industries. Opting for this strategy of expansion resulted in a rapid and unexpected development in the proportion of expats to Qatari nationals within the workforce. Whilst many of the expats are highly skilled, as in the hydrocarbon industries and medicine, the influx of

unskilled and low-skill workers, e.g. in construction, was especially rapid and unforeseen. As well as the expected economic benefits, some of the potential challenges of the influx have been the possible impact on the cultural characterisation and orientation of Qatari society (Niblock, 2015), as expounded further at section 3.12.3.1.

To minimise and/or moderate this challenge, Qatar needs to ensure an appropriate quality and number of expats entering its workforce. Qatar also has to consider the costs of employing expats (particularly those working in construction projects and the oil and gas industry which depend significantly on expat employees) with regards to their cultural rights, access to public service, and housing requirements (GSDP, 2011; Nafi, 2014).

2.4 Qatar Infrastructure

In Doha, the government sponsors infrastructure and mega infrastructure projects such as the Inner Doha Re-sewerage Implementation Strategy. Qatar has undertaken four major infrastructure projects including a 318-kilometre rail system, an upgrade of the New Doha International Airport with two of the longest runways in the world to enhance capacity for both cargo and passengers. Qatar's Public Works Authority also unveiled 220 road and drainage projects around the country to enhance connectivity and sanitation, which are critical for the advancement of medical tourism as well. The fourth mega project is the construction of the four-lane dual-carriage highways to ease traffic congestion by the National Highway Projects. Easing congestion is expected to enable Qatari nationals, residents, and tourists to circulate within the city more freely and this will also make access to medical tourism and supportive facilities such as HMC, airports, tourist attractions sites, accommodation, and so on more accessible. Table 2.4 below illustrates the mega infrastructure projects, their purpose, vision, and cost incurred.

Table 2.4. *Qatar infrastructure projects*

Infrastructure Project	Purpose	Vision	Cost	Relevance to Medical Tourism
Rail System	a super infrastructure project is (318km) rail system being developed by Qatar Railways Company to incorporate freight and an overland passenger system (roughly 325km), a city rail system and a metro with four lines (underground of 100km).	World's primary sustainable downtown regeneration project, intended to redevelop and protect the historical heart of Doha, and it will also include fifteen museums, and other tourists' attractions. Currently, brand new station sites are appearing everywhere in the city of Doha	$35 billion	A robust rail system will enhance mobility within the country while giving medical tourists an opportunity to visit other tourist attraction sites.
The New Doha International Airport (Hamad International Airport)	Two of the longest runways in the world are the airport's feature with a capability of A380 and it will be three times larger than the previous airport once it is fully completed, and it has the capacity to receive 2 million tons of cargo and 50 million passengers on an annual basis. When the initial phase of the airport opens, it will be capable of receiving 24 million passengers annually; this will be 12 times more than the present country's population.	The services that are operated by Qatar Airways are across Europe, Africa, Far East, Indian subcontinent, Oceania, Middle East, Central Asia, South America and North America. Such an airport facilitates the influx and efflux to Qatar	$16 billion	Increased accessibility of Qatar's medical tourism services from numerous global destinations
Local drainage/roads projects	Qatar's Public Works Authority is covering over 220 projects that are taking place all over the country.	Better drainage and roads reflect a better life style, which is the attractive point for tourists and foreign workers.	$14.6 billion	This contributes to better appeal for medical tourism facilities and promotes Qatar's reputation to potential medical tourists
National Highway Projects	Its concentration is to lessen the traffic congestion (as well as the execution of a number of four-lane dual highways).	Citizens and tourists will circulate within the city more freely and without being restrained by the traffic.	$8.1 billion	Less traffic congestion means that medical tourists are able to access medical services facilities and other tourist attraction centers more easily

Sources: Qatar Statistics Authority (2012), Losa and Papagiannakis (2014), and Oxford Business Group (2014).

The spending on infrastructure has nourished the country's economy, leading to more influx of population into Doha (the capital city) which in turn has increased the demand for services due to higher consumption. The other cities of Qatar also have good opportunities to

advance and maintain growth as they progress. As these cities sustain their development, human talent is identified as an increasingly valuable resource, particularly when merged with technological modernization. Ultimately, this is expected to enhance the overall life-quality of the Qatari nationals.

2.5 Qatar Culture

Prior to the discovery of oil Doha was a small and homogenous coastal town. Since the discovery in the 1940s, it has been transformed into a modern metropolis with a multinational population (Naggy, 1997). The lifestyle in Qatar is mainly separated into two distinct lifestyles by a single generation i.e. those born and raised in the pre-oil era and those born and raised in the much more affluent aftermath. This kind of lifestyle distinction has led to feelings of anxiety amongst the older generation about protecting 'the past' as well as ensuring that knowledge of this earlier lifestyle is passed on to the younger generation (Excell and Rico, 2013). As discussed in section 2.1.3 on the economic growth pillar, the need to safeguard the affluence that the population has grown accustomed to (especially the younger generation, which comprises the majority of the Qatari population) is critical and, hence, the diversification of economic activities into areas such as tourism even as the hydrocarbons sector remains a vital economic contributor. However, there are certain concepts that are culturally, socially and religiously appreciated by the entire population in the country, such as loyalty, devotion and great respect for the tribes' sheikhs, older family members and the rulers where their obedience is perceived as part of obedience towards God.

Qataris have been recognised to be a very hospitable people, which is an important trait that can be offered to international visitors. In 2010, Doha was elected as the Arab Capital of Culture, a program organized by UNESCO, to promote cooperation in the Arab region, as well as to encourage and celebrate Arab culture by the Cultural Capitals Program (Excell and Rico, 2013). This aimed to profile and promote Qatar as being at the heart of Islamic culture and a

tourist destination. According to the Al Mohannadi (the chairman of the QTA), the percentage of international visitors increased from 30 percent previously to 41 percent in 2015. He also described the country as a "world class hub with cultural roots" (Shankman,2015). Thus, developing the tourism sector including medical tourism has considerable potential to continue sustaining the reputation of Qatar's heritage and its popularity as a cultural tourism destination. The structure of the family remains predominantly patriarchal deeply rooted in an extended family system that spans at least three generations. The extended family structure offers stability and psychological and physical support especially when one is in need (Dhami and Sheikh, 2008). Muslims from the Arab world sacrifice individuality and separateness to sustain cohesiveness in the family. Identity, security, esteem, and self-image are deduced from family relationships (Daneshpour, 1998).

There exists a positive relationship between esteem and respect on the one hand and age on the other (Lovering, 2012). This explains why elderly Arab patients command more respect within the family unit for their hierarchical position, wisdom and experiences in life. Generally, the older children, spouses, and the parents in ascending order wield more decision-making powers compared to all other relatives (Al-Shahri and Al-Khemanizan, 2005). The value of children rests in their provision of higher social status for their parents, giving them a life purpose, and fostering connectedness in the family system. Generally, children will be expected to respect their elders, obey and devote to their parents, and remain loyal to the family (Lovering, 2012).

2.6 Qatar Health Facilities Master Plan (QHFMP)

The QHFMP 2013-2033 is a 20-year road map, directing the improvement in the healthcare division in Qatar, which should be completed by 2033.The full proposal, included as part of the National Health Strategy (NHS) 2011-2016, illustrates how Qatar might build and sustain a world class health structure via pioneering buildings and services and through the

intelligent deployment of its resources (Supreme Council of Health, 2011a). The plan also proposes the expansion of the structure of the NHS' main elements, which entail worldwide access to healthcare for everyone in Qatar by supporting the development of high-standard expertise in small and tertiary hospital care within Qatar.

This plan might appear to be about construction and equipment, but the intention is to improve the health of the people (Supreme Council of Health, 2011a). Designing a clear and efficient plan to develop the infrastructure is necessary to support a more effective healthcare system. Qatar is expected to invest around $2.7 billion in the development of the healthcare sector by 2020. This is expected to contribute to the advancement of the healthcare market in the Gulf Corporation Council (GCC) especially with the investment of $56 billion into the health sector by the end of 2020. According to a report provided the World Economic Forum (2015), Qatar's arrangement to enhance infrastructure expenditure reflects similar proposals in neighbouring countries, mainly UAE and Saudi Arabia. These countries are central to the rapid development of globally competitive healthcare facilities in the Gulf Region especially in the UAE after the construction of their Health Care City, which has attracted people seeking medical interventions from different areas in the world (Khan and Alam, 2014). International healthcare associations and workers were and are encouraged to partner in starting innovative services in Qatar, which could further catalyse the development of medical tourism in Qatar.

2.6.1 Hamad Medical Corporation

The Hamad Medical Corporation (HMC) is the leading public healthcare provider for Qatar. The HMC has been established in Qatar since 1979 and it is considered to be Qatar's leading health care supplier. HMC is dedicated to dynamically contributing to and facilitating the sustainable development of Qatar and its nation in line with the QNV 2030 (see Appendix I). To meet the healthcare needs of Qatar's rising population, HMC has evolved into a flourishing and integrated holistic healthcare provider which is able to provide effective

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diagnosis and treatment of diseases many of which used to be treated in oversees medical centres, as well as medical learning and research. Currently, the health system in Qatar is considered to be one of the best within the Middle East according to the 2018 Legatum Prosperity Index (The Legatum Institute Foundation, 2018).

HMC continues to improve its services and has also started a proactive expansion plan, focusing on the growing areas of their community. HMC opened three hospitals in 2017 tackling the needs of the community; female only and rehabilitation hospitals and ambulatory surgery centres represent the three specialties most needed in Qatar (HMC, 2017). HMC operates 18 hospitals and centres in addition to running the national ambulance service, a residential healthcare service, trauma system, continuing care, and an international medical affairs office (HMC, 2019a).

Healthcare services are available to all Qatari residents, those with full citizenship (whether by birth or otherwise) can access all standard care in public hospitals such as HMC free of charge. However, they are expected to pay 10 percent of the cost of treatment and their insurance pays the rest when they opt for private medical facilities: this option is only accepted for Qatari citizens with insurance cover. For anyone who is permitted to reside in Qatar legally and have a health card, they pay between 10 and 20 percent of the total cost. Any resident with a valid long-term visa but with no valid health card has to pay for healthcare services in full. GCC nationals who access healthcare services in Qatar and share rooms do not pay. If they opt for private rooms, they receive surgical services for free, but are required to pay for the private room in full. All other people falling outside this category pay for healthcare services in full, shown in Table 2.6.1 below.

Table 2.6.1. *Qatar's treatment payment criteria for different categories of citizens, residents and visitors*

Category	Primary Criteria	Additional Criteria	Entitlement to Treatment
Qatari National	Born in Qatar or with full citizenship	Standard care in public hospital e.g. at HMC	Free
		Choice of medical facility apart from HMC e.g. private and with insurance	10% and insurance pays the rest
Qatari resident including expatriates	Legally permitted to reside in Qatar	Valid long-term visa with valid health card	10% or 20% of total
		Valid long-term visa without valid health card	Full payment
GCC Nationals	Citizens (not residents)	Sharing rooms	Free
		Private room	Pay in whole except for treatment or surgery, which is free
Any other visitors	Not on resident visa	Alone or accompanied (whether one travels alone or in the company of another e.g. spouse)	Pay full cost

The organisation has a policy to support the development of tourism in Qatar (HMC, 2015), (see Appendix II). In support of tourism in Qatar, HMC has been partnering with the QTA. For example, HMC stationed 11 ambulances at the Sealine Medical Clinic during the April 2019 camping season in collaboration with QTA. This was the ninth successive that HMC operated the clinic (HMC, 2019b).

2.7 Qatar and the Growth in Healthcare Sector

The full amount of health expenditure is the total of both public and private health expenditure as a proportion of total population. It included the cost of health services, family planning performance, nutrition performance, and emergency aid allocated for health but does

not comprise water and hygiene expenses. To be more specific, private health expenditure comprised direct family expenditure, private insurance, charitable contributions and private corporations to direct service providers.

According to the most recent data from the World Bank Group (2019), Qatar had the highest per capita spend in healthcare in the Middle East at US$1,827.06 in 2016 and it was the fastest rising healthcare market in the GCC within the six-year period 2013 to 2018. The GCC Health Care Industry Report (2012) identified that Qatar had one of the maximum growth rates of healthcare expenditures because of the development of innovative medical technologies and improved healthcare services. The report also mentioned that members of staff within the Qatari healthcare sector are paid the highest wages in the GCC region, which aids in staff recruitment and retention. This is particularly important in attracting those with a very high level of expertise to work in Qatar (Abujaber and Katsiouloudes, 2015) since the World Health Organization (WHO) predicted that the healthcare labour force scarcity will increase to 12.9 million employees worldwide by 2035.

2.7.1 The Qatari State of Health and Regional Medical Tourism

Since it was established in 1995, the Qatar Foundation has been progressing in terms of promoting education and scientific research. For this reason, the City of Education was built to guarantee the availability of education for all industrial sectors in Qatar (2015). In 2014, the World Innovation Summit for Health (WISH) Conference was held in Doha. In choosing to host WISH in Qatar the Foundation was supporting its vision and mission to unlock human potential as well as serving to emphasise Qatar's leading role as a promising centre for healthcare development. Qatar Foundation coordinates the activities of WISH in Qatar to promote and spread healthcare improvement and best practice.

The Qatar Foundation works in co-operation with the Supreme Council of Health to help identify how incidences of preventable damage to patients could be decreased (Supreme

Council of Health, 2011c). Appendix IV illustrates the Qatar Healthcare Facilities Master Plan (QHFMP) structure. The GCC Health Care Industry Report (2012) stated that medical tourism is increasing significantly in the GCC region. This is because more attention is being paid to expert care and wellness nowadays reflected, for example, by the rapid rise in cosmetic care centres, up by 3.2 per cent in the GCC region. This confirms the movement towards keeping up with international standards and competition by the region. Additionally, the most recent GCC Health Care Industry Report (2016) anticipated the increase in each Gulf Cooperation Council country would be in between 11 to 13 percent by 2020. Less positively, the report also pointed out that increasing income levels and inactive lifestyles has led to an increased occurrence of diabetes and obesity in the local population leading to an increased need for expert healthcare services within the GCC region.

The QHFMP declared that by 2020, most of 48 proposed healthcare infrastructure projects should be completed. These projects consist of 31 health centres, 8 diagnostic and treatment units, a general and specialised hospital, 2 patient-centred long-term care facilities and 5 hospital expansion plans will be completed during 2015 to 2020. Four of the expanded hospitals are expected to open by the end of 2019. The fifth hospital development will be finished in 2020 whilst 17 more health centres were anticipated to be finished between 2018 and 2020 (Varghese, 2014). In addition to the previous facilities, 14 health centres and 8 diagnostic divisions have already been opened and are operational (HMC, 2019). This has had a significant impact on the development of health care sector in the country.

Reviews of Qatar's medical tourism largely portray it as a source or origin of medical tourists more than a destination for medical tourism suggesting a lack of attention dedicated towards developing medical tourism. For example, neither medical or health tourism is mentioned in key government tourism and health ministry documents and nor are the terms health and medical captured anywhere in the annual tourism reports. The 2017 Annual Tourism

Performance Report (QTA, 2017) highlights a 23 percent decline in number of visitors in 2017 compared to 2016. However, it does not mention the reason for the decline or any contribution of medical or health-related services.

Despite the lack of explicit attention that has been accorded to medical tourism, the Medical Tourism Index (MTI) (2019) ranks Qatar 30th globally in terms of appeal as a medical tourism destination with an overall score of 60.07 while Canada topped the list with an overall score of 76.62. The MTI computes the scores based on the three dimensions of destination environment, medical tourism industry, and quality of facilities and services. In each of these indicators, Qatar scored 54.65, 60.98, and 64.58 points respectively. Within the Arab nations, MTI (2019) ranked Qatar at position 4 overall out of the 13 countries considered. Since Qatar is also an exporter of medical tourism and the industry is not well established yet, the high ranking within the region could be an indication that medical tourism within the Arab nations is still in the very early development stages save for countries like Saudi Arabia.

The environmental dimension was high and this was attributed to Qatar's reputation, overall economic conditions, and political stability thereby aiding in balancing out the lower scores that were recorded for the country with respect to culture similarity. With respect to a medical tourism industry, Qatar was ranked sixth with notable efforts in continuous progress in building the country into a reputable, tourism-friendly country with proper infrastructure and numerous attractions. However, MTI (2019) also noted the absence of a proper cost structure and added that developing one would enable Qatar to compete for patients better against rival medical tourist destinations. On the index about facility and service quality among Arabic countries, Qatar ranks third and this was mainly attributed to international accreditations, medical staff recognition, and superior overall experience for patients.

2.8 Key Performance Indicators of Qatar Healthcare

The Supreme Council of Health (2011a) indicated that the NHS targets were to achieve a sustainable world-class, integrated health care institution, develop a preventive health care, grow a skilled Qatari staff, develop a national health policy, offer accessible services, and carry out high-quality research. In carrying forward the six targets identified in the 2011 NHS, the NHS (2018-2022) dubbed, "Our Health Our Future", contributed to QNV 2030 by underscoring the significance of improved health of the populations and delivering healthcare (Ministry of Public Health (MOPH), 2018). In the foreword section of the NHS 2018-2022, the MOPH Minister, Her Excellency Dr. Hanan Mohamed Al Kuwari, described the new strategy as reflecting, "a global shift in thinking by focusing on seven priority population groups" with the intention that the system-wide priorities will help Qatar in delivering "a genuinely integrated model of care that strives to maintain well-being, while making sure that people receive well-coordinated care, delivered in a professional and safe environment at the appropriate level" (MOPH, 2018, p.7). The NHS 2018-2022 has seven goals within its strategic context, which will be achieved through the "triple aim of better health, better care, and better value" (MOPH,2018, p.19) with focus on seven priority areas, as summarised in Figure 2.8 below.

Figure 2.8. *The strategic context, triple aim, and priority areas of Qatar's NHS 2018-2022*
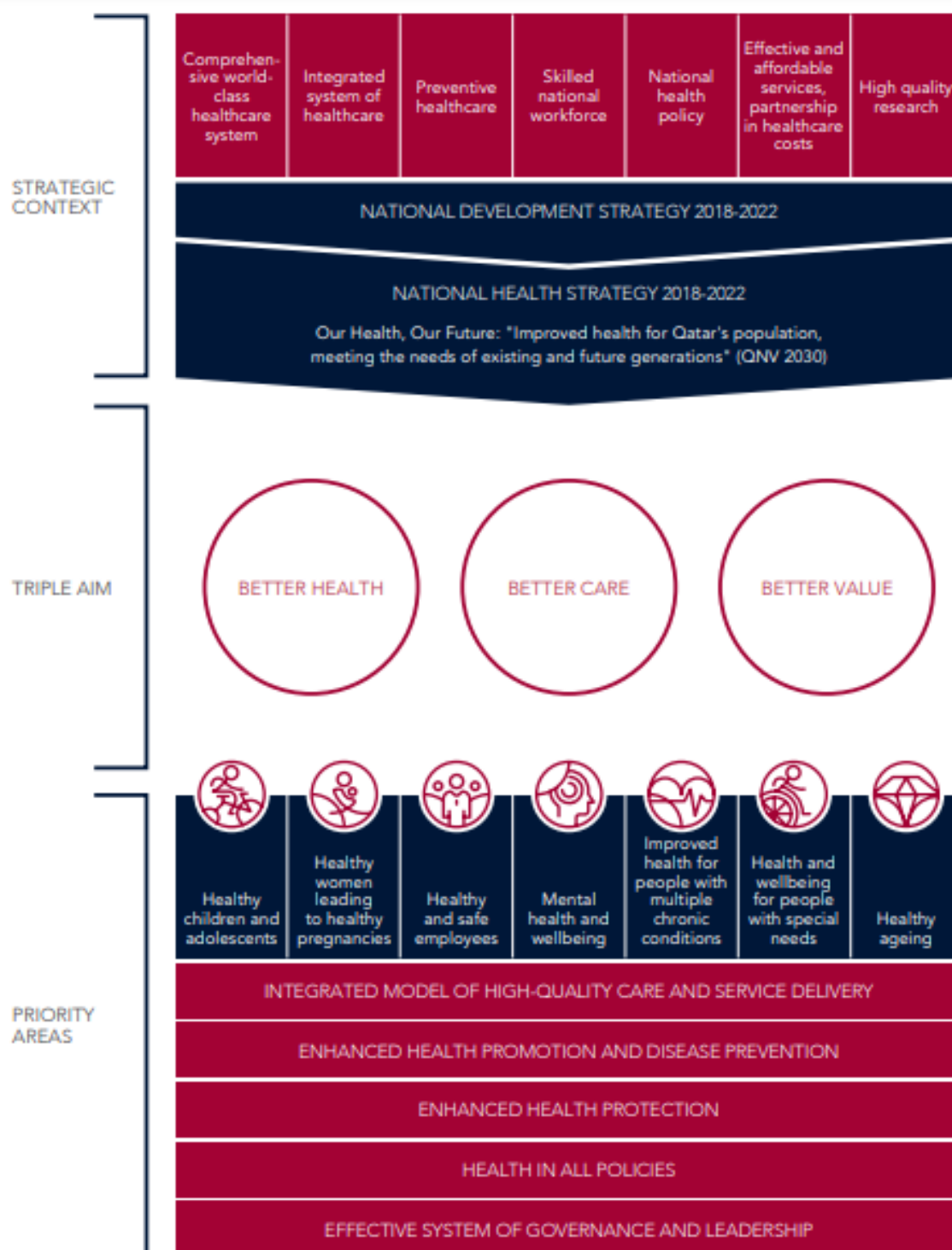
Source: MOPH (2018) NHS 2018-2022, p. 19

Two public healthcare organizations, HMC and Primary Health Care Corporation
(PHCC) are well-known for being the main health care providers in Qatar. Although the
principal provider of inpatients care is the HMC, as described previously in section 2.6.1, the
PHCC has 21 basic health care centres. Additionally, Qatar has a further 4 private hospitals

with a capacity of 314 beds and the Supreme Council of Health (SCH) has 4 health centres which are managed by private system. There are also two facilities owned and run by the Medical Commission (Supreme Council of Health Annual Report, 2014). However, the lack of clarity about the kind of medical tourism that Qatar should pursue in the six integral elements of NHS and the National vision of Qatar would limit the development of medical tourism in Qatar.

2.9 Tourism Facilities Available in Qatar

Qatar is a multicultural country. It is regarded as home to communities from various origins (Bagnall, 2015) which enhances its global appeal as a hospitable and welcoming destination for tourists. The key tourism attractions in Qatar can be divided into five main segments, traditional (sun, sea and sand), innovative (sport, health centres, skyscrapers and shopping centres), events (exhibitions, financial and economic incentives and conferences), nature (safari parks, sea and desert) and culture where tourists can visit many historical and heritage sites in addition to museums and art galleries (QTA, 2015). Tourists can discover Qatar by selecting any choice from the five segments. The QTA (2015) stated that the strategy designed for the tourism sector is to move further from the sand, sun and sea image to others because the country is focusing on sustainable development and to achieve this goal more sectors must be part of the tourism plans. A depiction of this strategic change towards diversified tourist products is given in Figure 2.9 below.

Figure 2.9. *Qatar's diversification of tourism products*
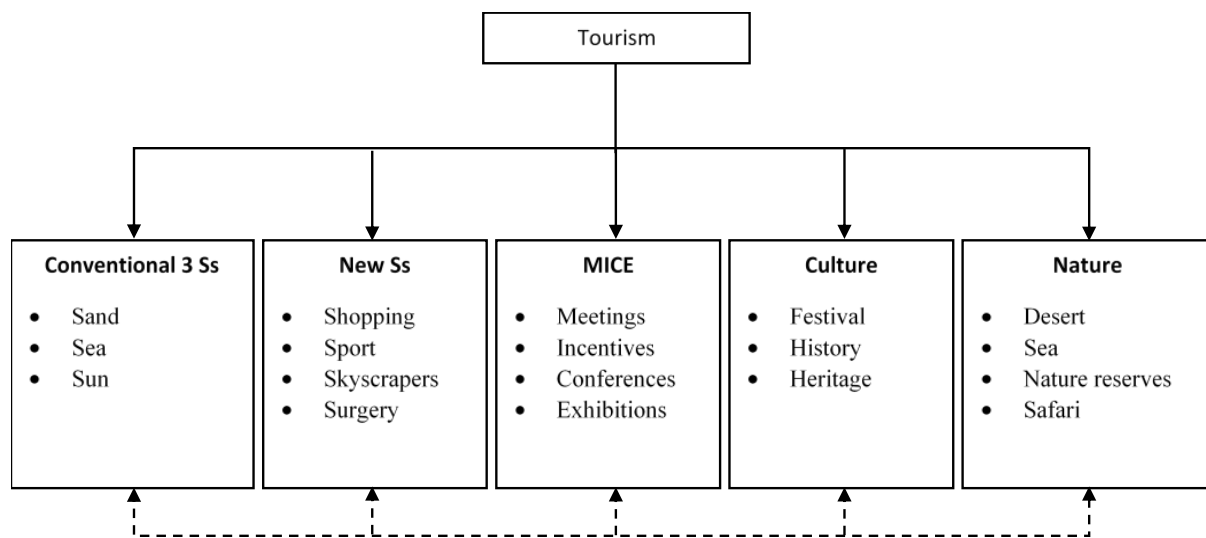
Examples of these new tourism sectors include the seven "Tourist Hotspots in Qatar", which have been identified by Qatar's National Tourism Council (2019). They include Doha's Waterfront Promenade that circles the Doha Bay, Souq Qaqif (the traditional market), Doha's Corniche housing artefacts and finest Islamic art, Katara's performances, galleries, and theatres for recreation and culture, contemporary elegance at The Pearl, the Inland Sea and the Al Zubarah Fort, which is a UNESCO Heritage Site. Although Figure 2.9 implies diversification towards surgery tourism as one of the New Ss, the use of the term in this research suggests a considerably limited understanding of what the full scope of medical tourism in Qatar entails. This is because it excludes other forms of medical tourism services such as rehabilitative medical services and leisure medical tourism such as spa services and so on.

Although the information derived from the MTI (2019) and presented in Section 2.7.1 on page 30 portrays Qatar as a medical tourism destination already, such statistics are not currently verifiable via agencies such as Qatar's Tourism Authority. Therefore, there is no data available publicly to enable a near-accurate characterisation of medical tourism in Qatar in terms of volume, industry or segment value, breakdown of the kinds of procedures on highest demand, and geographical origin of medical tourists among other issues. At the present time

the Government of Qatar, through the QTA, still views Qatar as the country of origin for medical tourists going to other countries and not as a medical tourism destination, as shown in the same section 2.7.1 from page 31 to page 32.

2.10 Tourism Development in Qatar

Tourism development in Qatar can be clearly seen by the contribution of this sector to the country's GDP. Data obtained from the World Travel & Tourism Council (WTTC; 2019) showed that the direct GDP contribution of the Qatari Travel and Tourism sector in 2018 was 9.4% of the total economy, which translated to QAR 64.5 billion. This figure includes the economic action of several different industries such as hotels, travel companies, airlines and other traveller services. Further, it was revealed that the sector contributed about 194,400 jobs in 2018, which was 9.5% of the total employment with projections that this would grow to about 300,700 jobs by the end of 2019. Saudi Arabia, India, and the UK topped the list of inbound arrivals accounting for 28%, 13%, and 5% respectively. International spending accounted for 84% of gains while leisure spending was more than business spending at 61%. Figure 2.10 below is an infographic summarising the various aspects of the economic contribution by the Qatari travel and tourism in 2018 based on the WTTC data.

Figure 2.10. *Overall contribution of travel and tourism to Qatar's economy in 2018*
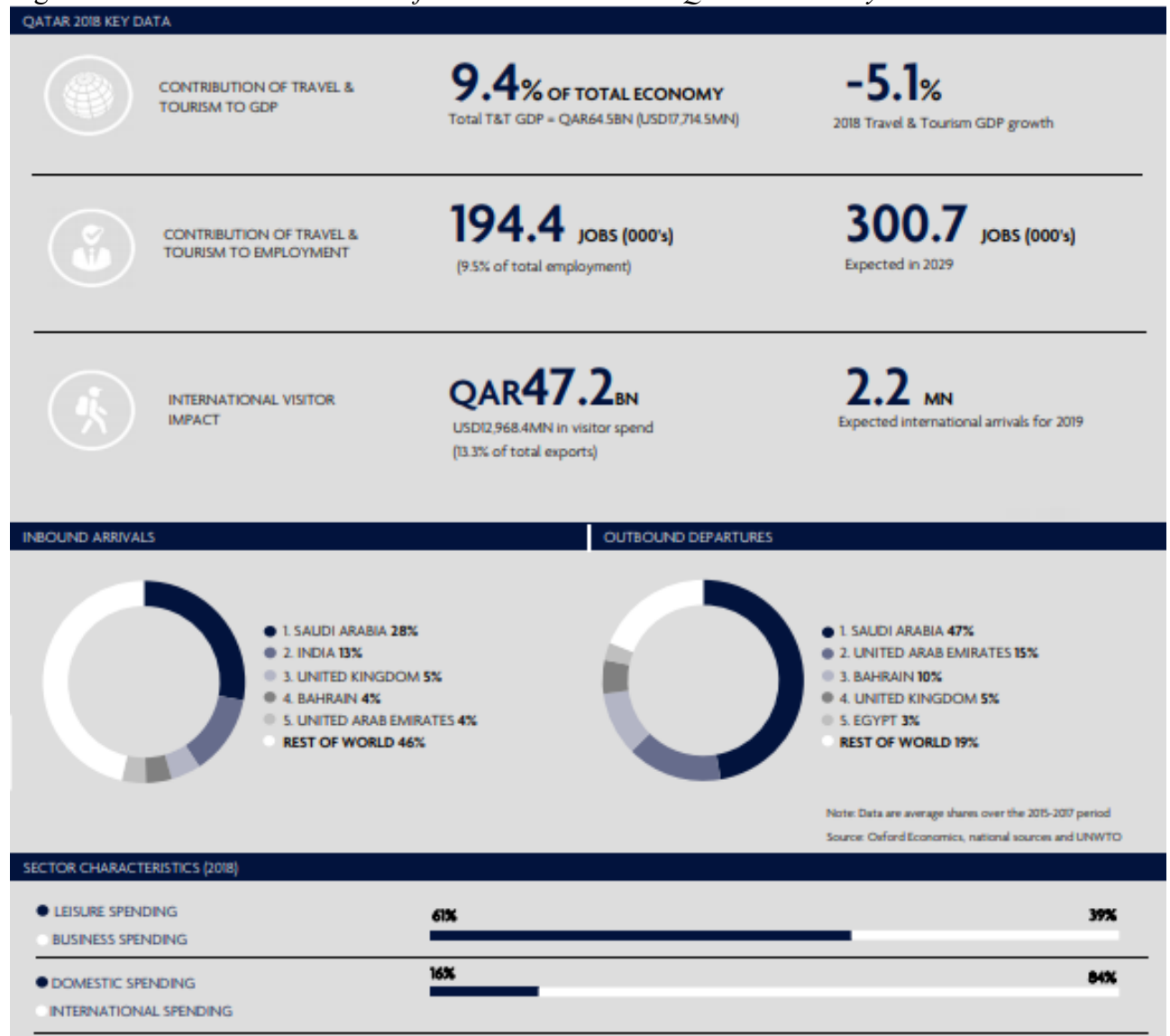
Source: WTTC (2019)

In recent years, Qatar has been identified as a travel hub, mostly due to the rapid development in all Qatar transportation methods (Hassanien and Dale, 2013). According to Theobald (2014), this development has positioned Qatar well on the international tourism map. In addition, Doha has also become a diplomatic hub in the Middle East region which brings more international travel related activities to the country (Hassanien and Dale, 2013). Reflecting the increasing number of international events taking place in Qatar, such as UN Climate Change Conference in 2012, a notable increase in businesses offering different

tourism-related services such as accommodation, air travel agencies, and food courts has been experienced in the country (Theobald, 2014). Besides past events, the forthcoming 2022 FIFA World Cup will also be instrumental in enhancing the reputation of Qatar as a preferred tourism destination.

According to the Qatar National Tourism Sector Strategy 2030, many projects and programs are being established with short, medium and long-term goals and positive outcomes for Qatar and Qataris. The Culture, Arts and Heritage Ministry, Health Ministry, Transportation Ministry, Municipality and Urban Planning Ministry together with many public entities (such as Qatar Museum Authority, Civil Aviation Authority, Qatar Development Bank, Hamad International Airport Steering Committee) and private sector institutions in Qatar are engaged actively in the development of the Strategy. When completed these projects are expected to have a positive impact on the daily lives of Qataris in terms of better access to leisure and entertainment hubs. For tourists, they will increase access to a variety of amenities to spend their vacations with the availability of luxurious hotels, spas, restaurants, and improved entertainment facilities. However, some of these are futuristic projections and aspirations that do not necessarily reflect the actual situation despite ongoing efforts to accomplish the goals of the Strategy.

2.11 Summary of Key Issues

The discussion above sheds light on Qatar's vision in its pursuit of sustainable development among all sectors. It shows that Qatar is a politically stable nation with impressive growth in its economy. The excellent HDI scores shows that Qatar has been able to develop its human capital and invest in her people. This, in the context of this topic, means that Qatar has been able to dedicate adequate resources for her residents and could be able to extend the same to the development of medical tourism. The economic prowess of Qatar means that the living standards are fit for medical tourists from different countries including developed nations and

continents such as Europe and North America. Thus, Qatar would be able to compete with other renowned medical tourism destinations around the world in terms of investments in healthcare and supportive packages for medical tourism such as good hotels and infrastructure.

Community stability under the social development pillar means that Qataris are likely to be hospitable and welcoming of different, foreign and consanguine cultures and communities. Moreover, Qatar's great achievements in the infrastructure, education, health care and tourism services has led to more influx of populations as they made a significant difference in the lifestyles of its nationals. Qatar is also setting plans to drive the services in its healthcare system as well as to ensure the patient safety and security to world-class level. However, although there are significant improvements in pursuing environmental growth and sustainable development, the challenges with air quality, for example might impact upon where medical tourism could best be developed.

Although Qatar has made significant developments politically, environmentally, economically, and in terms of tourism and healthcare sectors, there are evident gaps into addressing and growing medical tourism in line with the QNV such as lack of a clear regulatory and implementation framework for the development of medical tourism, infrastructural capacity to support medical tourism, and proper marketing to ensure competitiveness in the global market. Despite this, evidence from external medical tourism rankings show that Qatar has the potential to become a competitive medical tourism destination both globally and regionally among Arabic countries. One of the most outstanding challenges mentioned in such rankings is the absence of a proper cost structure to cater especially for medical tourists and a comprehensive understanding of the full scope of medical tourism. Overall, though, Qatar has potential to grow her reputation as a tourist destination and a world-class provider of quality healthcare services.

Chapter Three

Literature Review

3.1 Introduction

Travelling abroad for medical tourism, where customers (patients) go outside their home country for medical, wellness, or therapeutic treatment, is becoming an important form of tourism in countries that have invested in healthcare (Lee and Balaban, 2014). The popularity of medical tourism has grown due to increasing demands for improved healthcare; this includes escalating prices forcing the patients to travel abroad (Paffhausen *et al.*, 2010) and the exponential growth of international travellers seeking cosmetic surgery and answers to different medical conditions. (Connell, 2011). This chapter presents a comprehensive review of literature on niche tourism. The main emphasis is on topics relevant to medical tourism plus a detailed review of SERVQUAL theory with its application in different business contexts. Stakeholders in healthcare institutions as well as non-medical services attributes in hospitals, and customer satisfaction are also critically reviewed. The chapter also explores health seeking behaviour concepts and model as well as discussions of antecedents' impacts (experience quality, perceived value, and satisfaction) on tourists' behavioural intentions.

3.2 Definitions of Tourism Concepts and Terms

In 1976, the Tourism Society in Britain defined the concept of tourism as "the temporary short-term movement of people to destinations outside the places where they normally live and work, and activities during their stay at these destinations; it includes movement for all purposes, as well as day visits or excursions" (Holloway, 1988, pp. 2-3). Normally, people perceive tourism as travelling not only for pleasure with an overnight stay, but also travel for holiday or feast activity. In 1991, the World Tourism Organisation (WTO) proposed a definition for tourism as:

"The activities of persons travelling to and staying in places outside their usual environment for not more than one consecutive year for leisure, business and other purposes not related to exercise of an activity remunerated from within the place visited" (Theobald, 1998, p.13).

Therefore, tourism, as commonly agreed upon, involves travel to other countries and places for pleasure or other purposes. Many researchers attempted to define medical tourism as travel for healthcare purposes. The term was first instituted by travel agencies and communication agencies to spread this new type of travel (Leggat and Kedjarune, 2009); nowadays, it has become a typical expression that depicts the rapidly growing number of tourists travelling abroad for healthcare services. Some definitions of medical tourism focus on the reasons that lead the medical tourists to leave their home country. Johnston *et al.,* (2010) explained medical tourism as "patients travelling outside their home country to well established cross-border care arrangements, made the cause of attaining medical care, frequently surgery, abroad" (p. 24).

Similarly, Lunt and Carrera (2010) define medical tourists as patients who are prepared to travel for medical care. However, some definitions exclude the individuals who are sent to another country for "urgent" treatment by healthcare institutions like hospitals, insurance agencies, or governmental institutions, as this may be due to the issue of waiting lists, lack of experts or inaccessible facilities rather than patient choice. According to Thompson (2008, 2011) medical tourists are completely different to 'medical migrants' those who are directed by institutions instead of setting their own choices. In medical terms, medical tourists are recognized as 'patient-consumers'.

The analysis of literature (see section 3.7 for a comprehensive review) shows that the term *'health tourism"* has not been comprehensively defined. However, Goodrich and Goodrich (1987) defined health tourism as:

"An attempt on the part of a tourist facility to attract tourists by deliberately promoting its health-care services and facilities, in addition to its regular amenities. These health care services may include medical examinations by qualified doctors and nurses at the

resort or hotel, special diets, acupuncture, trans-vital injections, vitamin complex intakes, special medical treatments for various diseases, such as arthritis, and herbal medicines" (p. 217).

Since the 1970s, health tourism was inferred as "the provision of health facilities utilizing the natural resources of the country, in particular mineral water and climate" (Lunt and Carrera 2010, p. 23). In literature, medical tourism can be distinguished from health and wellness tourism as the latter is usually defined as being too 'soft' and less essential medically (Smith and Puczko, 2009). The growth of the '*wellness*' concept is related to two factors suggested by Koncul (2012). The first factor was the promotion of the integrated concepts of well as being and fitness into the World Health Organisation global health policy. The second factor is the rise in peoples' overall education which has improved the human attention to personal health (Koncul, 2012). Jonathan (1994) defined health tourism as luring individuals from all over the world through an amalgamation of unique attractions along with healthcare facilities. Connell (2006, p.10) proposed that "the medical tourist can be either a traveller committed to receiving medical treatment, or one who incorporates an element of pleasure tourism in their trip, alongside medical treatment." Wongkit and Mckercher (2013) suggested that medical tourism could mean different things to different researchers depending on their research contexts and areas of focus. Cohen (2008) suggested that there are four categories of medical tourist. The first classification is those tourists who receive therapies for accidents or health complications and this usually occurs during an overseas holiday. These people are recognized as 'medicated tourists. The second category termed as '*medical tourist proper*', includes people who planned to travel to a country to get medical treatment, but who may also decide once they are in that country to participate in some conventional tourism activities although they had not planned to do so in advance. *"Vacationing patients"* are tourists who plan trips that are for medical treatment purposes, but also plan to include some touristic activities.

According to Khan (2010), "the last category comprises tourists that travel for only medical treatment and these are the "mere patients" (p. 34). Thus, any group who takes part in providing or accepting health services, such as a patient, a dealer, a trader, a bureaucrat, can be termed as a medical tourism stakeholder. According to Khan (2010), the US, Western Europe, and Middle East although Thailand, Malaysia, Singapore, India, and Mexico top the list of medical patients who travel for medical treatment globally. For the purposes of this research, the definition of medical tourism proposed by Connell (2006) is adopted because it is more inclusive in terms of the aspects it covers of travelling for medical and nonmedical reasons.

3.3 Historical Background of Medical Tourism

3.3.1 Medical Tourism in Ancient Times

Recorded medical tourism dates back to the twenty fifth century BC, when Europe and Asia were recognized as destinations for health and well-being due to the availability of spas and other resorts (Erfurt-Cooper and Cooper, 2009). Under the reign of the Greek empire, tourists believed in the supreme power of the gods and their mighty effects on their destiny (Health Tourism, 2012). They travelled long distances to reach healing temples, such as the temples of Asclepia that were built to honour Asclepius "the god of medicine", the Olympian temple of Zeus and the Delphi Temple. Such temples contained gymnasiums and places of prayer that would offer the visitor an atmosphere of physical and mental peace (Li and Cui, 2014).

In the Middle East, the first recorded spa resorts located on the Dead Sea shoreline were established by Pharaoh Cleopatra. Between 54 BC and 450 AD, the Romans built 170 bathing centres like bathing facilities, and large imperial baths *"thermae"* found all over Europe, the Middle East and North Africa, which attracted tourists from all over the world to experience the wealth and comfort brought by mineral thermal springs and hot baths (Erfurt-Cooper and

Cooper, 2009). This includes the thermae in the city of Bath in the UK which one of the largest and best-preserved sites.

3.3.2 Medical Tourism from the Renaissance Period to the 19th Century

In the 14th Century in France, a town near Ville d'Eaux city turned into a centre for preventative medicine becoming famous due to the presence of iron-loaded hot springs. It is during this time when the term spa, originated from the Romanian expression *salude per aqua* "*health through waters*", was used for the first time. Well known historical figures, such as the writer Victor Hugo and the Russian Czar, Peter the Great, utilized the Ville d'Eaux spa as a healing resort (Li and Cui, 2014).

At the beginning of the 18th century, during building works to improve sanitation in Bath the ancient Roman baths were rediscovered and major parts of the Roman complex were modernized and opened up again to the public for use as a spa. Several improvements were made in the city like paved roadways, lighting in the streets, hotels, and decorated restaurants. This significantly boosted the city's spa-wellness tourism business, and therefore, its economy was enormously enhanced (Health Tourism, 2012).

3.3.3 Twentieth and Twenty-First Century Medical Tourism

The modern development of medical tourism in the US dates back to the increased birth rates era (baby boom generation) in 1970s, which brought about expanded enthusiasm for wellness and alternative treatment choices (Ross, 2001). However, initially the concept of medical tourism in the US was restricted to patients seeking medical health care such as staying in Sanatoriums; usually a medical facility for long-term treatments in foreign countries which are unavailable domestically. They copied the behaviours of Europeans who visited the Sanatoriums for wellness and health benefits (Ross, 2001). Perhaps the best-known examples of sanatoriums were the tuberculosis sanatoriums which were located at the Swiss Alps. These remained popular and in use until the late twentieth century. However, this switched so that by

the late twentieth century the US had risen to be among the most popular destinations for health

care due to their technological advancements in medical services (de Arellano, 2011).

In the 1980s and 1990s, foreigners seeking eye, heart and cosmetic procedures sought special

programs in Cuba which provided the tourists with cheaper treatment and faster processes. De

Arellano (2011) stated as follows:

> "Other Caribbean countries, such as Jamaica, Barbados, and Puerto Rico, established
> their own mark in the medical field in order to avoid competition; Jamaica excelled in
> plastic surgery, while Barbados in infertility, and Puerto Rico in cardiovascular and
> orthopaedic surgeries, neurology, and oncology" (p. 293).

The main target of these programs was to attract patients from North America and

Europe. Concurrently, several Asian and Latin- American countries also established programs

for medical tourism which also aimed to attract tourists from Western countries by enabling

patients to avoid long waiting times, high expenses, and complicated legal restrictions.

Westerners, particularly those searching for sexual and reproductive health care services, could

use these overseas options to maintain their social confidentiality. Initially these treatments

were exclusively accessible to wealthy Westerners, but as more treatments became available,

middle-class people were also able to benefit from these programs (Turner, 2007) and expand

the market for medical tourism.

The Asian economic crisis, which started in 1997, led some countries to invest

intensively in medical tourism as in Thailand for instance, where it made advancements in

plastic surgery so it could attract many foreigners. In particular, the country specialized in

affordable programs and gender reassignment surgical operations with less-restricted pre-

surgical psychological conditions, and built several touristic medical institutions such as the

Bumrungrad International Hospital in Bangkok Thailand (Li and Cui, 2016).

In the 21st century, Thakkar (2010) identified that the growth of medical tourism had

been particularly great in 12 countries spread across South and North America, Asia, and

Europe due to different factors such as the low cost of medical services, the location of the

countries and the investment in healthcare services by the countries' governments as shown in

the figure 3.3.3 below.

Figure 3.3.3. *Global medical tourism destination countries*
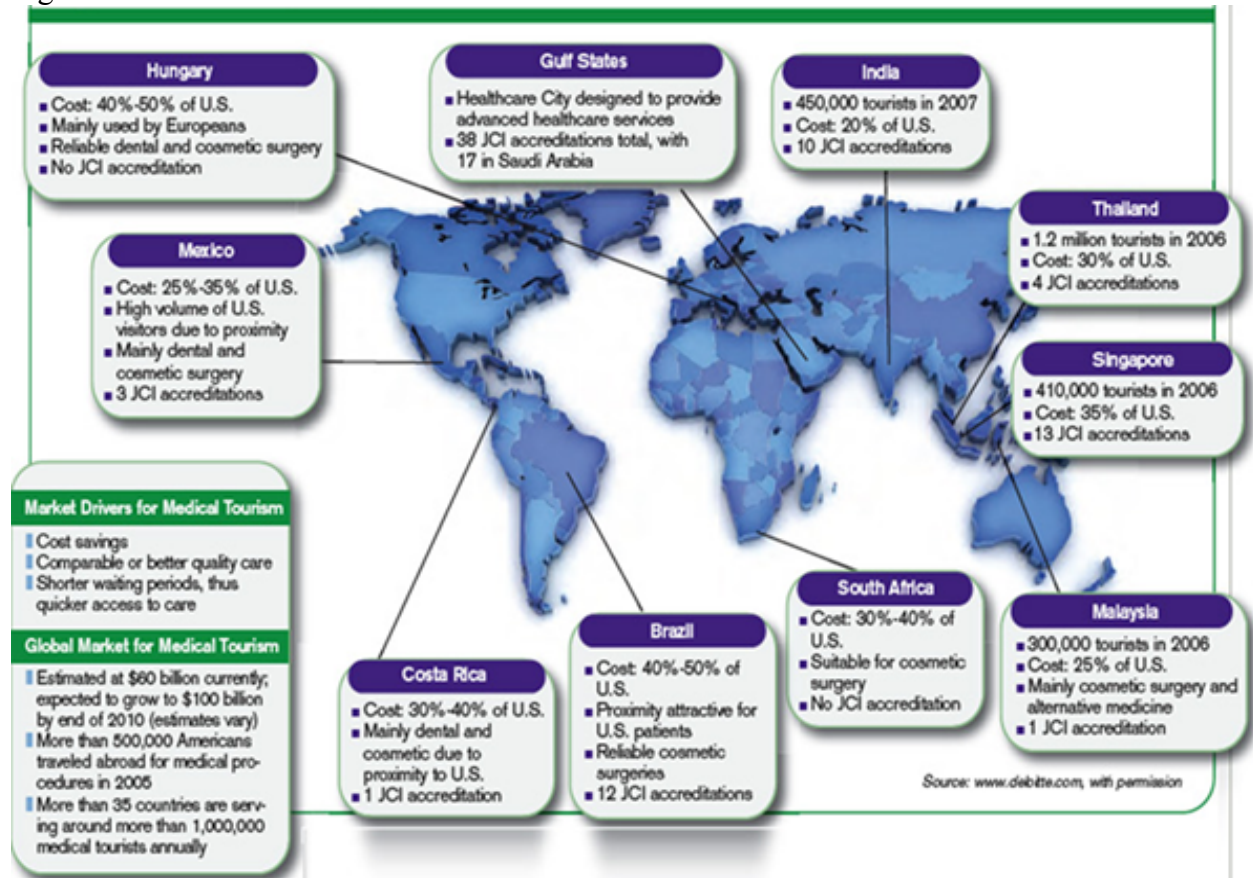
While projecting the growth of medical tourism the Joint Commission International

(JCI) - an international organisation that tasked with improving the quality of healthcare in the

international community - has accredited "more than 375 hospitals in 47 countries across

Europe, Middle East, Asia, and South America" (Eades, 2010, p. 230). At the beginning of the

21st century, the media largely ignored medical tourism as a subject but, since then, reporting

has improved significantly from about 40 stories in 1990 to more than 2000 in 2007 (Eades,

2010). Among the reasons that led to the rise in media attention in 1990s was the development

of new destinations, an increase in specialist medical tourism organisations and the publication

of manuals, dedicated industry journals, restorative tourism traditions articles and academic

awareness programs. The 21st century witnessed an increasing number of less-affluent medical tourists from developed nations seeking high quality medical care with reasonable prices in certain regions of the third world countries (Connell, 2011).

However, much of the data available on such medical travel is unreliable because of the inaccessible sources, unjustified estimated figures (Hanefeld *et al.,* 2014) and agreed procedures for the collection of data is often lacking (Connell, 2013). In addition, as previously discussed, definitions of the term medical tourists vary. For example, Singapore gathers data on medical influxes via exit polls at the airport to approximate its medical travellers; those with a precise main objective of gaining medical care. Thailand conflates the number of strangers getting medical care at hospitals with that of those who are travelling for tourism or beauty treatments, using spa and wellness resorts. When Thailand announced that it receives over 1.5 million medical tourists on yearly basis NaRanong and NaRanong (2011) suggested that only one third of these tourists actually travelled for strictly medical purposes. More reliably Hungary is one the cores of medical travel in Europe as it receives 1.8 million medical tourists on yearly basis; most of them are short-stay visitors on fitness or dental care normally travelling on other trips and most come from European countries such as Germany, United Kingdom and Spain (Piazolo *et al.,* 2011).

In North Africa, Tunisia is the dominant medical tourism destination with approximately 150,000 international tourists visiting Tunisia according to the US Chamber of Commerce (2014)., Tunisia has been drawing patients from nearby as well as the more affluent parts of Western Europe, although some from Western Europe were migrant Tunisians, and other Francophone origins. The country's thalassotherapy treatment ranks first globally (US Chamber of Commerce, 2014). Egypt is another significant player in the North African region. Egypt reported that from 2004, it received 50,000 medical tourists on a yearly basis from other Arab countries; 40,000 perhaps were from Libya until 2010 (Helmy and Travers, 2009;

Johnson, 2010). However, the medical tourists' inflow, in 2014, dropped by twenty-eight percent in comparison with the previous years' trend in the country (UNWTO Commission for the Middle East, 2014). New figures reported by the United Nations World Tourism Organisation (UNWTO) in 2015 showed that tourism North Africa had fallen by 8% due to the political instability in the area. Although unfortunate for the countries concerned, it opened up opportunities for other counties such as Qatar, which are seen as more politically stable (UNWTO, 2015)

South Africa has established a growing African market. The country has also developed prominently, particularly in cosmetic surgery (Connell, 2011). The managing director of Treatment Abroad, Keith Pollard stated that, "*Most African countries are focused on solving domestic health care issues rather than seeking overseas patients*" (cited Easen, 2009, p. 81). Additionally, even if the focus remains on internal medical matters, external perceptions of the quality of African medical care present a massive challenge. However, Easen (2009) explained how potential European consumers have a negative perception regarding the quality of healthcare services that are offered by the Sub-Saharan African countries and many non-western countries. For example, for many years, the health systems in nations like India were regarded as inadequate by the West. Professional bodies in certain countries even went to the extent of issuing cautionary notes after remedying complications and botched procedures during a medical tourism encounter in the East (Dalstrom, 2012). This creates another opportunity for Qatar, which has considerably advanced medical technology, to take up the market. In certain Arab countries like Yemen, Sudan, and Libya, the availability of expertise in the medical field has previously been perceived to be low, leading medical tourists to travel to Jordan, as it was regarded as the "*Middle East leader in medical tourism*" (Smith and Puczko, 2009, p. 163).Table 3.3.3 shows the combined mixture of inbound and outbound medical travellers in different countries over the past ten years.

Table 3.3.3. *Medical traveller estimates*

Receiving country	Estimated no. of annual medical travellers	Year
Australia	13 000	2010
Brazil	49 000–180 000	2005 and 2009
Costa Rica	25 000–150 000	2006, 2007 and 2008
Cuba	3500	2003
Cuba	200 000	2007
Egypt	68 000–108 000	2003, 2004, 2005 and 2006
Germany	50 000–70 000	2008 and 2009
Hungary	1 500 000–1 800 000	2007 and 2009
Hungary	300 000	2008
India	1 000 000–1 180 000	2004
India	100 000–150 000	2005
India	300 000–731 000	2006, 2007, 2008 and 2010
Israel	35 000	2009
Jordan	120 000–250 000	2002, 2004 and 2009
Malaysia	300 000–489 000	2006, 2007, 2008 and 2010
Philippines	100 000–250 000	2006, 2009 and 2010
Republic of Korea	60 000	2009
Singapore	270 000–450 000	2004, 2005, 2006 and 2008
Singapore	571 000–725 000	2007 and 2010
South Africa	330 000	2010
Thailand	450 000–700 000	2004, 2006 and 2007
Thailand	1 000 000–1 580 000	2008and 2010
Tunisia	10 000–42 000	2002, 2003 and 2007
Turkey	15 000	2007
United Kingdom	52 000	2010
United States of America	250 000–400 000	2006 and 2007

Source: Ruggeri *et al.,* (2015), The World Bank research database, Europe PubMed Central and EMBASE.

The movement of medical tourism from one country to another is influenced by perceived quality, availability, familiarity, affordability, geography and culture (Glinos *et al.,* 2010). More recently Bennie (2014) suggested that those seeking medical treatment under the cover of medical tourism are not just travelling overseas, but are also interested in destinations that involve cultural affinities, short distance travel, common language, and simulating attractions. Thailand and Singapore are mostly visited by Australians and New Zealanders due to closeness of the host country plus the differences in the costs of treatments (Connell, 2011). Patients from the United Kingdom, Sweden, and Germany tend to migrate to Hungary, Poland and Lativa (Connell, 2011), even though skilled health workers (nurses and doctors) are present in their own countries. Mexican Americans and those from Central and South American States tend to move to Mexico and Cuba (Ventures Onsite, 2015).

3.3.4. Medical Tourism Development in the Middle East

As shown in table 3.3.3, Medical tourism has developed slowly in the Middle East, particularly assisted by foreign patients from different locations such as the US and India. Jordan serves medical tourists arriving from particular areas of the Middle East and was the premier regional medical tourism destination in 2005, especially for travellers from Iraq, Palestine and Syria, due to its low costs (Jabbari *et al.,* 2012). Jordan's own data suggests that almost 220,000 cases across the globe received medical care in Jordan's private healthcare institutions in 2009 compared to 200,000 in 2008 and 190,000 in 2007 (Kreishan, 2010). However, Jordan now ranks sixth regionally on the Medical Tourism Index having lost to Dubai in the recent years (IMTJ, 2018b).

On the other hand, Israel provides some medical services, such as female infertility, IVF and high-risk pregnancy treatments for Jewish patients and others from neighbouring countries (Connell, 2010). It is also a well-known tourism destination in the Middle East, in combination with being well-known for its traditional treatments and its use of the medicinal qualities of the Dead Sea (Connell, 2011). The Hadassah Medical Centre is the main medical facility and is best known for performing the first computer-assisted hip replacement surgery in the World. The Ministry of Health, State of Israel (2019) reported that about 30,000 medical tourists arrive annually mostly from Eastern Europe and neighbouring countries.

Lebanon, like Egypt, is also a major medical tourism player hub in the Middle East and has sought to break into this new market following political stability (Connell, 2011). Making Lebanon the 'hospital of the East' is the ambition of the Lebanese Tourism Council, and according to the Agency for Investment Development in Lebanon (2010), the growth of medical tourism was expected to average around 30% between 2009 and 2011(IMT, 2010). However, in 2013 Lebanon and Jordan suffered from reduced tourists' arrivals especially from the Gulf, due to the civil war in neighbouring Syria (UNWTO Commission for the Middle East,

2014). Most medical tourists have gone to safer destinations in Asia, or to high-cost European destinations instead.

The huge loss of medical tourists overseas prompted the Gulf States in particular to instigate the development of national services that targeted medical customers in the gulf region as well as to redirect the flows of medical tourists inward. In 2013, Qatar, Yemen, Tunisia, and Saudi Arabia were the most successful as per international tourism revenues, where the former reported a twenty-one percent growth on its tourism sector (UNWTO Commission for the Middle East, 2014). In 2014, Qatar, Saudi Arabia and the UAE experienced sustained development in business tourism (UNWTO Commission for the Middle East, 2014). Dubai, in order to attract tourists from the Gulf and the Middle East and at the same time to discourage the Gulf medical tourists from going to Asia, established the Healthcare City DHCC (Dubai Healthcare city). However, medical tourism competition in the Gulf is not based on price but on quality. The Sultanate of Oman has signed agreements with Bavaria Medical Group (BMG) in Germany and Qatar Airways to transport its patients to Germany, and let BMG specialists visit Oman (John, 2006).

In addition, the GCC authorities are attempting to encourage medical tourism in the region through a great deal of investments into state-of-the art facilities. The GCC health ministries have set up strategies to promote official recognition of their health and wellness facilities through the cooperation of their healthcare institutions with international organisations in the health sector. An example is the Abu Dhabi and Dubai health institutions, which have collaborated with international renowned health organisations such as Medical Cornell and Johns Hopkins (Connell, 2011). As previously discussed, the Arab Spring revolution has shaken the political stability of many Arab countries, thus making Qatar the gateway for many Arabs from Saudi Arabia and Dubai, especially those who want to undergo cosmetic surgery and other medical procedures.

3.3.5 Medical Tourism Development in Qatar

Currently, progress in the healthcare sector has been rapid because of government intentions (see sections 1.2 and 2.7) for Qatar to play an active role in the medical tourism business. As part of this intention, medical practice in the country has been characterized by developments in specialist advanced robotic surgery skills. According to the Ventures Onsite report (2015), investments were allocated to the healthcare industry in 2015 as the country progressed, its intention to double the number of health facilities by 2022. The Qatar Government raised the healthcare budget from 3.9 billion dollars in 2014 to 4.3 billion dollars in 2015. Funds were assigned to improve facilities at Hamad General Hospital and Hamad Medical Corporation, complete the Sidra Medical and Research Centre, launch a hospital dedicated for maternity services and establish new health centres (Ventures Onsite, 2015).

At the 2014 Qatar British Business Forum networking event, Professor Lord Darzi of Denham declared that Qatar had overcome challenges with healthcare because of its huge investment in the health sector. He said, *"If you look at Qatar's research and science developments, as well as investment in new hospitals, it is fantastic. Not only that, but value for money is excellent. We can learn a lot from Qatar"* (Gulf Times, 2015). In 2015 Gupta stated that if Qatar was not yet a top medical destination there were such a number of healthcare facilities that people could be left spoilt for choice if it did become one. These comments suggest that the large investments in medical tourism are therefore making Qatar an attractive destination for many medical tourists from different countries.

3.4 Theories and Concepts of Medical Tourism

3.4.1 The Wellness Lifestyle

Lifestyle perception is one of the most widely used concepts in modern marketing activities, because it provides a way to understand consumers' everyday needs and wants (Solomon *et al.*, 2006). Lifestyle has an influence on consumer's behaviour (Kesić, 1999)

which includes tourism and it directly affects travel motives (Konu, 2010; Aziz and Ariffin, 2009). The first model of health-seeking behaviour was developed in 1950s by Hochbaum (1958) *"health belief model"* which forms the most common basis for all subsequent models. The *"Health belief model"* was used to explain various key behaviours identified as five constructs: *perceived susceptibility, perceived severity, perceived benefits, cues to action and self-efficacy"*. In their analysis of *"Health belief model's"* Sheeran and Abraham (1996), emphasised that the model was based on two parts: *'threat perception"* and *"behavioural evaluation"*. *"Threat perception"* arises from perceived exposure to sickness along with expected severity. *"Behavioural evaluation"* comprises beliefs regarding the profits of a specific behaviour as well as the limitations of it. *"Cues to action"* and shared *"health motivation"* were incorporated in the model (Glanz et *al., 1997*). However, the *"Health belief model"* was criticized by Seydel *et al.,* (1990) and Schwarzer *et al.,* (1992) as making people like *"social financial decision makers"*.

The concept of a healthy lifestyle, i.e., wellness was first developed by Dunn (1959) who stated that a special condition of health comprises an overall sense of well-being which views 'the person' as being dependent of their environment spiritually, physically, and mindfully. This was developed later by Witmer and Sweeney (1998) where they described lifestyle wellness meaning through the *"Wheel of Wellness model"*.

3.4.1.1 The Wellness Wheel

Viewing the person as "a whole, seeking reciprocal actions of the mind on the body, for both of them are parts of the whole with which we should be concerned" (Adler, 1956, p. 255) is a legacy from psychology. Jung (1958) and Maslow (1954; 1970) developed this concept claiming that achieving progress, self-fulfilment and excelling are universal human desires and life goals. The U.S. Department of Health and Human Services, (1990) concluded that "reliable and valid measures of the many dimensions of health behaviour in general and of

health promoting behaviour specifically" (p. 57) are clearly desired and because wellness is "an observable and measurable behaviour" (Palombi, 1992, p. 225), the process of developing such procedures was conceivable.

However, any such procedure needs to have a strong theoretical basis to ensure credibility for any interventions. Based on theoretical and experimental literature, Sweeney and Witmer (1991), Witmer and Sweeney (1992), Witmer *et al*., (1998) and Myers *et al*., (2000) proposed an all-inclusive model of wellness that "incorporates concepts from psychology, anthropology, sociology, religion, and education" (Witmer and Sweeney, 1992, p. 140). The wellness tourism wheel is based on research findings, and social, health, clinical, personality, social and developmental psychology perceptions. Its conceptualisation was also informed by aspects of ecology and stress management.

Figure 3.4.1.1. *The wellness tourism Wheel Model*

Source: (Witmer *et al.,* 1998).

Figure 3.4.1.1 shows the wheel model, exhibiting five life aspects which, are interrelated and intertwined with a further subdivision of the self-direction life task into 12 tasks. These include:

> "sense of worth, sense of control, realistic beliefs, emotional awareness and coping problem solving and creativity, sense of humour, nutrition, exercise, self-care, stress management, gender identity, and cultural identity" (Witmer and Sweeney, 1992, p. 142)

These life aspects intermingle harmoniously with a variety of life powers, including but not restricted on *"one's family, community, religion, education, government, media, and business"* (Witmer and Sweeney, 1992, p. 140). The Wheel Model shows the complex nature of medical tourism although it outlines the various stakeholders required to facilitate the development of medical tourism in the industry including governments, private sector, community, business and industry, education, and media.

3.4.2 Medical Tourism and Health Tourism Typologies

Connell (2006) suggested that there should be a distinction between health tourism and medical tourism as the latter should address cases that involve medical interventions. The discussion about the terms medical tourism and health tourism is important in identifying whether medical tourism is part of health tourism or separate from it (Carrera and Bridges, 2006: Smith and Puczko 2009). Hall (2011) suggested that medical tourism is a part of health tourism because medical and wellness tourism are merged under the banner of health tourism. Other researchers believe that medical tourism includes only medical examinations instead of the full package (American Medical Association, 2008; Reed, 2008; Lunt and Carrera, 2010). The amount of overlap between medical services and tourism is particularly noticeable where the basis of the medical tourisms' offering is characterized by aspects of the tourism industry and medical services (Connell, 2011). Therefore, in order to define medical tourism, a combination of those areas should be considered. Understanding the medical and health tourism topologies is important in understanding the aspects that are included in any analysis of the medical tourism sector.

Figure 3.4.2. *Model clarifying the differences between wellness and medical tourism*
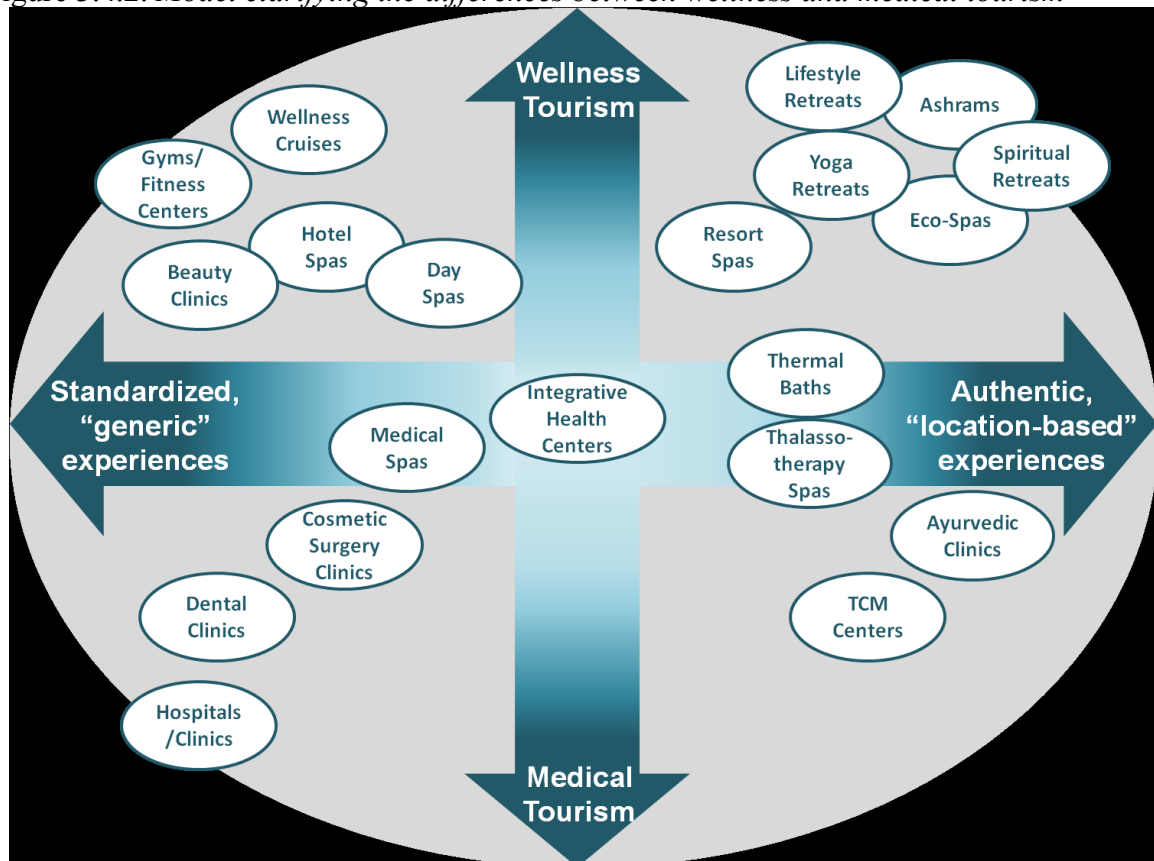
Source: Johnston *et al.,* (2011)

In 2011, Johnston and her colleagues proposed a model (Figure 3.4.2) to envision and clearly understand medical tourism and wellness tourism divisions, by highlighting two points. First, by identifying what is medical tourism versus what is wellness tourism, and therefore in turn, showing the actual distinction between both sectors (since confusion occurs most of the time between these markets). Second, a variety of service offerings that ranges from conventional or *"generic"* services to authentic or *"location-specific"* services are highlighted. Medical tourism and wellness tourism are identified as two of four *"typologies"* in this continuum all of which are potentially productive markets. However, when improving and marketing a menu that offers services for medical and wellness tourists, industry stakeholders such as governments, health institutions and transport operators should consider the unique opportunities and tourist demands/interests across the four typologies (Johnston *et al.*, 2011).

3.4.3 Niche Tourism

The notion of niche tourism has recently emerged as an alternative to what is known as mass tourism (general tourism activities), as it comprises a diverse set of refined systems that categorize and classifies tourist basing on the particular activities that they are involved with (Robinson and Novelli, 2005). Unlike mass tourism, niche tourism is characterized by its uniqueness and richness in a world where sameness is growing exponentially. Robinson and Novelli (2005) explained how a particular aspect of niche tourism is that it is a reaction to negative impacts that have evolved from mass tourism, such as the degradation of the environment as well as society and cultural disturbance. It can provide greater opportunities than mass tourism to planners and destination managers who are trying to improve economic development of their countries through a touristic approach (Han and Hyun, 2014). In addition, niche tourism can offer a more sustainable tourism that is less destructive and more attractive to high-spending tourists. An advantage is that tourists' individual needs and wants are more precisely met by niche tourism, as it offers a tailored set of experiences and knowledge (Han and Hyun, 2014).

Niche tourism includes large subdivisions (macro-niches) such as cultural, rural, sportive, environmental, and urban tourism, where each can be further divided into smaller micro-niches, such as ecotourism, cycling tourism, gastronomy tourism (Figure 3.4.3). Niche tourism's focus is mainly based on these small micro-markets (Han and Hyun, 2014).

Figure 3.4.3. *Macro-niches and micro-niches components of tourism*

Alternative tourism Development
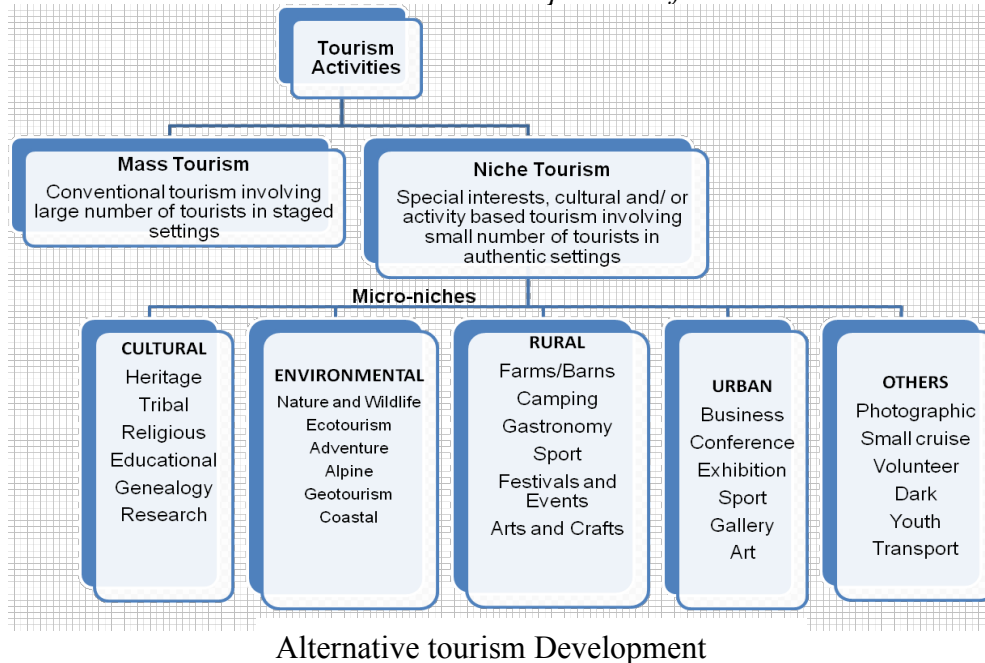
Source: Novelli (2005)

3.4.4 Aesthetic Tourism

There is an increase on the focus of beauty in the modern world where body beauty is more appreciated than the knowledge or wisdom that one has (Connell, 2011). In China, for example, beauty pageants were banned until 2003 when it became recognized as a means for young Chinese women *'to get ahead in a fiercely materialistic society'* (Spencer, 2003). However, body changes are not really new in some cultures like the extension of necks by rings or lip discs (Spencer, 2003), but unlike in the past, where such extensions and rings were associated with tribal communities, these practices have now become mainstream in western and eastern cultures (Brean, 2013); perfumes, hair oils and coiffeurs all adding to self-images of prosperity and stylish joy (Connell, 2011). Yet, in spite of such a large number of decisions about cosmetic surgery being connected to consumerism and the changing perceptions on beauty, it overlaps into the medical world because many of the 'enhancements' valued by consumers are based on medical procedures (Connell, 2011).

For example, cosmetic medical tourism has become a globally recognized expanding industry in which attention to individual care has been substantially modified from minor

wellness to changing body shapes and many people have utilized, and keep on utilizing some types of bodily decoration and cosmetic medical procedures (Spencer, 2003; Connell, 2011). In a society where image has become important to superstars, and their imitators, cosmetic medical tourism offers means of acquiring instant 'perfection' (Garrod and Fyall, 2011). The more image centred society has become the more pressures are exerted on individuals to match up to, often, unrealistic ambitions to be '*the best that one can be*' which cannot simply be resisted even in an age of individuality (Garrod and Fyall, 2011). Garrod and Fyall (2011) assert that the most affected by such pressures are women, since beauty is often recognized as an assessment of a women's value. More recent research suggests that men, particularly when teenagers, are also affected by fashion and beauty pressures (Han and Hyun 2014).

In addition, and following advances in medical technology, certain reconstructive surgeries, such as breast regeneration following tumour removal, eye surgery using laser surgery, or conventional plastic surgery operations are often described as aesthetical or cosmetic although many are based on real needs (Connell, 2011). The most commonly known cosmetic operations in US are liposuction, eyelid surgery, nasal surgery, breast augmentation, and abdominoplasty (GFC; Saint-Louis, 2010). In 2007, nearly 12 million cosmetic operations took place in the US alone, and this rate had dramatically increased from the beginning of the century where only about 2 million cosmetic operations were carried out (Connell, 2011). Cosmetic operations are not only performed in the US.

According to Keenan (2004), more than fifty thousand cosmetic operations were performed in Australia in 1998, which was a double-digit rise in the number of cosmetic procedures performed in 1995. In Australia, cosmetic surgeries were dominated by liposuction, breast implants, facelifts, and eyelid surgery. Although Europe represents the second largest market for cosmetic operations, Latin America was an early starter and Asia is catching up quickly (Connell, 2011).

3.5 The Economic Impact of Medical Tourism

Although medical tourism has many macro and microeconomic benefits, there is little evidence demonstrating the positive impact of medical tourism on the economy. Basically, this is because access to data regarding this topic is normally restricted and this makes a clear analysis of it challenging (Jagyasi, 2008) therefore there is inconsistency in evaluating the exact contribution of the industry (Lunt *et al.*, 2011). Nevertheless, medical tourism has created a promising and positive increase in the economic growth rate of different countries particularly in the gulf region (Musa *at al.*, 2012). Turner (2007) suggested that the spending of a medical tourist is three times more than the spending of a regular tourist due to the additional medical-related expenses and the tendency to also engage in the ordinary leisure tourism upon recovery. The basic constituents of a medical tourism package are the fees for the medical treatment, international tariffs, housing, prearranged trips, shopping, food and drink, and local transportation (Musa *et al.*, 2012). This list identifies that half of the financial resources in medical tourism are associated with medical facilities, while the remaining outlay is associated with tourism. In addition, medical tourists are usually escorted by at least one other person, which increases the amount of money spent during the trip or visit (Connell, 2011; Lautier, 2014; Musa *et al.*, 2012). This means that a medical travel trip generates much more income than a conventional leisure trip to a country or region.

Lautier (2014) suggested that in 2009, almost 37,000 job vacancies were opened by medical tourism in Tunisia, whereas 19,000 job vacancies were opened by other forms of tourism activities in the same year. The United Nations World Tourism Organisation (2019) barometer for 2018 showed that international tourist visitors increased from 1.32 billion in 2017 to 1.40 billion in 2018 to continue the consecutive rising trend since 2009As shown in the figure 3.5 below, Europe received highest number of international tourists in 2018 at 713

million while the Middle East region received the lowest number of international tourists at 64

million the same year.

Figure 3.5. *International Tourists Arrivals (1950-2018)*
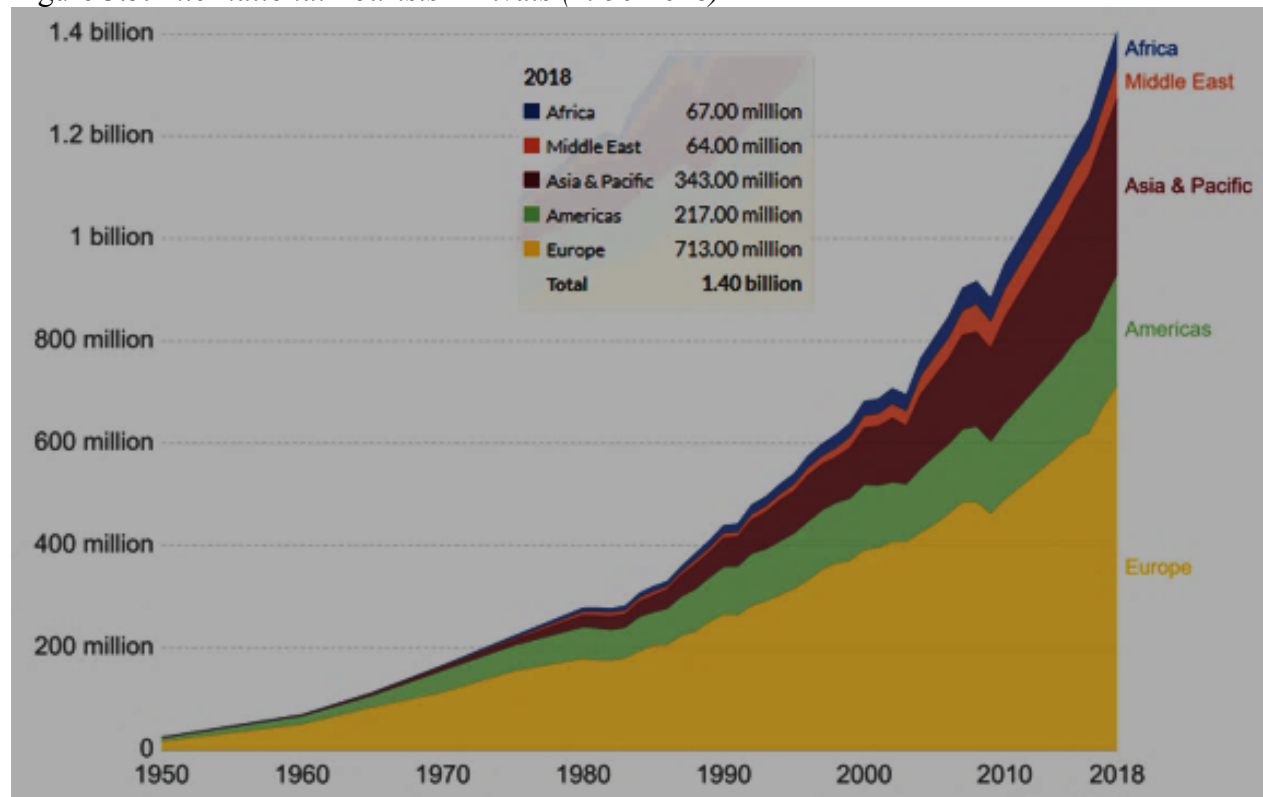
Source: Our World in Data (2019)

Understanding how countries could use the data showing increased number of tourists

globally in realising that within the general tourism figures medical tourism has the potential

to generate higher per capita revenue per tourist across a wider range of industries than many

other forms of tourism. In turn, this could help different countries such as Qatar to come up

with ways of promoting medical tourism in their borders.

3.6 Medical Tourism Cultural Requirements and Obstacles

The significance of tourism is not limited to the economic domain only. Tourism is

mostly a cultural phenomenon designing ways through which we recognize and perform in the

world which extends further than the simple activity of travelling (Stausberg, 2011). The

association between the tourism industry and culture is highly integrated. According to Liu and

Chen (2013) understanding how culture interacts with the tourism industry is important in

improving the efficiency and attractiveness of tourism sites enabling them to better become the main driving forces of destination attraction and affordability. Understanding this interaction will contribute to the knowledge on how the quality of medical tourism services in Qatar and other countries can be improved.

Many destinations are now dynamically evolving their overt/covert cultural resources in order to develop their tourism experiences in a highly competitive tourist market and to create local uniqueness in the face of globalism. The entire medical tourism experience incorporates not only first-class healthcare for foreign patients but also interaction with and experiences of the local cultures of the hosting countries. Medical tourists usually take into consideration unique cultural worth, priorities, or behaviours when selecting medical services in other nations (Liu and Chen, 2013). When tourists are in foreign surroundings, they face physical and mental challenges. However, ailing medical tourists are more open to subtle environmental influences and are usually not limited by cultural barriers to introduce themselves openly and amenably to unfamiliar medical staff (Liu and Chen, 2013).

The cultural approach of the native populace towards foreigners is also a significant element in medical tourists' preferences (Han and Hyun 2014). For example, during the month of Ramadan, Muslims prefer not to take conventional medicines where they can only undergo an emergency surgery during the month (Han and Hyun 2014). Additionally, for medical or nursing care a female Muslim usually prefers to be treated by a female doctor or nurse while a male Muslim prefers a male doctor or nurse. Appropriate cultural awareness and empathy is crucial during the medical treatment when severe discretion is likely to be essential (Han and Hyun 2014).

3.6.1 Cultural Orientations' Influence on Medical Tourists Perceptions

The universal and human co-dependent aspect of the medical touristic concept has prompted investigators to research the relation of cultural impacts to medical services. Donthu

and Yoo (1998) observed that customers' cultural interests influence their anticipation of the service to be provided. Additionally, Furrer *et al.,* (2000) noticed that clients from differing cultures allocate distinct significance to the elements of service standards in order to quantify apparent quality of service. Liu *et al.,* (2001) suggested that customers from differing cultures have distinctive views in relation to the quality of service that is given in health facilities. These results suggest that patients from different cultures possess various levels of motivation or expectations of medical tourism due to their differing levels of awareness and performance, which are impacted by the reciprocated cultural potentials (Donthu and Yoo, 1998; Mooij, 2005; Zhang *et al.,* 2008). A critical question is whether *"culturally different others"* will show ambiguous keenness of perceptions and mindsets toward medical tourism. To address this challenge, studies focusing on the numerous cultural perceptions to improve theoretical interpretation of global patients' assessments of medical tourism have been undertaken (Mooij, 2005).

Literature (Milliken and Martin, 1996; Connell, 2011) contains numerous examples of how culture influences perceptions of service. Milliken and Martin (1996) proposed that differences in cultural orientations and especially the notable, tangible differences are critical influencers of the perception a customer has about the effectiveness of a servicescape when encountering a service. In other words, the physical appearance of an employee could offer a visual cue to customers about whether s/he shares a similar or the same culture as the employee delivering the service. In instances such as those, culture may not be influential and some other factors such as personality might influence the perceptions of the customer with respect to the effectiveness of the service script. Alternatively, the physical appearance might constitute a visual cue for the customer about the existence of culture difference between him or her and the service employee. Moreover, other differences in cultural orientation might just manifest such as differences in language. Such differences in cultural orientation have the potential to

make the service experience of the customer unacceptable (Hopkins, Nie, and Hopkins, 2009). Appreciating the role of culture in medical tourism, various medical tourism destinations have responded to the cultural demands by preparing distinctive food, staff training, offering prayer rooms and separating floors and wards (cf. Connell, 2011).

Religious differences are critical in a broader context of culture as well as medical tourism. For example, Islam's Shi'a and Sunni branches have varying views and beliefs concerning assisted reproductive technologies to the extent that Shi'a Muslims in nations dominated by Sunni Islam prefer traveling to Iran for treatments related to fertility (Moghimehfar and Nasr-Esfahani, 2011). Medical tourists might also prefer one destination over another to evade government regulations especially in terms of restrictions to particular cultural and medical practices. For example, the one-child policy by China (Ye, Qiu, and Yuen, 2011). However, less directly related cultural preference notions that return migrants often invoke such as personal attention, rapid service, clinical discretion, effective medication, and privacy might actually be matters that are associated with their experiences in private hospices when overseas as opposed to state-owned hospitals (Horton and Cole, 2011).

Medical tourism's most distinctive feature is the tendency to take patients over international borders beyond the comfort and familiarity of their cultures, linguistic prowess, and climatic norms to unfamiliar contexts (Connell, 2013). However, there is scanty evidence as to whether encounters with foreign cultures are major influencers of medical tourists' decisions to engage in medical tourism (Bell *et al.,* 2011). It is also not clear whether the cultural encounter that medical tourists often encounter is deliberately functional in its entirety. This begs the question of what the social and medical experiences of medical tourists entail particularly in regions where they encounter unfamiliar cultural contexts (Connell, 2013).

3.6.1.1 Language and Meaning Confusion

Language as a component of culture is critical to the customer's service experience because it is often perceived as a competence indicator (Fernandez, 1991). It affects the effectiveness of the service script from the perspective of communications. In the existence of wide cultural variations as in medical tourism contexts, the language a customer speaks may not be the service employee's native language (Hopkins, Nie, and Hopkins, 2009). Communication between people with different native languages produces more opportunities of miscommunication to happen (Triandis, 1994). Furthermore, even the proficiency of a service employee in the native language of the customer does not always translate to effective communication (Beamer, 1992). For example, service employees might not understand the nuances involved in the native language of the customer and, as Chaney and Martin (2000) noted, they are likely to speak with a non-native accent that could constitute a barrier to effective intercultural communication. In turn, this affects the effectiveness of the service script (Hopkins, Nie, and Hopkins, 2009). Consistent with Victorino, Verma, and Wardell (2008), the following definition of service script adopted in this study borrows the hospitality industry perspective:

> "a detailed guide for front-line employees to follow during a service encounter. A script includes a predetermined set of specific words, phrases, and gestures, as well as other expectations for the employee to use during each step of the service process" (p. 7).

Besides the employee presenting with communication or language competence, s/he must behave in accordance with the expectations of the customer with respect to nonverbal service script facets. This is because the way an employee says something is as important as what s/he says. As an example, communication aspects like body language, employee attentiveness, space, use of eyes, speed, volume, and voice are also language aspects that could influence the effectiveness of the service script (Dahl, 1998).

According to Connell (2013), geographical and cultural factors modify the basic rationale for medical tourism with medical tourists often going to nations within the same language locations or those where English is commonly spoken. Medical tourists also prefer similar cultural contexts to those of their country of origin and this includes similarity in religion.

In terms of meaning, the acquisition, processing and sharing of information is critical to decision-making processes (Miranda and Saunders, 2002). Typically, research on sharing of information considers this activity via the objective lens of disseminating information where everyone is able to draw the same meaning out of it. An alternative information sharing rationale constitutes "the social construction of meaning" (Miranda and Saunders, 2002, p. 1). The language-culture overlap remains extensive to date. The sturdiest form of language dependency on culture anchors on language being a cultural entity (Gao, 2002; Martin and Nakayama, 2014). Contrastingly, cognitive linguistic theories also acknowledge that cultural knowledge constitutes the basis for both lexicon and central grammar facts. Simultaneously, language transmission happens through culture and is a fundamental carrier for cultural transmission and interaction. Subsequently, this implies that knowledge of a language surpasses familiarity with its structure and what expressions in that language mean (Gao, 2002). As Firth (1957) noted, knowing a language is about being totally aware of all associations that the expressions in that language carry especially in the cultural and situational context.

Agreeing with the views of Grosjean (1982) and Haugen (1956) that the coextensive nature of biculturalism and bilingualism is not always existent, and accepting Bamgbose's (1994) supposition that not every bilingual is bicultural, one can safely conclude that language transfer also involves the translocation of a cultural aspect. This translocation could result in confusion, misunderstanding, and conflicts related to meaning (Gao, 2002). Pratt and Ashforth (2003) portray meaning as the output of making sense about something or interpreting what it

denotes. For example, a person referring to what their work means or the role they play within the life context could refer to work as a higher calling, an oppression, a pay check or simply something to do. Ultimately, perceptions of meaning are dependent upon the individual albeit the social or environment context may influence it (Wrzesniewski, Dutton, and Debebe, 2003).

From an intercultural communication perspective, reconciliation of the interplay between societal forces and personal competence remains a challenge (Martin and Nakayama, 2015). An earlier description by Nakayama and Martin (2014) implied that most scholarship on competence within the discipline of communication considers identifying and modelling the difference facets of intercultural communication at the individual level. Most models that conceptualise intercultural communication reflect the "'ABC' (Affect, Behaviours, and Cognitive/Knowledge) triumvirate" (Martin and Nakayama 2015). The Affective aspect includes open-mindedness, empathy, attitudes, curiosity and respect. The cognitive aspect involves language proficiency, cultural knowledge and self-knowledge, capacity to develop new categories, and mindfulness. Finally, the behavioural dimension is both micro and macro. The micro aspect includes head nodding, message skills, eye gaze, and self-disclosure. On the other hand, the macro dimension encompasses social skills, adaptability, decoding, and flexibility (Martin and Nakayama, 2015). More recent additions to the ABC list include mixes of outcomes, motivation, and context. Outcomes are about relational satisfaction and communication, goal attainment, effectiveness, and accomplishment of tasks among others (Warren, 2012).

3.6.2 Behavioural and Demographic Influencers of Medical Tourism Consumption

In medical tourism, personal traits including status of health insurance, income level, and age affect the decision of the patient to choose health services and destinations (Klein *et al.,* 2017). Personal traits such as gender, income, and age have been noted as influencers of the relationship between loyalty and satisfaction of the customers based on their influence of

customer perceptions of a service or product (Homburg and Giering, 2001). In this section, focus shifts to the demographic and other traits that have been shown to affect medical tourism perceptions among customers. These include gender, age, income, education, insurance, previous medical tourism experiences, and perceived risks, which are reviewed under distinct sections below respectively.

3.6.2.1 Age

Several studies implicate the overarching role of age in terms of both preference for medical tourism and experiences of the same. For example, a study conducted by Abd *et al.,* (2015) demonstrated that majority of medical tourists in Malaysia were below 40 years old. Another industry-based study conducted by Deloitte (2008) revealed an inverse relationship between aging and willingness to undertake medical tourism. Specifically, only 29.1 percent of the Seniors in the study were willing to consider medical tourism compared to 36.7 percent, 41.9 percent, and 51.1 percent of Baby Boomers, Generation X, and Generation Y respectively. In their study, Research conducted by Gan and Frederick (2011) revealed expectations for young people and individuals in early mid-ages to have higher motivation or willingness to take up medical tourism compared to the elderly and those in late mid-ages. Contrastingly, Lunt and Carrera (2010) reported higher likelihood for middle agers to consider and require medical tourism particularly for elective medical procedures. In the Korean medical tourism context, Ren, Hyun, and Park (2017) reported that majority of the medical tourists visiting the country were below 50 years and they were mainly interested in cosmetic tourism. These studies imply that young people (typically below 50 years) are more likely to engage in medical tourism than older ones.

3.6.2.2 Gender

Distinction by gender is not common in previous medical tourism studies therefore a small number of studies are available on the subject. In the Deloitte (2008) study, 44.5 percent

of the male participants had a considerably higher willingness to consider engaging in medical tourism compared to 33.3 percent of their female counterparts. However, in the more recent study by Klein *et al.,* (2017) it was reported that females showed higher willingness to undergo medical surgery compared to males. The rationale for this distinction was that females perceived aesthetic value that is associated with medical surgery more important than the males did. Ren, Hyun, and Park (2017) also found that majority of medical tourists visiting Korea were female and this was linked to the value they associated with cosmetic surgery. These results show the likelihood of female medical tourists exceeding male ones when a medical tourist destination is more popular for a service niche that is more female-oriented such as cosmetic surgery.

3.6.2.3 Education

Previous studies suggest a consensus that more educated people tend to enjoy better health on the overall and visit doctors more frequently (Lantz, Lynch, and House, 2001; Ichoku and Leibbrandt, 2003). Individuals with moderate education levels exhibit more sensitivity to travel factors such as communication and safety issues compared to the highly educated individuals (Gan and Frederick, 2011). Guy, Henson, and Dotson (2015) argued that individuals with low income were more likely to receive financial assistance for treatment from charitable and government sources. However, lower health correlated with lower socioeconomic status and poor health correlated negatively with extensive travel in general. On the other hand, Naidu (2009) found that higher education levels have a positive relationship with health consciousness and consumer rights' awareness. Therefore, highly educated individuals are more likely to be inquisitive and challenge medical decisions and recommendations at times.

3.6.2.4 Income

As would be expected, individuals with lower income levels tend to be less interested in seeking care abroad compared to those with middle income levels. Paradoxically, people who have higher incomes might not need medical tourism because they have higher buying power, and could perhaps afford private treatment in their home countries albeit at a higher rate. However, they may also have more opportunities for traveling abroad and are also likely to "be less dissuaded by cultural concerns or stereotypes" (Guy, Henson, and Dotson, 2015, p. 69). There are also reports in literature that indicated that individuals in middle-income and lower-income groups are likely to engage when there are economic incentives than those in the upper income group (Gan and Frederick, 2011).

Klein *et al.,* (2017) contended that a tourist's income level is a crucial determinant of his/her choice of destination. Often, patients in the higher income bracket seek high quality medical service and are keen on being offered the best quality care and service. Jun and Oh (2015) found that tourists in the low-income bracket overlook service level, but are keener on the cost of medical tourism. In other research in the Korean context, Ren, Hyun, and Park (2017) did not find income level to be a moderator of satisfaction and health consciousness.

3.6.2.5 Insurance

Insurance is a determinant of medical tourism in the sense that it influences the destination choice and service of the medical tourist (Ren, Hyun, and Park, 2017). Several studies conducted around the world in countries such as the US (Deloitte, 2008; Peters and Sauer, 2011) and Indonesia (Mostert *et al.,* 2008) revealed that the biggest percentage of the population did not have medical insurance. In the GCC states, efforts to achieve universal healthcare are still facing challenges such as the emergence of new healthcare challenges (Morgan, Ensor, and Waters, 2016) including the need to develop new payment systems (World Bank Group, 2015). Yet, medical tourists may be attracted to a medical tourism

destination if the quality level of medical care and services is the same or better in the destination as the home country (Al-Lamki, 2011).

3.6.2.6 Previous Medical Tourism Experiences

An individual who has had preceding experience with medical tourism is more likely to comfortable with the practice than one who has not experienced medical tourism before (Guy, Henson, and Dotson, 2015); such individuals also tend to be more comfortable while traveling abroad. Previous medical tourism experiences also influence the customer satisfaction levels. Earlier studies (Smith and Forgione, 2007; Gan and Frederick, 2011) had also reported similar findings, that experienced medical tourists were more motivated to engage again than those who were experiencing medical tourism for the first time. However, they also suggested that repeat medical tourists also help in influencing the perceptions of first-time medical tourists. For example, Crooks *et al.,* (2010) reported that some medical tourists have aided potential medical tourists' initial worries about negative experiences by speaking highly of extraordinary staff, care, and high-tech facilities. This introduces the significance of WOM (word of mouth) in the development of medical tourism. According to Chen, Dwyer, and Firth (2014), WOM in tourism development is a bottom-up process that is useful in countering or complementing the top-down negatives or positives of tourism development. Yet, stakeholders such as destination marketers, governments, and policymakers remain critical to the process of developing tourism as does the host community (Jeuring, 2016).

3.6.2.7 Perceived Risks

Perceived risk refers to the perception of the consumer regarding the possibility that an action is likely to expose them to some form of danger, which could affect their decision to travel if it exceeds the acceptable levels (Mansfeld, 2006). Khan *et al.,* (2017) noted that perceived risks associated with tourist behaviour and travel risk is circumstantial and varies by destination. Based on previous literature, Khan *et al.,* (2017) identified five major perceived

risks in international medical travel. These include risks concerning health at medical tourism destination, long flight risks, risks of medico-legal nature, recuperation and preoperative risks, and other risks related to the destination such as crime, racism, crime, and sexual assaults.

With respect to risks concerning health at medical tourism destination, medical tourists risk contracting new illnesses while undergoing treatment at the medical tourism destination. For instance, nine US medical tourists who underwent liposuction in Venezuela contracted mycobacterial infection in 1998 (Khan *et al.,* 2017). Long flight risks can upset already suffering patients such as those with conditions like thrombosis that result in reduced blood supply to infected areas. Risks of medico-legal nature are mainly about the lack of strong laws to guard against medical malpractice, which implies that medical tourist victims of such malpractice might not get compensation (Crooks *et al.,* 2013). Recuperation and preoperative risks mainly arise when sickly medical tourists fail to consult local physicians on the need to seek medical attention such as surgery in the intended tourist destination. In turn, the local practitioners may destroy the patient's medical records (Balfour *et al.,* 2004). Moreover, some medical tourists can suffer emotional distress during the recovery process if away from home (Lautier, 2008).

3.7 Health-Seeking Behaviour Concepts

Worldwide, health advancement programs have for some time been predicated on the belief that providing information about the causes of bad health and making medical information more accessible will go far towards advancing a modification in individuals' behaviour, to more positive health-seeking behaviour (Lunt *et al.,* 2011). However, according to Johnston *et al*., (2011) there is an increasing acknowledgment in developed as well as developing countries, that providing training and learning to people to support a modification in behaviour is not sufficient in itself. Since accurate health information centre around the human being as a conscious agent, there is a concern that encouraging "*good*" health-seeking

behaviours is not easy as these behaviours relate to active, cooperative, collaborative elements. As a result, health scholars such as MacKian have begun investigating the way the home-grown dynamics of groups influence the healthcare of the residents (MacKian, 2013). This is an area of increased interest in the social sciences within the contested idea of social capital such as the understanding on how social pressure can influence people to seek cosmetic services.

3.7.1 Health-Seeking Behaviour Instrument

In 1996, Norman and Corner stated that in order to explain potential behaviour patterns, various *"social cognition models"* had been produced. These identified a mix of cognitive, emotional, social, and demographic attributes which were important and relevant because they looked into the psychology of how people made decisions about their health. This fits in with the Wellness Wheel (section 3.4.1.1), which also includes social, spiritual, and psychological aspects as constituent elements of wellness. Their focus was on the perceived signs, as well as access to care together along with character of individuals who seek healthcare services. The fundamental postulation was that behaviour is best comprehended in terms of an individual's awareness to their communal surroundings.

Later researchers such as Champion (1999), Gözüm and Aydın (2004) and Reynolds *et al.,* (2007) introduced common health incentive and self-assurance to the original health belief paradigm. *"Health motivation"* refers to a generalized state of intent that leads to a designed behaviour that sustains or enhances health, whereas *"confidence"* introduces the increase in the perceived confidence through the performed behaviour concept which results in an improvement in that behaviour (Champion 1999; Gözüm and Aydın 2004; Reynolds *et al.,* 2007). The model has been used in different, albeit complimentary, fields. Research conducted later by Gutierrez and Long (2011) suggests that these concepts are still current and can be applied in the complimentary medicine field.

3.8 The Main Antecedents to Influence Tourists' Behavioural Intentions

Past research has identified four main antecedents influencing tourists' behavioural intentions. These antecedents were termed as *"experience quality, perceived value, satisfaction and behavioural intentions"* (Baker and Crompton, 2000; Petrick, 2002, 2004).

3.8.1 Experience Quality

The quality of customers' experience has been identified by many researchers as a crucial element in customer's behavioural studies (Grove *et al.,* 1992; Kao *et al.*, 2008; Chen and Chen, 2010). The experiential quality was first defined in 1995 by Crompton and Love as *"involving not only the attributes provided by a supplier, but also the attributes brought to the opportunity by the visitor"* (p. 12). Söderlund (1998) mentioned that the key to pleasing clients' lies in supplying great quality of experiences. The positive impression of the recognition of quality on customer's trust was reconfirmed by Foster and Cadogen (2000). Chan and Baum (2007) found that the experience quality concept incorporates the responses of tourists' emotions to their anticipated emotional wellbeing from a visiting experience. Chen and Chen (2010) were more particular in differentiating the service quality from the experience quality in a tourism context, where they referred the former to service performance, and the later to the mental and emotional aftermath subsequent to tourists' engagement in touristic activities.

Chen and Chen (2010) also suggested that service quality is measured by the excellence of service's characteristics which are managed by service givers, while the experience quality involves expectations on the consumers of the service given. Chen and Chen (2010) showed that improving a tourist's encounter quality brings about great levels of perceived value. Mehta (2011) confirmed that quality in the hospital context is best reflected in patient contentment. However, the relationship between perceived value and experience quality in the medical tourism literature is scarce (Pine and Gilmore 2011). Despite this, they explained the need for

service providers in making the experiences of the customers worthwhile as a way of enhancing customer satisfaction on the quality of all services given.

Chang *et al.*, (2013) proposed that tourists are more likely to put their trust in the personnel of a service business when the provision of experience quality is identified as being as exceptional. Although researchers tried to correlate between patient confidence and contentment and experience quality, still there is lack of existing literature about them from the perspective of social-based therapeutic service meetings which forms a gap in preceding studies (Chang *et al.,* 2013; Wu and Li, 2014).

3.8.2 Perceived Value

Perceived value is the consumers' assessment of the service effectiveness depending on observations of what was expected and what was actually received. Psychological study approaches and facilities marketing characteristics are often merged to measure the consumers' subjective perceived value (Zeithaml, 1988) and several studies (Zeithaml and Parasuraman, 1988: Wang, 2012: Wang and Wang, 2013) have indicated that in medical tourism literature, perceived value is recognized as a key element of behavioural intentions. However, to achieve the desired market targets and to best meet the customers' satisfaction, countries, which offer medical tourism services, should acknowledge the value that medical tourists seek by directing their attention to meet that sought value (Cronin *et al.,* 1997; Hallem and Barth, 2011).

Hallem and Barth (2011) stated clearly that perceived value affects behavioural intentions. From a marketing standpoint it is important to examine the medical tourism experience via the perceived value notion. However, despite the fact that the perceived value concept is important, few studies have been undertaken examining perceived value as a segment of medical tourism experiences (Sweeney and Soutar, 2001; Hallem and Barth, 2011; Wang, 2012). Some studies (McDougall and Levesque, 2000; Cronin *et al.,* 2000; Duman and Mattila, 2005) suggested that quality of the experience perceived was an antecedent of

perceived value of health amenities, where the latter is a vital precursor to patient gratification. These findings were confirmed later by Wu and Li (2014).

3.8.3 Patient Satisfaction

In the context of medical tourism academic theory has identified patient satisfaction as customer satisfaction (Rad *et al.,* 2010). As identified by Ford *et al*., (1997) and confirmed later by Pakdil and Harwood (2005) and Pollack (2008), patient satisfaction was recognized to be one of the most essential attributes of quality assessments and a key success indicator in the medical tourism literature. Patient fulfilment as stated by Donabedian (1998) is the main outcome of medical care as it is important in understanding clients' awareness on the level of service quality that they deserve. Parasuraman *et al.,* (1985; 1988; 1991) said that a positive perception by customers in relation to the quality of the provision of medical services will result in a promising association with complete patient contentment. In turn, patients might recommend the hospital quality to others. Zineldine (2006) indicated that patient contentment is an aggregate model which involves gratification with numerous hospital aspects such as infrastructural, practical, mechanical, communicational and environmental factors. However, little research has focused on the connection between patient behavioural intentions, gratification, and quality in the medical tourism literature (Lertwannawit and Gulid, 2011). In a more recent study, patient satisfaction was defined by Chang *et al.,* (2013) as the mental and emotional attitudes of patients integrating their constructive or destructive sentiments or behaviours towards their experience in the service encounter.

3.8.4 Behavioural Intentions

Behavioural intentions in medical tourism play a significant objective in marketing of healthcare services. In the medical tourism context, behavioural intentions are explained as the prospective behaviours of medical tourists arising from the excellence and quality of the services that are proposed to be given (Kang *et al.,* 2004). There is direct correlation between

satisfaction and behavioural intentions, but behavioural intentions in satisfaction studies, positive responses on the part of satisfied clients, are seen as a consequence dimension (Kang *et al.,* 2004). Although some early research (Boulding *et al.,* 1993; Parasuraman *et al.,* 1996) argued that quality and behavioural intentions are closely related more recent research suggests that behavioural intentions can be affected by quality of the medical services given to the customers (Cronin *et al.,* 2000; Yu *et al.,* 2006; Hu *et al.,* 2009; Wu and Li, 2014). In the case of wellness tourism, which is a form of medical tourism, Chen and Chen (2010) found out that measuring behavioural intentions can provide an improved interpretation of clients' return potential.

3.9 Service Quality

Zeithaml's (1988) pioneering study defined service quality as the consumers' feedback on a product's overall fineness. Since then, service quality has been recognized as a serious factor in the hospitality arena and much research has been conducted to explore its various aspects. For example, Cronin and Taylor (1992) proposed that service quality was a significant driving force of consumer purchase intentions. Lee (1998) identified a correlation between actions taken to reduce customer defections and service quality. Young (2000) proposed that service quality solutions to problems with the services given positively influences the consumer's perception of credibility in relation to the business which extends to organisational benefits. Young (2000) specifically reported that historically most organisations looked for customer's satisfaction, claiming that an improvement in service quality would lead to positive influence on the company's financial figures.

Building on these results, Yuksel and Yuksel (2002) concluded that high satisfaction leads to investment in the sense of loyalty and returning to the venue again and reputation improvement in the service provider market. Barsky and Nash (2003) went beyond customer loyalty and suggested that satisfaction with the service provided may positively affect the

intention of customers to repeat the experience as well as their readiness to promote the company's services to others. This view was supported by Pullman and Gross (2003) who suggested that many organisations were currently focussed on the customer's loyalty, which was more than just simple satisfaction, and whether there was a high probability for loyal clients to relive the experience more than once and spend more money, as well as spread constructive feedback.

Numerous early social scientists (Kotler 1973; Shostack 1977; Boom and Bitner 1982; Upah and Fulton 1985; Zeithaml *et al.,* 1985; Bitner 1986 and Baker 1987) identified that the physical environment was able to control behaviours and produce an image particularly in service industries like banks, hotels, cafés, offices, stores of retail business, and healthcare institutions which has a positive impact upon the financial viability of the business. As Oh (2000, p.136) explained, "*When a high level of quality is experienced by customers, they perceive better worth for their money*".

More recently Ryu and Jang (2007) identified another aspect of service quality which is the impact of the environment on clienteles' contentment within the hospitality industry. Since the physical environment is assumed to be a significant factor amongst the most persuasive determinants influencing a client's psychological circumstances and activities in hospitality service conditions, a call to realize the perception of environmental components on customers' emotional status and behaviour change is required.

3.9.1 Service Quality and Niche Tourism

Evidence of this notion (service quality and customer expectation) can be traced back to very early research when Berry *et al.,* (1989) advocated that a service provider must stay conscious of continuously rising customers' expectations and deliver consistent and superior service in order to attain a distinctive improvement amongst the competitors. Vieira (2005) observed that balancing customer expectations is the key to preserving quality in tourism-

related services and that successful tourism services' providers are those who meet or exceed customers' expectations. This occurs when tourists receive a premium service: their tourism experience is memorable and they tend to be loyal business customers; however, should tourism services providers fail to satisfy the tourists' prospects they will gain an untrustworthy reputation and are unlikely to be consulted for future trips.

Bhat (2011) suggested that organisations which are leaders in quality have risen and begun to develop systematic methods to manage quality in order to obtain and maintain a competitive position, promote and advance their tourism business and maintain a sustainable future. He added that in order to withstand a changeable business environment an organisation must improve its client care, efficient marketing, benchmarking and training of employees.

3.9.2 Measuring service quality

Gilbert *et al.,* (2003) highlighted the most common ways in which service is measured. These included the use of expectancy-disconfirmation theory which determines consumer's evaluation of their expectations in relation to what they actually have received. The method measures the service performance against the consumer's anticipations. Another way that service quality can be measured is via performance theory which investigates service quality by questioning consumers about their degree of contentment with different aspects of the service after conducting a service meeting. This theory dissects service into two dichotomous components '*technical and functional components',* and their contribution to consumer satisfaction. The technical components include: durability, security, and physical features, while the functional elements relate to quality which is linked to the relationship between provider-consumer, such as speed of delivery, civility, and goodwill (Gilbert *et al.*, 2003).

The concept of service quality as opposed to service satisfaction is based on two interrelated service elements (Gilbert *et al.*, 2003). The first element is the *"transition-specific assessment",* which assesses specific quality features. The second one is *"general*

assessment", which appraises the quality of the complete experience. It can also be used in measuring the quality of services offered. This method can link the perceived value of the service with the service provision to ensure the complete satisfaction of (medical) tourism customers. However, perceived value is mainly based on the service characteristics where the organisation has control and does not include the customer's perspective. Service quality can also be measured by the quality importance method which draws attention to the impact of the customer's point of view on qualities identified to be associated with service satisfaction (Gilbert *et al.*, 2003).

3.10 The Evolution of Service Quality Theory and Models

Understanding or evaluating the concept of service is a popular topic in hospitality management literature (Grönroos, 1984; Parasuraman *et al.,* 1988; Cronin and Taylor, 1992). The focus in understanding the service concept and models is influenced by the need to establish efficient models that align with the organisations' operations from the client's perspective and that can be used in explaining organisation strategies that improve the quality of service or products given (Cronin and Taylor, 1992).

3.10.1 Grönroos and the Model of Technical and Functional Quality (1984)

Within the hospitality industry one early researcher Grönroos (1984) defined two aspects of service quality: purposeful and methodological service quality. The first element challenges the impact of the service given whereas the latter refers to the method of the customer-staff interaction. In general, service quality is usually assessed by customers; they compare the performance received to their preconceived expectations in terms of trustworthiness, tangibility, openness, assertion and empathy (see Fig 3.10.1 below). A third dimension to Grönroos's model was added by McDougall and Levesque (1994), the physical environment.

Figure 3.10.1. *Technical and functional quality model*
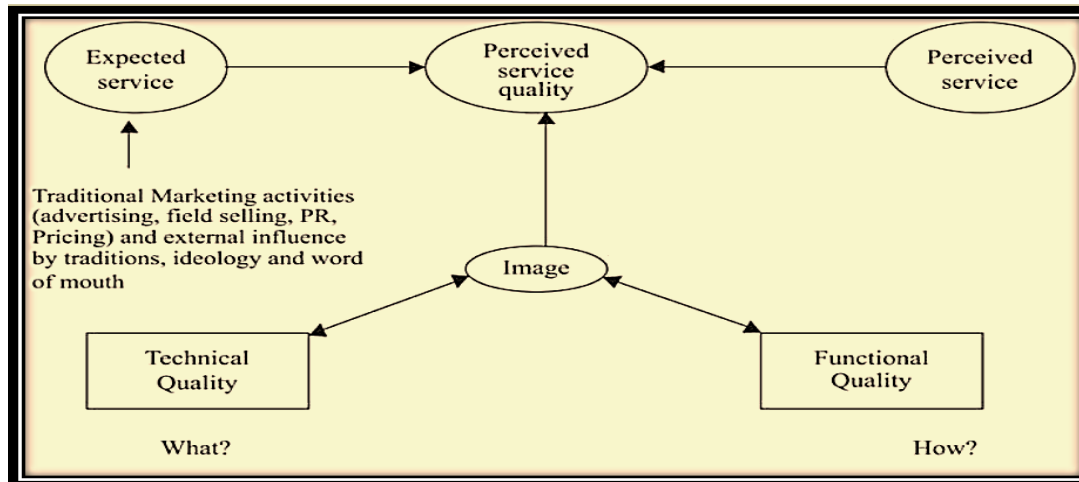
Source: Grönroos (1984, p.916)

3.10.2 Parasuraman Models (1985;1988)

The best-known research into service quality is that of Parasuraman *et al.,* (1985) which is based on research conducted on customer's appraisal of service quality in *"retail banking, credit card, securities brokerage, product repair, and maintenance businesses"* Parasuraman *et al.,* (1985, p. 916), Parasuraman *et al.,* (1985) established the *"GAP Model"* (see Figure 3.10.2a below) has identified five (5) significant potential gaps in the service quality concept and upon which most subsequent research in this area has been built.

Figure 3.10.2a. *Gap Service Quality model*
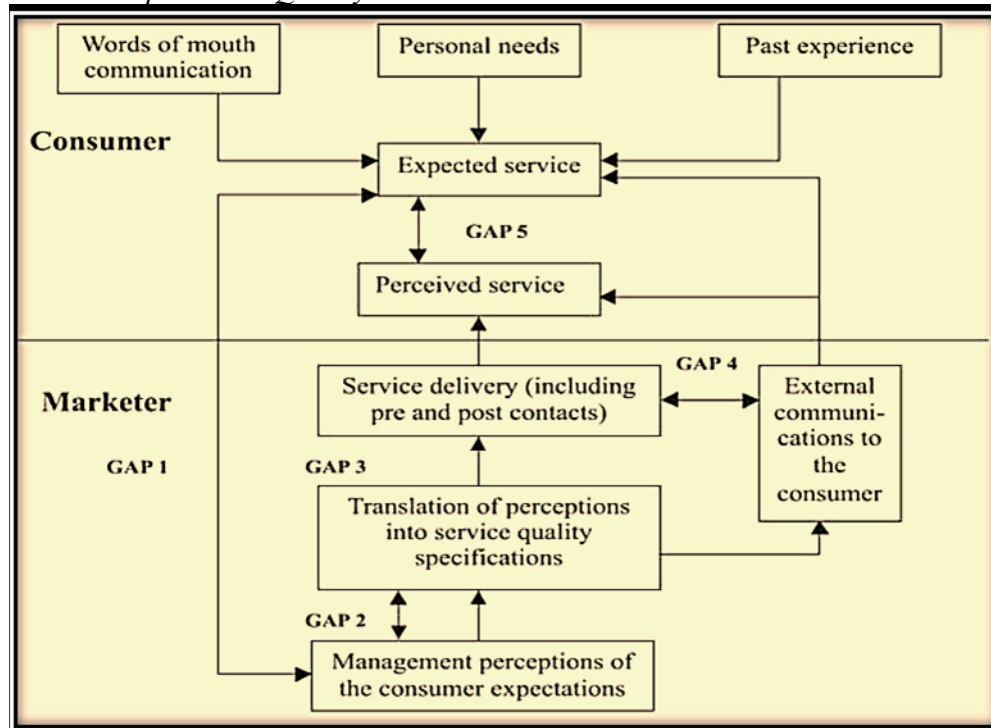
Source: Parasuraman *et al.,* (1985, p. 917)

Gap 1: Management Perception Gap-Customer Expectation (Parasuraman *et al.*, 1985)

Firms may fail to recognize the attributes that a service should have in order to fulfil consumers' needs. However, the implementation of desired attributes of the services given is needed in order to attain high quality of service delivery. This results in customers' evaluation influencing the service prominence.

Gap 2: Service Quality Specification Gap – Management Perception (Parasuraman *et al.*, 1985)

The second gap identifies failure in the means of delivery of customers' expectations. Attributes, such as resource constraints, conditions of the market as well as management unresponsiveness could influence this gap and eventually affect the consumer's view point in relation to service quality.

Gap 3: Service Delivery Gap – Service Quality Measurements (Parasuraman *et al.*, 1985)

Although the GAP model identified the rules for good service performance and clients' treatment, high service quality is not always guaranteed when (medical tourism) services are offered. As human beings, the staff providing services may experience inconsistencies in their

performances; thus, if the performance is not as expected, the service delivery will be affected in a negative way.

Gap 4: External Communications Gap – Service Delivery (Parasuraman *et al.*, 1985)

External communications influence clients' enjoyment of the service provided as well as their perceptions significantly. When companies fail to acquaint customers of special efforts to guarantee improved quality, customers' perceptions of the service quality could be influenced.

Gap 5: Perceived service gap-expected service (Parasuraman *et al.*, 1985)

In order to maintain good service quality, customers' expectations have to be met or exceeded. Identification of excellent and less-than-average service quality are subject to the customers' ability to recognise the tangible performance within the structure of what they expected prior to the experience (Parasuraman *et al.,* 1985). This is an important strategy which could be utilized by hospitals and wellness facilities in improving the quality of services offered to their customers.

As Parasuraman *et al.*'s research evolved it identified that clients employ ten ranges encompassing diverse styles of services to develop expectations and insights about the expected services. These are, *"reliability, responsiveness, competence, access, courtesy, communication, credibility, security, understanding and tangibles"* (Parasuraman *et al.,* 1985, p. 47, see Figure 3.10.2b on the next page). However, in 1988, Parasuraman *et al.,* reduced these ranges into five, *"Reliability, Assurance, Tangibles, Empathy and Responsiveness (RATER dimensions or SERVQUAL instrument)"* (Parasuraman *et al*., 1988, see Figure 3.10.2c on the next page). This SERVQUAL instrument is characterized by a multi-item spectrum, to assess customer views of service quality. Service quality is, then, measured based on the confirmed difference between the expectations and experience of the consumers. If the expectation is higher, lower or equivalent to the experience, negative or positive impacts could

be obtained. In 1991, SERVQUAL was further modified by replacing the term "*would*" with "*should*" to emphasize assertion; however, the five-dimensional constructs were left unchanged.

Figure 3.10.2b. *Service quality extended model*
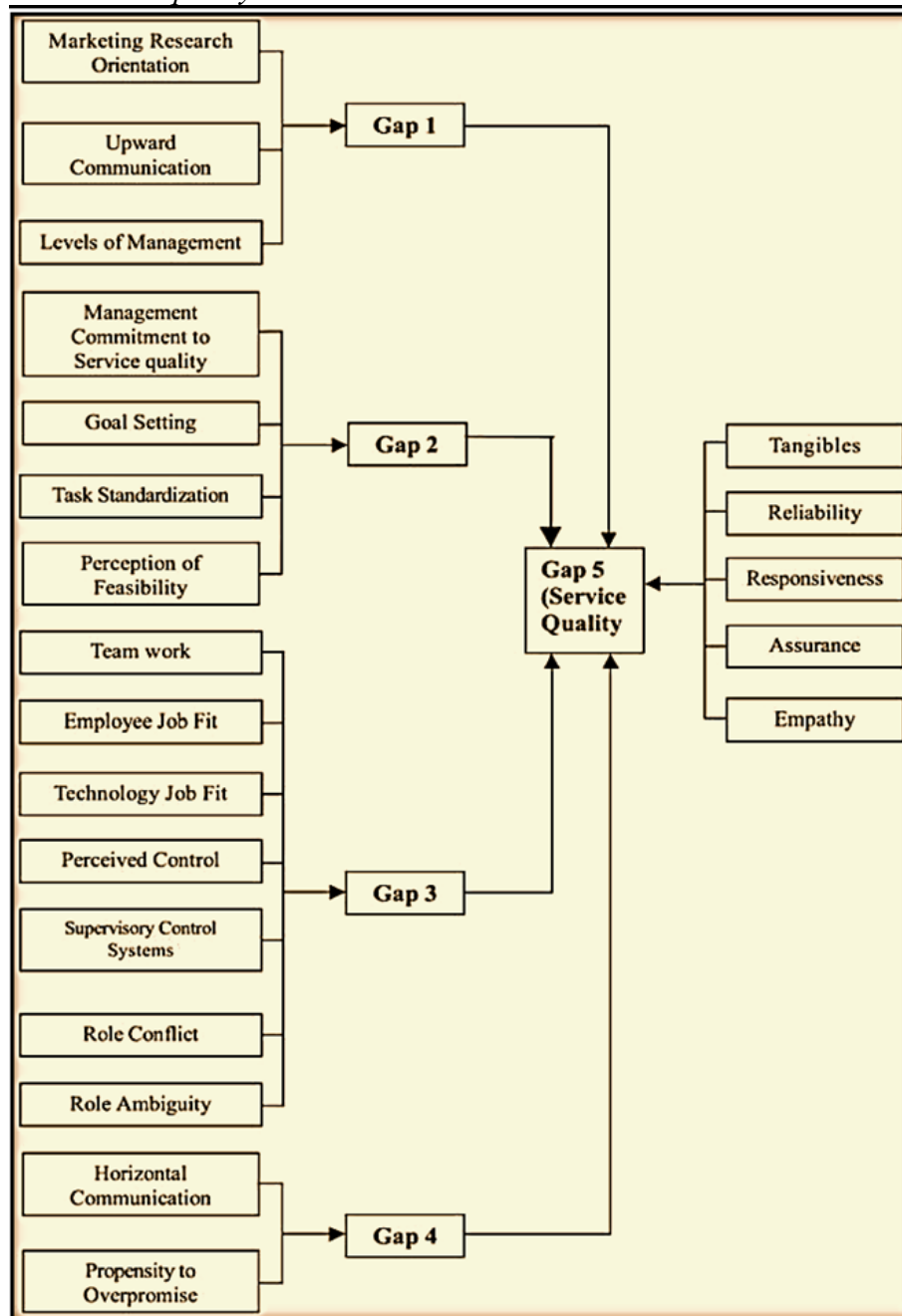
Source: Parasuraman *et al.,* (1985)

Figure 3.10.2c. *Measuring service quality, SERVQUAL Model*
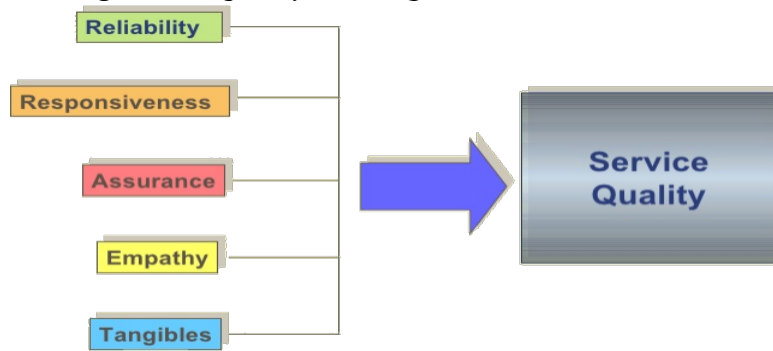
Source: Parasuraman *et al*., (1988)

Teas (1993) established the assessed performance model (EP) to resolve part of the limitations in the service quality divergence perception established by Grönroos (1984) and Parasuraman *et al.,* (1985, 1988). Teas (1993) perceived their interpretations as "*somewhat vague*" and examined the explanation of the people who responded in the initial SERVQUAL project. He found that those who responded might have been utilizing any of six ways of interpreting particular phrases which included, service attribute importance, forecasted, ideal deserved, equitable, and minimum tolerable performance. Service attribute importance implies that customers may rate statements based on importance. Forecasted performance is where customers use a scale for predicting their expected performance. Ideal performance is optimal or the achievable performance while deserved and minimum tolerable performances are about, "The level of performance customers feel they ought to receive given a perceived set of costs" and "What performance 'must be?" (Teas, 1993, p. 30).

Each of these explanations is slightly dissimilar, and Teas suggested that a substantial ratio of the discrepancy of the SERVQUAL potential measure can be understood by the change in respondents' explanations. Based on this conclusion, Teas (1993) proposed assessing the difference between the observed performance and the expected value of an attribute without customers' anticipations. Parasuraman *et al.,* (1994) replied to these criticisms by redefining "expectations as the service customers would expect from excellent service organisations",

rather than normal services that are offered by the service providers. They also decreased the

entire items number in their original questionnaire to 10 ranges and vigorously defended their

use and interpretation of these statements in SERVQUAL research against Teas' criticism.

3.10.3 Spreng and Mackoy Model of Perceived Service Quality and Satisfaction (1996)

Another early researcher, Oliver (1993) established perceived service quality to

differentiate between service quality and contentment. Oliver reasoned that service quality is

measured by comparing desires and insights of performance concerning quality dimensions,

whilst satisfaction (or dissatisfaction) is due to the disconfirmation of the extrapolative

expectations for both quality and non-quality dimensions. However, Oliver's model did not

describe the relationship between desire congruency/disconfirmation and satisfaction neither

did it insist on the consequences of expectations on perceived performance. To bridge this gap,

Spreng and Mackoy (1996) developed a model (Figure 3.10.3) which confirmed the distinction

between the two concepts (desire disconfirmation and satisfaction) and improved the perceived

service quality model by showing that satisfaction is directly subjected to desire

congruency/disconfirmation. Therefore, when the desire is met by the perceived performance

the overall satisfaction level will be higher compared to the situation where the desire is not

met.

Figure 3.10.3. *Satisfaction-Service Quality Model*
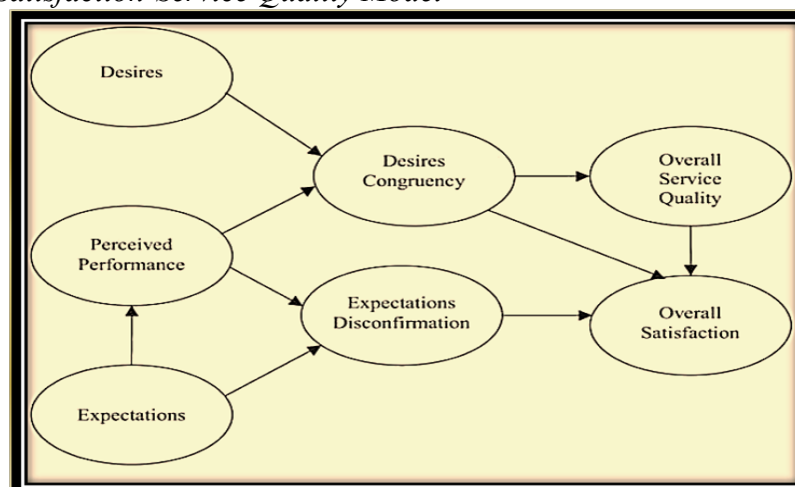
Source: Spreng and Mackoy (1996, p. 925)

In addition, Spreng and Mackoy's model (see Figure 3.10.3 in the previous page) also identified the double influences of expectations on satisfaction for the following reason: the negative effect of anticipations on satisfaction throughout disconfirmation is caused by the practice of lower expectations and over-delivery of service (lower anticipation results in higher positive disconfirmation which, in turn, leads to greater contentment). Needless to say, if expectations are lowered the organisation is at risk of decreasing the perceptions of performance which may subsequently decrease satisfaction. For this reason, hospital managers should understand the positive and negative consequences of anticipation and plan to ensure their customers' expectations of quality of medical tourism services are met.

3.10.4 Philip and Hazlett Pivotal-Core-Peripheral Attribute Model (1997)

Philip and Hazlett (1997) developed a model with hierarchical structure, founded on three encapsulated sets of attributes: pivotal, core and tangential (Figure 3.10.4). The pivotal features of their model are mainly concerned with the "*end product*" or "*output*". Positioned centrally to their model are the attributes which are collectively considered to be the principle attributes in determining the reason behind the customer's decision to approach a specific organisation. In other words, this set of attributes signifies the outcome the customer hopes to obtain via the use of a specific service.

Figure 3.10.4. *Pivotal-Core Peripheral attribute*
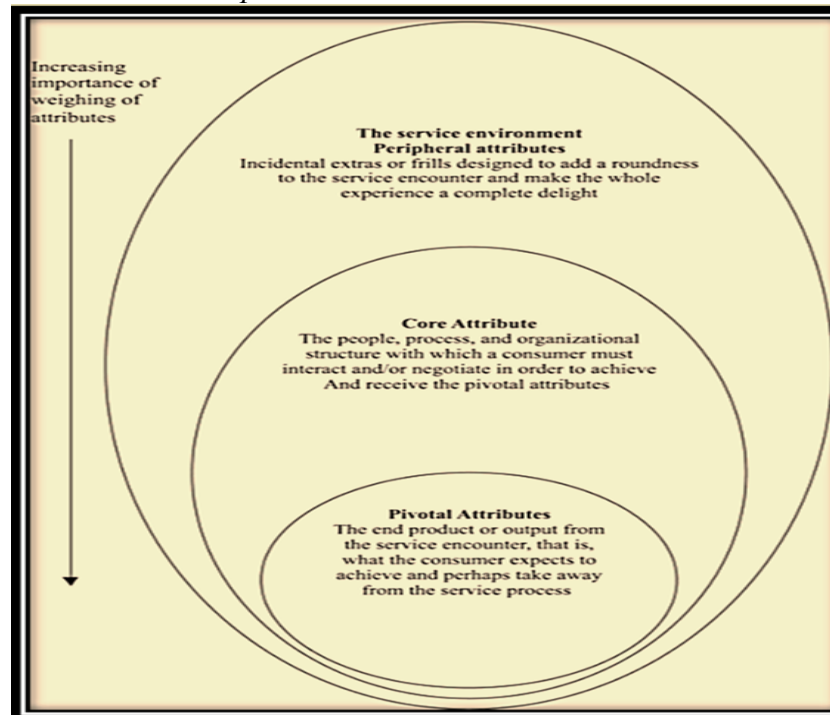
Source: Philip and Hazlett (1997, p.926)

Surrounding the fundamental characteristics are the needs and expectations of the people, and procedures and the service administrative body through which customers must communicate and/or negotiate so that they can reach the pivotal quality. Simply speaking, in a service experience if the client meets or deals with anyone or anything within the service organisation then these dealings are fundamentally recognized to be essential qualities. For example, all the amenities, politeness, compassion and trustworthiness of the staff are considered to be fundamental characteristics in the appraisal and the gratification levels of the customer.

The peripheral aspects in Philip and Hazelett model are recognized as the "*incidental extras*" or facilities which it is anticipated by the service provider will build in "*roundness*" to the service as well as coming up with a holistic encounter for total client enjoyment. If a client evaluates any service encounter and he/she is satisfied this means that the pivotal aspects were delivered well by the service provider.

3.10.5 Dabholkar, Shepherd and Thorpe Model of Antecedents and Mediator (2000)

Figure 3.10.5. *Antecedents and Mediator Model*
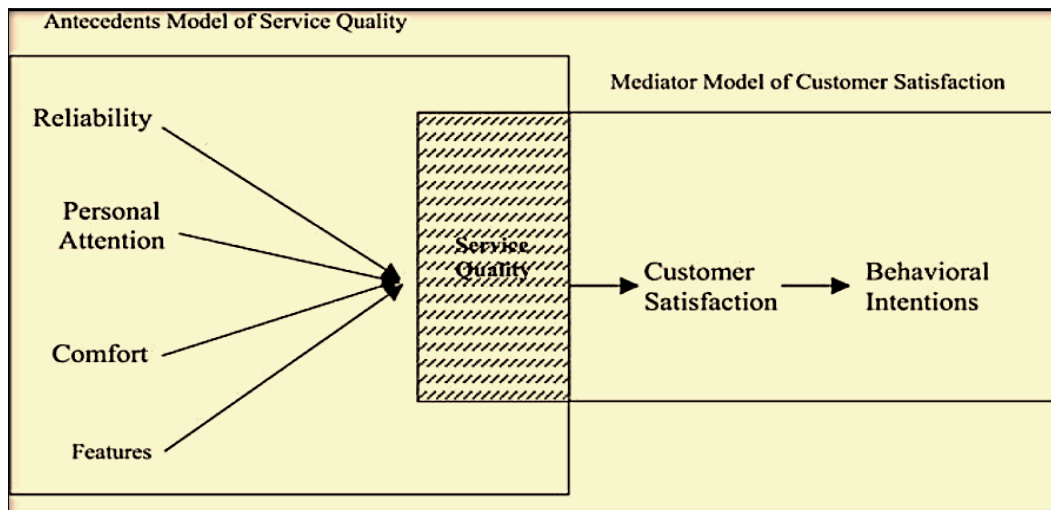
Source: Dabholkar *et al.,* (2000, p.929)

Dabholkar *et al.* (2000) designated the elements that are related to service quality as antecedents. Principally, four antecedents were identified (reliability, personal attention, comfort and service features) and they formed a basis upon which organisations could achieve a total assessment of the service provided. Their model claimed that customers formulate a distinctive evaluation of the quality of service as well as of various service attributes instead of a simple summation formulation of these attributes. Rather than focusing on all service attributes (reliability, personal attention, comfort and service features) when rating the quality of service given most clients will rate the service given on the basis of a single attribute. Additionally, their research discovered that client gratification is the product of service quality at the level of behavioural intentions where it is more comprehensively linked to particular factor assessment of the service such as the reliability or the comfort of the service given. Simultaneously, the research confirms the importance of measuring client contentment separately from service quality when client's assessment of service is determined. By focusing in the implementation of four antecedents (reliability, personal attention, comfort and service features) when offering healthcare services, medical tourism institutions such as hospitals

would be able to meet their client's expectation on the quality of the service given and ensure their clients are highly satisfied.

3.10.6 Brady and Cronin Service Quality Model (2001)

Brady and Cronin, (2001) put forward a multidimensional and hierarchical construct that demonstrated service quality in accordance with three key dimensions: outcome, physical environment and interaction. Overall, the three dimensions are used to assess the quality of the service that they are given. Specifically, the physical dimension is used in assessing the physical features where services are given. The outcome dimension is used to measure the impact of services given while the interaction dimension analyses the relationship between the service providers and their customers as shown in the Figure 3.10.6 below (Brady and Cronin, 2001).

Figure 3.10.6. *Service quality model*
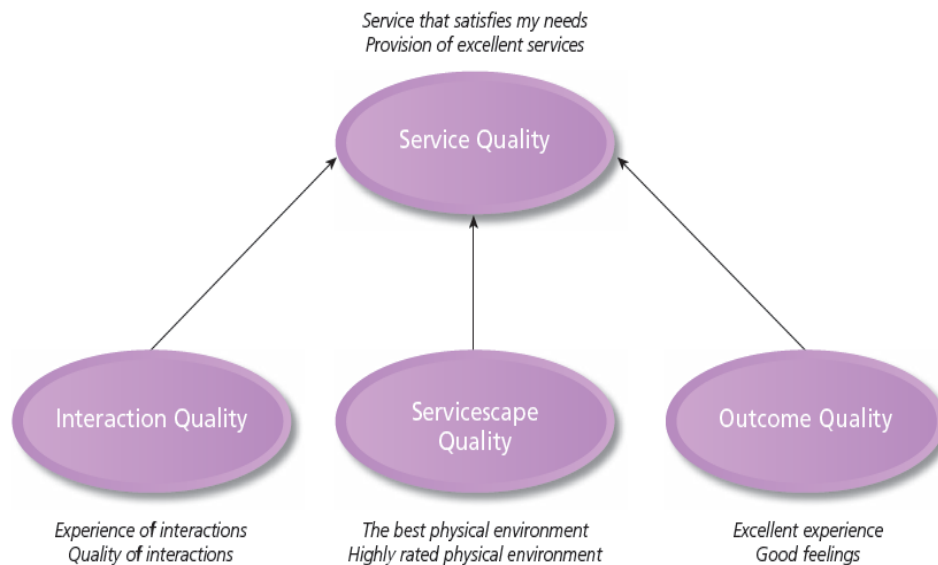
Source: Brady and Cronin (2001)

In the case of health services, each of these dimensions is further broken down into three sub-dimensions: the interaction dimension composed of mind-sets, conduct and proficiency, the physical environment quality comprises quiet and relaxing surroundings,

organisational and social variables, and finally the end result quality involves perceived items, conduct, and waiting period.

3.10.7 Saravanan and Rao (2007)

In a review of SERVQUAL literature in the automobile industry, Saravanan and Rao (2007) identified six critical factors of customer-perceived service quality. These factors were:

1) Human mannerisms expressed in the delivery of the service such as consistency, receptivity, guarantee and sympathy.

2) Hub service (fulfilment, attributes).

3) Social accountability (shared image refinement).

4) Organisation of the delivered service such as technology, procedures, expertise, and structures).

5) Perceived items service (equipment, apparatus, signage, operative appearance).

6) Marketing of the service.

Understanding the six critical factors is important for medical tourism organisations as they can lead to better recognition of service quality, customer's satisfaction as well as customer loyalty in the industry.

3.10.8 SERVQUAL Model Application in Various Contexts

3.10.8.1 IT Services

Badri *et al.,* (2005) assessed and employed the Spreng and Mackoy SERVQUAL model (see Figure 3.10.3, p. 88) to measuring service quality in the information technology field. In their study, which targeted three higher education institutions in UAE, they investigated the gap in the dimensionality issue of the SERVQUAL tools. The results identified that the service quality gaps in the IT business suffer a shortage of dimensions and that the fit between the model and the reality is seriously flawed, i.e., the five RATER dimensions were not capable of

interpreting the customer's satisfaction so they need to be topped-up with additional supportive dimensions.

3.10.8.2 Financial services

In a more recent study in the banking and finance sector, the SERVQUAL model was used in Malaysia to identify the comparative significance of elements crucial to the service quality in banks (Kumar *et al.,* 2009). The authors adapted the SERVQUAL instrument (RATER) to include six dimensions, *"tangibility, reliability, responsiveness, guarantee, empathy and convenience"* because, based on the researchers' exploratory research, *"Convenience"* was assumed to be of prime importance in determining customers' satisfaction. At the end of the study, the authors noticed four characteristics of utmost importance: *"tangibility, reliability, convenience and competence".* These characteristics had emerged with substantial modifications amongst outlooks and acuities, where perceptibility had the smallest gap and suitability had the largest one. Therefore, the authors recommended that banks should be more skilful in distributing and supplying their services to gain consumers assurance (Kumar *et al.,* 2009). In another service industry in which trust is of significant importance the results of this study may add to a better understanding of consumers' positive reception of quality offered by medical tourism operators such as the need for focusing on the *"tangibility, reliability, convenience and competence"* of the medical services that are given.

3.10.8.3 Healthcare services

Attempting to determine physiotherapy services quality, Curry and Sinclair (2002) employed the SERVQUAL instrument in three physiotherapeutic services in Dundee, Scotland, to try and measure the five gaps that were previously identified by Parasuraman *et al.,* (1988) (see Figure 3.10.2c // p. 87). They took the ten original dimensions evaluated, merged and summarised them into five; *"tangibles, reliability, responsiveness, assurance (which includes competence, courtesy, credibility, and security) and empathy (which include*

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access, communication, and understanding)" which was similar to but not identical to the later five dimensions identified by Parasuraman *et al.,* (1988) (see Fig 3.10.2b // p. 86) Curry and Sinclair's (2002) five dimensions were found to evaluate the difference between the apparent and estimated quality.

The study's findings indicated that the different dimensions were much valued by the patients despite the observations – minus – expectation (P-E) being undesirable. Data related to patient circumstances could be enhanced and, as has been established in similar preceding healthcare studies the dimension of reassurance and sympathy was emphasized as imperative. Despite some flaws, an evaluation of SERVQUAL typically identifies and shows specific flaws that necessitate settling. However, the reading approves the prospective effectiveness and significance of SERVQUAL in the community setting to determine customer preferences and appraise service presentation. These dimensions may help the medical tourism operators in understanding how the quality of the service they give to their clients may differ from the expected quality.

3.10.9 Criticizing SERVQUAL Model

The various models discussed in this section are all attempts at ensuring quality service delivery to the customer. While they have their strengths, they are not as comprehensive as the SERVQUAL. Altogether, models such as the Model of Technical and Functional Quality have been useful in the improvement of the SERVQUAL model. The SERVQUAL model helps in identifying the gap of poor delivery of services in the medical sectors when comparing customers' expectation with the quality of real delivery of service (Udupa and Kotreshwar, 2013). To date, SERVQUAL has been successfully applied to multiple private and public organisations across a variety of industries (Babakus and Boller, 1992; Brady and Cronin, 2001; Pashley, 2012; Shapiro, 2010). These various academic studies widely support the view that consumers don't perceive quality in a one-dimensional way; instead, they evaluate it based

on numerous elements pertinent to the setting as hypothesized by Parasuraman *et al.* (1991) in their RATER instrument (Kassim and Bojei, 2002; Orwig *et al.,* 1997) (see Figure 3.10.2c // p. 87). This explains why SERVQUAL is still taken to be the core model in this area of research.

However, although the original SERVQUAL model is one of the most noteworthy service quality prototypes it has been criticized both theoretically and operationally. Shapiro (2010) criticized SERVQUAL models as follows:

- Paradigmatic objections: SERVQUAL relies heavily on the disconfirmation paradigm. Pursuant to the 'Disconfirmation Paradigm', acuities of a service meeting are distinguished by either confirmation or disconfirmation of expectancies. Due to its reliance on the disconfirmation paradigm in lieu of the attitudinal one the SERVQUAL instrument may fall short in considering the economic conditions of the business/industry as well as the customer's psychological status.

- Dimensionality: the five scopes of the SERVQUAL tool are not similar depending on different industry contexts and items rarely depend on the prospective dimension as the researcher would anticipate. Moreover, the correlation among the five RATER dimensions is sometimes quite high due to overlapping service delivery items in the medical tourism sectors.

- Focus: SERVQUAL's main emphasis is on the service distribution procedure rather than service experience consequences. Sometimes all service delivery aspects may be met yet the end service is not delivered.

 Pashley (2012) also criticized the SERVQUAL model on the basis of

- Expectations: expectation is a "*polysemic"* term. Customers employ standards instead of expectations to assess service quality so SERVQUAL does not quantify its absolute potentials.

- Element configuration: the five ranges such as the reliability element are not enough to detect the inconsistency within each of SERVQUAL's aspects.

- Divergence: the inverted division of elements in the scale creates respondent blunder. This occurs specifically in the negatively-worded questions where higher scale values mean higher disagreement.

- Scale points: there is no factual evidence that the seven-point Likert scale is the best or may engender consistent results across different research in different contexts. Kumar *et al.,* (2009) had earlier expressed their disapproval of the scale because it requires verbal classification for point's two to six. Another issue that they criticized is the respondents' understanding of the implications at the centre of the scale "(e.g., is it a "don't know", "do not feel strongly in either direction" or a "do not understand the statement" response?")

The application of Spreng and Mackoy SERVQUAL in IT business service helped in showing the flaws that may exist when applying the SERVQUAL five RATER model in measuring the quality of healthcare services. Their research showed the need of using different SERVQUAL models when coming up with the results of the quality of services given by a healthcare provider.

Sumarjan *et al.,* (2013) also stated that another critical component of the SERVQUAL model is the perception of quality in achieving customer satisfaction concerning hospitality and tourism industries which is inconsistently aligned with all service delivery aspects that might not meet the end service desired delivery outcome.

3.10.10 The Theoretical Model Baseline for this Study

Derived from the GAP archetype established by Parasuraman *et al.,* (1988) and their SERVQUAL model, Frost and Kumar (2000) developed a service assessment model called INTSERVQUAL, which was intended to assess the measurements that define service quality

and the relations amongst internal customers "*front-line staff*" and inside-suppliers "*support staff*" within the service sector. The upper division of the instrument (Figure 3.10.10) comprises phenomena attached to the internal customer such as how employees perceive the service given to the clients whereas its lower part identifies phenomena attached to the service provider or stakeholder such as coming up with strategies for meeting service quality specifications. The rationale behind the selection of this model for the current study was that its definition of service quality and the relations amongst the frontline staff as internal customers and the support staff as the inside suppliers within the service sector helps in understanding the kind of potential service quality barriers within medical tourism in Qatar since Qatar is still a potential medical tourism destination in the early stages of development.

Figure 3.10.10. *Model of Internal Service Quality*
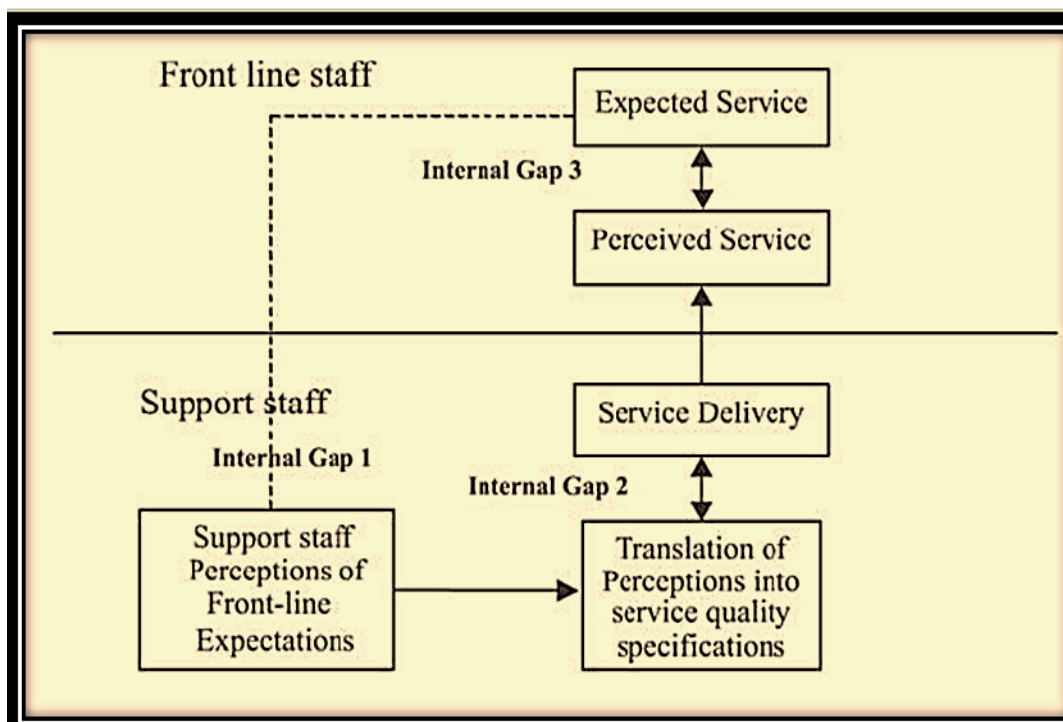
Source: Frost and Kumar (2000, p.929).

The expected service is designated as the outcome of the (internal) clients' previous experiences, their private needs as well as word-of-mouth communication. Expected service can also be affected by communication with the market. Perceived service is the outcome of sequential internal decisions and actions that are mostly subjective when specifying the aspects

of the service quality that an organisation should continue to give. Where there are variations

or inconsistencies in the expectations or perceptions among the personnel engaged in supplying

and consuming services, a "*service quality gap*" can take place, as shown in Figure 3.10.2a (p.

84).

The first internal gap in the model developed by Frost and Kumar illustrates the

variation between the personal expectancy in 'front-line staff' and 'support staff's acuity. The

second internal gap describes the main differences between the expected essential service

quality and the actual delivered service, leading to an "*internal service performance gap*". The

third internal gap focuses on the front-line workers and emphasizes their anticipation

differences with their respective perceptions on the provided service quality.

To sum up, SERVQUAL illustrates that employees (support staff) are required by

employers to identify the specifications of service quality from the customers' perspective,

identify the gaps and initiate an implementation phase in order to meet the anticipated service.

Considering that the customer's perception is the key to medical tourism development, and

because there is a straightforward union between service quality service and the gratification

of customers in the tourism industry, it is essential for the organisation to close the gap in the

quality of the service provided. In medical tourism, bridging the gaps would entail the

organisation understanding what the consumer's actual anticipations are and developing and

implementing complimentary service quality measurements.

3.11 Stakeholder Theory

The term 'stakeholders' encompasses all who could be contributing towards a particular

activity or goal and whose consciousness and support are essential to its existence (Golder,

2005). Stakeholder theory was first proposed by Freeman in 1984. He suggested that the

connections with various industries and individuals as well as workers, clients, contractors,

governments, and affiliates of the nations can determine the nature of an organisation. Freeman

(1984; 2010) defined the stakeholders in an organisation as any team and/or individuals who have the capability to influence or be influenced by the organisation's goals' performance, suggesting that, *"to be an effective strategist you must deal with those groups that can affect you, while to be responsive (and effective in the long run) you must deal with those groups that you can affect"* (Freeman 1984, p.46).

Therefore, and supported by Donaldson and Preston (1995), a group may be identified as stakeholder if it owns a legitimate concern with regard to the organisation's practices. Freeman also suggested that a stakeholder team has either the ability to impact upon the performance of the organisation and/or holds a share in it. Stakeholder theory's original base is accepted to be normative. It reformulates stakeholder responsiveness in an organisation by identifying two main concepts:

> *"First, Stakeholders are persons or groups with legitimate interests in procedural and/or substantive aspects of corporate activity. Stakeholders are identified by their interests in the corporation, whether the corporation has any corresponding functional interest in them. Second, the interests of all stakeholders are of intrinsic value. That is, each group of stakeholders merits consideration for its own sake and not merely because of its ability to further the interests of some other group, such as the shareowner"*. (Donaldson and Preston 1995, p.67)

This theory suggests that it is the obligation of managers and the administration to select undertakings that attain best possible profits to all known stakeholder groups with no advantage being given to one stakeholder's benefit at the expense of another. Regardless of the authority or concern of each stakeholder group consideration should be given to each. Correspondingly, every organisation should explore inputs from all stakeholders not just those who appear to have the most power. The theory assumes that administrators execute all activities as if all interests have intrinsic importance. Bonnafous-Boucher and Porcher (2010) argued that the entire management team needs to understand the importance of understanding stakeholder theory and that this extends to understanding the different needs of each stakeholders group involved and coming up with solutions to meet such needs. The researchers also suggested that

the task of stakeholder theory was to show moral and philosophical guiding rules to an organisations' administration.

From an executive point of view, Crane and Ruebottom (2011) said that stakeholder theory shows that different organisations should and are able to directly influence the administrative decision-making. They highlighted that the failure of an organisation may happen when it neglects to understand the contribution of any major shareholder group. This makes the engagement of stakeholders in the medical tourism sector critical to its successful development and implementation, as explained in the next subsection.

3.11.1 Medical Tourism Stakeholders

Byrd (2007) stated that *"for sustainable tourism development to be successful, stakeholders must be involved in the process"* (p. 6). Building on his original theory, Freeman (2010) suggested that stakeholders are any person, group of people, or foundation that possibly influences or would be influenced by activities or events of an entity and possess something to benefit from or lose if conditions of the entity are changed or they remain the same. Research indicates that it is very important to strengthen the link between tourist organisations both among themselves and with policy makers (Angelo and Maria, 2010). However, Angelo and Maria (2010) also suggested that the stakeholders in the public sector perform a more significant job in administering and advertising projects than in the private sector as they rank higher in the priorities scale.

One of the key questions when applying stakeholder theory in the medical tourism industry is the need to identify and understand the key stakeholders of the industry. Angell (2011) explained that stakeholders in the medical tourism industry are those groups, which are essential in the medical services system and have considerable influence upon any changes to the system. The main stakeholders in the healthcare system are patients, doctors, administration, insurance agencies, pharmaceutical companies and government. Insurance

agencies are included because they offer health coverage arrangements, specifically to patients or through managers or governmental intermediaries (Angell, 2011). In an Iranian study, Jabbari *et al.,* (2016) investigated the main stakeholders of medical tourism in Isfahan and provided strategies for the development of the industry. The findings revealed nine groups of principal stakeholders including the Tosea Saderat Bank, investors, tourism services providers, the Chamber of Commerce, health service providers, the Isfahan University of Medical Sciences, the Medical Council, the Cultural Heritage and Tourism Organisation of Isfahan, and the provincial governance of Isfahan. All these stakeholders had significant roles and different powers of influence (Jabbari *et al.,* 2016).

Numerous countries and regions promote business developments in tourism (Aliu *et al.,* 2016). Through the utilisation of territorial networks these business developments in tourism continually draw significant attention from both the private and state sectors which have interest in promoting solidarity at local level where collaborations form the platform to engage with the local community and civil society (Page, 2015). Public actors work together with not-for-profit, community/civil society, and private actors by combining the centralised top-down approach that tends to be more bureaucratic with the more inclusive, decentralised bottom-up approach multilevel governance approach (Ruhanen *et al.,* 2010). This integration happens in businesses and territorial societies to foster better cooperation and communication for better governance of destinations. The transformation of government structures and the thriving realisation of the role played by good governance continues to spark global interest in enhancing mutual social interactions between civil society organisations, communities, private sector, and state sector (Aliu and Aliu, 2015 as cited in Aliu *et al.,* 2016).

Intergovernmental networks and the level of cooperation with local organisations is critical for successful involvement of all medical tourism stakeholders in decision-making. From a stakeholder perspective, the inter-organisational networks within destinations and the

impact of the cooperation between the organisations provide stability that continually improves institutional platforms (Aliu *et al.,* 2016). Additionally, destination governance could encompass hierarchical tiers comprising networks of government and other stakeholders such as businesses and not-for-profits. Therefore, decision-making in tourism could enhance ownership and democratic actions when numerous stakeholders participate and fuse it with sustainable development according to Bramwell and Lane (2011).

To ensure the successful development of medical tourism, the involvement of all relevant stakeholders such as tourist attraction sites' managers, hospitality and hotel enterprises, travel agencies, government authorities, trade service institutions, tourist information centres and civil society representatives across multiple levels need engaging in organisational activities, effective collaborative interactions, and cooperative planning is essential (Aliu and Aliu, 2015, as cited in Aliu *et al.,* 2016). This form of collaboration coupled with communicative social actions has the potential to mitigate complexity risks in the governance of tourist destinations through collaborative efforts and synergy between major stakeholders situated in different networks. This means that the governance of tourist destinations can be affected even by a small number of public stakeholders and entities within the said inter-organisational destination networks provided such stakeholders and entities are more influential over the other stakeholders. This way, interventions to develop stakeholders' allegiance, innovation, communication, and knowledge management could enrich the extent to which inter-organisational collaboration (Cooper, Scott, and Baggio, 2009).

D'Angella and Go (2009) recommended the structuring of formally institutionalised arrangements to build effective collaboration that is driven by consensus among the diverse networks of private, peripheral and public stakeholders and organisations. This is because the legitimisation of group activities to cover stakeholders in decision-making processes and fostering the will to collaborate results in enhanced policy and activity coordination.

Nonetheless, Aliu *et al.,* (2016) noted that divergent interests, differing goals, conflicts and complexity in the governance of a destination can be bypassed by looking at the destination from an interdependent environment perspective where diverse stakeholders take responsibility and engage actively.

3.11.2 Stakeholder collaboration in medical tourism: Benefits and challenges

The tourism sector is diverse and includes a vast amount of small and medium sized businesses. Within a destination, the experiences of tourists are formed by a collection of services normally provided by a range of different organisations (Voigt and Pforr, 2013). These services are not solely supported by private, commercial industries, but also by publicly controlled information offices, attractions and infrastructure (Voigt and Pforr, 2013). The tourist's final evaluation of their experience is the combined outcome of all contacts built with stakeholders at the destination (Voigt and Pforr, 2013). Therefore, it is to the benefit of all stakeholders to collaborate since a single business might be strong but at the same time be the weakest connection within the value chain in which experiences are co-provided (Voigt and Pforr, 2013) which could prove detrimental to the whole supply chain set.

The fragmented nature of tourism, including growing competition and the need for continuous innovation, are all influential arguments to promote the concept of cooperation among tourism stakeholders. In fact, cooperation has been identified as a, if not the, key element for competitive destination (Bramwell and Lane, 2004; Jackson and Murphy, 2006; Pechlaner *et al*., 2008), as well as a fundamental feature of competitive health tourism destinations (Sheldon and Park, 2009). Understanding cooperation between different stakeholders in the medical tourism sector is important in understanding how such collaboration influences the quality of the service given within the industry.

3.11.3 Tourism and Attitudes of Host Communities

The role of local, host communities and their support or rejection of tourism development continues to attract significant attention in studies about tourism. In general, research concerning the support of host communities for tourism development has dependent upon psychological and anthropological views with the assumption that host communities are not homogenous groups with capacity to support the tourism industry or not (Gursoy, Jurowski, and Uysal, 2002). Debates concerning relationships between tourism development and communities have also been considered in sociocultural impact research studies (for example Mowforth, 2008; Simpson, 2008). There are significant numbers of studies demonstrating positive and negative perceptions of the host communities towards tourism development. Nonetheless, the results reported in such studies have been conflicting in various ways.

For instance, Yoon, Gursoy, and Chen (2001), the perception of local communities on the negative social and environmental social impacts as well as the positive effects of economy and culture of host population. In their study, Andereck *et al.,* (2005) discussed the positive economic and environmental effects of tourism on the host community and the negative effects on the cultural and social interactions. For Dyer *et al.,* (2007) found five major perceived positive and negative impacts of tourism development. Emphasis was on the vital role that positive tourism development's cultural influences play in getting support from the host community. Literature has also shown the reliance of community support on the current state of the economy of the host community (Meimand *et al.,* 2017). In theory, the dominant view has been that a host community's low economic development has a higher likelihood of receiving tourism acceptance from the local community (Gursoy and Rutherford, 2004). Despite this view, the sociocultural factors still dominate the relationship between locals/host communities' perceptions towards tourism development and their support or rejection of

tourism. These factors include culture and religion, knowledge concerning tourism, intrinsic motivation, and community attachment, as reviewed in the subsections below.

3.11.3.1 Culture and Religion

The construction and transformation of tourism destinations encompasses differentiation and homogenisation processes according to Saarinen (2004). Tourism destinations often homogenise both in comparison to other destinations and from within. This is aligned to Relph's (1985) 'placelessness' and Appadurai's (2011) cultural absorption concepts. Differentiation happens in rat-races with other destinations in the quest to develop a competitive identity, as explained by Anholt (2007). This happens through emphasis on unique features of the place with differences from physical assets like mountains or beaches to the cultural ones like festivities and food (Saarinen, 2004). Similarly, marketing strategies for regional tourism focus on development of destinations with the capacity to withstand global competition through capitalisation of local distinctiveness, authenticity, and regional identities (Dredge and Jenkins, 2003).

Moreover, there is strong spatial structuring of tourism marketing along territorial boundaries across different levels. This introduces the potential limitation of transforming destinations and regions that are not strongly bound to territory to tourism destinations (Pearce, 2014). This could develop controversies between external and internal destination marketing orientations such as when various countries, states, or municipalities try to collaborate as a tourist region (Thomas, Harvey, and Hawkins, 2013), which necessitates alignment of identifies and histories (Jeuring, 2016).

Host populations can also have social concerns that influence their support for the development of tourism within their locations (Gursoy and Rutherford, 2004). Religion is one of these influences (Meimand *et al.,* 2017) and interpretations of Islam vary across Islamic nations and are subject to cultural influence, local community roles and intervention in

religious matters by government. In connection with Islamic religiosity, there has been evidence that demonstrates significant concerns for moral standards, possession of increasingly conventional attitudes and conservativeness in religious communities (Johansson-Stenman, Mahmud, and Martinsson, 2006). A study by Zamani-Farahani and Musa (2012) evaluated the influence of Islamic religious concerns on how the local communities perceived tourism impacts in an Iranian context. Based on previous literature, they had hypothesised that the presence of religious sensitivities concerning non-Muslim tourists across various Muslim nations may also cause negative perceptions towards tourism development although this was not supported in their study. Altogether, there are several studies whose findings demonstrate intolerance by religious individuals to others with varying religions (Daniels and von der Ruhr, 2005; Johansson-Stenman, Mahmud, and Martinsson, 2006). For example, Islamic believers oppose alcohol consumption consequently, they may perceive tourism negatively if it seems to encourage it (Zamani-Farahani and Musa, 2012). However, despite the similarities in religious beliefs in Muslim nations across the world local community roles, host cultures and the governmental intervention levels differ and cause variations in perceived benefits and costs from a social perspective across various Muslim nations. In a recent study, Meimand *et al.,* (2017) found that Islamic religiosity had significant influence on the support for development of tourism perceptions of sociocultural costs and benefits in the Malaysian homestay tourism context. Altogether, Henderson (2003) previously argued that tourism destinations where the dominant religion is Islam are known to encounter formidable dilemmas in their attempts to ensure that modern mass tourists are accommodated. Some aspects of such attempts at times contravene Islamic strictures.

Arabic cultural values also influence a patient's health experiences based on the Arab worldview (Lovering, 2012). The most dominant of the values include the central role that the family unit plays within Arab society, beliefs related to health, healing and illness and the

significance of ensuring patient dignity and modesty. For instance, Arab culture has more reverence for family than an individual and family, unity, honour, and commitment are the core values.

Therefore, medical tourists from such Arabic backgrounds are likely to go to hospitals which adhere to Islamic principles (Iranmanesh *et al.,* 2018) for example, hospitals that offer gender-concordant healthcare whereby female medical staff are the only ones that examine and treat female patients. Medical facilities offering services to Islamic medical tourists which do not have such compliance practices need to inform their patients and provide alternatives like requesting the presence of female staff members or relatives while a male medical practitioner examines a female patient. Additionally, doctors can further ensure the comfort and ease of their Muslim patients by announcing their arrivals just before getting to a room with a patient. This interval gives a female patient the time to cover her whole body apart from the face and the hands (Din, 1989), as a value that Muslim women adhere to in order to ensure modesty in line with the *awrah* protection principle (Lovering, 2012; Iranmanesh *et al.,* 2018). However, it is noteworthy that neither Islam nor culture requires separation of gender during care encounters; rather it is the individual conservativeness within a particular cultural context which influences the perceptions and expectations of patients of gender-concordant care. However, healthcare services such as gynaecological or maternity care often demands gender-specific care (Padela and del Pozo, 2011).

In the Islamic medical practice realms, patients who have higher levels of education are likely to value the practice of physicians in terms of disclosure of substances that are not halal to them. Such individuals might be more knowledgeable of what prescriptions available in market are and are not halal (Hoesli and Smith, 2011). As medical tourists, they are likely to demand proactivity on the part of the pharmacist and clinician following the rising levels of

regulations and product choices which surely imposes obligation on the pharmacy or hospital department to label drug micro-packaging (Sadeeqa and Sarriff, 2014).

3.11.3.2 Tourism Knowledge

Knowledge concerning tourism is also a sociocultural factor that literature portrays as an influencer of the extent to which a host community can accommodate any form of tourism. In general, knowledge concerning tourism informs the perceptions that the host community has towards any forms of tourism development in their area (Feighery, 2002). In the Western context, for example, the knowledge that local community members have about tourism influences their perceptions of the benefits and costs of tourism is largely positive (Meimand *et al.,* 2017). However, Meimand *et al.,* (2017) also noted the scarcity of research particularly in developing nations where tourism knowledge level differs and the perceptions of locals towards tourism development also differ significantly.

The higher the knowledge about tourism and the local economy among residents, the higher the likelihood that they will support tourism development (Meimand *et al.,* 2017). Indeed, Andereck *et al.,* (2005) found that locals with higher knowledge levels of tourism had more favourable perceptions of its impact on the life, economy, and image of the community. However, these positive perceptions did not apply in the case of community environment.

3.11.3.3 Intrinsic Motivation

Although there are very few studies on intrinsic motivation factors and perceived social benefits, the two have been portrayed in literature as crucial role players in community support for tourism development (Kayat, 2002). The most important aspects of intrinsic motivation factors of community members in social contexts include opportunities to host tourists, create relationships, play roles, feel needed, gain self-respect, and collaborate as a community. The common characterisation of tourism is that of an opportunity for destinations to develop economically (Cheong and Miller, 2000). However, these assumptions often invoke ethical

concerns related to development ideologies and practices that inform these practices. These concerns are further exacerbated by concerns about exoticisation and othering whereby destinations become exceedingly reliant on the unstable tourism industry and tourism policies are prioritised (Caton, 2012). Othering happens via interactions within tourist spaces including inside promotional content that reinforces exoticism and various facets of a destination that is more industrialised and developed places (Buzinde and Yarnal, 2012).

According to Cheong and Miller (2000) tourism discourses end up naturalising tourism development and practices in middle- and lower-income nations including medical tourism. Narratives about travel to therapeutic destinations of medical tourism and consumer choice market discourses combined with increased patient autonomy within the medical tourism context are evident in literature about medical tourism. Stakeholders of medical tourism often take up these discourses (Ormond, 2013). Due to a lack of research it is not clear how intrinsic motivation factors would influence the perceptions of the host community towards medical tourism particularly in the Qatari context.

3.11.3.4 Community Attachment

The sociocultural lens portrays community attachment as another critical factor affecting support for tourism development from locals (Meimand *et al.,* 2017). While early studies (e.g. McCool and Martin, 1994) found no clear linkage between the support for tourism development by locals and community attachment more recent empirical studies suggest that residents of a community tend to perceive tourism development negatively when they have resided at the destination for a long time (Huttasin, 2008). Mason and Cheyne (2000) stated that rural host populations may perceive tourism development differently than urban host populations and this could trigger tiered attachment levels to their community, which eventually influences their support toward tourism development. However, place attachment is

critical in influencing the perceptions of residents and their attitudes towards the perceived effects of tourism development (Gursoy and Rutherford, 2004).

Attachment in the case of tourism does not only relate to place attachment. It includes the relationships that people in the community have and their environment, as reflected in mixed, negative or positive feelings (Campón-Cerro, Folgado-Fernández, and Hernández-Mogollón, 2017). Therefore, tourism support factors also include perceptions of tourism's impact on the community in terms of economic, environmental, and sociocultural implications (Stylidis *et al.,* 2014). In the context of this study, this implies that the Qatari community is more likely to embrace and support medical tourism development if it perceives its economic, environmental, and sociocultural impacts positively.

3.12 Hospitality and Hospitableness

According to Lashley and Morrison (2000), hospitality includes an obligation to cater to guests' necessities as a key element in commercial practices in the liaison between the host and guest. This association, described as hospitableness, is typically comprehended by the host and exhibited to the guests, then, reciprocated by the guest to the host. A convivial attitude and atmosphere are important elements in hospitableness (Brotherton, 1999; Oh and Pizam, 2008). These components engender not only exceptional service but also outstanding experiences among the consumers of the experience (Hemmington, 2007). From this standpoint, the inclusive philosophy of hospitality within an organisation is pertinent to any industry and can assist in developing interactions among industries. A medical facility with hospitality settings where the patient is treated like a guest provides a remarkable model of the host-guest rapport. According to Pizam (2007, p. 500), "t*he difference between hospitals and hospitality is 'ity', but that 'ity' can make a significant difference in the recovery and stay of hospital patients.*" Many hospitals have adapted programs used in hospitality industry to enhance their patient's stays (Studer, 2003). These programs focus on improving the process of people's

communications throughout the client experience. The process comprises improving the services given and providing psychological and emotional welfare in the host/guest or patient/provider interaction (Ferguson *et al.,* 1999).

The designs of the hospital's facilities have been shown to have a great influence on patients' perceptions. Studies undertaken on patients in physically attractive waiting room areas showed that the patients gave higher ratings of quality of care and patient-staff interactions and recommended the facility to other patients as opposed to those in unattractive waiting areas (Arneill and Devlin, 2002; Becker *et al.,* 2008). Hospitals with attractive environments also scored higher in retaining staff and increasing staff satisfaction than those with less attractive ones (Becker *et al.,* 2008).

Agreeing on the importance of enjoyable surroundings, Goldman and Romley (2008) also identified that hospitable facilities, such as good food, alert staff and enjoyable surroundings as well as all basic requirements such as the reputation of a healthcare entity and the qualification of healthcare professionals have played a significant part in promoting demand for specific hospital care. Patients valued hotel-like features, such as views, room service meals, private and family-friendly rooms, as well as massage therapy twice as much as they valued the clinical reputation while making their hospital decisions.

3.13 Built-in Environment in Hospitality

A developing amount of evidence endorses the association between the physical or *"built"* setting and optimum patient results, patient contentment with the hospital experience, staff gratification with the work environment and administrative performance. Numerous contemporary studies have revealed that physical environmental elements, such as room designs, lighting, and level of noise promote constructive or destructive developmental, psycho-social, medical and welfare consequences among employees, families, and patients (Joseph, 2006, Gulwadi *et al.*, 2009; Joseph *et al.,* 2008; Sadler *et al.,* 2009; Ulrich *et al.,* 2008).

Another factor that contributes to optimizing patients' contentment and engenders outstanding levels of gratification among staff and families is environments (the physical environment and culture and work processes) that embrace the parents' as crucial players in the care process (Koontz, 2003; Miceli and Clark, 2005; Harris *et al.,* 2006; Maijala *et al.,* 2004; Varni *et al.,* 2004). When looking for elective treatments in both private and public hospitals, healthcare consumers will seek for facilities with single-patient rooms that provide abundant space for visitors since such consumers are keen on the interior design alterations, such as locating furniture to promote social communication and integrating natural components and artwork have also been shown to boost confidence and contentment among staff (Douglas and Douglas, 2005; Dijkstra *et al.,* 2006; Joseph *et al.,* 2008).

3.13.1 Reception Areas in Hospitals

In the hospitality business, the reception an indispensable part of the hotel for it provides the guests with important points of references like the front desk, restaurants zones and other service areas. It also acts as a get-together place and a security control point for the building (Wu *et al.,* 2013). In addition, the reception, as the first point of entry, sets the tone of the hotel or hospital in the consumers mind (Rutes *et al.,* 2001). For the reception to reach high standards its design must equalize its visual effects and effective functionality.

Since the 1990s, many of the hospitals which have been built have been influenced by the idea of large reception that includes atriums and other similar elements (Wu *et al.,* 2013) as large public spaces always have the potential to look fascinating and interesting for hospital visitors (Wu *et al.,* 2013). In general, patients do not experience hospital receptions for a long period of time (Wu *et al.,* 2013) however the relatives or the care giver of the patients do as they wait for their relatives and friends to be treated. Having a high-quality reception area ensures the hospital is more likely to attract and reassure new medical tourists for both the

private and public hospitals as the reception creates a welcoming environment to all stakeholders who are involved.

3.13.2 Patient Rooms

In general, medical terms private rooms have plenty of advantages such as reduction of medical error rates, decrease in patient stress and depression, as well as minimizing the length of stay, and increasing the degree of satisfaction with the hospital however, in most developing countries only private hospitals have private rooms for their patients (Urich *et al.,* 2008). However, the trend is changing as new public hospitals in the GCC region offer single rooms to assure customer's privacy as well as providing in-room *"stay over"* facilities for the patient's family member, thus acting like a hospital and a hotel at once. This is very important in medical tourism where the accompanying person needs to be treated appropriately as well as the patient. (Happ *et al.,* 2007).

In Qatar, public hospitals have raised the ceiling of their clinical service to provide not only a comfortable, single-patient rooms, but also luxurious suites to attract the customers who are willing to pay for this service especially if they are covered by insurance companies (Wu *et al.*, 2013). They not only target the customers within the country but are also focused for foreign customers who consumer medical tourism services.

3.13.3 Food and Beverages: Catering Services

In Qatar public hospitals, most hospital patients' meals provided by the hospital are standard diet meals; these meals do not require adhering to comprehensive nutrition criteria for a healthy diet (Moran *et al.*, 2015). The absence of care given to patient nutrition may be attributed to the prospect that the standard diet meals given already follow dietary guidelines given by the Qatar health department (Deluco and Cremer, 1990; Watters *et al.,* 2003). Unlike in western health facilities, there is little information about the dietary structure of patient food. Although medical policy requires medical facilities to adopt a diet guidebook to conform to

accreditation criteria and government protocols, the focus of the public hospital in Qatar remains on providing cures and supervising critical and chronic illnesses rather than supervising diet-related issues (Department of Health & Human Services, 2015). While the *standard* patient nutrition (conforming to the minimum diet guidelines) constitutes most inpatient meals, public hospital in Qatar have established therapeutic diets for patients who cannot consume the standard meals (Stanfield, 2010).

In contrast, most of the private hospitals in the GCC region have invested in additional facilities that contribute to the whole meal experience in a similar way to a commercial restaurant or hotel (Hartwell *et al.,* 2015). In private hospitals, patient gratification is acknowledged as a means of evaluating the quality of the provided services' (Dall'Oglio *et al*., 2015). The patients' perception of food availability and the meal experience are becoming acknowledged to be highly significant within the range of therapeutic and provision services provided by hospitals (Spencer and Walshe, 2009; Andersson *et al.,* 2013, Russell *et al.,* 2011). Hartwell *et al.,* (2015) asserts that upgrading the food quality and presentation continues to be the most significant aim of medical facilities food service providers. They outline the existence of a positive correlation between the qualities of food given to the recovery time of medical patients. Quality food which complies with the dietary guidelines leads to better medical outcomes (Dall'Oglio *et al.,* 2015).

3.13.4 Healthcare institution Spas, Therapy Programs, and Wellness Centres

Over the past twenty years, spas and wellness centres have acted as profit centres for dealing with every aspect of health and wellbeing, socially, psychologically, spiritually, and physically (O'Fallon and Rutberford, 2011). In Dubai and Turkey private hospitals spas and wellness facilities in hospitals assist the clinical staff in investing in all possible ways of healing in order to benefit the patients and supply them with the kind of alternative therapeutic amenities lacking in standard medical facilities (Wu *et al.,* 2013). Not only can the hospital

patients enjoy and take advantage of spas and wellness facilities but their family members are also able to enjoy the facilities during their relatives' period of treatment (Murray *et al.,* 2006; Nicholson *et al.*, 2005). Hospitals have invested in spas and wellness facilities as a strategy of attracting medical customers from within and outside the countries where they are located. Apart from the clinical side, spas and wellness centres are also considered to be good additional facilities which can provide competitive advantages (Andersson *et al.,* 2013).

3.14 The Conceptual Framework

Figure 3.14 shows the conceptual framework developed from the literature reviewed. The framework not only shows the dependent and independent variables of the available research, it also summarizes the findings of concepts and theories which have been developed by past and present researchers.

Figure 3.14. *Conceptual framework*
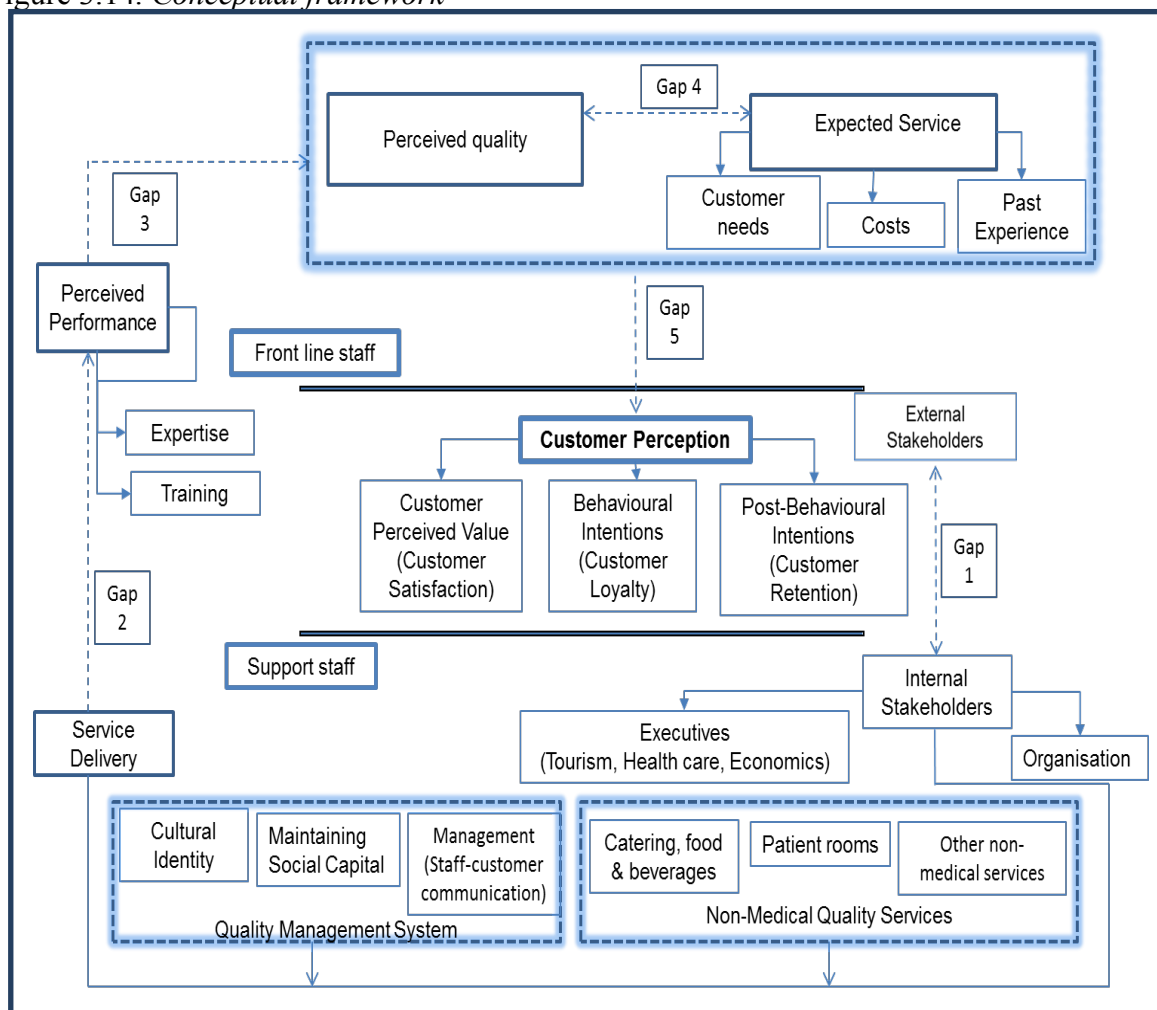
The conceptual framework is divided into two main areas, which include service quality management and external management (see Figure 3.10.10 // p. 98). The service quality management section shows the interactions between the independent variables and the dependent variables such as the how the service delivery and perceived performance independent variables influence the perceived quality of the medical tourism services given (dependent variables) (see Figure 3.10.10 // p. 98). Independent variables such as cultural identity, maintaining social capital and management influence the quality management system of a hospital.

The right part of the framework shows how external management issues (issues that the management of a medical tourism facility cannot influence) such as expected services (dependent variable) are influenced by customer needs, costs and past experience when they consumed medical tourism services (see Figure 3.10.10 // p. 98). The framework contains the factors such as the customers' perception and external and internal stakeholders as playing a key role influencing the quality of expected services. The customer experience is also viewed as a dependent variable that is influenced by independent variables such as non-medical services (patient rooms, reception and catering food and beverages) and the actions of relevant stakeholders. The two parts of the conceptual framework show how employees who have training and expertise identify customer needs by identifying customers' expectation and how they meet such expectations through the implementation of quality medical and non-medical services.

3.15 Summary of the Literature Review

The literature review chapter reviewed on past and recent literature which has analysed the theories and concepts of quality of medical tourism services. The chapter has not only given the definitions of key terms of medical tourism but it has also given the history of the medical tourism concept such as the role that governments play in encouraging medical tourism within

their borders. There is also analysis of the different concept and theories of tourism such as wellness and niche tourism concepts. The chapter has also shown the impact of medical tourism in different arenas such as its impact on the economy and the culture of different localities. The analysis of behaviour theories and concepts is important in showing the factors that influence medical tourists' perceptions of the service given within the industry. One of the key areas of the research is the service quality model where the differences in customer perceptions and views on the quality of the services that they receive is explained. The section not only shows how customer expectations influence their satisfaction with the service given but also shows the impact of the delivery of services to customer satisfaction. The chapter has also highlighted the application of customer service models such as the use of non-medical services in influencing customers to have a positive view of the services that are provided by a hospital facility. The conceptual framework has shown the application of the dependent and independent variables.

Chapter Four

Methodology

4.1 Introduction

This chapter presents a comprehensive review of the methodological theories and systematic approaches which were employed in the assessment of the various dimensions of service quality within the Qatar medical tourism context. According to Driscoll *et al.,* (2007) the methodology chapter is central to research implementation as it offers guidance on the approaches used in the collection and analysis of research data. The research design and methodologies adopted in this study were chosen to allow the researcher to analyse the concepts of service quality and medical tourism; identify service quality gaps in developing medical tourism; define who the customers are and the implications for service quality; establish the implications of different cultural contexts using a SERVQUAL approach; and establish the current customers perceptions, expectations, and/or experiences of medical tourism within Qatar. Accordingly, this chapter starts with the analysis of the theoretical perspective and then moves onto the practical approach with a discussion of the methodological perspectives, research philosophy, research approach and research design used in the implementation of the current study. The chapter also reviews ethical considerations, the study's validity and reliability and reflects on the research process, including its limitations.

4.2 Methodological Perspectives

Methodological perspectives are defined as the various theories, principles and systems of research or the branches of knowledge applied to a field of study to generate knowledge (Allen and Eby, 2011; Strijbos and Sluijsmans, 2010). They consist of "the theoretical perspectives that lie behind the methodologies under the analysis" and the "epistemology that informs this theoretical perspective" (Crotty, 1998, p.2). According to Levers (2013), the success of the research process depends partly on the manner in which the researcher chooses

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their methodological approach. Levers (2013) explains that the chosen paradigms and approaches must be consistent with the beliefs of the study and the nature of its reality. Methodological perspectives and theories are critical when undertaking research because they provide the disciplinary framework that helps the researcher to identify the characteristics, practices and methods which will be used to conduct the study (Peterson 2014). Drawing on a variety of methodological and theoretical perspectives this section reviews the various concepts of epistemology, ontology and axiology as well as their applicability in generating new knowledge in relation to medical tourism and service quality. The methodological perspective includes the research philosophy, and research approach.

4.2.1 Epistemology and theoretical perspective

According to Crotty (1998), the theoretical perspective entails the philosophical stance that is used to inform the design and process of choosing the specific research methods. Therefore, theoretical perspectives are significant in research because they provide a context for the processes and ground the criteria and logic (Crotty, 1998). Crotty (1998) suggests that epistemology offers an explanation and understanding of what we know and how we know it while the theoretical perspective is a philosophical stance which enables an understanding and explanation of the human world and society built upon the particular assumptions that each researcher brings to their research project.

Other researchers have also tried to explain these concepts. For instance, Johnson and Christensen, (2012) suggest that epistemology deals with the theory of knowledge, mainly with regard to what people consider to be the foundation of acceptable knowledge as well as how people construct, understand and implement knowledge. Scotland (2012) suggests that ontology is the fundamental belief that focuses on the nature of reality or that explains what constitutes a fact. According to Saunders *et al*., (2012) axiology is the branch of knowledge which deals with the role that the values and the stance of the researcher plays in the research

and how this affects the research However, as Lincoln *et al.,* (2011) point out, these methodological beliefs are simply models which the researcher uses to obtain knowledge during the research process. It is up to each researcher to choose the particular epistemological and theoretical perspective which is most appropriate to their individual research project (Lincoln *et al.,* 2011).

Crotty (1998) divides the epistemology into three, that is, objectivism, constructionism and subjectivism and the theoretical perspective into positivism (and post-positivism), interpretivism, symbolic interactionism, phenomenology and hermeneutics (critical inquiry, feminism and postmodernism) as shown in Table 4.2.1 below.

Table 4.2.1. *The four elements of research*

Epistemology	Theoretical perspective	Methodology	Methods
Objectivism Constructionism Subjectivism (and their variants)	Positivism and post-positivism Interpretivism • Symbolic interactionism • Phenomenology • Hermeneutics Critical inquiry Feminism Post modernism	Experimental research Survey research Ethnography Phenomenological research Grounded theory Heuristic research Action research Discourse analysis Feminist analysis	Sampling, measurement and scaling Questionnaire Observation • Participant • Non-participant Interview Focus group Case study Life history Narrative Visual ethnographic methods Statistical analysis Data reduction Theme identification Comparative analysis Cognitive mapping Interpretive methods Document analysis Content analysis Conversation analysis etc.

Source: Crotty (1998, p.5)

Constructionism is a research paradigm which views knowledge as being constructed through human social interactions rather than being an insight into existing reality; objectivism views knowledge as a meaningful entity which exists independently of human experience and consciousness; and subjectivism regards reality as subjective (not absolute), i.e. truth exists only within one's experiences and consciousness (Crotty, 1998).

On the other hand, Saunders; Lewis and Thornhill (2012) define four major research philosophies that a researcher can undertake, which are: pragmatism, interpretivism (constructionism), post-positivism (critical realism) and positivism (naïve realism). Each one of these four research paradigms have fundamental beliefs that include ontology, epistemology, axiology and research methodology (McKerchar, 2008; Saunders *et al.*, 2012).

Within the positivism paradigm, the nature of reality is assumed to be objective, external and independent of social actors (Ponterotto, 2010). The epistemology within the positivism paradigm stipulates that only observable phenomena can be relied upon to generate facts and credible data. Accordingly, positivists put more emphasis on determining cause and effect and making law-like generalisations which reduce the research phenomenon into its simplest element. Positivists view of axiology is that research is etic and value-free, which implies that research is carried outside values boundaries and that the researcher's role is independent of the facts (Saunders *et al.*, 2012). Therefore, the researcher is assumed to maintain objectivity throughout the research; these types of study tend to rely entirely on quantitative methodologies.

The post-positivism paradigm, which is also known as critical realism, is similar to positivism in its ontology and epistemology except that post-positivists regard knowledge as existing independently of human beliefs and thoughts although construed through social conditioning (Saunders *et al.*, 2012). The post-positivists' epistemology also focuses on describing the research phenomenon where the role of the researcher is regarded as one that is biased by cultural experiences, world views and personal conditions such as upbringing (Wahyuni, 2012). Therefore, post-positivists tend to rely on both quantitative and qualitative research models.

The interpretivism paradigm is the opposite of what Wahyuni (2012) describes as a naïve realism and post-positivist approach in that it views knowledge as subjective, flexible

(subject to change), socially constructed and multiple. Acceptable knowledge within the interpretivism paradigm consists of social phenomena and subjective meanings, the focus of the research is mainly to describe the specific details of the phenomenon being studied as well as to identify subjective meanings, motives and reality behind these details (Wahyuni, 2012). The role of values in the interpretivism paradigm is emic and bound. The researcher is regarded as part and parcel of what is being researched and, as such, subjective and cannot be separated from the study (Saunders *et al*., 2012). Interpretivists tend to use qualitative research methods.

According to Wahyuni (2012) the pragmatic paradigm is among the most modern research philosophies as it seeks to resolve differing fundamental beliefs and create a balance between the positive and interpretive paradigms. The nature of reality in the paradigm approach is regarded as multiple, meaning that it can be subjective or objective depending on the purpose of the study (Wahyuni, 2012). In addition, consideration of what constitutes acceptable knowledge can include either or both subjective meanings and observable phenomena depending on the research question. Accordingly, the pragmatic approach focusses mainly on practical applied research which allows for the integration of a range of perspectives as long as they lead to an appropriate and critical interpretation of data (Saunders *et al*., 2012). Pragmatism usually employs a multi or mixed methodology that combines both qualitative and quantitative methods.

In the current study, the researcher used SERVQUAL theory to build upon Frost and Kumar's (2000) service quality model in identifying internal service quality knowledge gaps about medical tourism in the Arabic context, using the Qatari health sector (see Figure 3.10.10 // p. 98). It was considered a pragmatic approach to use a research philosophy that would satisfactorily answer the research questions and meet the research aim of creating a model which enables removal or minimisation of any gaps identified in the Qatari context. It was the researcher's belief that the research questions, "*What is the complexity of the concept of*

medical tourism?", "Who is the medical tourism customer in the Qatari and Arabic context?" *and, "What are the service quality barriers in medical tourism in Qatar?",* could be best answered using a pragmatic paradigm. This was because answering this research question required the practical application of various stakeholder perspectives to help in the development of a framework which would identify critical service quality factors in medical tourism in an Arabic context.

The study focused on exploring the concept of medical tourism and service quality in detail (which is interpretivist in nature) as well as providing a contextual explanation of medical tourism and service quality within the context of Arabic countries and Qatar (which is fact in nature). This called for a paradigm that would help to capture and interpret the research phenomenon under investigation. Additionally, the research problem could not be resolved through the application of one method. The need to collect a wide range of data in order to better understand the potential implementation of medial tourism in Qatar necessitated the use of a paradigm that would allow for a mixed method design. The use of a pragmatic paradigm was also preferred because it allowed the researcher to use methods that allow for an in-depth exploration and sense making (interpretivism) as well as determining the cause-effect relationship between how the quality of service and treatments offered in Qatar's hospital affect the country's medical tourism (positivism). This was achieved through data collected from the survey where correlation and regression tests were performed to determine the underlying relationships between the quality of service and medical tourism aspects covered in the survey prompts. Therefore, the pragmatism paradigm ontology was considered to be the most appropriate to address this study's research question.

The ontological assumptions made were that:

- Medical tourism and service quality can be interpreted both through social conditioning or social construction of human experiences (stakeholders) and interactions.

- Medical tourism and service quality exist as a result of various human observations, knowledge, interpretations and experiences.

- Medical tourism and service quality are social phenomena whose realities are multiple and varied.

In addition, the following epistemological assumptions were made, that:

- The concepts of medical tourism and service quality can be comprehended by observation or mental processing of social interactions.

- The stakeholders within the medical tourism context can socially construct knowledge by using their experiences, skills, experiences and knowledge in the field.

- The researcher can engage with a representative sample of the stakeholder groups in order to collect in-depth data identifying key issues and themes.

4.2.2 Research approach

Neuman and Robson (2012) define the research approach as ways of reasoning and identify three categories; inductive, deductive and abductive. The main difference between these approaches is that a deductive approach focuses on generating hypotheses which can be used to test extant theory while an inductive approach constructs new theory from newly generated data especially in relation to a phenomenon where there is little prior evidence (Eisenhardt *et al.*, 2016). The starting point for researchers undertaking a deductive approach is developing hypotheses that will be tested via the research study. In contrast a researcher undertaking an inductive approach would start by identifying the research question and its boundries within the study to be undertaken (Neuman and Robson, 2012). Deductive approaches are common among positivists because they are mainly concerned with causality and applied quantitative research while inductive approaches are common among interpretivists because they rely on exploring a new research problem or studying an existing

research phenomenon from a different perspective using qualitative approaches (Eisenhardt *et al.*, 2016).

The aim of this study was to ensure better insight into the complexity of medical tourism and the complexity of medical tourism in term of being defined as a distinct niche market in the Qatari context based upon the SERVQUAL model and to critically analyse how service quality theory can be used to help enhance medical tourism within Arabic context. This clearly shows that the aim of the study was to build upon the existing theories and not to develop one. Accordingly, this study was found to be abductive in nature because it moves from a pre-determined theory, and thus, tests some existing theories and information. In addition, the literature review found that the concept of medical tourism and service quality are not new research phenomena *per as* they have been previously subjected to empirical testing. Therefore, much secondary data was analysed and from these previous findings, the researcher was able to identify various gaps in knowledge in relation to the development of medical tourism and service quality in the Qatar context, which were subjected to further testing. The use of a mixed approach allows for the generation and analysis of new data from different perspectives such as the use of qualitative interviews with government and HMC employees and quantitative questionnaires with consumers of medical services in Qatar.

4.2.3 Research purpose

According to Creswell (2013), depending on the purpose that the researcher wants to fulfil or the existing knowledge available in a particular field of study, a study can be classified into three main categories; explanatory, exploratory or descriptive. An exploratory study is mainly carried out in circumstances where the research topic lacks enough research focus, or rather, there is limited research on the topic. The purpose of an explanatory study is to identify core information within the research area with regard to the what, how, where, when, variables, limitations and its context (Ankarcrona and Holm, 2016). However, if the researcher

undertakes primary research and identifies that knowledge or a considerable amount of research has been undertaken on the topic, the approach then becomes descriptive. In the event that the researcher wants to further identify the cause and effect or the relationship between two or more variables, an exploratory study is found more suitable (Ankarcrona and Holm, 2016). Creswell (2013) identified a third approach, the normative, which he explained is used in the identification of courses of action to solve the research problem and the consequences of the actions.

Given the nature and purpose of the current study as well as the current extant knowledge on medical tourism and service quality, this study took an exploratory approach. This is mainly because the review of the literature undertaken earlier identified that while there was considerable relevant research mainly from Western countries and perspectives (see section 3.3.3), there was a lack of research focused on the subject within the Arabic and specifically Qatari context. Therefore, the researcher believed that using an explorative approach, the context and the specific characteristics of medical tourism and service quality in Qatar would be explored further. In addition, new understanding would be developed through a review of the respondents' perceptions and experiences, which would contribute to existing theory. Table 4.2.3 below is a summary of the choices made in this research.

Table 4.2.3. *Summary of choices of research methodology*

Methods' aspect	Choice for this research
Epistemology	Constructionism
Theoretical perspective	Pragmatism
Methods	Mixed methods
Data collection	Qualitative interviews and quantitative questionnaire

4.3 Research Methodology –Mixed Methods Approach

The research design is practical in approach and the following discussion comprises the overall strategies that the researcher used in integrating the various components of the study in the most logical and coherent manner so as to effectively address the research issue (Creswell,

2013). The research design is very important in a study because it offers the blueprint for gathering, measuring, analysing and interpreting the data. According to Saunders *et al.*, (2012), the research design comprises of three main components, that is, research methods, research methodologies and the time horizons as discussed in the subsections below.

There are various methodologies that a researcher can utilise when undertaking a study. They include case study, experiment, surveys, grounded theory, action research, ethnography and archival research designs. In this study, a mixed methods approach was used with the Hamad Medical Corporation (HMC) in Qatar acting as the vehicle for implementing the methodology while interviews and questionnaires were the sources of primary data. An exploratory sequential mixed methods research design normally involves two phases where the qualitative data takes precedence to explore the research phenomenon/phenomena and used to inform the development of the quantitative phase (Creswell and Plano Clark, 2011).

However, this research deviated from the norm by including two qualitative phases that later informed the third quantitative phase. The completion of the initial qualitative phase yielded interview data from government officials whose outcomes necessitated more information from a managerial perspective. The findings of both phases demonstrated the need to investigate the perceptions and experiences of service users in Qatar in order to understand the potential of Qatar delivering medical tourism through their existing facilities and services related to medical tourism. As the largest provider of medical care in Qatar HMC was chosen as a vehicle through which the perceptions and experiences of service users in Qatar with respect to service delivery and healthcare could be understood.

A study's design is also determined based on the time horizon of the research, and using these criteria, studies are categorised into either cross sectional or longitudinal. A cross-sectional design has no specific time dimensions (the data is collected at a specific point in time), relies on existing differences and participants are chosen based on existing differences

(Barratt and Kirwan, 2009). Longitudinal design involves the testing of the data through multiple stages over an extended period (Ployhart and Vandenberg, 2010). All the data developed for this study was collected in three phases, points in time, which made a cross-sectional design more applicable particularly as the researcher did not perform any follow ups or repeated observations of the participants after the research process was completed.

4.3.1 Methods

There are two main types of research methods; that is qualitative and quantitative methods although the two can be combined in mixed methods research. The use of qualitative methods has numerous advantages such as allowing researchers to collect in-depth information on a given study. These methods also allow the collection of expert opinion on the research question being studied. However, qualitative methods have some limitations such as its use of subjective analysis when identifying the conclusions of the research data especially if the researcher does not ensure that a critical approach to the data is maintained throughout the process. Qualitative research methods have also been discounted by some for their inability to generate generalizable findings often caused by the use of small data samples. However, there are many others who argue that the aim of qualitative research methods is never to generalise findings, but to yield in-depth findings about a specific case or research question (Bryman, 2015).

Quantitative methods, on the other hand, enable the collection of objective information which can be replicated by future researchers. The factors which motivated the choice of a survey design included its flexibility, ability to collect extensive data from a large population within a short time, cost-friendly manner and its ability to yield high reliable, unbiased and valid data (Lavrakas, 2008). According to Bordens and Kirwan (2009), surveys allow the researcher to collect meaningful comments, feedback and opinions in a more objective and open manner. Thus, the survey design was considered to be the most applicable method to

explore potential medical tourists' perceptions and experiences of service quality within medical tourism.

This method also allows the application of statistical analysis such as the use of statistical programs such as SPSS. However, as Creswell (2013) explains, the disadvantage of using a purely quantitative methodology is that it generally leads to the collection of a breadth of information which lacks in-depth insight on the research topic that is being reviewed. This lack of in-depth insight is mainly due to the tendency to use rigid and highly-structured data collection instruments and procedures for gathering and analysing quantitative evidence.

Some of the advantages of using a mixed methods approach are: it helps the researcher collect in-depth data through the use of various qualitative methods; it helps collect data that has a deeper insight to the research problem because the different types of questions (qualitative and quantitative questions) can be answered; the data collected has high credibility and reliability due to the possibility of triangulating the results from both the qualitative and quantitative enquiries; it allows for generalisation of findings; and the opposing weaknesses of the various research methodology are compensated for (Feilzer, 2010). The limitations associated with the use of a mixed methods approach include the process being complicated and requiring high management, analysis and interpretive skills as well as being resource intense in terms of cost and time (Driscoll *et al*., 2007). However, as can be seen from the previous discussion the advantages of a mixed methods approach were believed to outweigh the disadvantages in this study. In order to generate the research findings a combination of both qualitative and quantitative data collection was used although the former was dominant.

4.4 Research Methods Used in this Study

Initially the researcher had preferred and intended only to use qualitative research methods, such as interviews, due to their ability to develop concepts and important theories that were vital in understanding the major issues regarding service delivery in the Qatari

medical tourism industry (Berg *et al.*, 2004). A qualitative approach was also considered to be appropriate because it allowed for the exploration of the participants' opinions, feelings, and experiences with the aim of developing a better understanding of the medical tourism phenomenon (Brinkmann, 2014) in Arabic countries. In addition, qualitative methods are best suited to exploring issues which may be deeply personal and which participants may only want to discuss in private (Creswell and Plano Clark, 2011) such as issues relating to the service quality of an in-patient hospital experience.

However, quantitative methods, such as a questionnaire, were later considered to be appropriate for the final stage of data collection where the themes and issues arising from the earlier qualitative sets of data collection could be critically explored with a much larger population sample (Onwuegbuzie and Leech, 2005: Creswell, 2013) to verify trends regarding critical service quality factors in medical tourism in Qatar.

4.4.1 Data sources

Various sources of data, both primary and secondary, were used in this study to meet the study aims and objectives. The sources of the secondary data were academic journals and books, organisational records, statistical data and other sources of data available in the public domain (Koziol and Arthur, 2011). Primary data was generated from the three key stakeholder groups identified from the secondary data collection; government officials, the medical employees of HMC and HMC services users as discussed in the literature review chapter (see section 3.11.1).

4.4.2 Data collection method

A combination of semi-structured qualitative interviews using an interview guide and a questionnaire using a structured SERVQUAL questionnaire were the two methods used to collect primary data in this study. The primary data collection was performed in three phases. The first two phases involved data collection through semi-structured interviews. The first

interview phase involved government officials while the second one involved HMC employees. The third data collection phase was with those who had experienced HMC services as a patient and or visitor using a questionnaire. The rationale behind including users of HMC services was that, as discussed on p36. there is only a very limited and poorly understood medical tourism industry currently in Qatar and whose participants would not live in Qatar or be available to the researcher. Since there was no reliable information or data available about medical tourists in Qatar this necessitated finding respondents with experience of medical and hospital services' in Qatar. This was because, taking into consideration the significance of positive service experience, individuals who had experienced the healthcare and medical services in Qatar were considered to be the closest proxy sample available to the researcher in this regard. Indeed, some of the individuals who participated in the data collection were expats who helped to enrich the sample with a non-Qatari perspective that was deemed to be close to medical tourists' potential experiences of medical tourism in Qatar. In addition, there were other individuals in the proxy population who were medical tourists from countries other than Qatar. Additionally, some of the Qataris in the proxy population had been medical tourists in other countries as well as users of HMC services. Given these traits, it was deemed that the proxy population identified in lieu of medical tourists allowed the researcher to garner a broad range of views and this enabled a close replication of the key features of actual medical tourists' experiences of medical tourism. Therefore, they were pragmatically considered to be the most suitable proxy available to the researcher.

As previously discussed, semi-structured interviews were chosen for the first two sets of data collection because they allowed the researcher to gather in-depth expert information, beliefs, opinions and experiences as well as important background data about the research phenomenon (Brinkmann, 2014). Semi-structured interviews were preferred over unstructured interviews because it gave the researcher some control over the research process (Newton,

2010) while also allowing the participants to express themselves freely without the limitations

imposed by the use of structured interviews (Harrell and Bradley, 2009). As the interviewees

were busy people the researcher had to be available when they were therefore, pragmatically

the interviews had to be arranged on an individual basis. In addition, the researcher believed

that the interviewees would be franker when interviewed in private and confidential settings

than in the presence of another interviewee (Saunders, Lewis, and Thornhill, 2012).

The first two sets of data collection were followed by a quantitative survey undertaken

using a structured SERVQUAL questionnaire based upon the SERVQUAL model discussed

in the literature review chapter (see section 3.10.10) and extended by the themes emerging

which emerged from the interview data analysis. Table 4.4.2 below illustrates the three phases

of data collection methods employed in this research and respective target populations.

Table 4.4.2 *Data collection methods by phases, target population, and sample*

Phase	Time Line	Data Collection Method	Target Population	Sample
Phase 1	June 2017- October 2017	Semi-structured interviews	Government ministry officials	6
Phase 2	January 2018-April 2018	Semi-structured interviews	Full time senior operative HMC personnel	20
Phase 3	May 2018- August 2018	Structured questionnaire	HMC service users	350

4.4.3 Data collection tools

4.4.3.1 Interview guide

Initially, the researcher had intended to collect qualitative data through semi-structured

interviews with government officials only. However, upon completion of the first phase and

analysis of the results, various previously unidentfied gaps in knowledge and practice were

noted. For example, the government officials did not seem to have clear experience or

understanding of either the concept of medical tourism or of the customers daily customer

service encounter. In other words, they were more conversant with the macro issues of high-

level administration, capacity and legal and governance matters than they were with customer

experiences of services such as admission service proceedures, room preferences and car parking isues. Therefore, the researcher identified a need to verify whether some of the issues (e.g. confusion of meaning) that emerged from the first phase of interviews also applied to management and daily experiences at HMC.

The semi-structured interviews were carried using an interview guide, which contained different types of questions such as the descriptive, structural and contrast questions (Diefenbach, 2009). The majority of the questions in the interview guides were exploratory. Whilst it can be time-consuming to answer, such questions were identified to be best suited for the study because they enabled the researcher to generate wide-ranging information about service delivery in the medical tourism sector (Diefenbach 2009). As can be seen from Appendices V and VI the first question was of a grand tour type (general questions meant to elicit interviewee experiences), which aimed at encouraging the respondents to express themselves and yield detailed answers from the respondents (Harrell and Bradley, 2009). The researcher also incorporated mini tour questions to follow up to the answers given by the respondents in the grand tour questions. Both grand tour and mini-tour questions may be typical specific, guided or task-related. Respectively, they entail asking participants to describe the way things normally are, recounting the most recent events, asking the participant to show the researcher around, and asking the participants to undertake simple tasks that help in the description. The only difference between grand tour and mini-tour types of questions is that the latter have smaller units than the forms (cf. Spradley, 1979).

The inclusion of mini tour questions was intended to generate specific information about some aspects of the grand tour question response. Structural questions were also incorporated into the interview guide to enable the researcher to flush out knowledge in situations where there might have been difficulties in obtaining information from the respondent and, in some cases, to ensure that a correct meaning of the words used was

generated. Probing was used for further clarification (Whiting, 2008). The rationale to interview government officials was that the government is responsible for developing and implementing national policy which in this case relates to the QNV and medical tourism. The rationale for interviewing the senior hospital management at HMC came up as a need to collect extra information following the interviews with the government officials. This is because senior HMC managers were more likely to oversight the implementation of medical tourism in Qatar and handling the medical tourists in a more direct, on-the-ground manner than the government. HMC services users were considered an important population to help demonstrate the potential perceptions of service quality in Qatari healthcare.

4.4.3.2 Questionnaire

The questionnaire that was administered to the HMC services users (see section 4.4.4.3) was based on the results of the first two phases of qualitative interview data and aligned to the SERVQUAL measurement tool. This method was chosen because of its capacity to yield highly reliable and credible data in relation to gaps in service delivery by different employees and other service aspects (O'Leary, 2004). The tool was originally based upon 22 pairs of statement constructed on a Likert scale (Anbari and Tabaraie, 2013). Within the present study, the researcher based the data collection on the five dimensions of the SERVQUAL tool, that is; Tangibility, Reliability, Responsiveness, Assurance, Courtesy and Empathy. The tool was scored on scale 1 to 7 with 7 denoting the strongly agree while 1 corresponding to strongly disagree. The use of a 7-point Likert scale instead of a 5-point one was informed by the understanding that "the more points you use, the more precision you get with regard to the extent of the agreement or disagreement with a statement" (Hair *et al.*, 2011, p. 222).

The questionnaire developed was tested with a pilot sample of 20 individuals to verify its ability to accurately reflect the meaning of the researcher within each question (Chung *et al.*, 1998). The results revealed the need to remove redundant questions and rephrase some

questions. Other vital prompts that had not been included in the initial draft were included in the document. The questionnaire was self-administered; this approach was chosen because it is quick gives the respondent more autonomy and is relatively cheap (Bryman and Bell, 2007). To limit the low response rate often associated with self-administered questionnaires, the researcher made them widely available and accessible from multiple channels including receptionist desks and in waiting areas.

4.4.4 Sampling and research process

The sampling and the data collection process was done in three phases. In the first and second phase data was collected from the participants via semi-structured interviews while in the third phase data collection was via a structured questionnaire.

4.4.4.1 Phase I: Semi-structured interviews with government officials

The sample selected for phase one was made of key personnel in the Qatari government health, finance, and tourism sectors. The inclusion of the government finance and health personnel was based on the fact that SERVQUAL theory considers service delivery gaps as an important aspect that determines the quality of service that is offered to customers (Subonteng *et al*., 1996). The key people for this phase of the data collection were identified based on their knowledge and interest in service delivery in the Qatar medical tourism sector (Legg and Gilbert, 2006). One Government minister was already known to the researcher; via snowball sampling 5 other appropriate individuals (Bryman, 2015) were identified, approached and agreed to participate in the research. These included a government official from the Ministry of Finance, three officials from the Ministry of Public Health and two others from the Tourism Authority. The government officials were the first to be interviewed and the interviews followed the interview guide attached in the Appendix V.

4.4.4.2 Phase II: Semi-structured interviews with staff of HMC

The second phase of study targeted the second key stakeholder group, people employed at HMC who were directly involved with the provision of medical and nonmedical services to HMC customers as part of their daily work. In other words, these were people working as senior physicians and senior management officials in departments such as customer service, back office (e.g. accounting) and front office (reception and appointment booking). They were the preferred interviewees for this phase because they were likely to have the most valuable first-hand and lived experiences of service delivery at HMC. Since the researcher is employed at HMC the staff who participated in this study were recruited through convenience sampling, which allows the selection of individuals who are easy to recruit without significant focus on the representativeness of the sample (Castillo, 2009). After interviews with 20 staff members saturation point was deemed to have reached when it is appropriate to cease data collection in a qualitative study (Guetterman, 2015). The interview process for senior management officials at HMC followed the interview guide provided in appendix VI.

4.4.4.3 Phase III: Structured questionnaire with HMC services users

The third phase was a structured questionnaire, which targeted current HMC services users. Sampling was done both randomly and voluntarily while the questionnaire was self-administered by the researcher or the customer service representative due to privacy issues, which meant no access to potential respondents' details. Random sampling was done by handing some of the questionnaires in person to individuals within the hospital premises at random. Voluntary sampling was done by asking the participants about the willingness to take part in filling those questionnaires while waiting at for their appointment in different waiting areas at the hospital. To ensure confidentiality, the completed questionnaires were collected in daily batches from the feedback and suggestions boxes in those areas. It also meant that every patient or hospital visitor had an equal chance of being chosen as a participant. For the purpose

of this research an HMC services' user was any person, over 18, who was visiting HMC at the time of data collection either as a patient or visitor or both and therefore had had some interaction with the services provided by HMC and so was were able to comment on the quality of the services provided and received.

The questionnaire topics for this phase of data collection were identified from the literature review and analysis of the data collected in phases one and two. The researcher obtained permission from the HMC Research Committee to target HMC users with the sample size being based on the bed capacity across their hospitals; since the institution is able to accommodate at least 2013 clients a target of 350 was agreed to be appropriate. The participants were recruited regardless of their gender or socio-economic background but were limited to age as only individuals aged 18 years and above were allowed to participate. The duration for this questionnaire was between 10-15 minutes. The questionnaire was produced in Arabic and English because the people being asked to participate were both Arabic nationals and English-speaking expats (see Appendices VII).

The questionnaire was a structured one and the participants were requested to answer close-ended questions which limited risk of dangerous knowledge being asked for or given. It was made clear to all repondents that their participation was entirely voluntary, that they were free to withdraw at any point during the research, that they would not be able to be identified from the published results and that all raw data collected would be held securely and only be seen by the researcher, not by managers or anyone else employed by HMC.

4.4.5 Data analysis

The study yielded both qualitative and quantitative data, and the analysis began by transforming the qualitative data from interviews into quantitative data through transcribing, coding and development of sub-themes that shared similarities (Vaismoradi *et al*., 2013). In other words, the researcher analysed the results of each phase at the end of its data collection

period and used them to inform the development of the data collection instrument for the subsequent phase. The interview data obtained from government ministry officials and senior managers at HMC were first transcribed into Microsoft Word documents before inputting the data in summary/point form under each prompt by interviewee code. This aided in the identification of categories of themes based on the patterns identified in the data. The constituent themes were then coded and the sub-themes. A theme or subtheme was considered one if it was referred to by at least three interviewees in each case. The themes and sub-themes were then reviewed iteratively to determine which ones could be collapsed into one major theme or to identify overlapping subthemes for merging. During the identification of the key findings all the themes from the two interview datasets were then compared and contrasted with similarities and differences being noted before progressing to the quantitative data collection and analysis.

Similarly, the quantitative data from the questionnaire was identified, coded and entered into the SPSS version 22 for further analysis. Basic descriptive statistics such as count, percentage and frequencies, means and standard deviation were used to express the findings and to identify the different factors in relation to the quality of service delivery. The results were then analysed qualitatively against the results of the preceding qualitative sets of data obtained from government officials and senior HMC managers.

4.5 Ethical Considerations

This study was conducted in compliance with Cardiff Metropolitan University's ethics policy. That is to say that ethics approval was sought prior to each stage of the primary data collection and the researcher observed normal research ethics conventions with regard to the respondents' confidentiality, anonymity, informed consent, data protection and storage, and protection of their rights and freedoms (Bryman, 2015). The participants interviewed in stage one and two of the study were given information sheets containing details about the study and

their rights and freedoms prior to their interviews and signed consent forms agreeing that their participation was voluntary as recommended by Houghton *et al.*, (2010). In addition, the participants were not asked to provide personal information that could have identified them, as can be seen in table 6.1, they were then coded to ensure a further level on anonymity. Data security was assured through storage in a computer that was protected by a password known only the researcher. The researcher was the only one who had access to the raw data. Although this did not arise, the participants were informed that sharing of sensitive information (should any arise) would only be done with their prior consent (DiCicco-Bloom and Crabtree, 2006; Ponterotto, 2010). The researcher was respectful of the participants and the participants were informed of their freedom and rights to ask questions or stop the interview at any point they wished to.

In addition, they were advised that participation was entirely voluntary and withdrawal of participation from the study would not be penalised in any way. Finally, they were assured of complete anonymity and the researcher did not present information in the findings that would be traceable to an individual. For the questionnaire respondents, the ethical information was placed in the opening section of the questionnaire since the researcher did not meet each of them as was the case with the interviews. To get permission from the HMC research committee to undertake the research, the researcher made a written submission through the HMC Research Centre since the researcher was a member of staff and the approval was granted through the same channel upon vetting by the HMC research committee (see Appendix VIII).

4.6 Validity and Reliability

In order to ensure that the study's validity and reliability was not compromised, the researcher tested the research instruments to ensure they met the intended goal. As a strategy of enhancing the validity of the research, once the main themes for the interviews had been identified from the literature review, a pilot study was carried out to test the interview guides.

The interview guide for the first phase was piloted using 2 government employees and a university lecturer of Qatari origin. In the second phase, an interview guide was developed from the literature review and the results of the first data collection phase. This was then piloted with 4 medical staff and 13 medical students who tested and reflected upon the validity of the interview questions. This pilot study resulted in the exclusion of some of questions which were repetitious and might have caused data duplication in the results. In addition, some of the questions which were compounded (were two-in-one questions) were split while others were reworded to ensure clarity of meaning. The semi-structured interviews were administered to both government employees (data set one) and HMC staff (data set two).

The interview guides and questionnaire, the researcher used cognitive interviewing that relied on a convenience sample of respondents who were not be part of the study population (Brinkmann, 2014). This helped in the identification and correction of the vague responses and indications of unclear terminologies and also in the assessment of whether the interview guide addressed the research questions. The flow of questions was also assessed and questions were reorganised to achieve the required flow. This process also allowed the researcher to identify where probes could be appropriately introduced, which enhanced the collection of the required information (Low, 2012). Combining the three phases of data collection and analysis led to the triangulation of both the data and methodology. This strengthened the methodology and provided more in-depth and robust findings (Lincoln & Guba, 2000). This is because methodological triangulation entails the deployment of multiple quantitative and/or qualitative methods during the investigation of one issue on the one hand and the use of various data sources and dissimilar forms of data from various sources in the examination of the same subject or object (Denzin, 2010) on the other.

4.7 Reflections on the research approach

The use of semi-structured interviews in data collection required the researcher to combine a variety of competencies such as communication, probing and listening skills in order to obtain a deeper insight into the research question. The researcher used personal connections with the Minister of Health, who is also the Managing Director at HMC, to help in facilitating the interviews with other key people. The researcher excelled in this part in that she was able to get along with the participants when the interviews occurred. Unfortunately, in phase one, the researcher couldn't conduct the nine interviews that had originally been intended with the senior personnel from the governmental sectors (3 in each department). This was partly due to the limited involvement of those employed in the ministries of finance and tourism in this aspect of the QNV. It was also limited by tight time-constraints due to their busy schedules which made it hard for the researcher to keep to the time constraints of her research programme pragmatically this resulted in six interviews with Government officials. However rather than introducing bias it was felt that this suggested a very interesting limited awareness of and involvement with this aspect of the QNV by both departments. Carrying out the study in the second phase at the interviewee office's in the hospitals was easier to organise but due to their busy schedules great flexibility by the researcher was needed to manage the interview time. However, the participants were cooperative and helpful in providing the information requested.

Because of its nature, this study had many ethical issues to be considered. In particular, it required that the researcher be very considerate to sensitive questions especially when undertaking the third phase as some of the participants were patients filling in time while in the waiting areas. This meant that obtaining ethical permissions from the various authorising bodies was exhaustive and exhausting. Initially, the researcher had had to obtain written permission from HMC to involve the institution in the study, which took time for the Board approval. Following this, and as discussed in section 4.5, the researcher had to get permission

from the university ethics committee to undertake each set of primary data collection. However, the researcher feels that the deep scrutiny of each phase of data collection only strengthened the final data collection instruments. Although the population statistics presented in section 2.1.1, would generally imply the likelihood for more male participants that female ones, the researcher was aware that the context within which this study was being conducted (hospital setting) was likely to have more female respondents for the questionnaire data collection since women tend to be more in the hospitals in Qatar due to their cultural roles of taking care of the family, as mentioned in section 2.1.3. Altogether, it was expected that most government officials and senior managers at HMC would be male due to the longstanding patriarchal nature of the Qatari culture.

Although the university could have provided the researcher with access to a useful online survey tool Qualtrics for phase three which would have speeded up the data input and initial analysis in the end it was not considered practical to use it. First, because most of the participants targeted only spoke Arabic but more pragmatically because an online survey would require the use of IT to complete which could not be made available to all HMC services users. This meant that the survey had to be conducted using hard, paper, copies which extended the time of the survey phase. However, regardless of the various challenges, the entire research process was successful and exciting.

4.8 Conclusion

The theoretical and methodological approaches employed in this study have been discussed. The pragmatism paradigm using a deductive mixed-methods approach was identified as the most appropriate. The research design was a three-phase exploratory sequential mixed methods research design with HMC as the vehicle backed by interview and questionnaire data. The data was collected from semi-structured interviews with 6 government officials and 20 personnel of HMC, and a structured questionnaire involving 350 customers of

HMC. These were administered using an interview guide and a structured questionnaire respectively. The data gathered was coded, developed into themes and then analysed statistically using the SPSS software. Ethical considerations, validity and reliability and reflections of the research process have also been discussed. In the next chapter, the data collected is presented whereby the results of the first phase of data collection informed the development of the second phase and the third phase was designed based on the combined outcomes of the first and second phases, as shown in Figure 4.8 below.

Figure 4.8. *Connection between research phases and discussion of findings*

Phase 1 Data Collection:

Interviews with Qatari Government officials

Results

Phase 2 Data Collection:

Interviews with Qatari Senior Managers at HMC

Results

Phase 3 Data Collection:

Questionnaires with HMC services' consumers

Discussion

Final Research Findings
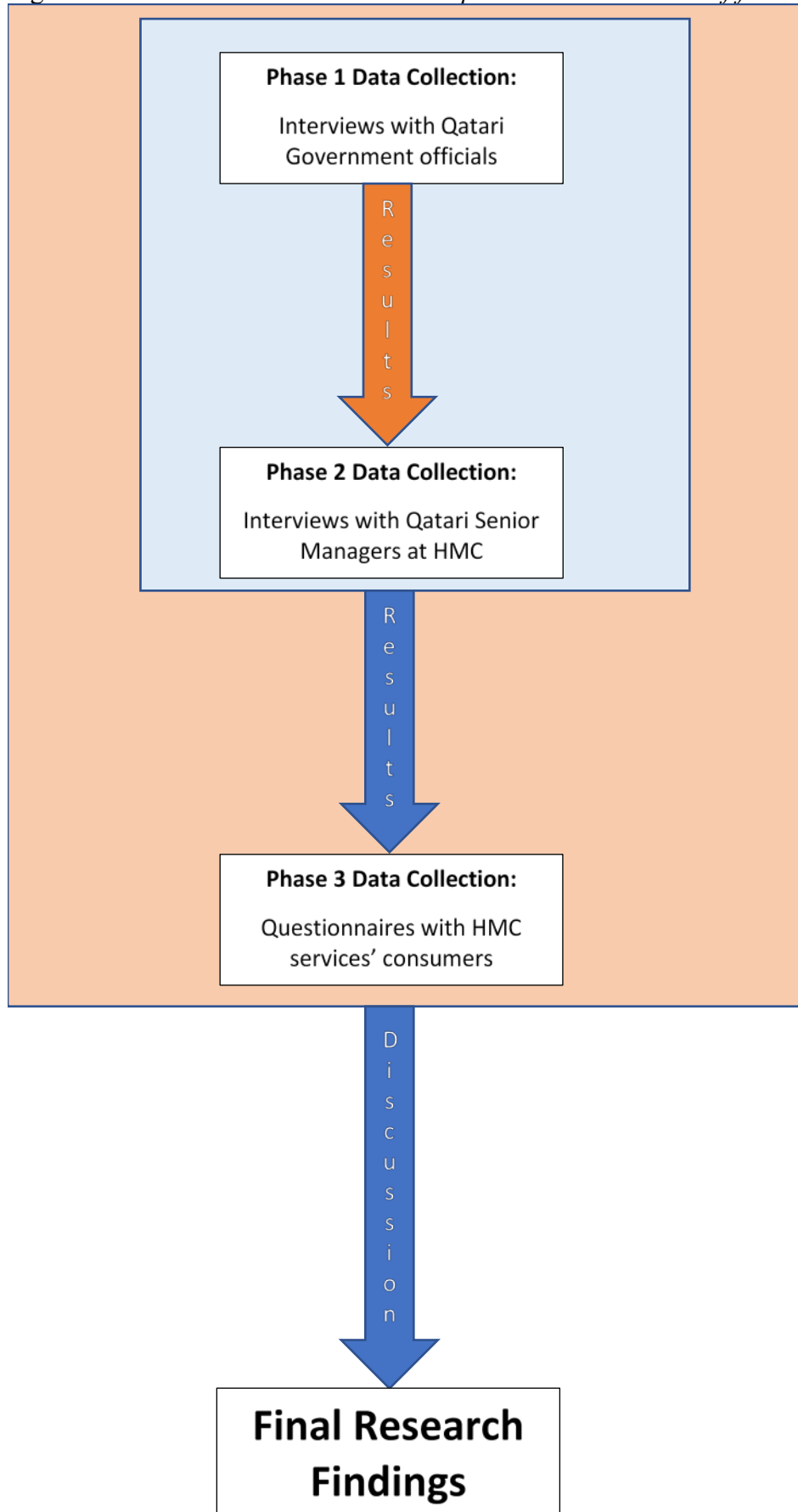
Chapter Five

Phase One Results and Discussion: Government

5.1 Introduction

The current chapter presents the findings of the qualitative interviews that were carried out with employees of the Ministry of Finance, the Ministry of Public Health and the Tourism Authority in Qatar. They were coded as shown in table 5.1:

Table 5.1 *Government interviewees' codes*

Interviewee Code	Ministry and Interviewee Reference
GOF	Ministry of Finance
GOT1 and GOT2	First and second interviewees from the Qatar Tourism Authority
GOH1, GOH2 and GOH3	First, second, and third interviewees Ministry of Public Health

The results presented in this chapter emerged from a thematic analysis of the data and identification of common patterns. Among the different themes presented is understanding of the QNV, current key objectives of medical tourism in Qatar, Qatar's unique selling point and the target market and medical procedures which could work well as part of medical tourism in Qatar. Separate themes were identified for financial and economic issues related to funding medical tourism in Qatar, factors that will affect its implementation and the projected impact of medical tourism. These themes are evaluated under their respective sub-headings below.

5.2 Understanding of the QNV

The results regarding understanding the QNV indicated a significant inclination by the interviewees towards defining it in terms of economic development to better the lives of the Qatari citizens. Four interviewees drawn from all three ministries alluded to economic development. For example, GOF described QNV as follows:

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> *"Economic development forms an essential factor in the national vision of Qatar 2030, [because] it resembles the drive for development by providing more opportunities and better life for Qataris. Qatar's economy seeks diversification in resources and this implies finding a balance between an economy based on oil and an economy more dependent on knowledge, such kind of development will ensure a stable and sustainable business climate."*

The view given by most of the respondents, that the QNV aims to support development within Qatar, is also evident in the literature review exemplified by research such as that of Goldman and Romley (2008) who showed that Qatar is seeking to gain developed country status by implementing the QNV as a way of boosting its economy. GOH1 and GOH2 praised the QNV for being a clear and realistic vision with a calculated and well-planned process. The researcher interpreted this as an endorsement of the QNV. However, GOT2 viewed the QNV as having two significant components where one dimension focused on tourism and the other on the Qatar economy. This respondent thought that the Vision was effective in outlining how the tourism sector could be managed effectively but limited on the strategies that it offered in relation to enhancing the growth of Qatar economy.

This perception was also found in the research by Ibrahim and Harrigan (2012) who argued that the QNV has clearly outlined where it is anticipated that the country's tourism sector will be by 2030 but has failed to show the strategies that should be employed to realize the vision. In other words, it appeared that the respondent felt that the QNV is good in theory but not necessarily in practice considering the limited enabling strategies for its implementation and achievement. In addition, during the data collection process, the researcher noted that some of the government bodies such as the Qatar Tourism Authority (QTA) have formulated different strategies which can be employed by the tourism sector to meet the QNV goals on tourism and economic development. Among the strategies was the diversification of the tourism sector products into different areas such as the health and wellness tourism programs.

While meeting the tourism objective was not challenged by any other interviewee, it is likely that GOT2's particular analysis of the tourism dimension arose because as an employee

of the QTA he had a more in-depth understanding of the operational issues involved. The fact that most of the respondents were supportive of the QNV supports the view of Connell (2013) that Qatar government employees have knowledge of what the QNV entails and are supportive of the Vision's different aspects such as its support on new forms of tourism. It should be noted that GOT2 was not disagreeing with the aim of the QNV. Instead, GOT2 was sceptical and questioned whether the strategy and approach towards achieving the aim had been given adequate consideration. The work of Al Mohannadi (2017) reflects these findings. Building on the work of Ibrahim & Harrigan (2012) and Connell (2013), Al Mohannadi (2017) also suggested that, whilst most government employees support the QNV in principle those with knowledge of a particular sector are often, like GOT2, sceptical as to whether the relevant strategies to achieve the aim had been sufficiently thought through.

5.3 Current key objectives of medical tourism in Qatar

There were two competing, but complimentary views about the current objectives of medical tourism in Qatar. All respondents agreed that medical tourism in Qatar is about attracting people from various countries to come to Qatar to seek medical services. However, the interviewees had varying explanations about what attracting people from other countries meant to them with respect to medical tourism. The differences in their explanations may have emanated from the two views of medical tourism services which exist among Qatari government employees: as part of healthcare services or medical tourism as part of tourism. All viewed medical tourism as an important strategy that can be employed by the Qatari government in diversifying the Qatari economy and most recognized that the meaning and definition of medical tourism may differ between different people, as reflected by the statement of GOF that

> *"...the concept of medical tourism might vary when considered by different age groups. For example, elderly people and the retired might see the good in what it might offer with regards to medical spas services, while the Ministry of Finance sees it as an investment or more like a source of income"*

However, there were indications that some government officials were clearer about the objective of medical tourism in Qatar than others. For example, GOT2 who had significantly fewer years of experience compared to GOT1, appeared less convinced of the idea of achieving effective medical tourism in Qatar than GOT1 until such a time as essential support systems were in place. GOT1 stated, "*There is need for essential support systems to be established first before we can achieve effective medical tourism.*" However, GOT2 focused more on promotion of wellness tourism instead of medical tourism, making six observations critiquing the current medical tourism approach and limited support in Qatar, summarised as follows:

1) *We can't tell and say this is the objective of medical tourism*

2) *We can't market medical services*

3) *We need to have excess capacity, the health ministry, their job*

4) *We are not going to try to bring in people from the outside*

5) On medical Tourism in the region: *"Look I am not up to date on it..."*

6) *It is not a priority for us the tourism authority right now*

The sentiments clearly summarized the views of government employees who are not very clear about the specifics of medical tourism as projected in the QNV. In other words, all respondents supported the QNV even though they did not always see how it could be achieved. These findings reflect the views of Connell (2011) who explained the need to educate government employees as a way of preparing them for medical tourism implementation in a country. According to Rybkowski *et al.*, (2017) this aim has still not been achieved: most Qatari government employees still have a negative perception of medical tourism as they believe that this type of tourism will utilise healthcare facilities which have been developed for Qatari citizens rather than facilities specifically developed for medical tourism purposes.

Without having a common understanding of the term 'medical tourism in Qatar', it is clear that there exist challenges amongst the Qatari Government and its employees as to how

medical tourism may be implemented in the country. The disparity and perceived discord in use of terminologies and descriptions among the interviewees could be due to variation in understanding the meaning of words and barriers in communication. Drawing from the work of Martin and Nakayama (2014) on intercultural communication, it is possible that the interviewees interpret, understand and communicate the QNV and its objectives differently based on context. This view is supported by the range of terms the interviewees used to define the concept of medical tourism, for example GOF and GOT2 said it was wellness and spas, GOH3 said it was medical procedures, while GOH1 and GOH2 considered it to be Qatari nationals not travelling to other countries for operations.

The second view concerning the objective of medical tourism in Qatar was proposed by interviewees from the Ministry of Public Health i.e. GOH1 and GOH2. This view was about limiting the number of Qatari nationals that currently travel abroad to get treatment. It entailed ensuring that these treatments were available in Qatar as an alternative. This would also transform Qatar into a destination country as opposed to a country of origin for medical tourists or nationals seeking non-essential medical treatments. These two interrelated expressions were best captured in the following sentiments made by GOH1:

> *"As for the key objectives of medical tourism from the perspective of the Ministry of Public Health… the key objectives at this stage are working on limiting the number of patients going overseas to seek treatment, especially when the possibility of receiving treatment is available in Qatar"*

In addition, it might be possible that the language they used to define or describe the objectives of the QNV ended up communicating more or less enthusiasm or support towards the QNV than they actually have. In their positions of policymaking and implementation at high societal levels the interviewees are also bound to encounter numerous issues about the QNV all happening at the same time. In other words, the QNV has many aspects which require implementation simultaneously by different entities in Qatar. Each of these aspects has its own challenges which the interviewees might not always fully understand given that they work on

distinct (although integrated) aspects of the QNV. This could cause what Martin and Nakayama (2014) refer to as polychromic conflict rhythm, which ends up distorting construction and communication of meaning and understanding. In line with this, the individual departments and ministries from which these interviewees came have different approaches and strategies for achieving the overall the QNV aim which at times may conflict with those of other departments.

It is also accepted that conducting the interviews in Arabic and English, as preferred by the interviewee, might also account for variation in meaning through semantic differentials. Semantic differentials refer to the notion that numerous languages possess activity, potency, and evaluative dimensions (Martin and Nakayama, 2014). Activity is about the motion or speed one associates with a given word or phrase such as vision aim or medical tourism as in the case of the QNV. Potency describes the strength or reaction towards a work in question while the evaluative dimension is about whether the connotation of the word is bad or good. Since language has an impact on the thinking and perception of an individual the words each interviewee used to describe concepts such as purpose of the QNV, aims and medical tourism may have reflected their support for the QNV or otherwise (Martin and Nakayama, 2015). In addition, it is noteworthy that the way one interprets the words used could also constitute a barrier for the establishment of common meaning.

If the objective of the Ministry of Public Health is realized, and medical procedures available expanded, the implication is that Qatar becomes an exporter of medical tourism services rather than being an importer of those services when Qatari citizens visit other countries to access medical tourism services. Currently the Qatari government pays for medical treatment for all its nationals, whether such treatment expenses are incurred home or abroad. According to Gupta (2015), most governments in the world focus on exporting goods and services rather than having their citizens visit foreign countries to access goods or services that

are not available in their own country. In the current situation a high number of Qatari citizens visit western countries such as the US and Europe to access medical services. Therefore, supporting the development of medical tourism by developing some very specialist services not already in existence could reverse the emphasis and make sure that Qatari citizens consume the services they currently go for in the US and Europe within the country. The development of these treatments would bring in medical tourism from different countries while supporting economic development of Qatar (Scharfenort, 2017).

5.4 Qatar's unique selling point

Anecdotally Qatar seems to be appealing to medical tourists already even as the QNV's implementation is underway despite the International Medical Tourism Journal (IMTJ; 2019) placing the count of inbound medical tourists to Qatar below 1,000 in 2018. Although there is no concrete evidence in literature as to why medical tourists are already arriving in Qatar especially from neighbouring countries in the Gulf region, this influx of medical tourists from other neighbouring countries is assumed to be attributed to the state-of-the-art investments and advancements in medical care in Qatar which surpasses that of countries such as Oman and Bahrain. An example of this is the Hamad Medical City which features cardiothoracic surgery and cardiac rehabilitation facilities far in advance of other countries in the region. It is also likely that Qatar is perceived as a luxury medical tourist location compared to competing countries such as Saudi Arabia due to the high living standards in Qatar.

The response by GOH3 reflects the potential to establish Qatar as the preferred medical tourism destination in the Gulf region. It is also reflective of the potential for tapping into the existing demand for medical services from neighbouring countries. This position is consistent with the sentiments of four interviewees about the importance of starting with the already existing health/medical/wellness spas. For example, GOF asserted, "*we can start the work with the available medical spas, and then expanding gradually at a later stage…*" This comment

offers evidence about the already existing medical spas. According to Gupta (2015), medical

spas can provide the infrastructure to enhance the level of medical tourism that already exists

within the country.

Concerning state-of-the-art technology to support the achievement of high-quality

medical tourism services, the majority of the interviewees indicated that Qatar already had

advanced medical technology such as the advanced spinal navigation system and HMC's

Advanced Heart Failure Unit (AHF). However, the same interviewees indicated that it was

necessary for Qatar to ensure ongoing implementation of the latest technologies. For example,

GOF argued that, *"Keeping up with developments and utilizing the best technologies are two*

important factors in attracting patients…" In addition, three interviewees called for high

integration or inter-linkage of such technology although, according to GOH1, such integration

is already ongoing:

> *"The Ministry of Public Health and Hamad Medical Corporation ensure being up to*
> *date with the latest technologies and techniques in order to provide complete and*
> *integrated high-quality service. For example, the Robot has been already used in the*
> *operation room at Hamad General Hospital."*

5.5 Target market

All six interviewees unanimously indicated that the target market for the Qatar medical

tourism concept would mainly be people from the neighbouring countries who were seeking

medical and/or wellness treatments or specific treatment areas. However, and as discussed in

section 3.3.3, according to Connell (2011) residents of the US are the leading customers for

medical tourism services while Europe represents the second largest market for cosmetic

operations. Latin America is an early starter but Asia is catching up fast in terms of

consumption of medical tourism services globally. Interestingly, some interviewees were very

specific in defining what abroad meant to them and the specific target market, they defined the

target market within a narrower scope. In other words, there were differences in what some

interviewees saw as the target nationalities either being from neighbouring countries or as

coming from other more distant parts of the world. For example, GOH1 defined such people and abroad as, *"people from the neighbouring countries to [seek] treatment in Qatar"*. GOH1, GOH2 provided a broader scope and described potential recipients as *"patients from other countries to get medical care in Qatar."*

The difference in language may have huge implications on interpretation and eventual implementation of the QNV. For instance, treating the target market for medical tourism as patients implies the need to focus on medical services only while the treatment of medical tourism target market as tourists implies the need of offering different packages, even when issues of well-being and health are part of the package, coupled with appropriate tourism infrastructure to support such packages. For medical service provision targeting patients, this would mean targeting only the people that have been confirmed ill or need medical attention services such as surgery, physiotherapy and other treatments such as cancer treatment.

In other words, medical tourism for those with illnesses was narrowly constrained to receiving conventional medical treatment. On the other hand, viewing medical tourism as holistic and not targeted just at patients requiring specific medical treatments makes it more open to a broader customer segment and other tourism services such as luxury spas. Thus, it might be more economically beneficial for Qatar to approach medical tourism from the perspective of holistic medical tourism. However, there was no clear indication from the interviewees that when one refers to the target market as patients and as tourists, they were using these words either interchangeably or to imply the distinctions highlighted in this section.

Further probing about medical tourism in the region (mainly the Gulf region) revealed that most of the interviewees were actually referring to people coming from other countries in the Gulf. For example, GOH3 stated;

> *"Lately, medical tourism has started to spread in the region and the neighbouring countries. A number of patients from these countries have started to arrive to Qatar to receive treatment for certain diseases"*

However, it is noteworthy that some of the officials do not perceive medical tourism as being for outsiders only. In explicit terms, GOH3 stated that Qatar medical tourism "*is about attracting clients or "patients" whether from inside or outside the country.*"

When prompted to describe medical tourism in the region, GOH3 responded as follows:

> *"Lately, medical tourism has started to spread in the region and the neighbouring countries. A number of patients from these countries have started to arrive to Qatar to receive treatment for certain diseases related in particular to heart and cardiovascular disease as well as cancer and kidney transplants."*

When focusing on meeting the demands of the target market the majority of the interviewees raised issues such as the need to identify the products that are offered or medical procedures that are expected to be offered in order to ensure that the Qatar medical tourism market works well. Apart from GOT1 and GOH3 all the other interviewees mentioned medical spas explicitly. Also called a medi-spa, a medical spa is "*a medical facility that offers medical aesthetic procedures and traditional spa or aesthetic services in a spa like setting*" (Milady Standard Esthetics, 2013, p. 779). However, they also used other terms in describing the services that are marketed to the medical tourism market; wellness spas (GOT2) and health spas (GOH1) were all used to refer to the same thing. According to GOH1, "*health spas are the best form of medical tourism*" although "*spas are in need of a complete infrastructure with facilities arranged particularly to serve this purpose.*"

GOT2, who was more critical of the quality of medical tourism services that are proposed to be offered in Qatar, seemed particularly concerned about expanding the scope of medical tourism products or procedures in order to target a wider mix of tourist markets, included issues of wellness spa, plastic surgery, and other issues such as rehabilitation for alcoholism and drugs:

> *"we could start bringing in [more medical tourists] … For example, you know it [is] more [about] medical and wellness kind of tourism, but there are going to be new, very high [quality] wellness spas to be built in the North. People come [for] plastic surgery... another example is planned drug and alcohol addiction centre…"*

Similarly, GOH1 and GOH3 suggested different procedures that could work well as part of Qatar's medical tourism. For GOH1, medical tourism "*is appropriate for rehabilitation as in post thrombosis cases…*" However, the potential challenges such as traveling distances and using flights for travellers with conditions such as post-thrombosis may prevent medical tourists from far away countries such as the Latin American countries, where the demand for medical tourism services is high, from coming to Qatar (Romero 2017).

5.6 Stakeholders analysis

The most common themes that the participants mentioned as part of a shared vision were in relation to collaboration between industries, government ministries and agencies and international accreditation for institutions delivering medical services. In addition to these two aspects of the shared vision, technology, nationalization, and education emerged as significant sub-themes. Further in-depth analysis identified that the target was to establish high quality standards and attract more medical tourists to Qatar. Thus, the aspects of collaboration, international accreditation, education and training, nationalization and technology were found to be supportive of achieving high quality standards and international accreditation (recognition) to attract medical tourists.

In relation to collaboration, four interviewees argued that collaboration between different ministries and industry sectors was crucial for the achievement of high-quality medical tourism standards in Qatar. They explained how collaboration was central to the realization of medical tourism goals. While GOF alluded to "*collaboration between Ministry of Health and the Ministry of Development*", in the development of medical tourism services, GOH3 proposed "*inter-industry collaboration - healthcare facilities need medical and hotel management (and transportation) in order to provide high quality hospitality services.*" From this quote, it is evident that GOH3 seemed to be aware that medical tourism also encompasses hospitality services. The views by GOH3 and GOF showed how collaboration between

different stakeholders is required for an effective implementation of medical tourism services.

A more comprehensive response was by GOT2 who also seemed to have good understanding

of what medical tourism entails although he was less supportive of medical tourism in Qatar:

> *"...this is a huge endeavour that requires a huge strategy on its own and many different pieces to fall into place you need to have the services, you need to have the quality, you need to have the marketing, you need to have everybody..."*

The explanation that development of medical tourism in Qatar requires the involvement

of everybody reflects the views of Lunt (2017) who explained how some of the countries such

as Turkey, the United Kingdom and South Korea have developed medical tourism via effective

collaborations between governments and different stakeholders such as local communities and

medical and wellness facilities. According to Connell (2006) every stakeholder in the medical

tourism industry is equally important and should be consulted on behalf of organizations who

want to have success in its operation.

Similarly, education and training for both medical and non-medical staff was

considered essential for the delivery of high-quality medical tourism services. Most

interviewees linked the issue of training and education with the importance of equipping

Qataris with adequate, specialized medical skills to ensure that they were employed before

other nationalities when medical tourism is implemented. This was in accordance with the

Qatari Nationalization Policy as enshrined in The QNV because *"skills and qualifications are*

priority for employment" (GOT1). Although nationalization dictates the prioritization of

Qataris for employment, there is a gap in terms of adequate Qatari expertise in the medical

field for nurses and specialist technicians. This means that the achievement of the medical

tourism vision will require more medical expertise than is currently available and will need ex-

pats with suitable skills combined with more training for Qatari nationals. The government has

been undertaking reforms in education to train future medical science professionals since this

is critical to establish a strong labour force for the already prospering healthcare system of

Qatar (Aziz, 2015). This is why the interviewees did not view the current lack of fully trained Qatari nationals as a hindrance to the achievement of high-quality medical tourism since expatriate expertise can always be sourced. For example, GOF noted:

> *"...the state's nationalization policy is, by no means, an obstacle, especially with the use of incentives and training. In cases where there is lack of expertise or competency in a certain specialty, foreign expertise and the proper help is sought"*

International accreditation was perceived as the key indicator of high-quality service delivery by all of the respondents. GOF made a direct connection between the two stating that "*the international accreditation certificate is a proof of commitment to high quality standards.*". One interviewee from the QTA and all Ministry of Public Health interviewees confirmed the importance of international accreditation in attracting more medical tourists and getting global recognition and reputation. For instance, GOT1 asserted that "*obtaining international accreditation is a must and will attract patients and put us on the international map of medical tourism...*" In addition, international accreditation was also considered essential in order to be able to attract international medical expertise because "*successful doctors won't work in medical facilities that are not well-known or if they don't provide services of high-quality standards*" according to GOH3. The view reflected Golder's (2005) assertion that international accreditation is an important 'badge' from both the demand side (medical tourists) and the supply side (medical staff).

5.7 Financial and economic issues concerning funding medical tourism

It is noteworthy that the funding being referred to here is the start-up kind since Qatar will need to continue investing in medical tourism before the sector begins to yield returns on investment. From a general perspective, the interviewees had diverse views about how a medical tourism infrastructure in Qatar would be funded. All three MPH interviewees and the official from the Ministry of Finance indicated that the initial infrastructure funding would be best sourced from the MPH annual budget allocation. However, both GOF and GOH2

underscored the importance of collaboration between MPH and MOF. GOF narrated a

systematic approach to how the funding for medical tourism should work:

> *"The Ministry of Public Health should first present a comprehensive study of the project to the Ministry of Finance. His Highness the Prince, who stresses the health subject, is to set instructions, which are to be taken into consideration by the Ministry of Finance which in turn supports the projects presented by the Ministry of Public Health and QTA. An annual budget is consequently allocated for the Ministry of Public Health and QTA in regard of this issue."*

Despite being from the same government agency, GOT1 and GOT2 had different views

about how the funding of medical tourism infrastructure and systems could be approached in

Qatar. While GOT1 acknowledged the importance of state funding, he felt that the best

approach was for the sharing of the allocation between tourism and health sectors. In such an

arrangement, GOT1 proposed that *"the funding [will] be shared between the two, whereby each*

sector will fund its own part of the budget provided that the action plan is clear." Conversely,

GOT2 proposed the inclusion of the private sector to fund health and wellness spas with the

assistance of the tourism authority and private stakeholders. Such a view is similar to the

research by Vural (2017) who identified how the growth of medical tourism in Turkey was

developed through public and private partnerships. *"Private and public partnership input leads*

to efficiency as most of the private entities are profit oriented and will engage in activities that

can reduce operational costs" (Vural, 2017, p. 279).

5.8 Projected impact of medical tourism

Most of the interviewees alluded to economic gains for the Qatari economy either

directly or indirectly. Retaining the money that would otherwise be spent in other countries

when Qataris seek medical services abroad within Qatar after introduction of more advanced

and diverse treatments was the most frequently mentioned projected impact. This retention of

funds within Qatar was expected to boost the economy of the country:

> *"When nationals receive healthcare in Qatar, there will be no waste of income, but instead, the offered services, being in the front, will contribute in raising the Qatari economy."* (GOH1)

Additionally, reducing the cost of funding overseas treatments and redirecting the funding that would be used to fund such overseas treatments towards the development of medical tourism infrastructure was seen as a viable option. In fact, the Qatari Government is already funding the laying down of infrastructure and systems that will enable the achievement of The QNV objectives including medical services where it is investing in medical facilities, equipment, education and research such as Hamad Medical City (Ventures Onsite, 2015).

The other significant projected impact was related to growing the competitiveness and quality of both tourism and healthcare service delivery in Qatar. Three interviewees spread across the three government ministries mentioned competition as a driver of high-quality services. GOH2 summed up the projected benefits associated with medical tourism in Qatar including reduced expenditure of public funds abroad, competition, high quality service delivery and economic gains:

> *"...medical tourism will create competition among medical institutions and consequently will work to develop services offered to be of high quality. Medical tourism will boost Qatar economy since it will help attract patients from all over the world and limit the number of patients sent abroad for treatment. Also, it will help decrease the public finances waste since citizens and residents will seek medical services offered by the state and consequently limiting expenses of traveling for treatment."*

So, in theory, medical tourism should create a 'win-win' situation. This would entail increased income from visitors and reduced spend on Qataris receiving medical treatment abroad. This concept could be the one thing that Qataris need to understand in order for them to embrace and support the implementation of medical tourism in Qatar.

5.9 Factors affecting adoption and success of medical tourism in Qatar

Various subjective views were considered as important to the adoption and success of medical tourism in Qatar. In other words, these subjective views were seen as factors which could cause internal barriers based on the perceptions of high-ranking government officials by their support staff, affecting overall responsiveness by Qataris towards the introduction of

medical tourism (Frost and Kumar 2000). Cultural context and social perspective, religion and gender and power issues and nationalization were identified as the overarching sub-themes under the subjective views.

5.9.1   Cultural context and social perspective

While there were no explicit statements indicating that the Qatari cultural context could be averse to the introduction of medical tourism whereby the tourism and health sectors would work together, the repeated suggestions by the interviewees of the need to create awareness could indicate a potential prejudice against medical tourism. For example, the calls for cooperation by all six interviewees to inspire acceptance of medical tourism by Qataris hints at the possibility of the cultural context in Qatar/Arab world being unwelcoming of the fusion between health and tourism. Such view may exist particularly when some Qataris think that funding is being taken away from their healthcare and invested in healthcare facilities for tourists as suggested by GOT2. Thus, there is need to create harmony between the cultural orientation of the Qatari people considering the impact that culture wields over tourism and the eventual effect that this has on tourist amenities.

Consistent with the observation by Liu and Chen (2013) that culture causes an indirect impact on destination attraction and affordability, the success of medical tourism as envisioned in the QNV 2030 will be influenced by how well Qataris understand the benefits of fusing health and tourism and embrace it. As Liu and Chen (2013) and Stausberg (2011) amongst others have pointed out (see section 3.6), medical tourists are known to consider the unique cultural behaviours, attraction and affordability of the destination in addition to the quality of medical treatments available when they select medical services abroad. This is especially true for medical tourists who are not sick, i.e. those seeking wellness tourism, because they have the option of being adventurous and exploring the local culture as part of their medical tourism experience.

On the other hand, acknowledgement that cooperation is needed between industry sectors and government agencies in order for medical tourism to be embraced is an indicator of a positive attitude towards achieving this goal. Cooperation would enable the government agencies championing medical tourism and the relevant industry sectors to understand the best approaches for aligning such expectations with the target achievements of the QNV. Pro-active cooperation might also help to abolish some of the linguistic, conceptual barriers previously identified with respect to what medical tourism is and its target market. When the government agencies and industry sectors work together the significance of medical tourism to society is likely to be elevated among Qataris.

In addition, this will offer the government agencies and such other industry sectors the opportunity to develop effective strategies that will engage the Qatari people into owning the medical tourism goals as envisioned in the QNV. In other words, the government and respective industry sectors will have exhibited empathy towards the cultural orientation of the Qatari people. As Han and Hyun (2014) recommend, there is need for suitable cultural awareness and empathy. Reflecting the demand for the development of sustainable cooperation between medical and tourism sectors to assist society in understanding the role of, and services offered through medical tourism, GOH2 commented that:

> *"We consider that the cooperation between medical and touristic sectors will play an important role in the development of medical tourism since cooperation can create new job opportunities as mentioned earlier. By raising awareness of touristic services offered, society will start to accept the idea of medical tourism and even embrace it."*

The sentiments about current social attitudes toward medical tourism are traceable to the conservative Arab culture. While all the interviewees presented with some level of optimism about the Qatari society accepting and embracing medical tourism, their expressions suggested that this would be a daunting task, for example, GOF commented that "*… we are worried about the way to introduce medical tourism in our society…*". GOT2 asserted, "*Like tourism, [acceptance of medical tourism] is growing in people - some are open to it and others*

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are not…" From the interviewee responses, it is evident that the worry that Qataris have concerning medical tourism is attributed to the fear of the unknown including mixing with other cultures which could be associated with the sense of exclusive entitlement by Qataris to the progress Qatar makes. Concerning fear of the unknown, these interviewees believed that not all Qataris understand what medical tourism really entails yet and why it is different from the ordinary healthcare services that they access already. Since the healthcare system in Qatar is already working well for them, Qatari people might not understand the need for extending services that they feel entitled to and own to 'outsiders' in the name of tourism; not every Qatari can draw the connection between medical services and tourism.

Most Qatari society is very conservative and the QNV 2030 exemplifies the Qatari constitution's desire to nurture a society that upholds religious values, morals and traditions (see section 2.1.3). This is mainly traceable to the strong entrenchment of Islamic faith in Qatari society and its influence upon societal norms. This has strong values and principles which guard against the influx of alien behavioural trends which, it is believed, could water down the morals and values of the society. In other words, Qataris like many conservative societies are less receptive to new ways of life that they are unfamiliar with especially ways that might seem too worldly and Western. GOH2 identified the need to work on mind-set change through awareness especially concerning those seeking healthcare from other countries. However, it is noteworthy that none of the interviewees suggested that such efforts were underway and no evidence of any effort to increase awareness were identified during desk research performed by the researcher suggesting that currently no such awareness raising strategies exist. However, the responses of GOT1, GOH1 and GOH3 suggest that despite coming from a conservative culture many Qataris would be open to the development of medical tourism, if they better understood it. GOH3's explanation exemplifies this observation:

"...developing medical tourism will be especially welcomed by citizens…. On the other side, Qatari people are very loving and welcoming, and would enhance visitors' impressions and could help attract patients from abroad."

5.9.2   Religion and gender

Curiously, all six interviewees stated that religion and gender would not hinder the acceptance and implementation of medical tourism in Qatar. However, considering the conservative nature of the society and that Islam is the dominant religion in Qatar, it is likely that none of the interviewees would want to be seen to openly criticize it by suggesting that it could be a hindrance in the development of medical tourism. Indeed, according to Goldman and Romley (2008) treatments and products offered as part of medical tourism in Qatar must be aligned to Islamic teachings and conform to halal requirements if they are to be accepted by Qatari society. This postulation borrows heavily from the insights on the societal perspective presented in the previous section, which demonstrated the likelihood of a reserved attitude towards medical tourism. In other words, it both borrows and also contradicts what they said about Qatari people being open to the potential for medical tourism. This signals the kind of confusion that government employees currently express with respect to implementing The QNV's objectives of medical tourism.

Gender was the more contentious of the two issues because of the highly patriarchal nature of the Qatari society and the common restriction of females in terms of what they can and cannot do. GOF, GOT2, GOH1 and GOH3 suggested that it would not be a problem in the adoption of medical tourism. In contrast, GOH2 believed that some female Qataris may have reservations about working in the tourism and hospitality sector, including medical tourism, because "*some refuse the idea of mixing [with people of the opposite gender] at work.*" The implication of this viewpoint is that simply increasing the number of medically qualified Qatari males and females to serve in the medical tourism sector is not enough. There will still be a need to ensure that those staff who prefer not to work in a mixed environment have their

preferences and values respected. In addition, while some medical tourism sectors might be able to separate male and female customers, both in terms of medical service providers and in terms of medical tourists, some medical tourists might not be open to being separated. For example, if a married couple visited Qatar say for business and chose to sample some medical tourism services such as massages and spas, they might not wish to be separated. To overcome this Qatar would need to come up with a scheme which enabled male and female staff and clients to express their preferences and for these to be met.

From a more positive perspective on gender, GOT2 expressed optimism in that the number of females entering the work place was increasing and that many of these younger women had less restrictive views on workplace interaction:

> *"The number of girls will probably be higher because we have more female graduates than males. There have also been some major changes in the mind-set of our society where choosing a path is now solely up to one's personal choice and not based on their gender… In light of this, I do not expect there to be any issues that will prevent them from working in the tourism or medical tourism sectors in future."*

While it would be inaccurate to assume that the patriarchal structures in the Qatari context have been so abolished as to allow outright freedom for women to choose their career paths and mix with males in workplaces and other such meeting points, the fact that more females are enabled to gain professional qualifications (Aziz, 2015) may have some positive effects on medical tourism as well if more females take up courses that could get them employed in medical tourism. This would mean that potential female Muslim consumers of medical tourism seeking nursing or medical care in Qatar would have enough female practitioners to treat them in accordance with their cultural dictates and social norms (Han & Hyun, 2014). This goes hand-in-hand with the prospects of the QNV about empowering women with education to ensure that they are able to take up professional careers (see section 2.1.3).

5.10 Summary Conclusion

There is a serious controversy that signals looming confusion between sectors concerning what medical tourism means. This confusion could easily hinder the development of medical tourism in Qatar. This confusion is also manifested in relation to whether the target market is international consumers or consumers from the local market. There also seemed to be evidence of little or no knowledge of what form medical tourism customers might be interested in. Unfortunately, the findings did not show evidence concerning work in progress to consider what medical tourism is or entails. Evidence from the interviews also showed that there is a deficiency of infrastructure for supporting medical tourism. Beyond the technical and physical infrastructure, the interviews showed almost no understanding of the requisite total hospitality and hotel packages for supporting medical tourism. Yet, there was no doubt that developing medical tourism will benefit the national economy and Qatari nationals especially in terms of reducing the number of Qataris moving abroad to seek medical services at high costs.

Concerning culture, the results expressed the notion that Qatar might need to provide medical tourism with gender segregation. However, the extent to which such gendered implementation of medical tourism might appeal to medical tourists was not considered. Still on gender, there was an indication that qualified female nationals will address the gender issues and current skills gap although it is not clear how this might be achieved. However, the skills gap is unlikely to impede the development of medical tourism in Qatar since hospitals can currently continue to draw on expat labour. Although nothing indicated it concretely, it is probable that Qatar will draw on the support of expats until such time as enough Qatari nationals have obtained the technical skills required for implementing medical tourism effectively.

The interviewees discussed the need for cooperation between medical providers and industry since there was almost no discussion concerning generation of profits; most discussion

concerning finance related to seed funding. It was unclear from the interviewees how such seed funding would eventually translate into a profit venture based on revenue generation. Considering the confusion about the definition of medical tourism and what it would entail, it is clear that there is lack of for-profit strategy. Moreover, there was no evidence of action being taken to implement medical tourism clearly. In other words, there is a lot of talk about medical tourism within the QNV framework and negligible action to actualise it.

Chapter Six

Phase Two Results and Discussion: HMC Senior Management

6.1 Introduction

Twenty senior management officials participated in the second data collection phase. They were interviewed on various aspects of medical tourism and service quality in the Qatari context. More male senior management officials than females were interviewed. One main cultural reason might explain this huge difference, which does reflect, the general trend in Qatar. Qatar has traditionally been a conservative patriarchal society where the roles of women were mainly constrained to a certain level of leadership within the community and other sectors. The implication for this in the current study is there is potential for the findings to reflect the patriarchal bias of Qatari society where the feminine voice tends to be weaker. However, while the much higher number of male interviewees compared to females could mean the findings of this research do not achieve a balanced view in terms of representation of female views and voices with respect to medical tourism in Qatar it does reflect actual current employment practice. As demonstrated in section 2.3, the high number of expats interviewed also reflects actual current employment practice. Pragmatically the researcher accepted that this was a constraint when doing research in a society where females are not well situated in senior management positions. Additionally, the gender disparity reflected in the number of interviewees by gender did not feature in terms of the experience in years, as even the few female interviewees included in this study had diverse years of experience.

Indeed, the female interviewee with the least years of experience (IF2) had 5 years of experience compared to the least experience male (IM9) who had 2 years only. Among all interviewees, the most experienced interviewee had worked in the medical sector for 44 years while the least experienced one had worked for only 2. For the purpose of maintaining the anonymity and confidentiality of the interviewees their names and job titles are not reported in

this thesis. This is because some of the titles are held by only one person and hence that

interviewee could be easily identified. Instead, the researcher developed interviewee codes

based on nationality, gender and number. For example, the first Qatari male to be interviewed

is referred to as QM1 whereas the second non-Qatari female national is referred to as IF2

whereby 'I' denotes international. Table 6.1 below is a summary of the profile of the

interviewees.

Table 6.1. *HMC senior Management profile*

Interviewee	Gender	Nationality	Department	Experience (Years)
IM1	M	International	National Centre for Cancer Care & Research (NCCCR)	5
QM1	M	Qatari	Heart hospital admin	31
IF1	F	International	NCCCR, Hamad Medical Corporation	6
ME M1	M	Middle East	NCCCR	27
IM2	M	International	Medical City Hospitals Complex	9
IF2	F	International	Corporate	5
IM3	M	International	HH & NCCCR	9
QM2	M	Qatari	Continuing Care Group	32
QM3	M	Qatari	NCCCR Administration	33
IM4	M	International	Hamad General Hospital - Executive Office	9
IM5	M	International	Tertiary Hospitals Group and Health Facilities Development	10
IF3	F	International	Tertiary Hospitals Group	9
IM6	M	International	Corporate Hospitality	3
QM4	M	Qatari	Corporate	44
IM7	M	International	Corporate	3
QM5	M	Qatari	Corporate - Finance	38
QM6	M	Qatari	Hamad General Hospital (HGH)	30
IM8	M	International	Chief Medical Group	4
IM9	M	International	Chief Quality of Group	2
IM10	M	International	Corporate/Homecare	11

Four major themes were identified from the interviews following thematic analysis.

The first theme relates to HMC's capacity to deliver quality of service and this entailed both

organisational and infrastructural capacities. The impact of introducing medical tourism in

Qatar in terms of both positive and negative impacts emerged as the second theme. Customer

experience at HMC was identified as the third theme. The fourth theme related to types of hospitality and medical tourism services. Under this fourth theme, the role of hospitality, employees, and culture were considered as subthemes. The next four sections contain the results and discussions of the four themes in this order. It is noteworthy that although the interviewees were asked about actual medical services that could be offered to medical tourists, they hardly mentioned any.

When considering these results, it should be noted that HMC is a not-for-profit healthcare provider which is fully funded by the Government of Qatar to provide healthcare to Qatari residents. Where payment for treatment is commented upon it refers to payment for treatment services received by non-Qatari individuals based on their nationalities, resident status in Qatar, and GCC citizenship. However, there are also some additional conditions that influence the charges an individual incurs notwithstanding his/her nationality or resident status in Qatar. For example, standard treatment at HMC is free for all Qataris. However, they might opt for a private facility instead of HMC i.e. use another provider altogether. This would cost them 10% of the treatment cost. A summary of these variations was given in table 2.6.1 in the country context chapter.

6.2 Capacity to Deliver High Quality Service

In the context of this research, service means a combination of both quality medical care and the supporting nonmedical services. In other words, a high-quality service does not only depend on how good the actual medical care is it also includes how good the nonmedical services associated with such medical care provision is in terms of meeting and exceeding customer expectations. This definition is in accordance with the views of Vieira (2005), as discussed in section 3.9.1.

6.2.1　Organizational capacity

When asked whether HMC has the ability to undertake medical tourism in Qatar in terms of the capacity to provide quality of service, most interviewees (8) felt that HMC was not capable of doing so at present. The interviewees raised a myriad of reasons to support their views. However, the issue of population increase, which has put the system under pressure to support the Qatari population alone (see sections 3.13.1 through 3.13.4) dominated the explanations. The main issue was the inability of the current HMC setup to accommodate patients for adequate periods without compromising on quality of medical services due to inadequate accommodation facilities i.e. rooms and beds. When the interviewees considered the current pressure on the system, they believed that adding medical tourism into an already overstretched HMC would create even bigger problems in terms of delivery of service quality. For example, IM10 acknowledged that HMC had the capacity to accommodate the medical tourism sector but had reservations on service quality delivery in terms of timely access. He stated:

> *"HMC is a world class provider of healthcare plus with its academic and research affiliation. It has the potential to accommodate the MT sector. However, with the current high demand from the local population, HMC may not be able to provide the timely access [to accommodation due to shortage of beds] that MT would expect."*

Consistent with literature (Parasuraman *et al*., 1988; Curry and Sinclair 2002), this view demonstrates the potential for a gap between anticipated service quality and the actual service received if demand becomes too high. In other words, the interviewees suggested that while HMC can offer medical tourism actually delivering excellent service quality in a timely fashion would be a challenge with current provision. This is due to the pressure on the organisation's accommodation capacity plus, IM7 suggested, a lack of capacity to bill or charge for the medical tourism services accurately. This point is discussed further in 6.2.1.1.

In addition, the organisational capacity of HMC is further inhibited by its current setup in terms of the legal framework to support engagement in for-profit healthcare provision such

as medical tourism. An enabling legal framework would need to be created by the Government and would mean intensive revisions into the existing operations of HMC and adjustments in almost the entire medical practice legal framework in Qatar. This would need to happen before HMC could engage in the commercial provision of healthcare services. This is because the original rationale and legal framework behind the national Qatari approach to healthcare anchors on providing healthcare access to the Qatari population without a view towards making profits or commercialising health care. QM6 explicitly stated,

> *"[The way] HMC is created legally, it cannot work as a facility that takes money in place of service. The legal part should be changed…"*

This view was reiterated by IM8 when he was responding to the issue of whether HMC can offer partner packages to future customers. He argued that HMC did not have the appropriate permission to venture into tourism. Consistent with the legal dimension of their sentiments, QM5 also introduced the need for legal reviews in terms of visa issuance periods. He stated, "*the visa, should be access easy not to wait two years to get visa.*" This implied the need for legal backing to support medical tourism visa considerations which are not currently covered in law. The issue of changes required in Qatari legislation in order to be able to undertake medical tourism signals the underlying need for a fundamental change of the Qatar healthcare system to accommodate medical tourism as a service that cuts across health and tourism sectors. This legal dimension reflects Turner's (2007) comments on the need to amend legal restrictions as was done in Asian and Latin- American countries to enable the establishment and proliferation of medical tourism (see section 3.3.3).

Turner (2007) highlighted the danger of just focusing on monetary investments to develop infrastructure with little or no consideration for systemic and organisational adjustments to suit the needs of medical tourism. However, service quality is unlikely to be achieved if an organisation such as HMC fails to develop systematic methods to manage quality in order to achieve and guarantee a competitive position (see Bhat 2011 at section 3.9.1). These

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interviewees believed that developing the infrastructural capacity of HMC, such as bed capacity and so on, did not make sense unless and until the Qatari legal framework had been changed to enable for-profit healthcare provision.

In contrast to this majority view, five interviewees felt that HMC did have the current capacity to undertake medical tourism in terms of infrastructure capacity. They cited reasons such as HMC having adequate facilities (QM3 and QM2) including the medical system having a well-established expansion strategy. However, the meaning of the term facilities in these instances can be questioned since it is a multi-use term which can as easily refer to physical infrastructural facilities such as equipment or system-based facilities such as billing and insurance (see section 3.6.1 for discussion on barriers to linguistic understanding and confusion of meaning). However, in these instances the researcher is convinced that the term 'facilities' meant adequate monetary resources and technology because ME M1 noted that HMC has "all of the resources" and QM1 that:

> *"HMC has the best technology among GCC Countries it has some of the best staff in particular physicians and other allied health professionals it also has the facilities to cater for such services."*

Three interviewees (IF3, ME M1, and QM1) had mixed views about HMC's capacity deliver quality medical tourism. IF3 noted that the capacity of HMC to deliver was subject to receiving national support from the Qatari people. Such national support for the implementation of medical tourism is not one-sided, but holistic. This is why aspects of cultural support and infrastructural support as discussed at sections 5.9.1 and 5.9.2 respectively are critical in ensuring service quality delivery in Qatar's medical tourism sector.

The establishment of universal standards to processes such as billing systems and insurance were also critical support areas identified, as shown in the two subsequent subthemes below. Service quality based on the SERVQUAL model proposed by Frost and Kumar (2000) underscores the need to include service suppliers and employees and their perceptions of the

service given to the clients. The model shows why building employee capacity is also critical to the delivery of service quality in Qatar's medical tourism through HMC, as elaborated at sections 3.10.10 and 5.3.

6.2.1.1 Billing System

When asked whether HMC had a billing system in place, most interviewees (16) responded in the affirmative. However, it was interesting to note that different factors informed each affirmative response. For example, ME M1 argued that it existed for visitors and not for locals even when they were required to pay for services that are not covered by Government subsidies (see Table 2.6.1), which was similar to IM4's view that the billing system at HMC was for patients using insurance schemes and that in its current state is incapable of representing actual costs. In the end, the overarching view was that the current billing system at HMC is inadequate and would require considerable amounts of investment to guarantee the service quality level required in medical tourism and would require modification to cope with its demands and the complex range of charges involved. According to IM3:

> *"HMC does have a billing system but I do not believe it is sufficiently accurate or robust enough to support any form of medical tourism. Significant effort would need to be invested in an infrastructure to support any such initiative and an agreement reached to determine how any income generated would be allocated…"*

The lack of a sophisticated billing system can be explained by HMC's not- for-profit approach and the entire healthcare sector in HMC where government subsidies ensure that Qataris access health care services which the government pays for on their behalf. In fact, IM5 explained, *"the billing system does not relate to true cost so would not be useful for profit and loss purposes."* This not-for-profit structuring of the healthcare sector in Qatar means that there is a need to reconsider and reconfigure the billing system to accommodate the for-profit approach that medical tourism would require. However, changing the billing system alone is unlikely to achieve the intended outcomes of service quality and business-related profits. Some of the interviewees already understood this need for a holistic change of all financial systems

including the non-profit approach that runs currently. For example, IF3 identified that

procurement procedures and the regulations under which HMC currently operates would also

have to change:

> *"There is a billing system in place. Major changes need to take place in the areas of cost accounting, finance and procurement activities (e.g. tendering process) before we could successfully venture into medical tourism. First, we need to change our bylaws because we are a non-profit organisation. We are already quality conscious but we need to be very cost-conscious and activity conscious as well in order to improve our business competitiveness."*

These types of modifications are reflected in literature (Connell, 2011; Lautier, 2014;

Musa *et al.*, 2012), which demonstrates how medical tourism entails bills and expenses by

medical tourists across a multitude of sectors including hospitality, transport, and medical

services (see section 3.5). IM9 provided an interlinked response concerning the billing system

by bringing in the aspect of billing and insurance:

> *"No, it's [the billing system] very immature. It's fragmented… that's what again the commercial insurance company is going to ask you for, if you are trying to fill the insurance they will asked how much [will it] cost and we don't know"*

6.2.1.2 Insurance

With respect to the existence of insurance in the case of HMC, the highest number of

interviewees (14) indicated that either HMC lacked an elaborate system for billing patients

whose treatment is being covered by an insurance scheme (10) or they were not aware of its

existence (4). Considering the significance of insurance as a key stakeholder in healthcare

systems (cf. Angell 2011 at section 3.11.1), this implies that HMC might not be ready to engage

fully in medical tourism and provide some services such as luxury medical care. This is because

the HMC financial system is not sufficiently integrated as to enable billing of current patients

who already have insurance cover. Altogether, literature reviewed in section 3.11.1 also shows

that most people lack insurance covers to cater for their medical tourism expenses. Thus, the

results of this research in this respect challenges the findings of earlier literature and queries

the actual current ability of Qatar's public hospitals towards inclusion of customers who are

willing to pay for this service especially if they are covered by insurance companies (see Wu *et al.*, 2013 in section 3.13.2).

There is need for further clarity to establish the extent to which HMC and the Qatar healthcare system has incorporated billing of insurance service providers and the extent, accuracy and frequency with which invoicing patients with insurance cover happens. Notably, some patients will pay privately upon being invoiced thereby implying that fee payment and insurance cover will be acceptable. As such, HMC would need to first develop a comprehensive billing system with the capacity to handle both insurance and private payment systems. This plus continued government allocations for Qataris will require the development of an economic model that integrates all payment systems for non-Qataris and perhaps even Qataris. However, there does seem to be effort to create an insurance environment in Qatar to support the healthcare system and medical tourism provides for that opportunity, as explained by IM7:

> *"At the moment work has been to develop insurance in the country as the major public provider of hospital services in the country. HMC will need to be much more business-focused in that way. At the moment, we just have [… an] allocation from the government to do all the things that we need to do… in an insurance world, [...] we need to have a sound economic model for running the corporation based on income covering the expenditures. Medical tourism into the country strictly for some of the non-specialty, and not so expensive services gives us an opportunity to contribute to that model."*

Most of the interviewees (11) agreed that HMC has the capacity to integrate different services with medical care. The implication of this finding is that capacity for developing services including insurance services and a more robust billing system exists. However, it is noteworthy that although many interviewees were positive about developing capacity for different services, some like IM3 were not convinced that such services need to be developed to enable or appeal to medical tourism:

> *"HMC clearly has the capability to plan and deliver additional services but. I do not believe that this ought to be done with the intention of attracting medical tourists…this is not our core business."*

The sentiments in the quote indicate some managers were not convinced that medical tourism was a good thing for Qatar to venture into despite the QNV.

6.3 Perceived and Potential Impacts of Medical Tourism in Qatar

6.3.1   Negative impact of introducing medical tourism in Qatar

The main negative impact that several interviewees (4) mentioned was increased pressure on the healthcare system due to capacity issues thereby overwhelming the healthcare system. The following response by IM6 conveys this fear:

> *"A negative impact is that it may bring an additional burden on the national healthcare system depending on the available capacity. This in turn may have a negative social impact since the residents will realise that the system is giving priority to other paying customers than them."*

Considering Zeithaml's (1988) ground-breaking study on service quality (see section 3.9), overwhelming the Qatari healthcare system with demands that cannot be met would likely impact negatively on service quality. Ultimately, this would lead to significant decline in customer satisfaction for both locals and internationals. For example, unless capacity is increased there is the potential that initiating medical tourism would mean that Qataris and even some medical tourists would have to compete for both accommodation and medical services thereby encountering difficulty in accessing healthcare services. Consequently, this could lead to the exclusion of some from accessing healthcare services particularly Qataris, IM8 explained, *"...if there is a restriction on capacity that I am squeezing out others by choosing to see external patients."*

Another potential consequence would be patients having to endure long waits to access health care services yet there are already experiences of "*long waits for some treatments, orthopaedic department appointments, and diagnostics*" (IM7). The increased competition would most likely trigger lower quality service provision. Currently, the waiting time for an appointment is slightly over a month and this could worsen with the introduction of medical tourism due to increased demand for medical services and other related aspects of medical

tourism such as medical staff and accommodation facilities if new facilities were not developed.

The second most mentioned impact of introducing medical tourism was also negative and related to increased infrastructural capacity pressure and overloading of the already pressurised Qatari healthcare system due an increasing population and demand for healthcare services. Concerning HMC's infrastructural capacity to support medical tourism, eight interviewees (8) stated that this currently inadequate or lacking. The interviewees used diverse terms such as constrained (IM8), limited (IM1), lacking (QM5 and QM6), not ready (IM6), or under pressure due to population (IM7), overloaded (IM10) or needing to increase (IF3) to describe the infrastructural limitations of HMC with respect to integration of medical tourism. Even without medical tourists coming to Qatar, the HMC system "*is overloaded to meet current demands and expectations due to the growing population and health awareness/expectations*" according to IM10.

Additionally, some felt that the introduction of more services could also mean that healthcare services become more expensive because cost subsidies were unlikely to apply to new services (QM5). Should this be the case, IM6 predicted that it is likely for Qataris to have negative perceptions towards medical tourism. Considering the symbiotic relationship between hospitableness and hospitality as discussed by various authors (e.g. Brotherton, 1999; Hemmington, 2007; Oh and Pizam, 2008) and reviewed in section 3.12, an aversion by Qataris to foreigners could mean that medical tourists as guests feel unwelcome in Qatar. The ripple effect could be such that medical tourists and Qataris themselves develop negative perceptions towards healthcare in Qatar. Ultimately, medical tourism will not succeed in Qatar under conditions where the customer experience by both locals and medical tourists is negative.

Progress has been made to advance HMC's infrastructural capacity through the establishment of new facilities as mentioned by five interviewees. Although there are real

issues with making sure that there is capacity for Qatari citizens, some of the new facilities at

HMC have the potential to enable medical tourism more effectively than the older ones.

According to IM2, the new facilities at HMC come with infrastructural capacities and other

service-related aspects:

> *"Newly build facilities such as Qatar Rehabilitation Institute, Al Wakrah Hospital and*
> *PET-CT centre are most attractive facilities for medical tourism in terms of the*
> *infrastructure, length of stay, hospitality services and capacity."*

6.3.2   Positive impact of introducing medical tourism in Qatar

Literature in sections 3.9.1 and 3.12 (cf. Vieira 2005; Goldman and Romley 2008)

shows that good reputation due to high customer satisfaction creates demand for more service

consumption by customers and that the converse is true. Reflecting this perspective, six

interviewees considered the introduction of medical tourism to be a key ingredient for building

international reputation and establishing HMC as a top medical centre with a high-quality

healthcare system (QM4). Status is an important part of Qatari culture. Indeed, some

interviewees like IM1 used the terms "proud" while describing their commitment to

accreditation by JCI as shown below:

> *"We are proud to be continuously JCI accredited, last as an Academic Health System.*
> *This is a great achievement for the corporation."*

Therefore, it could be that the benefit of reputation accrued from medical tourism might

not be just about economic gains. Instead, it might also be about psychosocial gains such as

pride, status, and achievement, as shown in literature in section 3.3.3. As part of the Qatari

culture, prestige, reputation and status are important aspects of achievement more than

monetary gains. However, revenue generation discussion emerged as a significant theme when

the interviewees were asked to identify the advantages of providing nonmedical services.

Revenue increase per se was also cited as a benefit by eight interviewees either directly or

indirectly. QM5 saw the increase in revenue as a gain for government and country in the same

way it was projected in the literature review (see section 3.5). He argued that charging for

medical tourism:

> *"will be supporting the government... [and…] at the same time support the income to provide services."*

IM6 saw the increase in revenue from the direct perspective of earning foreign

exchange and IF3, in a manner aligned to the one aim of the QNV on economic diversification

especially from oil alone, commented that:

> *"If medical tourism in Qatar would be successful, it would be a great [...] way to achieve diversification of business and could be an approach to balance the country's budgetary dependence on oil, given the volatility of oil prices"* (IF3)

QM1 and IM3 considered that the development of medical tourism in Qatar would

mean that Qataris might not have to go abroad for as many treatments as they would be able to

access more in Qatar. Therefore, if new treatments were developed for medical tourists which

Qataris could access at home, while not generating income directly, this would reduce the cost

that the government incurs on overseas treatment. This is more expensive because it also entails

travel costs that the government would otherwise not incur if Qataris were treated in Qatar.

6.4 Customer Experience at HMC

Discussion with the interviewees about customer experiences at HMC were based on

the aspects of physical environment, patient rooms, patient feedback, and employee

interactions. The general view was that the customer experience at HMC is good albeit with

challenges of long waiting times. From the interview results, the waits were classifiable into

two types. The first type of waiting referred to the kind of waiting, which could go up to a

month, which patients have/had to endure before getting specific treatment services. This type

is connected to waiting for appointments, as alluded to by IF2: "*we have long waits for some*

treatments, OPD appointments & diagnostics."

The second type was the general "*long waiting times for all services*" mentioned by

QM1. An example of such long waiting times is when one has to wait to find a car parking

space, which translates to the negative impact that supporting services/facilities can have if they are not delivered appropriately and as expected by customers. In general, most of the interviewees expressed the need for significant improvements of the customer experience at HMC. The following quote from IM10 sums up the dominant view of the interviewees:

> *"HMC has a dedicated department for Patient Experience and Hospitality which are geared up to provide the best patient experience and satisfaction though sometimes the inability to provide immediate care hampers its ability to please all of the patients."*

As discussed in section 3.13, many authors (Joseph 2006; Joseph *et al.,* 2008; Ulrich *et al.*, 2008; Gulwadi *et al.*, 2009; Sadler *et al.*, 2009) have demonstrated the connection between the built, physical environment and the promotion of constructive or destructive developmental, psycho-social, medical, and welfare consequences among employees, families, and patients. Others (cf. (Koontz, 2003; Miceli and Clark, 2005; Harris *et al.*, 2006; Maijala *et al.*, 2004; Varni *et al.*, 2004) have shown how the physical environment contributes to contentment, which translates as an aspect of customer satisfaction. In this research, most interviewees (13) described the physical HMC environment as good although with need for continuing improvement. Potentially this means that the physical environment at HMC is likely to promote favourable customer satisfaction outcomes.

However, if the newer, more up to date facilities are seen to be more suitable for medical tourists this might mean that some Qataris view medical tourism negatively because they might feel that it is taking away facilities that would have otherwise been meant for them. It should be noted that the most positive opinions were from those interviewees who were specifically associated with the newer facilities as opposed to older ones. For instance, IF3 explicitly stated that the physical environment is "*excellent for the newer hospitals*" while IM6 asserted the following concerning the physical environment:

> *"HMC is trying to provide good medical services within a clean and safe environment. There is a variety of patient rooms available, which also vary depending on the age of the facility."*

Some aspects of the physical environment such as car parking were cited as negative spaces by some interviewees within an overall good physical environment. For example, a number of interviewees (6) mentioned the issue of the car park at HMC either needing improvement, not being large enough or generally not being good. Although not obvious, limited car parking space might be a problem for patients flying in to Qatar who are accompanied by their families and who need locally-hired drivers to drive and wait for them. Companies around the world who sponsor their employees or clients (insurance) medical care and hire private ground transfers might also receive negative experiences as feedback from their clients if space is limited and access to the hospitals difficult. Although an efficient public transport system is available in Qatar, Qataris generally prefer to drive to hospitals for convenience and comfort. In the service model by Dabholkar *et al.,* (2000), which was reviewed in section 3.10.5, comfort was identified as one of the principal antecedents that an organisation can use to measure service quality. Literature in section 2.4 shows that the huge investments that Qatar has made toward transport infrastructural development is set to increase accessibility.

Some reservations (5) were also expressed with respect to shared patient rooms which are mostly in the older facilities. The newer facilities were said to have better patient rooms. For example, QM1 stated that patient rooms were *"Spacious in almost all hospitals, except few sharing rooms in Hamad General Hospital."* The issue of shared rooms also arose when the interviewees were asked about how they would cope with customers from different cultures with respect to the built-in environment. IF1 stated that they were *"trying to respect requests for male/female separated areas; never [having] shared rooms in inpatient units."* This reaffirms the results indicating that only the newer HMC facilities are better suited for medical tourism. The older facilities are predominantly situated inside the capital, Doha, where Qataris prefer to go as opposed to going to hospitals in the outskirts of the capital. This introduces the

aspect of geographical preference for medical treatment by Qataris. This could also account for why the newer facilities, which are outside the Capital, are seen as better suited for medical tourism because they are not in such high demand from the Qataris as the older facilities in Doha.

Concerning patient feedback, the highest number of interviewees described it as positive (9) with notable improvements in customer feedback collection since the installation of a system for collecting such feedback. This being the case and considering Zeithaml's (1988) description of service quality as the feedback that a customer gives concerning the overall quality of a product or service, these results can be interpreted as meaning that the service quality at HMC is high and favourable. In other words, the results here show that the managers believe that current customers are satisfied with the quality of services they receive from HMC. Indeed, IM4 expressed as much and hinted at further enhancements although in relation to the newer facilities:

> *"In these later facilities the high satisfaction level is achieved with a very strict adherence to high standard and gradual improvement. (staff empathy, furniture, lay out, services, and innovative approach etc….) The feedback has greatly improved with the launch of the Nesmaak service and dedicated long awaited Complaint Management system. Further developments are in progress in this field and it will enhance further the customer experience and satisfaction."*

The expression that further enhancements are underway complements the need for constant improvement that IM3 and IF3 mentioned. This affirmation by IM4 on progressive enhancements of customer experience and satisfaction has two implications in light of the calls by IM3 and IF3 for improvement. First, it is an acknowledgement that customer experience and satisfaction at HMC is not excellent and needs to improve. Second, it is an indication of a consciousness by staff at HMC to continually improve the experience and satisfaction of their customers by meeting customer expectations consistently. These two views find support in literature on service quality and niche tourism (section 3.9.1) where Berry *et al.,* (1989) advocated for the same and Vieira (2005) contextualised this in the tourism context. One of the

areas, which HMC might need to improve the most, in terms of customer/patient feedback, is their response to feedback once customers/patients send it to them. In fact, both IF1 and IM3 recommended that HMC staff should be more responsive to patient feedback.

In the literature reviewed concerning the evolution of service quality theory and models in section 3.10 (Grönroos 1984; Brady and Cronin 2001; Aliu *et al.,* 2016), interactions between staff and customers were underscored as key influencers of final customer experience outcomes including satisfaction. Similarly, literature about hospitality and hospitableness (section 3.12) highlighted the importance of relationships between staff and customers by improving the services given and providing psychological and emotional welfare in the host/guest or patient/provider interaction (Ferguson *et al*., 1999). However, the interview results revealed a division amongst the senior staff concerning how good the employee interactions at HMC were. An equal number of interviewees felt that the employee interactions were good (6) or were not as good and could improve (6). For example, IM3 expressed some reservations about the inconsistency in employee interaction albeit based on anecdotal evidence:

> *"This is very variable…at our best we are excellent however there is much anecdotal evidence (and complaints) that suggest we could do much better in our direct interaction and communication with patients and their families."*

The implication of this sentiment is important in that a poor initial communication or first impression might encourage tourists to turn to another medical tourism destination since communication is a principal element of patient contentment (Zineldine, 2006), as discussed in Section 3.8.3 previously. Even the comments by the interviewees who felt that employee interactions were good reflected the three gaps identified in the model by Frost and Kumar (2000). For example, QM5 suggested that employee interactions are more applicable to staff working on the front line, within the patient units, who have opportunities to interact with patients rather than for those like himself who work in a back-office capacity:

> *"Well with customer it depends, because if it's in the patient unit there are lot of direct contact. But we are sitting in the back office so our contact is limited to case by case if somebody comes and so on."*

However, roles executed by staff in the back office can enhance or impair the medical tourism experience, as incorrect bookings or billings, etc. can impact directly on the overall customer experience. For example, back office Information Communications Technology (ICT) employees ensure that the customer appointment and billing systems are working properly. Failure of these systems directly impacts the customer experience yet frontline staff have little or no control over them. This holistic view extends to the role of both frontline and back office employees in aiding the implementation and development of medical tourism in Qatar since it places them at the epicentre of ensuring customer satisfaction based on their experience of the facilities, services and the employees themselves. It is likely that the back-office staff do not fully understand the importance of their roles in influencing customer satisfaction.

When asked about the extent to which employees might be aware of the medical tourism concept, eight interviewees were not convinced that HMC employees were aware of it. For example, IM2 stated explicitly, *"No. Majority of HMC staff don't have a solid awareness of medical tourism and its requirements."* Five interviewees indicated that some were aware or some were partly aware of medical tourism. QM5 captured this partial knowledge of medical tourism by professional segment and level, *"-Not everybody, but they know what it means. At least the senior level, clinicians and so on they know…"* Only two interviewees felt that the employees of HMC were aware of medical tourism and they attributed this mainly to international exposure through traveling to international conferences, for example. However, such international exposure would only apply to senior management staff. Additionally, such international exposure cannot be said to be lived experiences or actual encounters with medical

tourism. Instead, this would count more as general exposure to travel and theoretical presentations of what the outcomes of medical tourism might look and feel like.

This lack of awareness means that Qatar may have a difficult time developing medical tourism if most of its healthcare and hospitality employees are not aware of what they should be working towards, i.e. medical tourism as specified in the 2030 Vision or do not quite agree with the some of the principles of the QNV (described in section 2.1.3). This lack of awareness reiterates poor or lack of proper communication of the QNV, as was demonstrated in the results reported based on the data obtained from the interviewees working in the Ministries. If even a small section of the employees does not have an adequate understanding of what medical tourism is and its requirements, their performance may affect an overall move towards medical tourism (see literature at section 3.10.10 on the "internal service performance gap" in the SERVQUAL Model that was developed by Frost and Kumar (2000, p.929). The senior employees interviewed were aware of this, as when they were asked whether employee performance would impact on medical tourism development there was near-unanimous consensus that it would (18). IF1 made a direct connection between how the performance of employees based on attitude and behaviour affects medical tourism development, which is aligned to the need for investment in human capital development as outlined in the QNV (section 2.1.3):

> *"Employee attitude and behaviour would impact on the patient experience, which would in turn impact on the development of the [medical tourism] service"*

At HMC, it is common practice to outsource nonmedical services, especially low-skilled labour such as housekeeping, call centre, landscaping, security, transport and some catering services. The interview data showed that the only reason HMC was outsourcing some services was because having such services in house was more expensive than outsourcing. In some instances, HMC partially outsources some services. The following statement by QM5 demonstrates this:

> *"Cleaning hospital is not cheap; we will not be able to do it in-house. So, we depend on outside catering, materials maybe we are buying but companies are cooking and delivering. Outsource is the future as this is the only thing to go."*

Outsourced employees, who mainly constitute expatriates, take up not only unskilled jobs such as cleaning services, but also skilled nonmedical services jobs such as front line and call centre jobs where they interact with patients and their families when they come to HMC. On the other hand, many interviewees did not feel that the performance of the outsourced expatriate staff in general would have a significant impact on the implementation of medical tourism. The rationale was that outsourced expatriates may not necessarily be committed to Qatar's National the QNV or the vision of HMC concerning the implementation of medical tourism. While this may be addressed if Qatarisation succeeds, it is not still clear whether the vision of Qatarisation will be met fully and after how long (see Nejad, 2016 in section 2.1.3). Instead, the overarching view was that permanently employed staff, especially those from Qatar, had the greatest potential to impact significantly upon the development of medical tourism. This seemed to be mainly because the interviewees preferred having Qatari nationals taking up employment, compared to having expatriates, for example. This was also connected with the question of Qataris maintaining ownership and control of medical tourism. It also could be traced to the possibility that the interviewees believed Qataris to be more familiar and knowledgeable about their country and therefore the provision of nonmedical, tourism services and believed this would, therefore, extend to high standards of medical service delivery mainly due to patriotism in terms of both the final product and the development of packages especially for accompanying partners. For example, IM8 commented that:

> *"Having an outsource staff per say would not affect. Personally, it will depend on what the contracts are and how they are managed. If a standard set in the contract [outlines the] scope of service, the contract itself and monitoring of the contract… then it will have an impact on what we do. If those standards are managed well, monitored well, the relationship with outsource provider is good then you could get a possible good experience."*

The most dominant view among the interviewees concerning outsourcing, embodied by the response of IM8, was that monitoring of outsourced employees and services would ensure the success of medical tourism development in Qatar. Yet, both outsourced and permanently employed support staff and frontline staff are essential to service quality delivery based on Frost and Kumar's (2000) SERVQUAL Model, particularly in attempts to bridge the service quality gap. Thus, outsourcing could affect the development of medical tourism especially when customers interact daily with the outsourced staff more than they do with the permanently employed HMC staff. For example, outsourced staff could impact upon the performance of HMC in terms of the quality of hospitality services and sixteen interviewees commented that quality hospitality services are necessary for the implementation of medical tourism. Some of the outsourced services are likely to impact on quality of medical tourism services more significantly than others. For example, an outsourced call centre attendant might have more influence on the service experience of a medical tourist than a cleaner, as long as the hygiene standards of the facility are maintained. This is because a call centre attendant has to interact with existing and prospective medical tourists while booking appointments or handling complaints and other queries. Ensuring that Qatarisation succeeds will address this challenge in the long term. However, there is need to ensure that non-Qataris working in Qatar also understand and own medical tourism in Qatar.

The final issue identified as affecting the customer experience was that of language. The underlying influence of language on service experience is that if there are difficulties in communication due to language barriers it can affect the perceived medical tourism service experience (Parasuraman *et al.,* 1985) and patient care. QM4 cited the relevance of language in the context of service delivery in the context of medical services as follows:

> *"Language has impact not only on patient care, but also on their safety. If a patient can't explain their problems to a care provider [and the] care giver can't communicate with patients because of language barrier, patients might miss diagnosed and patients will receive wrong treatment or medication."*

The interview results showed that eight interviewees (8) were aware of a language bank to aid in translation thereby increasing the chances of better staff-patient communication. Currently the language bank is aimed at facilitating communication between existing patients and medical staff to ensure appropriate medical care. However, the availability of a language bank and interpretation services would be useful in supporting medical tourism service experiences especially for medical tourists who are not proficient in Arabic. For example, IM8 mentioned the following:

> *"...we are investing in the future it includes medical interpretation and that would help to avoid barriers and communication between staff and patients. I cannot remember how many we have I think we have 55 languages. We are waiting to pilot possible expand."*

The language bank is a department at HMC which offers translation services to patients who cannot speak or understand Arabic or English languages. This language bank signals the efforts that HMC has been making towards ensuring that the facility is better able to serve a diverse and broader range of customers than just Qataris. It is also an indication that HMC is offering quality service delivery to its clients.

6.5 Types of Hospitality and Medical Tourism Services

Several interview questions investigated the various types of hospitality and medical tourism services that could be implemented in Qatar. Initially, they sought to determine whether the interviewees considered hospitality to be an important aspect of implementing medical tourism. Most of the interviewees (16) expressed the view that involving the hospitality services sector (hotels, accommodation, travel packages) is necessary for developing medical tourism in Qatar. Whether this connection was made because the interviewees subconsciously linked the term hospitality services with the term tourism in medical tourism remained unclear although this could not be ruled out as a possibility and may have influenced the responses obtained. The perception that hospitality would be important in

supporting medical tourism as a secondary aspect of medical tourism, which improves the

medical tourism experience overall, implies that the interviewees consider medical services to

be the crucial aspect of medical tourism. IF3 stated the following:

> *"Of course, hospitality could provide an added value to the medical services that HMC is providing. It would help HMC build a brand that would make it a selling point attracting patients to do their treatment in Qatar."*

In other words, provision of hospitality services together with medical services would

make the latter more appealing than if or when medical services are provided without

accompanying them with hospitality services. This connects well with the issue of provision

of partner packages to further enhance medical tourism in Qatar and the need for accompanying

hospitality packages during the implementation of medical tourism, as shown in section 3.5

(Ruka, 2015; Sandberg, 2017). While there were some interviewees (such as ME M1, IM2, and

IM3) who had no idea or were not sure about the potential of HMC offering partner packages,

most expressed optimism in this regard. The results about the partner packages demonstrated

that most interviewees thought of them in line with costs and hospitality services. For example,

IM10 mentioned hotels explicitly when asked about provision of partner packages:

> *"With the current stock of hotel rooms in Qatar, HMC has the potential to offer special packages at very competitive rates. (difficult to quantify cost)"*

However, even the supporters of the idea to develop partner packages indicated that

reforms to the current system were inevitable. This is because the development of partner

packages would only be possible if a system-wide approach was taken to ensure that the entire

medical tourism can accommodate the packages. The following response by IM9 is an example

in this regard:

> *"You know if you have evidence that you have a good quality assurance and good quality control, then I'm going to consider it, if the price is more affordable, I'm going to consider it. Then the outcome is similar, then I could develop a package, which says okay. If you go to Doha where they have a centre of excellence for coronary artery surgery and it's a third of the cost. We will put you in a five-star place. We will provide you with a menu of our services. The data says you will get a good outcome. You and your family will be in this environment. And will get you there and back home… you*

have to create a medical tourism system [...] that includes the healthcare, hospitality, the additional services, to say, "Here's our packages for you".

The types of services that it was believed that most patients/customers usually sought in Qatari healthcare institutions fell into three categories. These included quality hospitality services, medical and related services, and other general services. Concerning quality hospitality services, the most common service was related to quality and quantity of food. It was mentioned by five interviewees. This finding was consistent with literature under section 3.13.3 underscoring the significance of perceived food availability and the meal experience in medical facilities (Hartwell *et al.*, 2015). Proper and adequate parking amenities was mentioned by four interviewees while hotel accommodation and especially the issue of single or private rooms were mentioned by four interviewees. It is notable that the same interviewees at times mentioned food and accommodation together. For example, QM3 mentioned both the demand for single rooms and food services while discussing aspects of hospitableness and hospitality, as discussed at Section 3.12:

> *"Buildings, yes when you say private room it's attractive. For example, if you are in such business you must have a choice, private and double cost price. So, it's attractive to people to have a private room. Its attractive to people hotel, motel service, food and of course the atmosphere it makes a difference. People will look at something which is environment is appealing and attractive. That's hotel motel service includes all this food, TV, and whatever and so on."*

The third category entailed speed and easy access to services with an aspect of friendly care. Six interviewees mentioned that accessing services at HMC in a speedy and easy manner was the most sought-after service by clients. This is an indication that patients/customers that were visiting the HMC were currently experiencing delays and difficulties in accessing services. Although the results described earlier in Section 6.3.1 showed that delays (mentioned as long waiting times) could be a potential negative impact resulting from the development of medical tourism, the results in this section imply that delays are already a problem at HMC.

Interestingly, QM6's comment raised an issue concerning diverse views about whether patients/customers mostly sought medical or nonmedical services by stating the following:

"They [customers/patients] want to feel that they are being taken care of. They don't care about the medicine, the doctor. They want to feel they are being treated well"

While this statement might imply that high quality medical care service is not important to the patients at HMC it is important to emphasise that Qatar already offers quality healthcare services to its citizens and so is taken as a given. Therefore, patients might consider hospitableness as the most important need because they feel that they do not experience the same quality of service at the moment unlike the quality of medical care which they receive. This interpretation could also mean that the patients/customers at HMC are currently exhibiting medical tourist traits unconsciously as opposed to the traits of the health tourism typology, as described at section 3.4.2. In accordance with the Frost and Kumar's (2000) model (see section 3.10.10) and literature about hospitableness and the relevance of the built environment in hospitality (see sections 3.12 and 3.13) it is arguable that the patients/customers at HMC believe that their expectations of quality medical services should also entail timely, quality delivery of other amenities which make them feel that they are treated like guests (Hemmington, 2007).

It is noteworthy, however, that most of these interviewees viewed medical tourism clients as patients and not customers since they believed that medical tourists were primarily seeking medical services (12). This perception contradicts the literature review which shows that while medical tourists are seeking a high-quality medical procedure, they are also seeking a hospitable experience and since they are able to choose, they will usually choose the most hospitable provider especially if the quality of medical care offered appears similar. Seven of the interviewees identified excellent service delivery, which is customer-focused including managed processes such as full clinical engagement of patients (IF2) and specific areas of medical tourism such as the appointment system (QM2; IM4, IM7) in the form of effective

affordable, procedures (IF1). As QM6 noted, achieving this will most likely require restructuring of the current healthcare system based on market research and improved organizational management and commercialization (IM8). QM5 and QM6 indicated that such reconfiguration will entail more investment in infrastructure and staff. It will also require improving the capacity that HMC currently has to offer partner packages to future customers as acknowledged by nine interviewees.

Once the system has been reconfigured and established to accommodate the demands and pressures associated with the introduction of medical tourism in Qatar on large scale, IM7 commented that the marketing and promotion of services available and Qatar as the preferred medical tourism destination will be necessary especially through advertising (QM1; QM3).

6.6 Culture

The interviewees were prompted for their views about the influence culture has or is likely to have on medical tourism. This was investigated from two angles. The first angle was that of investigating the role of culture in patient experience from the perspective of religion, age, and gender. Secondly, the interviewees were asked to comment on the mechanisms instituted by HMC and Qatar in general to cope with different cultures.

6.6.1   Role of culture in patient experience and expectations

All the interviewees stated that culture plays a very influential role in the experiences and expectations of patients. For example, IM2 stated, "*The role of the culture is too important…*" while IF2 argued, "*I think that culture is important and that patient's needs' should be assessed individually on admission to an HMC Facility.*" The response by IF2 as a representation of the views of the rest of the interviewees coincides with existing literature (Liu and Chen, 2013), which underscores the significant impact that culture has on tourism (see Section 3.6). The impact of four aspects of culture i.e. age, gender, religion, and language emerged from the interviews as significant influencers of the patient experience and

expectations. Significantly, the issue of conflicted language whereby some of the interviewees used the terms patient and customer interchangeably continually manifested in their responses, as was the case in the interview results with the government ministry officials.

6.6.1.1 Age

Concerning age, the interviewee responses could be viewed from three perspectives. The first emergent view was the local Qatari perspective. Under this perspective, the importance of age within the Qatari cultural context was emphasised. For instance, there was a clear indication that older people (synonymously referred to as elders, the elderly, or adults) should be accorded different social treatment. This is because seniority in terms of age in the Qatari context was presented by the interviewees as requiring more respect. Such respect for older people was primarily linked to their role in the family and mostly as parents. For example, IF1 stated, "*parents have significant importance; older people are highly respected.*" Such preferential respect for older people from the family perspective also manifested in the response by IM1, "*Age and position in a family context are important to understand for proper patient management.*"

However, it should be noted that respect for the elders or older people does not imply disrespect for the younger ones only that the older people would be prioritized over younger ones if they were to require the same service at the same time. Of course, in some instances, younger people may be prioritised over older ones. An example of this would be prioritising a younger person who requires immediate medical attention over an elderly person who is not critically ill. On the other hand, an older person can decide to relinquish such prioritisation in favour of the younger person if they so desire. For example, an older person who is moved to the front of the queue because of his/her age can decline the favour and extend to a younger person. Either way, this indicates that the will of the older person (particularly the elderly) prevails in most cases.

On the other hand, some of the interviewees considered it common knowledge that elders are respected in most cultures. Therefore, they considered age to be a non-issue because it was a given that older people would be accorded more respect than younger ones. For example, IM4 asserted, "*The age aspect might not be so much of a concern, most of the societies sharing values in common (respect of the elders, respectful tone and nature of language).*" From a superficial cultural perspective, this might seem like a good assumption. However, the researcher approached this response from a more critical perspective, which demonstrates that HMC might need to develop two physical services What if a younger medical tourist feels they are more deserving of more immediate treatment than elders because they have paid for luxury service or the culture from which s/he originates does not share in this value as strongly as Qataris do? Such a younger customer might consider preferential treatment of elderly people biased and therefore have a negative customer experience. After all, literature (Furrer *et al.,* 2000) at section 3.6.1 demonstrates how clients from various cultures allocate distinct significance to the elements of service standards in order to quantify apparent quality of service.

The second emergent view about age was from the service perspective. In this regard, it is important to underscore that most interviewees used the term customer more than patient. Four interviewees alluded to the role of age within the service context and this was more relevant to medical tourism expectations and experiences of customers. According to ME M1, "*adults [are] more appreciating [of] the role and their expectations almost high level.*" One of the potential explanations to this view that older people have high expectations was found in the response by QM4, "*...elderly patients have more experience and knowledge about the quality of service provided to them.*" This means that many interviewees felt that older consumers of medical tourism services were likely to be more critical of the quality of medical tourism services than their younger counterparts.

The third emergent view about age was from the medical perspective. The responses in this category were mainly about response to treatment whereby younger people were viewed as having better response to treatment and older ones were seen as more vulnerable to illnesses. QM1 stated, *"younger patients can cope with treatment more than the elders and children. Again, they are physically and psychologically more ready to stand the treatment."* On the one hand, QM1s response might have been influenced by his background as a heart hospital administrator where youthful heart patients often record higher chances of recuperation and survival from heart procedures than elderly patients and children (Wilson, Baig, and Ashraf, 2005). On the other hand, his response may also suggest a preference for younger medical tourists, as they would have higher chances of coping with treatment and a better recovery rate and recovery rates are important in the marketing of the medical side of medical tourism.

This latter premise seems to have been corroborated by QM4 who stated that he preferred HMC to attract younger, athletic people as captured in the statement, *"I wish to attract young people with sport injures and patients require organ transplant."* Despite such explicitly stated preferences to treat younger people, it emerged that HMC already had a strategic plan that appreciated the need for segmentation of medical tourists (see Section 3.6.2.1 on segmentation) by age. Thus, the development of medical tourism may need to separate the complex and interrelated illnesses of old age from the more straightforward one issue treatments of younger patients to ensure optimal attention and care for each segment. In any case, the elderly might feel more comfortable being attended to in a facility with other elderly people than in a mixed setting. Consider the following response by QM5:

> *"With sickness [it] is not sign [of] age. However, [as…] age is increasing, different needs [increase]. This is part of plan you need to be ready for different level of service, different need of age group and so on. It is there, it is all in the strategic plan."*

While it is important that this has been included in the strategic plan, this response by QM5 raises the question of why no other interviewee mentioned it. This may be a potentially

significant gap because the strategic plan was not the first thing that came to the interviewees' minds when they were asked about strategic issues such as target customers, which is also in the HMC strategic plan. It is also possible that they were conversant with the HMC strategic plan, but they could not link it to medical tourism. Either way, these two perspectives could mean difficulties for HMC to meet its expectations for medical tourism, as stipulated in its strategic plan and in line with the QNV.

IM8 also raised the issue of a segmentation approach by underscoring the attraction of differing types of elective care for different age groups:

> "*I would expect that it might be elective care for adults, which is more likely to be area to attract patients… elective paediatric possibly could be an area of attraction [given] that the significant course of that care is going to be outside of HMC.*"

With this response, it seems that IM8 would be more inclined to support HMC developing adult based medical tourism over child based. In addition, the provision of elective care at HMC seems to be priority considering the response by IF1 to the prompt on the ways in which medical tourism should be delivered effectively by HMC that "*single, elective procedures are the most likely to work well.*". Essentially, the responses indicate a general inclination towards targeting younger adults with single-issue patient needs for the international medical tourism market and offering a different package type to those from neighbouring countries with ongoing complex issues.

6.6.1.2 Gender

The interview results showed that gender is a significant role player in the way Qataris might treat medical tourists or expect them to be treated. This is because of the conservative, patriarchal nature of the Qatari culture, as demonstrated in the following response by IF3:

> "*[Gender is] significant since Qatar is a conservative country. For instance, …husbands are not allowed to be with their spouses during the delivery, contrary to the common practices elsewhere.*"

From the interview results, it was evident that the views that Qataris hold about gender are likely to influence the type of medical tourism which could be offered. Altogether, offering a service that is fully staffed by expats is another potential solution. This is because some respondents felt that perceptions related to gender are subjective (IM8) with HMC considering it important to separate men from women during service delivery. As a result, *"HMC provides and organizes services for males and females"* separately (QM3) despite planning and organizing services for both male and female patients (QM2). Granted that even hospitals in the West have separate facilities such as wards for males and females, it is important to mention that Qatar's approach is more restrictive. At times, female patients -particularly Muslim, Qatari women - will even refuse treatment if they are assigned male physicians.

In this regard, there were views that patients' decision-making will be affected by their gender. IF1 asserted that gender *"affects decision making abilities of some individuals; some decisions are delegated to other members of the family."* While the interviewees did not mention it explicitly, decisions for female Qatari nationals will be made by either a man or the eldest member of the family. This is because a man is normally perceived and expected to be stronger than the woman. This is likely to be the case with medical tourists from the GCC and Arab countries whose cultural orientation is similar to Qatar's. In the context of this research, two interviewee responses illustrate this perception of masculine strength.

ME M1 stated, *"male tends to be more accepting and accommodating than females with certain restrictions from females' side."* This subjective, almost-sexist perception was also manifested in a response related to medical treatment. According to QM1, *"Physiologically, psychologically and emotionally men are stronger. They can stand and bear the treatment process through the journey more than woman."* This prejudiced view could also be interpreted as a potential indication that physicians may also prefer to treat male patients rather than female

– perhaps because they believe that the success rate will be better and a high success rate is one of the factors people look at when choosing a medical facility.

It is worth noting that this perception towards women is not unique to Qatar as it has been identified in the Chinese context (Spencer, 2003; Garrod and Fyall, 2011), as shown at section 3.4.4. Since many women who live in the West are aware of this patriarchal bias, it may also suggest that Western women are unlikely to choose elective surgery in an environment they perceive to be unequal. Nonetheless, the success of medical tourism at HMC will be determined by how well female and male clients feel they are treated in terms of both care and service delivery. It also suggests that it may be easier to develop medical tourism for male clients rather than female ones especially initially although most spa and wellness medical tourists are women (Han and Hyun, 2014). Although there are already many spas in Qatar there is need to consider the development of wellness tourism in this regard without thinking through the whole process such as how welcoming Qatar is to female customers. Section 3.4.1.1 showed that gender identity is a remarkable component of the Wellness Tourism Wheel Model (Witmer and Sweeney, 1992).

6.6.1.3 Religion

The interviewees reinforced the importance of religion in terms of medical and service perspectives. The dominant medical perspective was that religion affects how well individuals respond to treatment and his or her health behaviour. According to IF1, religion in Qatar "*is significantly important and influences health behaviour more than in other parts of the world.*" The relationship between treatment and religion also manifested from a spiritual perspective whereby "*in any health care plan the individual spiritual needs must be considered as part of the care plan*" (QM4). This means that integration of religious matters in treatment was considered by several interviewees to be an essential element of treatment as demonstrated in the following response:

"Spirituality provides support through the treatment journey; it helps patients to move from sickness to wellbeing. It counts for a great percentage of the healing process. It helps patients understand the meaning of life. Patients with chronic medical conditions in particular (i.e. cancer, terminally ill …) need prayers and other religious practices to help them cope with their illness" (QM1).

From the responses above, it is clear that many Qatari and non-Qatari interviewees considered spirituality, faith, and religion to be one and the same thing. It appeared that they considered their responses from an Islamic perspective with Islam being the dominant religion in Qatar. Altogether, one does not have to be Muslim to have faith in recovering or even be spiritual. For chronically ill patients, spirituality, prayers, and other religious practices are portrayed as means for helping medical tourists in this category to cope with their illnesses, as QM1 mentions. However, two interviewees (IM9 and QM5) did not consider religion to be influential over all medical tourists. This observation was derived from the response indicating that, although religion is a significant influencer of customer expectations or experiences, its significance overall is dependent on the target market for medical tourism, as shown below:

"Religion would play a significant role, depending on the target market. For instance, if medical tourism would target GCC or other neighbouring countries, then it would be less of a problem since most of these countries share a common culture" (IF3).

This reflects a point discussed in Section 3.3.3, that the nascent medical tourism industry in the Gulf States has, to date, been targeting only its nationals and customers from within the Gulf Region (UNWTO Commission for the Middle East, 2014).

6.6.2 Coping Strategies to Respond to Cultural Differences

Even though the current orientation of medical services in Qatar is towards a Gulf-centred customer approach, which could imply focus on local/regional medical tourism, it emerged that HMC has a number of strategies to deal with the challenge of meeting diverse cultural needs. IM2 confirmed this in his response to how HMC copes with different cultures:

"We [HMC] are trying to develop Culturally Competent Employee: It has been suggested that one of the reasons culture becomes salient during a service encounter is because customer and service employee from different cultures have different understandings regarding the interaction process and different styles of dialogue."

The concept of a culturally competent employee has been discussed in the healthcare sector. Rittle (2015) identifies five factors of culturally competent healthcare workers from the works of Cross *et al*., (1989) and Leishman (2004). These include value for diversity, development of cultural self-assessment capacity, inter-culture interaction consciousness, institutionalisation of cultural knowledge and development of service delivery adaptations which reflects an understanding of cultural diversity. Understanding cultural influence on customer experiences and expectations is beneficial to the development of high levels of service quality in the provision of medical tourism services. Indeed, the literature in section 3.6.1 underscores the relevance of cultural influence on customer expectations and experience of quality of service in a healthcare setting. One strategy identified to cater for the range of needs of culturally diverse medical tourists was that HMC provides a wide range of foreign and local meals (QM1; QM5; QM6; IM6) and provides "*enough spaces for religion*" (QM2). However, IM3 admitted that coping with multiple cultures was challenging for HMC:

> "*In HMC, the challenge is pronounced as we have both a multi-cultural patient population as well as staff... which can occasionally lead to inadvertent conflict if cultural differences aren't recognised and catered for.*"

This was likely to be an ongoing issue if there was an increase in international tourists seeking medical tourism in Qatar and a resulting increase in expat HMC staff. Yet, IM10 expressed confidence in HMC's capability to "*provide an inter-continental [international] experience due to its diverse workforce and facilities.*" Such capabilities are critical for the successful implementation of medical tourism.

6.7 Conclusion

The results discussed in this chapter showed Qatar would need to make significant legal amendments to pave the way for the introduction of a more robust healthcare management system that allows HMC to conduct for-profit business. Such amendments are to be holistic as to cover other sectors that complement medical tourism such as visa processing regulations,

which would allow for shorter visa issuance times. The results also showed that that there are significant concerns among the employees about the organisational capacity of HMC to deliver high quality medical tourism services. The major organisational capacity issues identified were in terms of the lack of a standardised and adequately robust financial accounting system capable of handling billing and insurance documentation arising from the medical and nonmedical services involved in efficient medical tourism. However, most interviewees mentioned that the development of robust organisational capacity in Qatar was underway for both insurance and billing systems.

The results with respect to the (potential) impact of introducing medical tourism in Qatar showed that the main perceived benefit was about status, image and reputation of Qatar as an internationally reputable healthcare and medical tourism services provider globally. This explained the rationale for the pride expressed by most interviewees in HMC being JCI accredited and ensuring that the accreditation remains. Revenue generation was also cited as another important positive impact of introducing medical tourism in Qatar as the increased number of services available would both reduce the number of Qataris seeking medical attention abroad and increase the number of high paying clients.

The findings related to current customer experiences at the HMC revealed significant gaps that require addressing for medical tourism to be effective in Qatar. One of the most significant challenges was handling system pressure that culminated in long waits for customers in terms of receiving appointments due to infrastructural capacity challenges, including inadequate parking and accommodation facilities. It was confirmed that the new facilities at HMC were superior to the older ones in terms of handling these issues. The newer facilities also had features which were better suited for medical tourism services such as private rooms and state-of-the-art medical technology facilities. The results also showed that the interviewees were conversant with the significance of quality customer interactions with staff

although they acknowledged the need for improvements in this regard. However, it was notable that that very few interviewees mentioned any medical procedures which they considered to be particularly suitable for medical tourism in Qatar. This underscored the need for better understanding of what medical tourism entails, but it also signals one of the challenges that Qatar has to overcome to ensure successful implementation of medical tourism. Similarly, the results showed very little awareness of partners and partnership packages that HMC needs to develop or enter into to enhance its capacity to deliver medical tourism. Notably, the only focus when partnership packages were mentioned related to cost and hospitality services with no mention of other enabling packages such as travel packages.

The findings showed three categories of hospitality and medical tourism services. The first category pertained to quality hospitality services, which was also shown to include hospitableness. Private rooms, quality and quantity food and beverages and adequate parking facilities were shown to be critical components of this category. Concerning other general services, ease and speed of accessing services emerged as the most sought-after services by customers/patients at HMC. However, the most striking revelation in this research was the belief by senior staff that current customers/patients cared more about receiving top quality, guest-like treatment and care. They took quality medical attention for granted because they are already receiving that. The implication of this for the development of medical tourism is that quality medical attention should surpass any other service delivery indicators or else it would be challenging to implement it successfully.

The role of culture in influencing medical tourism development at HMC in terms of customer experience and expectations of medical tourism and with respect to how HMC currently copes with cultural issues including diverse patient/customer cultures. The findings showed that culture is a significant influencer of customer expectations from the perspectives of age, religion, and gender. All three were found to be significant although it was also revealed

that HMC was making significant effort to deal with the challenges of multicultural medical tourists/patients. Nonetheless, this was still a significant challenge the subjective views of the conservative Qatari culture.

Another emergent trend in the findings was when HMC senior management discussed medical tourism per se they frequently alluding to two distinctive forms of medical tourism. The first kind was related to health tourism and comprises aspects such as conventional medical diagnosis and treatment procedures. The second form was elective wellness tourism which includes aspects such as spa experiences and is more leisure based than medical.

Chapter Seven

Phase Three Results and Discussion: HMC Service Users

7.1 Introduction

The study involved a total of 350 HMC service users, people who either had been or were about to be patients of HMC plus to people who were visiting and or helping sick friends or family at HMC in Qatar: they were all HMC service users. The rationale for the choice of HMC service users is explained in section 4.4.2. The purpose of this study was to investigate how the services received by those seeking health care at HMC were rated and patients' perceptions of the potential for medical tourism in Qatar. The following sections include the demographic data for the HMC service users involved knowledge and awareness of medical tourism and the potential for developing medical tourism in Qatar. From the results shown in Figure 7.1 below, those who had experienced HMC as both patient and visitors were 196 followed by 118 who had experienced HMC as patients only. Only 35 respondents had experienced HMC as visitors only. Concerning the frequency of visiting HMC, 278 of the HMC service users had visited HMC more than twice, 43 had visited twice and 29 only once.

Figure 7.1. *How HMC service users visited the country and the frequency of visits*
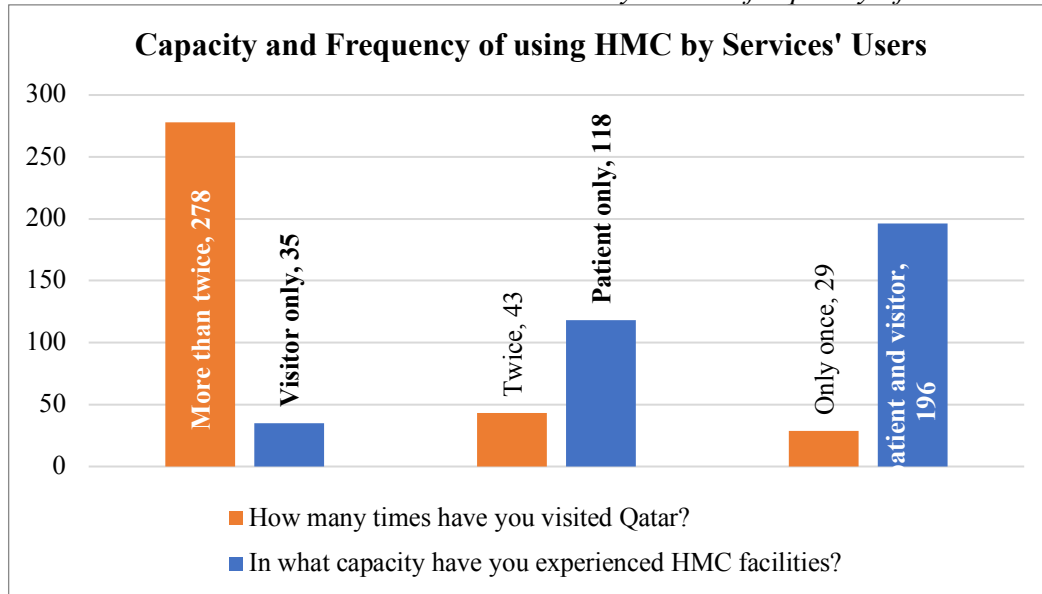
7.2 Demographic Data

7.2.1 Age

The respondents' age was categorized into eight age brackets following the standard statistical age ranges used by Qatari government data collection. From the respondents age distribution, as illustrated in Figure 7.2.1, most of those involved in the study were young and middle-aged adults, although there were respondents from the elderly population. While this does not necessarily reflect the general profile of those seeking or using medical care in Qatar, it reflects the general population in Qatar by age group (cf. population statistics by Ministry of Development Planning and Statistics, 2016). Therefore, there is a likelihood that the results of this study were biased by age in the sense that they may have reflected the views of the younger and middle-aged population more strongly than those of the elderly population who tend to use health services more than these two groups. However, the literature reviewed in section 3.6.2.1 regarding age as a behavioural influencer of medical tourism consumption (for example, Alsharif, Labonté, and Lu, 2010; Lunt and Carrera, 2010; Gan and Frederick, 2011) revealed the likelihood of younger populations being more inclined to engage in medical tourism compared to their older counterparts. More specifically, these age groups reflect the work of

Alsharif, Labonté, and Lu (2010) who found that most medical tourists preferring the UAE were aged between 36 and 45 years.

Figure 7.2.1. *Age distribution of respondents*
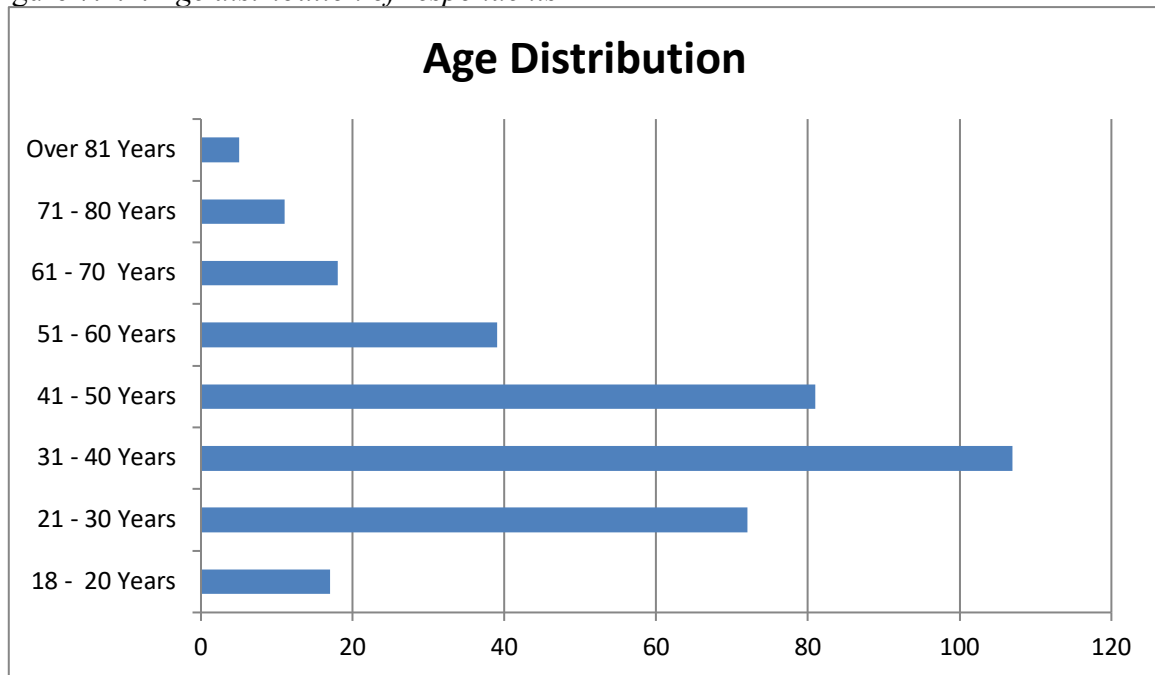
7.2.2 Gender

  In terms of gender, slightly more females, totalling 184 (52.8%), were involved in the study while 166 males participated. One reason for this could be that it is females in Qatar who most frequently accompany and or visit their children or relations in hospital settings. For example, the existence of women's hospitals and dedicated paediatric wings would mean that women are more often accompanying other women or their children than men (Dhami and Sheikh, 2008). The other explanation for the higher number of female respondents with experience HMC in Qatar relates to the extent to which females are more comfortable undergoing some elective procedures than men (Klein *et al.,* (2017), as reviewed in section 3.6.2.2).

7.2.3 Nationality

  Most of the HMC service users were non-Qataris by origin at 228 (65.1%) while those from Qatar were 122 (34.9%), as illustrated in Figure 7.2.3 below.

Figure 7.2.3. *Nationalities of the users of HMC's medical services*
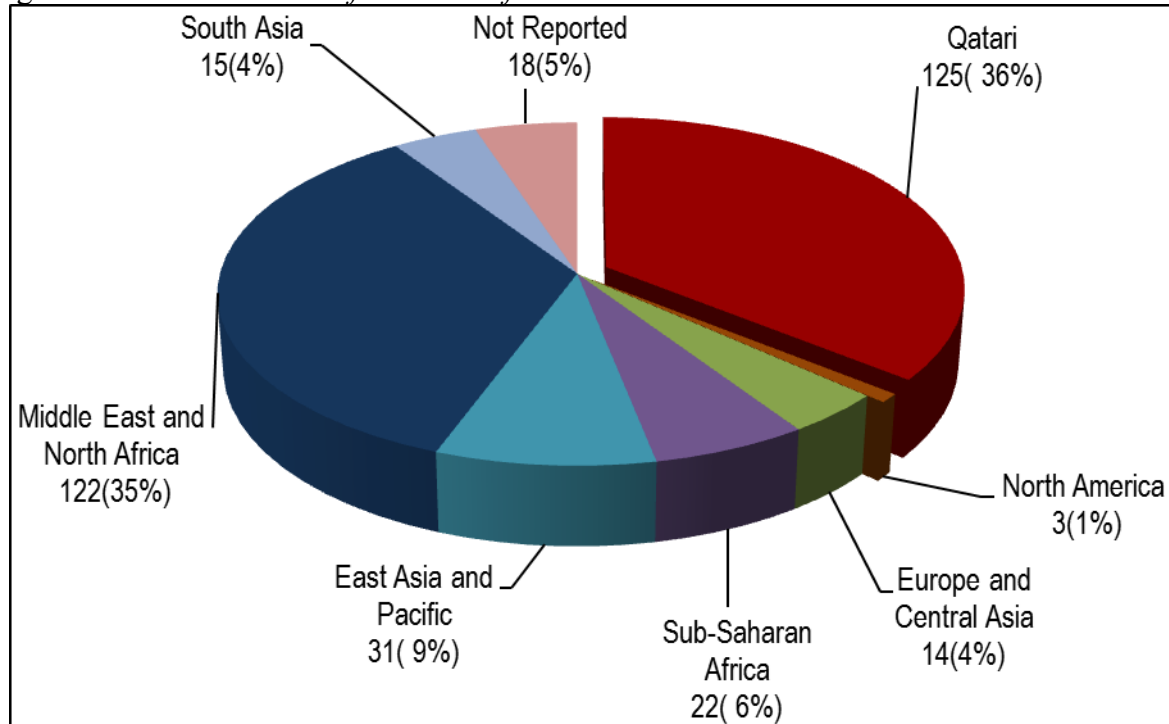
Interestingly, this reflects a similar trend in the nationalities manifested in the interview results with the senior management officials at HMC, (see chapter six) where more of the providers of medical services in Qatar were non-Qataris than Qataris. The questionnaire asked those not from Qatar to identify their nationality by name. Part of the reasons for the high proportion of non-Qataris is the proximity some of these countries to Qatar. A further, related, reason is the high unemployment levels in many of those countries which causes their citizens to migrate not only to Qatar but to all GCC countries as well (see section 3.3.3). As previously discussed, while many expats are unskilled there are also a large number of highly skilled expats from other counties working in areas such as the petrochemical industries some of whom live in Qatar with their families.

Previous literature suggests a relationship between geographical closeness and medical tourism movement from a country to another (see section 3.3.3). Therefore, it can be expected that many medical tourism customers visiting Qatar will be from the neighbouring countries inasmuch as the target is to establish Qatar as a preferred medical tourism destination globally.

As it is, there exists a low-profile type of local medical tourism between GCC countries and Qatar and this could be developed further. However, as demonstrated in section 3.6.1, it is noteworthy that the compatibility of the Arab cultures and the Islamic religious practices in these countries to those of Qatar may also be influential determinants for the high prevalence of expats from these countries. This compatibility in cultural values and practices could be useful in promoting more locally targeted medical tourism service delivery since the literature identifies the importance of the influence of cultural orientations on the perceptions of medical tourists (Hopkins, Nie, and Hopkins, 2009), see section 3.6.1. Altogether, it is unlikely that the medical tourism packages designed for medical tourists from the GCC countries would include the leisure elements of a conventional tourism package.

7.2.4 Education

The education background of the HMC service users participating in this research was also evaluated given that level of education is a considerable factor influencing heath perception, health care services uptake and the ability to seek quality health care services (see section 3.6.2.3). Most of the HMC service users taking part in this study, apart from just 19 (5.4%), had a formal education. Those with graduate degree comprised 158 (45.1%) while those with high school education were 125 (35.7%). The highest academic qualification, post graduates, were 39 (11.1%). The complete data about the education levels of the HMC service users is as presented in Figure 7.2.4 below.

Figure 7.2.4. *Highest education level of users of HMC's medical services*
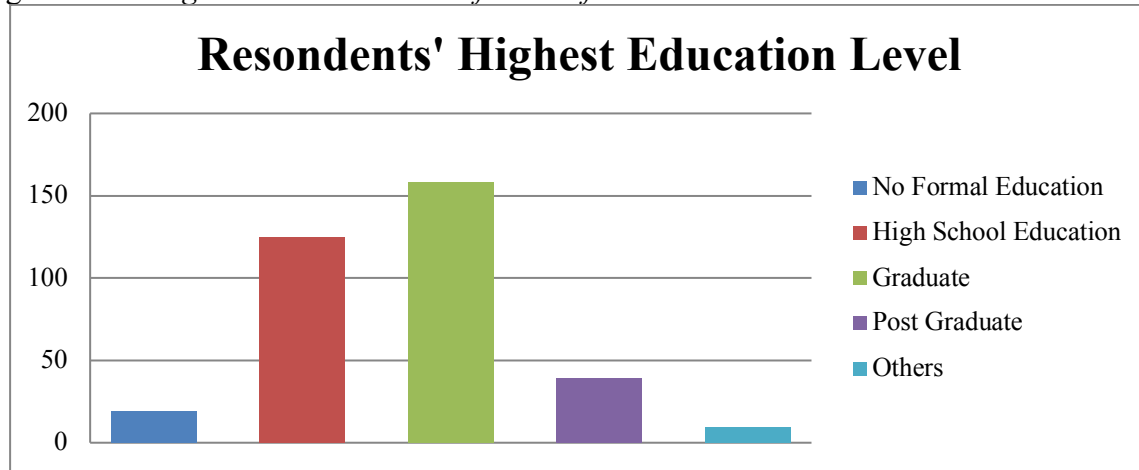
The literature reviewed in section 3.6.2.3 shows that education levels are critical influencers of health consciousness and awareness of consumer rights (Naidu, 2009) from the medical tourist's perspective and that education enables or inhibits favourable medical tourism perceptions. Considering the statistics presented in section 2.1.1 that there is a significantly higher number of non-Qataris accounting for up to 88.4% of Qatar's population, Figure 7.2.4 above would imply that the expats in Qatar also include learned individuals even though they are normally hired for unskilled labour regardless of their education levels.

7.2.5 Occupation

In terms of occupation, 85 respondents (24.3%) who were the majority worked in public sector while 83 (23.7%) respondents were working in the private sector. There was a higher-than-expected population of 54 (15.4%) HMC service users who were housewives, which can be explained by the fact that most users were females. Altogether, the cultural and religious orientation of Qatar is such that the woman is normally expected to be the caretaker of the family. Of the respondents, 11 (3.1%) were self-employed while 18 (5.1%) were students, 45 (12.9%) were professionals, and 32 (9.1%) were retired. These results are illustrated further at Figure 7.2.5 below.

Figure 7.2.5. *Occupation of users of HMC's medical services*
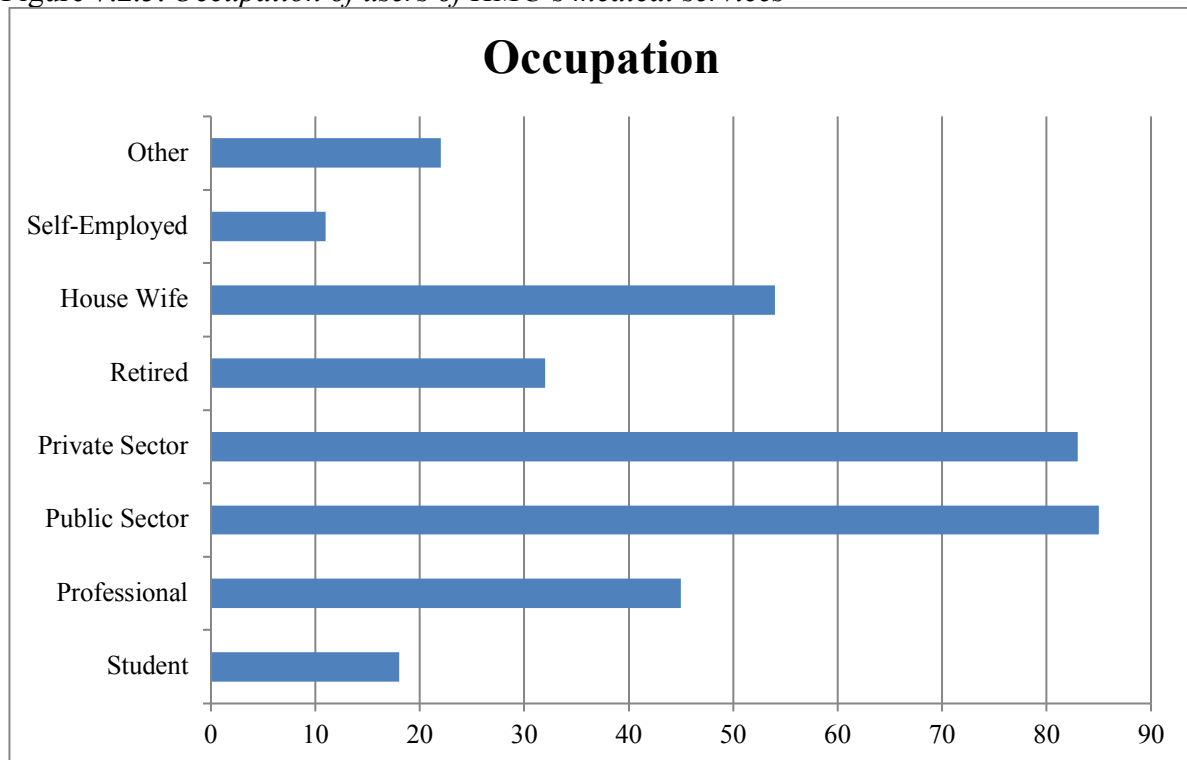
Despite these results, it is impractical for occupation and nationality to influence age, for example. Thus, the researcher believes that age, nationality, and education influence the occupation of a respondent. Although based on the same rationale it would appear as though nationality could not influence gender or the other way around, the fact that there were more non-Qataris in the study than Qataris means it is a possibility. This is because most expats are often hired for low-skilled or unskilled labour regardless of their education levels while Qataris have jobs that are considered to be more skilled and better paying in line with the Qatarisation ideologies presented in the QNV 2030 (see section 2.1.3). Such low-skilled or unskilled labour is usually hired for manual jobs where Qatari employers tend to higher more male than female expatriates.

The central role of occupation in influencing perceptions towards service experiences was also established further although literature in section 3.6.2.4 would imply that such influence is highly dependent on the income level of an individual. Such influence may be direct or indirect based on these two sets of results and implicates other demographic traits by

extension. For example, the fact that occupation influences perceptions towards service experiences and age has a positive relationship with occupation means that age is also an indirect, influential trait of the perceptions towards service experiences. Similarly, gender cannot also be dismissed in totality as an influencer of perceptions towards service experiences because it relates with nationality, which is a significant influencer of perceptions towards service experiences negatively. In other words, the influence of one demographic trait has the potential to cause ripple influence through another demographic trait.

7.3 Hamad Medical Corporation (HMC)

7.3.1 Acquisition of Knowledge About HMC

As illustrated in Table 7.3.1, most of the HMC service users i.e. 143 (40.9%) knew of HMC through family members. 106 (30.2%) had heard about the institution through local hospitals, 105 (30%) through friends and 94 (26.7%) through health care referral. Only 49 (14%) knew about HMC through their website.

Figure 7.3.1. *How respondents came to know about HMC*
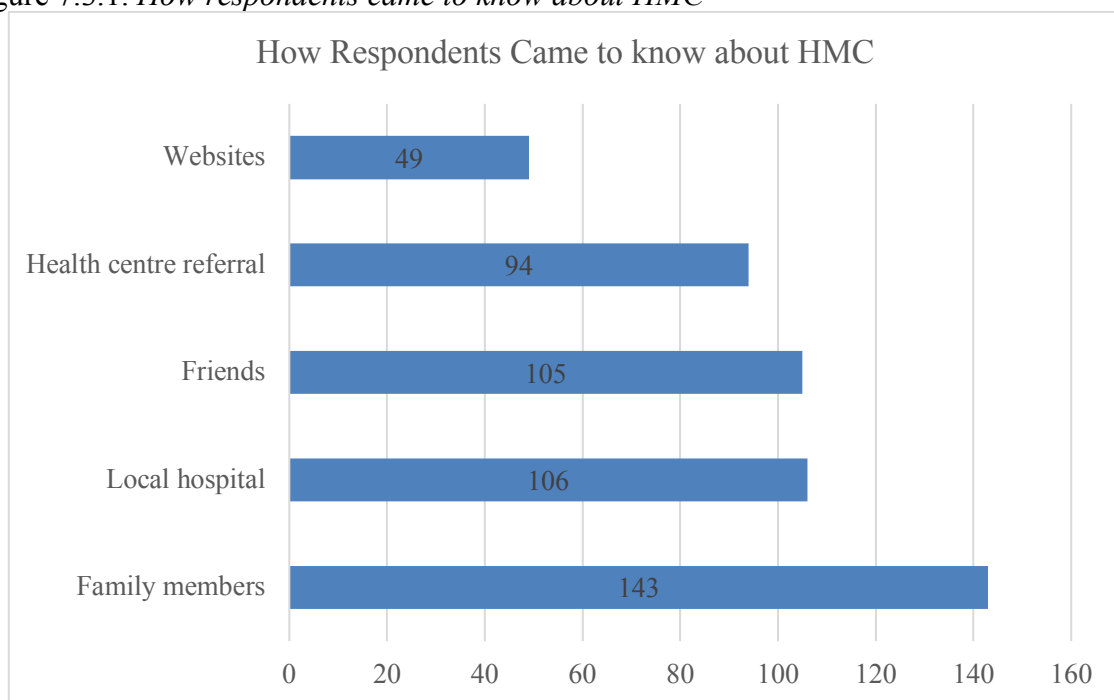
These results also show the significance of WOM for both those seeking healthcare and for those marketing HMC. This is because knowing about HMC through family members,

friends and health care referral are all forms of WOM. The literature (Chen, Dwyer, and Firth, 2014; Jeuring, 2016) reviewed in section 3.6.2.6 portrays WOM as a critical component for the development of tourism in general and medical tourism specifically even as multiple stakeholders including destination markets and host communities remain crucial.

7.3.2 Main reasons why HMC was chosen as the medical service provider

The survey explored the main reasons for the HMC service users choosing HMC for treatment. The main factors include facilities (152, 43.4%), expertise of physicians (143, 40.9%) and quality of health care service (122, 34.9%). Table 7.3.2 below illustrates the frequencies and the percentage of the total selections made.

Figure 7.3.2. *The main reasons for choosing HMC for treatment*
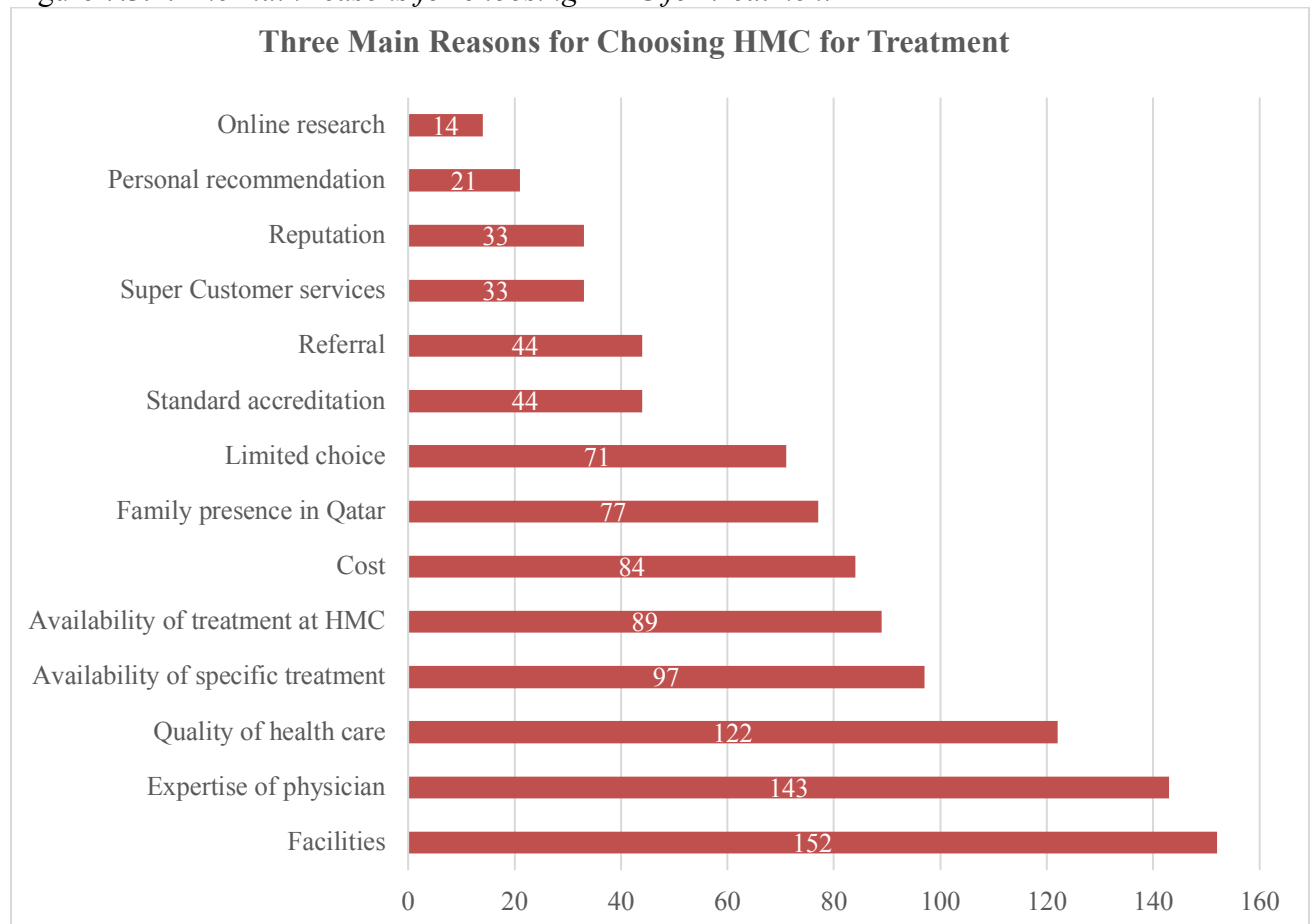
Although the prompt was about the choice of HMC for treatment, it is interesting that the HMC service users ranked facilities, which is not a nonmedical factor per se, together with two other medical factors of expertise of physician and quality of health care. This is consistent

with the findings presented in section 6.4, senior management results. However, it is important to mention that the survey did not enquire about whether the facilities were medical (like treatment equipment, technology, and so on) or nonmedical facilities (such as car parking, ward infrastructure, beds, etc.). Even though the HMC service users were HMC service users, the inclusion of facilities as a critical determinant for seeking treatment at HMC tallies with the notion of providing health facilities (medical equipment and infrastructure) as a critical component of medical tourism (Lunt and Carrera, 2010). This is also an indication that the investments made towards improving health facilities at Hamad General Hospital and HMC were important in positively influencing the perceptions of customers/patients towards seeking treatment at HMC (Ventures Onsite, 2015).

At a surface level, these results may be interpreted as a reflection that Qatari residents (both Qataris and non-Qataris) consider facilities to be nearly as important an influencer of their choice as the expertise of the physician and even more important than quality of healthcare. However, reflection back to phases one and two (see chapters 5 and 6) would suggest that this is an incorrect interpretation of the data. This is because the results obtained from interviews with the officials from the Ministry of Finance, the Ministry of Public Health and the Tourism Authority in Qatar and senior management officials suggested that the people of Qatar consider quality medical services to be a given. Utilising this perspective, it is possible that the ranking of facilities indicates that HMC service users value it for the advanced facilities it already has. These results are consistent with literature presented in section 3.12 where facilities such as physically attractive waiting rooms have been shown to influence the perceptions of patients positively in a significant way (Arneill and Devlin, 2002; Becker *et al.,* 2008).

The ranking of these top three criteria suggest that purely medical plus supportive nonmedical aspects of medical tourism are a critical combination for holistic medical tourism offering of a

high-quality medical service. It also reflects the results of second phase of the qualitative results with senior management officials at HMC who commented on the significance of combining aspects of medical services (including advanced treatment approaches and medical expertise) with those of nonmedical facets (such as private rooms and good food), as shown at sections 6.2 and 6.5. Indeed, both phases one and two suggested that there was need for constant improvement of medical facilities, number of physicians and continued provision of quality healthcare services to ensure success of medical tourism in Qatar. These results, therefore, complement the two sets of qualitative results in this regard.

7.3.3 Evaluation of HMC Medical and Non-Medical Staff

The HMC service users were asked to comment on the interpersonal skills of both the medical and non-medical front line staffs at HMC. In total, 201 HMC service users (57.4%) responded positively and said the medical staff were friendly while those who considered non-medical staff as friendly were 206 (58.9%). Medical staff were considered as helpful by 194 respondents (55.4%) or welcoming by 168 respondents (48%) as compared to the statistic for non-medical staff which were 174 (49.7%) for helpful and 183 (52.3%) for welcoming. Figures 7.3.3a and 7.3.3b below illustrate these results.

Figure 7.3.3a. *Medical Staff Services and Performance (percentages indicate weight toward performance rating)*
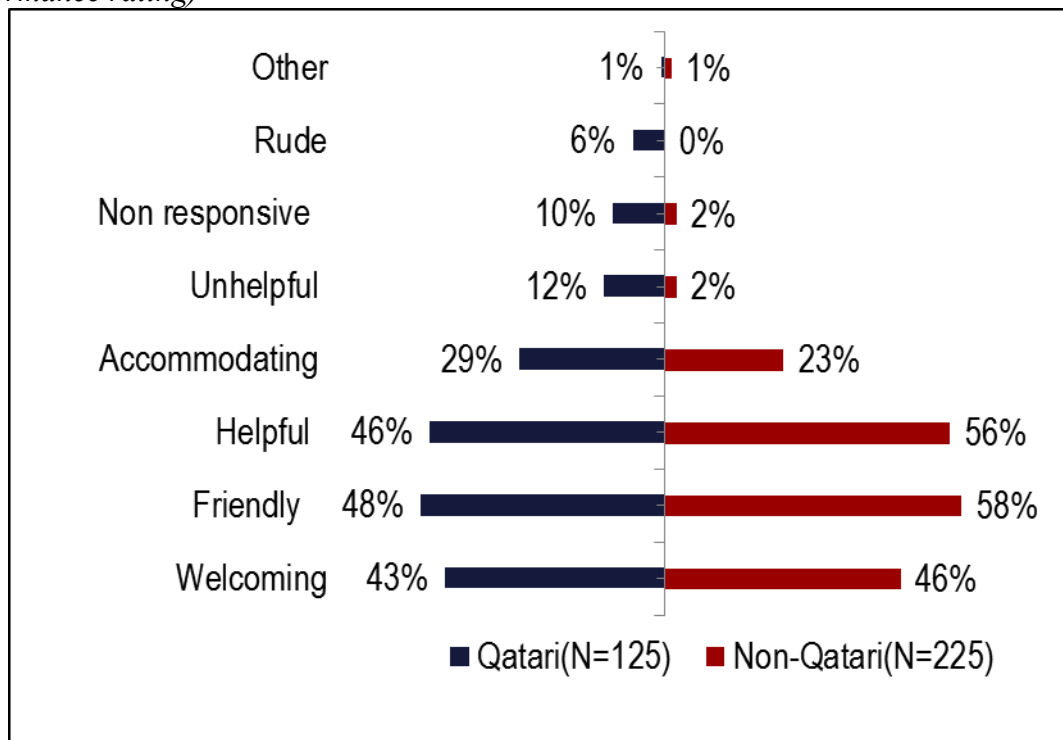
Figure 7.3.3b. *Non- medical staff services and performance (percentages indicate weight toward performance rating)*
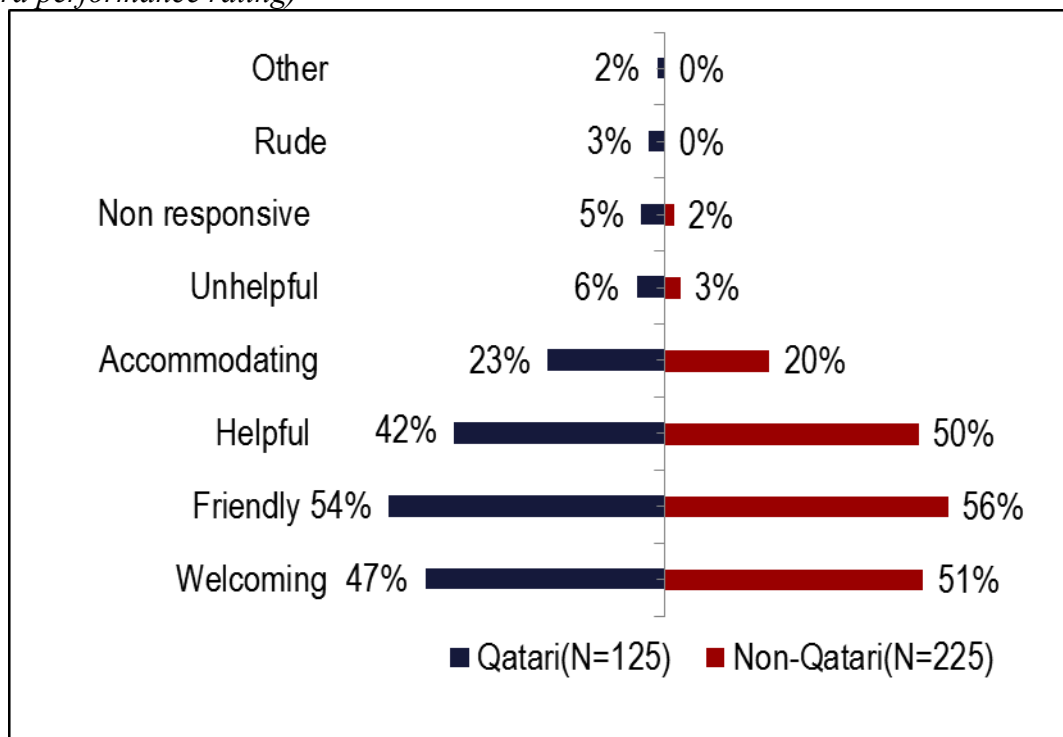
In both cases, more non-Qataris rated the medical and nonmedical staff higher than Qataris on the same metrics except for the trait of being accommodative in both cases of

medical and nonmedical staff. This trend is also notable for the negative ratings of where the percentage of Qataris who thought that medical and nonmedical staff were unhelpful, rude, and nonresponsive was higher than that of non-Qataris who thought the same. The fact that non-Qataris consider medical staff and nonmedical staff to be performing better than the Qataris raise three issues.

First, although the results relate specifically to HMC, this is an indication that Qataris feel that there is a gap in terms of service performance by both medical and nonmedical staff. Literature about the service delivery gap of the service quality extended model by Parasuraman *et al.,* (1985), as reviewed as section 3.10.2 identifies inconsistencies in performance by staff on service delivery as a significant contributor to perceptions of poor service delivery. This could suggest that the Qataris in this study felt that there were inconsistencies in service performance by both medical and nonmedical staff at HMC despite their overall service performance being good. Alternatively, it could simply be because Qataris expect the availability of high-quality medical services whenever they want them. Thus, they tend to be more critical of a provider like HMC who does not meet each of their needs such as provision of adequate car parking space.

Second, the comparatively better evaluation of nonmedical and medical staff service performance by non-Qataris could be an outcome of comparatively poor medical and nonmedical staff service performance in their home countries or countries of origin considering literature in section 3.2 since in Qatar they are assured of access to superior quality medical service whether they pay for it in full or partially while residing in Qatar. If this is the case, this could be an indication that HMC is likely to attract medical tourists from where these non-Qataris originate because of the perceived superiority in medical and nonmedical service delivery. Although the findings reported here are based on the views of the HMC service users, this argument is supported in literature about the definition of medical tourism in section 3.2,

which shows that it entails patients moving from their home countries to pursue advanced cross-border care (Johnson *et al.,* 2010). Thus, the views of the expats about the superiority of medical services in Qatar could form a basis from which to build perceptions of the quality of medical care in Qatar. This view is further supported by literature in section 3.3.4 about the significant investments in development of the healthcare sector in Qatar to raise it above most other countries that neighbour it and the results reported in section 7.2.3 that show that most non-Qataris came from Libya, India, Sudan, Pakistan, Bangladesh, Egypt, Palestine, Jordan, Syria, and Nepal. Phase two suggested that Saudi Arabia is Qatar's only competition in provision of quality healthcare service in the GCC.

Third, these results raise concerns about the support of the host communities towards medical service provision if their perceptions of service performance by medical and nonmedical staff are unfavourable. This is because the medical services and staff provided by HMC were seen more positively by non-Qataris that the Qataris. It may be that such Qataris are more likely to be critical/suspicious of the efforts of the medical and nonmedical staffs in delivering medical tourism at HMC than they are likely to be supportive because they are accustomed to high quality medical services and anything that falls short of their high expectations is met with sharp criticism. Yet, the support and positive perception of local host communities are critical to ensuring the successful implementation of both tourism in general and medical tourism (Gursoy, Jurowski, and Uysal, 2002; Mowforth, 2008; Simpson, 2008), see section 3.11.3.

In addition, the Qatari HMC service users who have negative perceptions towards the level and quality of medical and nonmedical staff are likely to engage in negative WOM about medical and nonmedical staffs at HMC. Considering the results presented in section 7.3.1 on the crucial role played by WOM and eWOM in notifying people about HMC, their negative perceptions about the performance of medical and nonmedical staffs at HMC is a critical

concern. This is because it could influence the perceptions of other potential users/customers who have not yet experienced the medical and nonmedical services of HMC.

7.3.4 Evaluating the Services provided at HMC

As illustrated in Figure 7.3.4 below, most of the HMC service users recorded a positive attitude towards and description of HMC. The majority of the HMC service users strongly agreed, agreed, or slightly agreed with the argument that HMC maintains high standards of hygiene and cleanliness, observes confidentiality and professionalism, offers high quality treatment and uses valid and effective technology in their treatment. The findings on the cleanliness and hygiene tally with those of the second phase, where IM6 (section 6.4) mentioned that HMC has been striving to deliver quality medical services within a clean environment. These results indicate that HMC performs well in these service delivery indicators, which signals the ability to perform well in delivering medical tourism services.

Figure 7.3.4. *Evaluation of services provided at HMC*
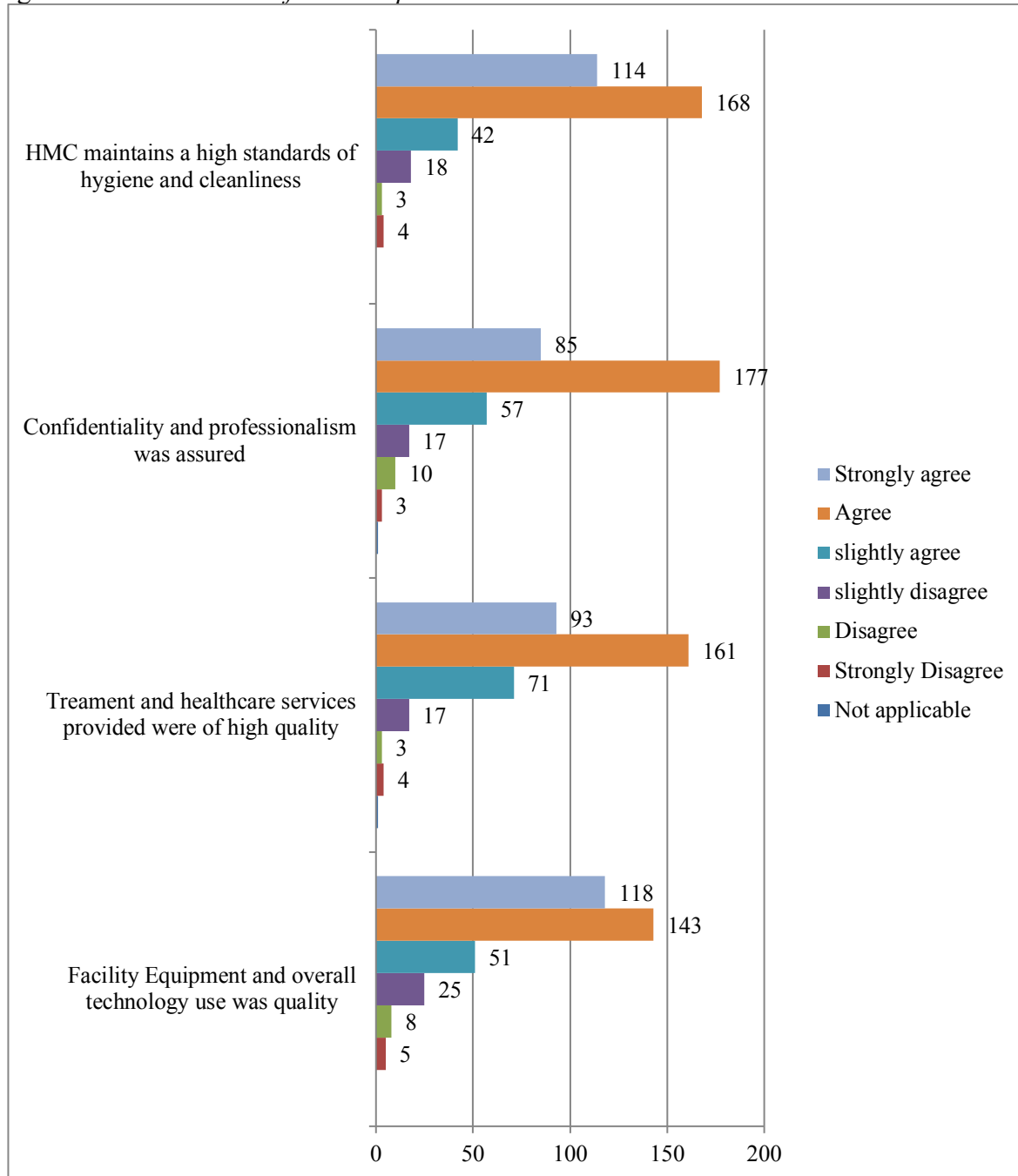
However, the results challenge the concerns raised by some of the respondents about the service performance of both medical and nonmedical staff. This discord is similar to the theorisation of the internal gap 2 of Frost and Kumar's (2000) model of internal service quality on expected service and perceived service although from the perspective of the respondents.

7.3.5 Rating Physical and Experiential Servicescape at HMC

When evaluating their physical surroundings, privacy, entertainment, Wi-Fi, noise, lighting and heating, most of the respondents rated the services as satisfactory, good, very good and excellent. However, there were a high number of HMC service users who considered shared patient rooms, Wi-Fi and entertainment as poor (see Figure 7.3.5 below).

Figure 7.3.5. *Rating physical and experiential servicescape at HMC*
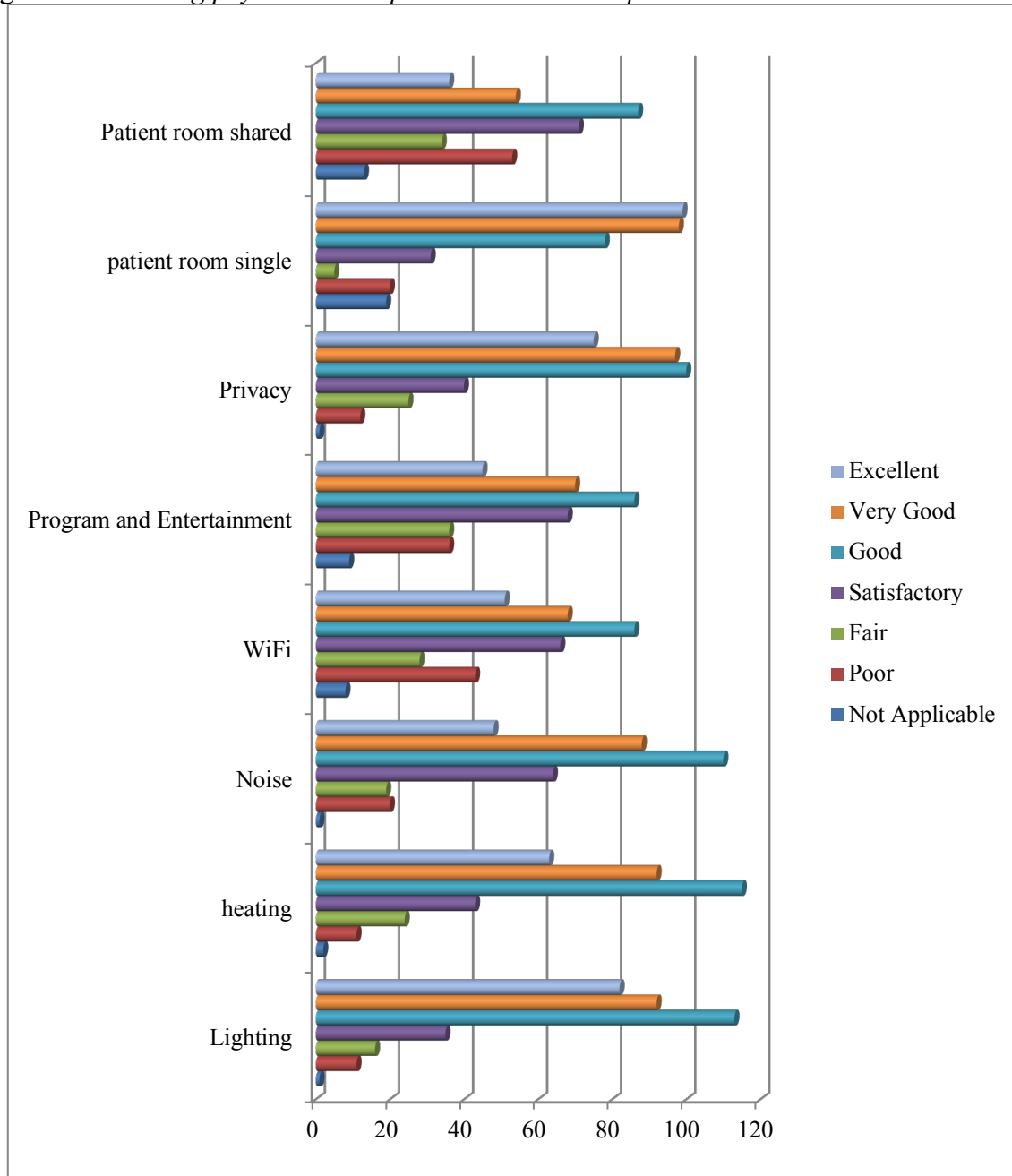
These results compliment those reported at section 7.3.2, which indicated that facilities in general are amongst the most influential factors when the respondents to this study chose HMC as their hospital. Moreover, these findings are also consistent with literature about the importance of the physical environment including room designs, lighting, and level of noise in promoting constructive or destructive developmental, psycho-social, medical and welfare consequences among patients, families and employees (Joseph, 2006, Gulwadi *et al.*, 2009; Joseph *et al.,* 2008; Sadler *et al.,* 2009; Ulrich *et al.,* 2008) as discussed in section 3.13. Such literature also underscores the significance of ensuring privacy of facilities such as single-patient rooms in the medical tourism environment.

7.3.6 Laundry services at HMC

Similarly, the laundry services such as bed comfort or linen changing were mainly positively rated as satisfactory, good, very good or excellent as illustrated in Figure 7.3.6 below.

Figure 7.3.6. *Evaluation of laundry services at HMC*
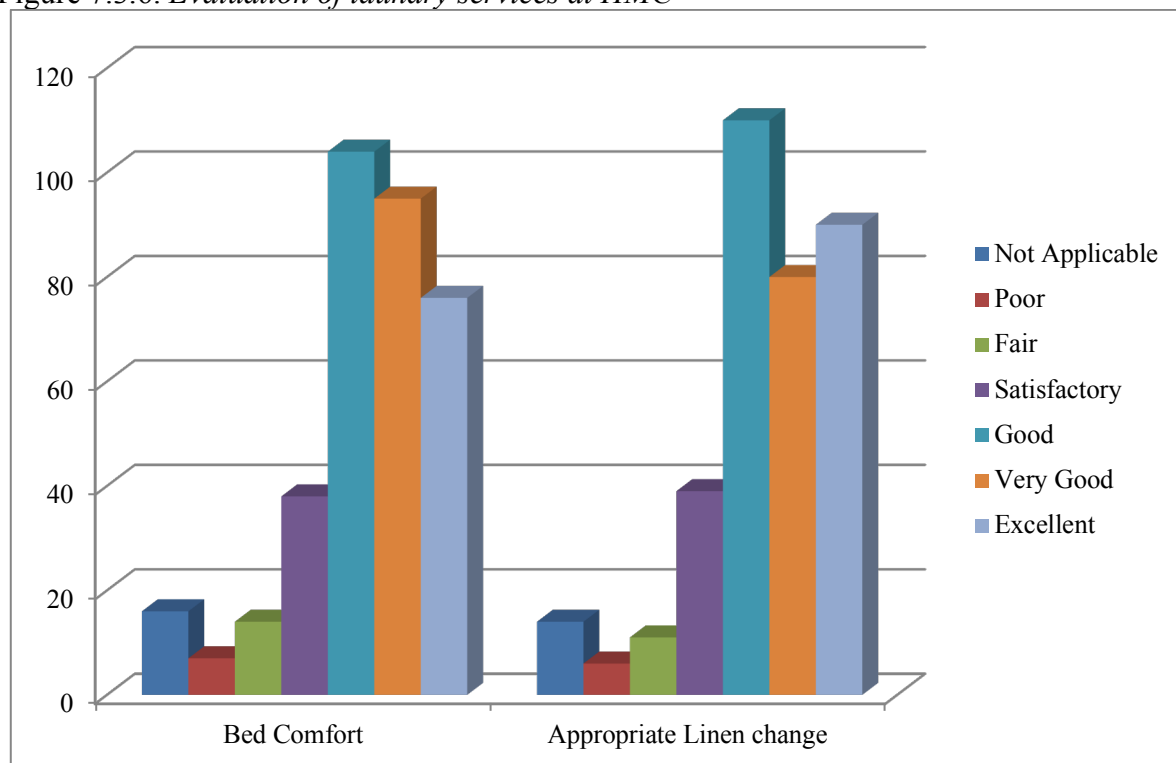
These results support the results presented at section 7.3.4 about HMC maintaining high standards of hygiene. However, the results in this section are more specific in the sense that they show the exact constituents of hygiene that the respondents considered essential in the maintenance of hygiene by HMC. Although literature only mentions comfort with respect to single-patient rooms and customer preference for luxurious suites (see Wu *et al.,* 2013 in section 3.13.2) which are much bigger, have additional sitting areas, bigger beds, couches and private, ultra-modern bathrooms, the results of this study in this section highlight that such expectations for comfort refer to specific aspects such as bed comfort and appropriate linen change. Of course, it is expected that luxurious suites, for example, are used by a customer segment, which can afford and is willing to pay for such services i.e. medical tourists. Therefore, HMC would need to make such bed comfort and appropriate, regular linen change a basic provision. One current facilities issue may be that HMC might not have as many luxurious suites as it has standard rooms considering that its current purpose to serve the Qatari public per se.

7.3.7 Catering Services at HMC

The respondents were also asked to rate and comment about the catering services at HMC since it was one of the criteria raised during medical tourism provision. Staff presentation and interaction with patients, quantity of food, quality of food and variety of menus were rated positively by most of the respondents. Figure 7.3.7 below illustrates the results about the rating of catering services at HMC by the HMC services users.

Figure 7.3.7. *Evaluation of catering services at HMC*
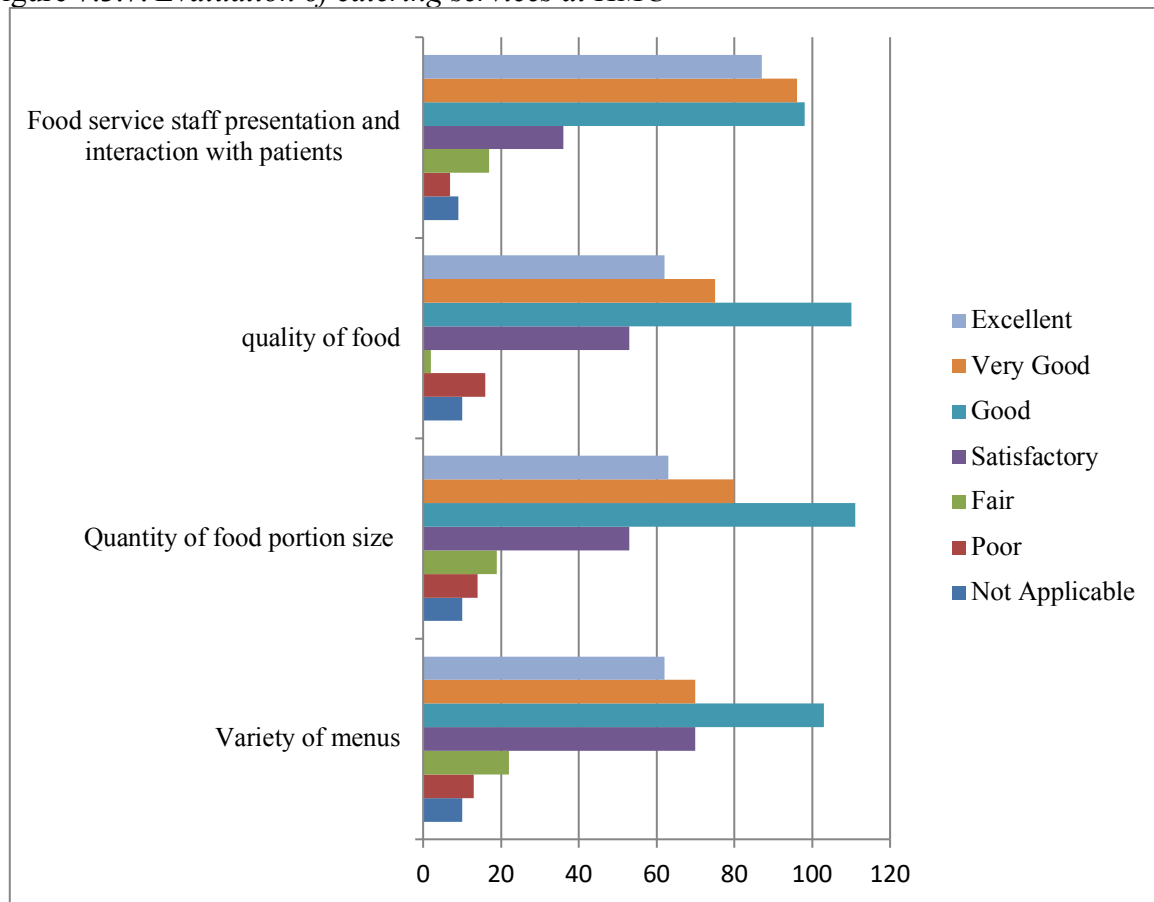
Approximately 90.6% (317) of the respondents thought that food service staff

presentation and interaction with patients was between satisfactory and excellent. Again, this

brings out the paradox between the results showing low ratings of service performance by

nonmedical staff as shown at section 7.3.3 and the high rating of some nonmedical staff like

food service staff in this. It would appear that the staff that the respondents understood to be

nonmedical in section 7.3.3 did not necessarily encompass all nonmedical staff. While previous

literature only alludes to medical and nonmedical service providers (see section 3.11.2), the

results presented in this section show that there are subgroups within the nonmedical staff

category, which respondents perceive differently. For example, the respondents might have

thought nonmedical staff the be those such as administrators and receptionists but not staff such

as cooks, food service staff and cleaners. This segmentation of nonmedical staff implies that

the managers and practitioners who are responsible for implementing medical tourism cannot

simply apply blanket measures to ensure quality delivery of services by nonmedical staff. Instead, the need to look into the contribution of each subgroup towards nonmedical quality service is important so that one subgroup does not underperform and end up affecting the perceived performance of another or even that of the entire nonmedical services' staff.

7.3.8 Access to Services at HMC

The admission process, securing appointments and waiting times had the most negative scores, although overall access to all services variables assessed recorded a positive attitude. Reception and discharge process were the variables rated most positively, as illustrated in the Figure 7.3.8 below.

Figure 7.3.8. *Ranking of access to services at HMC*
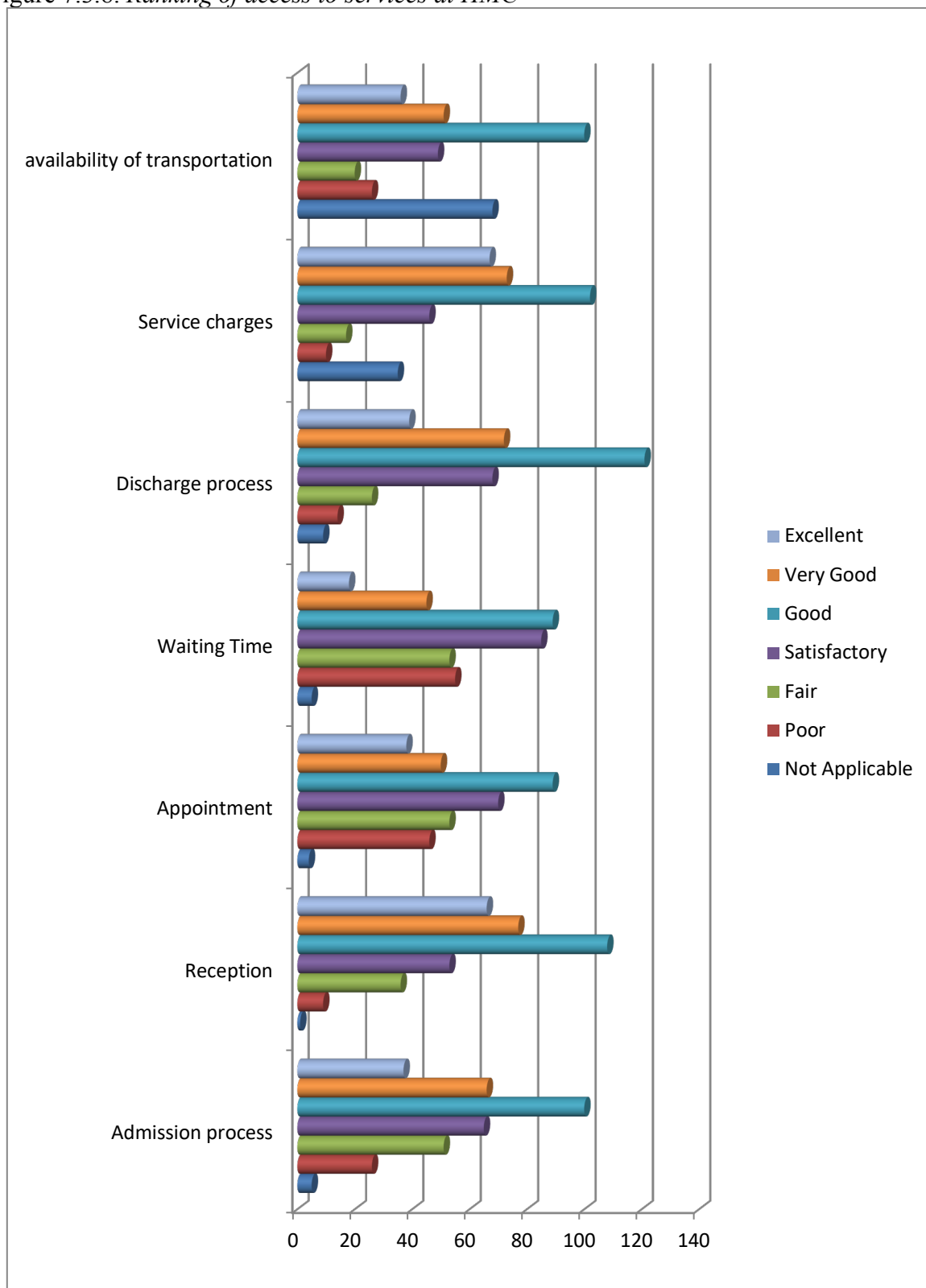
The negative scores of admission process, securing appointments and waiting times signal the need to ensure synergy between the nonmedical and medical services' delivery. This

is because while the face of these three processes is in the nonmedical administrative staff domain the actual cause of the problem may lie within that of the medical staff. For example, even if the administrative staff are able to process appointments sooner and reduce waiting times, their efficiency depends on the availability and schedule of the medical personnel. The complaint about long waiting times by the users of HMC's services matches the views of the senior managers, as discussed in section 6.4. However, all these three issues are more managerial and administrative than they are medical. For example, the length of time it would take to be admitted depends on the number of medical staff available to attend to the patient, availability of specialist facilities and the availability of rooms etc.

7.3.9 Overall Experience of Services at HMC

Most users of HMC medical services in Qatar rated the experience as good 105(30%), very good 99 (28.3%) and excellent 74 (21.1%). In total, 50 users of HMC medical services in Qatar (14.2%) rated the experience, as satisfactory and the combined rating for fair, poor and not applicable was 22 (6.3%). These results are illustrated in Figure 7.3.9 below.

Figure 7.3.9. *Overall experience of services at HMC*
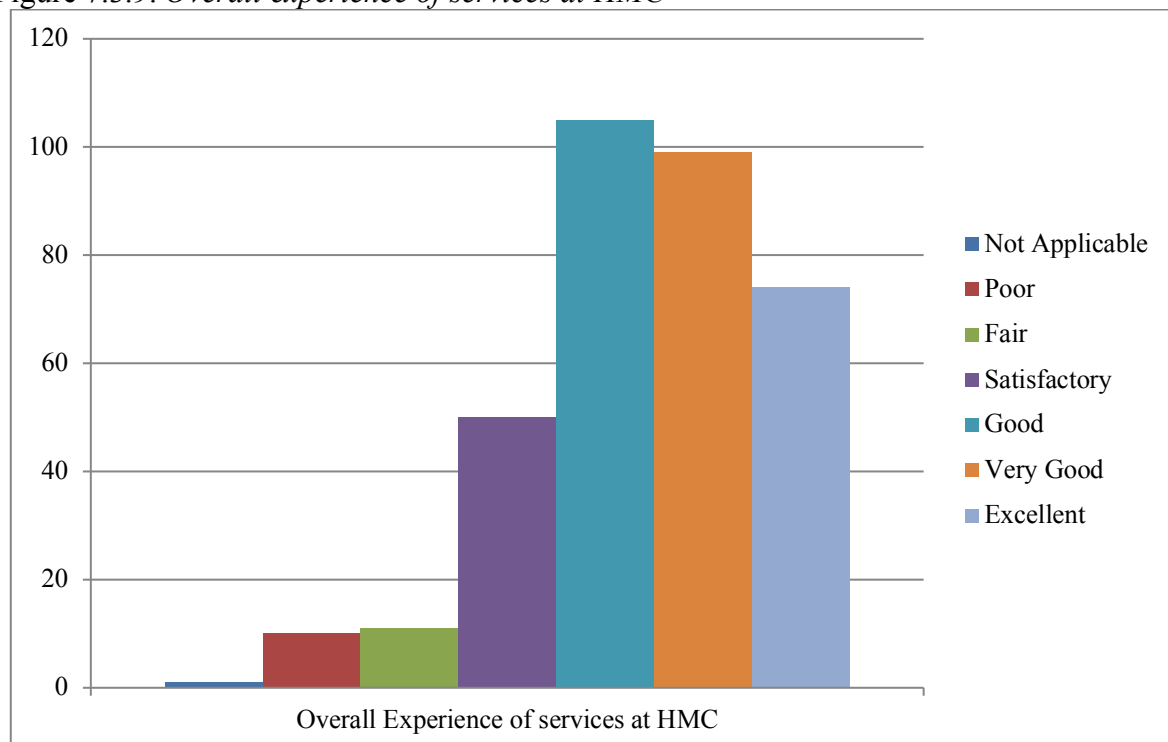
The results portrayed in Figure 7.3.9 above show that the vast majority of current patients and visitors were happy with the service provided by HMC although they may have had some specific issues as highlighted in the previous sections. In terms of medical tourism development in Qatar this suggests that medical tourists would be likely to be happy with the service provision at HMC. However, HMC alone would not be adequate to cater for largescale medical tourism. Thus, Qatar would need to ensure that service provision in other medical tourism facilities matches or even exceeds that which is available at HMC.

7.4 Meaning and Concept of Medical Tourism

One part of the survey had intended to establish the respondents view of HMC and the services it provides from the user perspective. The other part, discussed in this section, sought to probe establish their views on medical tourism.

7.4.1 Understanding of the Concept of Medical Tourism

As Figure 7.4.1 shows, 133 (38%) HMC service users considered medical tourism to be traveling to another country to receive medical treatments and participate in leisure activities (i.e. medical leisure such as spas, rehabilitation, relaxation). Another 102 (29.1%) considered medical tourism to be getting medical treatment and visiting new places. 69 (19.7%) believed that medical tourism was simply about seeking medical treatment in another country while 45 (12.9%) had no knowledge of what medical tourism meant. The data illustrates that most HMC service users had some knowledge of medical tourism, though most associated it with leisure rather than seeking essential medical treatment.

Figure 7.4.1. *Meaning of medical tourism to respondents*
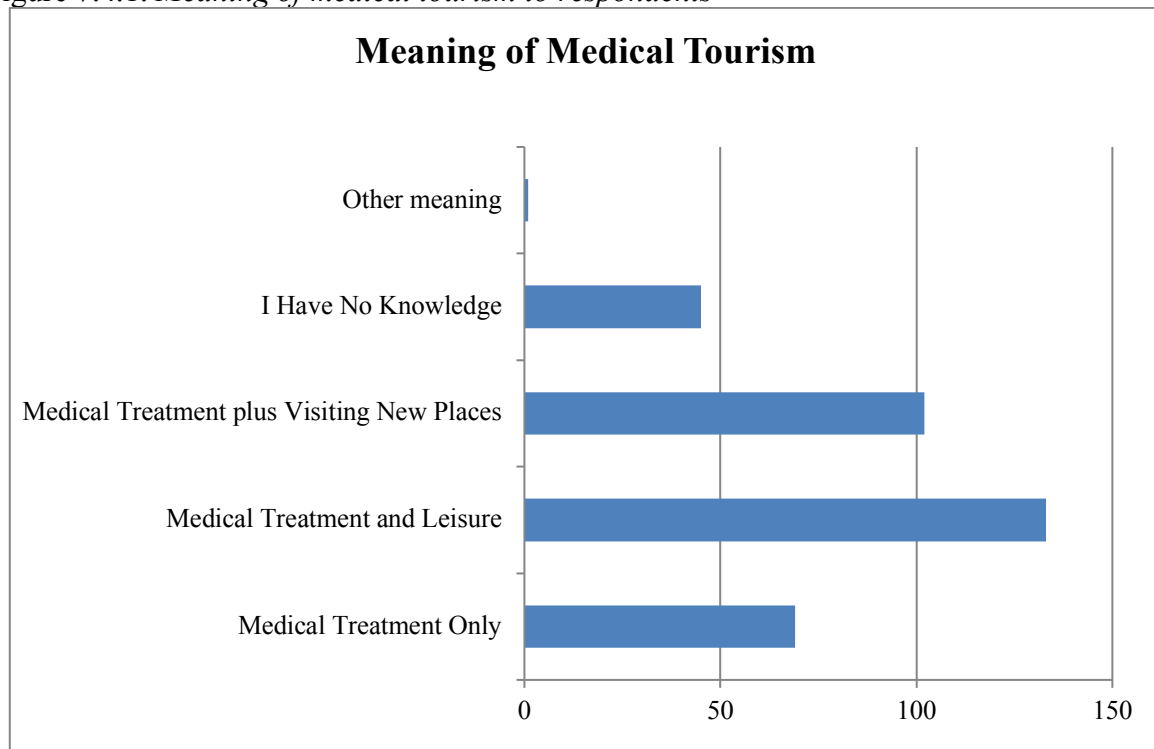
These results already indicate the possibility of two types of medical tourism. The first kind is health tourism whereby medical tourists travel to Qatar to get treatment for illnesses that they may have. The second is the elective wellness type of medical tourism where the medical tourist travels mainly for leisure purposes although s/he may also be seeking to undergo an elective procedure that does not necessarily have a medical imperative. An example of such elective procedures would be cosmetic or spa experiences. Pure medical health tourism seems more suitable for neighbouring countries while the elective wellness form best suits the more international medical tourists. This is because medical tourists from neighbouring countries are likely to pursue medical services and treatment than they would luxury in Qatar, which they are already able to access with ease.

7.4.2 Preferred companions if participating in Medical Tourism

It was considered important to know who people would choose to be accompanied by if participating in medical tourism in order to be able to identify the type of partnership packages required in the implementation of medical tourism in Qatar. Interestingly, 167

(47.7%) respondents considered a family member other than spouse as their choice of companion while 133 (38%) chose their spouse as their preferred person to accompany them. As illustrated in Figure 7.4.2 below, 25 (7.1%) indicated that they would consider a friend or no one to accompany them.

Figure 7.4.2. *Preferred companion for medical tourism package*
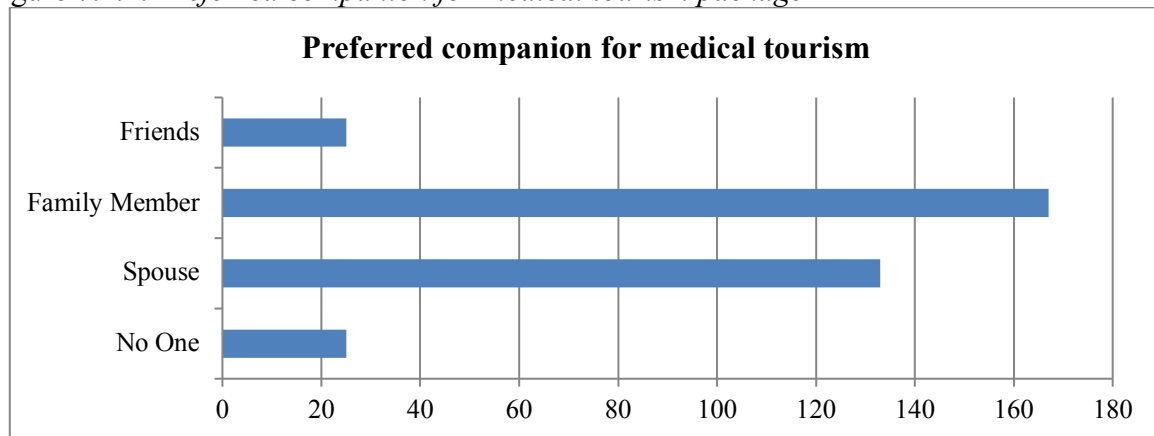
This confirms that Qatar would need to consider developing medical tourism packages that include family members and spouses as well as the medical tourist. This could translate to consideration for family accommodation facilities, for example, instead of private rooms only. This may necessitate the development of close working links with nearby hotels and accommodation facilities. This would especially be important for medical tourists originating from the neighbouring countries that have similar cultural and social orientations.

7.4.3 Medical Procedures Appropriate for Medical Tourism

The HMC service users were asked to identify the medical procedures and services they considered to be most appropriate for medical tourism. Medical tourism has been linked to consumers moving out of their countries of origin because the treatment required is either absent, too expensive or offered at low quality in the home country (see section 3.5) and cardiology, diagnostics or techniques for performing diagnosis, rehabilitation and orthopaedic are the most frequently identified procedures sought by medical tourists. Noting that

rehabilitation was cited by numerous respondents and that HMC is in the has already built a

new rehabilitation unit, this could constitute Qatar's medical tourism niche.

Figure 7.4.3. *Medical procedures considered most suitable for medical tourism*
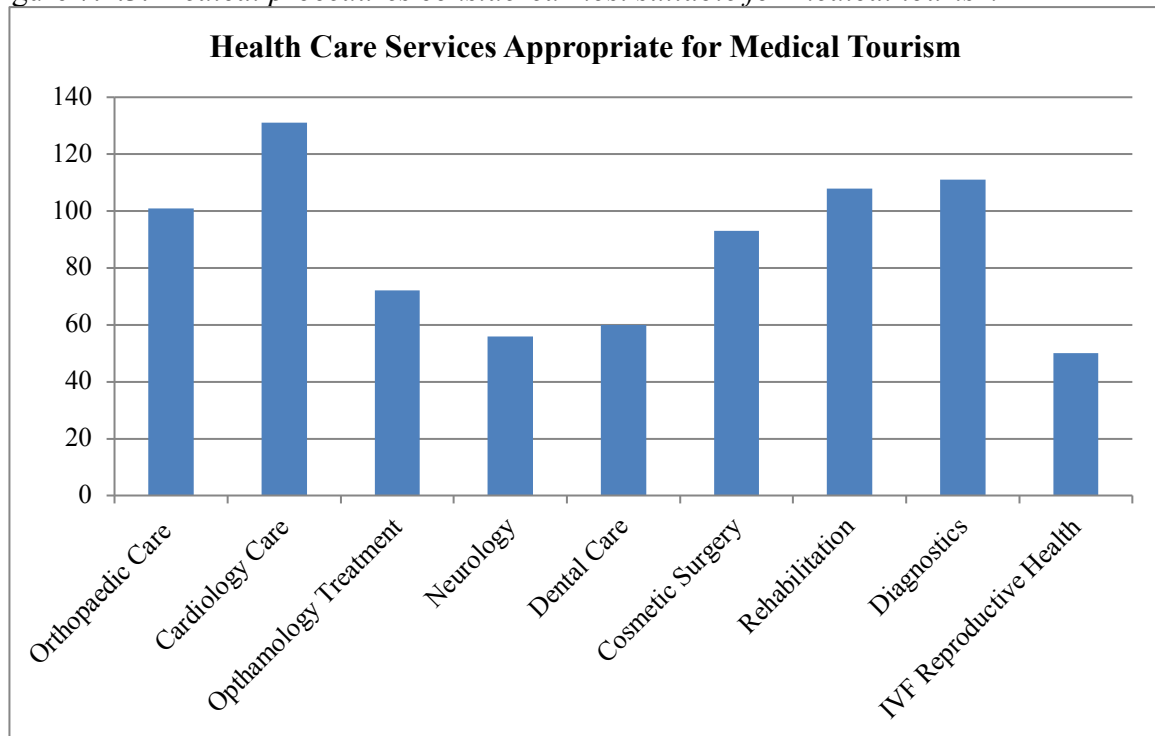
7.4.4 Reasons for Choosing Medical Tourism

The HMC service users were asked what their reasons would be if they were to

participate in medical tourism. As illustrated in Figure 7.4.4, high quality care the most

important followed by having a vacation and getting treatment. Time constraints in one's own

country affordable cost and exposure to new opportunities were also mentioned by many

respondents. Interestingly, exposure to new opportunities was not limited to medical tourism

opportunities. Instead, as demonstrated in section 3.6, it includes access to new networking

interactions, business opportunities and cultural and tourism experiences (Liu and Chen, 2013).

Figure 7.4.4. *Reasons for choosing medical tourism*
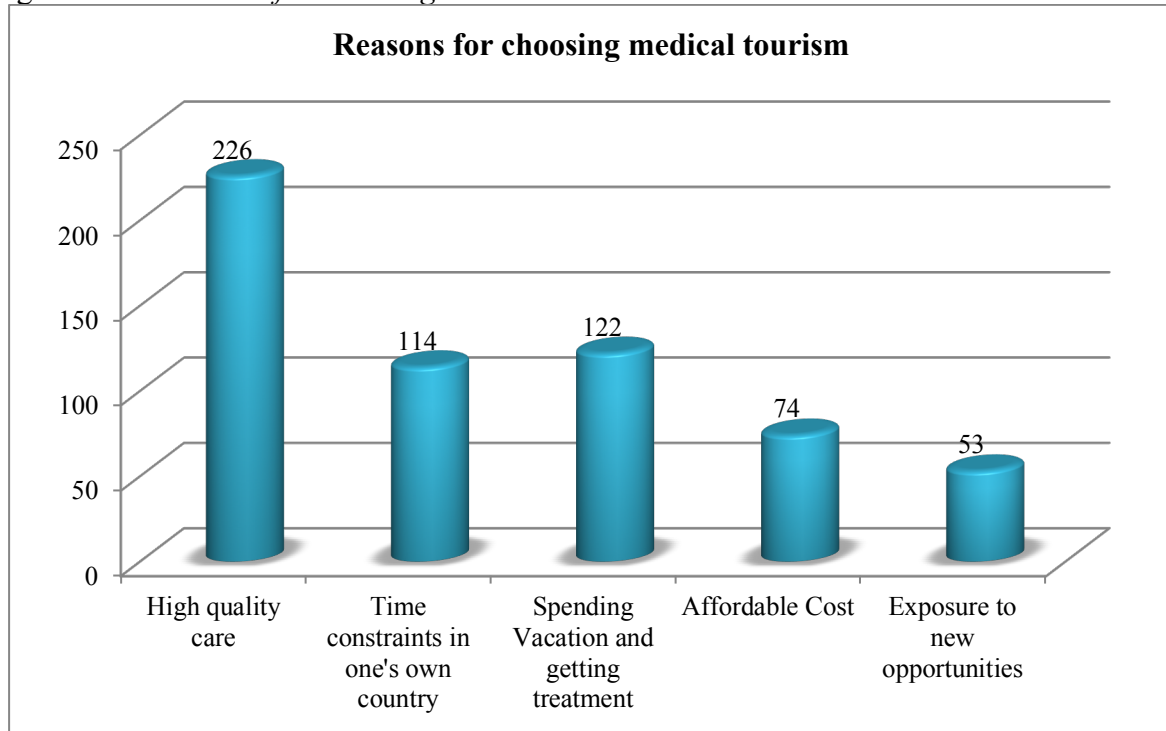
The ranking of high-quality care as the most cited, likely reason for choosing medical tourism if the HMC services' users were to choose shows that the huge government investments in healthcare in Qatar (see section 2.7) are worthwhile. The issue of time constraints being a potential influencer for choosing HMC insinuates speed of access to HMC services.

7.4.5 Potential Influencers in the Decision to Participate in Medical Tourism

The HMC service users were asked to indicate who they believed would influence them if they ever decided to participate in medical tourism. The two most important influencers were self and advice from a doctor with 187 respondents (53.4%) for each influencer. Other influencing forces included friends and relatives, websites, advertisement, medical tourism guide and medical tourism agency, as illustrated in Figure 7.4.5 below.

Figure 7.4.5. *Influencers of respondents' choice of medical tourism decision*

Influencers of Respondents' Choice of Medical Tourism Decision
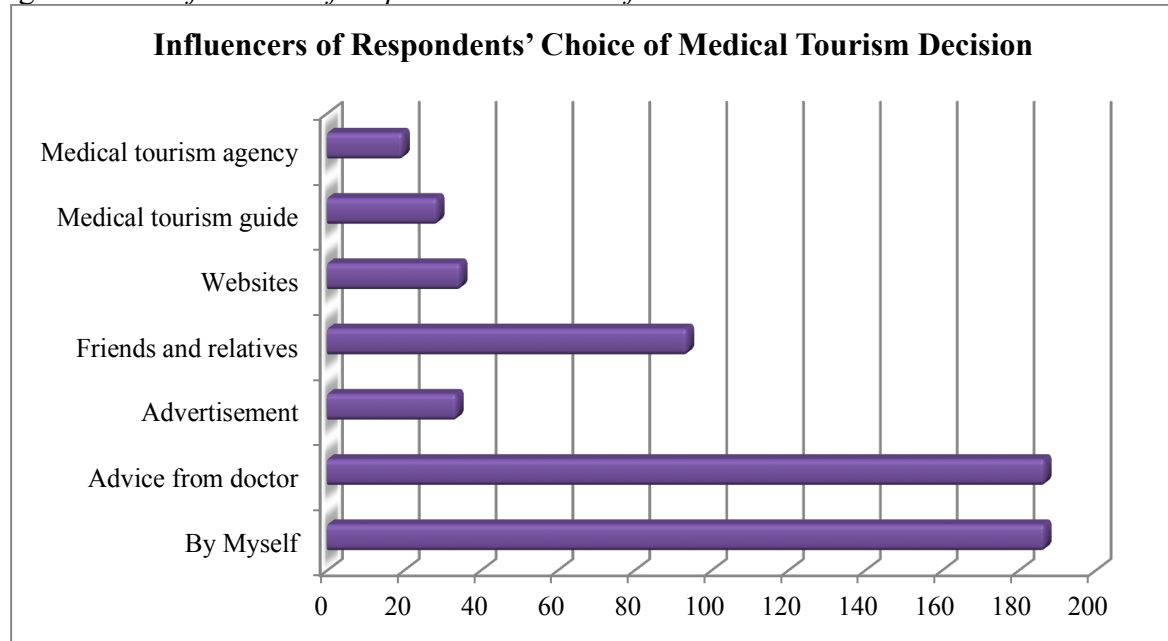
Although friends and relatives are considered important in spreading the word about HMC, the results in Figure 7.4.5 above show that the respondents would still make the final decisions about medical tourism by themselves or when advised by doctors. In other words, this shows that some influential factors are only influential to the extent of informing the service user as a decision-maker, but such factors do not have the same influence on the final decision made.

7.5 Developing Medical Tourism in Qatar

A total of 282 HMC service users (80.6%) had never participated in an elective procedure outside Qatar therefore, most HMC service users had no lived medical tourism experiences. However, they were asked what in their opinion would be the features that they felt could make Qatar an attractive destination for medical tourists. The rationale for the prompt was to establish the most important features of medical tourism and tourism in general in Qatar.

7.5.1 Qatar's Attraction Features for Medical Tourists

From a list of the most frequently cited reasons for choosing a particular medical tourism destination derived from previous literature (see sections 3.8 and 3.13) the HMC service users were allowed to choose more than one factor. Among the top factors considered

to be critical in attracting medical tourists and those accompanying them to Qatar safety and security topped the list with 61 Qatari respondents (76%) and 158 non-Qatari respondents (70%) choosing it. This was followed by hospitality, which was chosen by 56 Qataris (45%) and 124 non-Qataris (55%). Advanced medical facilities came third with 45 (36) Qataris and 70 (31%) non-Qataris, followed by culture with 38 (30%) Qataris and 79 (35%) non-Qataris. Other considerations in the Qatari/non-Qatari order were urban development with 31(25%)/81 (36%), nature with 25 (20%)/45 (20%), and other factors, which were the least favoured with only 3 (2%)/5 (2%) selecting it. These findings are illustrated in Figure 7.5.1 below. The difference between Qataris and non-Qataris' perceptions is illustrated so that the views of 'insiders' and 'outsiders' can be distinguished in order to demonstrate any potential variations between foreigners and locals, which may impact upon the implementation of medical tourism.

Figure 7.5.1. *Comparison of views of Qataris and non-Qataris about what would attract medical tourists to Qatar*
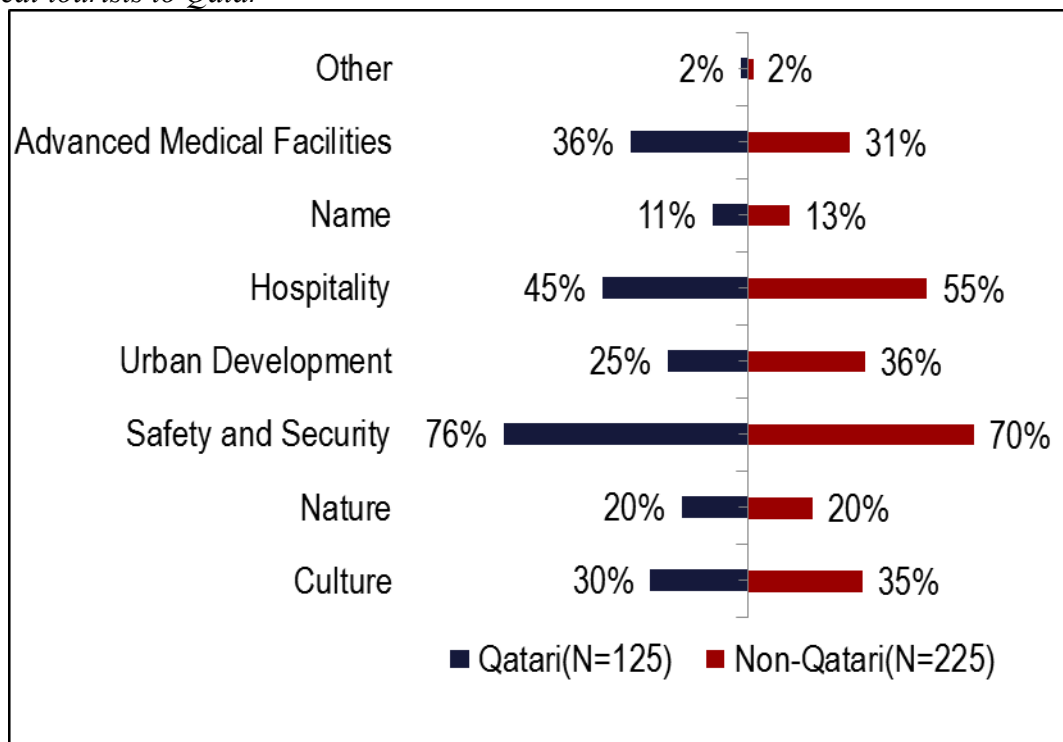
The importance given to safety and security is in line with literature concerning political instability or stability as a crucial component of the behavioural and demographic influencers of medical tourism consumption (section 3.6.2) where it is listed as one of the most significant

perceived risks (section 3.6.2.7) which influences the choice of a medical tourism destination (Carter, 1998: UNWTO Commission for the Middle East (2014). Similarly, the literature in section 3.12 shows that hospitality is a critical attraction for medical tourists because it creates the appeal of outstanding experiences and excellent service (Hemmington, 2007). These findings also reflect the literature in section 3.6.1, which identified culture as another important influencer of medical tourism choice.

7.5.2 The Potential for Qatar to Become a Popular Destination for Medical Tourism

The majority of respondents, 217 (62%), believed that Qatar has a real possibility of becoming a popular destination for medical tourism although 104 (29.7%) were not sure about it. Only 29 (8.3%) respondents disagreed that Qatar had the potential to become a popular medical destination for medical tourism. The reasons behind the potential for Qatar to become a popular medical tourism destination are illustrated in Figure 7.5.2 below.

Figure 7.5.2. *Reasons behind Qatar's potential to become a medical tourism destination*
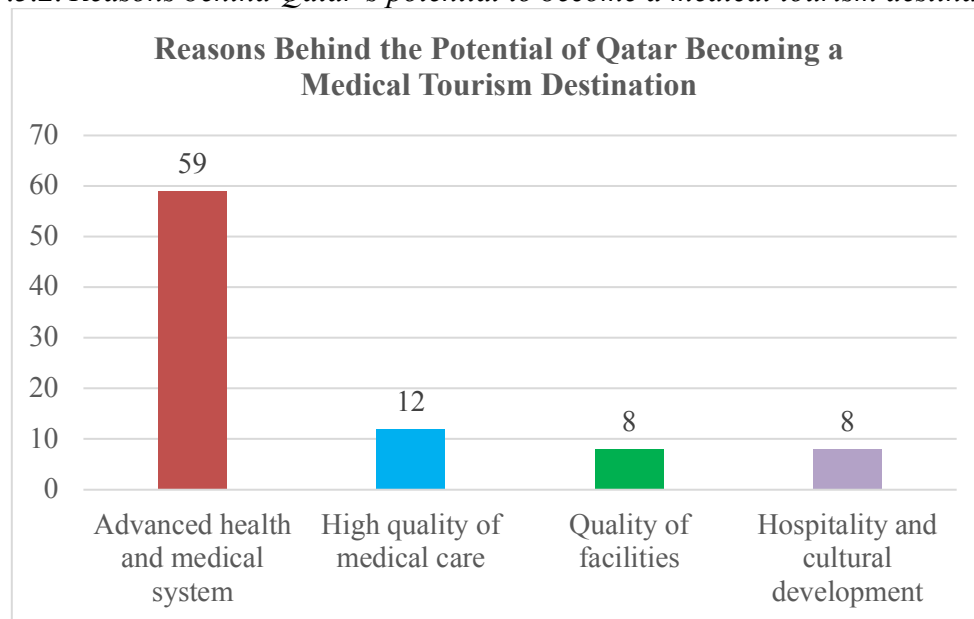
The most commonly cited reason for this potential was the current HMC advanced health and medical system according to 59 HMC service users (16.85%), high quality of medical care according to 12 HMC service users (3.43%), quality of facilities mentioned by 8 HMC service users (2.29%) and for hospitality and cultural development, which 8 HMC

service users (2.29%) mentioned. Of the 29 HMC service users who disputed the idea of Qatar

ever becoming a popular medical tourism destination long-waiting times for appointment at

HMC topped the list, were cited by 3 HMC service users (0.86%). These results, the views of

those who actually use medical services in Qatar, challenge the interview findings of the second

phase which indicated that managers were sceptical about the people of Qatar accepting

medical tourism.

7.5.2.1 Ease of Accessing Qatar

A large number of HMC medical services users, 84 (24%), strongly disagreed,

disagreed, slightly disagreed, or slightly agreed with the statement that the entry process to

Qatar was an easy one, as illustrated in Figure 7.5.2.1 below. This is a significant number of

respondents considering it translates to about one in every four respondents at best slightly

agreeing that the immigration process including visa granting is easy.

Figure 7.5.2.1. *Immigration policy and ease of accessing Qatar*
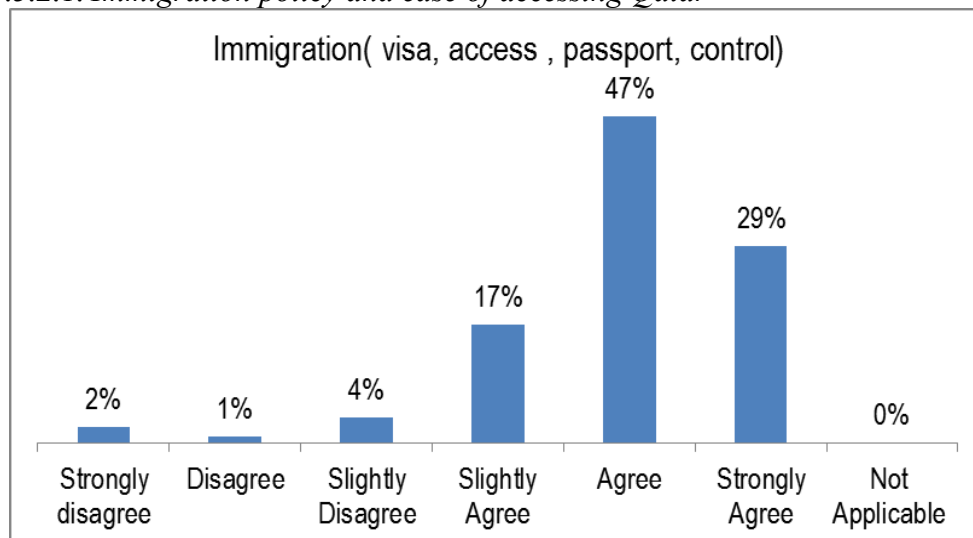
Regardless of Qatar offering quality healthcare (see section 7.5.3 below), this issue of

some of the respondents rating ease of accessing Qatar due to immigration policy reflects the

previously identified need for amendment in legislation that governs immigration so that it

makes it easier for medical tourists to access healthcare in Qatar, as reported in the findings of

the first and second interview phases with government officials and managers respectively. The

implication of this result is that there are nonmedical impediments, like the current immigration

laws which make it difficult to enter Qatar, which would be likely to affect the development of

medical tourism in Qatar negatively even if potential medical tourists considered it to be a good

destination.

7.5.3 The Quality of Healthcare in Qatar

More than half of the HMC service users agreed and strongly agreed that the health

care institutions in Qatar provide quality care and that these institutions could be considered

for medical tourism destinations (see Figures 7.5.3a and 7.5.3b below).

Figure 7.5.3a. *Evaluation of quality of healthcare in Qatar*
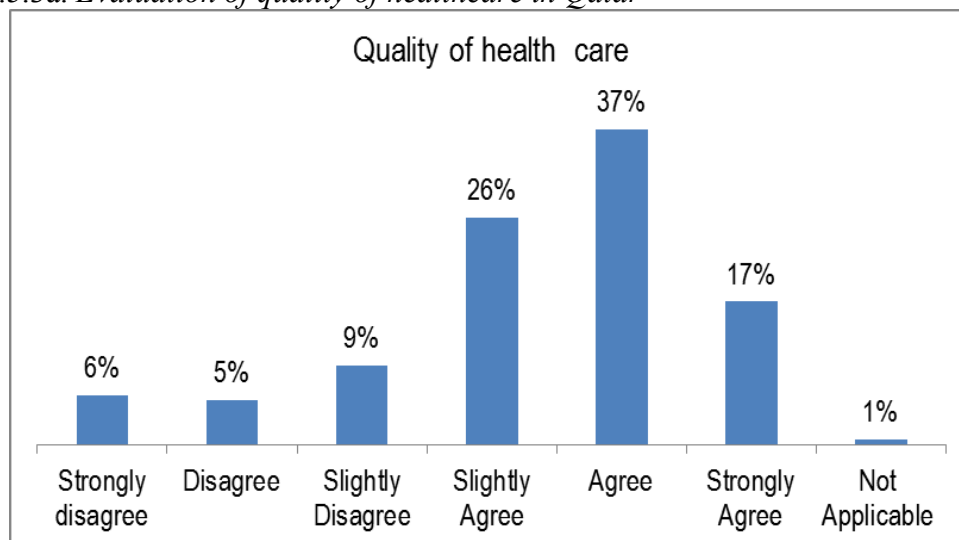
Figure 7.5.3b. *Evaluation of the suitability of Qatar as a medical tourism destination*
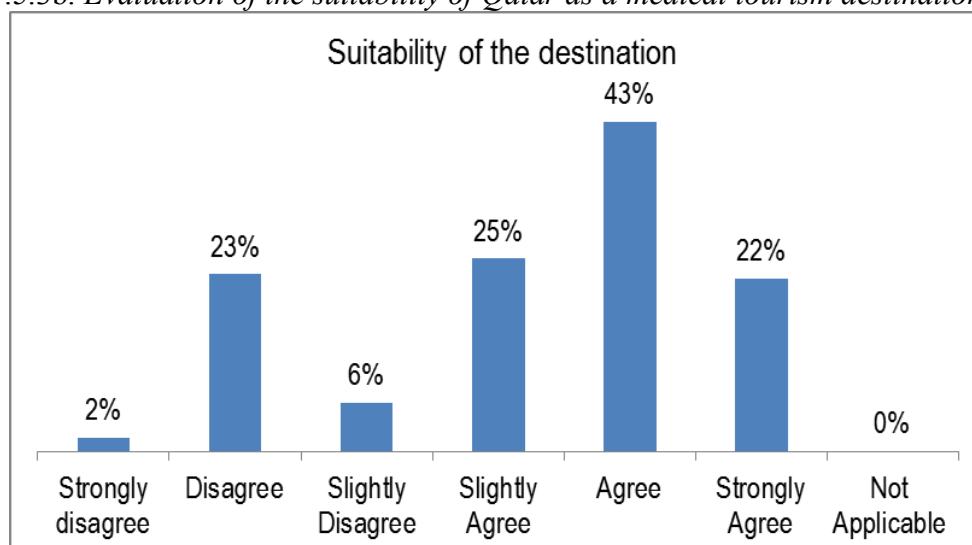
7.5.4 Impacts of Medical Tourism

Other than having an impact on the health status of those seeking such services, medical tourism may have profound impact on a country's healthcare system. In total, 304 HMC service users (86.9%) thought medical tourism would be appreciated and accepted by Qatari society with 330 HMC service users (94.3%) thinking that its impact would be positive. Figure 7.5.4 below illustrates the results described in this section.

Figure 7.5.4. *Potential impacts of medical tourism in Qatar*
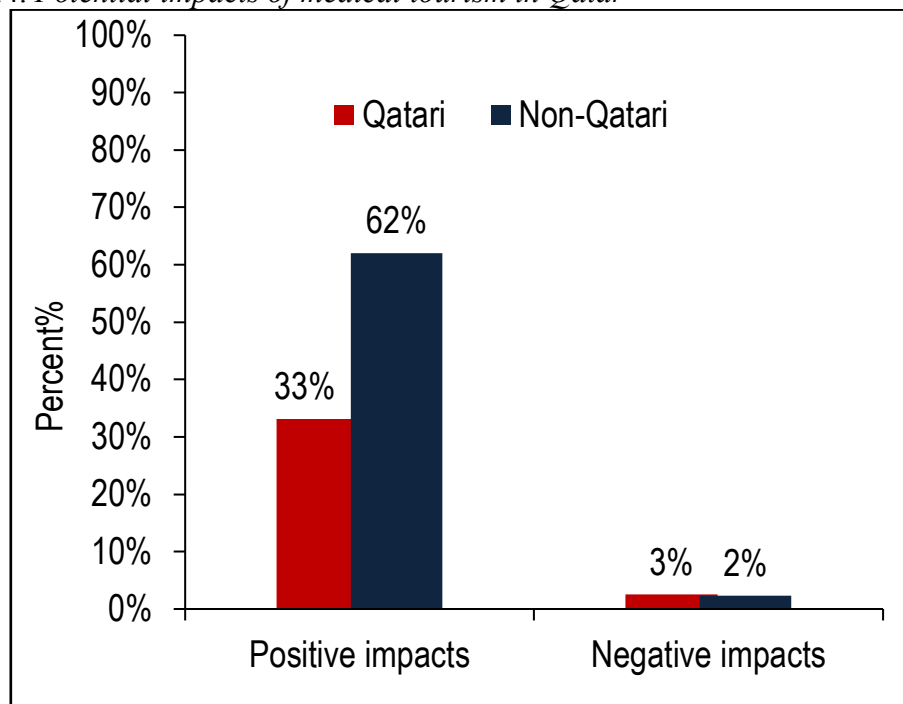
The main reasons quoted were helping to improve the country's economy and increasing the number of foreign tourists visiting the country. These results complemented those reported in section 5.9 following the interviews with the employees of the Ministry of Finance, the Ministry of Public Health and the Tourism Authority in Qatar where majority of the interviewees indicated that, as suggested by the QNV, the impact of medical tourism would be positive on Qatar. In contrast, in phase two, the senior managers while expressing optimism that medical tourism would affect Qatar positively also discussed potential negative impacts of medical tourism on Qatar (section 6.3) where positive economic gains would need to be

balanced against the potential to compromise the current quality of healthcare delivered to Qataris.

Only 20 HMC service users (5.7%) comprising both Qataris and non-Qataris believed that medical tourism would have a negative impact on Qataris citing issues related to safety concerns, own rights of receiving the services in their mother country, and increasing foreigner flow in the country. While this is a genuine concern, it is possible that the reason why the percentage of HMC service users citing the potential increase of foreigner flow into Qatar and safety as potential negative impact was so low was because there are already many expatriates working in Qatar and this has not caused any notable safety issues.

7.6 Conclusion

This chapter has presented the results of the questionnaire involving 350 HMC service users. Education, occupation, and nationality were found to be influential factors of the overall experience of services at HMC. Family members and local institutions topped the list of how the HMC service users learnt about while facilities, expertise of physician, and quality of healthcare were the main reasons for choosing HMC. There were more non-Qataris with favourable evaluations of the medical and nonmedical staff and services than Qataris. The physical and experiential servicescape at HMC also received positive assessment as did the laundry and catering services. While access to services at HMC was assessed in positive light overall, admission processes, securing appointments and waiting time had the most negative scores.

It was also found that most HMC service users had a good understanding of medical tourism and considered it to be more about leisure more than medical services. Family members and spouses would most likely be their companions if they were to engage in medical tourism. Cardiology, performing diagnosis, rehabilitation, and orthopaedic services were ranked as the most appropriate medical procedures for medical tourism in Qatar. Access to high quality care

and having a vacation while receiving treatment topped the list of reasons that would influence the HMC service users to engage in medical tourism if they were to do so. The most important influencers for engagement in medical tourism were self and advice from a doctor.

While appreciating that most of the HMC service users who took part in this study had never experienced medical tourism, they nevertheless indicated that safety and security, hospitality, and advanced medical facilities would likely be the main attractors of medical tourists in Qatar as elsewhere. Due to its advanced health and medical system and high quality of medical care, the HMC service users believed that the country has a real possibility of becoming a popular destination for medical tourism. While it emerged that the quality of healthcare in Qatari institutions was suitable for medical tourism, entry to Qatar was described as difficult by a large number of HMC service users. Contrary to previous indications by ministry officials and some senior managers about potential scepticism and likely aversion of medical tourism by Qataris, the HMC service users thought that the impact of medical tourism in Qatar would be positive and that the Qatari society would accept and embrace it.

Chapter Eight

Integration of Key Findings

8.1 Introduction

This chapter integrates the findings of the three primary data collection phases reported in chapters five, six and seven in order to draw out the main findings. Based on these findings five key themes were identified. These are governance and legal framework, language and confusion of meaning, medical tourism development and perceptions of Qataris' fears, medical tourism and Qatari culture, organizational capacity and customer satisfaction. These appear under separate sections with subsections which address respective subthemes under each theme. After the key findings have been discussed they are linked to the conceptual framework in chapter nine.

8.2 Governance and Legal Framework

The findings of the interviews with the senior managers revealed that the current governance and legal framework within which HMC was established and operates is not entirely compatible with supporting medical tourism. This is because the framework is focussed on providing services to Qataris free of charge since the government pays for all standard healthcare services; i.e. if a patient opts for treatment in a private medical facility (see section 2.6.1). As will be discussed, one unintended consequence of this policy has been the inhibition of the development of administrative systems within HMC which would enable the complete integration of supportive or complimenting services like a robust insurance and billing system to cater for medical tourism consumers.

8.2.1. Not for profit status

Currently relevant policy and legislation in Qatar is focused on the provision of quality healthcare in public facilities free of charge (see section 2.6.1). The ability to generate income through medical tourism would require altering this enabling HMC and other public healthcare

facilities to also become profit-making entities since investment in medical tourism is about income generation balanced with ensuring better service provision (see Botterill (2013) in section 1.3) The legislation which governs charges, treatment options, payment/non-payment procedures and profit-making ability for medical services in Qatar would need amending, for example to allow non-Qataris to be charged, accommodate foreign insurance companies' regulations and enable the transparent receipt of a significant rise in private payments.

Moreover, the lack of clarity in Qatar's constitution concerning the QTA, now replaced by the National Tourism Council (section 2.1.2), implies the lack of a clearly established legal and governance framework for implementing and developing tourism let alone medical tourism. Thus, it is currently likely that there are numerous legal and/or governance-related loopholes and hindrances with regard to implementing medical tourism. The reconsideration of the legal/governance framework would require the integration of multiple medical tourism stakeholders in a bottom-up governance approach (Ruhanen *et al.,* 2010; Aliu *et al.,* 2016), as discussed in section 3.11.1.

8.2.2. Review of the financial administration system

This is especially important considering that health insurance status has been shown to influence medical tourism consumption even in terms of destination choice (cf. Ren, Hyun, and Park, 2017 in section 3.6.2.5). Thus, medical tourists from countries whose medical insurance policies cannot be integrated into the HMC billing system are very likely to opt for other medical tourism destinations in which their cover is accepted. In addition, the changes to the legislation and governance framework could also allow Qatari residents to buy insurance cover which would cater for their medical expenses should they opt for services beyond the free standard care that government currently provides, such as elective procedures (see sections 2.1.3 and 2.1.4). With the proposed diversification of the Qatari economy from its current single oil-dependent status being central to the QNV 2030, as discussed in section 2.1.3, growth

in the insurance and allied service sectors in Qatar would help accelerate the achievement of the Vision.

8.2.3. Visa regulations

The final aspect of the legal framework that would be necessary to modify pertains to immigration laws; to enable easier access to medical tourism services for foreigners. At present, the immigration laws especially on visa processing and issuance regulations in Qatar are very strict and lengthy especially for residents outside the GCC region or the Arab League. The results reported in section 6.2.1 based on the views of senior managers suggested that the current visa processing periods take longer than they would in India, for example, with the on-arrival M-visa (Chinai and Goswami, 2007). This would discourage potential medical tourists from choosing Qatar as their preferred medical tourism destination. The HMC service users (section 7.5.3) also suggested that the current immigration policy could make it difficult for medical tourists to access the quality healthcare services Qatar offers. Again, this points to the need for changes in the law that would foster much deeper multisectoral cooperation and cooperation between government agencies, which would speed up and link the application for medical tourism visas for medical tourists and visiting visa applications of the person(s) accompanying the medical tourist. This might involve the establishment of a special, dedicated unit or department in the immigration ministry to process such package of visa applications.

8.3   Confusion of Meaning

The issue of difference in language and the subsequent confusion of meaning in reference to various aspects of medical tourism emerged from the first phase of interviews with the employees of the Ministry of Finance, the Ministry of Public Health and the Tourism Authority in Qatar. The second phase also contained issues that were traceable to use of different languages and communication in a language which was not the first language for all concerned, which could account for loss of meaning and nuance as well as confusion.

Different construction of meaning based on language has been shown wield significant influence over the service script (cf. Dahl, 1998; Hopkins, Nie, and Hopkins, 2009 in section 3.6.1.1). The main areas of language confusion and meaning were related to the concepts of medical treatment versus wellness and patients versus medical tourists by various participants.

8.3.1 Medical treatment versus wellness

During the first phase of the interviews, the majority of the interviewees used terms related to medical treatment to refer to healthcare, hospital-based services (such as ward admissions, surgery and treatment). Others like GOT2 defined medical tourism as wellness tourism and considered it primarily from a general tourism perspective. GOF also referred to wellness tourism when discussing medical tourism referencing spas and similar treatments but not the medical treatment procedures per se. Of all the government ministers only GOH3 seemed to have a full understanding that medical tourism also incorporates hospitality services although GOT2's comment suggested some recognition of this point. Essentially, this shows that the employees of the various ministries which are responsible for spearheading the implementation of medical tourism had different understandings of the term medial tourism and this was divided between either health, medical procedure, tourism or wellness tourism. In addition, there was very little understanding of the hospitality packages required to support the development of international medical tourism.

This variation in meaning, understanding and expression of what medical tourism entails by ministry officials has three main implications for the development and implementation of medical tourism in Qatar. First, it shows that government officials in Qatar do not have a clear uniform understanding of what medical tourism entails or could entail. This could be because the phrasing or expression of medical tourism in the QNV 2030 is not explicit in terms of what the key, measurable indicators of medical tourism are. As mentioned in section 2.1.2, Qatar's constitution lacks of a clear definition of tourism as does the establishment of

QTA under which medical tourism would generally fall. Subsequently, this ambiguity then allows room for subjective interpretation of what medical tourism in Qatar should look like. More positively this variation in language and meaning of medical treatment versus wellness suggests the potential for development of two streams of medical tourism in Qatar whereby one is focussed on required medical treatments and the other on elective procedures, which could be described as lifestyle choices.

Secondly however, this discordant understanding of medical tourism means that the various employees across different ministries are pursuing different goals in relation to the development of medical tourism rather than working towards a common vision. This could jeopardise the development of any form of effective medical tourism in Qatar because the ministries and the officials entrusted with the mission of achieving medical tourism lack a cohesive focus. The literature reviewed in section 3.11.2 underscores the critical role of stakeholders in the development of medical tourism. However, there is a gap in literature concerning the importance of understanding and communication of internal government stakeholders such as ministry officials. As demonstrated in section 5.3, this discord in views reflects the polychromic conflict rhythm that Martin and Nakayama (2014) describe by distorting what the term medical tourism means and how it is communicated by different stakeholders.

Language and confusion of meaning were also reflected in the interview findings with the senior management officials during the second research phase, as demonstrated in chapter six. The main similarity between their findings and those of ministry officials was in terms of medical and nonmedical managers viewing medical tourism impacts in terms of health improvement or revenue generation (see section 6.3.2). For example, senior managers working in the tertiary hospitals group department like IF3 considered medical tourism to be about wellness and earning of foreign exchange. On the other hand, managers like IM10 considered

timely provision of quality healthcare as being central to ensuring that Qatar succeeds as a medical tourism destination (see section 6.4).

The variation in what medical tourism means also manifested in the responses of the HMC service users, as shown in section 7.4.1. Their dominant view was that medical tourism was about traveling abroad in pursuit of medical treatments, leisure tourism or simply visiting new places. Following these results, it would appear that the HMC service users had a more robust understanding of the conventional view of medical tourism, in line with literature reviewed in section 3.3.1 compared to ministry officials or senior management. Where all groups did agree was in relation to travel; that it was about travelling abroad. Most ministry officials and senior managers saw the significance as travelling to Qatar and earning foreign exchange and making Qatar a tourist destination, which is consistent with the pursuit of medical tourism for income generation (Botterill, 2013; Hall, 2013)

8.3.2 Patients or medical tourists or customers or service users

In phases one and two, the interviewees referred to consumers of medical tourism as patients, medical tourists or customers depending on context or the occupation of the interviewee. Another determinant of how the interviewees referred to medical tourism consumers was the age of the consumer being referred to by the interviewee, as demonstrated in section 6.6.1. However, it should be noted that the demographic-based reference to customers was predominantly linked to the Qatari culture where elderly people are likely to be seen and referred to as patients more than customers due to the respect normally accorded them within the society. Referring to an elderly person as a customer within the medical context could be perceived as disrespectful. As shown in section 2.5, being older generally commands more respect in the Qatari culture (Al-Shahri and Al-Khemanizan, 2005; Lovering, 2012).

A reason for the tendency to refer to younger medical tourism consumers as customers rather than patients, which emerged from the second data analysis phase, could be linked to the

variation in language and confusion in meaning with respect to what medical tourism entails, as revealed in section 8.3.1 above. For instance, the perception that medical tourism is about wellness and leisure tourism may have caused the interviewees to connect leisure tourism with younger customers who are in pursuit of adventure. This perception of medical tourism as entailing leisure and adventure more than medical treatment renders its consumers as customers and not patients in most cases.

This interchangeable reference to medical tourism consumers as both tourists and patients is not unique to this study. As was the case with the second and third phases of this research, in the literature (see section 3.4) medical tourists are often identified as patients when they are seeking non-elective medical treatments, such as a hip replacement. However, when the consumer travels abroad to seek elective medical attention or wellness treatments then the reference transforms into that of customer (Jun and Oh, 2015; Ren, Hyun, and Park, 2017). It would appear, therefore, that medical tourist as a term is not contained in either 'patient' or 'customer' but rather it can be seen as a continuum between these terms depending upon the treatment being sought and the perception of the provider of the medical service i.e. medical tourists are both patients and travellers who consume medical-related services in a foreign country. However, it is noteworthy that the terminology is influenced by the subjective perceptions of the person using the term towards the medical tourism consumer. In other words, two people in the same department or even industry sector might refer to the same person as a medical tourist or a patient or a customer depending on the service the consumer intends to consume plus their age.

For example, reflection about the comments of managers such as QM4 (section 6.6.1.1) about attracting young people with sports injuries and patients requiring organ transplant would suggest that a young athlete seeking medical treatment in Qatar such as surgery due to a sports injury would not strike a senior manager as a patient. Instead, such a young athlete would most

likely be referred to as a customer or simply medical tourist. On the other hand, a young person traveling to Qatar to undergo an organ transplant would be referred to and considered as a patient. Such views from senior managers suggest that it is the nature of the service being sought by an individual which takes precedence in defining them as either a patient or a customer. However, no matter how they are perceived they would fall into the category of medical tourists. Thus, this study advances the understanding of medical tourism by demonstrating that medical tourists can be perceived subjectively as patients and/or consumers.

The confusion in both the meaning of medical tourism and medical tourists impacts upon the type of collaborations required for the effective implementation of medical tourism in Qatar and the type of stakeholders who need to be involved. If senior managers at HMC and ministry officials consider medical tourism to be an income or revenue generation channel, then the likelihood that everyone seeking medical and nonmedical wellness services in Qatar will be treated as a customer is quite high provided that they recognise the need for high-quality hospitality and partner packages to support the development of high-quality medical tourism. Failing to recognise this would also mean lost opportunities in the hospitality and mainstream tourism industries in Qatar.

8.3.3 Employee roles and misunderstanding

This research was based on the SERVQUAL model and the understanding that all employees have the potential to impact upon the experience of a medical tourist. For instance, the role of employees and especially frontline employees, in ensuring the successful delivery of medical tourism in Qatar was of critical importance to this research. However, the findings also showed that confusion of meaning caused a misunderstanding of the roles which various employees thought they would need to play in the delivery of medical tourism. While frontline employees were portrayed as understanding their capacity to influence the satisfaction of patients/customers at HMC, back office employees such as accountants did not feel that they

were critical to delivering the overall customer experience (see section 6.4). The basic rationale was traceable to the perception that back office employees would rarely influence perceptions of quality of service as they do not often interact with customers/patients directly. However, the over-billing of a medical tourist by a billing officer working in the back office could trigger negative service perceptions even if the medical tourist has received excellent services in the hands of physicians, nurses, cleaners, receptionists and such other front office or frontline staff. Equally, a potential customer might choose a different medical tourism destination for their treatment if the admissions service was poor.

There was a notable trend especially among the senior management interviewees to consider outsourced and support staff to be less important in delivering medical tourism services effectively compared to their frontline staff (see section 6.4). This supports the concept that senior managers and even ministry officials perceive medical tourism in fragments as opposed to taking a holistic, integrated and interrelated view. The fact that senior managers felt that outsourced nonmedical staff who mostly offer low-skilled services such as call centre, security, catering and housekeeping services did not have a significant impact on the implementation of medical tourism (see section 6.4) further confirms the level of confusion about what the full scope of medical tourism entails and the very wide range of different stakeholders and employees needed to support it. This was an indication that senior managers, along with the government officials, have very little understanding of the full range of services required in providing high quality Medical Tourism.

8.4 Medical tourism development and Qataris' fears

The findings of interviews with both Government officials and senior managers suggested that one reason for not developing medical tourism in Qatar was the belief that Qatari nationals would not accept it. These interviewees believed that Qataris believed that an influx of medical tourists would cause issues of access to the national healthcare system as demonstrated in the

response by IM6 in section 6.3.1. This presumed fear and scepticism towards medical tourism was linked to the issue of potential pressure on the capacity of the Qatari healthcare system to handle the needs of its residents plus the needs of foreign medical tourists. For instance, one of the current issues that was raised by many senior management interviewees and the HMC service users was the problem with perceived long waiting times for Qataris (see sections 6.4 and 7.4.8). Indeed, one of the reasons why Latin American and Asian countries were able to establish medical tourism successfully was by taking advantage of the problem of people from Western countries with regard to their very much longer waiting times at home (Turner, 2007). Thus, the fear that waiting times could get longer if Qatar begins to receive an influx of medical tourists could be justifiable given the current situation.

Significantly, however, the HMC service users did not consider medical tourism to be a threat to access to their healthcare system for themselves (see section 7.6.4). Therefore, these findings suggest that there is a gap in the understanding of consumer needs by government officials and senior managers who are the decision-makers and implementers of medical tourism in Qatar. The sense of entitlement projected by government officials to good healthcare without having to share with 'outsiders' (medical tourists) is a misplaced factor and the potential aversion towards medical tourism development in Qatar, as demonstrated in section 5.9.1 is incorrect. Additionally, since like most other visitors, medical tourists book their trips (treatments) in advance an efficient administrative system should be able to harmonise appointments to avoid potential overbooking or extended waiting times. Medical tourists could also be guided to the underused hospitals and away from the more popular ones in the capital, further reducing the potential for Qataris to have to wait longer.

8.5 Medical tourism and Qatari Culture

The findings of the three phases and reference to literature especially in section 3.6.1, confirm that the culture of a medical tourism destination could hinder or support the successful

development that destination. As demonstrated in section 3.11.3.1, the Qatari culture is predominantly patriarchal and conservative (Lovering, 2012; Iranmanesh *et al.,* 2018) and the issue of gender is interlinked with the conservative nature of the Qatari culture. This could affect medical tourism implementation since, as previously discussed, male and female patients and visitors may need to be separated while on hospital premises. The other aspect of the Qatari culture identified concerned concepts with regard to the age of the medical tourist or patient. The three subheadings below elucidate the findings pertaining to each of these subthemes respectively.

8.5.1 Conservative patriarchal society

The results of the interviews with ministry officials and with senior managers suggested that the risk of cultural value erosion would be seen by some Qataris and could cause them to reject or oppose the development of medical tourism if it meant that they would lose their cultural and religious standing or be offended by less conservative medical tourists who visit Qatar. Although it is true that Qatar is considered a culturally conservative and patriarchal society, it is worth noting that at present there are more non-Qataris than Qataris resident in Qatar because of the huge expat population and that they have lived together harmoniously to date (see section 2.1.1). Moreover, the social growth pillar of the QNV discussed in section 2.1.3 is about enhancing social cohesion and the continued promotion of cohesive coexistence between non-Qataris and Qataris remains critical to the achievement of this social pillar. Interestingly, the findings showed that the expat participants interpreted the Qatari culture to be somewhat more restrictive than the Qatari nationals, patients, saw it themselves. If this perception were to reflect the way Western and other international tourists per se perceive Qatar, it could constitute another barrier to the development of medical tourism in Qatar. However, this was not an issue raised by any of the HMC service users (Qataris and non-Qataris) based on their questionnaire responses. Indeed, as shown in section 3.6, since

experiences of authentic local culture is a driver of medical tourism some potential medical tourists may want to experience and gain a better understanding of traditional Qatari culture.

This integrated analysis reiterates the suggestion that there are two different forms of potential medical tourism emerging from this research. One which is local and culturally similar to Qatar and a second which is both geographically distant and culturally diverse due to its international nature.

8.5.2 Gender

The literature in section 3.6.2.2 (Klein *et al.,* 2017; Ren, Hyun, and Park, 2017) supported the view that gender is a significant influencer of medical tourism consumption whereby women tend to consume more elective treatments than men. The results reported in section 7.2.2 and in the literature (cf. Klein *et al.,* 2017; Ren, Hyun, and Park, 2017) indicated that women may be more likely to pursue medical tourism for elective procedures, such as cosmetic surgery, than men. As mentioned before, the female voice in phases one and two of this research was considerably less than that of their male counterparts and the findings of the interviews with the senior managers showed a positive correlation between age and occupation which, while reflecting the actual employment profile, suggests the likelihood that decisions about medical tourism in Qatar will be made by older, males. This could suggest an indication that medical tourism development in Qatar is likely to be relying on the executive direction of the male voice despite current efforts to include more women in decision-making positions in Qatar and in accordance with the social pillar of the QNV where female empowerment is critical.

Although efforts have been made to educate women, they still remain a minority in roles such as medical doctor and senior management; this patriarchal bias may hinder the development of medical tourism by deterring potential female medical tourists from the West from choosing elective procedures in Qatar. On the other hand, normal career progression to

senior management usually occurs after several years of experience, plus the cultural orientation of Qatar is such that older people (especially men) are likely to dominate the senior positions in corporations and Government.

The findings of this study, as demonstrated in sections 6.6.1.2 based on the managers' responses and 7.2.2 based on the views of the HMC service users, also show that the role and place of the woman in the conservative Qatari culture may affect the success of medical tourism. For example, Qatari women and those from the GCC countries would normally expect to be segregated from men in the hospital and only be visited by female members of the family especially when the procedure they are undergoing is of a more feminine than masculine nature e.g. gynaecology procedures.

The other aspect relates to the availability of adequate facilities for women to accompany their fellow female patients and children upon admission in hospitals, as this is generally considered the cultural norm in Qatar (Dhami and Sheikh, 2008). This applies to accommodation facilities both within and without the hospital provision itself. Considering the two forms of medical tourism emerging from this research, this could affect the growth of international medical tourism from non-Arab countries since a need for different facilities to cater for female medical tourists from Arab countries and those from the West may develop. This is because, for example, a female medical tourist from the West who has been admitted at HMC might be more comfortable if her husband stayed with her while a conservative Qatari woman in a nearby room might find the presence of that husband offensive or intrusive. Therefore, it will be important for Qatar and HMC specifically to consider this potential incompatibility when developing and managing a medical tourism infrastructure. This signals the need for significant government clarity to eliminate the confusion about the type of medical tourism to develop and simultaneously reiterates the importance of a robust administration and booking system for medical tourism.

8.5.3 Patient Age

Concerning age, the findings showed that the elderly in Qatar are culturally entitled to receive privileged treatment over younger counterparts even in hospital settings. With medical tourism this could change in the event that, for example, younger, non-Qatari medical tourists who are paying a substantial amount for the same treatment have to 'compete' for the same services as elderly Qatari residents. The situation could even get more complex if the elderly patient believes that the Qatari medical practitioner that they are both seeing prioritizes the younger, high-paying medical tourist. This complexity could occur because most Qataris are not willing to pay for priority treatment in Qatar since high quality standard healthcare is guaranteed and paid for by government. This would affect the receptiveness of Qatari residents and their tolerance towards medical tourists negatively. However, this issue is only likely to occur if both residents and medical tourists have to share the same facilities thereby reinforcing the need for the development of a two-track system based on facilities. However, as demonstrated in the primary results in section 6.4, Qataris generally prefer to be treated in Doha and the new facilities outside Doha are the ones with the private rooms etc., which would suit medical tourists better suggesting the likelihood that medical tourism development may need to be focused on the cities outside Doha, although some medical tourists may also prefer receiving services in Doha. Prioritising one group to one set of facilities and the other to the others might eliminate this potential issue. In addition, this is primarily an administrative issue, which could also be managed by the development of an efficient booking system.

The literature in section 3.11.3.1, interview results of from the senior managers in section 6.6.1.1 and the survey results in section 7.2.1 all suggested that younger people would most likely constitute the biggest fraction of medical tourists. This is especially true in the case of what the survey respondents referred to as leisure medical tourism where younger people

aged between 21 and 50 were most likely to travel to pursue services such as spa and therapeutic rehabilitation.

These findings are consistent with the Korean study by Ren, Hyun, and Park (2017) (section 3.6.2.1) who found that younger people were more likely to outnumber the elderly when it comes to engaging in medical tourism. Altogether, the needs that drive elderly persons to pursue medical tourism often differ from those that drive younger adults. The implication of this finding is that the management of HMC needs to devise medical tourism packages, which although tailor made to attract typical international medical tourists, also consider the diverse needs of elderly and younger medical tourists. This is particularly necessary if Qatar also plans to target Arab countries for localised regional medical tourism. These Gulf residents may be sceptical about participating in medical tourism in Qatar if they feel that it has diluted its cultural mores and standards in order to attract both elderly and young international medical tourists and lost its reputation as a serious Arab-Muslim medical tourism destination. However, again, an efficient administrative regulation to pursue a two -track system for both elective and non-elective care procedures can easily address this challenge in addition to having different hospitals with different specialisations.

8.6 Organizational Capacity and Customer Satisfaction

In terms of strategy, the achievement of the NHS 2018-2022 strategy illustrated in Figure 2.10 at Section 2.10 is likely to benefit the successful implementation of medical tourism in several ways. For example, integrating high-quality care with service delivery easily translates to enhanced customer satisfaction and positive reputation for Qatar as a world-class medical tourism destination. The development of a national health policy coupled with an effective system of governance and leadership could be harnessed in such a way as to ensure that medical tourism in Qatar is accessible and that medical tourists also benefit from the triple

aim of better health, care, and value. In addition, ensuring that the Qatari national workforce is skilled will be beneficial in various ways.

For example, it will mean that Qataris will be better placed to take charge in the implementation of medical tourism since they will be skilled enough to take up different top roles. This, in turn and in time, will create employment opportunities and promote a sense of medical tourism ownership among the Qatari nationals since they will be at the centre of its implementation and development. During the interviews with the ministry officials only GOT2 expressed the need for better capacity than there currently is in the Qatari healthcare sector (see section 5.3). At that juncture, it was not clear what the term capacity referred to specifically i.e. whether it was about infrastructural capacity or service delivery capacity etc. However, the results of the interviews with the senior managers helped in disambiguating this into the capacity of the physical environment and service-related aspects which influence customer satisfaction. These are discussed in detail in the two subsequent subsections.

8.6.1 Physical Environment

The most outstanding characteristics of the physical environment that was shown to have the potential to affect customer satisfaction and the development of medical tourism in Qatar was infrastructural capacity. The literature in section 3.13 supports the view that the physical environment influences customer contentment, which translates to an aspect of customer satisfaction. In terms of infrastructural capacity, the key issues raised included a lack of private accommodation facilities and inadequate car parking space at HMC, which then influenced perceptions of waiting times (see QM1's response in section 6.4) and ultimately customer satisfaction.

The findings of phase three (section 7.3.2) showed that facilities were the most important influencers of the choice of HMC as the treatment centre by the respondents. However, the fact that sources such as Ventures Onsite Report (2015) show that Hamad

General Hospital and HMC were working toward doubling private hospital beds and tripling car parks by 2030 is an acknowledgement that these infrastructural facilities are important not just for medical tourism but for Qataris as well. This was mentioned by the senior managers as well and the significance is that it will improve the capacity that Qatar can handle in terms of medical tourism (see section 6.2.1).

The physical environment in terms of infrastructure also has a significant impact on the choice of medical facility because of the perceived space to accommodate family members accompanying the patient and who expect to stay closer to their patient without compromising on the privacy of the patient, as shown in literature (Joseph, 2006, Ulrich *et al.,* 2008; Gulwadi *et al.*, 2009). This is because it is quite common in Qatar to have several family members staying at the facility where their relation is hospitalised. Normally, private rooms will have common lounges or be big enough to accommodate at least one person besides the patient for a short stay only. However, other accommodation facilities would still be necessary considering that hospitals may not have enough hospitality services which include room services such as patient's personal laundry; restaurant and entertainment for patients and those who accompany them. Those services might not be seen as necessary for local patients who normally have access to their accommodations in Doha. Thus, it is crucial to provide the non-local with such services to facilitate their stay at the hospital. Private rooms were shown to be fundamental requirements for customer satisfaction in sections 6.5 and 7.3.2 and for medical tourists in Qatar. The successful implementation of medical tourism means that the demand for infrastructural facilities, such as private rooms for patients; hotel and accommodation facilities including restaurants as well as leisure facilities such as swimming pools and or gym for accompanying partners, is likely to increase. For instance, the medical tourism packages in India is inclusive of different services such as hotel stay overnight and breakfast, touring the monuments (Medical Tourism Indida,2019). However, it could also mean better services for

Qatari people if the government and other stakeholders invested heavily in developing medical tourism through cutting-edge infrastructure and enhanced capacity for HMC to ensure that it appeals to consumers of both medical and nonmedical services.

8.6.2 Hospitality and hospitableness

The literature in section 3.12 shows a positive relationship between hospitality and hospitableness which reinforces the importance of ensuring that hospitality services are provided either by HMC or through partner packages. It also identified the influential role that nonmedical Qatari service providers would be likely to have on the perceptions of customer satisfaction of medical tourists in general. The provision of specialised high-quality hospitality services to support the development of medical tourism in Qatar featured in all the three research phases (see sections 5.4, 6.4 and 7.5.1). However, offering partner packages in Qatar would require an adjustment in the legislative and governance framework of HMC, as shown in section 6.2.1. and revisited in section 8.2 above. This is because the development of partnership packages would require that HMC and other currently not-for-profit healthcare centres collaborate with profit-making businesses in the hospitality and travel industries, for example. Currently, the HMC legislative and governance framework prevents this.

The Government officials suggested that the development of different medical tourism packages, which include a holistic medical and nonmedical experience of Qatar beyond the confines of hospital walls would be most beneficial. Generally, it would be attractive to medical tourists who seek leisure services such as wellness spa and general tourism opportunities such as visiting historical sites experiences for those who are strictly interested in medical procedures such as surgery or chemotherapy in Qatar. This reinforces the view that there is potential for the development of two forms of medical tourism with the first one being to cater for wellness tourism consumers such as spa experiences whose accompanying partners also stay within the spa facility and both potentially engage in some additional tourism activities

such as sightseeing. The other form is the strictly medical or treatment-oriented type where the patient would be hospitalised and the accompanying partner would normally stay at a nearby hotel and visit the patient during the duration of treatment. As demonstrated in section 3.5, Musa *et al.,* (2012) identify medical treatment, international tariffs, housing, prearranged trips, shopping, food and drink, and local transportation as the main constituents of medical tourism packages. Yu and Ko (2012) identified accommodation and airfare and Ruka (2015) treatment arrangement, flight itinerary, leisure, accommodation and recuperation in a local hotel for a few days. Consistent with this previous literature, the package recommended by most senior managers was one involving the services of the hospitality sector i.e. travel packages, hotels, and accommodation.

This view was supported by the results of the study involving HMC service users where respondents who did decide to participate in medical tourism would opt to be accompanied by a family member. All accompanying people especially for the strictly medical-related tourism such as those whose patients are in Qatar for surgery would definitely require specialist travel services and accommodation outside the hospital confines since the hospital regulations mostly only allow for one additional person to stay with a patient who needs special round-the-clock care or, for example, a child admitted in the paediatric unit. Examples of such comprehensive packages for this form of tourism may include travel (air tickets, ground transfers, travel insurance), immigration services (visa application and processing, clearance by immigration on arrival), accommodation (hotels/hospital room choices, meals), medical services (appointment booking, physician/doctor identification, procedures involved) and other tourism-related services (such as sight-seeing or cultural immersion experiences). On the other hand, wellness tourists would not require packages where medical services are involved. Instead, including excursion components in their travel and spa selection packages may be more beneficial.

In either case, this would require the modification of not just healthcare laws and regulations, but the harmonisation of regulations that govern other industry sectors like transport and hospitality as well. The HMC and the Government of Qatar would need to ensure a seamless collaboration with stakeholders in the hospitality industry to supplement the existing facilities. For example, working with hotels to provide tailormade medical tourism accommodation packages especially for those accompanying medical tourists who would be admitted into the hospital might be easier than constructing new infrastructure to meet a probably ever-increasing demand for private rooms and other accompanying services like variety of foods. The literature about involvement of multiple stakeholders in the delivery of medical tourism as reviewed at section 3.11.1 shows the importance of collaboration between medical services providers and service providers like hotels (cf. Aliu and Aliu, 2015, as cited in Aliu *et al.,* 2016).

The link between hospitality and hospitableness also extends to the need for all employees and government officials to understand both the concept of medical tourism and their role in supporting the successful implementation of it. This includes working to reduce misunderstandings caused by confusion of language and meaning as described in section 8.3, and manifested in the studies with ministry officials (section 5.3) and senior managers (section 6.5). In short, uniformity is needed to describe what the term medical tourism means in Qatar across all the stakeholder groups involved to ensure that the good and welcoming nature of Qataris transcends into service delivery in medical tourism. This includes the importance of understanding the vision and strategy of each sector implicated in delivery medical tourism services directly and indirectly and removing any perceptions of medical tourists as 'invaders' of the national healthcare system.

HMC may provide top-quality medical services and ensure that the medical and nonmedical facilities at the hospital cater for the needs of medical tourists to their satisfaction.

However, if the people the medical tourist encounters from the immigration desk to the transport system and at the tables of restaurants in Qatar are not hospitable, the likelihood that the medical tourist will recommend HMC to others may be very slim. Hospitableness also speaks to the interactions that a medical tourist will have with the local community in Qatar. If these are positive then HMC and Qatar will gain a reputation for wonderful hospitableness, which extends beyond the pure medical experience and into a holistic Qatari one. As previously discussed, one way the conservative nature of the Qatari society is manifested is in terms of how influential family is in decision-making and recommending services and institutions like HMC. The influential role of family WOM in decision making in Qatar was highlighted (Daneshpour, 1998; Dhami and Sheikh, 2008; Lovering, 2012) and it is likely that this is replicated throughout the GCC as well and perhaps in other Arab cultures which could be potential target consumers of Qatar's medical tourism. Previous studies (Crooks *et al.*, 2010; Chen, Dwyer, & Firth, 2014), as reviewed in section 3.6.2.6 underscore the significance of WOM both in general and within the context of tourism. While such literature does not mention medical tourism specifically, there is no evidence to suggest that WOM would not be significant in the implementation of medical tourism especially considering that recommendations by family and relations ranked third in terms of influencing choice of treatment facility by HMC service users.

8.7 Key findings

Following the discussion of the various results and their linkage as presented in this chapter, the key findings of this research were as follows:

1) One of the paramount findings of this research relates to the need for the revision of the Qatari governance and legal framework in two aspects. The first is a revision of the current governance framework for healthcare in Qatar so that it allows hospitals and other medical facilities to participate in the commercial delivery of medical tourism alongside the current

government-funded healthcare for Qatari nationals and residents. The second is the need for revision of current immigration laws to allow for easier access to Qatar by medical tourists and their accompanying partners coming from outside the GCC region and the Arab League.

2) There is great confusion of meaning with regard to the term and concept of medical tourism. The terms medical treatment and wellness are frequently used interchangeably and there is often confusing reference to medical tourists either as customers, patients or simply medical tourists. However, the results of this research suggest that this is because there is the potential for Qatar to develop two different forms of medical tourism. One type would target local neighbouring and Arab countries, be more chronic health-focused and the other would focus on international, elective wellness medical tourism, cosmetic surgery and one-off procedures such as knee or hip replacement. This scenario explains the rationale for the differences in the use of the term patients versus medical tourists whereby the former is seen as those who consume medical/health tourism services such as medical treatment often from neighbouring countries and the latter are international consumers of elective and wellness procedures such as spa treatments.

3) The findings showed conflict between the views of the ministry officials and senior managers on the one hand and those of HMC service users on the other over potential fears relating to the development of medical tourism. Ministry officials and senior managers indicated that Qataris would be sceptical or even unsupportive of medical tourism while this was not a concern among most of the HMC service users. Thus, the key finding here is that ministry officials and senior managers have an incorrect perception about how Qataris would receive medical tourism and this could affect the approaches and strategies that they adopt; they may initiate unnecessary strategies which could delay the delivery of effective medical tourism as projected in the QNV.

4) The Qatari culture, with respect to its conservative and patriarchal nature, underscores the roles and positions of family, gender and age as influencers of medical tourism. Within the Qatari and local Arabic culture family was identified as being extremely influential with regard to the decisions to engage in medical tourism, choice of providers and accompanying partner. It is important to note that the Qatari voice dominates the findings presented in this research because the sample respondents were Qatari citizens and residents. However, it is likely that potential medical tourists from Arab countries such as the GCC countries will find the restrictions of the Qatari culture familiar, comfortable and appealing. In contrast, those from different cultures may find it unacceptably restrictive if, for example, a man could not accompany his wife while she is undergoing eye surgery or they could not both stay in the same room in a spa due to the said restrictions. This could constitute a barrier to the development of international medical tourism.

5) Finally, the capacity of Qatar's medical and nonmedical facilities to deliver excellent customer satisfaction in terms of the physical environment and supportive hospitality capacity, which was linked to the hospitableness were found to be critical determinants of the potential for successful development medical tourism in Qatar. The need to develop suitable partner packages that involve both the medical and nonmedical service providers such as HMC and hotels emerged as a key finding of this study. Essentially, the results show that there is a far wider range of stakeholders involved in the successful development of medical tourism in Qatar than had been previously considered and that each group is essential and needs to be given the same status. This includes the previously overlooked hospitality elements.

8.8 Linking the Key Findings to the Conceptual Framework

These key findings bring out various aspects that relate to the gaps identified in the conceptual framework (Figure 3.14), which is re-illustrated below as Figure 8.8. The need for

the revision of the Qatari healthcare governance and legal framework to allow public healthcare facilities to participate in profit based commercial delivery of medical tourism services is fundamental to addressing all the five gaps identified in the conceptual framework. In addition, currently it is not possible for internal and external stakeholders to play their roles in developing and contributing towards the implementation of medical tourism in Qatar.

Figure 8.8. *A re-illustration of the conceptual framework*
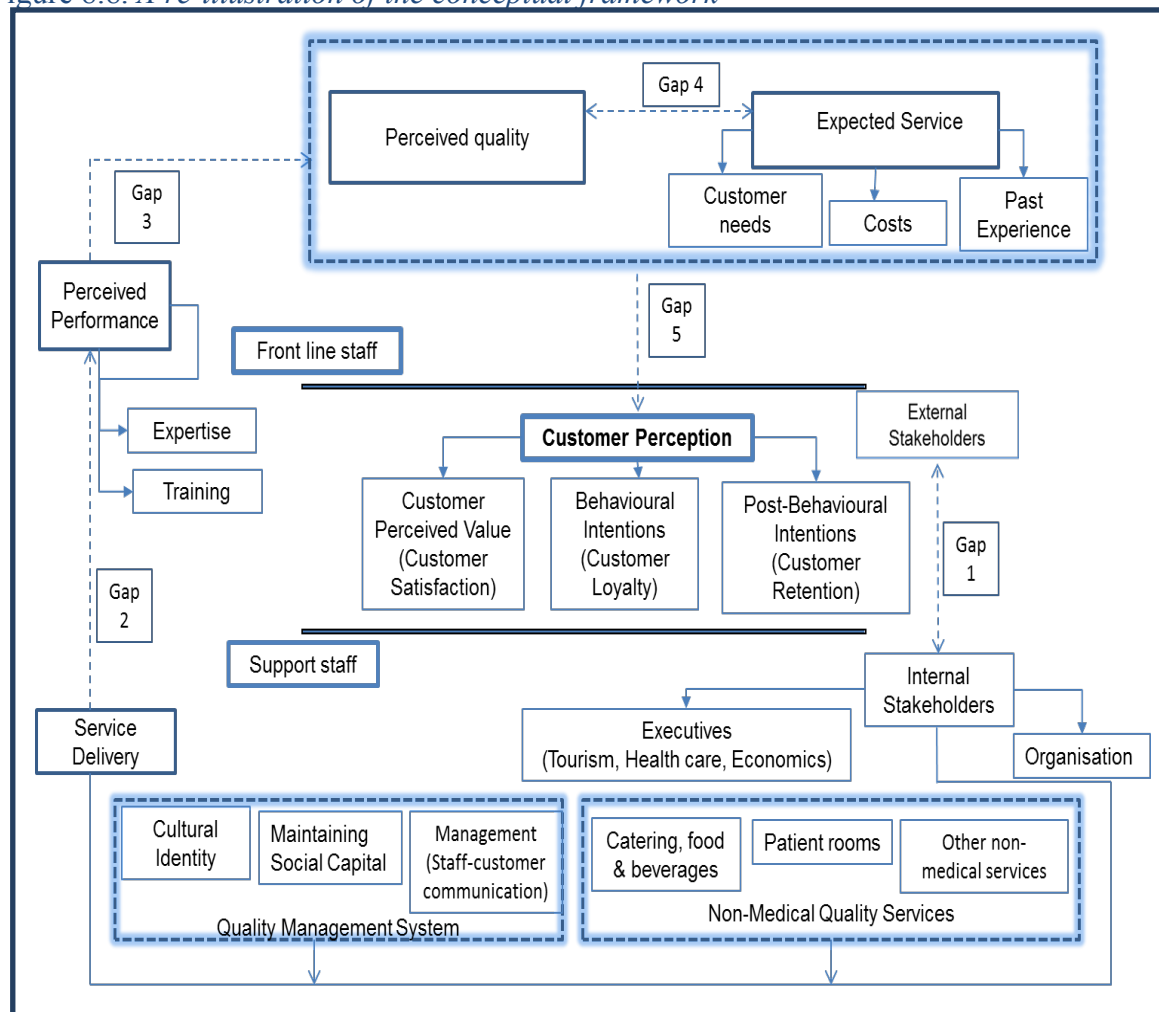
It is necessary that the government commits to reviewing and revising the governance and legal framework in order to create a path through the immigration laws to ease access to medical tourism; this would also influence customer perception of the extent to which Qatar is accessible as a medical tourism destination. Less stringent immigration laws which foster easier access to Qatar would address gap 5 particularly between customer perception and expected service.

The fact that Qatar already has strong healthcare regulations, which provide nationals and local residents with free high-quality healthcare service, implies that the government is capable of guaranteeing high quality healthcare and medical tourism to others. The track system of billing within the current healthcare governance framework is an indication that Qatar can scale up a similar framework for two different forms of medical tourism for localised regional and international service delivery. This strength facilitates the maintenance of both the nonmedical quality services and the quality management system. Nonetheless, the need to reappraise the healthcare governance and immigration policies to accommodate the diverse needs of a fully functioning system with the capacity to support and accelerate the development of medical tourism is critical. One of the paramount findings of this research relates to the need for the revision of the Qatari governance and legal framework in two aspects. The first is a revision of the current governance framework for healthcare in Qatar so that it allows hospitals and other medical facilities to participate in the commercial delivery of medical tourism alongside the current government-funded healthcare for Qatari nationals and residents. The second is the need for revision of current immigration laws to allow for easier access to Qatar by medical tourists and their accompanying partners coming from outside the GCC region and the Arab League.

The key finding about the confusion of meaning with respect to the term and concept of medical tourism implies potential continued discord in addressing gap 2, gap 3, gap 4 and gap 5. Failing to address the confusion in meaning also means that executives in government and management of healthcare facilities and other industry sectors implicated in the delivery of aspects of medical tourism such as hoteliers and tourism agencies would probably work in fragmentation as opposed to working collaboratively. Consequently, the maintenance of quality management and nonmedical services would be difficult to achieve thereby increasing Gap 1 between external and internal stakeholders (gap 1). For example, many employees are

not be in a position to understand the expectations of medical tourism consumers. This discord would mean that the service delivery and perceived performance gap would persist. Also, the quality of service provided by employees, for example, would be unlikely to meet the needs of the customers and this would aggravate the perceived quality and expected service gap (gap 4).

The findings showing conflict between the views of ministry officials and senior managers on the one hand and those of HMC service users on the other hand concerning the potential aversion towards medical tourism by the latter links to the conceptual framework in the sense that it also demonstrates the significance of gap 1 in the relationship between external and internal stakeholders. The findings in this regard show that the government and senior managers would not be in a position to understand what translates into customer satisfaction and their expected treatment, which is critical to enhancing the customer experience, thereby influencing gap 5 and gap 4 on expected service and perceived quality and customer perception.

In line with the fourth key finding, the conservative, patriarchal nature of the Qatari culture and the unequal role of women could cause negative customer perceptions especially with respect to the international medical tourists from the West who are likely to be sensitive about gender issues; this could further enlarge gap 5 as less conservative, competitor medical tourism destinations may take advantage of this limitation. Paradoxically however, this finding also gives Qatar an edge in regional medical tourism provision where GCC countries, for example, may be more comfortable with the Qatari culture and societal structuring. This further reinforces the rationale for development of the two forms of medical tourism as demonstrated in this research to ensure that customer perceptions do not widen the gaps 2, 3, and 5 involving service delivery, perceived performance, perceived quality, expected service, and customer perception.

Consistent with the findings about the capacity of Qatar's medical and nonmedical facilities to deliver excellent customer satisfaction in terms of the physical environment and

supportive hospitality capacity, this is relevant to the conceptual framework in terms of bridging the gap between service delivery and perceived performance since it implies that nonmedical and medical services are guaranteed to strike medical tourists especially those from the Arab region as superior. This is likely to enhance their perception of medical tourists in consistency with gap 5 in the conceptual framework.

Chapter Nine

Overall Review, Contribution, Conclusions and Final Reflections

9.1 Introduction

As the concluding chapter for this study, this chapter provides a holistic yet detailed view into the entire research process and its outcomes. The next section contains a review of the research objectives, methods employed to accomplish them and a summary of the respective findings. The third section outlines the contributions to both theory and practice based on the findings reported and discussed in the previous chapters. The conclusions and practical recommendations are captured in the fourth section while the limitations of study and reflections are in the fifth one. In the sixth section, the opportunities for further research based on the findings and limitations of the current study are highlighted. This chapter concludes with personal thoughts of the researcher concerning the entire research process, the research topic and their development as a researcher.

9.2 Review of Research Objectives

The aim of this research was to ensure better insight into the complexity of medical tourism and the complexity of medical tourism in term of being defined as a distinct niche market in the Qatari context and to critically analyse how service quality theory can be used to help enhance medical tourism within the Arabic context. A framework was developed to identify the critical service quality factors in that context using HMC as a vehicle in Qatar which signalled the need to rethink the SERVQUAL model within this context, as shown in Figure 9.2.4 (p. 273) and Table 9.3.1 (p. 277). This aim was achieved through five objectives which are reviewed under their respective subsections below.

9.2.1 To Undertake a Critical Literature Review in Relation to Service Quality and

Niche Tourism with a Focus on the Medical Tourism Sector

Objective one was to undertake a critical literature review in relation to service quality and niche tourism with a focus on the medical tourism sector. The rationale for this was to identify the prevalent theoretical contentions concerning medical tourism, service quality, cultural issues and the expectations that medical tourists have with respect to nonmedical services. The key outcome associated with the achievement of this objective was the development of a conceptual framework (see Figure 9.2.4 // p. 273). To achieve this objective an extended yet critical review of existing literature was undertaken as demonstrated in chapter three. The researcher drew upon numerous sources of literature including journal articles, books, industry reports and government documents such as the QNV. In addition, other sources such as credible websites and news sources were also used.

The critical review of literature commenced with the definitions of the concepts and terminologies used in tourism in general and included the definitions of medical tourism. Tourism was defined based on Theobald's (1998) capture of the 1991 World Trade Organisation definition which portrays it as comprising of aspects of traveling and staying in places away from their usual environments for purposes such as business and leisure. The review of literature concerning definitions of medical tourism revealed argument among various authors. The debates centred around when tourism qualifies as medical tourism and the main basis for this was why someone travels. It was found that the main contention in literature was about the meaning and understanding of whether a medical tourist must be traveling away from the home country seeking conventional medical services exclusively, wellness treatment exclusively or a combination of both medical and wellness services. Literature specific to the context of this research and review of the QHFMP in section 2.6 helped to underscore the rationale for the significant investments being made by the Qatar Government to develop the

healthcare sector in areas such as technology and health infrastructure. The improvement of facilities throughout HMC, at Hamad General Hospital and completion of the Sidra Medical and Research Centre were among the most notable of these (Ventures Onsite, 2015).

Further critical reviews of theories and concepts of medical tourism included the Wellness Lifestyle based on the concepts of lifestyle perception and healthy lifestyle (Dunn, 1959) for understanding consumer behaviour in tourism (Konu, 2010; Aziz and Ariffin, 2009). The Wellness Wheel (Witmer and Sweeney, 1992), niche tourism (Robinson and Novelli, 2005) and aesthetic tourism (Spencer, 2003; Garrod and Fyall, 2011; Connell, 2011) were also reviewed. The economic impact of medical tourism, the roles played by culture and demographics were critically reviewed to inform the development of the conceptual framework. The critical review of literature with respect to niche tourism and service quality focused on medical tourism informed the development of the conceptual framework shown and discussed in section 3.14. The conceptual framework, which is based on SERVQUAL theory, comprised two major components of service quality management and external management where perceived quality of the medical tourism services given was the independent variable. The conceptual framework highlighted five gaps in external/internal stakeholders, service delivery/perceived performance, perceived performance/perceived quality, perceived quality/expected service, and customer perceptions versus perceived quality/expected service.

9.2.2 Identification and Critical Examination of Government and HMC Management's Perceptions about Service Quality Theory

The second objective of this study was to identify and critically examine government and HMC management's (the case organisation) perceptions in relation to service quality theory by undertaking primary research with those employed in these areas using SERVQUAL theory as a starting point. Emergent findings revealed differences in use of language and

confusion of meaning whereby some government officials and senior managers used different terms to describe the various aspects of medical tourism. Of particular significance in this context was the confusion and overlap in reference to the terms medical and wellness tourism. Although most ministry officials and senior managers used medical treatment terminologies to refer to healthcare and hospital-based services (such as ward admissions, surgery and treatment) as medical tourism, others described medical tourism as wellness tourism and included elective leisure-based services such as spas as opposed to conventional medical procedures and treatment.

Consistent with the SERVQUAL model which formed the basis for the conceptual framework adopted in this study, the variation in language and the subsequent confusion in meaning was also linked to misunderstanding in the roles of employees and particularly the frontline employees. The ministry officials and the senior managers also expressed the likelihood of Qataris being afraid and even rejecting medical tourism altogether. Physical environment, hospitality and hospitableness emerged as the main aspects of organisational capacity with the potential to affect customer satisfaction although this was contingent on changes to the Qatari legislation and regulatory framework to allow for medical tourism to occur. The need to ensure more facilities and to devise partner packages with providers of nonmedical services such as hotels and other hospitality service providers was also highlighted although this again was contingent upon governance and legislative revision which would permit the development of medical tourism. Many of these findings were in contrast with those of the users of medical services in Qatar as explained in the next section.

9.2.3 HMC Service Users (Potential Medical Tourists) Experiences of Medical Tourism in Relation to Service Quality

Objective three was developed to critically examine the HMC service users (proxy medical tourists) experiences of medical tourism in relation to service quality. The perceptions

and experiences of the users of HMC medical services in Qatar were critical in this study because they gave experiential-based insights into how medical tourists might want to be treated, the kinds of procedures that they would be most likely to be interested in and their experiences of medical services and tourism, all of which could affect perceived service quality. The findings showed that the users of HMC medical services understood there to be two types of medical tourism; the treatment of ongoing and chronic illnesses targeting those living in the GCC or other neighbouring states and the elective wellness type targeting international medical tourists. Most of them thought Qatar had real potential to become a medical tourism destination due to its advanced health and medical system, high quality of medical care and quality of facilities. In general, the users of HMC medical services also welcomed the idea of medical tourism and viewed HMC positively overall.

9.2.4 Aligning Internal and External Stakeholders' Perceptions and Experiences of Service Quality

The fourth objective of this study was to critically align internal (government and HMC management) and external (service users) stakeholders (medical tourists) perceptions and experiences of service quality in relation to medical tourism in order to identify gaps in knowledge and provision, establish critical service quality factors and to revise the conceptual framework. To achieve this objective, the findings of the interviews with ministry officials and senior managers were analysed against those of the questionnaire responses by the users of medical services in Qatar in chapter eight and the results mapped against the five gaps identified in the conceptual framework presented in section 3.14.

This mapping suggested that, unlike the initial conceptual framework, the revised framework actually only contained four gaps. The first gap was between the perceptions of internal and external stakeholders in which maintaining social capital was exempted. The second gap was retained between perceived performance and service delivery based on the

findings associated with internal and external stakeholders respectively. The third gap in the initial conceptual framework was modified to be between perceived performance and expected service since perceived quality was not a major concern for the users of medical services in Qatar. With the removal of the perceived quality dimension from the conceptual framework, gap 4 between perceived quality and expected service was subsequently dropped. This explains the reduction in the number of gaps from five in the original conceptual framework in section 3.14 to four in the revised conceptual framework (see Figure 9.2.4.) below.

Figure 9.2.4. *Revised conceptual framework for service quality in Qatari Healthcare*
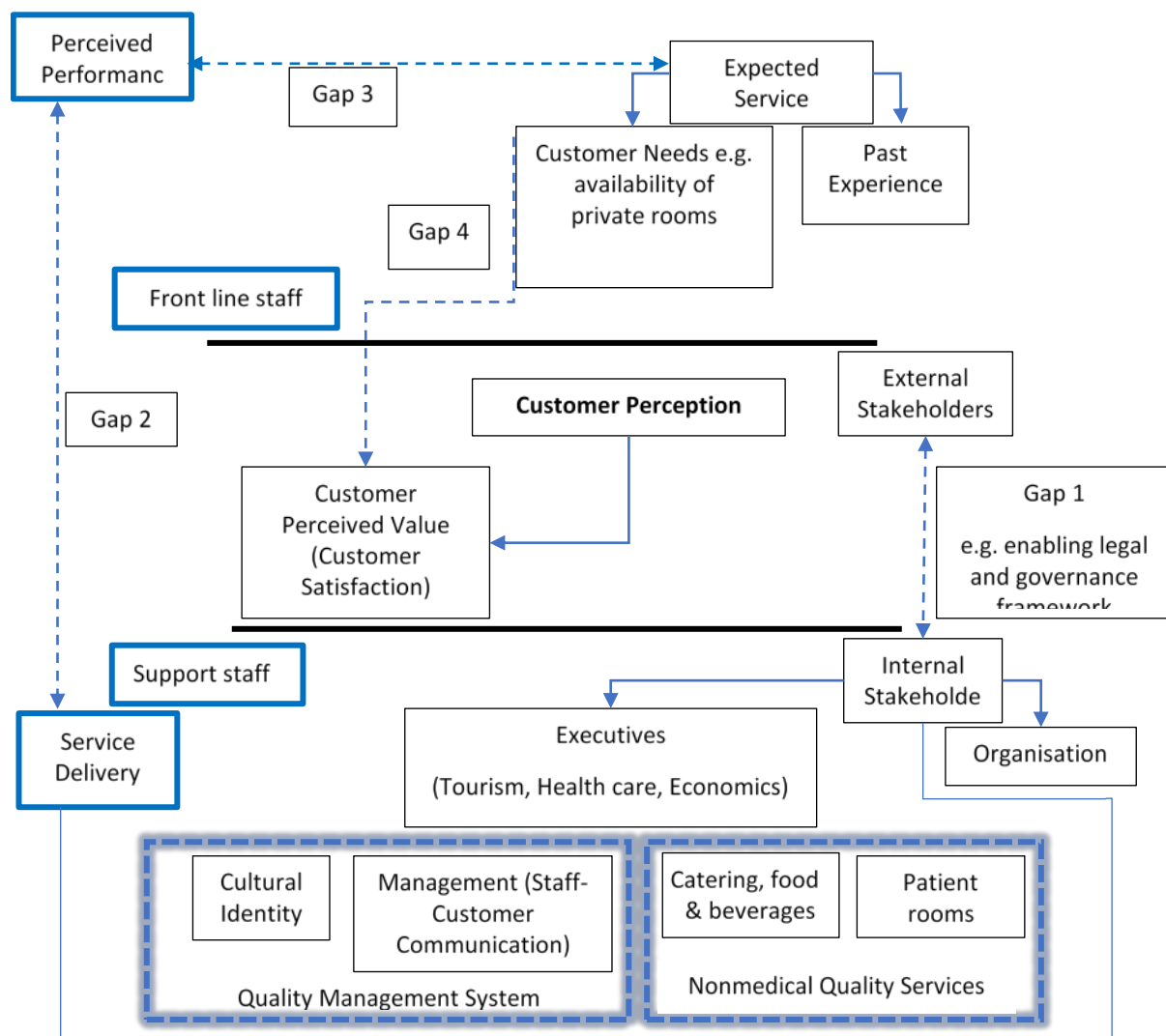
As costs did not emerge as significant influencers of medical tourism in Qatar nor of customer perceptions and satisfaction with the service quality in the healthcare sector in Qatar it was removed from the constituent components of expected service. The fourth gap was then determined to be between expected service (customer needs and past experience) and customer perceived value (customer satisfaction).

9.2.5 Reflection on Adopted Framework and Recommendations to Enable Qatar to Become a Leading Medical Tourism Destination

The target of objective five was to reflect on the adopted framework and make recoomendations to enable Qatar to become a leading medical tourism destination. Partial achievement of objective five was met by the interpretation and consolidation of the research findings which led to the revision of the conceptual framework (see Figure 9.2.4 // p. 273). The critical review of literature, critical analysis of the interview data collected through interviews with ministry officials and senior managers working in the Qatari healthcare sector and critical analysis of data from users of medical services in Qatar all informed the finalisation of the framework presented in Figure 9.2.4 (p. 273). Complete achievement of objective five is shown in sections 9.3 and 9.4 through the presentation of contribution to theory, contribution to practice, and recommendations based on the conclusions and findings of this study.

9.3 Contributions

This research makes several contributions to both theory and practice. The section is divided into two subsections accordingly. Respectively, the sections cover the theoretical and practical contributions.

9.3.1 Contribution to theory

The findings of this research first challenge extant theory concerning the current definition of medical tourism (see section 3.2). This research suggests that medical tourism should be viewed as a continuum containing two distinct forms at its extremities, see Figure

9.3.1 below. At one end is the more conventional international elective and wellness-based concept while at the other is a more regional concept based upon healthcare for ongoing and chronic illnesses.

Figure 9.3.1. *Continuum representing the different forms of medical tourism*

Regional Healthcare tourism

Inability to travel long distances, little interest in leisure or tourism in the host country	One off elective treatments ie hip replacement or cosmetic surgery
Chronic illnesses, ie requiring repeated treatments	Willing to travel, interested in leisure and tourism in the host destination

International elective medical tourism

Medical tourism

Existing academic theories tend to present medical tourism as a blanket form of tourism that entails travel primarily for medical services such as disease treatment, surgery or medical diagnosis across borders in order to obtain some critical or elective medical treatments (Hall, 2013; Connell, 2011). However, this research demonstrates that while this definition remains true, medical tourism can also contain a local, regional form based primarily upon chronic repeat treatments with very little interest in leisure or tourism activities. Thus, the findings of this research lead to the definition of medical tourism as a continuum comprising the local or international movement of people (customers or patients) outside their own countries to access non-elective and/or elective, critical or non-critical healthcare and wellness services.

Based on this understanding of medical tourism, the next contribution of this research to theory relates to the modification of Frost and Kumar's (2000) SERVQUAL theory when

applied to the Qatari medical tourism context. While the research reaffirms some of the aspects of the theory by testing and establishing their relevance to the medical tourism context in Qatar the most outstanding modification was the establishment that the third gap in the theory was not relevant to the medical tourism context in Qatar. The main rationale for the removal of perceived quality from the theory was informed by the existing guarantee of quality healthcare in Qatar. The findings of this research showed that quality of medical care was not raised as a concern by users of medical services in Qatar and nor did the ministry officials and senior managers involved in this study have any serious concerns about either the actual or perceived quality of healthcare services in Qatar. Thus, this research contributes to Frost and Kumar's (2000) theory by demonstrating that perceived quality is not applicable if quality is a guaranteed given in the particular context under study. The findings of this research also contribute to the theory by Sumarjan *et al.,* (2013) concerning hospitality and tourism by demonstrating that perceived quality is not always one of the most critical components in the achievement of customer satisfaction even though hospitality services, which accompany the medical services, also need to be good if a service gap is not to reappear. Table 9.3.1 below illustrates the variations where all text in red means that the item was in the initial conceptual framework (see Figure 3.14 // p. 116), but has since been removed as not applicable in the context of this research.

Table 9.3.1. *Comparison of the components and constituents in the original; earlier developed and modified conceptual frameworks*

Gap	Main Components	Original Constituents	Revised Constituents
Gap 1	External Stakeholders	Customer Perception: • Customer Perceived Value (Customer Satisfaction) • Behavioural Intentions (Customer Loyalty) • Post-behavioural intentions (Customer Retention)	Customer Perception: Customer Perceived Value (Customer Satisfaction)
	Internal Stakeholders	Executives (Tourism, Healthcare, Economics) Organisation	Executives (Tourism, Healthcare, Economics) Organisation
Gap 2	Service Delivery	Quality Management System: • Cultural Identity • Maintaining Social Capital • Management (Staff-customer communication Nonmedical Quality Services • Catering, food & beverages • Patient rooms • Other nonmedical services	Quality Management System: • Cultural Identity • Management (Staff-customer communication Nonmedical Quality Services • Catering, food & beverages • Patient rooms
	Perceived Performance	• Expertise • Training	Same
Gap 3	Perceived Performance		
	Perceived Quality + Expected Service	Expected Service: • Customer needs • Costs • Past Experience	Expected Service: • Customer Needs e.g. availability of private rooms • Past experience
Gap 4	Perceived Quality	Dropped	
	Expected Service		
Gap 5	Perceived Quality + Expected Service	• Customer needs • Costs • Past Experience	• Customer Needs e.g. availability of private rooms • Past experience
	Customer Perception	• Customer Perceived Value (Customer Satisfaction) • Behavioural Intentions (Customer Loyalty) • Post-behavioural intentions (Customer Retention)	• Customer Perceived Value (Customer Satisfaction)

Thirdly, this research contributes to extant theory by revealing that previously theorised customer behavioural intentions aspects may not always apply to all populations receiving a service. In the case of this research, when the SERVQUAL frameworks are adapted for medical tourism then there are two levels of customer expectation to be satisfied i.e. medical and non-

medical. Where the medical care is acknowledged to be world class then this ceases to be an issue and only the non-medical expectations remain. It would appear that if a healthcare brand or service provider is established as the ultimate go-to service provider by customers, then customers are likely to remain loyal and stick to the brand or service provider regardless. Although many satisfied HMC customers would be cured and not need to return, as this research has shown there are also those with chronic conditions to manage who, if satisfied, would continue to return to HMC. Both groups, if satisfied, would be likely recommend HMC to their families and friends. In the case of this research, HMC is considered the top, quality provider of healthcare services by Qataris and non-Qatari residents and their behavioural intentions and post-behavioural intentions, identified in the questionnaires, indicated that they expected to continue to have positive perceptions of HMC. This study contributes to theory by showing that customer satisfaction as conceptualised through customer perceived value is paramount to customer loyalty. Thus, the theory was modified to include customer satisfaction as the only influencer of customer perception, as demonstrated in section 7.3 as a whole and particularly sections 7.3.2 and 7.3.3. This research also contributed to extant theory by modifying gap 3 in Frost and Kumar's (2000) work from a gap between perceived performance and expected service plus perceived quality to a gap between perceived performance and expected service only.

In addition, since the Qatari users of medical services rarely incur significant healthcare costs, and this is unlikely to change, costs under expected service were not supported as a relevant constituent of the expected service dimension in this context. This research contributes to existing theory, therefore, by showing that cost is not always a determinant of expected service while customer needs and past experiences are and this applies to GCC countries where governments pay for the medical expenses of their citizenry except when they opt for medical services from private hospitals. Hence, the cost could become a relevant constituent to medical

tourism in Qatar if the medical tourists did not have insurance to cover costs. However, this only supports the view that cost is relevant only in some circumstances and not in others.

Reflecting on the modifications made to the original conceptual framework, this study contributes to the theory by underscoring the significance of adjusting the theory to suit different cultural contexts. This is because this research underscores the importance of culture of the different medical tourists in defining and influencing the perceptions of both internal and external stakeholders towards the different components of the SERVQUAL model. This is an affirmation of the theory by Sumarjan *et al*., (2013) that culture is a significant influencer of tourism and extends it by showing that this also applies to the context of medical tourism in Arabic countries. Similarly, this modification to Frost and Kumar's (2000) initial theory underpinning the SERVQUAL model confirms the importance of adapting various theories into specific contexts of industry sectors. This research demonstrates that the SERVQUAL model, robust as it is, cannot be applied as-is to the medical tourism sector in Qatar without modifications. In response to this, the other contribution of this research to theory was the development of a framework as discussed in section 9.2.4 //p 272 for aligning the internal and external stakeholders' perceptions and experiences of service quality.

9.3.2 Contribution to Practice

This section highlights the contribution that this research makes to practice based on the findings. In terms of having a product that offers world class services, the findings of this study demonstrated that medical tourism in Qatar is set to offer world class services. The findings in this regard also matched the evidence that Qatar has a high-quality service environment, superior facilities, and advanced technologies that would ensure trust within the global patient community.

This research makes three main contributions to practice. These include, changes required to the governance and legal framework, clarity from government and senior

management at HMC about the form of medical tourism that needs to be developed and the appropriate administrative systems to support this, and the development and understanding of actual and appropriate partnership packages. The three subsections below expound on these contributions to practice in the order they are listed here.

9.3.2.1 Changes required to the governance and legal framework

The findings of this research show that Qatar's current legal and governance framework currently works to inhibit the successful implementation of medical tourism rather than to promote it. It was revealed that both internal and external stakeholders were concerned that the current healthcare regulatory framework in Qatar prevents the development of medical tourism per se since it prevents healthcare facilities from making a profit and, in addition, inhibits its development because of the current time consuming and complex visa system. Essentially, the findings of this research signal the need to revise the Qatari governance and legal framework in two main ways. The first revision should focus on allowing hospitals and other medical facilities to actively engage in the commercial delivery of medical tourism alongside the current government-funded healthcare provision for Qatari nationals and residents.

The second revision would be to revise current immigration laws to enable international medical tourists, particularly those from outside GCC and the Arab League, and their accompanying companions to access Qatar with greater ease. Therefore, the findings of this study underscore the need for a comprehensive review of all the relevant legal and governance frameworks to be supportive of medical tourism. This may also entail changing the legal framework that governs the various industry sectors that are likely to play supportive roles to the healthcare sector in the process of developing and implementing medical tourism in Qatar so that, for example, the partnership packages proposed in section 9.3.2.3 work seamlessly. This is because writing a new government policy, no matter how well intentioned, for top down

implementation is unlikely to be effective if all the underpinning detail is not in place to support it.

9.3.2.2 Developing two types of Medical Tourism

The findings of this research revealed the potential for the development of two forms of medical tourism where one form targets the local neighbouring and Arab countries and is more chronic, long-term health-focused while the other is mainly designed for international medical tourists, elective wellness medical tourism, cosmetic surgery and one-off procedures such as knee or hip replacement. However, this potential also underscores the significance of harmonising the divergent views and perceptions of government officials and senior management officials at HMC who are responsible for implementing medical tourism in Qatar. The difference in use of language and terminologies related to medical tourism is reflective of both different understandings about the concept of medical tourism and a lack of synergy between the various agencies and departments who are responsible for delivering medical tourism in Qatar successfully. If left unaddressed this could translate to the failure of medical tourism in Qatar particularly as this research has identified two differing potential forms of medical tourism each with their own needs.

Further, the findings of this research show that it is critical for the government and management, as the lead implementers of medical tourism, to develop an accurate and comprehensive understanding of the expectations and demands of the full range of medical tourism consumers. The successful implementation of the two forms of medical tourism proposed in this study will require significant adjustments to the current admissions and billing systems enabling it to accommodate a wide range of customers' demands based on geographical origin, type of service sought and whether the primary consumer (the one seeking the service) is accompanied or not and the kind of services that accompanying tourists (if any)

may want to participate in such as leisure activities, sightseeing and so on. This would be linked to the development of a successful, medical-tourist-centred marketing strategy.

Additionally, it may be necessary for the Government of Qatar and managers of healthcare and wellness service providers to review the facilities currently under construction, but which are not popular with Qatari nationals, so that they become more suited to the needs of international medical tourists. Since more facilities outside Doha will be available to cater for the possible demand from potential medical tourism consumers who would prefer non-urban or peri-urban facilities to those in Doha.

9.3.2.3 Partnership packages

The findings demonstrated that government officials and managers were sceptical of Qataris embracing medical tourism yet the HMC medical services users indicated that they would be supportive of it and that they believed that Qatar had real potential to become a medical tourism destination despite senior managers and government officials identifying potential issues. They also showed a better understanding than the government officials and senior management of the hospitality requirements and partnership packages needed to support the development medical tourism. This reinforces the suggestion that there is need for better understanding of hospitality/partnership packages by the providers of medical tourism which ensures that Qatar is clearly focussed on its medical tourism offering enabling the Qatari people to see and relate clearly to the benefits of participating in the development of medical tourism within the country.

Once it had decided upon its preferred form/s of medical tourism the Government of Qatar needs to clearly communicate this vision of medical tourism in Qatar to every stakeholder group and outline the facilitative roles that each stakeholder group is expected to play. Reference to the findings of this research especially in section 9.2.4 demonstrates the inclusive, participatory roles that each stakeholder group has. The understanding of medical tourism and

actual appropriate partnership packages has to be developed so that they can be marketed and so that the Qatari people can see the benefit of medical tourism to themselves and remain positive about its development which are both crucial to ensuring the successful development and implementation of medical tourism.

9.4 Conclusion and Recommendations

The findings of this research provided appropriate evidence with which to respond to the three research questions as the basis of the conclusion. Consistent with the first research question about the complexity of the concept of medical tourism, it is concluded that government officials and senior managers at HMC do not fully understand what medical tourism entails in all its aspects. The complexity of the meaning of medical tourism also manifested itself in terms of how employees understand and are therefore likely to execute their roles in the development of medical tourism. The issue of difference in use of language and terminologies related to medical tourism in Qatar demonstrates the potential for discord or disharmony among the government agencies, ministries, and entities which would be responsible for the implementation of medical tourism. These results show that there is need for various measures to be taken to address this discord especially in light of the need identified to develop holistic partnership packages. Since the QTA is already in existence and is supported by the Government of Qatar to work on tourism matters, it is recommended that the same authority become responsible for bringing harmony between the various stakeholders in government institutions with respect to the implementation of medical tourism. The QTA should also become the platform through which medical personnel, business and the people of Qatar come together to provide input on how best to run medical tourism in the Country. In order to do this it is recommended that, the Government of Qatar should establish a medical tourism board under the QTA that comprises representatives from the QTA itself, Ministry of Public Health, the Ministry of Commerce and Industry, Ministry of Municipality and Urban

Planning, and the Ministry of Administrative Development, Labour and Social Affairs. This would aid in the development and institutionalization of a clear medical tourism implementation strategy within the Country and help in achieving multisectoral synergy that would propel Qatar into being a premium medical tourism destination.

The second research question was about determining who the medical tourism customer is in the Qatari and Arabic context. In response to this, all medical tourist customers were perceived to be foreign consumers of medical services in Qatar but a variety of motives were identified for this consumption. Thus, it is concluded that a customer is a non-resident or non-citizen of Qatar who travels to Qatar for the primary purpose of consuming either essential or elective healthcare-related services in Qatar for a fee to the institution delivering the service. This research has also concluded that while all travel to Qatar for treatment which they pay for there are two primary types, the local chronic heath seekers and the international elective seekers, which have different needs and expectations to be met.

The third research question was about identifying the service quality barriers of medical tourism in Qatar. It is concluded that the service quality barriers to medical tourism in Qatar fall into four SERVQUAL related service gaps. Gap 1 is the gap between the views of external and internal stakeholders. This gap is primarily occasioned by a variance in language and confusion of meaning when referring to medical tourism, medical tourists and other related issues which have the potential to influence the development of and quality service in Qatar's medical tourism. The other gaps are between perceived performance and service delivery, perceived performance and expected service (customer needs and past experience) and between expected service and customer perceived value, which equates to customer satisfaction. The findings showed that the Qatari cultural context demands a revision of the SERVQUAL framework to suit its particular non-western context. For example, in the case of Qatar, the gap between perceived performance and perceived quality was not relevant in the context of

medical tourism. However, cultural identity was found to be extremely influential in the gaps between internal stakeholders and external stakeholders and between service delivery and perceived performance.

The findings reported in this study informed the development of five key recommendations to aid in the successful implementation of medical tourism in Qatar. They are centred around the issues of changes to Qatari legislation, language and meaning confusion, handling medical tourism fears in Qatar, and development of packages to support medical tourism. These recommendations are listed and elaborated below:

1. The Qatari government will need to develop new legislation governing and regulating medical tourism which firstly defines exactly what form/s of medical tourism it seeks to develop and secondly removes the not-for-profit prohibition from organisations offering medical services within Qatar. Without these fundamental changes it is very unlikely that any organisation would become interested in partnering with the government, its agencies and institutions in order to develop medical tourism in Qatar.

2. The Government of Qatar needs to undertake comprehensive awareness and education campaigns for all stakeholders and Qatari residents in relation to medical tourism and its potential benefits to the country and themselves. It is crucial that HMC, the Qatari hospitality and tourism industries and Qatar in general begin considering medical services' seekers as customers and not restrictively as patients and sensitise all stakeholders about this. It is also crucial that Qataris understand that the development of an efficient, high quality medical tourism service will translate into multiple economic gains through improved infrastructure, increased medical tourism influx and the growth of service sectors such as transport and hospitality.

3. In addition to the legal and governance changes noted in the first recommendation the issue of visas emerged as a potential barrier to the successful implementation of medical tourism in Qatar. Therefore, it is recommended that adequate research be undertaken to determine the requisite, comprehensive amendments which would ameliorate this issue. In terms of increasing access to Qatar as a medical tourism destination, Qatar could follow in the steps of India and introduce a special visa for medical tourism like the M-visa (Chinai and Goswami, 2007).

4. A robust billing system was found to be a critical factor essential to the development of medical tourism in Qatar. It was clear from the findings of this research that while there is a billing system in place it is currently limited to reclaiming costs from the Government and billing for extra services. Therefore, it is recommended that a full investigation is carried out to provide further clarity concerning the extent to which HMC and the Qatar healthcare system will need to develop a robust billing system with the capacity to handle multiple national and international payment methods. Additionally, there is a simultaneous need to develop a linked and equally robust admissions' system, which would enable medical tourists and Qatari nationals to be booked into appropriate hospitals or other medical facilities in a timely fashion which prevented clashes and extended waiting times.

5. Once the systems have been reconfigured and established to accommodate the admission, partner packages, and billing systems to facilitate medical tourism in Qatar on large scale, marketing and promotion of the services and Qatar as a preferred medical tourism destination will need to be developed. Decisions will have to be made as to whether the government will coordinate this or whether each provider will do their own marketing. In light of the medical tourism continuum identified from the findings of this research, it is critical that appropriate marketing

is developed for whichever type of medical tourism the Qatari government decides

to support; the chronic regional health and or international wellness / single

treatment sectors. This will enable synergised and properly coordinated marketing

of Qatar as a preferred medical tourism destination.

Table 9.4 below illustrates the recommendations, pointing out the party responsible for

its implementation, how to implement the recommendation, and the timeframe for

implementation.

Table 9.4. *Recommendations, responsible parties, achievement and timeframe*

Recommendation	Responsible	How to Achieve	Timeframe
1) Development of legislation governing and regulating medical tourism partnerships	Government	• Country-wide stakeholder consultations with interested partners e.g. through stakeholder conferences and baseline surveys	Long-term
2) Medical tourism awareness and education campaigns	Government & HMC	• Conventional and social media campaigns • Informal approaches through social gatherings, mosques and so on • Websites	Short-term and ongoing
3) Development of legal and governance framework to facilitate medical tourism access	Government	• Undertaking comprehensive market research to understand the legal needs for development of medical tourism • Restructuring of immigration and visa rules • Restructuring current healthcare system	Long-term
4) Healthcare billing and insurance incorporation	HMC	• Simultaneous need to develop a linked and equally robust admissions' system	Long-term
5) Marketing & promotion of Qatar as the preferred medical tourism destination	HMC	Advertising and promotion locally and internationally through: • Social media • International mass media • WOM • Exhibitions and sponsorships of events	Short-term, but ongoing

Besides the practical recommendations described above, the following recommendations would help to advance theory:

1) The research findings have shown the need for adapting and contextualising the SERVQUAL model to suit the cultural traits of a country. There is need for further investigations to determine how different aspects of the SERVQUAL model are influenced by culture and societal orientations within Arabic and other non-western countries.

2) This research has identified two distinct but linked forms of medical tourism. While, the characterisation of the forms of medical tourism presented in this research provides direction as to what they might look like it is by no means exhaustive. To advance medical tourism literature and theory, it is important that researchers and theorists of medical tourism investigate the traits of the entire continuum of medical tourism.

3) Advancing theory as proposed in recommendation (2) above would also aid theorists and researchers in medical tourism marketing to develop a range of strategies more appropriately suited to the full range of medical tourism. This may also necessitate the review and revision of existing marketing theories such as the 7Ps to suit the new characterisation of medical tourism

9.5 Limitations and Reflections

Although the objectives of this study were accomplished, several limitations impeded the completion of a more robust study with even stronger findings. For example, the choice of a largely qualitative approach to the research process means that the findings of this study may not be generalizable to the entire Qatari nation and across all industry sectors. A further difficulty was the fact that Qatar has not yet developed a robust and well understood medical tourism industry; therefore, the respondents to the questionnaires were users of medical

services in Qatar as opposed to medical tourists per se. Contextualising or interpreting these findings as though they came from medical tourists may mean that their accurate application when medical tourism is eventually implemented in Qatar requires further verification. For example, the experience of Qatar for medical tourists may be different from experiences that they may have had in other countries. This point will need to be considered / reconsidered as it reflects the contextual variations that aspects such as culture, infrastructure, and attitudes of host communities (see section 3.11) have upon the tourist experience. In addition it is accepted that while the proxy population was accessible, unlike the actual population of medical tourists, it is not possible to guarantee that potential response bias did not infiltrate the data and influence the outcomes of this research. For example, the proxy population comprised a large number of Qataris who have been shown to value status (see p. 180) and who therefore may have been cautious of responding in a way that would lower or affect the status of their country. Even in the case of the non-Qataris in the proxy population, their responses may still have been influenced by the fact that they had been residing in Qatar. However, and as previously discussed, many of the respondents did in fact have many of the attributes of medical tourists in that they were seeking medical care in a country outside their own. Thus, they were well placed to offer insights about how they felt medical tourism could be like in Qatar and what they thought Qatar needed to do to become a top medical tourism destination. Indeed, the proxy population in this study provided a rich range of diverse views about the potential for medical tourism in Qatar in the absence of information about the actual medical tourists in the country.

The findings of this study showed that some of the users of HMC services rated the service performance by nonmedical staff in general as low. Paradoxically, the same users rated some nonmedical staff like those in the food service sector highly, as shown in section 7.3.7. These findings signal the possibility that the users of HMC services have misunderstood the terminology of nonmedical staff at HMC. Also, like the term facilities, the term staff can have

different connotations for different people. This may have impacted upon the findings and more clarity in such terminology would be needed in future studies in order to test and validate the results of this study more deeply. However, while accepting that more research will need to be undertaken as medical tourism within Qatar develops, it is argued that the findings of this study have been built pragmatically upon the most appropriate data currently available.

9.6 Suggestions for Further Research

During the process of this research, it emerged that that there were at least two forms of medical tourism identified by the participants. Therefore, these findings challenged the circle model which was developed earlier on in this research based upon current literature, which suggested the existence of a single model of medical tourism; the international tourist travelling for wellness or single treatment services and looking for a certain amount of adventure in the destination country. In a world with an increasingly aging population which is often prone to ongoing chronic illnesses there seems to be very little research into this type of medical tourist and their needs. However, time constraints and the scope of this research made it difficult for the researcher to investigate this issue further. Further research is needed to ascertain the current characteristics of the full range of modern medical tourists.

One of the main contributions of this study was the development of a context-adapted SERVQUAL framework for investigating and understanding medical tourism in Qatar. Further research is needed to test the framework in other Arabic or Gulf contexts which have similar cultural stances as Qatar. For example, testing the framework in an established medical tourist destination like Saudi Arabia, Tunisia or Morocco could further help in validating the framework or refining it. This would be essential in demonstrating the extent to which the framework can be relied upon in investigating service quality in medical tourism.

Some of the findings reported in this research require further research. For example, billing and the remittance of health insurance claims were identified as critical success factors

for medical tourism in Qatar especially based on the findings of the interviews with senior managers at HMC. However, the findings of this research suggested that the current financial systems are not sufficiently advanced or robust. Therefore, it is recommended that further research is carried out to determine how the HMC and Qatar healthcare financial systems can become able to meet international financial requirements.

This study identified the need to develop sophisticated partner packages comprising both medical and nonmedical services such as hotels and other hospitality services which could be offered to both medical tourists and those accompanying them (see pages 173, 191 and 269). However, it was not within the scope of this research to investigate fully what the constituents of such partner packages could entail. Therefore, while excellent healthcare services are central to successful implementation of medical tourism in Qatar as well as revision of legislation to allow this, integrating them with other nonmedical tourism services such as air ticketing, visa processing, sightseeing and cultural experiences could set Qatar apart from competition. Current research suggests that those accompanying the medical tourists may want to experience more than just the medical bit of tourism in Qatar. With the numerous tourism activities which Qatar has to offer based around its five key tourism attractions (traditional, innovative, events, nature, and culture (see p. 36)) their integration with medical tourism would most likely ensure that Qatar is a step ahead of competition in the competitive medical tourism industry. For example, this could include tourism activities such as sport tourism, tours to the museums, the Qatar International Food Festival, nature and wildlife tours, and desert safaris. However, there is need for further research to investigate how such integration may be achieved, the opportunities that exist, the challenges that are likely to be encountered, and benefits and drawbacks of integrating the five key tourism attraction segments with medical tourism.

9.7 Personal Reflections

At the commencement of this research, the initial thoughts were that I would investigate medical tourism in Qatar based on the QNV. This is why I had initially imagined that cross-sectional interview data with ministry and government officials working on various aspects of implementing QNV would be adequate to inform the findings of this study, a limited approach, I now understand. After the completion of the data analysis of the interviews with the ministry officials and with the help of my supervisors I quickly realized that I had more questions I needed to investigate. After interviewing the ministry officials, my own experience as a hospital administrator led me to realise that their beliefs challenged my personal experiences. In order to gain an in-depth and holistic understanding I needed to gain information from other stakeholder groups and so the study evolved. The main lessons I learnt from this experience were the importance of remaining open-minded and letting the findings of your research direct the course of the study.

While I was interviewing senior managers for the second data collection phase, I was able to further hone my participant recruitment and interviewing skills. It was also another chance for me to understand qualitative research methods better and to apply them in a sequential manner where the findings of one qualitative interviewing phase informs the questions of subsequent phases so that comparisons can be made between the findings. Further contentious issues emerged over critical aspects of this research and, with the help of my supervisors, I began to understand that the findings of the two interview phases were largely one-sided. This one-sidedness was mainly due to the fact that they projected the views of implementers and managers of medical tourism without giving an opportunity to the voice the prospective consumer of medical services in Qatar.

Stopping at ministry officials and senior managers would have meant that the SERVQUAL model's aspect of the consumer voice in terms of perceived quality, perceived

performance and expected service would have been unrepresented. Although the intention had been to include the voice of actual medical tourists from Qatar in the research, I found that there was no target population available to me. From this I learnt that the researcher has to be vigilant and pragmatic in determining what population would best suit the research needs when the ideal one is not available. The recruitment of users of medical services within Qatar carried the risk of getting findings from a population which had not experienced the subject under investigation in a pure sense but from this research phase I learnt how to develop questions about intended as well as actual behaviours. Including a quantitative aspect to this study also enabled me to learn about other analytical approaches; integrating interview data with survey data and presenting both descriptively to analyse trends and patterns through a qualitative-driven process.

This entire research process was an eye-opening, skills-sharpening challenge with more learning points than can be covered or experienced in theoretical studies. Besides upskilling my scholarly potential, the whole process equipped me with new skills and improved existing ones. For example, the interview processes and the intense writing enabled me to become a better communicator with other people whether in person or in writing. I am also better at analysing new situations more objectively and looking at problems as opportunities for research. My critical thinking skills have improved greatly and so has the identification of what the real, underlying meaning of a concept or a statement is when engaging in research and in real life.

References

Abd, M.N.H., Hussin, H, Jahn, K.P.N., Alavi, R. and Dahari, Z. (2015). Country perspective on medical tourism: The Malaysian experience. *Leadership in Health Services, 28*(1), pp. 43-56.

Abujaber, A. and Katsioloudes, M. (2015). Impact of HR retention strategies in healthcare: The case of Qatar. *AVUCENNA*. http://dx.doi.org/ 10.5339/avi.2015.6

Adams i'hD, E. (2010). The joys and challenges of semi-structured interviewing. *Community Practice, 83*, 21.

Adler, A. (1956). The individual psychology of Alfred Adler. In H. L. Ansbacher and R. R. Ansbacher (Eds.), *The individual psychology of Alfred Adler: A systematic presentation in selections from his writings*. New York, NY: Basic Books.

Akongdit, O. and Issam, M. (2013). *Political stability and economic development: Case of South Sudan*. LAP Lambert Academic Publishing.

Al-Khouri, R. and Dhade, A. (2014). *Effect of Savings reducing oil price volatility and vulnerability of GCC Economies for sustainable economic growth*. Doha, Qatar: Publication of College of Business and Economics, Qatar University.

Al-Lamki, L. Medical tourism: Beneficence or maleficence? *Sultan Qaboos University Medical Journal, 11*(4), 444-447.

Al-Marri M. and Dawoud, S. (2001). Pediatric asthma hospitalizations trends in the state of Qatar. The value of 24 hours observation care in pediatric emergency room. *Middle East Journal of Emergency Medicine, 1*(2).

Al-Shahri, M. Z. and Al-Khemanizan, A. (2005). Palliative Care for Muslim Patients. *Journal of Supportive Oncology* 2005 November- December ;3(6):432- 436.

Aliu, A., Cilginoglu, H., Özkan, Ö. and Aliu, D. (2016). *Medical tourism market and inter-stakeholders' relations in Turkey: A comparative investigation from reverse*

innovation and destination governance viewpoint. Istanbul. Available at:

http://nbnresolving.de/urn:nbn:de:0168-ssoar-46867-7 [Accessed 7 Sept 2018].

Aliu, D. and Aliu, A. (2015). Surdurulebilir turizm perspektifinde hibridite ve paydas yaklasimi: almanya, ingiltere ve turkiye kiyaslamalari. *I. EITOC 2015, 1*, 357-371, Available at: http://hdl.handle.net/11467/1270 [Accessed 7 September 2018].

Allen, T.D. and Eby, L.T. (Eds.). (2011). *The Blackwell handbook of mentoring: A multiple perspectives approach*. Hoboken, NJ: John Wiley & Sons.

Alsharif, M., Labonté, R. and Zuxun, L. (2010). Patients beyond borders: A study of medical tourists in four countries. *Global Social Policy, 10*, 315-335.

American Medical Association. (Aug. 4, 2008). Setting the standards for medical tourism. *Editorial*. Available at: http://www.ama-assn.org/amednews/ [Accessed 25.03.10].

Anbari, Z. and Tabaraie, Y. (2013). Measurement of quality of hospital services via SERVQUAL Model', *Bull EnvPharmacol Life Sci, 3*(1), 51-56.

Andereck, K.L., Valentine, K.M., Knopf, R.C. and Vogt, C.A. (2005). Residents' perceptions of community tourism impacts. *Annals of Tourism Research, 32*, 1056–1076.

Andereck, K.L., Valentine, K.M., Knopf, R.C. and Vogt, C.A. (2005). Residents' perceptions of community tourism impacts. *Annals of Tourism Research, 32*, 1056–1076.

Andersson, A.-C., Elg, M., Perseius, K.-I. and Idvall, E. (2013) Evaluating a questionnaire to measure improvement initiatives in Swedish healthcare. *BMC Health Services Research, 13*(1), 1-11.

Angell, M. (2011). *Health care reform: Duties and responsibilities of the stakeholders*. Saint Joseph's University Institute of Catholic Bioethics.

Angelo, P. and Maria, C. (2010). Analysing tourism stakeholders' networks. *Tourism Review, 65*, 17–30.

Anholt, S. (2007). Competitive identity: the new brand management for nations, cities and regions. *Journal of Brand Management, 14*(6), 474–475.

Ankarcrona, G. and Holm, K., (2016). *The entrepreneurship ecosystem and its supports in Nairobi: A Qualitative study of their relationships*. Available at: https://pdfs.semanticscholar.org/352c/9fdf67b1dd7cec9651d0e43fb7b2946378a3.pdf [Accessed 18 June 2018].

Appadurai, A. (2011). Disjuncture and difference in the global cultural economy. *Cultural Theory: An Anthology*, 282–295.

Arneill, A. and Devlin, A. (2002). Perceived quality of care: The influence of the waiting room environment. *Journal of Environmental Psychology, 22*, 345-360.

Arroyave, E. (2013). Milady's Standard Esthetics: advanced/editorial contributor: Judith Culp. *Clifton Park, NY: Cengage Learning*.

Ash, J., Berg, M., and Coiera, E. (2004). Some unintended consequences of information technology in health care: The nature of patient care information system-related errors. *Journal of American Medical Information Association, 11*, 104-112.

Asubonteng, P., McCleary, K.J., and Swan, J.E. (1996). SERVQUAL revisited: A critical review of service quality. *Journal of Services marketing, 10*(6), 62-81.

Athina, L., (2011). *Quality assurance in healthcare service delivery, nursing and personalized medicine: Technologies and processes*. USA: IGI Global.

Australian Department of foreign Affairs and trade (DFAT) Home. Available at: https://dfat.gov.au/[Accessed 29 July2015].

Aziz, N. and Ariffin, A. (2009) Identifying the relationship between travel motivation and lifestyles among Malaysian pleasure tourists and its marketing implications. *International Journal of Marketing Studies, 1*, 96-106.

Babakus, E. and Boller, G. (1992). An empirical assessment of the SERVQUAL Scale. *Journal of Business Research, 24*, 253-268.

Badri, M., Abdulla, M., and Al-Madani, A. (2005). Service quality assessment and application of SERVQUAL. *International Journal of Quality & Reliability Management, 22*(8), 819-848.

Bagnall, N. (2015). *Global identity in multicultural and international educational contexts: Student identity formation in international schools.* New York, NY: Routledge.

Baker, D. and Crompton, J. (2000) Quality, satisfaction and behavioural intentions. *Annals of Tourism Research, 27*(3), 785-804.

Baker, J. (1987). The role of the environment in marketing services: The consumer perspective. In J. Czepiel, C. Congram and J. Shanahan (Eds.), *The services challenge: Integrating for competitive advantage.* Chicago: American Marketing Association, pp.79-84.

Balaban, V. and Marano, C. (2010). Medical tourism research: A systematic review. *International Journal of Infectious Diseases, 14*(1), 135.

Balfour, F., Kripalani, M., Capell, K. and Cohn, L. (2004). Sand, sun and surgery: Asian hospitals are luring more patients from around the world. *Business Week*, (3870), p. 48.

Bamgbose, A. (1994). Pride and prejudice in multilingualism and development? In R. Fardon and G. Furniss (Eds.), *African languages, development and the state*. London and New York: Routledge, pp. 33-43.

Barratt, H. and Kirwan, M. (2009) Cross-Sectional Studies; Design, Application, Strengths & Weaknesses of Cross-Sectional Studies. *Health knowledge, organising your social science research paper. Lib-guides at University of Southern California*.

Barringer, A.R., (2008). Customer loyalty: An exploration of the relationship between service quality and customer intent to return and willingness to recommend in the restaurant industry. *ProQuest.*

Barsky, J., and Nash, L. (2003). Customer satisfaction: Applying concepts to industry-wide measures. *Cornell Hotel and Restaurant Quarterly, 44*, 173-183.

Beamer, L. (1992). Learning intercultural communication competence. *The Journal of Business Communication, 29*, 285-303.

Becker, E. Sweeney, B. and Parsons, K. (*2008) Ambulatory facility design and patients' perceptions of healthcare quality. Health Environments Research and Design Journal, 3*(4), 35-54.

Becker, M. Haefner, D. and Maiman, L. (1977) The health belief model in the prediction of dietary compliance: a field experiment. *Journal of Health and Social Behaviour, 18*, 348-366.

Bell, D., Holliday, R., Jones, M., Probyn, E. and Taylor, J. (2011). Bikinis and bandages: An itinerary for cosmetic surgery tourism. *Tourist Studies, 11*, 139-155.

Bennie, R. (2014). Medical tourism: A look at how medical outsourcing can reshape health care. *Texas International Law Journal, 49,* 583.

Berg, B.L., Lune, H., and Lune, H. (2004) *Qualitative research methods for the social sciences* (Vol. 5). Boston, MA: Pearson.

Berry, L, Bennett, D., and Brown, C. (1989). *Service quality: A profit strategy for financial institutions*. Homewood, IL: Dow Jones-Irwin.

Berry, L., Lefkowith, E. and Claek, T. (1988). *Harvard Business Review, 66*, 28-32.

Bertelsmann Stiftung's Transformation Index (BTI). (2018). *BTI 2018 Country Report*. Available at:

https://www.btiproject.org/fileadmin/files/BTI/Downloads/Reports/2018/pdf/BTI_201 8_Qatar.pdf [Accessed 04April 2019].

Bhat, M. (2011) Tourism Service Quality: A Dimension-specific Assessment of SERVQUAL. *Global Business Review SAGE Publication, 13*(2), 327-337.

Bitner, M. (1986). Consumer Responses to the Physical Environment in Service Settings. In: D.M.S. Venkatesan and C. Marshall (Eds.), *Creativity in services marketing*. Chicago: American Marketing Association, 89-93.

Blee, K.M. and Taylor, V. (2002). Semi-structured interviewing in social movement research. *Methods of social movement research*, *16*, 92-117.

Bonnafous-Boucher, M., & Porcher, S. (2010). Towards a stakeholder society: Stakeholder theory vs theory of civil society. *European Management Review*, *7*(4), 205-216.

Booms, B. H., & Bitner, M. J. (1982). Marketing services by managing the environment. *Cornell Hotel and Restaurant Administration Quarterly*, *23*(1), 35-40.

Bordens, K.S. and Abbott, B.B. (2012) *Research design and methods: A process approach*. McGraw-Hill.

Botterill, D., Pennings, G., Mainil, T., and Macmillan, P., (2013). Medical tourism and transnational health care. New York, NY: Palgrave Macmillan.

Bougoure, U. and Lee, B. (2009). Service quality in Hong Kong: Wet markets vs supermarkets. *British Food Journal, 111*(1), 70-79.

Boulding, W., Kalra, A., Staelin, R., and Zeithaml, V. (1993). A dynamic process model of service quality: From expectations to behavioural intentions. *Journal of Marketing Research, 30*(1), 7–28.

Bouman, M. and Van der Wiele, T. (1992) Measuring service quality in the car service industry: Building and testing an instrument. *International Journal of Service Industry Management, 3*(4), 4-16.

Brady, J., Ebbage, A., & Lunn, R. (2013). *Environmental management in organizations: the IEMA handbook*. Routledge.

Brady, M. and Cronin, J. (2001). Some new thoughts on conceptualising perceived service quality: A hierarchical approach. *Journal of Marketing, 65*, 34-49.

Brain, C. (2000). *Advanced subsidiary psychology: Approaches and methods*. Cheltenham, UK: Nelson Thornes Ltd.

Bramewell, B. and Lane, B. (2004). *Collaboration and partnership: Politics, practice and sustainability*. Clevedon, UK: Channel View Publications.

Bramwell, B. and Lane, B. (2011). Critical research on the governance of tourism and sustainability. *Journal of Sustainable Tourism, 19*(4-5), 411–421.

Brean, J. (2013). From counter-culture to mainstream: Why the red-hot tattoo boom is bound to end. *National Post Canada, August 16*. Available online at: http://news.nationalpost.com/news/canada/why-this-red-hot-tattoo-boom-is-bound-to-end-with-regret-again.

Brebbia, C. (2013). *Sustainable development and planning VI*. WIT Press.

Brinkmann, S. (2014). Interview. In: *Encyclopedia of critical psychology*. New York, NY: Springer, pp. 1008-1010.

Brotherton, B. (1999). Towards a definitive view of the nature of hospitality and hospitality management, *International Journal of Contemporary Hospitality Management, 11*(4), 165-173.

Bryman, A. (2015). *Social research methods*. Oxford, UK: Oxford university press.

Bryman, A. and Bell, E. (2007) *Business research methods*. Oxford, UK: Oxford University Press.

Buttle, F. (1996). SERVQUAL: Review, critique, research agenda. *European Journal of Marketing, 30*(1), 8-32.

Buzinde, C. N., & Yarnal, C. (2012). Therapeutic landscapes and postcolonial theory: A theoretical approach to medical tourism. *Social Science & Medicine*, *74*(5), 783-787.

Byrd, E. (2007). Stakeholders in sustainable tourism development and their roles: Applying stakeholder theory to sustainable tourism development. *Tourism Review, 62*, 6–13.

Cachia, M. and Millward, L. (2011). The telephone medium and semi-structured interviews: A complementary fit. *Qualitative Research in Organizations and Management: An International Journal*, *6*(3), 265-277.

Campón-Cerro, A., Folgado-Fernández, J., & Hernández-Mogollón, J. (2017). Rural destination development based on olive oil tourism: The impact of residents' community attachment and quality of life on their support for tourism development. *Sustainability* , *9* (9), 1624.

Carruthers, J. (1990). A rationale for the use of semi-structured interviews. *Journal of Educational Administration*, *28*(1), 63-68. doi/10.1108/09578239010006046/full/html

Carter, S. (1998). Tourists' and travellers' social construction of Africa and Asia as risky locations. *Tourism Management, 19*(4), 349-358.

Castillo, J.J. (2009). *Convenience sampling*. Available at: http://www.experiment-resources. com/convenience-sampling.html[Accessed 25 October 2016].

Caton, K. (2012). Taking the moral turn in tourism studies. *Annals of Tourism Research*, *39*(4), 1906-1928.

Champion V. (1999) Use of the Health Belief Model in determining frequency of breast self-examination. *Research in Nursing & Health, 8*, 373–379.

Chan, J. and Baum, T. (2007). Eco-tourists' perception of ecotourism experience in lower Kinabatangan, Sabah, Malaysia. *Journal of Sustainable Tourism, 15*(5), 574–590.

Chaney, L.H., and Martin, J.S. (2000). *Intercultural business communication*. Upper Saddle River, NJ: Prentice Hall.

Chang, C., Chen, S., and Lan, Y. (2013). Service quality, trust, and patient satisfaction in interpersonal-based medical service encounters. *BMC Health Services Research, 13*(22), 1–11. doi: 10.1186/1472-6963-13-22.

Chang, T. and Chen, S. (1998) Market orientation, service quality, and business profitability: A conceptual model and empirical evidence. *The Journal of Services Marketing, 12*, 246-264.

Che-Wu, H. and Yu-Li, M. (2016). A study of behavioural intentions, patient satisfaction, perceived value, patient trust and experiential quality for medical tourists. *Journal of Quality Assurance in Hospitality & Tourism, 17*(2), 114-150.

Chen, C., and Chen, F. (2010) Experience quality, perceived value, satisfaction and behavioural intentions for heritage tourists. *Tourism Management, 31*(1), 29–35.

Chen, N., Dwyer, L. and Firth, T. (2014). Effect of dimensions of place attachment on residents' word-of-mouth behaviour. *Tourism Geographies, 16*(5), 826–843.

Cheong, S. M., & Miller, M. L. (2000). Power and tourism: A Foucauldian observation. *Annals of tourism research*, *27*(2), 371-390.

Chinai, R., & Goswami, R. (2007). Medical visas mark growth of Indian medical tourism. *Bulletin of the World Health Organization, 85*, 164–165.

Chung, K.C., Pillsbury, M.S., Walters, M.R., and Hayward, R.A. (1998). Reliability and validity testing of the Michigan Hand Outcomes Questionnaire. *The Journal of hand surgery, 23*(4), 575-587.

Clarkson, M. (1995). A stakeholder framework for analyzing and evaluating corporate social performance. *Academy of Management Review, 20*, 92-117.

Cockerham, W., (2014). *Social causes of health and disease* (Second Ed.). Hoboken, N.J.: John Wiley & Sons.

Cohen, E. (2008). Medical tourism in Thailand. In E. Cohen (Ed.), *Explorations in Thai tourism*. Bingley: Emerald, pp.227-255.

Cohen, I., (2014). *Patients with passports: Medical tourism, law, and ethics*. Oxford University Press. UK.

Connell J. (2013). Contemporary medical tourism: Conceptualisation, culture and commodification, *Tourism Management, 34*, 1–13.

Connell, J. (2006). Medical tourism: Sea, sun, sand and surgery. *Tourism Management, 27*, 1093-1100.

Connell, J., 2011. *Medical tourism, chapter one, introduction: Patients without borders*. Oxon, GBR: CAB International Publishing.

Conner, M. and Norman, P. (1996b). The role of social cognition in health behaviours. In M. Conner and P. Norman (Eds). *Predicting health behaviours: Research and practice with social cognition models*. Maidenhead, BRK: Open University Press, pp. 197-225.

Cooper, C., Scott, N. and Baggio, R. (2009). Network position and perceptions of destination stakeholder importance. *Anatolia: An International Journal of Tourism and Hospitality Research, 20*(1), 33–45.

Cooper, P. and Cooper, M. (2009). Health and wellness tourism: Spas and hot springs. Channel View Publications.

Crane, A., & Ruebottom, T. (2011). Stakeholder theory and social identity: Rethinking stakeholder identification. *Journal of business ethics*, *102*(1), 77-87.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: SAGE publications.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Los Angeles, LA: SAGE Publications.

Crompton, J. L., & Love, L. L. (1995). The predictive validity of alternative approaches to evaluating quality of a festival. *Journal of travel research*, *34*(1), 11-24.

Cronin, J. and Taylor, S. (1992). Measuring service quality: A re-examination and extension. *Journal of Marketing, 6*, 55-68.

Cronin, J., Brady, M., and Hult, G. (2000). Assessing the effects of quality, value and customer satisfaction on consumer behavioural intentions in service environments. *Journal of Retailing, 76*(2), 193–218.

Cronin, J., Brady, M., Brand, R., Hightower, R., and Shemwell, D. (1997). A cross sectional test of the effect and conceptualization of service value. *Journal of Services Marketing, 11*(6), 375–391.

Crooks, V. A., Kingsbury, P., Snyder, J. and Johnston, R. (2010). What is known about the patient's experience of medical tourism?: A scoping review. *BMC Health Services Research, 10*, 266–277.

Crooks, V. A., Turner, L., Cohen, I. G., Bristeir, J., Snyder, J., Casey, V., & Whitmore, R. (2013). Ethical and legal implications of the risks of medical tourism for patients: a qualitative study of Canadian health and safety representatives' perspectives. *BMJ open*, *3*(2), e002302. doi:10.1136/bmjopen-2012-002302.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Toward a culturally competent system of care (Vol. 1)*. Washington, DC: Georgetown University.

Crotty, M. (1998). *The foundations of social research: meaning and perspective in social research*. Thousand Oaks, CA: SAGE Publications.

Cummings, T., and Worley, C., (2014). *Organisation development and change* (10th Edition). Boston, MA: Cengage Learning.

Curry, A. and Sinclair, E. (2002). Assessing the quality of physiotherapy services using SERVQUAL. *International Journal of Health Care Quality Assurance, 15*(5). 197-205.

D'Angella, F. and Go, F. M. (2009). Tale of two cities' collaborative tourism marketing: toward a theory of destination stakeholder assessment. *Tourism Management, 30,* 429–440.

Dabholkar, P., Shepherd, C. and Thorpe, D. (2000). A comprehensive framework for service quality: an investigation of critical conceptual and measurement issues through a longitudinal study. *Journal of Retailing, 76*(2), 131-139.

Dahl, S. (1998). *Communications and culture transformation: Cultural diversity, globalization and cultural convergence*. Project presented to the European University, Barcelona. University of Luton, UK.

Dall'Oglio, I., Nicolò, R., Di Ciommo, V., Bianchi, N., Ciliento, G., Gawronski, O., Pomponi, M., Roberti, M., Tiozzo, E. and Raponi, M. (2015). A systematic review of hospital foodservice patient satisfaction studies. *Journal of The Academy of Nutrition and Dietetics, 115*, 567-584.

Dalstrom, M. (2012). Winter Texans and the re-creation of the American medical experience in Mexico. *Medical Anthropology, 31*, 162-177.

Daneshpour, Manijeh. (1998). Muslim families in family therapy. *Journal of Marital and Family Therapy, 24,* 355-368. doi: 10.1111/j.1752-0606.1998.tb01090.x.

Daniels, J.P. and von der Ruhr, M. God and the global economy: Religion and attitudes towards trade and immigration in the United States. Socio-Econ. Rev. 2005, 3, 467–489.

Darwich, M. (2011). Political stability: The mysterious case of Qatar. Available at:
http://mepei.com/in-focus/4608-political-stability-the-mysterious-case-of-qatar?format=pdfdisplay¼graph[Accessed 29 July2015].

Das, R. (2017). Medical marketing in promoting medical tourism in India. *ELK Asia Pacific Journal of Marketing and Retail Management, 8*(3), 1-10. doi:
10.16962/EAPJMRM/issn. 2349-2317/2015.

De Arellano ABR. (2011). Medical tourism in the Caribbean. Signs. *Winter, 36*(2), 289-97.

Deloitte. (2008). *Medical tourism: Update and implications*. Washington D.C.: Deloitte Centre for Health Solutions.

Deloitte. (2015). *Medical Tourism Study*. Available at: http://www.deloitte.com/assets/Dcom-unitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy(3).pdf [Accessed 20/5/2015].

DeLuco, D. and Cremer, M. (1990) Consumers' perceptions of hospital food and dietary services. *Journal of the American Dietetic Association, 90*, 1711–1715.

Denzin, N. K. (2010). Moments, mixed methods, and paradigm dialogs. *Qualitative Inquiry, 16*, 419-427. http://dx.doi.org/10.1177/1077800410364608.

Department of Health & Human Services. (2015). Revisions to Appendix A—Interpretive Guidelines for Hospitals, CMS Manual System, Pub. 100-07 State Operations Provider Certification, Centres for Medicare & Medicaid Services. *Transmittal, 37*. Available at:https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf [Accessed 07 March 2016].

Dhami, S., & Sheikh, A. (2008). Health promotion: Reaching ethnic minorities. *Practice Nurse, 36*(8), 21-25.

Dhami, S., and Sheikh, A. (2008) The family: Predicament and promise. In: A. Sheikh and A. Gatrad (Eds.), *Caring for Muslim patients*, (2nd Edition). Oxford, UK: Radcliffe Publishing, pp. 57-66.

DiCicco-Bloom, B. and Crabtree, B.F. (2006) 'The qualitative research interview. *Medical education*, *40*(4), 314-321.

Diefenbach, T. (2009). Are case studies more than sophisticated storytelling? Methodological problems of qualitative empirical research mainly based on semi-structured interviews. *Quality & Quantity*, *43*(6), 875-894.

Dijkstra, K., Pieterse, M., and Pruyn, A. (2006). Physical environmental stimuli that turn healthcare facilities into healing environments through psychologically mediated effects: Systematic review. *Journal of Advanced Nursing, 56*(2), 166–181.

Donabedian, A. (1998). The quality of care. How can it be assessed?. *Journal of American Medical Association, 260*(12), 1743–1748.

Donaldson, T., and Preston, L. (1995). The Stakeholder Theory of the corporation: Concepts, evidence, and implications. *Academy of Management Review, 20*, 6591.

Donthu, N. and Yoo, B. (1998). Cultural influences on services quality expectations. *Journal of Services Research, 1*(2), 178–185.

Douglas, C. and Douglas, M. (2005). Patient-cantered improvements in health-care built environments: Perspectives and design indicators. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy, 8*(3), 264–276.

Dredge, D. and Jamal, T. (2013). Mobilities on the gold coast, Australia: Implications for destination governance and sustainable tourism. *Journal of Sustainable Tourism, 21*(4), 557–579.

Dredge, D. and Jenkins, J. (2003). Destination place identity and regional tourism policy. *Tourism Geographies, 5*(4), 383–407.

Driscoll, D.L., Appiah-Yeboah, A., Salib, P., and Rupert, D.J. (2007). Merging qualitative and quantitative data in mixed methods research: How to and why not. *Ecological and Environmental Anthropology (University of Georgia)*, p.18.

Duman, T. and Mattila, A. (2005). The role of affective factors on perceived cruise vacation value. *Tourism Management, 26*, 311–323.

Dunn, H. L. (1959). High-level wellness for man and society. *American Journal of Public Health, 49*, 786-792.

Dyer, P., Gursoy, D., Sharma, B., and Carter, J. (2007). Structural modeling of resident perceptions of tourism and associated development on the Sunshine Coast, Australia. *Tourism Management, 28*, 409–422.

Eades, J. (2010) Sun, surgery and cyberspace: the role of the Internet in the rise of medical tourism. In W. Pease, M. Cooper and R. Gujurajan, R. (Eds.), *Biomedical knowledge management: Infrastructures and processes for e-health systems*. IGI Global, Hershey, Pennsylvania, pp. 217– 231.

Easen, N. (2009). Stitching up Africa? *Africa Investor, 7*(6), 80– 81.

Eisenhardt, K.M., Graebner, M.E. and Sonenshein, S. (2016). Grand challenges and inductive methods: Rigor without rigor mortis. *Academy of Management Journal*, *59*(4), 1113-1123.

Ellis, A.P., West, B.J., Ryan, A.M. and DeShon, R.P. (2002). The use of impression management tactics in structured interviews: a function of question type? *Journal of Applied Psychology*, *87*(6), 1200.

Energy Information Administration. (2014). International Energy Annual. Available at: http://www.eia.doe.gov [Accessed April 9, 2014].

Eraqi, I., (2006). Tourism services quality (TourServQual) in Egypt: The viewpoints of external and internal customers. *Benchmarking: An International Journal, 13*(4), 469-492.

Erfurt-Cooper, P.J. and Cooper, M.J. (2009). *Health and wellness tourism: Spas and hot springs*. Bristol, UK: Channel View Publishing.

Essam, G., (2005). *Marketing Intelligence & Planning Journal.* A positioning strategy for a tourist destination, based on analysis of customers' perceptions and satisfactions. *23*(2), 172-188.

Excell, K., and Rico, T., (2014). *Cultural heritage in the Arabian Peninsula: Debates, discourses and practices*. Farnham, UK: Ashgate Publishing, Ltd.

Feighery, W. G. (2002). Community participation in rural tourism development: a social representations approach. *Proceedings of the Tourism Research*.

Feilzer, M. Y. (2010) 'Doing mixed methods research pragmatically: Implications for the rediscovery of pragmatism as a research paradigm', *Journal of mixed methods research*, *4*(1), 6-16.

Ferguson, R., Paulin, M., Pigeassou, C. and Gauduchon, R. (1999) Assessing service management effectiveness in a health resort: implications of technical and functional quality, *Managing Service Quality, 9*(1), 58-65.

Fernandez, J.P. (1991). *Managing a diverse work force: Regaining the competitive edge*. Lexington, MA: Lexington Books.

Firth, J.R. (1957). *Papers in Linguistics 1934-1951*. London, UK: Oxford University Press.

Ford, R., Bach, S., and Fottler, M. (1997) Methods of measuring patient satisfaction in health care organisations. *Health Care Management Review, 22*(2), 74–89.

Forsén, L., Loland, N.W., Vuillemin, A., Chinapaw, M.J., van Poppel, M.N., Mokkink, L.B., van Mechelen, W. and Terwee, C.B. (2010). Self-administered physical activity questionnaires for the elderly. *Sports Medicine*, *40*(7), 601-623.

Forte, E., and Oppenheim, M. (Eds.). (2011). *The basic business library: Core resources and services* (5th edition). Santa Barbara, CA: Libraries Unlimited.

Foster, B., and Cadogen, J. (2000). Relationship selling and customer loyalty: An empirical investigation. *Marketing Intelligence and Planning, 18*(4), 85–99.

Fottler, M., Khatri, N., and Savage, G. (Eds.). (2010). *Strategic human resource management in health care*. Bingley, UK: Emerald Group Publishing. doi: 10.1108/S1474-8231(2010)0000009015.

Freeman, R. (1984). *Strategic management: A stakeholder approach*. Boston, UK: Pitman.

Freeman, R. (2010). *Strategic management: A stakeholder approach*. Cambridge, UK: Cambridge University Press.

Fromherz, A. (2012). *Qatar: A modern history*. London, UK: I. B. Tauris & Co Ltd.

Frost, F. and Kumar, M. (2000). INTSERVQUAL: An internal adaptation of the GAP model in a large service organisation. *Journal of Services Marketing, 14*(5), 358-377.

Furrer, O., Sudharshan, D., and Liu, B. (2000) The relationship between culture and service quality perceptions: Basis for cross-cultural market segmentation and resource allocation. *Journal of Service Research, 2*(4), 355–371.

Galletta, A. (2013). *Mastering the semi-structured interview and beyond: From research design to analysis and publication*. NYU Press.

Gan, L. L. and Frederick, J. R. (2011). Medical tourists: Who goes and what motivates them. *Health Market Quarterly, 30*(2), 177–194.

Gao, H. (2002). Language contact - Misunderstanding, confusion and conflicts. *Intercultural Communication Studies, XI*(3), 107-115.

Gaol, F., Mars, W., and Saragih, H., (2014). *Management and technology in knowledge, service, tourism & hospitality*. Boca Raton, FL: CRC Press.

Garrod, B. and Fyall, A. (2011). *Contemporary cases in tourism*. Oxford, UK: Goodfellow Publishers Limited.

General Secretariat for Development Planning (2011). *(*Gulf Education International Conference. Retrieved from: https://www.qp.com.qa/QP_Images/.../QP%20HR%20Conference%20-%20MDPS.ppt, 2012) [Accessed 20/04/2015].

General Secretariat for Development Planning (GSDP). (2014) Qatar National Vision. {online} Available at: http://www.qu.edu.qa/pharmacy/components/upcoming_events_material/Qatar_Natio nal_Vision_2030.pdf [accessed 15/3/2015].

Giampiccoli, A. and Mtapuri, O. (2015). Tourism development in Qatar: towards a diversification strategy beyond the conventional 3 Ss. *African Journal of Hospitality, Tourism and Leisure, 4*(1), 5.

Gilbert, D. and Wong, R. (2003). Passenger expectations and airline services: A Hong Kong Based Study. *Tourism Management, 24*, 519-532.

Glanz, K., Marcus Lewis, F., and Rimer, B. (1997). *Theory at a Glance: A guide for health promotion practice*. US: National Institute of Health.

Glinos, I., Baeten, R., Helble, M., Maarse, H. (2010). A typology of cross-border patient mobility, *Health Place, 16*, 1145–1155.

Golder, B. (2005). *Washington: WWF US, Sourcebook for WWF Standards, Stakeholder analysis. Foundations of Success*. Available from: https://www.intranet.panda.org/documents/folder.cfm?uFolderID=60976.[Accessed 01May2015].

Goldman, D. and Romley, J. (2008). Hospitals as hotels: The role of patient amenities in hospital demand. *NBER Working Paper No. 14619*. Cambridge, MA: National Bureau of Economic Research.

Goodrich, J. and Goodrich, G. (1987) Health-care tourism – an explanatory study. *Tourism Management, 8*, 217– 222.

Government of Qatar. (1996). *Labour Law State of Qatar*. Available at: https://portal.www.gov.qa/wps/wcm/connect/5f30f680423f8a149631df3cb857e4ca/Q atarþLaborþLaw.pdf?MOD¼AJPERES [Accessed 10/04/2015].

Goyal, A., (2013). *Innovations in services marketing and management: Strategies for emerging economies*. New Delhi, India: IGI Global.

Gözüm, S. and Aydın, I. (2004). Validation evidence for Turkish adaptation of Champion's Health Belief Model Scales. *Cancer Nursing, 27*(6), 491–498.

Grönroos, C. (1984). A service quality model and its marketing implications. *European Journal of Marketing, 18*(4), 36-44.

Grosjean, F. (1982). *Life with two languages*. Cambridge, UK: Harvard University Press.

Grove, S., Fisk, R. and Bitner, M. (1992). Dramatizing the service experience: A managerial approach. *Advances in Services Marketing and Management, 1*(1), 91–121.

Guetterman, T.C. (2015, May). Descriptions of sampling practices within five approaches to qualitative research in education and the health sciences. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *16*(2), 175–196.

Gulf Times. (2015 May 6). *Lord Darzi praises Qatar health sector*. Available at: https://www.gulf-times.com/story/438109/Lord-Darzi-praises-Qatar-health-sector[Accessed 17 July2016].

Gulwadi, G. B., Joseph, A., and Keller, A. B. (2009). Exploring the impact of the physical environment on patient outcomes in ambulatory care settings. *Health Environments Research and Design Journal, 2*, 21-41.

Gulwadi, G., Keller, A., and Joseph, A. (2009). *Improving the patient experience: Best practices for safety-net clinic redesign*. Concord, CA: Centre for Health Design.

Gupta, R. (2015). *Qatar investing in healthcare, Business in Qatar and beyond*. Available at: http://www.bq-magazine.com/industries/healthcare/2015/08/qatar-medical-facilities [Accessed 01/05/2019].

Gursoy, D. and Rutherford, D. G. (2004). Host attitudes toward tourism: An Improved Structural Model. *Annals of Tourism Research, 31*, 495–516.

Gursoy, D., Jurowski, C. and Uysal, M. (2002). Resident attitudes: A structural modeling approach. *Annals of Tourism Research, 29*, 79–105.

Gutierrez, J. and Long, J. (2011). Reliability and validity of diabetes specific health beliefs model scales in patients with diabetes and serious mental illness. *Diabetes Research and Clinical Practice, 92*(3), 342-347.

Guy, B. S., Henson, J. L. N. and Dotson, M. J. (2015). Characteristics of consumers likely and unlikely to participate in medical tourism. *International Journal of Healthcare Management, 8*(2), 68-76.

Habitat, U. (2013). *State of the world's cities 2012/2013: Prosperity of cities*. London, UK: Routledge.

Hair, J. F., Celsi, M. W., Money, A. H., Samouel, P., & Page, M. J. (2011). *Essentials of business research methods* (2nd ed.). New York: M. E. Sharpe Incorporated.

Hall, C. M. (2011) Health and medical tourism: Kill or cure for global public health? *Tourism Review, 66*(1/2), 4–15.

Hall, C., (2013). Medical tourism: The ethics, regulation, and marketing of health mobility. London, UK: Routledge.

Hallem, Y. and Barth, I. (2011) Customer-perceived value of medical tourism: An exploratory study – the case of cosmetic surgery in Tunisia. *Journal of Hospitality and Tourism Management, 18*(1), 121–129.

Hamad Medical corporation (2019a). *Home.* Available at: https://www.hamad.qa/EN/Hospitals-and-services/Nursing/Pages/default.aspx [Accessed 01 May 2019].

Hamad Medical corporation (2019b). *HMC concludes ninth consecutive year providing emergency care services at Sealine Medical Clinic.* Available at: https://www.hamad.qa/EN/news/2019/May/Pages/HMC-Concludes-Ninth-Consecutive-Year-Providing-Emergency-Care-Services-at-Sealine-Medical-Clinic.aspx [Accessed 01 May 2019].

Hamad Medical Corporation (HMC). (2017). HMC's Ambulatory Care Centre and Women's Wellness and Research Centre welcome first patients to outpatient clinics. Available at: https://www.hamad.qa/EN/Hospitals-and-services/WWRC/News/Pages/HMCs-Ambulatory-Care-Center-and-Women%E2%80%99s-Wellness-and-Research-Center-Welcome-First-Patients-to-Outpatient-Clinics.aspx [Accessed 01 March 2018].

Hammaker, D. (2011). *Health care management and the law: Principles and applications.* Clifton Park, NY: Delmar/Cengage Learning.

Han, H. and Hyun, S. S. (2014). Medical hotel in the growth of global medical tourism. *Journal of Travel & Tourism Marketing, 31*(3), 366–380.

Hanefeld, J., Smith, R., Horsfall, D., and Lunt, N. (2014). What do we know about medical tourism? A review of the literature with discussion of its implications for the UK

National Health Service as an example of a public health care system. *Journal of Travel Medicine, 6*, 410–417.

Happ, M., Swigart, V., Täte, J., Arnold, R., Sereika, S., and Hoffman, L. (2007). Family presence and surveillance during weaning from prolonged mechanical ventilation. *Heart & Lung, 36*(1), 47-57.

Harber, C., (2014). *Education and international development: Theory, practice and issues*. Oxford, UK: Symposium Books Ltd.

Harrell, M.C. and Bradley, M.A. (2009). *Data collection methods. Semi-structured interviews and focus groups*. Santa Monica CA: Rand National Defense Research Institute.

Harris, D., Shepley, M., White, R., Kolberg, K. and Harrell, J. (2006). The impact of single-family room design on patients and caregivers: Executive summary. *Journal of Perinatology, 26*, S38–S48.

Hartwell, H., Shepherd, P., Edwards, J. and Johns, N. (2015). What do patients value in the hospital meal experience? Journal of Appetite, 96, 293-298.

Haseltine, W., (2013). *Affordable excellence: The Singapore healthcare story*. Brookings Institution Press. Washington D.C.

Hassanien, A., and Dale, C., (2013). *Facilities management and development for tourism, hospitality and events*. Oxfordshire, UK: CABI. UK.

Haugen, E. (1956). *Bilingualism in the Americas: A Bibliography and Research Guide*. Alabama, AL: University of Alabama Press.

Health Tourism. (2012) *The history of medical tourism*. Available at http://health-tourism.com/medical-tourism/history/ [Accessed 13 March 2014].

Helmy, E. and Travers, R. (2009). Towards the development of Egyptian medical tourism sector. *Anatolia, 20,* 419– 439.

Hemmington, N. (2007) From service to experience: understanding and defining the hospitality business, *The Service Industries Journal, 27*(6), 747-55.

Henderson, J. C. (2003). Managing tourism and Islam in Peninsular Malaysia. *Tourism Management, 24*(4), 447–456.

Heung, V., Kucukusta, D., Song, H. (2010). A conceptual model of medical tourism: implications for future research. *Journal of Travel & Tourism Marketing, 27*(3), 236–251.

Hochbaum G. (1958). *Public participation in medical screening programs: A sociopsychological study. PHS Publication No. 572*. Washington, DC: Government Printing Office.

Hodges, J., Turner, L., Kimball, A., (2012). *Risks and challenges in medical tourism: Understanding the global market for health services*. Santa Barbara, CA: ABC-CLIO.

Hoesli, T. M., & Smith, K. M. (2011). Effects of religious and personal beliefs on medication regimen design. *Orthopedics*, *34*(4), 292-295.

Hogan, J.M. (1997). George Gallup and the rhetoric of scientific democracy. *Communications Monographs*, *64*(2), 161-179.

Holloway, C. (1998). *The business of tourism*, (5th Edition). London, UK: Addison Wesley Longman.

Homburg, C. and Giering, A. (2001). Personal characteristics as moderators of the relationship between customer satisfaction and loyalty: An empirical analysis. *Psychology and Marketing, 18*(1), 43-66.

Hopkins, S. A., Nie, W. and Hopkins, W. E. (2009). Cultural effects on customer satisfaction with service encounters. *Journal of Service Science, 2*(1), 45-56.

Horowitz, M., Rosensweig, J., Jones, C. (2007). Medical tourism: Globalization of the healthcare marketplace. *Medscape General Medicine, 9*(4), 33–41.

Horton, J., Macve, R., and Struyven, G. (2004). Qualitative research: experiences in using semi-structured interviews. *The Real-Life Guide to Accounting Research*, 339-357.

Horton, S. and Cole, S. (2011). Medical returns: Seeking health care in Mexico. *Social Science and Medicine, 72*, 1846-1852.

Houghton, C.E., Casey, D., Shaw, D. and Murphy, K. (2010). Ethical challenges in qualitative research: examples from practice. *Nurse researcher*, *18*(1), 15-25.

Hove, S.E. and Anda, B. (2005, September). Experiences from conducting semi-structured interviews in empirical software engineering research. In proceedings of the *11th IEEE International Software Metrics Symposium,* 19-22 IEEE Computer Society Washington, DC, USA, p. 23. doi: 10.1109/METRICS.2005.24.

http://www.medicaltourismindia.com/india-tour-packages/golden-triangle-trip-india.html

Hu, H., Kandampully, J. and Juwaheer, T. (2009) Relationships and impacts of service quality, perceived value, satisfaction, and image: An empirical study. *The Service Industries Journal, 29*(2), 111–125.

Huttasin, N. (2008). Perceived social impacts of tourism by residents in the OTOP tourism village, Thailand. *Asia Pacific Journal of Tourism Research*, *13*(2), 175-191.

Ibrahim, I., & Harrigan, F. (2012). Qatar's economy: Past, present and future. *QScience Connect*, *2012*(1), 9.

Ichoku, E. and Leibbrandt, M. (2003). The demand for healthcare services in Nigeria: a multivariate nested logit model. *African Development Bank, 15*(2–3), 396–424.

International Business Publication IBP, (2012). Qatar Country Study Guide Volume 1 Strategic Information and Developments. Int'l Business Publications, USA

International Healthcare Research Centre (IHRC). (2016). *2017 Monitoring medical tourism trends*. Available at http://www.healthcareresearchcenter.org/medicaltourism-index/ [Accessed 13 May 2018].

International Medical Travel Journal (IMTJ). (2010). *Medical tourism in Lebanon is expanding*. Available at: http://www.imtj.com/news/medical-tourism-lebanon-expanding/ [Accessed 04 February 2016].

International Medical Travel Journal (IMTJ). (2018a). *IMTJ analysis of 2017 India medical tourist data*. Available at: https://www.imtj.com/news/imtj-analysis-2017-india-medical-tourist-data/ [Accessed 12 February 2018].

International Medical Travel Journal (IMTJ). (2018b). *New strategy for Jordan medical tourism*. Available at https://www.imtj.com/news/new-strategy-jordan-medical-tourism/ [Accessed 12 February 2018].

International Monetary Fund. Middle East and Central Asia Dept. (2013). *Qatar: 2012 Article IV Consultation*. Washington, DC: International Monetary Fund.

Iranmanesh, M., Moghavvemi, S., Zailani, S., & Hyun, S. S. (2018). The role of trust and religious commitment in Islamic medical tourism, *Asia Pacific Journal of Tourism Research, 23*(3), 245-259. doi: 10.1080/10941665.2017.1421240.

Jabbari, A., Delgoshaei, B., Mardani, R., and Tabibi, S. (2012) Medical tourism in Iran: Issues and challenges. *Journal of Education and Health Promotion, 1*(39). doi: 10.4103/2277-9531.104809

Jabbari, A., Ferdosi, M., Keyvanara, M. and Agharahimi, Z. (2016). Stakeholders' analysis of the medical tourism industry: development strategies in Isfahan. *Journal of Education and Health Promotion, 2*, 1-7.

Jablin, F.M. and Miller, V.D. (1990). Interviewer and applicant questioning behavior in employment interviews', *Management Communication Quarterly*, *4*(1), 51-86.

Jackson, J. and Murphy, P. (2006). Clusters in regional tourism: An Australian case. *Annals of Tourism Research, 33*, 1018-1035.

Jagyasi, P. (2008). Defining medical tourism – A second approach. *Medical Tourism Magazine, Issue 6*, 9-11.

Jeuring, J. H. G. (2016). Discursive contradictions in regional tourism marketing strategies: The case of Fryslân, The Netherlands. *Journal of Destination Marketing & Management, 5*, 65–75.

John, Connell.(2006). Medical tourism: Sea, Sun, Sand and …Surgery, Tourism Management 27(2006),1093-1100.

Johansson-Stenman, O., Mahmud, M. and Martinsson, P. (2006). Trust and Religion: Experimental Evidence from Bangladesh. Newcastle, UK: Centre for Economic Research, Keele University.

Johnson C., Mues K., Mayne S., and Kiblawi A. (2008). Cervical cancer screening among immigrants and ethnic minorities: A systematic review using the Health Belief Model. *Journal of Lower Genital Tract Disease, 12*(3), 232–241.

Johnson, B. and Christensen, L. (2012). *Educational research: Quantitative, qualitative, and mixed approaches* (5 Edition). Thousand Oaks, CA: Sage

Johnson, J. (2010). Egypt. Where it all begins. *Medical Tourism Magazine, 15*, 36–38.

Johnston, K., Puczko, L., Smith, M., and Ellis, S. (2011). Wellness tourism and medical tourism: Where do spas fit?, *Global Spa Summit*, Available at: http://www.spaindustry.ca/files/file/Business%20Tools/spas_wellness_medical_touris m_report_final.pdf [Accessed 15 June 2016].

Johnston, R. Crooks, VA. Snyder, J., and Kingsbury, P. (2010). What is known about the effects of medical tourism in destination and departure countries? A scoping review. *International Journal of Equity Health, 9*(24), 1-13. doi: 10.1186/1475-9276-9-24

Jonathan, G. (1994). Health Tourism: A new positioning strategy for tourist destinations. *Journal of International Consumer Marketing, 6*(3), 227-238.

Jones, T. (1995). Instrumental Stakeholder Theory: A synthesis of ethics and economics. *The Academy of Management Review, 20*, 404-437.

Joseph, A. (2006). *The role of the physical environment in promoting health, safety, and effectiveness in the healthcare workplace*. Concord, CA: Centre for Health Design.

Joseph, A., Keller, A., & Kronick, K. (2008). Literature review. *In Evidence for innovation: Transforming children's health through the physical environment*. Alexandria, VA: National Association of Children's Hospitals and Related Institutions. Alexandria, VA: National Association of Children's Hospitals and Related, pp. 18–47.

Jun, J. and Oh, K. M. (2015). Framing risks and benefits of medical tourism: A content analysis of medical tourism coverage in Korean American community newspapers. *Journal of Health Communication, 20*(6), 720-727.

Kachwala, T. and Mukherjee P. (2009). *Operations management and productivity techniques*. New Delhi, India: PHI Learning Pvt. Ltd.

Kanady, S. (2008). *Qatar moves to cut emissions*. London, UK: The Peninsula.

Kanbur, S. and Spence, M. (2010). *Equity and growth in a globalizing world*. Washington, DC: World Bank Publications.

Kang, S., Okamoto, N., & and Donovan, H. (2004) Service quality and its effect on customer satisfaction and customer behavioural intentions: Hotel and ryokan guests in Japan. *Asia Pacific Journal of Tourism Research, 9*(2), 189–202.

Kao, Y., Huang, L., and Wu, C. (2008) Effects of theatrical elements on experiential quality and loyalty intentions for theme parks. *Asia Pacific Journal of Tourism Research, 13*(2), 163–174.

Kassim, N., and Bojei, J. (2002). Service quality: Gaps in the telemarketing industry. *Journal of Business Research, 55*(11), 845–852.

Kayat, K. (2002). Exploring factors influencing individual participation in community-based tourism: The case of Kampung relau homestay program, Malaysia. *Asia Pacific Journal of Tourism Research*, *7*(2), 19-27.

Keenan, M. (2004). *In whose image? The creation of the perfect woman through cultural globalisation and cosmetic surgery*. Unpublished Bachelor Honours thesis, University of Sydney, Sydney, Australia.

Khan, M. (2010). Medical tourism: Outsourcing of healthcare**.** *International CHRIE Conference-Refereed Track. 23*. Available at: http://scholarworks.umass.edu/refereed/CHRIE_2010/Friday/23 [Accessed 14 June 2014].

Khan, M. J., Chelliah, S., Haron, M. S., and Ahmed, S. (2017). Push factors, risks, and types of visit intentions of international medical travelers – A conceptual model. *International Journal of Healthcare Management, 10*(2), 115-121.

Khan, S. and Alam, M. (2014). Kingdom of Saudi Arabia: A potential destination for medical tourism. *Journal of Taibah University Medical Sciences, 9*(4), 257-262.

Kijs, J., Ormond, M., Mainil, T., Peerlings, J., and Heijman, W. (2016). A state-level analysis of the economic impacts of medical tourism in Malaysia. *Asian-Pacific Economic Literature, 30*(1), 3-29. doi: 10.1111/apel.12132

Kinninmont, J. (2015). *Future trends in the Gulf*. Available at: https://www.chathamhouse.org/sites/files/chathamhouse/field/field_document/201502 18FutureTrendsGCCKinninmont.pdf [Accessed 16 July 2017].

Klein, H. J., Simic, D., Fuchs, N., Schweizer, R., Mehra, T., Giovanoli, P., & Plock, J. A. (2017). Complications after cosmetic surgery tourism. *Aesthetic surgery journal*, *37*(4), 474-482.

Knight, J. (Ed.). (2013). *International education hubs: Student, talent, knowledge-innovation models*. Berlin, Germany: Springer Science & Business Media.

Koncul, N. (2012). Wellness: a new mode of tourism. *Ekonomska Istraživanja, 25*(2), 525–534.

Kong, C. (2005). *Relationship marketing in a globalised world*. Kuala Lumpur, Malaysia: Utusan Publications.

Konu, H. (2010). Identifying potential wellbeing tourism segments in Finland. *Tourism Review, 65*, 41-51.

Koontz, V. (2003). *Parental satisfaction in a pediatric intensive care unit*. Unpublished master's thesis. M.S.N., Marshall University, United States—West Virginia.

Kotler, P. (1973). Atmospherics as a Marketing Tool. *Journal of Retailing, 49*(4), 48-64.

Koziol, N. and Arthur, A. (2011). An introduction to secondary data analysis. *Research Methodology Series*. Available at: http://r2ed.unl.edu/presentations/2011/RMS/120911_Koziol/120911_Koziol.pdf [Accessed 13 November 2018].

Kreishan, F. M. (2010). Tourism and economic growth: The case of Jordan. *European Journal of Social Sciences*, *15*(2), 63-68.

Kumar, M., Kee, F., and Manshor, A. (2009). Determining the relative importance of critical factors in delivering service quality of banks; An application of dominance analysis in SERVQUAL model. *Managing Service Quality, 19*(2), 211-228.

Kushner, S. and Russell, J. (Eds.). (2015). *Case study evaluation: Past, present and future challenges*. Bingley, UK: Emerald Group Publishing.

Kuula, A. (2010). Methodological and ethical dilemmas of archiving qualitative data; *IASSIST Quarterly*, *34*(3/4), 35.

Langlois, E., Campbell, K., Prieur-Richard, A. H., Karesh, W. B., and Daszak, P. (2012). Towards a better integration of global health and biodiversity in the new sustainable development goals beyond Rio þ20. *Ecohealth, 9*(4), 381–385.

Lantz, P. M., Lynch, W. and House, J. S. (2001). Socioeconomic disparities in health change in a longitudinal study of U.S. adults: The role of health-risk behaviours. *Social Science Medicine, 53*(1), 29–40.

Lashley, C. and Morrison, A. (Eds). (2000). *In search of hospitality: Theoretical perspectives and debates*. Oxford, UK: Butterworth-Heinemann.

Lautier, M. (2008). Export of health services from developing countries: The case of Tunisia. *Social Science & Medicine, 67*(1), 101-110.

Lautier, M. (2014). International trade of health services: Global trends and local impact, *Health Policy, 118*(1), 105-113.

Lavrakas, P. J. (2008). *Encyclopedia of Survey Research Methods: AM* (Vol. 1). Sage.

Lawrence, P., (2014). Justice for future generations: Climate change and international law. Cheltenham, UK: Edward Elgar Publishing.

Lee, C., Balaban, V. (2014). Chapter 2. The pre-travel consultation. Medical tourism. In *CDC Health Information for International Travel 2014*. Oxford, UK: Oxford University.

Lee, D. (1998). *The effects of product quality and service quality on consumer satisfaction and loyalty-A study of gas station*. Unpublished master's thesis, National Cheng University, Taiwan.

Legg, L. and Gilbert, P. (2006). A pilot study of gender of voice and gender of voice hearer in psychotic voice hearers. *Psychology and Psychotherapy: Theory, Research and Practice, 79*(4), 517-527.

Leggat, P. and Kedjarune, U. (2009). Editorial – Dental health, 'dental tourism' and travellers. *Travel Medicine and Infectious Disease, 7*, 123–24.

Leishman, J. (2004). Perspectives of cultural competence in health care. *Nursing Standard,* *19*(11), 33-38.

Lertwannawit, A. and Gulid, N. (2011) International tourists' service quality perception and behavioural loyalty toward medical tourism in Bangkok metropolitan area. In proceedings of the *2011 Barcelona European Academic Conference*, Barcelona, Spain.

Levers, M. J. D. (2013). Philosophical paradigms, grounded theory, and perspectives on emergence. *Sage Open*, *3*(4), 2158244013517243.

Lewis, B. (1993). Service quality measurement. *Marketing Intelligence & Planning, 11*(4), 4-12.

Li, H. and Cui, W. (2014). Patients without borders: The. historical changes of medical tourism. *University of Western Ontario Medical Journal, 83*(2), 19-22.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin, & Y. S. Lincoln. (Eds.), *Handbook of qualitative research* (2nd ed.), pp. 163-188. Thousand Oaks, CA: Sage.

Lincoln, Y. S., Lynham, S. A. and Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage handbook of qualitative research*, *4*, 97-128.

Liu, I. and Chen, C. (2013). Cultural issues in medical tourism. *American Journal of Tourism Research, 2*(1), 78-83.

Liu, R., Furrer, O., and Sudharshan, D. (2001). The relationships between culture and behavioural intentions: An empirical examination. *Journal of Consumer Marketing, 18*(1), 54–74.

Losa, M., and Papagiannakis, T. (2014). *Sustainability, eco-efficiency, and conservation in transportation infrastructure asset management*. Boca Raton, FL: CRC Press.

Lovelock, C., Patterson, P., and Wirtz, J. (2015). Services marketing, (6th Edition). Australia: Pearson Education.

Lovering, S. (2012). The crescent of care: A nursing model to guide the care of Arab Muslim patients. *Diversity and Equality in Health and Care, 9*, 171-178.

Low, J. (2012). Unstructured and semi-structured interviews in health research. In M. Saks and J. Allsop (Eds.), *Researching health: Qualitative, quantitative and mixed methods*. London, UK: SAGE Publications, p. 87.

Lunt, J. (2017). *From sepoy to subedar: being the life and adventures of Subedar Sita Ram, a native officer of the Bengal army, written and related by himself*. Routledge.

Lunt, N. and Carrera, P. (2010). Medical tourism: Assessing the evidence on treatment abroad. *Maturitas, 66*, 27–32.

Lunt, N., Smith, R. and Exworthy, M. (2011). *Medical tourism: Treatments, markets and health system implications: A scoping review*. Paris, FR: OECD.

Mackian, S. (2013). *A review of health seeking behaviour: Problems and prospects*. Available at: https://assets.publishing.service.gov.uk/media/57a08d1de5274a27b200163d/05-03_health_seeking_behaviour.pdf [Accessed 4 June 2014].

Maijala, H., Paavilainen, E., Väisänen, L., and Astedt-Kurki, P. (2004). Caregivers' experiences of interaction with families expecting a fetally impaired child. *Journal of Clinical Nursing, 13*(3), 376–385.

Malik, K. (2013). *Human Development Report, The rise of the South: Human progress in a diverse world*. 2013.Available at: http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf [Accessed 9 April2014].

Mallakh, R. (2015). *Qatar (RLE Economy of Middle East): Development of an oil economy*. Abingdon, OX: Routledge.

Mankiw, N. (2014). *Brief principles of macroeconomics* (Seventh Edition). Boston, MA: Cengage Learning. USA.

Mansfeld, Y. (2006). The role of security information in tourism crisis management: the missing link. In Y. Mansfeld & A Pizam (Eds.), *Tourism, security & safety: From theory to practice*. Amsterdam, The Netherlands: Elsevier, pp. 271-290.

Market Research Future. (2018). *Medical Tourism Market Research Report -Forecast till 2023*. Maharashtra, India: Market Research Future.

Marshall, C. (1985). Can we be consumer-oriented in a changing financial service world? *The Journal of Consumer Marketing, 2*(4), 37–43.

Marshall, C. and Rossman, G.B. (2014) *Designing qualitative research*. Thousand Oaks, CA: Sage publications.

Martin, J. N. and Nakayama, T. K. (2014). *Experiencing intercultural communication: An introduction*, (5th Edition). New York, NY: The McGraw-Hill Companies, Inc.

Martin, J. N. and Nakayama, T. K. (2015). Reconsidering intercultural (communication) competence in the workplace: A dialectical approach. *Language and Intercultural Communication, 15*(1), 13-28. doi: 10.1080/14708477.2014.985303.

Maslow, A. (1970). *Motivation and personality* (2nd Edition). New York, NY: Harper & Row. (Original work published 1954).

Mason, P., & Cheyne, J. (2000). Residents' attitudes to proposed tourism development. *Annals of tourism research*, *27*(2), 391-411.

Mathew, B., (2015). *Anchor India 2015*. New Delhi, India: Info Kerala Communications Pvt. Ltd.

Mathijsen, A. (2019). Home, sweet home? Understanding diasporic medical tourism behaviour. Exploratory research of Polish immigrants in Belgium. *Tourism Management, 72*, 373-385. doi: 10.1016/j.tourman.2018.12.009.

Mays, N. and Pope, C. (2000). Assessing quality in qualitative research. *BMJ: British Medical Journal*, *320*(7226), 50-52.

McDougall, G. and Levesque, T. (1994). A revised view of service quality dimensions: An empirical investigation. *Journal of Professional Service Marketing, 11*(1), 189-209.

McDougall, G. H. and Levesque, T. (2000). Customer satisfaction with services: putting perceived value into the equation. *Journal of Services Marketing, 14*, 392-410.

McKerchar, M. (2008). Philosophical paradigms, inquiry strategies and knowledge claims: Applying the principles of research design and conduct to taxation. *E-journal of Tax Research, 6*(1), 1-8.

Medical Tourism Index. (2019), *Qatar – Medical Tourism Index*, Available at https://www.medicaltourismindex.com/destination/qatar/ [Accessed 02 May 2019].

Medical Tourism India (2019), Indian Tour Packages, Medical Tourism India, Available at http://www.medicaltourismindia.com/india-your-packages/golden-triangle-trip-india.html[Accessed 12 September 2019].

Meimand, S. E., Khalifah, Z., Zavadskas, E. K., Mardani, A., Najafipour, A. A., and Ahmad, U. N. U. (2017). Residents' attitude toward tourism development: A Sociocultural perspective. *Sustainability, 9*(1170), 1-29. doi: 10.3390/su9071170

Miceli, P. and Clark, P. (2005). Your patient—My child: Seven priorities for improving pediatric care from the parent's perspective. *Journal of Nursing Care Quality, 20*(1), 43–53.

Michell, V. (2013). *Handbook of research on patient safety and quality care through health informatics*. Hershey, PA: IGI Global.

Milliken, F. J. and Martins, L. L. (1996). Searching for common threads: Understanding the multiple effects of diversity in organisational groups. *Academy of Management Review, 21*, 402-433.

Ministry of Development Planning and Statistics. (2015). *Qatari Government plans for development*. Available at: http://www.gsdp.gov.qa/portal/page/portal/gsdp_en/nds/goals_benefits [accessed 15 June 2015].

Ministry of Development Planning and Statistics. (2016). *First section population and social statistics*. Available at: https://www.mdps.gov.qa/en/statistics/Statistical%20Releases/Population/Population/2016/Population_social_1_2016_AE.pdf [Accessed 01 May 2019].

Ministry of Foreign Affairs (MOFA). (2019). *General information*. Available at: https://mofa.gov.qa/en/qatar/history-of-qatar/general-information [Accessed 03 May 2019].

Ministry of Health, State of Israel. (2019). *Medical tourism in Israel*. Available at: https://www.health.gov.il/English/Topics/Medical_Tourism/Pages/default.aspx [Accessed 03 May 2019].

Ministry of Public Health (MOPH). (2018). *National Health Strategy 2018-2022: Our health our future*. Available at: https://www.moph.gov.qa/HSF/Documents/short%20report%20eng%2020.03.2018.pdf [Accessed 03 May 2019].

Miranda, S. M. and Saunders, C. S. (2002). The social construction of meaning: An alternative perspective on information sharing. *Information Systems Research, 0*(0), 1-20.

Mitchell, J.S., Paschyn, C., Mir, S., Pike, K., & Kane, T. (2015). In majaalis al-hareem: The complex professional and personal choices of Qatari women. *DIFI Family Research and Proceedings, 2015*(4), 1-12. doi: 10.5339/difi.2015.4.

Moghimehfar, F. and Nasr-Esfahani, M. (2011). Decisive factors in medical tourism destinations choice: a case study of Isfahan, Iran and fertility treatments. *Tourism Management, 32*, 1431-1434.

Mooij, M. (2005). *Global marketing and advertising*. Thousand Oaks, CA: Sage.

Moran, A., Lederer, A. and Curtis, C. (2015). Use of nutrition standards to improve nutritional quality of hospital patient meals: Findings from New York City's Healthy Hospital Food Initiative. *Journal of the Academy of Nutrition and Dietetics, 115*, 1847-1854.

Morgan, R., Ensor, T., and Waters, H. (2016). Performance of private sector health care: implications for universal health coverage. *Lancet, 388*(10044), 606-612.

Mostert, S., Sitaresmi, M. N., Gundy, C. M., and Veerman, A. J. (2008). Attitude of health-care providers toward childhood leukemia patients with different socio-economic status. *Pediatric Blood and Cancer, 50*(5), 1001-1005.

Mowforth, M. (2008). *Tourism and sustainability: Development, globalization and new tourism in the Third World*, (2nd Edition). London, UK: Routledge.

Murray, I, Nicholson, S., Pauly, M. and Berger, M. (2006). Investing in health to boost employee productivity: The employer's perspective. In R. G. Kessler & P. E. Stang (Eds.), *Health & work productivity: Making the business case for quality health care*. Ghicago, IL: University of Ghicago Press, pp. 185-206.

Musa, G., Thirumoorthi, T., & Doshi, D. (2012). Travel behaviour among inbound medical tourists in Kuala Lumpur. *Current Issues in Tourism, 15*(6), 525-543.

Myers, J., Sweeney, T., and Witmer, J. (2000). The Wheel of Wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78*, 251–266.

Nafi, Z., (2014). *Economic and social development in Qatar*. London, UK: Bloomsbury Academic.

Nagy, S. (1997). Social and spatial process: An ethnographic study of housing in Qatar. *Dissertations available from ProQuest.* Paper AAI9814892. Available at: http://repository.upenn.edu/dissertations/AAI9814892 [Accessed 14 November 2014].

Naidu A. (2009). Factors affecting patient satisfaction and healthcare Quality. *International Journal of Health Care Quality Assurance, 22*, 366-381.

Naik, N., and Lal., B., (2013). Economic Analysis of Indian Medical Tourism (International Health Care Destination). *Journal of Economic Analysis of Indian Medical Tourism. 5*(2), 259-277.

Nakayama, T. and Martin, J. (2014). Ethical issues in intercultural communication competence: A dialectical approach. In X.-D. Dai and G. M. Chen (Eds.), *Intercultural communication competence: Conceptualization and its development in cultural contexts and interactions*. Newcastle, UK: Cambridge Scholars, pp. 97–117.

NaRanong, A. and NaRanong, V. (2011). The effects of medical tourism: Thailand's experience. *Bulletin of the World Health Organization, 89*(5), 336–44.

National Health Service (NHS). (2018). *Guide to NHS waiting times in England*. Available at: https://www.nhs.uk/using-the-nhs/nhs-services/hospitals/guide-to-nhs-waiting-times-in-england/ [Accessed 16 November 2018].

National Tourism Council. (2019). *Tourist Hotspots Visit Qatar*. Available at: https://www.visitqatar.qa/discover/tourist-hotspots [Accessed 02 May 2019].

Nations Online. (2019). *Qatar - Country Profile - State of Qatar - Dawlat Qatar*. https://www.nationsonline.org/oneworld/qatar.htm [Accessed 02 May 2019]

Negi, R. (2009). Determining customer satisfaction through perceived service quality: A study of Ethiopian mobile users. *International Journal of Mobile Marketing, 6*(4), 31–43.

Nejad, Z. A. (2016). *Qatari youth unemployment: Evaluating Qatari governmental initiatives: Qatarization Policy through Bedaya Centre*. Unpublished Master thesis, Qatar University, Doha, Qatar.

Neligan, P., and Buck, D., (2014). *Core procedures in plastic surgery*. China: Elsevier Health Sciences.

Neuman, W.L. and Robson, K. (2012) *Basics of social research: Qualitative and quantitative approaches*. London, UK: Pearson.

Newton, N. (2010). The use of semi-structured interviews in qualitative research: strengths and weaknesses', *Exploring qualitative methods*, *1*(1), 1-11.

Niblock, T., (2015). *Social and economic development in the Arab Gulf (RLE Economy of Middle East)*. New York, NY: Routledge.

Nicholson, S., Pauly, M. V., Polsky, D., Baase, G. M., Billotti, G. M., Ozminkowski, R. J., and Sharda, G. E. (2005). *How to present the business case for healthcare quality to employers*. Available at http://knowledge.wharton.upenn.edu/papers/1303.pdf [Accessed 10 June 2014].

Niles, N., (2013). *Basic concepts of health care human resource management*. Burlington, MA: Jones & Bartlett Publishers.

Noe, R., Hollebeck, J, Gerhart, B., and Wright, P., (2013). *Fundamentals of human resource management* (5th Edition). London, UK: McGraw-Hill Higher Education.

Norman, P. and Bennett, P. (1996). Health locus of control. In M. Conner and P. Norman (Eds.), *Predicting health behaviours: Research and practice with social cognition models*. Buckingham, UK: Open University Press, pp. 62-94.

Novelli, M., (2005). *Niche tourism: Contemporary issues, trends and cases*. Oxford, UK: Routledge.

Nwafor, O. (2012). Niche tourism and the challenges of developing medical tourism in the Western Cape Province of South Africa. *Journal of Emerging Trends in Educational Research and Policy Studies, 3*(4), 600-604.

O'Fallon, M. and Rutherford, D. (2011). *Hotel management and operations*. Hoboken, NJ: Wiley.

O'Leary, Z. (2004). *The essential guide to doing research*. Thousand Oaks, CA: Sage.

Oh, H. (2000) Diner's perceptions of quality, value and satisfaction. Cornell Hotel and Restaurant Administration Quality,41(3), pp. 58–66.

Oh, H. (2000) The effect of brand class, brand awareness, and price on customer value and behavioural intentions, Journal of Hospitality & Tourism Research, 24(2), pp. 136-162.

Oh, H. and Pizam, A. (2008). *Handbook of hospitality marketing management*. Boston, MA: Butterworth-Heinemann.

Oliver, R. (1993). A conceptual model of service quality and service satisfaction: compatible goals, different concepts. *Advances in Service Marketing and Management, 2*, 65-85.

Onwuegbuzie, A. J. and Leech, N.L. (2005). On becoming a pragmatic researcher: The importance of combining quantitative and qualitative research methodologies. *International journal of social research methodology*, 8(5), 375-387.

Ormond, M., & Mainil, T. (2015). 15. Government and governance strategies in medical tourism. *Handbook on medical tourism and patient mobility*, 154.

Orr, T., (2007). *Qatar*. Singapore: Marshall Cavendish.

Orwig, R., Pearson, J., and Cochran, D. (1997). An empirical investigation into the validity of SERVQUAL in the public sector. *Public Administration Quarterly, 21*(1), 54-68.

Our World in Data. (2019). *Tourism – Our World in Data*. Available at: https://ourworldindata.org/tourism#international-arrivals-by-world-region[Accessed 29 July2 2019].

Oxford Business Group. (2014). *The Report: Qatar 2014*. Oxford, UK: Oxford Business Group.

Padela, A. I., & del Pozo, P. R. (2011). Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective. *Journal of medical ethics*, *37*(1), 40-44.

Paffhausen, A., Peguero, C. and Roche-Villarreal, L. (2010). Medical tourism: A survey. Washington, D.C.: United Nations Economic Commission for Latin America and the Caribbean.

Page, S. J. (2015). *Tourism management* (5th Edition). Amsterdam, The Netherlands: Elsevier.

Pakdil, F. and Harwood, T. (2005) Patient satisfaction in a preoperative assessment clinic: An analysis using SERVQUAL dimensions. *Total Quality Management, 16*(1), 15–30.

Palombi, B. (1992) Psychometric properties of wellness instruments. *Journal of Counseling & Development, 71*, 221–225.

Parasuraman, A., Berry, L. L., & Zeithaml, V. A. (1991). Understanding customer expectations of service. *Sloan management review*, *32*(3), 39-48.

Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1985). A conceptual model of service quality and its implications for future research. *The Journal of Marketing, 49*(4), 41-50.

Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1994). Alternative scales for measuring service quality: a comparative assessment based on psychometric and diagnostic criteria. *Journal of retailing*, *70*(3), 201-230.

Parasuraman, A., Zeithaml, V., and Berry, L. (1988). SERVQUAL: A multiple item scale for measuring consumer perception of service quality. *Journal of Retailing, 64*(1), 12-37.

Parasuraman, A., Zeithaml, Valerie A. & Berry, Leonard L. (1988). SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality. *Journal of Retailing, 64*(1), 12-40.

Parasuraman, S., Purohit, Y. S., Godshalk, V. M., & Beutell, N. J. (1996). Work and family variables, entrepreneurial career success, and psychological well-being. *Journal of vocational behaviour*, *48*(3), 275-300.

Pashley, H. (2012). Medical tourism presents opportunities and risks for patients. *AORN, 96*, C6-C7.

Patrick, J. F. (2002). Development of a multi-dimensional scale for measuring the perceived value of a service. *Journal of Leisure Research, 34*(2), 119–134.

Pearce, D. G. (2014). Toward an integrative conceptual framework of destinations. *Journal of Travel Research, 53*(2), 141–153.

Pechlaner, H., Fischer, E., and Hamman, E.M. (2008). Leadership and innovation processes: development of products and services based on core competencies. *Journal of Quality Assurance in Hospitality and Tourism, 6*, 31-57.

Peprah, A.A. and Atarah, B.A. (2014). Assessing Patient's satisfaction using SERVQUAL model: A case of Sunyani Regional Hospital, Ghana. *International Journal of Business and Social Research*, *4*(2), 133-143.

Peters, C. R. and Sauer, K. M. (2011). A survey of medical tourism service providers. *Journal of Market Development Competitiveness, 5*(3), 117–126.

Peterson, J. E. (2009). Life after oil: economic alternatives for the Arab Gulf States. *Mediterranean Quarterly*, *20*(3), 1-18.

Petrick, J. F. (2004). The roles of quality, value, and satisfaction in predicting cruise passengers' behavioural intentions. *Journal of Travel Research, 42*, 397-407.

Philip, G. and Hazlett, S. (1997). The measurement of service quality: a new P-C-P attributes model. *International Journal of Quality & Reliability Management, 14*(3), 260-286.

Piazolo, M. and Zanca, N.A. (2011). Medical tourism: A case study for the USA and India, Germany and Hungary. *Acta Polytech Hung. 8*(1), 137–160.

Pine, B.J. and Gilmore, J.H. (2011). *The experience economy*. Harvard Business Press.

Pizam, A. (2007). Editorial: the 'ity' factor. *International Journal of Hospitality Management, 26*(3), 499-501.

Ployhart, R.E. and Vandenberg, R.J. (2010). Longitudinal research: The theory, design, and analysis of change. *Journal of Management*, *36*(1), 94-120.

Pollack, B. (2008). The nature of the service quality and satisfaction relationship. *Managing Service Quality, 18*(6), 537–558.

Pollard, K. (2011). International patient streams past, present and future. In proceedings of *EMTC2011*, 28 April, Barcelona.

Ponterotto, J. G. (2010). Qualitative research in multicultural psychology: Philosophical underpinnings, popular approaches, and ethical considerations. *Cultural Diversity and Ethnic Minority Psychology*, *16*(4), 581.

Pratt, M. G., & Ashforth, B. E. (2003). Fostering meaningfulness in working and at work. In K. S. Cameron, J. E. Dutton and R. E. Quinn (Eds.), *Positive organisational scholarship*. San Francisco, CA: Berrett-Koehler Publishers, Inc, pp. 309–327.

Pullman, M., and Gross, M. (2003). Welcome to your experience: Where you can check out

anytime you'd like, but you can never leave. *Journal of Business and Management, 9*,

215-232.

Pynes, J., and Lombardi, D. (2011). *Human Resources management for health care*

organisations: A strategic approach. Hoboken, NJ: John Wiley & Sons.

Qatar Country Report. (2015). *The multiples group*. Available at:

http://multipesgroup.com/wp-content/uploads/2015/02/Qatar-Country-Report-

2015.pdf [Accessed 02/05/2019].

Qatar Foundation. (2015). *About Qatar Foundation Qatar Foundation*. Available at:

http://www.qf.org.qa/about [Accessed 29 July 2015].

Qatar Ministry of Economy and Commerce. (2014). *How to invest in Qatar*. Available at:

http://www.mbt.gov.qa/English/ForeignInvestor/Pages/InvestinQatar.aspx [Accessed

19 July 2015].

Qatar National Vision 2030 (QNV). (2008). Available at:

https://www.mdps.gov.qa/en/qnv/Documents/QNV2030_English_v2.pdf

Qatar Statistics Authority. (2012). *Qatar infrastructure statistics*. Available at:

https://www.psa.gov.qa/ar/knowledge/Publications/Economic/Eco_Qatar_Infrastructur

e_Statistics_En_2012.pdf [Accessed 13 May 2014].

Qatar Tourism Authority (QTA). (2015). *Qatar National Tourism Sector Strategy*

2030. Available at:

http://corporate.qatartourism.gov.qa/Portals/0/English%20Strategy.pdf [Accessed 17

July 2016].

Qatar Tourism Authority (QTA). (2017). *2017 Annual Tourism Performance Report*.

Available at:

https://www.visitqatar.qa/binaries/content/assets/corporate/statistics/en/2017/2017-
annual-tourism-performance-report_v2.pdf [Accessed 23 February 2019].

QTA (Qatar Tourism Authority) (2015). *Qatar National Tourism Sector Strategy 2030*. Available at:
http://corporate.qatartourism.gov.qa/Portals/0/English%20Strategy.pdf [Accessed 29 August 2015].

Rad, N., Som, A., and Zainuddin, Y. (2010). Service quality and patients' satisfaction in medical tourism. *World Applied Sciences Journal, 10*, 24–30.

Radzi, S., Bakhtiar, M., Mohi, Z., Zahari, M., Sumarjan, N., Chik, C., and Anuar, F. (2014). Theory and practice in hospitality and tourism research. Boca Raton, FL: CRC Press.

Ram, P., (2014). Management of Healthcare in the Gulf Cooperation Council (GCC) countries with special reference to Saudi Arabia. *International Journal of Academic Research in Business and Social Sciences December. 4*(12), 24-41.

Ray, N. (2015). *Strategic infrastructure development for economic growth and social change*. Hershey, PA: IGI Global.

Rebelo, F. and Soares, M. (2012). *Advances in usability evaluation*. Boca Raton, FL: CRC Press.

Reed, C. (2008). Medical tourism. *The Medical Clinics of North America, 92*(6), 1433-1446.

Reichheld, F. (1996). Learning from customer defections. *Harvard Business Review, 74*(2), 56-68.

Relph, E. (1985). Geographical experiences and being-in-the-world: the phenomenological origins of geography. In: D. Seamon, and R. Mugerauer (Eds.), *Dwelling, place and environment*. Netherlands: Springer, pp. 15–31.

Ren, T., Hyun, H., and Park, J. (2017). Medical tourism services: The role of patients' perceived health consciousness and value. *Journal of Service Science Research, 9*, 179-195. doi: 10.1007/s12927-017-0009-z

Reynolds, K., Metz, D., and Unger J. (2007). Health behaviour research and intervention. In R. Wallace (Ed.), Public Health & Preventive Medicine, (5th Edition). New York, NY: The McGraw-Hill Companies, pp. 941–942.

Rittle, C. (2015). Multicultural nursing providing better employee care. *Workplace Health & Safety, 63*(12), 532-538. doi: 10.1177/2165079915590503

Robinson, M. and Novelli, M. (2005). *Niche Tourism: an introduction.* In M. Novelli (Ed.), *Niche tourism: Contemporary issues, trends and cases*. Oxford, UK: Butterworth-Heinemann Ltd., pp. 4-9.

Rodrigues, P. M. & Ramos, C. M., (2013). Research note: the importance of online tourism demand. *Tourism Economics*, *19*(6), 1443-1447.

Romero, J. (2018). Exploring customer engagement in tourism: Construct proposal and antecedents. *Journal of Vacation Marketing*, *24*(4), 293-306.

Rosenstock, I. (1974). Historical origins of the health belief model. *Health Education Monographs, 2*(4), 328-335. doi: 10.1177/109019817400200403

Ross, J. and Shetty, Y. (1985). Making quality a fundamental part of strategy. *Long Range Planning, 18*(1), 53–58.

Ross, K. (2001). Health Tourism: An overview. *Hospitality Sales and Marketing Association International Marketing Review*. Available at: http://www.hospitalitynet.org/news/4010521.search?query¼%2522health tourism%2522 Accessed 22.10.2017 [Accessed 12 May 2017].

Ross, K. (2001). Health Tourism: An overview. *HSMAI Marketing Review*. Available online at http://www.hospitalitynet.org/news/4010521.search?query¼%2522health tourism%2522 [Accessed 22 August 2017].

Rowley, J. (2014). Designing and using research questionnaires. *Management Research Review, 37*(3), 308-330.

Ruggeri, K., Záliš, L., Meurice, C., Hilton, I., Ly, T., Zupan, Z. and Hinrichs, S. (2015) Evidence on global medical travel. *Bulletin of the World Health Organisation, 93*, 785-789.

Ruhanen, L., Scott, N. Ritchie, B. and Tkaczynski A. (2010). Governance: A review and synthesis of the literature. *Tourism Review, 65*(4), 4–16.

Ruka, E. (2015). *Medical tourism*. Brussels, BEL: HOPE Publications.

Russell, N., Wallace, L. and Ketley, D. (2011). Evaluation and measurement for improvement in service-level quality improvement initiatives. *Health Services Management Research, 24*(4), 182-189.

Rutes, W., Penner, R., and Adams, L. (2001). *Hotel design, planning and development*. New York, NY: W. W. Norton.

Ryan, C. (2002). Equity, management, power sharing and sustainability: Issues of the new tourism. *Tourism Management, 23*, 17–26.

Rybkowski, Z. K., Shepley, M. M., Bryant, J. A., Skelhorn, C., Amato, A., & Kalantari, S. (2017). Facility management in Qatar: current state, perceptions and recommendations. *Facilities*, *35*(5/6), 335-355.

Ryu, K. and Jang, S. (2007) The effect of environmental perceptions on behavioural intentions through emotions: The case of upscale restaurants. *Journal of Hospitality & Tourism Research, 31*(1), 56–72.

Saarinen, J. (2004). 'Destinations in change': The transformation process of tourist destinations. *Tourist Studies, 4*(2), 161–179.

Sadeeqa, S., & Sarriff, A. (2014). Comparing KAP regarding Halal pharmaceuticals among general practitioners and hospital doctors. *Journal of Applied Pharmaceutical Science, 4*(10), 92-96.

Sadler, B., Joseph, A., Keller, A., and Rostenberg, B. (2009). Using evidence-based environmental design to enhance safety and quality. [Electronic Version]. *IHI Innovation Series white paper*.

Sadler, G.R., Lee, H.C., Lim, R.S.H., and Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing & health sciences, 12*(3), 369-374.

Saint-Louis, C. (2010). Plunge in plastic. *Bangkok post 3 June 8*.

Sandberg, D. S. (2017). Medical tourism: An emerging global healthcare industry. *International Journal of Healthcare Management, 10*(4), 281-288.

Saravanan, R. and Rao, K. (2007). Measurement of service quality from the customer's perspective – An empirical study. *Total Quality Management, 18*(4), 435-449.

Saunders, M., Lewis. P., and Thornhill, A. (2012). *Research methods for business students*. 6th ed. Harlow: Pearson.

Scharfenort, N. (2017). Tourism development challenges in Qatar. *International Tourism Development and the Gulf Cooperation Council States: Challenges and Opportunities*, 140.

Schwarzer, R. (1992). Self-efficacy in the adoption and maintenance of health behaviours: theoretical approaches and a new model. In R. Schwarzer (Ed.) *Self-efficacy: Thought control of action*. Washington, DC: Hemisphere, pp. 217-43.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching*, *5*(9), 9-16. doi: 10.5539/elt.v5n9p9

Seligman, J. (2012). *Customer experience in modern marketing*. England: Lulu.com.

Seydel, E., Taal, E., and Wiegman, O. (1990). Risk-appraisal, outcome and self-efficacy expectancies: Cognitive factors in preventive behaviour related to cancer. *Psychology and Health, 4,* 99-109.

Shankman, S. (2015). *Interview: Qatar's tourism chairman positions his small country for big growth*. Available at: http://skift.com/2015/01/20/interview-how-qatars-tourism-chairman-positions-his-small-country-for-big-growth/ [Accessed 5 July 2017].

Shapiro, S. (2010). Does service matter? An examination of donor perceptions of service quality in college athletics. *Sport Marketing Quarterly, 19*(3), 154–164.

Sharpley, R. (2008). Planning for tourism: The case of Dubai. *Tourism and Hospitality Planning & Development*, *5*(1), 13-30.

Sheeran, P. and Abraham, C. (1996). The Health Belief Model. In M. Conner and P. Norman (Eds.), *Predicting health behaviours: Research and practice with social cognition models*. Buckingham, UK: Open University Press, pp. 1-22.

Sheldon, P. and Park, S. (2009). Development of a sustainable wellness destination. In R. Bushell and P.J. Sheldon (Eds.) *Wellness and tourism: Mind, body, spirit, place*. New York, NY: Cognizant Communication Corporation.

Shostack, G. (1977). Breaking free from product marketing. *Journal of Marketing, 41*(April), 73-80.

Sillitoe, P., (2014). *Sustainable development: An appraisal from the Gulf Region*. New York, NY: Berghahn Books.

Simpson, M.C. (2008). Community benefit tourism initiatives-A conceptual oxymoron?. *Tourism Management, 29*, 1–18.

Smith, M. and Puczko, L. (2009). *Health and wellness tourism*. Oxford, UK: Elsevier.

Smith, M., and Puczko, L. (2014). *Health Tourism and hospitality: Spas, wellness and medical travel* (2nd Edition). London, UK: Routledge.

Smith, P. and Forgione, D. (2007). Global outsourcing of healthcare: a medical tourism decision model. *Journal of Information Technology Case Applied Research, 9*(3), 19–30.

Smith, R. Alvarez, M., and Chandra, R. (2011). Medical tourism: A review of the literature and analysis of a role for bilateral trade. *Health Policy, 103*, 276–82.

Söderlund, M. (1998). Customer satisfaction and its consequences on customer behaviour revisited. The impact of different levels of satisfaction on word-of-mouth, feedback to the supplier and loyalty. *International Journal of Service Industry Management, 9*(2), 169–188.

Sohail, M., (2003). Service quality in hospitals: More favourable than you might think. *Managing Service Quality, 13*(3), 197-206.

Solomon, M., Bamossy, G., Askegaard, S., and Hogg, M. (2006). *Consumer behaviour: A European perspective*, (3rd Edition). Harlow, UK: Pearson Education Limited.

Sonmez, S. F., and Graefe, A. R. (1998). Influence of terrorism risk on foreign tourism decisions. *Annals of Tourism Research, 25*(1), 112-144. doi: 10.1016/S0160-7383(97)00072-8

Spafinder Wellness UK. (2016). *Wellness tradition from the Islamic World*. Available at: http://www.spafinder.co.uk/blog/trends/2015-report/wellness-traditions-from-the-islamic-world/ [Accessed 22 August 2017].

Spencer, E. and Walshe, K. (2009). National quality improvement policies and strategies in European healthcare systems. *Quality & Safety. Health Care, 18*(11), 122-127.

Spencer, R. (2003). You beauty! China joins a material world. *The Sun-Herald, 7 December*, 76.

Spradley, J.P. (1979). *The ethnographic interview*. Belmont, CA: Wadsworth Group.

Spreng, R. and Mackoy, R. (1996). An empirical examination of a model of perceived service quality and satisfaction, *Journal of retailing, 722*, 201-214.

Stanfield, P. (2010). *Nutrition and diet therapy: Self-instructional approaches*, (5th Edition). Sudbury, MA: Jones and Bartlett Publishers.

Stausberg, M. (2011). *Religion and tourism: Crossroads, destinations and encounters*. New York, NY: Routledge.

Stolley, K., and Watson, S. (2012). *Medical tourism: A reference handbook*. Santa Barbara, CA: ABC-CLIO.

Stone, P. (2005). Book review: Niche tourism: Contemporary Issues, Trends and Cases. *Journal of Vacation Marketing, 11*, 19.

Strijbos, J. W. and Sluijsmans, D. (2010). Unravelling peer assessment: Methodological, functional, and conceptual developments. *Learning and Instruction*, *20*(4), 265-269.

Studer, Q. (2003). Hardwiring Excellence. Gulf Breeze, FL: Gulf Breeze Publishing.

Stylidis, D., Biran, A., Sit, J., & Szivas, E. M. (2014). Residents' support for tourism development: The role of residents' place image and perceived tourism impacts. *Tourism Management*, *45*, 260-274.

Sumarjan, N., Mohd, Z., Mohd, R., Zurinawati, M., Mohd, H., Saiful, B., et al. (2013). *Hospitality and tourism: synergizing creativity and innovation in research*. CRC Boca Raton, FL: Press.

Supreme Council of Health. (2011a). *Government of Qatar. National Health Strategy 2011–2016*. Doha, Qatar. Available at: http://www.qscience.com/doi/pdfplus/10.5339/jlghp.2015.2http://www.qscience.com/doi/pdfplus/10.5339/jlghp.2015.2 [Accessed 20 May 2015].

Supreme Council of Health. (2011b). *Policy Affairs Directorate, Government of Qatar. Qatar National Health Accounts- 1st Report Years 2009 & 2010: A Baseline Analysis of Health Expenditure and Utilization*. Doha, Qatar: Supreme Council of Health.

Supreme Council of Health. (2011c). *Qatar Healthcare Facilities Master Plan 2013-2033*. Available at: https://www.moph.gov.qa/HSF/Documents/QHFMP%20-%20Report%20(1).pdf [Accessed 20 May 2015].

Supreme Council of Health. (2014). *Annual Report 2014*. Doha, Qatar: Supreme Council of Health.

Supreme Council of Health. (2015). *Healthcare facilities accreditation.* Available at: https://www.sch.gov.qa/about-sch/departments/healthcare-quality/healthcare-facilities-accreditation [Accessed 20 May 2015].

Sweeney, J. and Soutar, G. (2001). Consumer perceived value: The development of a multiple item scale. *Journal of Retailing, 77*(2), 203–220.

Sweeney, T. and Witmer, J. (1991). Beyond social interest: Striving toward optimal health and wellness. *Individual Psychology, 47*, 527–540.

Teas, K. (1993). Expectations, performance evaluation, and consumers' perceptions of quality. *Journal of Marketing, 57*, 18-34.

Tesone, D., (2008). *Handbook of hospitality human resources management*. London, UK: Routledge.

Thakkar, R. (2010). *Medical tourism. The hospitalist*. Available at: http://www.the-hospitalist.org/article/medical-tourism/2/ [Accessed 22 November 2016].

The Fund For Peace. (2019). *Country Dashboard Fragile States Index*. Available at: https://fragilestatesindex.org/country-data/ [Accessed 2 August 2019].

The Legatum Institute Foundation. (2018). *The Legatum Prosperity Index^(TM) 2018* (12th edition). London, UK: The Legatum Institute Foundation.

The World Factbook. (2019). *Middle East :: Qatar – The World Factbook – Central Intelligence Agency*. Available at: https://www.cia.gov/librarY/publications/the-world-factbook/geos/qa.html [Accessed 02 May 2019].

Theobald, W. F. (1998). *Global tourism* (2nd Edition). Oxford, England: Butterworth Heinemann.

Theobald, W., (2014). *Global tourism* (3rd Edition). Oxford, UK: Routledge.

Thomas, N. J., Harvey, D. C. and Hawkins, H. (2013). Crafting the region: Creative industries and practices of regional space. *Regional Studies, 47*(1), 75–88.

Thompson, C. (2008). Medical tourism, stem cells, genomics: EASTS, transnational STS, and the contemporary life sciences, East Asian Science. *Technology and Society, 2,* 433-438.

Thompson, C. (2011). Medical migrations afterword: science as a vacation? *Body and Society, 17*, 205-213.

Todd, M., (2011). *Handbook of medical tourism program development: Developing globally integrated health systems* (1st Edition). London, UK: Productivity Press.

Triandis, H.C. (1994). *Culture and social behaviour*. New York, NY: McGraw-Hill.

Turner, L. (2007). Medical tourism: Family medicine and international health-related travel. *CFP. 53*(10), 1639-1641.

Turner, L. (2007). First World health care at Third World prices': Globalization, bioethics and medical tourism. *BioSocieties, 2*, 303–325.

Turner, L. (2008). Cross-border dental care: 'dental tourism' and patient mobility. *British Dental Journal, 204*, 553-554.

U.S. Department of Health and Human Services. (1990). *Healthy people 2000: National health promotion and disease prevention objectives*. Washington, DC: U.S. Government Printing Office.

Udupa, A., and Kotreshwar, G. (2013). Implications of Service Quality Model for medical tourism in India. *Asian Journal of Management 1*(2), 65-68.

Ulrich, R. S., Zimring, C, Zhu, X., DuBose, J., Seo, H. B, Choi, Y. S., and Joseph, A. (2008). A review of the research literature on evidence-based healthcare design. *Health Environments Research & Design, 3*(3), 61-125.

United Nations World Tourism Organisation (UNWTO) (2014). Provisional agenda item 4: 4. Snapshot report on tourism trends in the region and Identification of key challenges for 2015 June 2014. In proceedings of the *UNWTO Commission for the Middle East Thirty-ninth meeting,* Cairo, Egypt, 14 September. Available at: http://cf.cdn.unwto.org/sites/all/files/pdf/cme39_4_snapshot_report_on_tourism_trend s_and_challenges_e.pdf [Accessed 12 August 2017].

United Nations World Tourism Organisation (UNWTO). (2015). *Commission Annual Report*. Available at: http://cf.cdn.unwto.org/sites/all/files/pdf/annual_report_2015_lr.pdf [Accessed 12 August 2017].

United Nations World Tourism Organisation. (2014). *UNWTO Tourism Highlights (2014) Edition*. Available at: http://mkt.unwto.org/publication/unwto-tourism- highlights-2014 edition [Accessed 4 November 2014].

Upah, G. and Fulton, J. (1985). Situation creation in services marketing. In: J. Czepiel, M Solomon and C. Surprenant (Eds.), *The service encounter*. Lexington, MA: Lexington Books, pp. 255-64.

US Chamber of Commerce (2014). Africa's medical tourism industry. *Africa Business Initiative, 4*(2), 1-4.

Vaismoradi, M., Turunen, H., and Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences*, *15*(3), 398-405.

Varghese, J. (2014). *48 healthcare projects are in the pipeline*. Available at: http://www.gulf-times.com/qatar/178/details/398802/48-healthcare-projects-are-in-the-pipeline [Accessed 12 August 2017].

Varni, J., Burwinkle, T., Dickinson, P., Sherman, S., Dixon, P., Ervice, J., and Sadler, B. (2004). Evaluation of the built environment at a children's convalescent hospital: Development of the Pediatric Quality of Life Inventory® Parent and Staff Satisfaction Measures for pediatric health care facilities. *Journal of Developmental & Behavioural Pediatrics, 25*(1), 10–20.

Ventures Onsite Report. (2015). Available at: https://www.venturesonsite.com/news/tag/hospital-development/ [Accessed 26 February 2016].

Ventures Onsite Report. (2015). *Qatar's Hamad Medical Corp plans to double hospital beds triple car parks by 2030*. Available at: https://www.venturesonsite.com/news/qatars-hamad-medical-corp-plans-to-double-hospital-beds-triple-car-parks-by-2030 [Accessed 20 July 2017].

Vequist, D., Bolatkale, E., and Valdez, E. (2009). Health Tourism economic report Jordan. *Health Tourism Magazine, 2*(August). Available at: www.healthtourismmagazine.com/article-detail [accessed 1 March 2010].

Victorino, L., Verma, R., & Wardell, D. (2008). Service scripting: A customer's perspective of quality and performance [Electronic article]. *Cornell Hospitality Report, 8*(20), 6-13.

Vieira, A. (2005). Delivering quality service all for one. *Journal of Quality Assurance in Hospitality and Tourism, 6*(1/2), 25-42. doi: 10.1300/J162v06n01_03

Voigt, C. and Pforr, C. (2013). Medical tourism: A destination perspective. In: C. Voigt and C. Pforr (Eds.), *Routledge Advances in tourism*, pp. 63-64. London, UK: Routledge

Vural, H., Koyuncu, M., & Guney, S. (2017, July). A systematic literature review on microservices. In *International Conference on Computational Science and Its Applications* (pp. 203-217). Springer, Cham.

Wahyuni, D. (2012). *The research design maze: Understanding paradigms, cases, methods and methodologies*. Santo Domingo: Dominican Adventist University.

Wang, H. (2012). Value as a medical tourism driver. *Managing Service Quality, 22*(5), 465–491.

Wang, H. and Wang, S. (2013) Mainland Chinese customers' intention toward medical tourism in Taiwan. *International Journal of Social, Management, Economics and Business Engineering, 7*(2), 221–223.

Warren, M. (2012). Professional and workplace settings. In J. Jackson (Ed.), *The Routledge handbook of language and intercultural communication*. New York, NY: Routledge, pp. 481–494.

Watters, C., Sorensen, J., Fiala, A. and Wismer, W. (2003). Exploring patient satisfaction with foodservice through focus groups and meal rounds. *Journal of the Academy of Nutrition and Dietetics, 103*(10), 1347-1349.

Whiting, L. S. (2008). Semi-structured interviews: guidance for novice researchers. *Nursing Standard*, *22*(23), 35-40.

Wiersema, F. (1998). *Customer service*. New York, NY: Harper Collins.

Wilson, M. F., Baig, M. K., and Ashraf, H. (2005). Quality of life in octagenarians after coronary artery bypass grafting. *American Journal of Cardiology, 95*(6), 761–764.

Wiseman, A., Alromi, N., and Alshumrani, S., (2014). *Education for a knowledge society in Arabian Gulf Countries*. London, UK: Emerald Group Publishing.

Witmer, J. and Sweeney, T. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling & Development, 71*, 140–148.

Witmer, J., Sweeney, T. and Myers, J. (1998). *The Wheel of Wellness*. Greensboro, NC: Authors.

Wittek, A., Miller, K., and Nielsen, P. (2013). *Computational biomechanics for medicine: Models, Algorithms and implementation*. Berlin, Germany: Springer Science & Business Media.

Wongkit, M. and Mckercher, B. (2013). Toward a typology of medical tourists: A case study of Thailand. *Tourism Management, 38*, 4-12.

World Bank Group. (2015). *Shaping healthier societies and building higher performing health systems in the GCC Countries: The Health, Nutrition, Population (HNP) Global Practice*. Available at: http://documents.worldbank.org/curated/en/907131468182345587/pdf/96393-WP-Health-Sector-Engagement-Note-Box391433B-PUBLIC.pdf [Accessed 22 August 2019].

World Bank Group. (2019). CO2 emissions (metric tons per capita). Available at: https://data.worldbank.org/indicator/EN.ATM.CO2E.PC [Accessed 07 May 2019].

World Travel & Tourism Council (WTTC). (2019). *Country Data WTTC*. Available at: https://www.wttc.org/api/sitecore/DownloadForm/DownloadPdf [Accessed 14 August 2019].

Wrzesniewski, A., Dutton, J. E., & Debebe, G. (2003). Interpersonal sensemaking and the meaning of work. *Research in organisational behaviour, 25*, 93–135. doi: 10.1016/S0191-3085(03)25003-6

Wu, H. and Li, T. (2014). A study of experiential quality, perceived value, heritage image, experiential satisfaction, and behavioural intentions for heritage tourists. *Journal of Hospitality & Tourism Research, 41*(8), 904–944. doi: 10.1177/1096348014525638

Wu, Z., Robson, S. and Hollis, B. (2013). The application of hospitality elements in hospitals. *Journal of Healthcare Management, 58*(1), 47-62

Ye, B., Qiu, H. and Yuen, P. (2011). Motivations and experiences of Mainland Chinese medical tourists in Hong Kong. *Tourism Management, 32*, 1125-1127.

Yoon, Y., Gursoy, D. and Chen, J.S. (2001). Validating a tourism development theory with structural equation modeling. *Tourism Management, 22*, 363–372.

Young, S. (2000). *The effects of customer loyalty on profitability*. UMI.: Published dissertation, Saint Louis University.

Yu, C., Chang, H., and Huang, G. (2006) A study of service quality, customer satisfaction and loyalty in Taiwanese leisure Industry. *The Journal of American Academy of Business, 9*(1), 126–132.

Yu, J. Y. & Ko, T. G. (2012). A cross-cultural study of perceptions of medical tourism among Chinese, Japanese and Korean tourists in Korea. *Tourism Management, 33*(1), 80–88.

Yuksel, A. and Yuksel, L. (2002). Measurement of tourist satisfaction with restaurant services: A segment- based approach. *Journal of Vacation Marketing, 9*(1), 52-68.

Zamani-Farahani, H. and Musa, G. (2012). The relationship between Islamic religiosity and residents' perceptions of socio-cultural impacts of tourism in Iran: Case studies of Sare'in and Masooleh. *Tourism Management, 33*, 802–814.

Zeithaml, V. (1988). Consumer perceptions of price quality and value: A means-end model and synthesis of evidence. *Journal of Marketing, 52*(3), 2-22.

Zeithaml, V. Parasuraman, A., and Berry, L. (1985). Problems and strategies in services marketing. *Journal of Marketing, 49*, 33-46.

Zeithaml, V., (2010). *Delivering quality service*. London, UK: Simon and Schuster.

Zeithaml, V., Berry, L. and Parasuraman, A. (1988). Communication and control processes in the delivery of service quality. *Journal of Marketing, 52*(2), 35-48.

Zeithaml, V., Berry, L. and Parasuraman, A. (1996). The behavioural consequences of service quality. *Journal of Marketing, 60*(2), 31–46.

Zhang, J., Beatty, S. E. and Walsh, G. (2008). Review and future directions of cross-cultural consumer services research. *Journal of Business Research, 61*(3), 211–224.

Zineldine, M. (2006) The quality of health care and patient satisfaction: An exploratory investigation of 5Q model at some Egyptian and Jordanian medical clinics. *International Journal of Health Care Quality Assurance, 19*(1), 60–92.

Appendices

Appendix I- Qatar National Vision 2030   **Attached CD**

Appendix II- Qatar National Tourism Sector Strategy 2030   **Attached CD**

Appendix III- Qatar National Health Strategy2011-2016   **Attached CD**

Qatar National Health Strategy2016-2022   **Attached CD**

Appendix IV- Qatar Healthcare Facilities Master Plan2013-2033   **Attached CD**

Appendix V. The Semi Structured Interview Questions with Government Official

"Phase One" and Sample of the Transcript

SEMI-STRUCTURED INTERVIEWS QUESTIONS

Order of semi structured Interview	Discussed
1) **Ask respondent approval to use recording systems** **Ask respondent to sign and acknowledge consent form**	
2) **Ask Background questions** Confirm information about; • Name of the Ministry	
• Respondents position	
• years working for the organisation	
3) **Discuss about Qatar National Strategy 2030** • Mission • Vision • Impact • Challenges \Limitations • What part the interviewee had in setting up the strategy? • What part the interviewee has in implantation and monitoring the strategy?	
4) **Discuss about Medical Tourism** • Precisely what is meant by medical tourism? o What do they see as the key objectives of medical tourism form their perspective as the XX Minister? • Medical Tourism in the region • What do you see in the evolution of Medical Tourism? • Rationale for developing it?	
5) **Discuss how we can meet the criteria for Medical tourism in terms of expertise, and built in environment within the Qatari/Arabic context**? • International accreditation • Training • Technology • Nationalisation Policy • Implications "Tourism people and Healthcare people • Education • Employment	
6) **Discuss about financial and economic issues** • How Medical Tourism will be funded? • Impact / Potential benefit /disadvantages / contribution towards the Qatar Economy?	
7) **Discuss about Cultural Context** • Do the tourism people and the health people see that it is beneficial to work together? From that what is doable in the Qatari/Arabic context? • Societal Perspective	

• How this sector might be seen in terms of a career choice?
    ○ Gender
    ○ Religion
    ○ Power issues as well as nationals v expat employment
    ○ Influence.	

Sample of the Transcript

Background questions:
Name of the Ministry: Ministry of Public Health "MOPH"

Respondent's position: Assistant Minister for Health Affairs
Years working for the organization: Eight Years

1- Discuss Qatar National Strategy 2030, from the perspectives of:

- **Mission**
- **Vision**
- **Impact**

The 2030 strategy and vision is a holistic vision that tackles all aspects that can help Qatari people progress while promoting for a better future. It also has realistic objectives that are achievable. Starting from this point, the Ministry of Development and Statistics has set its own strategies to realize these goals and consequently realize the 2030 vision, which has created an atmosphere of harmony and balance among these ministries and authorities. What's interesting about this is that the Ministry of Public Health is involved in all policies to realize what is called "health in all policies." In this sense the Ministry of Health coordinates its work with other sectors such as the environmental and professional health sectors. Work is also coordinated with some administrations in these ministries like the Ministry of the Interior where the health sector works closely with the accidents and traffic department in order to limit the number of accidents and their resulting effects. Their work in not limited to receiving the injured at emergency room but is encompasses more matters such as lighting, speeding, the age of the drivers, the effect of the medicinal drugs, etc…

- **What part the interviewees had in setting up the strategy?**

I have worked with a team assigned by the ex-minister to set up the health strategy which seeks to realize the 2030 national vision. Thanks God, until now, 87% of its goals have been achieved. Primary healthcare has been considered an important part of it and results show real progress, whether in in the primary healthcare facilities or the management itself. For example, when it comes to employment, most physicians have become consultants and big number of them are now general practitioners and family doctors. This has in turn led to improving health services offered.

- **What part the interviewees has in implantation and monitoring the strategies?**

Now with the close directions of the current minister, a team made up of primary health care and Hamad Medical Corporation has been formed to work on setting health strategy 2, which is complementary to health strategy 1.

2- Discuss Medical tourism

- **Precisely what is meant by medical tourism**

Medical tourism is not just about clients "patients" coming from neighbouring and other countries, but rather it is about patients seeking medical care from inside the country. Therefore, the goal is about attracting clients or "patients" whether from inside or outside the country.

- **What do you see as the key objectives of medical tourism from their perspective as the XX minister?**

Offering unique and high quality services at suitable prices is considered a basic goal for the ministry.

- **Medical tourism in the region**

Lately, medical tourism has started to spread in the region and the neighbouring countries. A number of patients from these countries have started to arrive to Qatar to receive treatment for certain diseases related in particular to heart and cardiovascular disease as well as cancer and kidney transplants.

- **What do you see in the evolution of medical tourism?**

Its necessity of developing medical tourism in Qatar. I considers it to be very important on the international level. it should tell apart the country's achievements at a level very similar to that in sports and the giant success it could attain in international forums. There are 8 months in the year when the weather in Qatar is just amazing and there are beautiful and unique touristic sites to visit.

Hamad Medical Corporation has become internationally well-known for the services it provides. Most private hospitals are now managed by Qataris who had worked in Hamad Medical Association. In the beginning medical tourism can be developed through emphasizing particular specializations such as cancer or heart diseases and then expanding to include other medical specializations.

Developing medical tourism needs marketing, so we need to work on promoting the offered medical services in the state. Marketing is not only limited to media but it also encompasses patients themselves and the results they see. When they do spread the word and talk about their experience and satisfaction, other would actually form a good image about these healthcare services and would want to receive them. Employees also have an important role in marketing these services, mainly by the word of mouth. Workers in the medical sector in Qatar are a mixture of around 60 different nationalities including Arab, Asian, and European nationalities. Residents in Qatar are also of around 120 nationalities.

In order to develop medical tourism, healthcare facilities need medical and hotel management in order to provide high quality hospitality services. Also the variety and malleability of options provided plays an important role in promoting turnkey solutions, such as room options (regular, deluxe or super deluxe) and suits remodelling upon request.

The development of tourism is not only the responsibility of the Ministry of Public Health but is also the responsibility of other sectors such as tourism and transportation.

- **Rationale for developing it?**

The development of medical tourism has become a necessity, especially that Qatar's medical health sector has become very refined lately, this has contributed for Qatar to become a destination for many visitors from different countries.

3- Discuss how we can meet the criteria for medical tourism in terms of expertise, and built in environment within the Qatari/Arabic context?

- **International accreditation**

I think that it is important to get international accreditation and that it is necessary to attract clients or "patients" as well as doctors with expertise. I believes that successful doctors won't work in medical facilities that are not well-known or if they don't provide services of high quality standards, especially successful doctors who continuously seek to develop their medical career.

- **Training**

The Ministry of Public Health pays special attention to training because of the important role it plays in improving and developing offered services. Training is definitely not limited to certain group or specialty. The high rank medical plants initiative has served to connect the medical facilities with their counterparts in developed countries. This came under the guidance of her majesty Sheikha Moza who emphasized the importance of selecting top notch facilities to work with in search for best quality levels. These initiatives have been applied to hospitals, and Hamad Medical Corporation has played an important role in improving services offered, including training medical and administrative staff. There is also an exchange of experience among countries in the field of performing surgeries. For example, a team from South Korea has performed three surgical operations in Hamad General Hospital, and in the coming months a team from Hamad Hospital will be performing surgeries in South Korea as well.

- **Technology**

The development of utilized technologies has become very evident. In the past Qatar would send patients abroad to receive treatment for the lack it has in certain apparatuses or machines. Now, however, a number of patients from the neighbouring countries visit Qatar to enjoy the availability of modern high-tech equipment.

- **Nationalization policy**

The country is best represented by its sons; this is why he supports nationalization policy. However, despite following nationalization policy, the percentage of nationalization in the medical sector is still considered meagre because of the shift in the new generation desires and their career choices. This generation happens to choose comfort over challenge, an issue that could be a result of the ease young people are getting their requests by their parents, which in turn influenced their personality traits in the sense that they are not willing to take challenging jobs and prefer to do easier tasks that offer them good income and less effort. This has mainly driven them away from working in the healthcare sector.

- **Implications "Tourism people and Healthcare people**

Medical tourism has positive effects on both healthcare and tourism sector. I sees that medical sector has taken a leap forward when compared to tourism, but this won't stand in the way of cooperation because this would help both parties reaping positive results.

- **Education**

Qatar pays special attention to education for the key role it plays in developing the community. Qatar Medical College has up till now accepted three batches of students, each of 40, 70 and 60 students consecutively. This is a good start, and the door is always open for student exchange programs in all medical majors. Nursing schools have opened doors with the cooperation of other universities as Weill Cornell. There has also been an increased awareness for pursuing medical majors among high school students, an awareness that is mostly acquired via medical media channels.

- **Employment**

Since jobs in the medical sector need certain scientific qualifications and some practical expertise, and since numbers needed in this sector exceeds available qualifications among Qataris, qualified non-Qataris are consequently hired in order to meet shortage and ensure offering high quality services.

4- Discuss financial and economic issues

- **How medical tourism will be funded**

Medical tourism is to be funded by Ministry of Public Health and through assigning part of its budget for sustaining the concept and developing medical services offered.

- **Impact/potential benefit/disadvantages/contribution toward the Qatar Economy?**

There is no possible drawbacks resulting from the development of medical tourism in Qatar. I believes that pros and potential benefits definitely overweigh any possible cons. In regard to Qatar economy, I believes that public finances will be spent inside the country instead of spending them abroad for treatment purposes. Medical tourism will be absolutely a new source of income, and since Qatar is a rich country, medical tourism will enhance the state's image which is very crucial at the time being.

5- Discuss the cultural context
- **Do the tourism people and the health people see that it is beneficial to work together? From that what is achievable in the Qatari/Arabic context?**

As mentioned earlier, the responsibility of developing medical tourism doesn't only entail ministry of public health. Actually the cooperation between the two sectors will play the biggest role in medial tourism development, consequently any cooperation in this regard is very welcomed.

- **Societal perspective**

In My opinion, developing medical tourism will be especially welcomed by citizens who will prefer receiving healthcare in their homeland and among their families. On the other side, Qatari people are very loving and welcoming, and I believed that this would enhance visitors' impressions and could help attract patients from abroad. Medical tourism, would encourage foreigners to seek medical care in Qatar and to trust what it has to offer.

- **How this sector might be seen in terms of a career choice?**

- **Gender**

Choosing a professional career path is not limited to males, especially that women have been empowered and have become effective members in society who work in all fields. The women have made big achievements and succeeded in so many fields, so they have come to compete with men, technically on many levels. They have proven their competency and their ability to assume responsibility and they might be more serious about their work than men. Lately, women have become head of many administrations in medical sector.

- **Religion**

Islam is not in any way an obstacle in the face of developing medical tourism since it is a religion which urges work, equality, and honesty among lots of other good values. These

values are actually supportive of the medical tourism project. It is worth mentioning here that Qatar is a state which respects other religions.

- **Power issues as well as nationals vs expats employment.**

As I mentioned earlier, the ministry can resort to hiring non Qataris if needed, for the purpose of improving the level of offered medical services.

- **Influence**

The way I see it, the effect of medical tourism will be greatly positive in general.

Appendix VI. The Semi Structured Interview Questions with HMC Senior Management

"Phase Two" and Sample of the Transcript

SEMI STRUCTURED INTERVIEWS QUESTIONS

Order of semi structured Interview	Discussed
1) **Ask respondent approval to use recording systems** **Ask respondent to sign and acknowledge consent form**	
2) **Ask Background questions** Confirm information about; • Name of the facilities/department	
• Respondents position	
• Years working for the organisation	

3)**Discuss about Medical Tourism**
 	
    • Are there features of the medical tourism business that you wish to conduct in the future? Do you wish to attract particular stakeholders?
    • What are the possible positive or negative impacts does medical tourism have on Qatar's health care system? Do you see yourself as a supporter for the patient/customer, for the business, or for the destination healthcare organization/country?
 	
 4) **Discuss about HMC**
 	
    • Does HMC have the ability to undertake the Medical tourism in Qatar and why? In terms of capacity the quality of service provided.
 	
    • In what ways should medical tourism be delivered effectively by HMC?
 	
    • Which facilities fit with Medical Tourism in terms of:
 -Length of stay
  - Treatment requirements
 -Following up "after treatment"
 -Cost
 -Capacity
 -Hospitality\Reception\welcoming
 	
    • Dose HMC have a billing system in place? If Yes , how it can help with developing Medical Tourism ? If No: how can we develop medical tourism in this case?
    • Do you think that HMC can provide partner packages to future costumers? If yes, what is your estimation of the cost?	

• Do you think HMC has the capacity of arranging different services? What would the services be? • Dose HMC use insurance systems? How can the insurance system help in improving the services? • As we know that HMC is following JCI standards, how are HMC facilities committed to those standards and how will it enhance the services to be provided? • Can hospitality play a role in implementing the medical tourism with in HMC? How? • What do you think of attracting medical tourists rather than having Qatari patients only? How can HMC be the centre of attraction for those patients? What will the procedures in terms of medical treatment and non-medical services be?	
5) Discuss about Services" Non-Medical services" • Throughout your experience, what are the most services that patients/customers usually seek in Qatari healthcare institutions? • Do you perceive individuals getting treatment as patients or customers? • In your opinion what will the advantages and disadvantages of the non-medical services at HMC be?	

6) Discuss HMC employees (majority of senior staff)
• Do you think HMC employees have the awareness of medical tourism and its requirements?
• How would the performance of the employee impact the development of medical tourism at HMC?
  • How can out source staff" contractors" affect the implementation of medical tourism in terms:
    -Performance
    - Quality of service
    -Sustainability
    - Customer experience	

7) Discuss about Customer
• How does HMC currently meet customer's satisfaction?
    -Physical environment
    -Patient rooms
    - Patients feedback
    -Employees' interactions.
 	
• What aspects could be improved in terms of customer satisfaction?	

• What are the strategies utilized by the corporation to meet the expectations of medical tourists?	

8) Discuss about Cultural Context
  • What is the role of the culture in patient experience/expectations?
   - Religion
   -Gender
   -Age
   -Language
 • How do you cope with customers from different culture?
   -Food
   - Race and Religion
   -Language
   -Reception
   -Built- in Environment	

Sample of the Transcript

1) Background questions

Information about;

- **Name of the facilities/department.**

    National Centre for Cancer Care & Research "NCCCR"

- **Respondent position.**

    CEO & Medical Director

- **Years working for the organisation.**

    4.5 yrs.

2) Discuss about Medical Tourism

- **Are there features of the medical tourism business that you wish to conduct in the future? Do you wish to attract particular stakeholders?**

    We are establishing a world class comprehensive cancer program including Blood Stem

    Cell Transplantation for malignant diseases. We offer our services to the Qatar

population and to patients from foreign countries in the greater MENA region and beyond. We are recognized for the high quality of our services which is the primary driver for any medical tourism towards Qatar. No need to attract any particular stakeholders.

- **What are the possible positive or negative impacts does medical tourism have on Qatar's health care system? Do you see yourself as a supporter for the patient/customer, for the business, or for the destination healthcare organization/country?**

  The positive impact is the consolidation of our recognized leadership role as a high quality healthcare provider in the region. The negative impact is the limited capacity of Qatar's hospitals in view of the growth of our population. Of course we support our patient/customer relationships, business development as a healthcare destination of our Organization/Country.

3) **Discuss about HMC**

- **Does HMC have the ability to undertake the Medical tourism in Qatar and why? In terms of capacity the quality of service provided.**
  - Medical Tourism to Qatar is a daily fact. Excellent service quality has been the driver for years. Capacity issues are the only limitation as our population needs to be serviced with priority.

- **In what ways should medical tourism be delivered effectively by HMC?**
  - Secure continued striving for excellence in service and service delivery. An effective system of performance monitoring is in place and internationally bench marked.

- **Which facilities fit with Medical Tourism in terms of:**
  - **Length of stay**
    NCCCR – excellent
  - **Treatment Requirements**
    NCCCR - internationally bench marked
  - **Following up "after treatment"**

NCCCR - internationally bench marked

- **Cost**

  To be determined as health insurance and reimbursement system is   under

  development.

- **Capacity**

  Limited: 2 beds per 1000 patients, other countries have double capacity

- **Hospitality\Reception\welcoming**

  Developing nicely, but more work needed

- **Dose HMC have a billing system in place? If Yes , how it can help with developing Medical Tourism ? If No: how can we develop medical tourism in this case?**
  - A billing system is in preparation. Medical tourism is not dependent other billing system but on the delivery of excellence in quality of care.

- **Do you think that HMC can provide partner packages to future costumers? If yes, what is your estimation of the cost?**
  - Yes, cost needs to be worked out as it will depend on the cost calculation system (DRG's etc).

- **Do you think HMC has the capacity of arranging different services? What would the services be?**
  - We are very well positioned with our new facilities to arrange for outpatient, day care, and inpatient services including hostel services

- **Dose HMC use insurance systems? How can the insurance system help in improving the services?**
  - An insurance system is mandatory for cost effective management of a hospital system like HMC. Proper accounting is also a driver for quality care.

- **As we know that HMC is following JCI standards, how are HMC facilities committed to those standards and how will it enhance the services to be provided?**
  - We are proud to be continuously JCI accredited, last as an Academic Health System. This is a great achievement for the corporation.

- **Can hospitality play a role in implementing the medical tourism with in HMC? How?**
  - Hospitality is central in service development. A more welcoming attitude towards patients and their families is mandatory. The attitudes towards work in

general and patients as clients has room for further development. The 'end of the work day' should be defined by 'the work finished' and not by the clock.

- **What do you think of attracting medical tourists rather than having Qatari patients only? How can HMC be the centre of attraction for those patients? What will the procedures in terms of medical treatment and non-medical services be?**

  - It is a fact that we are servicing a broader population beyond Qatar. This is due to the high quality of services offered. Patients should always be seen as welcome customers and not as 'work' only.

4) **Discuss about Services" Non-Medical services"**

- **Throughout your experience, what are the most services that patients/customers usually seek in Qatari healthcare institutions?**

  - Patient accommodation including Hotel accommodation for families and caretakers, food services, fitness/rehabilitation and wellness services and all related patient and family education.

- **Do you perceive individuals getting treatment as patients or customers?**

  - Unfortunately, too often as 'patients' only and patients are 'work' and the general work attitude is slightly 'work-averse'.

- **In your opinion what will the advantages and disadvantages of the non-medical services at HMC be?**

  - Only advantages if delivered with highest standards. Improves patient and family well-being in a generally stressful hospital environment.

5) **Discuss HMC employees (majority of senior staff)**

- **Do you think HMC employees have the awareness of medical tourism and its requirements?**

  - Partly. Room for development.

- **How would the performance of the employee impact the development of medical tourism at HMC?**

  - Greatly! This is the organization with the shortest work hours that I have seen in my professional life.

- **How can outsource staff" contractors" affect the implementation of medical tourism in terms:**

  - **Performance**

Our experience with 'outsourced staff contractors' has been poor.

- **Quality of service**

Poor control of services

- **Sustainability**

Not sustainable

- **Customer experience**

Mixed

6) Discuss about Customer

- **How does HMC currently meet customer's satisfaction?**

  - **Physical environment**

    Ok, could be better

  - **Patient rooms**

    Good, by international standards

  - **Patients feedback**

    Generally positive

  - **Employees' interactions**

    Room for improvement

- **What aspects could be improved in terms of customer satisfaction?**

  - Commitment and accountability in all services

- **What are the strategies utilized by the corporation to meet the expectations of medical tourists?**

  - Internationally bench marked quality control / KPI's

7) Discuss about Cultural Context

- **What is the role of the culture in patient experience/expectations?**

  - **Religion:** It is mandatory for any health care team to understand the religious background of patients and their families.

  - **Gender:** Gender issues have to be respected under cultural and religious considerations.

  - **Age:** Age and position in a family context are important to understand for proper patient management.

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- **Language:**

Language as a barrier of understanding has to be eliminated. To offer native language information is therefore mandatory if at all possible.

- **How do you cope with customers from different culture?**
  - **Food**
  - **Race and Religion**
  - **Language**
  - **Reception**
  - **Built- in Environment**
  - This requires a mutual understanding from caregivers as well as from patients and families. Compromises will most likely have to be made, but thorough information and respect for differences are guiding principles for positive and constructive relationships between healthcare teams and patients and their families.

Appendix VII. The Questionnaire with HMC service Users "Phase Three"

The Role of Service Quality in Developing the Medical Tourism Sector in an Arabic Context: using Hamad

Medical Corporation, Qatar

Questionnaire

Ethics Approval Number:2015S0078

I am a PhD student at Cardiff Metropolitan University in the UK. My PhD is sponsored by the Hamad Medical Corporation and supported by the Qatar government. The purpose of this research project is to investigate how to develop the medical tourism sector in Qatar so that it can increase the sector's economic contribution to the country. We are not seeking to collect any sensitive data on you as patients; this study is only concerned with the development of medical tourism in Qatar, which is aligned with the vision and mission of Qatar 2030. All responses are confidential and will be used for research purposes only. Please take a few minutes to complete the questionnaire below.

If you do feel that any of the questions are inappropriate then you can stop at any time. Furthermore, you can change your mind and withdraw from the study at any time – we will completely respect your decision. Returning the completed questionnaire to the researcher will consider as voluntary informed consent.

Many thanks in advance for your participation.

The Researcher

Asrar Mohammed Albaz

Email: A.K_M_Albaz@outlook.cardiffmet.ac.uk

_____

Part 1: General Information Questions and Demographic information

Gender: Male   Female

Age: 18-20   21-30   31-40   41-50   51-60   61-70   71-80   over 81

Nationality: Qatari   Non-Qatari: please specify:_____

Educational Qualification:

  No formal education   High School   Graduate   Post Graduate

  Other

Occupation:

  Student   Professional e.g. Doctor (please specify: ---------------------)

  Public Sector   Private Sector   Retired   Housewife   Self-employed

  Other please specify----------------------

Part 2: Medical Tourism

What does medical tourism mean to you?

Medical treatment only   Medical treatment and leisure

Medical treatment plus visiting new places   I have No Knowledge   Other, please specify: ----------

If you were going to undergo a medical procedure on a medical tourism basis, who would you ask to accompany you?

No one   Spouse   Family member   Friends

What medical procedures do you think are best suited to medical tourism? (Please tick all that apply)

Orthopaedics   Cardio   Ophthalmology treatment   Neurology

Dental care   Cosmetic surgery   Rehabilitation   Diagnostics and check-ups

IVF/reproductive system   Other please specify------------------------

What do you think are the main reason(s) for choosing medical tourism? (Please tick all that apply)

High quality of care   Time constraints in one's own country   Spending vacation and getting treatment   Affordable Cost   The exposure of new opportunities

Other; please specify:_____

If you were going to participate in a medical tourist procedure, would you make this decision by yourself or would someone influence on your choice? (Please tick all that apply)

By myself   Advice from own doctor   Advertisements   Friends and Relatives

Websites   Medical tourism guide   Medical tourism agency   Other please specify;_____

Part 3: Developing Medical Tourism in Qatar

Have you ever participated in elective procedures outside Qatar?

Yes   No

If yes, which and then why?

_____

_____

_____

What would attract visitors to Qatar? (Please tick all that apply)

Culture   Nature   Safety and Security   Urban Development   Hospitality

Nearness   Advanced Medical Facilities   Other please specify:_____

Do you think Qatar could become a popular destination for Medical tourism?

Yes   No   Maybe

Please say why:

_____

Please rate your opinion for each of the following questions:

	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Not Applicable
Do you consider the entry process to the state of Qatar an easy one?							
Do Qatar's' healthcare institutions have the range of facilities required to make the country a destination for medical tourism?							
Do you believe that Qatari Health Care institutions provide a good quality of Health care?							

What impacts do you think medical tourism will have on Qatar's health care system?

  Positive impacts   Negative impacts

Please say

why_____

_____

Do you think medical tourism will be accepted by Qatari society?

  Yes   No

Please say

why_____

Part 4: Hamad Medical Corporation "HMC"

How do you know about HMC?

  Family members   Friends   Websites   Local Hospital   Health Centre Referral

Have you experienced HMC as a:

  Patient   Visitor   Both

How many times have you visited HMC?

  First visit   Second time   More than three times

Please indicate the three main reasons for choosing HMC for treatment:

  Expertise of physician   Facilities   Availability of specific treatment   Superior

customer service   Personal recommendation   Online research   Quality of health care

  Standard accreditation   Reputation   Referral   Limited choice

  Cost

  Availability of treatment at HMC   Family Presence in Qatar   Other,

please specify:_____

How do you evaluate the performance of HMC Medical staff: (more than one choice can be selected)?

  Welcoming   Friendly   Helpful   Accommodating   Unhelpful   non

responsive   Rude   Other, please specify;_____

How do you evaluate the performance of HMC non-Medical staff: (more than one choice can be selected)?

Welcoming   Friendly   Helpful   Accommodating   Unhelpful   non

responsive   Rude   Other, please specify;_____

Please rate the services provided at HMC BELOW:

	Strongly disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree	Not Applicable
The facilities, equipment and overall technology used in HMC hospitals are up to international standards							
The treatment and healthcare provided are of high quality							
Confidentiality and Professionalism is assured(?)							
HMC maintains a high standard of hygiene & cleanliness							

The Physical services at HMC							
	Poor	Fair	Satisfactory	Good	Very Good	Excellent	Not Applicable
Lighting							
Heating							
Noise							
Wi-Fi							
TV Program and Entertainment							
Privacy							
Patient Room Single							
Patient Room Shared							
The Laundry Services at HMC							
Bed Comfort							
Appropriate Linen Change							
The Catering Services							
Variety of Menus							
Quantity of food, portion size are							
Quality of food is							
Foodservice staff presentation and interaction with patient is							
Access to Services							
Admission Process							
Reception							
Appointment System							
Waiting Time							
Discharge Process							
Service Charges							
Availability of Transportation							
Overall experience							
Overall experience of services received in HMC							

Appendix VIII. HMC Research Committee Approval

مـؤسسـة حمـد الطبيـة
Hamad Medical Corporation
صحة · تعليم · بحوث   HEALTH · EDUCATION · RESEARCH

مركز البحوث الطبية
Medical Research Center

Ref No: MRC 1006/2017
Date: 15th June 2017

Mr. Asrar Al Baz,
Manager,
Administrative Services,
NCCCR

Dear Mr. Asrar,

Research Proposal #17218/17: "The role of service quality in developing the medical tourism sector in an Arabic context: A case study of Hamad Medical Corporation, Qatar"

This is in reference to your submission of the above titled proposal to the Research Center for review.

We would like to inform you that Medical Research Center has no objection for this Non-Human Subject Research Case Study to be conducted/ published.

Yours sincerely,

Prof. Ibrahim A Janahi,
Executive Director of Research
Medical Research Center

JLJ

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