

Navigating the Intersection of Healthcare & Travel: A Critical Analysis of Medical Tourism Trends & Challenges

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Medical tourism has emerged as a significant global industry, driven by factors such as the rising cost of healthcare in developed countries, the increasing accessibility of advanced medical services in developing nations, and the appeal of combining healthcare with travel. This paper explores the key drivers, challenges, and ethical considerations surrounding medical tourism. Through a comprehensive review of existing literature, the study examines the motivations behind medical tourism, including cost-saving, healthcare quality, and the integration of tourism with medical treatment. It also highlights the ethical dilemmas posed by the commercialization of healthcare services and the potential inequalities faced by local populations in medical tourism destinations.

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Introduction

The international medical tourism market has expanded rapidly over the last few decades due to, among other reasons, rising healthcare expenditures in industrialized countries, developments in medical technologies, and growing demand for high-quality and low-cost healthcare services (Connell, 2013). As a growth industry at the nexus of medicine and travel, medical tourism refers to the industry of traveling to another country in order to acquire medical treatment by integrating the requirements for treatment and the attraction for travel and pleasure. As per Crooks, Kingsbury, Snyder, and Johnston (2010), medical tourism is not only a reaction to the economic differences between nations but also an indication of the need for specialized healthcare services that could be unavailable or too costly in one's native coun-

try. As a result, Asian, Latin American, and Eastern European nations have taken advantage of this trend by positioning themselves as competitive medical tourism markets that provide low-cost treatments with excellent healthcare services (Pocock & Phua, 2011).

This study seeks to identify the most important determinants that affect medical tourists' choices and satisfaction, with particular emphasis on the influence of cost, healthcare quality, service delivery, and destination selection. Knowing these determinants will help stakeholders come up with measures that will make medical tourism destinations more appealing, which will ultimately translate into more patient satisfaction and more economic gains for the host nation (Jiang & Hwang, 2017). In addition, the research points out the significance of service quality in determining the experience of medical tourism, highlighting its impact on the perceptions of patients and their tendency to recommend medical destinations to others (Lunt, Mannion, & Exworthy, 2011).

The growing rivalry between medical tourism destinations requires policymakers and service providers to be aware of the driving forces behind consumer behavior in the industry, more specifically regarding perceived value, quality of service, and the prospect of realizing beneficial medical outcomes. Through the discussion of these, this research aspires to inform academic literature about medical tourism as well as supply practical suggestions towards enhancing service delivery and policy making within the industry.

Literature Review

Medical tourism is an emerging international phenomenon in which individuals cross borders for medical treatment while incorporating healthcare provision with the activities of tourism. Although initially it was prompted by the quest for cheap healthcare, the expansion in medical tourism reflects wider socio-economic changes, such as the cost of healthcare services in developed economies and the enhancing accessibility of healthcare services in the developing world. Connell (2013) refers to this phenomenon as not only being a cost-reducing step but a complicated choice based on many factors like the quality of treatment, the appeal of destinations, and technologies available in the medical field. Various studies indicate the multidimensionality of medical tourism and how although cost is an important driver, some also value the quality and reputation of healthcare practitioners (Crooks, Kingsbury, Snyder, & Johnston, 2010).

One of the main driving forces for medical tourists is the economic benefit, with most traveling to receive treatments in nations where the procedure is much cheaper compared to their native countries. For instance, in nations such as India, Thailand, and Mexico, patients can save as much as 80% on medical expenses while being treated by highly qualified experts (Horowitz, Rosensweig, & Jones, 2007). Yet this cost factor is frequently combined with a wish to obtain high-quality care, and patients are willing to travel to seek treatments that may not be available, are too costly, or

involve lengthy waiting lists at home. According to research by Lunt, Mannion, and Exworthy (2011), medical tourists tend to regard the combination of low costs and good-quality care as a major advantage, which has contributed to the industry's continued expansion. This multifactorial process of decision-making highlights the necessity of both cost-efficient treatments and globally accepted standards of care to be provided by healthcare providers in medical tourist destinations.

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Healthcare quality, though, is a debated topic in the medical tourism literature. While some destinations host internationally accredited facilities and world-class practitioners, others are plagued by inconsistent care, inadequate regulation, and poor patient outcomes. As per Connell (2013), the standards of healthcare within medical tourism hubs are extremely unpredictable, and the patients can encounter risks due to poor quality of care or a lack of follow-up services. For instance, (Horowitz, Rosensweig, & Jones, 2007) point out that while there is easy access to state-of-the-art technologies in most medical tourism destinations, the medical infrastructure in some nations may not always be as per international requirements. These quality differences raise issues of patient safety, which potential medical tourists may not necessarily be able to see. Aside from healthcare quality, an-

other major element that distinguishes medical tourism from usual healthcare-seeking behaviors is tourism's role in it. Medical tourists do not simply select destinations for their medical procedures but also for the fun and recreation activities they can provide. Places like Thailand and Costa Rica bring medical treatment together with luxury resort holidays, cashing in on the recuperation stage of treatment. According to Pocock and Phua (2011), these medically focused tourism packages are attractive to patients who desire not just low-cost and good-quality care but also a fulfilling total experience. Nevertheless, the integration of healthcare and tourism has been controversial with regard to ethics. Jiang and Hwang (2017) imply that in some cases, patients might focus more on the tourist experience rather than the actual medical treatment itself, which may cause unrealistic expectations and discontentment with medical outcomes since recovery fails to meet vacation-like situations.

Moreover, the business-like character of medical tourism introduces significant ethical implications. Medical tourism's commodification of healthcare—regarding medical services as consumer goods—has the potential to create problems related to access and equity. Lunt et al. (2011) contend that the growing prioritization of overseas patients in most medical tourism destinations can distract resources from local populations and heighten inequalities in healthcare access. This has sparked calls for improved regulation of medical tourism to avoid denying local populations needed healthcare services to cater to

“adult” that signify the thematic centrality of human populations and health-seeking behavior in medical tourism research. The high connectivity among nodes indicates an interdisciplinary domain, which includes domains like global health, health policy, economics, and ethics. Geography-specific terms (e.g., “India,” “United States,” “developing countries”) reflect the international scope of the research, which covers both source and destination nations for medical tourists. The employment of terms “economic devel-

opment,” “health care costs,” and “medical tourism/economics” indicates a serious analysis of the economic and policy aspects of cross-border health care, whereas terms like “COVID-19,” “pandemics,” and “intention” indicate an increasing academic interest in the effect of global health emergencies on patient mobility and choice. More generally, the figure is an interdisciplinary research area where human, economic, ethical, and geopolitical considerations intersect.

Table 1 Keyword Metrics in Medical Tourism Research

ID	Keyword	Occurrences	Total Link Strength
10	Adolescent	6	49
11	Adult	28	202
22	Aged	9	66
98	Canada	12	69
107	Child	4	24
110	China	11	28
156	Cosmetic tourism	4	26
166	COVID-19	10	33
167	COVID-19/Epidemiology	5	26
172	Cross-sectional studies	8	49
177	Decision making	5	27
180	Delivery of health care	9	33
181	Delivery of health care/Economics	7	38
198	Developing countries	8	40
226	Economic competition	7	37
227	Economic development	4	9
232	Ecosystem	4	8
273	Female	40	256
274	Focus groups	4	24
301	Global health	8	42
330	Health care costs	6	35
348	Health knowledge, attitudes, practice	5	35
355	Health policy	9	35
359	Health resorts	4	13
364	Health services accessibility/Economics	6	30
372	Health tourism	9	36
402	Humans	132	543
409	India	10	48
414	Industry	5	24
429	Intention	5	36
431	International cooperation	8	32

437	Internationality	16	67
438	Internet	6	33
443	Interviews as topic	10	76
492	Male	32	225
523	Medical tourism	67	237
530	Medical tourism/Economics	15	73
531	Medical tourism/Ethics	7	31
534	Medical tourism/Statistics & numerical data	12	59
535	Medical tourism/Trends	6	35
545	Middle aged	25	184
560	Motivation	5	32
579	Nigeria	4	16
602	Pandemic	5	15
603	Pandemics	7	33
611	Patient acceptance of health care	4	28
675	Public health	9	36
680	Qualitative research	12	74
683	Quality of health care	7	35
715	Retrospective studies	6	39
719	Risk	5	20
728	Russia	5	16
741	Seasons	4	14
792	Surgery, plastic	4	22
797	Surgical procedures, operative/Economics	4	22
804	Surveys and questionnaires	10	67
816	Thailand	5	37
831	Tourism	20	80
850	Travel	21	94
853	Travel medicine	5	17
865	Turkey	4	26
867	United Kingdom	6	25
868	United States	14	73
898	Young adult	8	74

Note: Occurrences refer to the number of times a keyword appeared in the dataset; total link strength (TLS) indicates the cumulative strength of co-occurrence links with other keywords, often used in network visualizations.

The table presents keyword frequency and total link strength metrics derived from a bibliometric analysis of medical tourism literature. To further investigate the multidimensional nature of the field, a keyword co-occurrence analysis was conducted using VOS viewer, employing “all keywords” as the unit of analysis from a curated dataset of scholarly publications on medical tourism. Out of a total of 898 keywords, 64

met the threshold criterion of appearing at least four times. These 64 keywords formed a network comprising 716 co-occurrence links, with a cumulative total link strength of 1,934, reflecting the dense interconnections and thematic richness of the literature.

The co-occurrence of keywords in their repeated appearance identifies the most recurrent thematic categories and

conceptual relations in the scholarly discourse of medical tourism and associated healthcare fields. The most recurrent keyword is “humans” (n = 132; TLS = 543), a default keyword in health-related indexing that highlights the anthropocentric focus of the topic. More substantively, “medical tourism” presents as a key theme (n = 67; TLS = 237), reflective of its core significance in the corpus of literature, further analyzed by subthemes like economics (n = 15), ethics (n = 7), and statistics & numerical data (n = 12). These subthemes present a complex examination of medical tourism, including financial, moral, and numeric aspects (Connell, 2013; Lunt et al., 2011).

Demographic indicators like “female” (n = 40; TLS = 256), “male” (n = 32; TLS = 225), “adult” (n = 28), and “middle aged” (n = 25) indicate that gender and age-based analysis is a major component of the study, perhaps to investigate patterns of health-seeking behavior or focused market segments in health tourism (Hanefeld et al., 2014). The existence of “young adult” (n = 8) and “adolescent” (n = 6) adds further support to the age-stratified method for learning about healthcare mobility.

The high frequency of “travel” (n = 21; TLS = 94) and “tourism” (n = 20; TLS = 80) supports the interdisciplinary cross-over between leisure and health mobilities, oftentimes articulated under the health tourism (n = 9; TLS = 36) and cosmetic tourism (n = 4; TLS = 26) paradigm. This is testimony to the interest in elective, non-therapeutic medical care pursued across frontiers, specifically in

the Global South (Bookman & Bookman, 2007).

Terms like “quality of health care” (n = 7), “health care costs” (n = 6), and “health services accessibility/economics” (n = 6) reflect the decision-making criteria on patient mobility decisions—highlighting cost-quality tradeoffs and accessibility inequalities between countries (Runnels & Carrera, 2012). The emergence of “intention” (n = 5; TLS = 36) and “motivation” (n = 5; TLS = 32) are consistent with behavioral models employed in patient decision-making literature (Ajzen, 1991).

Some of these country-specific names—such as “India” (n = 10), “Thailand” (n = 5), “Turkey” (n = 4), “United States” (n = 14), and “Canada” (n = 12)—indicate the geographical reach of the literature, identifying both destination and source countries for medical travelers (Turner, 2010). Developing nations such as India and Thailand are commonly used to mention their cost-effective and high-quality services, and Western countries are commonly used as sources of outgoing patients.

Methodologically, the frequency of “qualitative research” (n = 12), “interviews as topic” (n = 10), “surveys and questionnaires” (n = 10), and “cross-sectional studies” (n = 8) indicates a major focus on empiric data generation and varied methodology. This can be seen consistent with the greater trend in health services research moving toward mixed-methods studies (Creswell & Plano Clark, 2017).

Lastly, the frequency of words such as “COVID-19” (n = 10), “pandemic” (n = 5), and “public health” (n = 9) indicates a recent thematic change towards comprehending the pandemic’s effect on global healthcare mobility and medical tourism disruptions (Shalini et al., 2021).

Overall, the bibliometric mapping indicates that medical tourism is influenced by an interplay of economic factors, demographic information, international events, ethical controversies, and geographic factors. The density of interlinkages between clusters indicates a highly interdisciplinary field, supporting the call for integrated research and policy frameworks that take into

account not only clinical outcomes but also socioeconomic and ethical aspects of global healthcare mobility.

Objective

The primary aim of this research is to explore the most important determinants of overall patient satisfaction within the framework of medical tourism. In particular, it seeks to analyze the effects of cost of treatment, healthcare quality, service quality, tourist attractions, outcomes of medical care, and destination attributes on patient satisfaction and word-of-mouth, employing a quantitative methodology based on factor analysis and regression modeling.

Table 2 List of Variables & Descriptions

Variable Code	Variable Description
Q1	Cost Affordability
Q2	Cost Reasonable
Q3	Cost_Significant_Factor
Q4	Quality_Met_Expectations
Q5	Quality_Skilled_Professionals
Q6	Quality_International_Standards
Q7	Tourism_Influence_Choice
Q8	Tourism_Enjoyment
Q9	Tourism_Reputation_Influence
Q10	Service_Quality
Q11	Service_Communication
Q12	Service_Care
Q13	Medical_Outcomes_Satisfaction
Q14	Medical_Outcomes_Improvement
Q15	Medical_Outcomes_Expectation
Q16	Destination_Choice_Healthcare_Tourism
Q17	Destination_Choice_Medical_Experience
Q18	Destination_Recommendation
Q19	Overall_Satisfaction
Q20	Healthcare_Services_Met_Expectations
Q21	Experience_Positive_Overall
Q22	WOM_Recommendation
Q23	WOM_Share_Experience
Q24	WOM_Future_Treatment

Research Methodology

This research applies a quantitative research methodology with a cross-sectional survey design to analyze the determinants of patient satisfaction in medical tourism. Data is obtained from a structured questionnaire from international medical tourists based on variables like the cost of care, quality of care, service quality, tourist opportunities, medical outcomes, and overall satisfaction. Total 171 sample is taken from patients who visit chosen healthcare providers and medical tourist destinations. Statistical analysis was done using SPSS, applying descriptive statistics, exploratory factor analysis (EFA), and multiple regression analysis to investigate the interrelations among independent variables and overall satisfaction.

Data Analysis

The internal reliability of the 24-item questionnaire was determined by using Cronbach’s alpha, and the value was 0.788. This reflects a good level of reliability, which means that the items are measuring consistently the intended constructs of medical tourism, including cost, quality of care, opportunities for tourism, service quality, satisfaction, and word-of-mouth intentions.

Based on laid-down guidelines (Nunnally & Bernstein, 1994; DeVellis & Thorpe, 2021), alpha scores of greater than 0.70 are adequate for social science research. Therefore, the instrument is reliable enough to facilitate further statistical analysis and interpretation.

Table 3 Reliability Statistics

Cronbach’s Alpha	N of Items
.788	24

Source: Primary data

Table 4 Demographic & Behavioral Variables

	Gender	Age	Education	Income	Past Medical Travel	Information Source
N	171	171	171	171	171	171
Missing	0	0	0	0	0	0
Mean	1.71	3.20	2.96	3.20	1.71	2.69
Median	2.00	3.00	3.00	3.00	2.00	2.00
Mode	1	2	3	3	2	1
Std. Deviation	.844	1.315	1.158	1.331	.453	1.613

Source: Primary data

A total of 171 valid responses were obtained for each of the demographic and behavioral variables in the study, with no missing data reported across the dimensions of gender, age group, education level, monthly income, past medical travel experience, and sources of information about medical tourism.

For age group, the mean value of 3.20 (SD = 1.315), with a median of 3.00 and mode of 2, indicates a concentration around the mid-range age categories. This implies that a substantial portion of respondents may belong to young to middle-aged adult segments, which aligns with prior research identifying these age groups as the most mobile and likely to engage in medical travel (Connell, 2013).

The gender distribution shows a mean of 1.71 (SD = 0.844), with a median of 2.00 and a mode of 1, suggesting a relatively balanced but slightly male-dominated sample (assuming 1 = male, 2 = female), though the exact coding scheme should be referenced for precise categorization.

In terms of education level, the mean (2.96) and mode (3) suggest that most participants possess a moderate to high level of education—likely tertiary or undergraduate education—reinforcing the idea that medical tourists are often informed individuals who engage in com-

parative healthcare decisions (Jiang & Hwang, 2017).

Monthly income statistics (mean = 3.20, median = 3.00, mode = 3, SD = 1.331) point to a middle-income profile, which supports previous studies that highlight affordability and value as key motivators for medical tourism among middle-income groups seeking cost-effective treatments abroad (Lunt et al., 2011).

Regarding past medical travel, the mean value of 1.71 (SD = 0.453) and the mode of 2 suggest that a significant number of respondents have prior experience with medical tourism. This past behavior

is important, as it can influence satisfaction levels, expectations, and likelihood of repeat behavior or recommendations (Han & Hyun, 2015).

Lastly, for information source, the data reveals a mean of 2.69 and a high standard deviation (SD = 1.613), with the mode of 1. This dispersion indicates diverse sources of information among respondents, though one source (coded as 1) may be predominant-potentially personal networks or internet-based platforms-emphasizing the varied yet influential role of both digital media and word-of-mouth in shaping medical tourism choices (Crooks et al., 2010).

Table 5 KMO & Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.798
Bartlett's Test of Sphericity	Approx. Chi-Square	2184.160
	df	231
	Sig.	.000

Source: Primary data

To confirm the data was appropriate for factor analysis, Kaiser-Meyer-Olkin (KMO) test and Bartlett's Test of Sphericity were performed. The KMO was 0.798, and this represents a high degree of sampling adequacy and indicates the correlation patterns are sufficiently compact to produce distinctive factors. As suggested by Kaiser (1974), values of greater than 0.70 are acceptable for factor analysis.

Bartlett's Test of Sphericity was also substantial ($c^2 = 2184.160$, $df = 231$, $p < .001$), validating that there are enough correlations between the variables to warrant factor analysis. Overall, these

findings affirm the determination to continue with exploratory factor analysis.

Communalities were also analyzed as part of the exploratory factor analysis to establish the amount of variance for each variable explained by the components extracted. Communalities are the percentage of variance for each item explained by the underlying factors after extraction.

Communalities after extraction ranged from 0.487 to 0.789 in this study, which implies that a large percentage of variance in most measures is accounted for by the factors that were retained. For

Table 6 Communalities

Variables	Initial	Extraction
Q1	1.000	.487
Q2	1.000	.679
Q3	1.000	.756
Q4	1.000	.525
Q5	1.000	.676
Q6	1.000	.766
Q7	1.000	.714
Q8	1.000	.789
Q9	1.000	.680
Q10	1.000	.633
Q11	1.000	.688
Q12	1.000	.779
Q13	1.000	.631
Q14	1.000	.685
Q15	1.000	.715
Q16	1.000	.708
Q17	1.000	.777
Q18	1.000	.539
Q20	1.000	.732
Q21	1.000	.546
Q22	1.000	.686
Q23	1.000	.659

Extraction Method: Principal Component Analysis. Source: Primary data

instance, items Q3 (0.756), Q6 (0.766), Q8 (0.789), and Q12 (0.779) revealed comparatively very high communalities, which imply strong representation by the underlying factors. These findings suggest that most of the variables used in the analysis are adequately explained by the extracted factors, hence the general adequacy and reliability of the factor solution.

Most of the variables used in the analysis are adequately explained by the extracted factors.

Just a single item Q1 had a lower communality value (0.487), which, although still acceptable, indicates it is rela-

tively less highly correlated with the derived factor structure. Nevertheless, since values greater than 0.40 are often regarded as being acceptable in social science studies (Hair et al., 2019), all items are within the minimum requirement for inclusion within the factor solution.

In order to determine the underlying patterns in the data, Principal Component Analysis (PCA) was employed. According to the general rule of retaining components with eigenvalues > 1, five important components were retained. The five components together accounted for approximately 67.5% of the total variance, which is acceptable for social science research (Hair et al., 2019).

Table 7 Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	6.079	27.633	27.633	6.079	27.633	27.633	4.529	20.587	20.587
2	3.868	17.581	45.214	3.868	17.581	45.214	3.069	13.950	34.538
3	2.023	9.195	54.409	2.023	9.195	54.409	2.821	12.822	47.360
4	1.619	7.361	61.770	1.619	7.361	61.770	2.764	12.564	59.924
5	1.261	5.732	67.503	1.261	5.732	67.503	1.667	7.579	67.503
6	.940	4.274	71.777						
7	.925	4.203	75.980						
8	.820	3.726	79.705						
9	.624	2.836	82.541						
10	.579	2.631	85.172						
11	.533	2.421	87.593						
12	.433	1.969	89.562						
13	.381	1.730	91.292						
14	.303	1.379	92.670						
15	.283	1.284	93.955						
16	.250	1.136	95.091						
17	.239	1.087	96.178						
18	.229	1.041	97.219						
19	.199	.903	98.122						
20	.176	.800	98.923						
21	.120	.548	99.470						
22	.117	.530	100.000						

Notes: Extraction Method: Principal Component Analysis.

Source: Primary data

Prior to rotation, the initial component on its own accounted for a significant proportion of the variance (27.63%), but upon performing Varimax rotation so as to simplify the factors, the variation was more equally distributed. The rotated solution indicated that the first factor accounted for 20.59%, the next four accounted for 13.95%, 12.82%, 12.56%, and 7.58%, respectively.

This finding implies that the data fall into five significant dimensions, which all uniquely contribute to the picture. It is also consistent with the multi-dimensional

character of this research, where several factors affecting medical tourism experiences are examined, including treatment cost, service quality, and patient satisfaction.

In order to get a clearer idea of the structure underlying the variables, a Varimax rotation was performed on the five extracted components, making clear which items have the strongest loading onto each factor and facilitating interpretation. The rotated component matrix yielded five clear dimensions of the medical tourism experience. Component 1 has

Table 8 Rotated Component Matrix

	Component				
	1	2	3	4	5
Q6	-.827				
Q3	.798				
Q5	-.785				
Q2	.759				
Q8	.702				
Q4	-.675				
Q1	.526				
Q17		.865			
Q16		.803			
Q18		.692			
Q14		.644			
Q15		.639			
Q22			.785		
Q23			.780		
Q20			.727		
Q21			.646		
Q12				.846	
Q11				.797	
Q13				.742	
Q10				.624	
Q7					.824
Q9					.765

Notes: Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. a. Rotation converged in 7 iterations.

Source: Primary data

high loadings from Q2 (.759), Q3 (.798), and Q8 (.702) and negatively loaded quality indicators (Q4, Q5, Q6). This factor can be interpreted as a cost–quality trade-off factor, implying that respondents balanced affordability with perceived healthcare quality when choosing a destination. Component 2 loads highly on Q16, Q17, and Q18, and Q14 and Q15, suggesting this factor represents the impact of combined healthcare and destination experience on medical outcomes and choice. Component 3 is defined by high loadings on Q22, Q23, and Q20, Q21. This implies a patient satisfaction and intention to recommend factor, reflect-

ing the affective and evaluative reaction to the overall medical tourism experience. Component 4 has high loadings from Q10, Q11, Q12, and Q13, reflecting a service quality and perceived medical effectiveness factor, which would be associated with interpersonal care and staff competence. Component 5 is characterized by loadings on Q7 (.824) and Q9 (.765), indicating this factor captures the destination’s tourism attractiveness as a standalone motivator for selecting the medical tourism destination. These components are consistent with the theoretical model, ensuring that medical tourism choices are complex and driven by economic, medical, experiential, and touris-

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tic factors, with all items having high loadings (>0.6) that ensure construct validity of the model.

Findings & Discussion

Exploratory factor analysis (EFA) conducted by applying Principal Component Analysis with Varimax rotation provided five components that collectively account for 67.50% of total variance. The result signifies an excellent model fit where the extracted factors explain most variability in perceptions by the respondents concerning their experience in medical tourism.

The first factor, identified as Cost and Healthcare Quality Trade-off, mixes items concerned with treatment affordability and views on healthcare quality. High loadings on both cost and quality items indicate that medical tourists balance cost factors against anticipated standards of care. This is consistent with the current literature highlighting cost savings as a major driver of medical tourism, typically offset by an acceptable standard of medical quality (Connell, 2013; Lunt & Carrera, 2010).

The second factor, Destination Choice and Medical Outcomes, comprises items that represent the impact of both the travel experience and the quality of medical treatment. Those who rated

their medical outcomes as good also indicated that the overall attractiveness of the destination was a significant factor. This result confirms earlier research identifying that medical tourists tend to select destinations that provide high-quality healthcare and a pleasant environment (Crooks et al., 2011; Heung et al., 2010).

The third factor, labeled Satisfaction and Word-of-Mouth Intentions, consists of items measuring satisfaction and intention to recommend the destination. The correlation between satisfaction and positive word-of-mouth is reinforced by research presented by Bies and Zacharia (2007), who stipulate that health tourists who are satisfied become ad hoc brand advocates, shaping the choices of other people through their online postings and personal recommendations.

The fourth element, Service Quality and Medical Care, reflects the organizational and interpersonal aspects of care, including staff responsiveness and communication. These findings are in line with Parasuraman et al. (1988), who emphasize service quality as a significant driver of patient satisfaction, especially in healthcare.

Last, the fifth attribute, Tourism Opportunities, captures the significance of tourist-related qualities such as the destination's image and leisure activities to be enjoyed there. The linkage between healthcare and tourism, in many cases portrayed as "medical tourism," is not only an instrumental exchange but also an experience-based one (Turner, 2007). This element implies that the destination's

popularity as a travel destination adds value to the whole trip for certain tourists.

Collectively, these results highlight the multifaceted nature of medical tourism decision-making. Travelers evaluate destinations not only on clinical efficacy

or price but also on experiential, affective, and service dimensions. Knowledge of these dimensions can assist policymakers, healthcare providers, and tourism marketers in creating more holistic and patient-focused medical tourism products.

Table 9 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.685	.469	.453	.772

i. Predictors: (Constant), Tourism_Opportunities, Satisfaction_Word-of-Mouth_Intentions, Destination_Choice_Medical_Outcomes, Service_Quality_Medical-Care, Cost_Healthcare_Quality_Trade-off
 ii. Dependent Variable: Q19

Source: Primary data

The multiple linear regression model showed a fairly strong predictive ability for explaining variation in overall satisfaction among medical tourists. The model yielded an R value of 0.685, showing a high positive correlation between the set of predictor variables and the dependent variable (Overall Satisfaction=Q19).

The R² value of 0.469 indicates that about 46.9% of the variance in overall satisfaction can be explained by the five independent variables:

- Cost–Healthcare Quality Trade-off,
- Service Quality of Medical Care,
- Destination Choice and Medical Outcomes,
- Tourism Opportunities,
- Satisfaction-Driven Word-of-Mouth Intentions.

Such a level of explained variance represents a moderately strong model fit (Hair et al., 2019). Adjusted R² of 0.453 takes into account the number of predictors and indicates that the model remains at a sufficiently high level of explanatory power so as to make overfitting less likely. The standard error of the estimate (0.772) reflects the average deviation of the observed values from the predicted values. While not minimal, this error is within an acceptable range for models in social science research (Field, A., 2024).

The results of Analysis of Variance (ANOVA) test whether overall regression model is significant in explaining variation in the dependent variable, Overall Satisfaction (Q19).

The ANOVA table reveals the regression model is statistically significant at F = 29.203 and p-value (Sig.) =.000, well under the typical alpha level of 0.05

Table 10 ANOVA

Model	Sum of Squares	df	Mean Square	F	Sig.
1 Regression	87.114	5	17.423	29.203	.000 ^b
Residual	98.441	165	.597		
Total	185.556	170			

a. Predictors: (Constant), Tourism_Opportunities, Satisfaction_Word-of-Mouth_Intentions, Destination_Choice_Medical_Outcomes, Service_Quality_Medical-Care, Cost_Healthcare_Quality_Trade-off
Source: Primary data

(Table 9). This tells us the model, consisting of the predictors—Cost–Healthcare Quality Trade-off, Service Quality of Medical Care, Medical Outcomes and Destination Choice, Tourism Opportunities, and Satisfaction-Driven Word-of-Mouth Intentions—all together gives a significant explanation for the variation in overall satisfaction ratings of medical tourists.

The regression sum of squares (SS = 87.114) represents the variation in the outcome explained by the model, while the residual sum of squares (SS = 98.441)

captures the unexplained variance. The total sum of squares (SS = 185.556) reflects the total variance in overall satisfaction. Therefore, the model accounts for about 47% of the variance in the dependent variable (as also indicated by $R^2 = .469$ in the model summary). These findings confirm the suitability of the model and imply that predictors utilized in the study contribute meaningfully to the comprehension of medical tourists’ satisfaction levels.

The multiple linear regression showed that out of the five predictors of

Table 11 Multiple Regression Analysis Predicting Q19 from Healthcare-Related Variables

Predictor	B	SE	β	t	p	95% CI for B	Tolerance	VIF
(Constant)	-2.12	0.64	—	-3.31	0.001	[-3.38, -0.85]	—	—
Cost–Healthcare Quality Trade-off	0.26	0.19	0.08	1.36	0.176	[-0.12, 0.64]	0.84	1.19
Destination Choice –Medical Outcomes	0.21	0.09	0.14	2.38	0.018	[0.04, 0.38]	0.91	1.1
Satisfaction–Word-of-Mouth Intentions	0.78	0.1	0.5	7.77	<.001	[0.58, 0.98]	0.78	1.28
Service Quality–Medical Care	0.28	0.08	0.21	3.36	0.001	[0.12, 0.45]	0.85	1.17
Tourism Opportunities	0.06	0.1	0.04	0.62	0.534	[-0.13, 0.26]	0.92	1.08

Note: Dependent variable: Q19. SE = Standard Error; CI = Confidence Interval; VIF = Variance Inflation Factor.

Source: Primary Data

Out of the five predictors of Overall Satisfaction with Medical Tourism, three were statistically significant.

Overall Satisfaction with Medical Tourism, three were statistically significant. The most powerful predictor was Satisfaction-Driven Word-of-Mouth Intentions ($\beta = 0.498$, $p < .001$), showing that those with a higher intention to recommend their experience were significantly more satisfied, proposing a supportive feedback loop between satisfaction and advocacy behaviors (Jin et al., 2015). Service Quality of Medical Care ($\beta = 0.206$, $p = .001$) also made a significant contribution to satisfaction, highlighting the need for effective communication, proper professional staff behavior, and a comfortable hospital setting, in accordance with Parasuraman et al.'s (1988) service quality model. Destination Choice & Medical Outcomes ($\beta = 0.142$, $p = .018$) was also positively associated with satisfaction, revealing that good outcomes and proper destination choice played a role in satisfaction. Conversely, Cost-Healthcare Quality Trade-off ($\beta = 0.084$, $p = .176$) and Tourism Opportunities ($\beta = 0.037$, $p = .534$) were not predictors, indicating cost and tourism attractiveness might affect initial choice but do not play a significant role in final satisfaction after treatment (Connell, 2013; Han & Hyun, 2015).

The model diagnostics reveal that multicollinearity is not an issue, as all the predictors possess Tolerance values within acceptable range and Variance

Inflation Factors (VIF) less than 1.3, ensuring that the independent variables are not highly correlated with one another. Moreover, the negative intercept (-2.118), although statistically obtained, has no practical meaning on its own and is mainly used as a baseline correction for the regression equation when all the predictors are zeroed out, representing the internal calibration of the model rather than providing substantive information.

Recommendations

Based on the findings of this study, it is evident that improving healthcare quality and service delivery is crucial for enhancing patient satisfaction in medical tourism. Healthcare providers need to give top priority to ongoing training and professional development of medical staff with a focus on patient-centered care involving effective communication, cultural sensitivity, and individualized attention to international patients. Just as significant is the upkeep of modern, well-equipped facilities, since patients will often judge their experience based on the surroundings and amenities level of the healthcare facility. Excellence in delivering services can result in improved patient results, more positive reputations, and higher levels of trust in medical tourism destinations.

Another key identified is the cost-effectiveness. Given that affordability will play a large part in medical tourists' decision-making, providers and policymakers would do well to look at the provision of competitive pricing models. This

can come in the form of bundled treatment packages that bundle medical services together with recovery or wellness programs to provide more perceived value. Transparency of pricing is also necessary; honest disclosure of all possible costs from the beginning will serve to engender trust and minimize the potential for dissatisfaction as a result of unforeseen expenditure. Meeting cost concerns without compromising quality will put destinations in a better position in a competitive global marketplace.

Destination reputation and attractiveness, aside from medical care, were also a main driver of choice among medical travelers. To tap into this, destinations need to invest in promoting the quality of healthcare as well as the individual tourism experiences available. Promoting scenic beauty, cultural heritage, and leisure experiences in addition to healthcare expertise can make one place stand out over another. A robust destination brand that combines medical excellence with travel appeal not only attracts new patients but also induces repeat visits and word-of-mouth referrals.

In addition, integrating the healthcare and tourism industries has a great potential to improve overall patient experience. Initiatives that bring hospitals, tourist boards, and service providers together can lead to packages that cater to both medical and recreational requirements. For instance, medical travelers may be offered recovery tours, spa visits, or cultural outings through a single service stream. This integrated approach not only increases the tourist's satisfaction

but also sustains local economies through enhanced spending across industries.

Lastly, sound policies and regulatory mechanisms are needed to sustain and make medical tourism credible. National strategies should be the top priority of governments that link healthcare provision to tourism planning, including investment in infrastructure, assurance of quality, and service integration. Certification and accreditation systems conforming to international standards can enhance confidence and convey safety to prospective patients. Moreover, establishing international partnerships and bilateral agreements can encourage patient mobility and increase the global competitiveness of a destination. Combined, these actions can enable a healthy ecosystem in which medical tourism is growing and developed, poised to benefit both the providers and consumers.

Conclusion

This study provides important findings into the key drivers of the medical tourism sector, including healthcare quality, cost, service delivery, destination selection, and patient satisfaction. The results highlight that collectively these drivers affect medical tourists' decisions, pointing to the need for the healthcare sector, the tourism board, and the government to come together in establishing a framework that facilitates sustainable development in medical tourism. By concentrating on improving healthcare quality, providing affordable treatment, enhancing service delivery, and tapping the special tourism appeal of medical desti-

nations, stakeholders can enhance the general experience for medical tourists, supporting both patient satisfaction and long-term success for the industry.

Also, the research proposes that combining healthcare and tourism industries and setting up clear regulations and international accreditations will make medical tourism destinations more appealing. Making sure that medical tourism products are up to international standards, with clear pricing and constant quality of care, is critical in mitigating fears of safety and trust, which are central in medical tourists' choice processes.

The study also encourages a well-regulated and strategic way of pursuing medical tourism, calling for the creation of national policies, international alliances, and a continuous quality improvement framework. This way of pursuing medical tourism will not only bring about economic development but will also increase patient loyalty, hence ensuring that medical tourism is a significant player in the world healthcare market.

In summary, though medical tourism has immense economic and health advantages, the success of medical tourism in the future is contingent on sustained action to solve service quality, patient satisfaction, and proper regulatory issues. With emphasis on these most important areas, stakeholders can build a prosperous, sustainable medical tourism sector offering high-quality, affordable healthcare solutions to foreign patients.

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