A Comprehensive Investigation on the Determinant Factors of Cultural Competency on Native Physician-Medical Tourists Interactions: A Case of South Korea

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Submitted to the
Institute of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy
in
Tourism Management

Eastern Mediterranean University
July 2017
Gazimağusa, North Cyprus

Approval of the Institute of Graduate Studies and Research

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ABSTRACT

Medical tourism as a service sector has brought authorities to a position in which they are required to revise their innovative competitive advantages. Non-clinical services are likely to be efficient to respond the demands in medical tourism. Doctor-patient interactions, is one of the most efficient strategy to deliver non-clinical services. Level of cultural competency can address the need of culturally appropriate service. Hence, it is essential to examine the determinants of cultural competency in medical tourism. In this study, an exploratory approach through a mix of qualitative and quantitative methodologies was adopted. The research was conducted in three main phases. The common point among the participants in 3 phases was to be active in the medical tourism. Results were reported based on the aims of study, the barriers of medical tourism development in Korea were reported, a framework of cultural competence delivery was developed. It was followed by expert's confirmation and finally the construct of the framework was tested. Delivering cultural competence in medical tourism would not occur appropriately unless a systematic combination of personal characteristics, external supports, and skillful abilities are established. Therefore, it is essential for authorities to focus on the workforce improvement in medical tourism. Besides, those individuals working in this domain are required to provide personal attempt, commitment, desire and abilities to adopt the best of their knowledge.

Keywords: Medical tourism, Cultural competence, Cross-cultural interaction, Doctor-patient interaction, Korea

ÖZ

Bir hizmet sektörü olarak tıp turizmi yetkilileri yenilikçi rekabet faydalarını gözden geçirmeye itmiştir. Klinik dışı hizmetlerin tıp turizmindeki ihtiyaçlara yanıt verirken etkin bir rol üstlendiği görülmektedir. Doktor hasta ilişkileri, klinik dışı hizmet vermek için en yüksek etkili stratejilerden biridir. Kültürel yetkinlik seviyesi, kültürel uyum servisine duyulan ihtiyaca dikkat çekmektedir. Bu yüzden, kültürel yetkinlik seviyesinin etmenkerini sınamak gerekir. Bu çalışmada, nitel ve nicel yöntemlerden oluşan keşifsel araştırma teknikleri kullanılmıştır. Araştırma üç ana evre üzerinden yürütülmüştür. Katılımcıların tıp turiziminde aktif rol almaları üç evrede de ortak noktadır. Sonuçlar çalışmanın hedeflerine göre, Kore'de tıp turizminin karşılaştığı engellere göre raporlanmıştır, Kültürel yetkinlik seviyesinde bir çerçeve geliştirilmiştir. Bunu, uzman tastiği takip etmiş, son olarak da, çizilen çerçeve test edilmiştir. Araştırma sonuçlarına göre doktorların özellikleri, dış destek ve mesleki becerilerin arasında başarılı bir kombinasyonu olmadan doğru bir kültürel yeterlilik ve klinik dışı hizmetler vermek mümkün olmayacaktır. Bu nedenle, yetkililerin Tıbbi Turizm'deki insan kaynaklarına odaklanması, örgütsel ve eğitimsel destek sağlayarak sektörün gelişmesine yardımcı olması gerekmektedir. Ayrıca, bu alandaki kişiler, yeni koşullara dayalı bilgi ve becerilerini geliştirmeyi kabul etmeli ve yerine getirebilmelidir.

Anahtar kelimeler: Kültürel yeterlilik, Kültürelarası iletişim, Tıbbi turizm, güney kore, Doktor-hasta ilişkileri.

DEDICATION

I would like to dedicate my dissertation work to my beloved **FAMILY**.

You **are** always there for me

"You gave me wings and made me fly"

...

"You stood by me and I stood tall"

ACKNOWLEDGEMENT

I could not accomplish my doctorate degree without the support of my respected supervisor Prof. Dr. Turgay Avçi and also the opportunity provided by my respected supervisor and manager Prof. Dr. Sam Hun Park.

I am most grateful to the members of my committee Prof. Dr. Kiliç and Prof. Dr. Öztüren, for their time and expertise throughout this project; I appreciate the time and comments from prof. Dr. İçöz and prof. Dr. Günay as well.

I always appreciate the support and kindness of all my family members, friends and colleagues throughout the project, specially, Dr. Ahad Alizade for statistical consultation and his encouragement; Cihan Alphun for her supports from the beginning, I always appreciate what she has done; my colleagues in Seoul for their sincere help and encouragement.

There are people in everyone's lives who make success both possible and rewarding. Mehdi has never left my side, he is the best companion ever, Aida made me feel positive, Maman encouraged me and Babaey is the one who has always inspired me for being in this position. I wish I could remember all other names, everyone who gave me an idea or new vision by their attitude, words or lifestyle.

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LIST OF ABBREVIATIONS

AT	Attitude
CC	Cultural Competence
EF	External Factors
C/HRW	Commitments & Hard Working
IF	Internal Factors
KN	Knowledge
M & D	Motivation and Desire
MT	Medical Tourism
OS	Organizational Support
SKL	Skillfulness
TR	Training

Chapter 1

INTRODUCTION

The first chapter provides detailed information on the framework of present thesis. This is an exploratory study which aimed to find the determinants of cultural competence in the scope of medical tourism. Chapter one starts with a systematic exploration of the literature and current facts which leads to the philosophy of the research. It is followed by the aims and objectives. Accordingly, the contribution of this survey is presented. Finally, a brief explanation of the methodology and outline of the thesis are provided, respectively.

1.1 Background

Providing service in two-way interaction of supply and demand sides leads to a variety of ambiguities since the preference of both sides are included. Moreover and even more important the science of psychology, with its wide variation, plays a key role, in fact, the demand and supply sides are the personality and attitude. Hence not a clear formula can offer the best service provided or the most preferred and required demand.

Despite the immediate difference between “tourism” and “healthcare”, both of these sectors are considered as service sector. Likewise, a range of rules in service offering are applied in both sectors. The most obvious one is the interaction between the individuals in two sides of supply and demand, including hotel employees-customers or doctors-patients interaction in tourism and healthcare sector, respectively.

One of the most emerging spot which shows the connection between tourism and healthcare sector is Medical Tourism. “Medical Tourism” (MT) definition varies based on the scholars and still there is lack of a widely accepted definition. What is clear from all the definitions is that MT has led to a new type of mobility out of the national borders, and tourist/patients seek out treatment and medicine. The best definition which covers the requirement of this thesis is:

> “Travel which involves patients crossing national borders in search of medical care and service” (Crooks, Turner, Snyder, Johnston, & Kingsbury, 2011).

It is a new type of healthcare mobility (Connell, 2013; Ormond, 2014) or patient mobility (Lunt & Carrera, 2010) and includes multidisciplinary domains of research. While there are other types such as “health tourism” or “wellness tourism”, it is still difficult to clarify their overlap. Nevertheless, in this thesis we only focus on medical tourism, which implies on the medicine and therefore doctor-patient interaction. Although some facts and rules of tourism and healthcare might be helpful, but a unique revision and combination of both is required for medical tourism in order to development. In both healthcare and tourism basis research, “cultural competence” has been widely suggested as a key requirement for health practitioners and tourism sector employees who are working with culturally diverse people.

According to this new trend of healthcare mobility, patients from culturally diverse group and with different cultural background can be seen as new patient-customers (Ormond, 2012). They mostly need a “culturally-congruent” service based on their preference and background which is different from that of their doctors. This situation leads to a range of cross cultural barriers, especially when doctors and patients have a direct interaction. On the other hand, the patient-customers are mostly

in their “most physically and emotionally vulnerable” situation (Ormond, 2012) and it is believed that it might provide added pressure to tolerate cultural differences (Woodman, 2009). They have faced a complex decision making process and it seems that the best way to respond them adequately and make them satisfy is to offer a high quality service.

It is essential to consider that the definition of quality may differ according to the cultural background (MTM, 2011). Health practitioners are proposed as a solution for providing equal and high-quality care to all groups of patients with different cultures (Alizadeh & Chavan, 2015) and their attitude can play a key role to provide a better perception on service quality (Paez, Allen, Beach, Carson, & Cooper, 2009; Saha et al., 2013) Hence, they can respond to varied ‘needs’ of patients (Ormond, 2012) and empowering them might potentially lead to better quality of healthcare service (Miguel & Luquis, 2013).

In many decision making process and models the issue of quality is a key factor (Connell, 2013; Heung, Kucukusta, & Song, 2011). But the point is that as far as competitors are emerging in different parts of the world, providing a high quality service, only in clinical service, is not likely to be a strong competitive advantage anymore, and medical tourism destinations needs to offer an innovative advantage to be considered as “highly qualified” among the other competitors. Based upon, medical tourism should be involved by a movement beyond the requirements of either clinical or non-clinical services, and will be evaluated by the patient-consumers as a united package.

Upon the commodification of healthcare, non-clinical factors such as "culturally oriented patient-centered care" (Ormond, 2012) might act as an asset. In this regard the cultural competence of healthcare practitioners was introduced as an innovative and progressive policy (Weech-Maldonado et al., 2012). Their level of cultural competency was shown as an affective factor to improve service quality in healthcare (Horowits, 2007; Daechun, 2014; Campinha-Bacote 2002, Henderson et al. 2011). Moreover, it is believed that lack of CC by healthcare providers has resulted in misdiagnosis (Andrews, 1999) and since CC delivery is a learned system (Kim-Godwin, Clarke, & Barton, 2001), it is essential to explore the concept of CC in medical tourism as well.

Ample literature exists on the issue of 'cultural competence' in healthcare, especially in the case of developed countries with significant level of migration and minority cultural population. Based on the Betancourt et al. (2002) definition of cultural competence in healthcare, it is defined as a vehicle to increase access to quality care for all patients (page. V), in order to deliver a high quality of care to patients regardless of their cultural background (Betancourt, 2003).

Mere studies, so far, considered the importance and role of cultural background/aspects in medical tourism (J. Y. Lee, Kearns, & Friesen, 2010; Ormond, 2012; Whittaker, 2009). Nevertheless, it is clear that cultural similarities (Rokni, Pourahmad, Langroudi, Mahmoudi, & Heidarzadeh, 2013) could change the geographical demography of treatment around the world (Ormond, 2012). Besides, it is clear that there is a relationship between the cultural competency and factors such as healthcare quality (Limberger, 2010), satisfaction (Paez et al., 2009), trust and health status (Thom & Tirado, 2006).

1.2 Research Philosophy

Delivering a high quality service which is ‘equal’ to all patient with different cultural background is vital (Betancourt, 2003; Campinha-Bacote, 2002; Henderson, Kendall, & See, 2011). It has been claimed that medical tourism resembles an ecosystem, in which, varied components should have a close relationship while presenting competitiveness (Jin, 2013). In some cases, although, almost all of the components are presented, the shortage of only one or two of them can affect the whole ecosystem.

In the case of South Korea, there are advances on medical facilities and infrastructure (KIMA-Website) and also government provides systematic and constructive supports in a range of requirements; currently there is a support of 400 million US dollar annually by the government, beside other non-financial support (Jin, 2016). However, medical tourism in this country is standing behind the competitors, especially in the East Asia region; it is likely that the competitiveness of all the ecosystem components (Cha, 2016) in Korea needs a revision.

Specialized manpower is one of the key components of medical tourism ecosystem (Jin, 2013); they should have ability to perfume different tasks and provide medical service to foreigners, such as client management, interpretation and other global level abilities (Turner, 2010). Medical Tourism Association has established a certification program in order to train “International Patient Specialist”, including doctor, nurse, administrator, hotel staff, etc., it was due to the gradual increase in demand for specialized manpower (Medical Tourism Association, 2012).

What is not clear yet is the component of CC in medical tourism. It is not clear how and by which abilities CC should/ could be delivered effectively and appropriately in MT. If we consider healthcare system as the most similar system to medical tourism, still there is uncertainty on the components of CC, although there are striking similarities. “Knowledge, awareness and skills” of healthcare providers has been mentioned as the most repeated components comparing the others (Alizadeh & Chavan, 2015). By the way, it varies according to the type of treatment and geographical/ cultural background. Hence, it might differ based on medical tourism requirements as well.

Therefore, it seems critical to clarify the way that doctors can be culturally competent and deliver their ability affectively and appropriately to the foreign patients.

1.3 Medical Tourism in South Korea

South Korea has newly emerged as a hub for advanced technology-medicine, facilities and robotic surgery after a remarkable increase in the number of inbound foreign patients, huge investments, and other governmental supports (Jun, 2016; Jun & Oh, 2015).

By the way, lately this country has faced a decreasing trend. Accordingly, authorities and researchers have started to investigate the reason and to provide strategies to combat such barriers. For instance, developing different marketing strategies based on each nation as a target group (Jin, 2016). Nevertheless, it seems that cultural aspects (especially the cultural differences of patient and doctors) has not been taken into account and none customized solution been provided.

1.4 Appraisal of Problem

A careful examination of the cultural competence literature in healthcare reveals a range of uncertainly among the available studies. There is no doubt that CC is essential when doctors are working in a cross cultural environment (Adeyanju, 2008). Furthermore it is clear that CC can potentially boost the perceived quality of service (Alizadeh & Chavan, 2015; Campinha-Bacote, 2002; Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013; Limberger, 2010; Paez et al., 2009; Saha et al., 2013) and enhance the level of satisfaction (Limberger, 2010; Paez et al., 2009; Thom & Tirado, 2006). Also, it is widely accepted that healthcare providers should combine their biomedical knowledge with other personal characteristics in order to provide a qualified health care (Campinha-Bacote, 2002).

Nevertheless, the components of CC in healthcare vary based on the specialty such as, HIV care providers (Saha et al., 2013), aged care providers (Chen, 2008) or hospice centers (Doorenbos & Schim, 2004) and rehabilitation practices (Balcazar, Suarez-Balcazar, & Taylor-Ritzler, 2009) or the geographic location which implies on different ethnic groups with different cultural background (Chae & Kang, 2013; Olt, et al., 2010).

The main problem is the lack of a uniform procedure to deliver CC within the healthcare context (Alizadeh & Chavan, 2015); particularly it is not clear how such a competence can be operationalized (Suarez-Balcazar et al. 2011). This shortage has been mentioned to have a negative effect on the usage of this concept, as well (Hayes-Bautista 2003).

According to the above-mentioned information, medical tourism has brought the authorities to a position where a revision on the competitiveness by CC is critical. Acknowledging that proving a culturally-congruent service to patient-costumers with different cultural backgrounds leads to positive outcomes (Alizadeh & Chavan, 2015; Campinha-Bacote, 2002; Delphin-Rittmon et al., 2013), it is essential to know the procedure and implementation of that competency in order to be delivered effectively and appropriately.

Since medical tourism is a new emerged and novel arena with a wide range of ambiguities; and given that a level of uncertainty is in the scope of CC in healthcare, it is assumed that a clear revision on the determinants of CC is essential in the scope of medical tourism. The essential requirement is to examine the components of CC in MT.

1.5 Aims and Objectives

Before suggesting the solutions, it is essential to examine the main cause and root problems. The nature of this study was exploratory; accordingly the objectives and aims were revealed stage by stage. The hypothesis did not developed in advance; however, the initial aim directed the authors to follow the upcoming objectives.

1. To explore the barriers to medical tourism development in South Korea.
2. To investigate on the effective and appropriate internal determinant (Personal Characteristics) of cultural competence delivery in medical tourism.
3. To investigate the effective and appropriate external determinant (organizational supports and training) of cultural competence delivery in medical tourism.

4. To test the function of achieved themes and components in order to deliver cultural competency.
5. To recommend strategies for implementation and delivering an appropriate and affective cultural competency in medical tourism.

By accomplishing the aforementioned objectives, this research aims to explore and test the significant determinants to deliver cultural competence within the scope of medical tourism services.

1.6 Contributions of the Thesis

Upon the addressing the main gap and reaching to the main aim, the achieved results contribute to the literature and provide several practical implications for authorities as well. Those researcher and authorities in tourism sector, healthcare sector and communication domain might apply the implication of this study.

Theoretically, a new framework of cultural competence was developed. It shows both the determinants and the delivery process. It is new framework to the literature, since quite clear differences appeared between the healthcare and medical tourism. New components of CC were introduced; and also external factors (training and organizational support) were suggested as essential due to the novelty and wide range of ambiguities in medical tourism. Also, it seems that the application of "social cognitive theory" makes sense regarding the cultural communication in medical tourism. It represents the delivery of CC in a logical classification.

In the scope of practical implication, it is expected that the result will be helpful for the top managers and authorities who are working in the medical tourism industry in South Korea. Yet, there is not practical evidence as to whether the suggested

components will be constructive or not, nevertheless, in accordance to the evidence from two relevant industries of tourism and healthcare, and also a clear comparison with the previously developed CC framework in healthcare, it is highly likely that the new emerged framework and suggested components will address the cause root.

The result of this study would assist researchers in becoming familiar with procedures of cultural competence delivery and implementation in the scope of medical tourism and would facilitate the process of conducting further studies within this context.

1.7 Proposed Methodology

In this exploratory based research, a mix methodology approach was applied in order to explore the determinant of cultural competence in the scope of medical tourism. Both qualitative and quantitate methodology were employed; the procedure was conducted in three main phases. First, top managers and authorities were interviewed with the aim of determining those factors that contribute to an appropriate cultural competence delivery. The result of this phase led to developed framework. After that, in the second phase, the pioneers of MT were invited to comment or modify on the emerged theme and developed framework. Finally at the third phase the themes were converted into questions and the doctors who are in direct interaction with foreign patients were invited to fill in that questionnaire. The result of analysis revealed the effectiveness of those factors in order to deliver a cultural competency in MT.

Seoul, the capital city of South Korea was the case study; sample size in the first phase was selected through judgmental sampling. The main including criterion was being involved in medical tourism of Korea, both academically and practically.

Meanwhile, the sample size for the quantitative phase was selected among the doctors who are working in a number of specified hospitals in this city. The questionnaire was, initially, tested with pilot samples of 30 doctors working in 2 different hospitals.

1.8 Theories

To develop the logic of this thesis, the authors applied both inductive and deductive approaches. A mixed methodology assisted us to conduct this research.

This study was grounded on the basis of two theories, namely “Social Cognitive Theory” and “Intercultural Competence, Reflection Theory”. The basics of these theories are described in literature review chapter. Also the methodology chapter shows how these two are relevant to this study and assist us to develop the framework.

1.9 Outline of the Thesis

There are 6 chapters in this thesis. The first chapter involves the information on the philosophy as well as aims and objectives of this explorative study. The potential contribution and the proposed methodology are explained in detail and briefly, respectively.

Chapter two involves all the relevant literature review on the following topics. A detailed description of medical tourism, cultural competence, cultural competence in the scope of healthcare, components of cultural component and its indicators and outcome are presented. It is followed by a content summary in terms of how all the above mentioned topics were applied in conducting this research.

The following chapter, 3, represents the methodology on present thesis. The applied qualitative and quantitative methodologies are given in detail. Since the nature of this study is an exploratory one, the analytical methodology is stablished on a chain-basis. Moreover, the approach, sampling, techniques, data collection are mentioned besides the structure of questionnaire in quantitative phase.

Chapter four represents the findings in both qualitative and quantitative phases. The former represents a developed framework, while the latter provides information as to whether the previous framework and its themes are rational or not.

The fifth chapter discusses the archived results. It also compares the result with the previously published literature and the practical facts about the Korea as well.

Final chapter, which is the most critical one, provides a general conclusion on the thesis, gives the theoretical and practical implication for researchers and top managers, respectively. Also the limitations and direction for further studies are discussed.

Chapter 2

LITERATURE REVIEW

This section presents the entire facts, figures, actual and practical information provided by previous researchers in the context of this research's framework. At the beginning arguments on the medical tourism (MT) are presented, it is followed by the situation of MT in South Korea, and the definition, arguments and measurements of cultural competence (CC), moreover, its position and function in healthcare. Eventually, this section provides the theories applied as the framework and a brief summary at the end; the summary aims to clarify how this research will be grounded on the previous literature while contributes to its own objectives.

2.1 Medical Tourism

Medical Tourism has emerged as the result of globalization of healthcare and a great form of mobility all around the world. The economical contribution of this industry/business is considerable in different part of the world. Nevertheless, economical achievement is not the only output it provides; but also from the other perspectives, MT should be taken into account as a business which leads to cross cultural interaction, advances in healthcare facilitates in developing countries and better quality of medical services. Also it caused a transformation on geography of health care (Connell, 2013).

Traveling with the aim of natural healing (mostly thermal waters) has been known since long time ago, 1000 to 5000 years BC. It means that health tourism which is

based on the natural resources (such as thermal water, healing in desert or forest, man maid spa and pleasant climate) has been started from ancient Rome. They have built the first Spa in Europe; it was followed by other empire and the first Turkish bath maid by Osmanian Empire (Smit, 2010). It is believed that the clinical usage of thermal water was considered in Europe from 19 century. Their customers are mostly people who need to be healed after a surgery, or those who have a specific difficulty. This background presents the birth of medical tourism in which people started to travel with the aim of treatment or healing that led to what is called wellness tourism and medical tourism. Moller and Kafman (2000), classified different types of tourism and among them was "health tourism". Health tourism is classified based on the situation of customers, either they are patients and need a specific treatment or they are healthy and aims to enjoy the product of predictive treatments. The former is implies on the clinical treatment either in spa or hospital, while the latter leads to wellness tourism. In this classification medical tourism is a type of health tourism. Other classification implies on the medical tourism, curative tourism and wellness tourism.

Nevertheless, nowadays there is a shortage of a specific classification which all the researchers from different disciplines have consensus on that. It was confirmed by the pioneers of medical tourism in on the latest MT conference in Seoul, 2016. They claimed that there is not a clear border between the concepts of health tourism and medical tourism and it is required to reconfigure the meaning and concept of the accosted concepts. Based on the notions written in the website of IMTJ (international medical travel journal) which is the most prominent reference in this domain, there is variety of concepts to categories, spa tourism, Medical spa and wellness treatment are considered as a specific type and all others are considered as medical travel in

this website. Medical travel involves different types of treatment ranging from care of the elderly and weight loss treatment to spine and back surgery transplantation.

A range of terminology and definition have been developed in regard to medical tourism ranging from 1989 by Goeldner to these days by scholars from different disciplines. Goeldner (1989) defined it as a traveling with the motivation of receiving medical treatment. Other group of researchers believed that this kind of traveling involves the touring and vacation as well (Upadhyaya & Swoni, 2008). From the business perspective, medical tourism is a special activity with "the potential to be a sustainable market segment for a destination" (Wongkit & McKercher, 2013). The present study applies the definition by Crooks et al. (2011), since they are a group of researchers on the topic of MT with the same discipline as the author of this thesis:

> "Travel which involves patients crossing national borders
> in search of medical care services" (Crooks et al., 2011).

Due to the novelty of MT, there is still shortage for a united organization to refer to; meanwhile two well-established groups of researchers/authorities are working in this context globally. The first is a business prominent journal called, "International Medical Travel Journal" (IMTJ) based in UK (https://www.imtj.com), while the second group are working in USA which is "Medical Tourism Association" (MTA) in USA (www.medicaltourismassociation.com). By the way, there are other communities such as Medical Travel Quality Alliance (MTQA) which specifically are working on the quality and safety for medical tourists. Also other regional or many national associations or communities are trying to work in a global level, from different part of the world. Yet, there is not a union definition of medical tourism accepted by all these scholars and authorities.

A variety of terminologies also is being applied for the concepts and as mentioned in previous chapter, there is still lack of a widely accepted definition. Some scholars believe that MT is under the cover of health tourism, while others insist that MT is a separate niche. By the way, in this research we only focus on the "medical tourism" which implies on the medicine and treatment based in hospitals.

Accordingly, it can be claim that different types of this tourism niche was started with health tourism and medical tourism was a sub category of that, but lately medical tourism is being considered as an independent category in which different type of hospital treatments are included.

2.2 Medical Tourism in South Korea

According to the facts and figures, also previous literature, South Korea is among the well-known destinations for medical tourism. Medical Tourism Index (MTI) developed by Fetscherin & Stephano (2016), rated this country as the 17th among 30 countries (Fetscherin & Stephano, 2016). This selection process was based on a range of criteria which a destination should presents to be considered as eligible for attracting foreign patients and start medical tourism. Another research attempted to frame the general image of medical tourism in Korea and found the following issues as the most preferred one by the service sector: "excellence in surgeries and cancer care" and "advanced health technology and facilities" (Jun, 2016). Despite the focus of other countries, Korea seems not to insist on the factor of 'cost-saving' and it is not the main concern of the government, but the 'safety and credibility' is (Jun, 2016).

It is widely accepted that the most obvious strength of Korea in MT is advances in technology and providing an IT-based medicine (KHIDI, 2016). Moreover, having

several hospitals of this country are listed as the best qualified hospitals for medical tourism, and there are many other well-known hospitals and clinics for different type of treatment.

The history of medical tourism in this country is not going so far. It was in 2005, when the authorities and government started to think about it for the first time. By the way it did not started until 2009, when the government officially opened the doors to foreign patients (Jun, 2016; Junio, Kim, & Lee, 2017). The duration between those two mentioned periods, was full of thinking about the policy and planning in order to start as strong as possible. There is no doubt that Korea could develop a well- established supporting system in those 4 years. The number of foreign patients coming to Korea increased dramatically from 60,201 in 2009, to 266,501 in 2014. It means an average annual increasing rate of 34.7% (Jin, 2016). The cooperation between different authorities and organization is another considerable factor in this county. For instance nowhere the positive cooperation of both private sector and governmental organizations can be seen than in Korea. There are a range of governmental established committees which there main mission is to provide support for the sectors and individuals active in healthcare system; some of them particularly, focus on foreign patients. For example, the 'Council for Korea Medicine Overseas Promotions (CKMOP)' to lead the 'communication activities with international patients' (Crooks et al., 2011), Korea health industry development institute (KHIDI), 'The committee for an advanced medical industry', Korean international medical association (KIMA), Korean tourism organization (KTO), Korean Institute for healthcare accreditation (KOLHA), etc., Beside these committees is the financial support and investment that government put aside for marketing activities and infrastructure, respectively (Stephano, 2013). Establishing

‘Medical Tourism Visa’ and evaluating hospitals regularly, are the other major activities of Korean government. Many hospitals, clinics and coordinator have been registered according to the evaluation standards, to provide healthcare services to foreign patients.

Meanwhile the problem is a huge difference between the money invested by the government for medical infrastructure and the achieved profit from medical tourism. The amount of investment was far more than the money which has been turned back. Every year $400 million US Dollar is being invested by the Korean government to promote MT (medical tourism association, 2016). Despite the excellence of the medical infrastructure in Korea, and designing an accurate system, lately, the number of patients-costumers is facing a decline. A key factor is likely to be missed from, which is not clear, yet. Scholars and authorities are searching for a main question; why the number of patients-costumers is decreasing?

There has been several assumption and beliefs to contribute to this shortage, so far. Firstly, although providing a safety for the foreign patient is of great importance in the government policy, yet, there is a shortage of sufficient efforts to protect medical tourist from potential risks in this country (Jun, 2016). The other introduced determinants are weakness on the exchange of information, and lack of a patient oriented service system in this country (Kim, Lee, & Jung, 2013).

On the other hand, the emergence of the competitors may negatively affect the MT in Korea, since each country, particularly in the East Asia region, is focusing on a specific competitive advantage. Malaysia, for instance, has claimed to have a natural cultural competence for MT through applying the diverse ethnicity of its residents.

Because it is believed that having a diverse ethnic, linguistic and religious, this country could achieve an international cultural competence (Ormond, 2012). It was important for the authors to focus on the case of Malaysia, since it is likely that cultural competence is going to be the most significant competitive advantage in this country.

Malaysia -as a successful case of having cultural competence in MT- started to locate value in the country's diversity and turned the situation as a threat to an opportunity. In fact this country applied an integrated strategy while applying and respecting the belief of different ethnicities for attracting tourist and improving the economy (Ormond, 2012). Based upon This county was introduced as a mini-Asia destination (Tourism Malaysia 2009 sited by Ormond, 2012) and started to sell its multiculturalism (Amran 2004: 2). Likewise, the authorities started to apply the similar strategy and policy in medical tourism. Accordingly, nowadays it is explained as a country with "culturally appropriate care expertise" and providing the feeling of "home away from home" (Palany 2004 sited by Ormond, 2012) for the similar lifestyle and culture around the Asia. The success tips of Malaysia are worthy enough to be followed since they are providing a highly qualified multi-ethnic medical staffs that have a recognized qualification and are multi lingual as well. Therefore, the needs of the patients with a culturally diverse background are being experienced naturally, to some extent, by Malaysian (Ormond, 2012). Nevertheless not all countries have the same situation; yet, the positive tips from Malaysia are likely to be helpful for other countries, particularly for South Korea with having only one ethnic group.

2.3 Culture and Cultural Competence

Several definitions have been offered for the word culture and cultural background of people. ‘Culture’, is believed to be as a “fixed and knowable entity that guides individuals’ behavior in linear ways …” (Gregg and Saha 2006: 543). Another definition of culture implies on “a system of interrelated values enough to influence and condition perception, judgment, communication, and behavior in a given society” (Mazrui, 1986, p. 239). Also culture is defined by Schein (1985) as “a basic belief and assumption that is shared unconsciously and taken for granted by members of society." The Africans: A triple heritage (pp. 89-99). London: BBC Publications.). Accordingly culture is values, beliefs and norms held by a group of people and it shapes how individuals communicate and behave (Deardorff, 2006). Birthplace, language and ethnicity are frequently employed in terms of culture.

In regard to the cultural competence, also, a range of terminology have been developed by the scholars, for instance “Intercultural relation/communication Competence”, ‘Cross-cultural competence” (Gibson & Zhong, 2005; Spitzberg, 1989). Meanwhile the terminology of ‘cultural competence’ has been applied by all the healthcare-base models and studies (Alizadeh & Chavan, 2015).

Mitchell Hammer, one of the pioneers in the field of “intercultural competence” was invited to offer a reflective article of this broad domain. According to all the available theories and studies, he offered two main paradigm of this concept: “CAB paradigm” and “developmental paradigm”. The first mainstream which lasted until 1989 stands for “cognitive /affective/behavioral” and is searching to respond to an essential question, “What are the personal characteristic factors that comprise

intercultural competence"? After 1989 the developmental paradigm emerged which were more constructivist-grounded approach and made efforts to respond the following question: "How do individuals experience cultural difference"? Finally the author recommended while new researches should be equal to the traditional framework, the distinction is required to be applied to improve the literature (Hammer, 2015). Since the present study tends to apply CC in a practical procedure, the research will be conducted on the ground of the second paradigm.

Generally, cultural competence is the ability to communicate with people from different culture background, both "effectively" and "appropriately" which are widely emphasized in definition and description of models. Appropriateness implies to the external factors as not offending the valued rules and it is evaluated by other people. Meanwhile, effectiveness implies to the evaluation on the internal ability to achieve the valued goals in intercultural interactions and can be evaluated by a self-rated system (Alizadeh & Chavan, 2015; Deardorff, 2006; Spitzberg B.H, 2009).

The ability of "Cultural competence" for improving over the time has been widely emphasized by the researchers. Spitzberg and Changnon (2009) conducted an exhaustive meta-analysis of intercultural competence research of 50 years and identified 4 cognitive dimensions (personality), 77 affective dimensions (attitudinal) and 127 behavioral factors (skill).

Dictionary meaning of CC implies on ability to perform certain task toward a professional domain. It enables efficient performance of a cultural mode defined by a specific group which may differ based on the circumstance as well (Burchum, 2002). Hence it means the ability to better appreciate the value of individual (Lum, 2005).

Cultural competence as a variable is composed of various variables. Firstly, Sue et al., (1982) conceptualized CC in three dimensions, including: attitude, knowledge and technology. Then, it was proposed that CC components are knowledge, behavior, awareness and attitude (Weaver, 1994). Following other scholars tended to generate other combination based on specialty and cultural differences. Developed models are presented in the section of CC models and tools. A newly published review article on the cultural competence models (Business and healthcare) highlighted major components of this variable; namely, cultural awareness, cultural knowledge and cultural skills (behavior), which have been widely replicated in different research in both field of business and healthcare (Alizadeh & Chavan, 2015). Following, the definition of each is presented:

- Cultural awareness: the view of an individual towards other cultures, it involves ethnocentric, biased and prejudiced beliefs.
- Cultural knowledge: it refers to a continued acquisition of information regarding other cultures.
- Cultural skills: it stands for the ability of communication to interact effectively with people from a cultural.

Apart from the above-mentioned dimensions, two other factors were replicated across several models, namely cultural encounter/interaction cultural desire/motivation. The former refers to face-to-face contacts or other type of interactions, while the latter is individual's willingness to engage and learn about cultural diversity.

Cultural competence, also, has been classified in 4 categories:

- Individual,
- Organization,
- Curriculum,

- And delivery of CC service and program (Echeverri, Brookover, & Kennedy, 2010).

2.4 Culture Competence in Healthcare

In terms of the healthcare, the meaning of cultural competence becomes more and more critical. The key reason is that all the communication directly contributes to personal health and community health as well (Miguel & Luquis, 2013). Since it is generally believed that cultural competency influence the fairness on the healthcare access all around the world (Olt, Jirwe, Gustavsson, & Emami, 2010); and moreover cultural competency of healthcare providers is proposed as a critical solution to inequality and improving quality of care (Betancourt, 2003; Campinha-Bacote, 2002; Henderson et al., 2011).

Generally, CC in the context of healthcare has been adopted as a significant key strategy in order to control and remove the racial and ethnic health disparities (Betancourt, 2003; Geiger, 2001). The first concerns with ‘cultural competence’ in healthcare started in 1980s as training and practice in USA to address the needs of culturally diverse population faced with a poor health services. In continue different countries started to provide various approaches to combat the marginalization of minority groups (with ethnic, linguistic and religious) for having formal healthcare system. The importance of cultural competence in healthcare emerged due to the generalization and political changes. Large migration wave were all around the world and in accordingly, the mismatch between two groups of health practitioners and patient were emerged and led to poor health outcome and dissatisfaction (Jeffreys, 2015).

As mentioned in chapter one, the demand side in healthcare service are patients and not in a good situation, also their privacy is of high importance. Accordingly many scholars all around the world started to notice the differences of CC in healthcare. The more the mobility of healthcare, the more the need to raise the awareness of the patients' cultural needs will be essential to provide them a culturally congruent service (Sharma et al. 2009). Since healthcare industry needs to deliver an equal high-quality care to patients with different culture background (Campinha-Bacote, 2002), it is critical for this industry to be proactively ready for different cultures.

Among the policies, cultural competence in healthcare has been closely linked to multicultural policy which can respond to varied 'needs' perceived from the diversity (Ormond, 2012). Furthermore some researchers added that culturally competent practices can act as a constructive strategy against who conflate race, ethnicity and biology with 'culture' (Shaw 2005: 292). Following is a definition for CC in healthcare service, it is offered by Joint Committee on Education and Promotion Terminology, sited in (Adeyanju, 2008):

> "The ability of an individual to understand and respect values, attitudes, beliefs, and more than differ across cultures, and to consider and respond appropriately to these differences in planning, implementing and evaluating health education and promotion programs and interviews" (P.5)

Mattew Adeyanju (2008) mentioned to the vital role of communicating across cultures when it comes to the health and diseases related issues. This author believes that in this type of communication across cultures, it is all about health and disease which can influence both personal health and the health system community at large. Accordingly, health educators should be willing to select effective communication and use multicultural and appropriate strategies which are all relevant to the cultural

environment. They need to have suitable listening and speaking skills for effective communication.

Although cultural competency seems a personal ability but it is required to appear in the organizational practice, such as evaluation and promotional programs. From the authorities' perspective, it is believed believes that the effective communication and cultural competence of healthcare practitioners should be considered in policy and planning; because by an effective communication the abilities of individuals will go beyond their responsibilities. Also cultural competency will enable them to go beyond their individual capacities (Adeyanju, 2008). The way that healthcare providers communicate can be verbal or non-verbal and a communication strategy describes how to deliver the message and is based on the deep understanding of knowledge, attitude and other personal factors.

Therefore cultural competence in healthcare and the field of medicine implies on a medical service which is provided in accordance to the cultural value, belief, tradition, and lifestyle of patients. Also it aims to reduce the cultural difference between medical service providers and patients in order to enhance the quality (Overall, 2009).

2.4.1 A Multi-Cultural Doctor-Patient Interaction

"Engagement in stereotyping of patients" may negatively lead the healthcare practitioners to have certain biases towards their patients. Based upon it has been practically shown by several investigations that all kind of racially and ethnically discordant will affect the patients' assessment of the quality of care (Limberger, 2010).

In terms of the doctor-patients relation, the main barrier mentioned is language and communication. It is believed that when the language of doctors and nurses are less than ‘very well’, they become stressful and cannot communicate effectively (Center on an Aging Society analysis, 2000). Likewise it was reported that Spanish-speaking Latin Americans show less intent on visit to doctors and preventive care such as mental health program and breast cancer exam (Fiscella et al. 2002).

This kind of barriers in language and communication lead to dissatisfy patients. The level of satisfaction was far less Spanish speaking Latin American patients than those of English-speaking patients (Carrasquillo, Orav, Brennan, & Burstin, 1999). The use of interpreter is widely going to be accepted more and more. It implied on 50% of non-English speaking patients (Collins, Clark, Petersen, & Kressin, 2002). Although being bilingual is important for the doctors who are working with foreign patients, by the way, the help of professional interpreter led to more satisfied patients than bilingual doctors, because the interpreter are trained specifically for this issue (Lee, 2002).

The other problem mentioned in literature is about the racial match in doctors with different cultures Saha et al. (2000). For instance, patients from African American and Hispanic background had a belief that there is racial discrimination in use of medical service. It leads to their preference on racial match with doctors (Chen et al., 2001). Likewise the satisfaction of treatments faces an increase when patients received the treatment from doctors of same race (LaVeist & Nuru-Jeter, 2002).

Patients tend to have a doctor with high intellectual level (Hill & Garner, 1991) who does not discriminate the minority patient because this attitude might be passed to patients through non-verbal cues (Van Ryn & Burke, 2000).

2.5 Cultural Competence and Medical Tourism

The significance and function of cultural competence in the scope of medical tourism is still under the examination and few studies, so far, have been conducted on this arena. It is likely that a different strategy is required in MT according to the differences between patient-consumers as a tourist and minority immigrants living in a country; the former groups just cross borders oftentimes for having medical care while the latter are living inside the country.

According to the existing literature, our knowledge of CC in medical tourism is far from a deep literature, nevertheless, travelling back to the country of origin seems logical for people, who are living far from their country to find more "cultural appropriate healthcare" (Ormond, 2012). For instance Lee et al. (2010) conducted a research to find why Korean immigrants preferred to have the medical care in their origin country and suggested the "familiarity with the structures and national health systems", also the "lack of linguistic obstacles" as the main reason that give them a sense of control over their health. Furthermore, traveling back home for reproductive tourism among the Thai woman is normal with the aim of "ease in communication and familiarity with healthcare practices' (Whittaker, 2009). Accordingly, migrants prefer to return their country of origin with the aim of treatment and in order to have an appropriate health system to their culture and their social construction as well (Elliot & Gillie, 1998). Such a process claimed to becomes a 're-assertion of place' (Whittaker, 2009).

There is no doubt that delivering CC in healthcare is not a simple task. Medical tourism as a new form of healthcare mobility (Ormond, 2014), is likely to complicate this situation even more, due to several reasons. The globalized "for-profit healthcare sector" largely mediates the tendency to focus from healthcare equity within the national level to a transnational level (Ormond, 2012). Provided that medical tourists are neither patient nor tourist (MTQA, 2017), the process of providing "cultural competence" in medical tourism is likely to be much more striking. Offering 'culturally-appropriate care' and linguistic proficiency is not only the duty of private facilities, but also entire country should work on it (Ormond, 2011). The patients are in their "most physically and emotionally vulnerable" situation (Ormond, 2012:189) and it provides added pressure to tolerate cultural differences in this situation (Woodman, 2009).

Cultural background and cultural similarities has been considered among the key motivation factors for patients-tourists in the process of choosing a destination (Mohammad Jamal, Chelliah, & Haron, 2016; Rokni et al., 2013) and leads to the existence of differences across nations' motivation (An, 2014). Besides Korea Tourism Organization (KTO, 2009) surveyed a sample of 544 patients from nine nations and found that travel motivations differed across nations according to the culture of home and destination countries.

Nevertheless, such a cultural and linguistic differences between the doctors and the patients could potentially influence on their relationship (Fisher, Burnet, Huang, Chin, & Cagney, 2007; Thomas, Fine, & Ibrahim, 2004). Accordingly, medical tourism is likely to be a key domain which is highly affected by these differences, while a dearth of information in this arena demands for more practical research.

2.6 Cultural Competence and Affiliated Components

There are two types of study in terms of CC; this classification is based on considering CC as a predictor or as an outcome. Alizadeh and Chavan (2015) reviewed the entire dimensions and outcome of cultural competence in order to find its efficacy in healthcare. They introduced cultural competence as a research variable that can impact research outcomes.

2-6-1 CC as a Dependent Variable

Some scholars aimed to examine the precedent factors of CC and their influences. The effect of education/ training and organizational support are explained in detail, while others are presented in the form of table. As shown in table different variables might lead to cultural competence, linguistic capabilities, for example, has been mentioned by scholars or different message delivered to patients or doctors (Table 2.1).

It is noteworthy to mention that two factors of training and organizational supports has not been practically tested as predictors of CC, while many scholars mentioned to its import and relationship with CC. Since this thesis found them critical in terms of medical tourism, it was essential to cover all the relevant literature.

2.6.1.1 Education and Cultural Competence

Although few studies found direct link between cultural competency trainings and healthcare improvement; available evidence have suggested that such training may influence knowledge, attitudes, and skills of health professionals as well as patient satisfaction. Coronado (2013) and Betancourt (2010) considered the training as a promising strategy (Betancourt, 2003).

Table 2.1: Predictor Variables of Cultural Competence

	Language	Education	Message	Empathy	Self-efficacy	Experience	Belief	Personal Relation
Sarver& Baker(2000)	*							
Wade & Bernstein (1991)		* (Training)						
Herek et al. (1998)			* (race, multi-cultural message)					
Kalichman et al. (1993)			* (culturally specific message)					
Stevenson (1994)			* (culture similar)					
Sussman (1995)			* (cultural likeability)					
Seo & Kwon (2014)				*	*			
Jin et al. (2010)	*			*		*		
Cuellar et al. (2008)							*	
Benkert et al. (2011)		*						
Park & Jung (2014)	*				*			*
Jung(2013)		*		*		*	*	
Jeon(2015)	*	*			*	*		

Since the cultural differences of health practitioners and patients, will influence on the relationship and the treatment process, and also based upon the fact that cultural competence is a learned process (Limberger, 2010), considerable efforts and focus have been made toward the education of healthcare providers and many strategies have been developed to assist employees for being more culturally-competent. Although cultural competence is being considered in two scales of organization and personal, the personal growth has been introduced as the main requirement which can potentially leads to better organizational performance (Miguel & Luquis, 2013). By the way it is believed that the most exponential barriers to the health educators

are to identify a specific framework and its construct (Adeyanju, 2008). Variety of training programs aimed to improve the cross-cultural competence of providers, such as computer-assisted hospital-based onsite education (Limberger, 2010); transcultural course for nurse specialist (Jeffreys, 2002), a general assessment on the health students training (Gozu et al., 2007). Furthermore the major approaches to cultural competence training programs include three main components of CC: knowledge-based, attitude-based and skill-building (Betancourt, 2003; Kripalani, 2006).

Medical Tourism Magazine lately mentioned the importance of identifying cultural and linguistic competency training and guidelines that can be established throughout the industry (MTM). Applying successful now-stablished procedures is advised rather than start from the primary points, those with a good background of caring for local patients from diverse backgrounds (Salimbene 2010). Jagyasi's (2010) observation, practically suggested adopting the existing Western-based cultural competence training and practices in medical tourism since it has produced a complex ways of performing culturally diversity in geographies of healthcare. US with having many immigrants from all over the work and consequently a diverse cultural background, is the pioneer country for adopting cross-cultural training programs in medical schools and clinics (Salimbene, 2010). The contents of the training are mostly regarding the following issues: sensitivity and diverse cultural and religious beliefs of body, healthcare and end-of-life practices, decision-making, handling of difficult news about health status. Although training in healthcare used to be focused on only the culture of one geography (Jagyasi 2010) medical tourism has turned the situation since the patients come from different geography (Ormond,

2012). An important strategy in medical tourism would be to train medical professional with the "culture of no culture" (Taylor 2003: 161 sited in Ormond, 2012).

Common goals can be seen in training programs for improving physician-patient interactions, meanwhile the programs differ based on the "content, setting, length, and frequency" (Crenshaw et al., 2011; Kripalani, 2006). The present study will consider the effect of university training of CC on advancing this important among the health practitioners in South Korea. While such training occurs during the first or second years of medical school, it is assumed that the linkage to patient care cultural competency is not well organized in the training systems (Beach et al., 2005; Betancourt, 2003).

The influences of 4 hour education on cultural sensitivity have been conducted by Wade & Bernstein (1991) on the counselors, and its effect was measured by the level of patients' satisfaction; in result, this study showed that education has a positive effect of CC (Wade & Bernstein, 1991). By targeting medical manpower, a research aimed to find the factors that can predict a positive CC. The authors found that the language capacity of doctors can positively increase the chance of a follow-up appointment (Sarver & Baker, 2000).

2.6.1.2 Cultural Competence and Organization Support

Although the effectiveness of these supporting systems has not yet been established, it is critical for hospitals and clinics to provide their employees the improvement programs of cultural competency (Limberger, 2010). This kind of support can tackle the problem of cultural differences between doctors and patients. Such a supporting system for staffs is essential also under the cover of Joint Commission on

Accreditation of Healthcare Institutions (JCI) which aims to improve the quality of care, patient safety, and institutional compliance.

The effect of organizational climate on health practitioners' cross-cultural competence is not clear yet (Lin, 2016). By the way, according to the literature, cultural competence has been proposed as a strategy for health care organizational, especially in US (Weech-Maldonado et al., 2012). The National Quality Forum (NQF) of this country asserted that cultural competency can be achieved by "policies, learning processes, and structures" in which both individuals and organization can improve the cross-cultural interactions (National Quality Forum, 2008; Weech-Maldonado, 2012).

Mere studies evaluated the relationship between CC and organizational support. It was asserted that organizational support can act as an affective factor in determining an employee's capability to achieve desired outcomes and deliver culturally competent services (Balcazar et al., 2009; Lin, 2016). It is believed that the healthcare practitioners are required to realize the internal policy of their own organization and according to that try to make a connection with the patients-customers. Also we know that the adoption of organizational support may vary through policies, procedures and allocation of resources (Alizadeh & Chavan, 2015). Undoubtedly patients have complex needs and accordingly a "customized solution" will be required from the organization (Medical Tourism Magazine , 2010).

A successful example of organizational support to improve the cultural competency in MT is the University of Chicago Medicine in US (Medical Korea Hospital Conference, 2016) in which they applied the competitive strategy of "service

excellence". They provided an extra service, freely, for their foreign patients to remove the cultural barriers and provide non-clinical services according to the customer's needs. Such a unique system aimed to provide a supporting system for patients in a variety of domain from interpreter service to nonverbal cultural needs. To provide this system their employee teams are combined from different nationalities and they are well trained for their cultural awareness to avoid judgment and being open to other cultures.

2.6.2 Cultural Competence as an Independent Variable

Second types of studies tend to consider CC as a predictor for other variables. The effect of CC for several outcomes has been shown in previous studies and was intruded as a potential variable to outcome measurements by a review study (Alizadeh & Chavan, 2015). Ethnic disparities and racial in healthcare have been well established in the literature. At the beginning scholars claimed that disparities are resulted from technical skills of nurses, technical aspects of care and the quality of procedures. But many experts started to introduce the significant influence of interpersonal aspects and its effects on patient satisfaction (Limberger, 2010). The health disparities not only are significantly affected by cultural and linguistic differences between patients and health providers (Fisher et al., 2007; Smedley, Stith, & Nelson, 2003; Thomas et al., 2004), but it is also influenced by many other factors that still are not clear. However the shortage of cultural competency will result in poor communication and dissatisfied patients of the quality.

In different studies researchers examined the influence of CC on both healthcare practitioners and patients, also the general outcome for the organization and country in large.

From a general perspective: Cultural competence has been considered as a significant proxy of healthcare. JCI (joint commission international) accreditation which is a worldwide accepted system to evaluate the quality of hospitals recently focused on the significance of cultural competence to provide a patient centered care. It is essential to consider that the definition of quality may differ according to the cultural background (MTM, 2011) and that is a significant alert for the healthcare providers to provide a service which is culturally appropriate. Accordingly the more the appropriate level of CC in health practitioners, the more the quality of interaction will improve. "Relationship quality" was introduced as one of the outcome variables (Griffit & Harvey, 2000). The potential of cultural competency also has been shown to be effective in order to reduce the medical inequality (Betancourt et al. 2003). In terms of chronic illness patients, it was revealed that African American or other minorities confronts doctors less devoted to the treatment and it lead to and dissatisfaction on medical services (Smedly, 2003; Saha et al., 2003).

From the patients perspective: On the other hand, CC can lead to several outcomes for the patients (Mazor, Hampers, Chande, & Krug, 2002; Way, Stone, Schwager, Wagoner, & Bassman, 2002); including, patient satisfaction (Castro & Ruiz, 2009; Limberger, 2010), trust (Paez et al., 2009; Thom & Tirado, 2006), adherence to treatment (Saha et al., 2013) and improved patient quality of life (Suh, 2004). The level of patients satisfaction differs based on the cultural competency of their doctors or nurses, also their linguistic abilities (Castro & Ruiz, 2009). Also it was shown that the satisfaction will increase in the case of more attention and better listening of doctors, also their respectfulness for the different opinions (Mazor et al., 2002). Also the following definition clearly shows the relationship between two concepts of CC and quality:

> "The ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs… [it serves as] a vehicle to increase access to quality care for all patient populations".

From the doctors' perspective: Finally it is clear that CC can potentially effect on the healthcare providers as well. A research revealed that there is a negative relationship between the level of CC and psychological burnout (Cha, 2016). Moreover, job performance was repeated as an outcome of CC in several studies. A study conducted by Ramalu et al. (2011) in Malaysia revealed that higher cultural and linguistic capabilities lead to higher CC and better performance. By contract, other study found that CC has influence on cultural adaptation and it indirectly it will lead to work performance (Lee & Sukoco, 2010). Moreover, better performance, feeling of self-worth and interest to promote healthcare were shown to be the outcome of CC in other studies (Kim-Godwin, Clarke, & Barton, 2001; Smith, 1997).

2.7 Cultural Competence Models and Tools

By reviewing the models of cultural competence, different categories can be seen. Alizadeh & Chavan, 2015, reviewed CC models in business and healthcare sector, and asserted that the efficacy of this concept is not yet clear. The variations of components in healthcare context are shown in table 2.2. Among them 'knowledge' and 'skills' repeated more than others.

The dimensions of cultural competence (CC) in the business context mainly stressed the skills of communication, while in the healthcare context these skills goes beyond the only communication and refers to the ability of providing an accurate physical assessment culturally/ethnically. Anand and Lahiri (2009) advised the healthcare

scholar to consider model generated by non-healthcare sector. A model produced by Deardorff (2006) has been widely recommended for healthcare sector.

Some of these models emphasis only on the components of CC, some of them examine how CC can be delivered, by contrast others aim to develop a tool in order to evaluate the level of CC in individual. One of the initial developed models is, LEARN, which implies on better relationship through cultural competency. It involves, listening, explaining, acknowledging differences, recommending and negotiating treatment (Berlin & Fowkes Jr, 1983). This model was a well stablished ground for that model developed in 2006 (Thom & Tirado, 2006).

Table 2.2: Cultural Competence Models in Healthcare

References	**Elements of Cultural Competence**	**Context**
Balcazar et al. (2009)	Desire, Awareness/ Knowledge, Skill, Organisational Support	Healthcare (rehabilitation)
Burchum (2002)	Cultural Awareness, Cultural Knowledge, Cultural Understanding, Cultural Sensitivity, Cultural Interaction, Cultural Skill	Healthcare (nursing)
Campinha- Bacote (2002)	Cultural Desire, Cultural Awareness, Cultural Encounter, Cultural Skill, Cultural Knowledge	Healthcare (nursing)
Kim-Godwin et al. (2001)	Caring, Cultural Sensitivity, Cultural Skill, Cultural Knowledge	Healthcare (nursing)
Papadopoulos et al. (2004)	Cultural Sensitivity, Cultural Awareness, Cultural Knowledge	Healthcare (nursing)
Doorenbos and Schim (2004)	Cultural Diversity, Cultural, Awareness, Cultural, Sensitivity	Healthcare (nursing)
Sue (2001)	Awareness/Attitude, Knowledge, Skill	Healthcare (counselling)
Suh (2004)	Attributes of cultural/competence: Ability, openness, and flexibility/Elements of cultural/competence: Cognitive Domain: [Awareness,/ Knowledge], Affective/ Domain: [Sensitivity], Behavioural Domain: [Skills]/ Environmental Domain:/ [Encounter]	Healthcare (nursing)
Teal and Street (2009)	Self- and Situational/ Awareness, Adaptability/ Knowledge,/ Communication Skills	Healthcare (physicians)

Resource: adapted from (Alizadeh & Chavan, 2015)

Table 2-1 provides the information on what elements have been applied in the previous models of CC in the context of healthcare. Although there is a slight difference, a general agreement on the definition and major components can be seen.

Campinha-Bacote (2002), developed a model of 'the process of cultural competence in delivery of healthcare services' and its relevant instrument accordingly. Included dimensions are 'cultural desire, awareness, encounter, knowledge and skills' (Campinha-Bacote, 2002). This model has been applied practically by the other scholars (Castro and Ruiz, 2009; Chen, 2008).

2.8 Theories

While the nature of this thesis is exploratory and it initially started with no theories in mind, after achieving the qualitative result, two theories were applied in order to develop the framework. Accordingly, it is grounded on two theories. Both of them are in the basis of social discipline. These theories are "social cognitive theory" and "intercultural competence framework, reflection theory". A brief description for each is provided as follows.

2.8.1 Social Cognitive Theory (SCT)

This theory dates back to long time ago in the decade of 1930, and after many changes Bandura brought SCT to mass communication (Bandura, 2002) and since then the theory has been widely applied in different domains.

As it can be seen in fig. 2.1 this theory comprises environmental influence (organizational climate), personal factors (cognition) and personal behavior. Three factors are linked together and interact with each other. The content validity of this theory has been demonstrated before (Tsai & Cheng 2010).

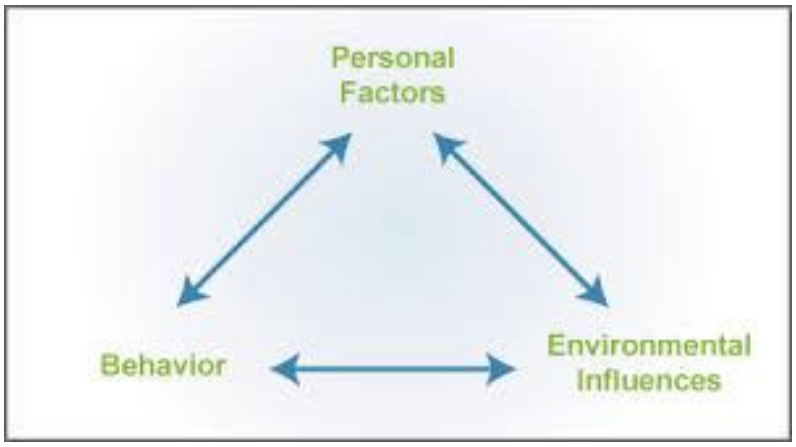

Figure 2.1: Social Cognitive Theory

The theory defines a psychological pattern of behavior in reciprocal interaction of environment and personal cognition factor, in a social context; it can appropriately examine the effects of the environmental factor and personal cognition on behavioral outcomes. This theory has been applied in psychology, education, communication and lately in healthcare context (Lin, 2016).

Since this theory supports the interaction of three factors that are assumed to be affective in cultural competence delivery in medical tourism, the author decided to apply the insights of this theory.

2.8.2 Intercultural Competence Framework, Reflection Theory

Under the cover of Reflection theory, intercultural competence emerged as a framework/model. Reflection theory dates back to 1988, when Gibbs G. developed the "Reflection Cycle". It is an effective tool to reflect the impact of events, regardless it is negative or positive, as long as the events occurred in the area of "learning, practical or personal". This cycle specially considered significant for the students who are new to a culture and examine their reflection (Gibbs, 1988).

In accordance to the above-mentioned theory, models and framework emerged for successful intercultural interactions, especially in the domain of international education. Healthcare industry employed those frameworks and models to improve the cross-cultural connections among different cultures and provide a successful interact. Concepts of "intercultural competence framework/ model" respond to a key question of how to provide a successful interaction. According to the Deardorff (2006, 2009) studies, one of the pioneers in intercultural competence, this framework is comprised of the following:

Attitudes: Implies to respect, openness, curiosity and discovery which are the willingness to risk and to move beyond one's comfort zone and to demonstrate that others are valued. A sufficient level of attitudes was claimed to be foundational to have further development of knowledge and skills.

Knowledge: While different concepts were concerned as a synonym- such as cultural self-awareness, culture-specific knowledge, a deep cultural knowledge and sociolinguistic awareness- one element agreed upon by all the scholars was the significance of understanding the world from others' perspectives.

Skills: it refers to the "acquisition and processing" of knowledge; for instance the skills of: observation, evaluating, listening, interpreting and etc.

Internal Outcomes: Three mentioned concepts, ideally, lead to an internal outcome consists of flexibility, adaptability and empathy. The degree of success on these outcomes varies among individuals. Generally they will be able to respond in according to others' perspectives and desires.

External Outcomes: Finally the combination of all previous abilities becomes the visible outcome which demonstrates through the communication of the individuals.

Accordingly, scholars reached a consensus on the definition of intercultural competence, which insists on the significance of "*effective and appropriate"*, the components and process of this framework, directed the path of this thesis.

> *"The effective and appropriate behavior and communication in intercultural situations"*

2.9 Summary of Literature

According to the literature it is assumed that a qualified medical tourism service can be achieved by a proactive strategy of cultural competency. It stands for this assumption that the higher the level of cultural competence in healthcare practitioners, the better the quality of interaction will be. Regarding the "intercultural competence framework, Reflection theory" a successful procedure of cultural competence should lead to appropriateness and effectiveness.

Meanwhile according to the social cognitive theory, other factors rather than only personal factors are influential. Three angles of personal factors, environmental influence and behavior are/should integrating to develop the service quality of MT.

Acknowledging that CC as a components has not received a uniform construction, it seems essential to explore the valid construction for MT, and this exploration is likely to be worthy due to its positive outcomes.

Chapter 3

METHODOLOGY

This chapter presents the procedure of the thesis, in detail. Following the titles and subtitles will clarify how the objectives and aim of study were addressed. At first it starts with a general view to the applied procedure and process and then data resources, participants and sampling techniques are presented. The final sections are the process of analysis and the ethical consideration during the research.

3.1 Research Design

Present study attempted to use an exploratory approach with the mix methodology of both qualitative and quantitative in order to clarify and test the determinants of delivering an effective and appropriate cultural competency in medical tourism.

Since this study was neither structured completely nor flexible 100 percent, combinations of two philosophies were conducted to evaluate the research. Hence, both deductive and inductive approaches assisted the research with quantitative and qualitative methodologies, respectively. It has been widely claimed by the scholars that quantitative methods are not trustworthy enough in cultural competence study (Hammer, 2015; Deardorff, 2006) and it is even more significant when it comes to the healthcare sector (medical tourism) (Alizadeh & Chavan, 2015); accordingly both qualitative and quantitative methods were applied to reach the reliable implications.

On the other hand it is believed that the evaluation of cultural competency is/should be based on its “appropriateness” and “effectiveness”. The former can be evaluated by other individuals, while the latter can be self-evaluated (Deardorf, 2006). Based upon this study will evaluate the “appropriateness” of CC through the qualitative methodology (semi-structured interview with the top managers), meanwhile the “effectiveness” of cultural competence in MT will be appraised applying the quantitative method (questionnaire will be filled in by the health providers).

Accordingly, the process of conducting this thesis is presented in the following sections. Despite the fact that developing a CC framework was the main aim of this study, an initial study was conducted with the aim of exploring the “barriers of developing medical tourism in a destination: a case of South Korea” (Rokni et al., 2017). This study was performed with the aim of determining the factors that potentially could lead to the present barriers of medical tourism development in this country. Adopting and following the model of Heung (2011), developed for the barriers of MT in Hong Kong; a systematic literature review and qualitative procedure directed the authors to determine the contributor barriers. Open-ended questions were asked from the authorities and during the interview; we aimed to make a discussion on the MT situation in Korea, rather than asking direct questions. Accordingly more explorative-oriented information was achieved comparing to semi-structured interviews (Denzin & Lincoln, 2011). The result of this study led the author to identify the variables (cultural competence) for further research (Juliet, 1990). Chart 3.1 presents the steps of the extensive and systematic review on the available facts, data and information.

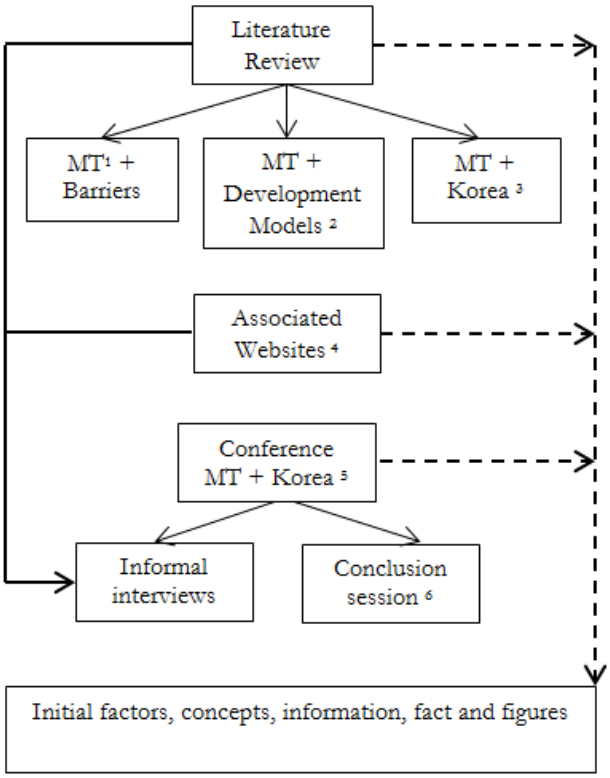

Figure 3.1: Summary of the Review Process (Source: adopted from, Rokni *et al.*, 2017)

1. Medical Tourism
2. Includes the published papers regarding medical tourism development models and requirements
3. Includes published papers regarding medical tourism in Korea
4. The available information within the website of organizations in Korea associated with medical tourism industry
5. The conference of Medical Korea and K-Hospital.
6. "Global healthcare policy and management forum". This session was held with the aim of discussing the main shortages of Korea in terms of medical tourism and based on the current trend in other countries.

3.2 Process and Procedures

Based on the abovementioned information, there were 3 main phases involved in this study. In phase No. 1 a qualitative study conducted with the aim of exploring the determinants of cultural competence delivery in MT, based on the content analysis, a framework developed. Second study aimed to improves the validity through seeking out the expert opinions. Afterward, the final phase was conducted through quantitative methodologies in order to examine the validity and reliability of the

developed model and also testing the correlation among the components and their items. The procedures of these three phases are explained in follows:

3.2.1 Phase One

The first phase aimed to explore the determinants of delivering an appropriate cultural competence in medical tourism. It was conducted through qualitative methodology and was conducted with semi-structured interview.

In-depth interviews were conducted by targeting participants from medical institutions. The interviews were carried out from December 2016 to February 2017 with 9 Participants, including hospital representative and top managers. There were all physicians and at the same time working in managerial level. A table in the "participants" section presents the demographic characteristics of participants.

It is believed that in some situation quantitative methods are not capable enough to describe a specific situation (Juliet, 1990). In this situation qualitative procedure was adopted to cover all the dimensions required for CC in medical tourism. A preliminary content analysis was applied to identify the key factors through an extensive review of the literature, for instance, CC in MT (Ormond, 2012; Salimbene, 2013), CC in healthcare (Campinha-Bacote, 2002; Lin, 2016), developed CC models and instruments to evaluate (Deardorff, 2006; Schim, et al., 2003; Spitzberg, 2009). The variation of these factors was collected in previous reviews (Alizadeh & Chavan, 2015; Gozu et al., 2007). The contents achieved from the interviews, have revealed the differences and similarities of CC dimension in MT and healthcare. After conducting in-depth interview, an accurate procedure of content analysis revealed the themes and accordingly the relevant determinant of CC.

Finally a framework was developed which implies on the CC delivery in medical tourism.

3-2-2 Phase Two

Second phase aimed to provide/improve the validity of gathered information in the previous phase. It was necessary to know whether these themes and factors would be applicable during the final survey period or not (Junio et al., 2017) It was suggested that inquiry on the expert opinion can improve the validity of result, besides being supported by other studies (Sarantakos, 2005).

In this regard, the gathered information in phase 1 (developed framework, classification of the internal, external and skill factors and also their themes) were examined by reviewing previous studies (Campinha-Bacote, 2002; Schim, Doorenbos, Miller, & Benkert, 2003). For the expert opinion, the key points – a brief description, developed framework and developed items- were sent to a group of selected experts who are all involved academically in medical tourism, their specialty was either social science and or healthcare. They were kindly asked to confirm or comment on the clarity and relevance of the information; if the items adhere to the attributed subcategory and its theme. The procedure was performed via Email, totally 7 experts responded to the email and sent the feedback. Appendix number 2 presents the letter and information sent to those experts.

3.2.3 Phase Three

The final phase aimed to examine the effectiveness of developed framework to deliver CC to foreign patinets. This phase was conducted through quantitative procedures. Questionnaire was employed for data collection and the target group was phicisians working in medical institutions registered as KOIHA (Korea Institute for Healthcare Accreditation) and are introduced as the most trusted institutions by the

"Patients Beyond Borders". Totally, 743 doctors participated in this study with almost 49.53 percent particaipation rate; data were analyzed both "SPSS" and "R" Softwares. Chart 3.2 represents the designed model of this thesis; all the phases are included.

Table 3.1: Procedure of Study

	Method	Resource	Analysis	Output
Topic selection	Explorative	Systematic literature review Observation Interview	Barriers Classification	Barriers of MT Development in Korea
Phase 1	Qualitative	Literature review Semi-structured interview	Content Analysis	Framework of CC delivery in MT
Phase 2	Inquiry	-	Revision	Revised Version of Themes / Confirmation on the framework Validity
Phase 3	Quantitative	Questionnaire	Factor Analysis	Validity & Reliability

3.3 Data Sources

Provided that mere studies are available in terms of CC in medical tourism, and given that a combination methodology was required to achieve a reliable result, this study has employed several sources of information.

The aim was to cover the available literature, information and data from relevant disciplines, including: secondary documents, observation, interview and questionnaire. The procedures were as follows:

3.3.1 Secondary Documents

A systematic literature review was conducted, in which the relevant articles reviewed systematically and then deeply for those more relevant. Data selection was based on the logics of this study, including: the latest research gaps in MT; MT in South Korea; current trends; issues and problems, cultural competence background; measurements; model and assessment tools of CC; cultural competence in health care and finally CC in medical tourism.

3.3.2 Observation

On-site observation of different hospitals and clinics was on progress during all the thesis procedure, it proactively and purposefully started before designing any topic, which led to the first publication (besides other type of resources); during the first phases all the interviews were conducted in hospitals or clinic sites which provided the opportunity for observing many cases directly; the final phase also facilitated the opportunity of onsite observation. The overall observation enabled the author to discuss the results on a logical basis.

3.3.3 Semi-Structured Interview

Second phase of this thesis was developed based on the collected information through interviews. This type of interview has the ability to assist both groups of researcher and the respondent, since the latter group may feel more convenient to respond, while, they might mention some essential idea forgotten by the former group (Denzin & Lincoln, 2011). The questions for these interviews were extracted from the literature and were modified based on the MT situation in Korea. The

discipline and methodology were, to some extent, similar to previous studies. One of them was related to essential cultural competence in healthcare (Delphin-Rittmon et al., 2013) and the other was a qualitative study on the cultural competency of healthcare managers (Mahbanooei et al, 2016). In study phase 1 in-depth interview were conducted using semi-structured procedure. Each interview lasted for 50 to 90 min. The themes of semi structured questions are presented in table 3.1. The questions mainly focused on issues surrounding cultural experiences in MT, CC practical dimensions, potential factors to improve the CC, promotional activities based on culture, and its outcomes. The process of data collection was from December 2016 to February 2017.

Table 3.2: Qualitative Questionnaire

Name of the Interviewee / Job position	**Date / Time / Place**

Interview Questions:

- The level of awareness on cultural competence
- Do you have any idea about the concept of cultural competence! (request for an explanation)
- Do you think cultural competence is a required qualification for doctors whom interact with foreign patients? Why?

1-Is there a specific section/ department/ a director for medical tourism / for cultural and linguistic competency in hospitals/ clinic?!

1-1: If yes, how is it proceeding? Before/ at the time / after the patients traveling to Korea

1-2: What is the plan to deliver the services, treating with the foreign patients?

2- Is there any policy or plan to enhance the quality of service to foreign patients? How?

2-1: Do you have a special plan for removing the ethnic bias? (Cultural differences)

3- Do you remember any experience of cultural differences how did you or your collogues managed that situation?

4- In your opinion, how doctors can control the situation of cultural differences?!

5- Which Behavioral characteristics do you think is the strength of personality to interact with the people from other culture, especially in healthcare system?

5- Is there a specific supportive program in your organization/country to enhance the level cultural competency among your employee?

6- How the employee can be ready for interacting with patients from other culture?

7- in your opinion, how we the level of CC can be improved?

3.3.4 Questionnaire

The quantitative phase (third and final one) was based on the questionnaire. Questions were generated in accordance with the themes achieved in previous phase. It evaluated the validity and the effectiveness of those themes and their correlations as well.

Questionnaire was designed with division into 5 sections consisted of 24 questions for internal factors, 11 questions for external factors and 10 as for skillfullness (Appendix. 1). Also demographic characteristic and basic qualification were asked trough several questions. At the end two general questions were asked to find the relationship of general ioinion on cultural factor in medical tourism and the level of different demisions for each indivitual. Table 3.2 represents different sections of questionnaire. The process of data collection was during June and July of 2017.

Table 3.3: Different Sections of Questionnaire

			No. of Question(s)
Socio-demographic characteristics	age		1
	gender		1
Job characteristics	Type of institution		1
	Department		1
Basic Qualifications	Speaking Language		1
	Experience of studding out of Korea		2
	Experience of working out of Korea		2
Extra Qualifications	Training experience in MT		3
	Training experience in CC		3
General opinion	Healthcare and Culture		2
Cultural Competence	Internal	Knowledge	6
		Attitude	6
		Motivation and desire	6
		Commitment and hardworking	6
	External	Training system	6
		Organizational support	5
	Ability	Skillfulness	10

3.4 Sampling Techniques

Since there are so many hospitals in South Korea offering variety of treatments, a specific sampling method is required to be appropriate enough to represent the situation of MT in this country. Undoubtedly in this regard non-probability sampling was adopted to provide the researcher the chance of selecting samples purposively. Under that context, judgmental sampling was applied to invite the participants for taking part in this survey. Judgmental sampling or purposive sampling has been applied in the similar previous studies in which the health practitioners where the participants (Lin, 2016; Maria Michelle, 2016). Moreover, this sampling method is effective since the participants are "far too busy" and a few of them are will be "the most prominent" and a good "representative of the entire population" (Altinay& Paraskevas, 2008: 96).

The interviewees and participants in phase 1 and 3 were selected through judgmental sampling in which the author can select those participants with more appropriate knowledge and experience, as suggested by (Altinay, Paraskevas, & Jang, 2015).

Meanwhile the participants in phase 2 were selected through non probability sampling- snowball sampling method to reach the opinion of the most appropriate experts.

3.5 Participants

Despite the fact that evaluating the attitude of patients is challenging in medical tourism due to their vulnerability (Ormond, 2014), the demand side, who are the healthcare providers and the facilitators, are being considered as the most influential group on the patients' satisfaction and other outcome (Alizadeh & Chavan, 2015);

Most of the previously developed models and tools targeted nurses, physicians and psychiatrists. Also, it was suggested to consider the attitude of doctors in order to combat the barriers in healthcare system and to find hinder problem(s) of medical tourism (Skountridaki, 2017).

Accordingly, the sample of the present survey were drawn from the health practitioners involved in MT in South Korea, in two categories of samples for qualitative and quantitative phases. Acknowledging that there were three main phases involved in this study, the participants for each section varied based on the requirements. Hence, the information of participants is categorised as follows.

3.5.1 Participants in Phase 1

According to the aim of this study the CC was required to be explored from an external point of view; meanwhile the participants were required to be familiar with the procedure. The representative of medical tourism in Korea were selected to be interview since they were aware and involved with medical tourism both academically and practically.

Table 3.4: Demographic Profile of Interviewees

Participant Number	Date of Interview	Gender	Position**
1	Dec.2016	Male	Hospital international relation Chief
2	Dec.2016	Male	University Professor
3	Dec.2016	Male	Hospital Chief Executive
4	Jan.2017	Female	Physician active in MT
5	Jan.2017	Male	Hospital human resources manager
6	Jan. 2017	Male	Hospital international representatives
7	Feb. 2017	Female	University Professor
8	Feb.2017	Male	Member of international affair team
9	Feb.2017	Female	Physician active in MT

** All the respondents have had experience of being directly involved in MT.

Accordingly the inclusion criterion for interview was, having a job position which represents their involvement in medical tourism industry, either academically or practically. Table 3.3 presents the demographic profile of the interviewees and their current job position.

3.5.2 Participants in Phase 2

As mentioned before, a group of experts in medical tourism were invited to comment and modify the gathered information in phase 1. They were all among the pioneer scholars of medical tourism with a background of either social science policy or healthcare domain.

3.5.3 Participants in Phase 3

In this final phase the effectiveness of CC dimensions were examined on a sample drawn from the doctors who are in direct interaction with the foreign patients. There are several hospitals in South Korea; accordingly an accurate sample selection was performed.

Firstly it was essential to focus on those hospitals which are known globally for international patients; hence the introduced hospitals in the website of "Patients beyond Borders" were selected (9 hospitals in South Korea). Afterward, Since CC is one of the non-clinical service skills, from those 9 hospitals, the one being accredited under the cover of KOIHA, as well, were selected (7 hospitals). This accreditation stands on the "Korea Institution for healthcare accreditation" and focuses on non-clinical quality. Diagram 3.3 represents the process of inclusion criteria for phase 3.

The inclusion criteria are mentioned below:

1- Being a physician or sergeant (considering the differences of CC based on the job characteristic)

2- Korean nationality (a new geo-social dimension)
3- Working in an institution which is: a) introduced by the website and, b) is accredited by KOIHA (a logical selection from long list of hospitals in Korea)

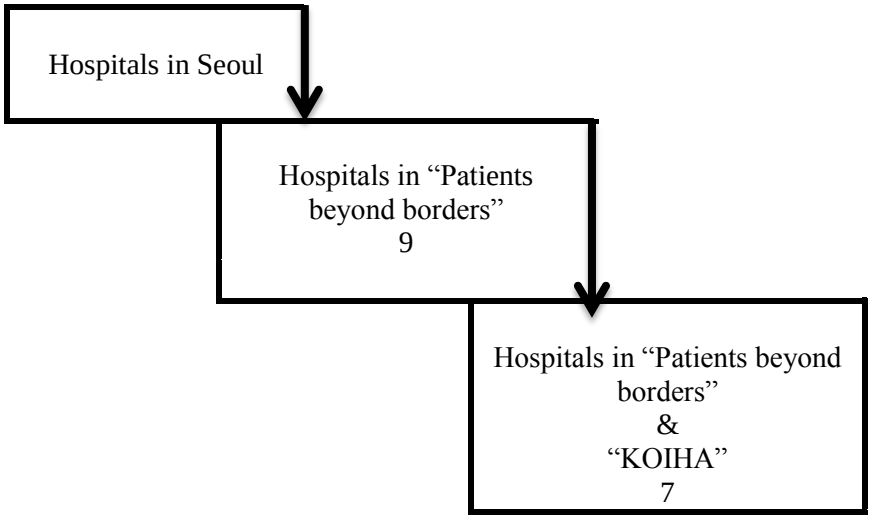

Figure 3.2: The Inclusion Criteria in Phase 3

Table 3.5: The Characteristic of the Selected Institutions

No	Name	Date Founded	No of Physicians & Surgeons	No of beds	Patient performed yr
1	Asan Medical Centre	1989	1589	2,680	In 900,000 Out4,000,000
2	Kyung Hee University Medical Centre	1971	171	1170	In32000
3	Inha University Hospital	1996	450	905	-
4	Severance Hospital, Yonsei University	1885	975	2000	In1000000
5	Jaseng Hospital	1991	160	174	In3200
6	Wooridul Spine Hospital	1982	120	-	-
7	St. Mary's Hospital	2009	1200	2000	-
Total			4665		

In a similar study about medical tourism, the author applied the list of suggested hospitals in the website of "Patients beyond Borders" in order to analyses their website's content Moghavvemi et al., (2017). This website was initially generated to

promote medical tourism and is claimed to be “The Most Trusted Resource in Medical Travel” since 2007. Nine hospitals are introduced in this website for South Korea.

At the second stage, the website of KOIHA was searched for the name of those nine hospitals. The names of 7 hospitals were found while the other two did not received/applied for the KOIHA accreditation. It is a Korean medical institution assessment system, sounded by the government. This Accreditation programs was designed in 2010 based on the JCI, but with the Korean criteria and based on the voluntary participation of the healthcare institution. The main aim is to provide patient safety and quality improvement in the medical institutions. Hence, the trustworthy medical institutions through this accreditation programs can be detected. The mission of this system is “Realizing a new medical culture to enhance patient safety and quality of care”. The authorities have designed the policy, strategies and tasks of this accreditation system clearly and among those strategies “Promote the R & D projects” and “realize high levels of customer satisfaction” are two of the main mentioned tasks (KOIHA website). In result, the characteristic of seven final selected hospitals are presented in table 3.4.

3.6 Data Analysis and Interpretation

Provided that a mix methodology was performed in this study, a constant system of analysis was required. Hence, both qualitative and quantitative procedures were conducted in order to interpret the information in the first and the final phases. The adopted procedures for data analysis are presented in the following sections.

3.6.1 Qualitative

For analyzing the gathered data in the phase one, a qualitative methodology was adopted. In order to follow a specific procedure, the framework suggested by Altinay & Paraskevas, 2015 was adopted. In fact, they have introduced the most widely accepted process for analyzing qualitative data. There were several stages involved.

Firstly, collected data from the recorded interview were transcribed based on the Hellstén (1998) method. An accurate content analysis was performed by the author and the help of a Korean language colleague for those parts discussed in Korean; this kind of analysis was previously used in healthcare and medical tourism (Heung et al., 2011; Jun, 2016). The entire emerging data were categories in the form of: keywords, concept, theme, pattern and description.

After receiving almost similar responses from the interviewees these stages were undertaken: “open coding, axial coding, selective coding and enfolding literature" in order to select and name the categories, combination based on overlap, searching for any integration of categories and codes, and finally check for the authenticity of the result with the literature, respectively. We searched for the correlation among all the emerged data and accordingly accomplished the initial classification into themes and categories. This stage is called ‘initial coding’ which aims to identify all the similarities and the differences among the categories. It was followed by the “refinement” through ‘cross-validation’ and also adding any required further coding after re-searching on the transcripts. Also the emerged concepts were compared with those introduced by secondary documents (Mehmetoglu & Altinay, 2006).

It is important to mention that 3 final interviews were conducted with the aim of confirm or affirm those coding emerged in previous interviews; it was continued until the data saturation was occurred.

Provided that there were logical co-relationship among the emerged categories and themes, a framework was developed based on the amalgamation of concepts.

Since Lincoln & Guba (1980) proposed the "trustworthiness" as an appropriate alternative for validity and reliability of results in qualitative analysis, in accordance to their procedure "constant comparison method" was used to ensure the trustworthiness. In this regards the process of developing the framework, was grounded on the logics of two theories, namely "Social Cognitive Theory" and "Intercultural Competence framework, Reflection Theory".

3.6.2 Quantitative

The qualitative analysis was followed by a pilot test on 32 questionnaires. After achieving the accepted reliability score, other questionnaires were distributed. Statistical analysis of this dissertation was conducted through employing SPSS for descriptive analysis and EFA; also "Lavvan" package from "R" software (Rosseel, 2011) for CFA according to the following method.

Characteristic of participants was conceptualized to socio-demographic characteristics, Job characteristics, basic qualifications and extra qualifications. The frequency of each category was calculated in number and percent and the demographic profile are presented separately.

Regarding data, the normality was analyzed in order to ensure the appropriateness of data for further analysis (Hair et al., 2010). Afterward, the reliability of the items' construct was tested through both confirmatory factor analysis (CFA) and exploratory factor analysis (EFA). Model fit indices were tested for each item; construct, group of construct and the whole model, CFI, RMSEA were the most important and reported in this study (Bollen1989; Hu and Bentler 1998). Also, Cronbach's alpha value showed the internal consistency of each construct (Nunnally, 1978).

3.6.3 Integrated Methodology

Although previous sections were categorized with different aims and they followed a specific procedure, a common goal was being followed by both of them. The procedure in both of them attempted to investigate on the determinant of an effective and appropriate delivery of CC in medical tourism. In this final stage, collected information will be compared and the final conclusion will be discussed based on the similarities and differences.

3.7 Ethical Considerations

It should be clarified in advance that while the self-assessment will lead to bias, particularly the "Social Desirability Bias" (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003), this study did not emphasized on "patients-tourists" as the sample group. It was due to very strike ethical consideration. These group of individuals are not ordinary patients (MTQA, 2017) since they are in their "most physically and emotionally vulnerable" situation (Ormond, 2012:189); being in such a situation they need their own privacy and it is not ethical to ask them to share their health related issues.

Since this study is going to be conducted in the hospitals and clinics, an ethical approval was achieved from each organization in advance (from the department of international relationship, International Clinic in hospital); however the questionnaire involved a form of consent to confirm the voluntary nature of participation.

This study, same as the other social research, is subjected to the risk of bias. In qualitative part the personal experience of researcher may influence the interpretation since the meaning differs based on individuals' attitudes. In quantitative section the research is subjected to the social desirability bias (Podsakoff et al., 2003). To tackle these problems, the author is tried to manage them in advance and by providing written consent in the questionnaire; also the problems will be mentioned as the limitation of study. It is essential to mention that the official authorization was confirmed before tending to start any research in each organization.

Chapter 4

RESULT

This chapter presents the output of this study. The barriers of medical tourism development in Korea, developed framework in the first phase and inquiry procedures in other phases are presented and a brief discussion is provided in order to clarify the given figures, tables and charts. Accordingly, the sections of this chapter are divided into the study phases.

4.1 Pre-Study

The initial part of this study aimed to explore the characteristic of medical tourism in South Korea. Adopting the procedure of Heung and his colleagues in Hong Kong (Heung et al., 2011), the results of that exploration were categorized in a framework which represents the current barriers of South Korea regarding medical tourism development.

It is clear that despite the exponential support of government into medical tourism industry (both financial and nonfinancial) in this country, still Korean medical tourism suffers from several limitations. “Lack of specialty and expertise among the health care practitioners in the scale of cross cultural communication”, is likely to be one of the most determinant factors to MT barriers. It is beside some other factors as for “promotional activities” and “action regulation”.

As previously noted the information for this stage was gathered through a systematic literature review and was followed / approved by sessions of in-depth interviews. We claim for the validity since all the interviewees were directly involved into the MT system and trend of Korea. It is essential to note that there was no differentiation between their notions and the "initial pool of barrier's concepts" found by literature review, but a confirmation. Provided that there were several similar factors mentioned in previous studies, it was possible to develop the final framework after facing with a high range of "saturation" among the interviewees' contents.

Chart 4.1 represents the identified core barriers of MT development in Korea. There are five main cores involved and each one entails a set of categories. The arrows show how those themes interact with each other.

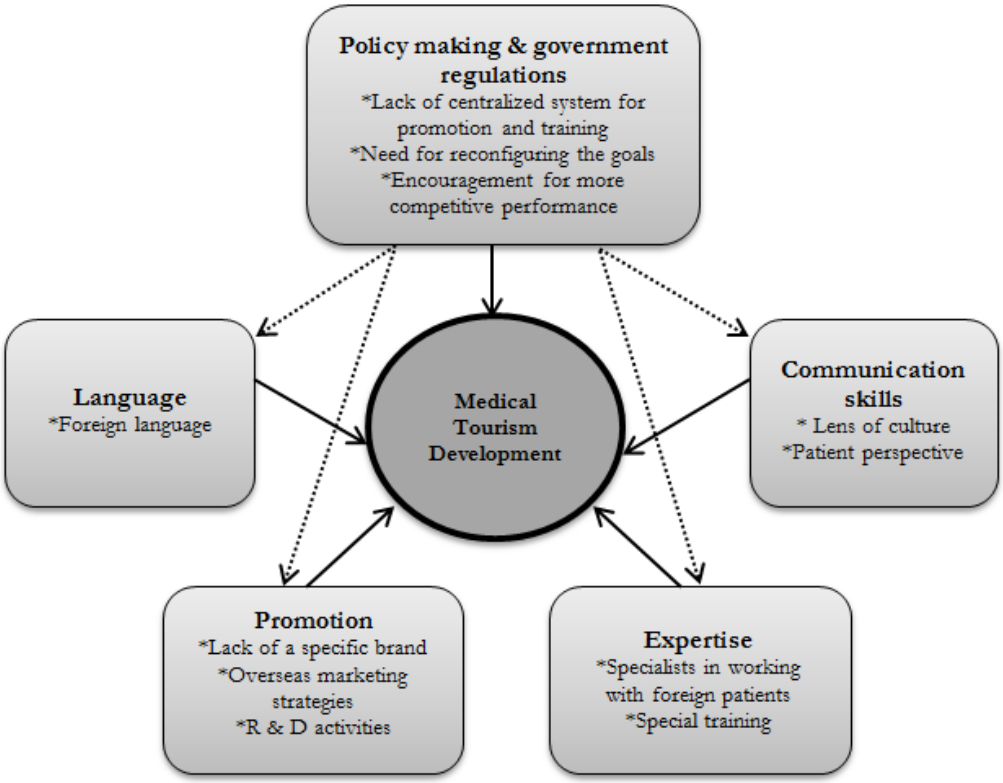

Figure 4.1: Framework of Barriers to Medical Tourism Development in South Korea

As sown by the solid arrows “policy making and government regulations, expertise, promotion, communication skills and language” have direct effect on the MT development in Korea, meanwhile, “policy making and government regulations” is likely to be the key barrier since it has influence on the other cores as well (shown with dashed arrows). A good example of this is the lack of “trained specialist”, in this regard there is an overlap between two cores of “policy making” and “expertise”, casing by the direct impact of “policy making” on the latter factor.

Among these barriers, “communication” was the most repeated factor, specifically during the interviews. It implies on providing a communication, based on the “patients’ own cultural perspective”

4.2 Study Phase 1 (Qualitative procedure)

The previous section led to selecting cultural competency of healthcare providers in medical tourism as the main content of this thesis. Accordingly, this phase aimed to explore the determinants of CC in the scope of medical tourism through a systematic literature review and semi-structured interviews.

The classified results of literature review process were presented in the second chapter. As shown there are several models of CC available in business and healthcare sector. The dimensions of CC in healthcare vary a lot based on different factors, and for two stablished instruments of CC evaluation (Campinha-Bacote, 2002; Schim et al., 2003; Thom & Tirado, 2006).

Acknowledging to this variation of CC determinants in healthcare, and considering the pre stablished frameworks and tools, we started to analyse the interviews contents. The results of the “content analysis” are presented in the following sections.

4.2.1 Themes and Classification

By conducting a 'content analysis' on the gathered information, the relevant themes, sub-themes and items were categorized. The initial version of this classification is not presented since it was amended in phase 2. The revised version of themes and categories are presented in Table 4.1. The classification was in accordance with the participants' opinion, after facing saturation on their notions and also approving the validity from the three final interviews.

To deliver a successful cultural competence service in MT, almost all respondents cited the importance of internal factors that implies on the characteristics of practitioners involved in MT as major factors. In addition, they mentioned the importance of some well-organized external support as the other strong factor, without them enhancing CC in their relationship with foreign patients would not be possible. Accordingly, through a blend of internal and external influential factors, a positive CC would be revealed through skilfulness. All these factors are classified by the associated theme and are discussed in the following sections. Also this classification was in accordance with the literature which is discussed in the next chapter.

The reason to classify the appropriate factors into 3 main themes of 'internal, external and outcome' was that, almost all respondents asserted to the novelty of MT. Accordingly, introducing cultural competence to this industry will lead to many ambiguities.

The following section provides a glance of participants' notions, presented based on the classified factors. It is noteworthy to mention that not all of the notions are

written here since there were huge ranges of information. Hence, only the most efficient notions are represented. Also, each notion can play a role for more than one theme or subtheme. A notion about the "desirability for training", for example, enrolled for both "motivation and desire" in internal factor and "training" in external factors.

4.2.1.1 Internal Factors

Four categories have been established as the theme of "internal factors". Those sub-themes were named "knowledge – attitude, motivation and desire, commitment and hard work". The theme of internal factors implies on the internal abilities that an individual should provide to enable him/her to be culturally competent in MT and the subcategories represent the unique abilities of the selected physician to be culturally competent. The participants mentioned to the importance of internal factors of individuals to deliver a CC service in MT.

> *"We can train individuals to treat foreign patients respectfully, but they should potentially have a suitable character to have a job in the medical tourism industry … we can just help them increase their awareness of their character and which parts of their character are important, especially in this job" (Participant No.1)*

Many respondents have mentioned to the desirability for training and improving their awareness:

> *"Foreign patients are different from Korean patients because each group of them has their specific needs, so their treatment should follow trends of cultural background of the patient ….it is the best strategy, it means we should prepare ourselves for the differences to be ready to react in different situations" (Participant No.9)*

> *"When a patient comes to our clinic we do not treat him/her as a foreign patient or Korean. …… Interviewer: Have you ever faced any problem?! Cultural conflict or dissatisfaction! ..... Respondent: --- I like to know about their cultures. It will enhance my abilities … I think we should get familiar with this aspects when we are studding*

in university or the Clinique provide training sessions" (Participant No.4)

A unique ability of "commitment and hard work" was emerged from the content analysis, owing to the novelty and difficulties of finding the right path and achieving goals in the treatment procedure of medical tourists.

> *"Having a positive attitude is the factor most required for doctors and employees who are working with foreign patients, afterward they should be familiar with patient's culture ... but they should continue to improve it and never give up. If we want to be successful in medical tourism, we should work hard and never stop .... Many sides of medical tourism are still dark, and without hardworking CC can never be achieved" (Participant No. 6)*

> *"Coordinators and interpreters help doctor and patients when they cannot talk easily in Korean, English or other language ... However, in those cased that doctors also try to be involved in the procedure, patients are more satisfy ... I regularly see this is happening, that patients feels better when doctors ask them about their religion or any family beliefs"(Participant No. 9)*

4.2.1.2 External factors

Two sub-categories of the "training system" and "organizational support" have been classified under the theme of "external factors". All nine respondents have noticed the importance of external support to deliver CC due to the novelty of medical tourism. They have mostly believed that healthcare providers are still not appropriately qualified to lead the procedure on their own. In addition, top managers are either confused in how to improve CC among their employees or are tending incorrectly and are not knowledgeable and skilful enough, accordingly, the following governmental strategic procedure has been suggested:

> *"Organizations and hospitals are not ready to provide support, they have certain ambitions for being globalized, but still are not convinced enough why they should spend money…. they are not aware how such investment would*

increase the number of patients and financial situation'...'there are different organizations with different aims, all are focusing on developing medical tourism in a logical manner … at the moment government is providing free training session with the aim to improve the quality of skills among employees whom their organization cannot afford to provide them a training system" (Participant No. 2)

Similarly a respondent (hospital international relation chief) was asked if he had provided or supported any training workshop for employees. He mentioned:

"I can understand the cultural differences and I try to control the conflicts during treatment or consultation sessions with foreign patient --- interviewer: what about the other doctors and employees? --- most of them can talk in another language, but about other abilities… it would be a good idea to provide them workshop sessions and train them" (Participant No. 5)

Also we found saturation on the need for training about the cultural differences:

"It is important to know about the culture of those countries where most of our patients are coming from … but we have no idea bout countries in middle East, we have many patients coming from Arab countries … although we know that they have some belief about Hijab, but my colleague and I have no idea how to treat them --- they need a specific privacy different from patients coming from the Japanese for example …" (Participant No. 3)

4.2.1.3 Skill

According to the interviewees' opinions, the successful delivery system of CC in the MT could not be guaranteed without a skilful and experienced team of providers. The term "Skilfulness" has been selected for this theme since it provides and reveals the effectiveness of previous themes.

According to the common belief among the respondents the final theme is defined in the following. The process of content analysis, lead us to define it as: "The abilities

which health practitioners either are enabled potentially or could achieve/enhance them by practicing, will represent their CC". The following comments made by Respondent No. 4 and 7 illustrate this.

> *"The ability to represent the cultural respect is a positive achievement for who are working with foreign patients because it can cover their shortage of knowledge and positive attitude ..... I don't mean those factors are not important, but for individuals without much experience this ability is an assistant as much as it is required for everyone in different positions" (Participant No.4)*

> *"...Inadequate communication skills can be seen in medical tourism industry of South Korea, many samples of conflicts can be seen ... having a positive attitude is very significant, but more important is to act. I mean caring with warm heart and showing their attention with body language, even the intonation when they are talking with foreign patients. It is an individual ability, but needs training and experience to be represented appropriately" (Participant No.7)*

> *"patients coming from western countries needs to be visited for half an hour --- it is right in their country, but here we do not have time, only five minutes is enough for check-up" (Participant No.4)*

4.2.2 Designed Framework

Based on the amalgamation of all categories and the main themes, a framework was designed to reveal the relationship among the contributors to deliver cultural competence in medical tourism. As shown in chart 4.1 the red arrows in the two main paths, show the delivery process that is influenced by internal factors from the right side and external factors from the left side. The final box also represents a skilfulness factor of healthcare practitioners, which is affected by two pre-mentioned factors.

This framework was developed based on the content analysis in the result and also in accordance with a deep literature review on the CC delivery framework in healthcare and business sector. The associated references were mentioned in chapter two and

are discussed in the following chapter. It is essential to consider that this framework is one package with all the involved themes.

Besides the opinion of participants, content analysis on the previous literature, assist the author to develop this framework. In this regards, the general trend was grounded based on two theories. “Social Cognitive Theory” is consisted of 3 main sections, and it implies on the direct interaction of those sections. The classification of the present framework was grounded on that of SCT theory. For “Intercultural Competence, Reflection Theory”, it is different since the classification of both frameworks is not similar, nevertheless, several items are similar during the process of delivery.

Figure 4.2: A Framework of Delivering Cultural Competence in Medical Tourism

Each variable is consisted of a number of items which create the associated variable. These items were converted to questions in phase 3 in order to design a questionnaire

(appendix 2) and to be tested by the participation of health practitioner involved in MT.

4.3 Phase 2 (Content Validity)

This phase aimed to provide a scientific confirmation on the themes and the framework developed in phase 1. Participants in this phase were selected among the pioneers and experts active academically in MT. They were kindly asked to confirm or comment on the clarity and relevance of the information; also, whether the items adhere to the attributed subcategory and its theme.

According to the arguments developed by the experts, the following issues needed to be noted or revised:

- To better clarify the requirement of additional aspects/model of cultural competency in medical tourism, comparing with healthcare
- Several revisions on the developed themes and items:
    - Corrections based on the existing academic literature on cultural competent in healthcare
    - Considering some subcategories as irrelevant for the selected theme
    - Corrections on the English editing

Accordingly to this suggestion, the reformations were accomplished, particularly in the scope of the items. Since, in phase 1, the author had developed a logical contribution based on the academic literature, and also the items and framework were connected to the previous theories and models in a logical trend, the expert were convinced after providing them the logical arguments.

Table 4.1 shows the final version of the developed themes and items after achieving the confirmation from the participants.

Table 4.1: Determinants to Deliver Efficient Cultural Competence in Medical Tourism

Theme	Sub-categories	Items
Internal factors * (IF)	Knowledge (KN)	-Considering CC as an ongoing process in MT -Intending to understand and assess the culture of patients -Being familiar with the verbal and non-verbal expression when interacting with foreign patients -Awareness of the differences for people from same cultural background -Being familiar with the importance of differences within a specific cultural group
	Attitude (AT)	-Being open-minded about the cultural differences between patients-providers -Respecting and valuing the beliefs of patients from different cultures -Positive attitude toward different/high expectation of foreign patients -Respecting people from different races group -Positive attitude toward cultural factors' application in MT
	Motivation and Desire (M & D)	-Motivated to interact with patients from culturally diverse group and beyond a specific national borders -Passionate to be called as an "experienced doctor in MT" -Passionate to learn and enhance their abilities -Seeking for training experience for interacting with foreign patients
	Commitment and Hardworking (C/HRW)	-Personal commitment to care for patients from culturally diverse group -Commitment to follow the required procedure presented by the organization (if available) -Investing the time and effort into improving knowledge and skills for interacting with foreign patients -Perceived commitment to assessing each patient individually according to their cultural and personal needs
External factors ** (EF)	Training System** (TS)	-The effect of providing a cultural diversity training -The effect of verbal and non-verbal training for interacting with overseas patients -The effect of attending practical workshops to learn about patient from different cultures
	Organizational Support *** (OS)	-The effect of encouraging doctors to foster and improve their CC -The effect of commitment to the development of a CC-trend environment -The effect of providing the opportunity of training, such as financial supports and research funds -The effect of a comprehensive policy for raising awareness, motivation and skill
Skillfulness (SKL)		-Ability to learn from, evaluate and analyse the situation for each patient (with culturally diverse background and different individual attitude) -Ability to be adoptable and flexible, in an intercultural situation -Ability to apply a blend of previously achieved knowledge and current situation in understanding patients preference -Ability to be involved with cultural and personal characteristic of patients -Ability to provide a service accordingly with patients' cultural and personal preferences -Ability to avoid generalization to stereotype groups -Intending to locate cultural needs of new patients

* Implies to the individual characteristic of healthcare practitioners involved in MT

** To be provided by relevant committees, ranging from government to private providers

***To be provided by the organizations that doctors are working for, manly a department in a hospital

4.4 Study Phase 3 (Quantitative Procedure)

4.4.1 Individual Characteristics

Individual characteristics are presented in 4 sections, namely: Socio-demographic characteristics, Job characteristics, basic qualifications and extra qualifications.

Respond rate was 49.53, as 743 questionnaires were received from 1500. As shown in table 4. 2 706 members filled in the questionnaire. The participation rate in centers No. 1 and 7 were higher than the others, which make sense based on number of doctors working in those hospitals in table 4.2 in previous chapter. Some of the participants ignored to fill in those parts for the individual characteristic, hence this group are mentioned as “missing”.

Table 4.2: Frequency analysis on the medical institute

Center	Frequency	Percent	Cumulative Percent
1	161	22.8	22.8
2	85	12.0	34.8
3	111	15.7	50.6
4	70	9.9	60.5
5	70	9.9	70.4
6	34	4.8	75.2
7	175	24.8	100.0
Total	706	100.0	

4.4.1.1 Socio-Demographic Characteristics

Age and gender have been considered for socio-demographic characteristics. For age, people between 31-40 years old had higher participation rate, 56.9 percent, followed by 41-50 (Table 4.3). Regarding gender, male participation was 3 times more than those of female, by the rate of 476 and 137, respectively (Table 4.4).

Table 4.3: Respond rate based on the age

Age	Frequency	Percent	Valid Percent	Cumulative Percent
20-30	45	6.4	7.4	7.4
31-40	346	49.0	56.9	64.3
41-50	158	22.4	26.0	90.3
Above 51	59	8.4	9.7	100.0
Missing	98	13.9	100.0	
Total	608	86.1		
Total	706	100.0		

Table 4.4: Respond rate based on the gender

Gender	Frequency	Percent	Valid Percent	Cumulative Percent
Female	137	19.4	22.3	22.3
Male	476	67.4	77.7	100.0
Total	613	86.8	100.0	
Missing	93	13.2		
Total	706	100.0		

4.4.1.2 Job characteristics

Type of the medical institute and years of experience were examined for Job characteristics. Type of institution was clear since it was classified before distributing the questionnaire among the hospitals. Table 4.5 shows the participation frequency of each institute. The mean of experience was 8.034 years with .5959 as the Standard Deviation.

4.4.1.3 Basic Qualifications

Speaking language, education and working experience out of Korea were examined for basic qualification. Korean and professional English speaker was highest with 70.4% (342 people). After that 75 doctors mentioned that they can speak in English with their patients, but not professional. It was followed by that group of doctors who can speak Korean, English and any other language such as Japanese, Chinese, Russian or others. This group accounted for 9.8 percent.

Table 4.5: participation frequency of each institute

Language	Frequency	Percent	Valid Percent	Cumulative Percent
Korean and not professional in English	75	10.6	15.4	15.4
Korean and professional English	342	48.4	70.4	85.8
More than 2 languages	69	9.8	14.2	100.0
Total	486	68.8	100.0	
Missing	220	31.2		
Total	706	100.0		

As for the experience of education or working out of Korea, 48.5% of participants had experience of studding out of Korea, either for a long time or a short period of training; meanwhile, 53.8% had experience of working out of Korea, mostly for a short period of time.

4.4.1.3 Extra Qualifications

Two questions examined the experience of training in medical tourism and non-clinical training, 14 and 27 percent of participants experienced medical tourism training and cultural competency training, respectively (Table 4.6).

Table 4.6: Frequency on the Experience of Extra Qualification Training

	Experience of MT Training	Experience of CC Training
Percent	14.3	27
Frequency	88	168
Missing	89	83

Moreover, general opinion of participants was examined through 2 main questions. Although it is not trustworthy enough to rely on the result of only two question, it is helpful to achieve this basic information about cultural competency. Participation rate in responding to these 2 questions was almost 100%. As presented in Table 4.7,

29.7 percent of doctors had no idea about the association between culture and medicine, and just over that rate, 30.9%, strongly supported this association.

Regarding their personal opinion as to whether they have cultural competency or not, most of the respondent had no idea with 42.6%, while 33.3 percent claimed for being CC.

Noteworthy is the fact that in both questions the level of unfamiliarity with the topic was low, and it is likely that the familiarity with cultural aspects in medicine is not a barrier, but the other hidden factors are playing a role.

Table 4.7: Frequency on the General Opinion about the CC and Medicine

		Somehow No	No	No Idea	Somehow Yes	Yes
I believe that there is an association between culture and medicine	*Percent*	2.7	12.2	**29.7**	24.5	**30.9**
	Frequency	19	86	210	173	218
I think that I have cultural competence for interaction with foreign patients	*Percent*	1.4	5.5	**42.6**	16.9	33.3
	Frequency	10	39	301	119	235

4.4.2 Analysis on the Structural Validity and Reliability

The aim of this phase was to test whether the developed variables in qualitative part are confirmed by the statistical analysis or not. On the other word whether the theoretical model will be explained based on the data or not. To address this goal exploratory factor analysis (EFA) and confirmatory factory analysis (CFA) were conducted. This phase was tested through R software and based on the Alfa Cronbach logic. The general reliability of all variables was 0.927 for all the 45 items asked in the questionnaire.

It was required in advance to test the appropriateness of sample size for factor analysis. In this regard two test of KMO and Bartlett's were conducted. As shown in table 4.8, amount of .939 for KMO shows that the sample size is appropriate and superb accepted for factor analysis since it is above 0.9 (Kaiser, 1974) and close to 1. Regarding the Bartlett's test, it is clear that there is a significant relationship among the data and it is possible to continue further analysis. It is believed that 300 respondents is likely to be probably adequate for factor analysis (Fiedel, 2005), which is lower than the participants in this study.

Table 4.8: KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.939
Bartlett's Test of Sphericity	Approx. Chi-Square	23,384.531
	df	990
	P value	.000

4.4.2.1 Pilot Test

At first a pilot study was conducted to check the construct of the questionnaire. According to the result of pilot-test, all the listed variables were indicated to be relevant. The reliability for 32 filled-in questionnaires was 0.788 and acceptable.

4.4.2.2 Exploratory Factor Analysis

In this section, all the variables were examined in the software without any pre assumption or specific classification. The extraction method was based on the Principal Component Analysis which caused extraction of 7 categories with Eigenvalues above 1, presented in table 4.9. It represents the association of items (latent variables) with the selected components (factor), and how many components were included in the questionnaire. It is clear from the result that without any theoretical model in mind, almost the entire developed model in phase 2 is confirmed.

It means that most of the tested variables in this phase, explained the classification of the theoretical variables, except the case of “knowledge” and “attitude”, two determinants of internal factor, it can be seen that two variables are likely to have a wide range of similarities in their associated items; also two items were classified to design a component, one from internal factors and the other from external factor.

Table 4.9: Rotated Component Matrix of Exploratory Factor Analysis

	Component						
	Skill	Attitude and Knowledge	Training	Organizational support	Commitment & Hardworking	Motivation and desire	-
S 8	.883	.147	.008	.047	.068	.064	.057
S 7	.869	.152	-.022	.027	.101	.115	.026
S4	.866	.134	.012	.049	.064	.030	.017
S 5	.862	.161	-.028	.028	-.003	.070	-.028
S 2	.860	.138	.046	.053	.087	.077	-.005
S 3	.858	.132	.027	.037	.067	.102	-.048
S 9	.854	.113	.020	.074	.076	.065	.022
S 6	.850	.131	-.019	.058	.087	.025	.043
S 10	.832	.124	.076	.019	.066	.067	.093
S 1	.812	.108	-.056	.063	.094	.090	.020
IF 7	.140	.804	.085	.089	.142	.090	.025
IF 2	-.192	-.800	-.099	-.088	-.087	-.078	.051
IF 5	.122	.798	.073	.115	.114	.060	.103
IF 4	.162	.778	.122	.116	.097	.123	-.008
IF 9	.140	.758	-.006	.143	.150	-.065	.066
IF 8	.054	.729	.088	.158	.186	.127	.207
IF 6	.117	.721	-.051	.008	.161	.061	-.030
IF 3	.269	.704	.011	.050	.002	.052	-.124
IF 12	.140	.669	-.005	.132	.152	-.009	.242
IF 11	-.035	.650	.013	.180	.276	-.006	.350
IF 10	.093	.646	.081	.097	.193	.058	.181
IF 1	.115	.418	.059	-.003	.148	.246	-.168
EF 4	.029	.059	.925	.013	.054	.008	-.024
EF 5	.014	.085	.921	.019	.038	-.002	.021
EF 6	.023	.106	.911	.040	.047	.009	.013
EF 3	-.017	.071	.907	-.006	.049	-.057	.016
EF 2	-.039	.020	.843	-.001	.106	-.108	.042
EF 9	.055	.130	-.003	.880	.133	.050	.013
EF 8	.116	.157	.028	.865	.079	.035	.060
EF 10	.037	.145	.005	.857	.122	.071	.045
EF 7	.074	.158	.004	.840	.138	.029	.048
EF 11	.049	.149	.049	.836	.034	.006	.050
IF 23	.095	.225	.088	.112	.731	.015	.238
IF 19	.053	.057	.134	.028	.683	.348	-.058
IF 21	.162	.334	.137	.096	.659	.214	.016
IF 20	.131	.231	-.102	.165	.640	.116	-.052
IF 24	-.178	-.374	-.157	-.117	-.638	-.167	.017
IF 22	.058	.263	.053	.116	.594	.034	.196
IF 18	.129	.113	-.034	.080	.058	.760	-.106
IF 16	.247	.061	.013	-.040	.130	.652	.165
IF 14	.024	.053	-.083	.066	.088	.643	-.053
IF 17	.112	.097	.032	.098	.242	.583	.491
IF 15	.076	.172	-.085	-.005	.212	.502	.243
IF 13	.056	.442	.026	.156	.105	.245	.645
EF 1	.167	.273	.389	.227	.362	-.032	.447

It is likely that both questions are focusing on a similar issue. Theoretically there were no support to this component and there in not any title given. On the other hand, it can be seen that both items have cross loading with their associated component developed in our classification.

It is noteworthy to mention that according to the new emerged classification in EFA, extra models were tested in CFA in order to examine the reliability of these new structures. The information of eigenvalues and variance of each determinant, presented in table 4.10, reveals that "skills" explain the largest amount of variance for the component of CC.

Table 4.10: Exploratory Factor Analysis

	Skill	Attitude/ Knowledge	Training	Organizational support	Commitment/Hard working	Motivation and desire	-
Eigen value	12.63	5.716	4.120	3.112	2.556	1.435	1.033
% of Variance	28.07	12.701	9.155	6.915	5.681	3.190	2.295

4.4.2.3 Confirmatory Factor Analysis

The final section of quantitative analysis, aimed to test the developed model through the procedure of confirmatory factor analysis. Accordingly, the model was introduced to software in order to test it based on the participants' opinion.

Since there were different sections/components of describing CC on medical tourism, the CFA was tested as follows: CFA for the components of "knowledge", "attitude", "hardworking", "motivation and desire"; also CFA for "internal factors". Afterward, CFA for "training", "organizational support" and for "external factor"; final model was tested for the "skillfulness". Also, new components suggested in EFA were tested to compare their reliability.

The correlation among the constructs was evaluated, for internal factors, external factors and the whole model. Table 4.11 shows the correlation coefficients between a single variable and every other variable. It is clear that the variable of “Attitude” is likely to have correlation with “knowledge”.

Table 4.11: Correlation matrix among constructs

correlation	KN.	AT.	M.D	C/HDW	TR	OS	SKL
KN.	1	0.957	0.438	0.585	0.18	0.316	0.391
AT.	0.957	1	0.476	0.661	0.178	0.388	0.311
M.D	0.438	0.476	1	0.625	0.024	0.263	0.345
C/HDW	0.585	0.661	0.625	1	0.236	0.361	0.342
TR	0.18	0.178	0.024	0.236	1	0.066	0.044
OS	0.316	0.388	0.263	0.361	0.066	1	0.174
SKL	0.391	0.311	0.345	0.342	0.044	0.174	1

In order to check the adequacy of the model several criteria were evaluated. The reliability of each variable was examined based on the Cronbach's alpha; the value above 0.7 was acceptable (Nunnally, 1967). Also the value of “Cronbach's alpha when the Item removes” shows the degree of influence by that item on the other, If the Cronbach's value change significantly by deleting that item, it implies that the associated item demand for a revision. Factor loading shows the influence of each item on the associated component; the more the value of factor loading is, the more the influence of that item is on the associated component. Being loaded above 0.4 was acceptable in this study. For the value of CFI (Confirmatory Fit Index) the value above 0.9, and for RMSEA (Root Mean Square Error of Approximation) the value below 0.1 (Hu & Bentler, 1999) was acceptable. For each component or model, the adequacy was rejected in the case that both of these values were out of the mentioned cut off. Also P-values below 0.5 were acceptable.

Following are a number of tables presenting these values for each component. Also, figures show the result of confirmatory factor analysis and how the items were loaded to that component.

Table 4.12: Confirmatory Factor Analysis for "knowledge"

abbreviation	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
Kn1	1.000	-	0.415	.879	-	0.985	0.067	0.859
Kn2	2.042	0.188	0.83	.815	0.000			
Kn3	1.677	0.161	0.718	.834	0.000			
Kn4	2.183	0.201	0.827	.818	0.000			
Kn5	2.155	0.199	0.813	.817	0.000			
Kn6	1.840	0.181	0.669	.842	0.000			

It can be seen from table 4.12 that all 6 factors contribute to construct "knowledge", the factor loading for item number 1 is close to cut off border and it can be revised to improve, nevertheless it is acceptable. The internal consistency of this construct is acceptable by 0.859; also both CFI and RMSEA indicate a good fit.

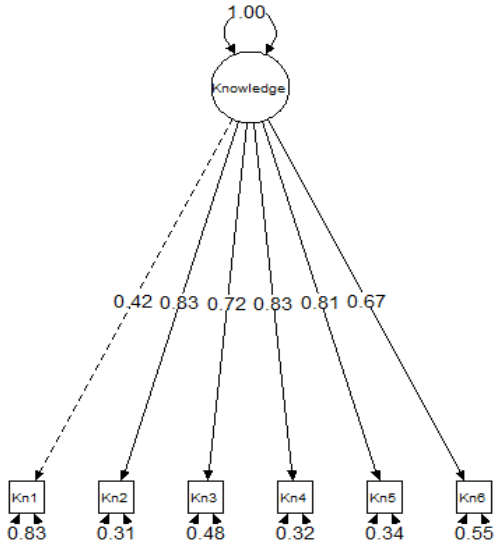

Figure 4.3: factor loading of "Knowledge"

For the component of “attitude”, the entire items indicated an acceptable factor loading, with a confirmed internal consistency. CFI and RMSEA indicated a close fit with the value of 0.974 and 0.092, respectively.

Table 4.13: Confirmatory Factor Analysis of “Attitude”

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
At1	1.000	-	0.791	.859	-	0.974	0.092	0.883
At2	0.982	0.044	0.798	.858	0.000			
At3	1.123	0.051	0.783	.858	0.000			
At4	0.921	0.050	0.674	.873	0.000			
At5	1.092	0.053	0.75	.861	0.000			
At6	1.124	0.058	0.711	.869	0.000			

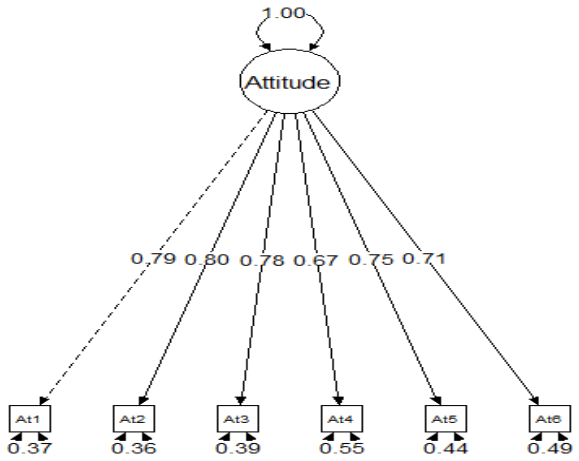

Figure 4.4: factor loading of “Attitude”

Regarding the factor of “motivation and desire” the internal consistency of items is weak (0.724). It might be because of deleting one item based on the EFA. Also the value of RMSEA and CFI suggested lack of fit. CFI is accepted, but it is preferred to be higher. RMSEA, meanwhile is out of the accepted cutoff value, nevertheless the general model can be supported.

Table 4.14: Confirmatory Factor Analysis of "Motivation and Desire"

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
M & D.2	0.767	0.089	0.533	.720	0.000	0.909	0.131	0.724
M & D.3	0.917	0.094	0.665	.706	0.000			
M & D.4	0.998	0.095	0.675	.695	0.000			
M & D.5	1.240	0.111	0.604	.666	0.000			
M & D.6	1.072	0.107	0.464	.694	0.000			

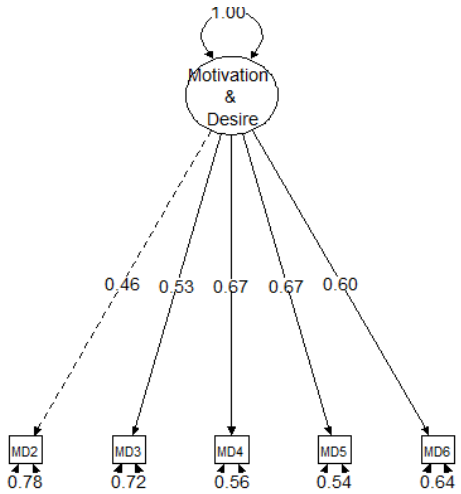

Figure 4.5: factor loading of "Motivation and Desire"

The same problem can be seen for "hardworking" as well. The CFI indicates a close model fit whereas RMSEA indicated lack of fit with the value of 0.13. Also the internal consistency of items is likely to be unacceptable. The same procedure of re-testing is required with deleting the items with the lowest factor loading.

Table 4.15: Confirmatory Factor Analysis of "Hardworking"

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
C/Hrw1	1.000	-	0.629	.820	-	0.93	0.13	0.836
C/Hrw 2	1.110	0.085	0.591	.821	0.000			
C/Hrw 3	1.543	0.095	0.787	.793	0.000			
C/Hrw 4	1.193	0.093	0.578	.826	0.000			
C/Hrw 5	1.305	0.086	0.712	.799	0.000			
C/Hrw 6	1.709	0.106	0.781	.796	0.000			

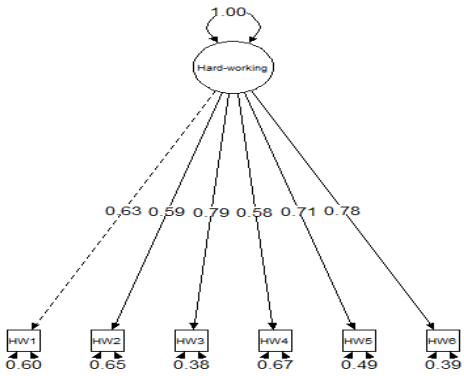

Figure 4.6: Factor loading of "Hardworking"

Acknowledging the internal strengths and weakness of each sub-factor, the accuracy of internal factor was evaluated. As presented in table 4-16, all factors are loaded with an acceptable value and the internal consistency is acceptable as well. The RMSEA indicates a close fit, while that of CFI is weak.

Although these values indicated that these items contribute to construct the internal factor, it is better to provide a revision on the items since they presented lack of fit in some cases.

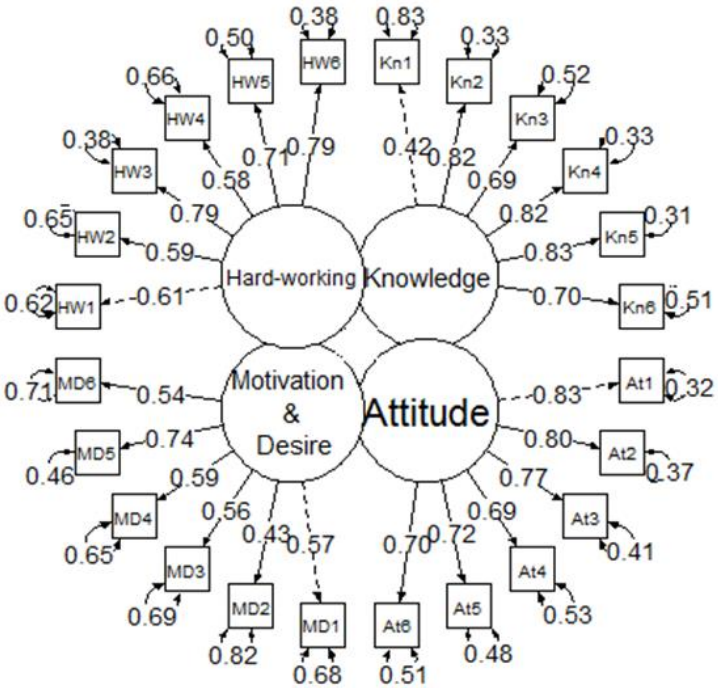

Figure 4.7: Factor loading of "Internal Factors"

Table 4.16: Confirmatory Factor Analysis of "Internal Factors"

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
Kn1	1.000	-	0.416	.854	-			
Kn2	2.020	0.182	0.82	.885	0.000			
Kn3	1.617	0.154	0.691	.851	0.000			
Kn4	2.159	0.195	0.817	.846	0.000			
Kn5	2.206	0.198	0.831	.845	0.000			
Kn6	1.919	0.182	0.697	.847	0.000			
At.7	1.000	-	0.825	.845	-			
At.8	0.939	0.038	0.796	.844	0.000			
At.9	1.058	0.045	0.771	.846	0.000			
At.10	0.890	0.044	0.685	.847	0.000			
At.11	1.004	0.047	0.72	.845	0.000			
At.12	1.060	0.051	0.7	.846	0.000	0.886	0.074	0.924
M & D.14	0.653	0.073	0.426	.858	0.000			
M & D.15	0.833	0.076	0.558	.854	0.000			
M & D.16	0.851	0.074	0.594	.856	0.000			
M & D.17	1.109	0.086	0.738	.852	0.000			
M & D.18	0.903	0.084	0.538	.856	0.000			
C/Hrw.19	1.000	-	0.613	.855	-			
C/Hrw.20	1.139	0.087	0.591	.852	0.000			
C/Hrw.21	1.586	0.098	0.789	.848	0.000			
C/Hrw.22	1.237	0.095	0.585	.850	0.000			
C/Hrw.23	1.327	0.089	0.706	.850	0.000			
C/Hrw.24	1.767	0.110	0.787	.892	0.000			

After testing all the internal factors, two external factors were evaluated. For "training", all the items can contribute in defining this variable (after deleting the first item, based on the result of EFA). The first item indicated a weak factor loading and also it is highly effective for Cronbach's alpha value; by deleting item number 1, this value increased from being unacceptable to strongly acceptable. The value of CFI indicates an appropriate fit, while that of RMSEA is above the acceptable cutoff.

Table 4.17: Confirmatory Factor Analysis of "Training"

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
TR.2	1.156	0.103	0.868	.864	0.000			
TR.3	1.274	0.111	0.923	.855	0.000			
TR.4	1.324	0.113	0.922	.854	0.000	0.959	0.205	0.948
TR.5	1.426	0.122	0.925	.849	0.000			
TR.6	1.392	0.119	0.783	.853	0.000			

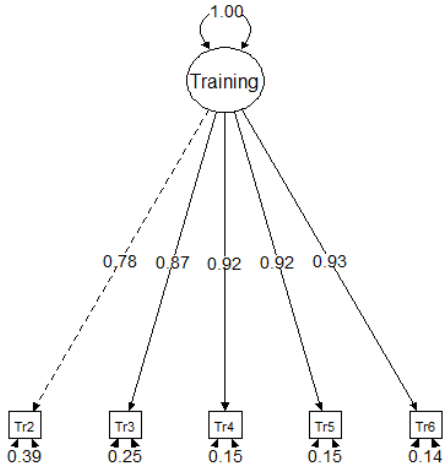

Figure 4.8: Factor loading of "Training"

The item of "organizational factor" is likely to fit, be acceptable and appropriate from different perspectives. The factor loading and models fits are good and the internal consistency is acceptable.

Table 4.18: Confirmatory Factor Analysis of "Organizational Support"

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
OS 1	1.000	-	0.834	.912	-	0.997	0.051	0.926
OS 2	1.056	0.037	0.869	.906	0.000			
OS 3	0.997	0.034	0.886	.903	0.000			
OS 4	0.948	0.034	0.854	.908	0.000			
OS 5	0.889	0.036	0.79	.919	0.000			

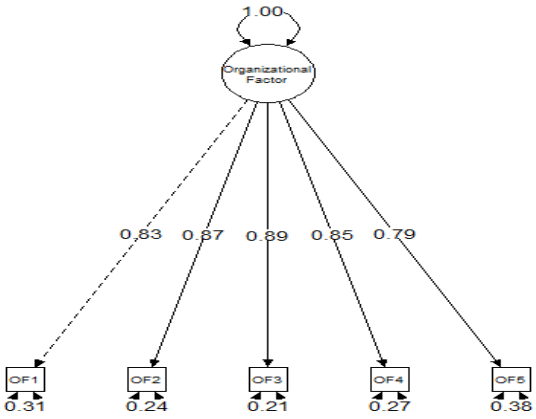

Figure 4.9: Factor loading of "Organizational support"

Table 4.19: Confirmatory Factor Analysis of "External Factors"

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
E.F.2	1.153	0.103	0.785	.842	0.000			
E.F.3	1.271	0.110	0.868	.840	0.000			
E.F.4	1.321	0.113	0.922	.838	0.000			
E.F.5	1.422	0.121	0.923	.837	0.000			
E.F.6	1.389	0.118	0.924	.836	0.000			
E.F.7	1.000	-	0.833	.840	-	0.958	0.095	0.852
E.F.8	1.059	0.037	0.869	.838	0.000			
E.F.9	1.997	0.034	0.886	.839	0.000			
E.F.10	1.950	0.034	0.853	.839	0.000			
E.F.11	0.894	0.036	0.792	.840	0.000			

Same as internal factors, a model was tested for external factors. It can be seen from table 4-19 that all the items contribute to define this factor; also the CFI and RMSEA values are acceptable with 0.958 and 0.095, respectively. But the internal consistency of items is below the cutoff and it needs a revision based on deleting those factors with a low value of factor loading.

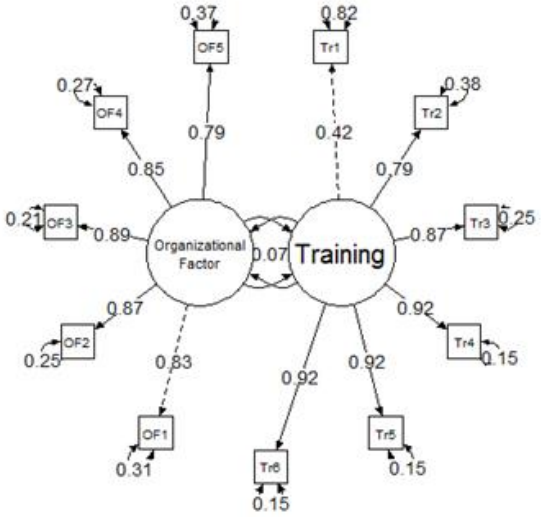

Figure 4.10: factor loading of "External factors"

In regard to the "skillfulness" the information from table 4-20, indicates the appropriateness of this factor from different perspectives, except for EMSEA value.

Table 4.20: Confirmatory Factor Analysis of “Skillfulness”

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
SKL 1	1.000	-	0.808	.963	-	0.943	0.131	0.965
SKL 2	1.052	0.038	0.864	.961	0.000			
SKL 3	1.043	0.038	0.857	.961	0.000			
SKL 4	0.998	0.036	0.862	.961	0.000			
SKL 5	1.058	0.039	0.858	.961	0.000			
SKL 6	0.975	0.036	0.854	.961	0.000			
SKL 7	1.017	0.035	0.889	.960	0.000			
SKL 8	1.014	0.034	0.896	.960	0.000			
SKL 9	0.989	0.036	0.859	.961	0.000			
SKL 10	0.981	0.038	0.828	.962	0.000			

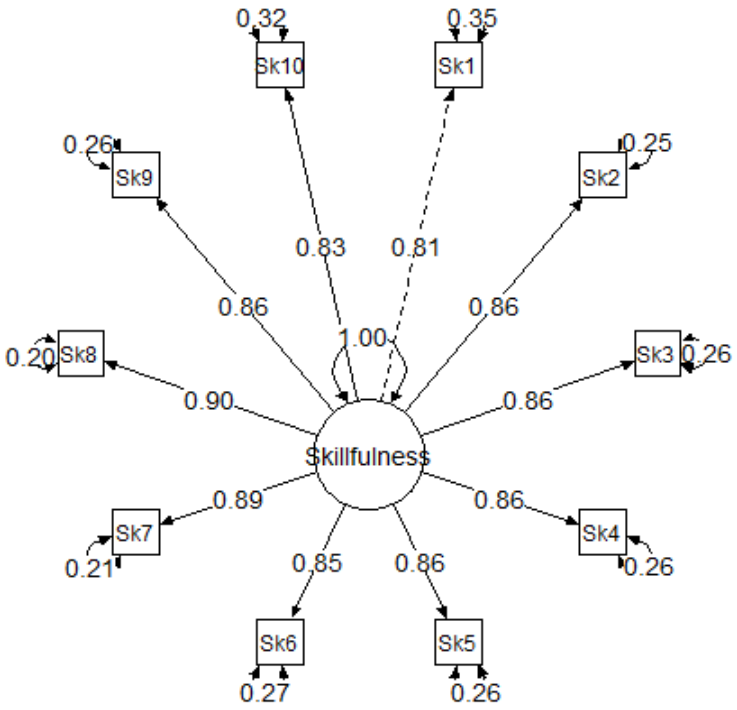

Figure 4.11: Factor loading of “Skillfulness”

Finally and taking all the above mentioned factors into account, the general model was tested with the aim of clarifying whether those factors contributes to constructing cultural competence as one component.

Table 4.21: Confirmatory Factor Analysis of the CC Model

	Estimate	Standard Error	Factor Loading	Cronbach's alpha when the Item removed	P Value	CFI	RMSEA	Cronbach's alpha of factor
Kn1	1.000	-	0.416	.936	-			
Kn2	1.967	0.117	0.82	.934	0.000			
Kn3	1.542	0.149	0.691	.935	0.000			
Kn4	2.093	0.188	0.817	.934	0.000			
Kn5	2.165	0.192	0.831	.934	0.000			
Kn6	1.903	0.177	0.697	.935	0.000			
At.7	2.113	-	0.825	.934	-			
At.8	1.946	0.038	0.796	.934	0.000			
At.9	2.195	0.045	0.771	.935	0.000	0.902	0.055	0.933
At.10	1.851	0.045	0.685	.935	0.000			
At.11	2.035	0.047	0.72	.935	0.000			
At.12	2.198	0.052	0.7	.935	0.000			
M & D.14	1.000	0.075	0.426	.938	0.000			
M & D.15	1.223	0.079	0.558	.937	0.000			
M & D.16	1.382	0.078	0.594	.937	0.000			
M & D.17	1.572	0.089	0.738	.936	0.000			
M & D.18	1.431	0.088	0.538	.937	0.000			
C/Hrw.19	1.000	-	0.613	.936	-			
C.Hrw.20	1.149	0.087	0.591	.936	0.000			
C/Hrw.21	1.599	0.098	0.789	.935	0.000			
C/Hrw.22	1.237	0.095	0.585	.936	0.000			
C/Hrw.23	1.314	0.088	0.706	.935	0.000			
C/Hrw.24	1.785	0.109	0.787	.934	0.000			
TR.2	1.000	0.103	0.788	.938	0.000			
TR.3	1.103	0.110	0.869	.937	0.000			
TR.4	1.147	0.113	0.921	.937	0.000			
TR.5	1.234	0.121	0.922	.937	0.000			
TR.6	1.207	0.118	0.923	.937	0.000			
OS.7	1.000	-	0.836	.936	-			
OS.8	1.061	0.037	0.868	.936	0.000			
OS.9	1.001	0.034	0.886	.936	0.000			
OS.10	0.950	0.034	0.852	.936	0.000			
OS.11	0.900	0.036	0.795	.936	0.000			
SKL 1	1.000	-	0.807	.936	-			
SKL 2	1.053	0.038	0.863	.935	0.000			
SKL 3	1.043	0.038	0.857	.935	0.000			
SKL 4	0.989	0.036	0.862	.935	0.000			
SKL 5	1.059	0.039	0.858	.936	0.000			
SKL 6	0.975	0.036	0.853	.935	0.000			
SKL 7	1.017	0.035	0.889	.935	0.000			
SKL 8	1.014	0.035	0.896	.935	0.000			
SKL 9	0.989	0.036	0.858	.935	0.000			
SKL 10	0.987	0.038	0.831	.935	0.000			

Table 4-21 reveals that the internal consistency of the questionnaire was acceptable and that all the tested items contribute to represent the delivery of CC; nevertheless, the value of CFI indicates weakness of model fit. Only the first item of knowledge was loaded close to the cutoff. The value of RMSEA fits well; acknowledging that there are some lacks of internal fit, presented in previous models, it is likely that some items demand for a revision.

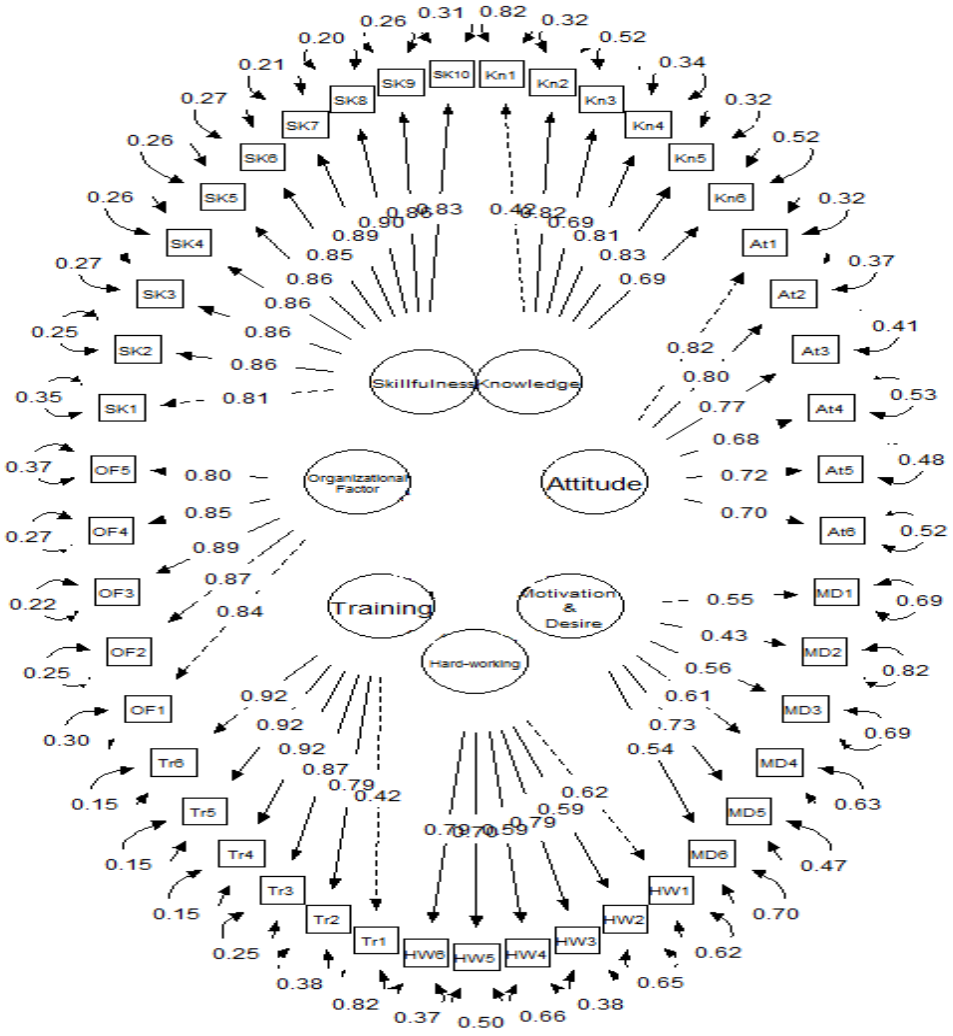

Figure 4.12: Factor loading of cultural competence delivery's components

4.4.2.4 Revised Models

Based on the result of EFA, two sub-factors of "Knowledge" and "Attitude" are similar and can be considered as one, also two items can build a construct. Accordingly the associated model was tested to compare the result of CFA between our classification and the suggested classification.

Combining "Knowledge" and "Attitude" resulted in accepted P-values, CFI 0.881 and RMSEA of 0.075; also the internal consistency was 0.924. Comparing to the previously tested models, there was not any differences between the correlated

values. Deleting two items in the final category showed CFI and RMSEA of 0.922 and 0.054, respectively, also the value of 0.933 for internal consistency.

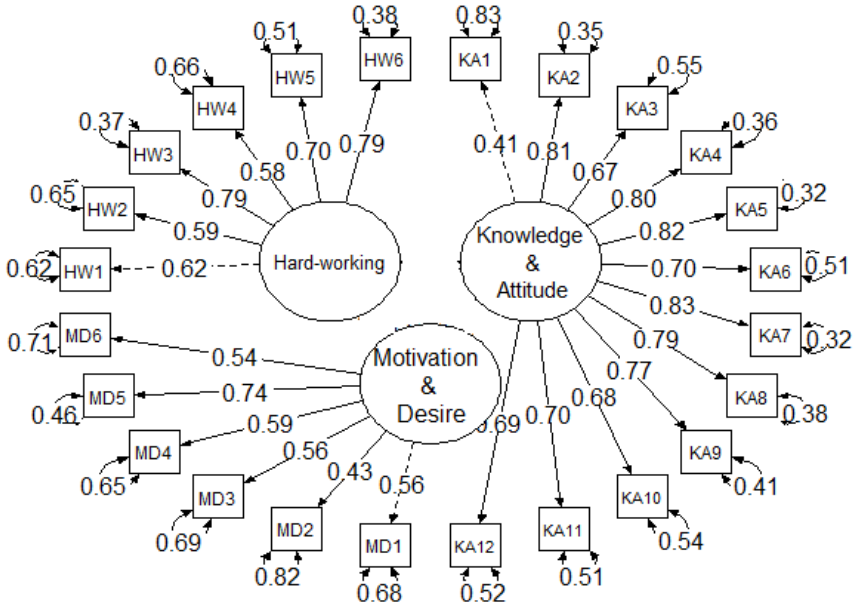

Figure 4.13: Confirmatory Factor Analysis for internal factor/ after revision

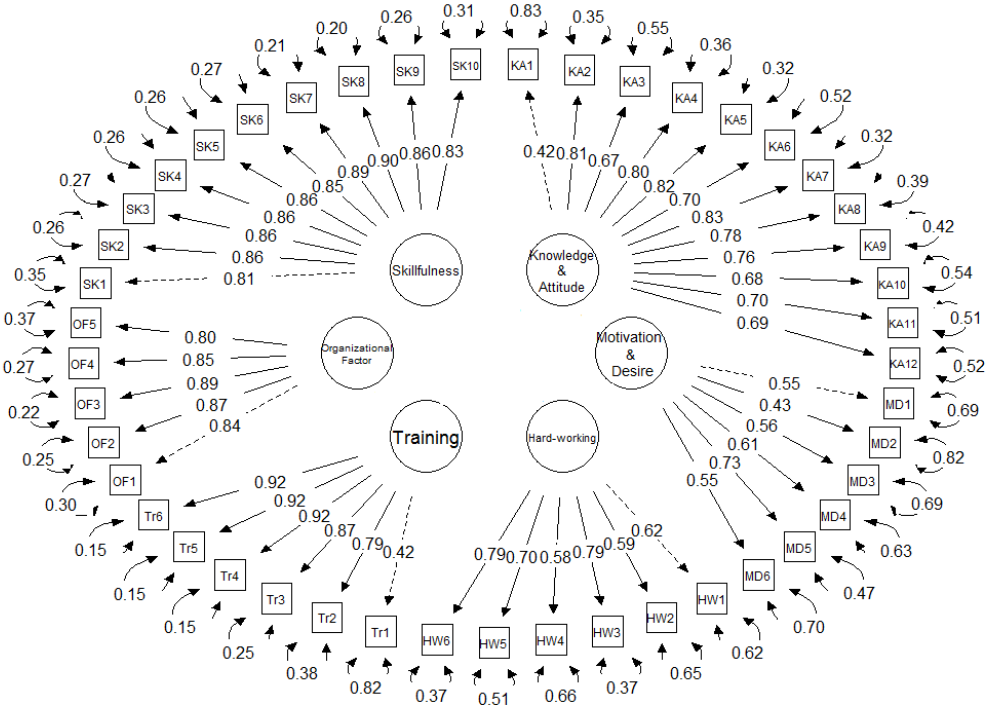

Figure 4.14: Confirmatory Factor Analysis for CC delivery/ after revision

Having these changes, the value of Alfa Cronbach's did not face any changes with the previous model (0.937), meanwhile the value of CFI experience a negligible change (0.899) and RMSEA remained the same. Figures 4.11 and 4.12 illustrate the factor loading for internal factor and CC delivery model, after revision.

4.4.2.5 Summary of Quantitative Results

Table 7.22 presents a summary on the above-mentioned information. Although the factor loading of items seems to be acceptable in most of the models, there is lack of fit for some of them. The general model can be considered as acceptable, and it means that the developed factors in qualitative phase are supported to be determinants of CC delivery, meanwhile there is a need for revision on some items; for instance the factor of "motivation and desire" was not supported and after deleting the first item and re-testing, it turned to be acceptable.

The idea of combination knowledge and attitude was tested and both are presented in table 4.22, the internal consistency will improve, but there in not significant changes on the final model.

Table 4.22: Confirmatory Factor Analysis result

	Model		Alfa
	CFI	RMSEA	
Knowledge	0.985	0.067	0.859
Attitude	0.974	0.092	0.883
Knowledge and attitude	0.881	0.075	0.924
Motivation and desire	0.909	0.131	0.724
Hardworking	0.93	0.13	0.836
Training	0.959	0.205	0.948
Organizational support	0.997	0.051	0.926
Skillfulness	0.943	0.131	0.965
Internal factors	0.886	0.074	0.924
External factor	0.958	0.095	0.852
Initial Model	0.902	0.059	0.937
Revised Model	0.92	0.055	0.933

4.5 Implication from Integrated Analysis

Integrating the gathered result from both qualitative and quantitate parts, shows several similarities and differences. This comparison shows the determinant of an appropriate and effective delivery of cultural competence.

Internal factor category faced several differences in two phases. From the top manager's point of view, it is essential for the doctors to be hard working in order to deliver CC in medical tourism industry. Likewise this issue was supported based on the data in quantitative part. Regarding the other internal factor, although it was believed that knowledge and attitude can be considered as two separated determinants, the data did not support it, by the way confirmed it in CFA. Also the most important differences between qualitative and quantitative phases was on the factor of "motivation and desire", it is likely that its items were not suitable enough to test the component, hence there is not enough evidence as to whether it can contribute to CC delivery of not.

The influence of external factors was highly accepted by both authorities and healthcare practitioners as well. It is likely that both training and the support from organizations can contribute to an efficient and effective delivery of CC. Nevertheless, it is essential to amend the items of training since there is not internal consistency with the present format.

In order to deliver an efficient CC to the patients, it was highly suggested by the authorities that healthcare providers should be skillful; likewise it was highly supported from the healthcare provider's perspective as well.

Finally the developed model in qualitative phase was supported based on the data, however several items should be amended and to improve the construct of this framework.

Chapter 5

DISCUSSION

This chapter provides a detailed discussion on the gathered results in previous sections; also a comparison with other literature provides more validity to the discussion. There were several similarities and differences with other literature, models and concepts in both tourism and healthcare sectors.

5.1 Medical Tourism in South Korea

The first study aimed to identify the barriers that contribute to the development of medical tourism in Korea. Comparing the developed framework in this study with previously introduced barriers in other countries, lead to several similarities. It is clear that despite the remarkable recent advances in infrastructure and facilities, also the exponential governmental support, still there are several barriers to MT development.

Policy making in governmental scale and communication skills in individual scale were identified as two main barriers in Korea; likewise other studies mentioned to these two factors as the key obstacles (Smith & Forgione, 2007; Ye, Yuen, Qiu, & Zhang, 2008). Nevertheless, it is noteworthy to mention that Korea does not have basic barriers in terms of the infrastructure and facilities, owing to the current facilities with an exponential high-quality. Furthermore, the medicine domain seems to be qualified in this country. Therefore, in most pre-stablished frameworks, quality and facilities plays a key role, while in Korea there is no obstacle in this scope.

Several factors have been suggested to be barriers of MT development in Hong Kong, Namely, promotion, expertise, policies, communication, and language (Heung et al., 2011). All these factors can be seen in Korea situation as well. Also, similar to the present thesis, other model developed to introduce the general procedure of MT, focused on "physician expertise" and "lack of regulation and training" as two main obstacles (Smith & Forgione, 2007). Also it was asserted that MT in South Korea is facing with the lack of a patient oriented service system (Kim et al., 2013).

The other barriers mentioned about the MT in Korea are "lack of insufficient promotion" in international scale and the shortage of "centralized administrative support system" (Kim et al., 2013). The latter factor is likely to be solved at the time we examined this study since a systematic supporting system is created by the government to protect healthcare providers from any potential problem(s), meanwhile the former factor is still one of the main barriers in this country.

Similar to this study the manner of medical staff was mentioned as a barrier, by a scholar, a study on competitive attributes of in Korea as an MT destination (Junio et al., 2017). It does not imply on this issue that the healthcare providers have a negative manner to patients; instead it means that although the Korean doctors try to be hospitalized, there is not enough awareness on how to deliver the hospitality, specifically in the scope of medical tourism. Also it is supported by a study carried out by Jun (2016) on the general characteristic of medical tourism in Korean. Among the factors identified by this author, there were two similar factors with this thesis as, "specializing in foreign patient care" and "English language service", with 50 and 94% repetition level, respectively (Jun, 2016).

Among the themes introduced in our result, there was a chief barrier of "communication skills". It could be considered as the lack of an effective and appropriate cultural competence which in result will enable doctors to offer a culturally appropriate service. Similarly, cultural competences in the organizational scale, besides global networking were introduced as the efficient factor for competition in medical tourism business (Jin, 2016). Since positive communication skills can be transferred through the ability of health practitioners (Alizadeh & Chavan, 2015; Campinha-Bacote, 2002), it is essential to enable them with the advantage of cultural competence. Although it is highly unlikely to offer an appropriate CC with the current level of linguistic and cross cultural unfamiliarity, it is not insurmountable. Nevertheless, it could not be happen unless providing a systematic policy from the top and assisting the healthcare providers to improve their awareness and ability by the government or organizations. Accordingly expert training seems to play a role in promotional policy.

The second key factor among the introduced barriers is the shortage on "global marketing strategies". It was similarly mentioned that Korea, is facing with the lack of a unique brand among the competitors (Geva, 2016; Kim et al., 2013). Therefore, it seems that government could not be successful in offering a specific competitive advantage despite providing both financial and non-financial supports. It is due to the fact that foreign patient can find the same quality of medical service in other countries with far better non clinical services.

The result revealed that the process of policy making by the government not only does play a significant role on medical tourism, but also it effect on the other barriers as well. It means that any changes on the governmental policy making will lead to

address the barriers in other arena. For instance supporting and encourage the organizations, providing valid information on global market or assigning the budget for R & D projects (Jin, 2016). It is also noteworthy to mention that although lately governmental organizations started to provide free training session and workshop with different topic related to MT, organization and individuals are not convinced enough to participate in those training sessions. Therefore it is essential to design a "persuasive policy" to encourage organizations and individuals for participation.

Finally it is important to mention that there are several other factors that influence externally. These factors have been introduced as "chance" in the Porter diamond model (Jin, 2016). For instance the effect of competitors, sudden changes in currency, political relationship, etc.

5.2 Framework of CC Delivery in Medical Tourism

The aim of this phase was to explore those factors with potential of contribution in delivering an appropriate CC, particularly on the Korean physicians-foreign patient's interaction. Based on the gathered information through semi-structured interview with authorities of MT in Korea, and also an accurate comparison with the available literature, a framework was developed with its associated items.

Although the availability of professional interpreter is critical in cross-cultural healthcare service and it could effect on the level of patients satisfaction (Lee, Batal, Maselli, & Kutner, 2002), still we cannot ignore the direct effect of doctors' impression on the patients. Hence, it is vital for the healthcare providers to be familiar with aspects of CC; in many cases, for example, interpreters are not available and they have to interact directly; also besides having interpreters, their

interaction provides trust in patients (Paez, Allen, Carson, & Cooper, 2008; Thom & Tirado, 2006) and will improve the quality of service (Limberger, 2010; Thom & Tirado, 2006). Patients prefer to have a doctor who spends a convenience amount of time for them, and has high interpersonal communication skills (Hill & Garner, 1991).

The classification of this framework is mostly similar to the categories that were previously presented (Echeverri et al., 2010). Also, the items (latent variables) of internal factors that have been repeated in same or different orders in other studies, some of them were developed specifically for healthcare sector (Balcazar et al., 2009; Deardorff, 2006; Doorenbos & Schim, 2004; Paez et al., 2008; Saha et al., 2013), except commitment and hardworking specifically developed in this study for the MT's demands. The mentioned items are also similar to other CC delivery models in healthcare (Campinha-Bacote, 2002; Doorenbos & Schim, 2004), except where the participants mentioned to a specific requirement of MT. for instance variable of 'commitment and hard work' which is believed to be essential in the scope of MT, because of its novelty and ambiguities for achieving to the goals and selecting the best path. Similarly, a practical research introduced CC as an organizational strategy and as an innovative policy, and the author believed that to be successful, CC should be linked with organizational performance as well (Weech-Maldonado et al., 2012); the significance of organizational climate has also been shown on the cross-cultural competence and performance of nurses (Lin, 2016), and only one study in healthcare mentioned to the importance of both external factors as training and organizational impact (Balcazar et al., 2009). The developed items in this study, are also consonant with those of "intercultural competence model" (Deardorff, 2006); in contrast, the item of 'curiosity and discovery' which is among the items of attitude in that model,

is introduced as a key sub-factor in this study, with a different name as “desire and motivation”.

In regard to internal factors and its latent variables, it is clear that the personal effort of health practitioners in the scope of MT would be potentially efficient. ‘Lens of culture’ (Helman, 2007) is a significant factor to differentiate the definitions, and MT is far from a ‘uniform’ developmental model around the world (Ormond, 2014). Accordingly, the offered service should be designed based on each individual and it requires specific internal abilities of providers. It is likely that only being aware or knowledgeable is not enough in MT and the healthcare providers should be passionate enough to improve their abilities and also have internal commitment to follow the path suggested by the general policy; moreover they should work hard to improve their abilities. Cultural competence has been considered an ‘ongoing process’ in previous studies (Kim-Godwin et al., 2001) which takes time and effort (Balcazar et al., 2009) but based on our knowledge not a single study has introduced commitment and hard work as a main dimension. Provided that MT is a domain full of ambiguities, and CC achievement demands effort, hardworking and commitment was emerged as a separate determinant.

The abovementioned reasons also implies on the critical role of the external factors. The importance of external factors in the context of CC has been practically conducted by being grounded on Social Cognitive Theory (Lin, 2016). Organizational support and cultural-diversity training, also, were introduced as the main dimensions of CC (Balcazar et al., 2009) and as an effective factor on the CC behavioral score (Doorenbos & Schim, 2004). A dearth of evidence has been reported for the association of CC training and healthcare quality (Price et al., 2005).

Nevertheless, providing CC training might positively influence awareness, knowledge, behavior and attitude (Smedley et al., 2003) and also skills (Beach et al., 2005) among health care providers. Given that healthcare providers involved in MT are faced with a wide ambiguities and even the associated hospitals are not aware enough how to enable their employees with CC, it is likely that a general policy by the government is required regarding both training (individual and organizational scale) and organizational support (for individuals working in different institute and for those institute as well). Talking about South Korea, the current situation of this country is a good example to reveal the importance of external factors; a general lack of awareness is obvious among the individuals who are working with foreign patients particularly, but lately the government is taking the main responsibilities to clarify the procedure and promote the level of cultural competency. The education of professionals in medical tourism has been announced among the measures to stimulate the industry in this country (Kim et al., 2013). Moreover, providing a service of training has been considered among seven key strategies to 'improve CC in the organization' (Delphin-Rittmon et al., 2013).

The last determinant of CC is known as 'skill' in different studies (Campinha-Bacote, 2002; Deardorff, 2006; Teal & Street, 2009), also two review articles mentioned 'skill' as one of the key factors of CC (Alizadeh & Chavan, 2015; Gozu et al., 2007). Also it is believed that cultural skills provide a connection between the roles required and direct care (Kim-Godwin et al., 2001). It means that through external factor the degree to which CC can be delivered more efficiently and effectively will be improved.

5.3 Discussion on the Tested Items

The aim of quantitative phase was to test whether the developed items can contribute to the delivery of CC, and whether each construct can describe CC. Several similarities and differences were achieved between the qualitative phase and this phase.

It is clear that the general framework is likely to have accuracy in defining the process of CC delivery; however, several revisions are required for the sub categories. Both internal and external factors were introduced as the determinants of CC in other studies (Balcazar et al., 2009; Doorenbos & Schim, 2004); meanwhile not a single study classified their importance as external factors. Although the internal consistency of external factors was not acceptable, it seems that providing revision on the items, specifically those of "training" will change the result.

Regarding the internal factors, it was highly unlikely that "motivation and desire" could contribute to present CC. It might be due to the weak fit index for this construct, or owing to the ethnic characteristic of the respondents, because this construct have been considered as the main contributors of CC in two well previously suggested models in healthcare (Balcazar et al., 2009; Campinha-Bacote, 2002). It is more likely that the problem comes from the construct since after deleting one item (the one that EFA considered it as a separated factor) the model fit index will be acceptable. On the other hand, although being hard-working was one of the main determinants in qualitative section, the result of CFA showed that there is a need for revision on the items construct, nevertheless the general significance of this construct for CC delivery was supported and the question of whether personal

attempt is determinant to deliver CC in an effective way, was addressed and supported positively.

The suggestion of EFA to combine two constructs of knowledge and attitude can be taken into account because the previous models in healthcare either did not considered it as a separate construct, or just include it into the items of knowledge (Kim-Godwin et al., 2001; Teal & Street, 2009). There is potential to support the combination of these two constructs with further studies. Regarding the final component, it involved one item from internal factor and the other one from external factor; logically there were no support to this component and it was better to delete them and conduct the test again.

Since the whole framework was supported, it is highly possible that after revision, better statistical result will appear. Also, re-testing this framework on different ethnic group may affect the result. Acknowledging the adequacy of all these constructs, and the degree to which their efficacy may differ, the developed framework was supported since it involves both internal characteristics and external factors which can direct individuals to be culturally competence. Similarly it was asserted that CC "is not a specific ability", instead it is a learned system or guideline (Kim-Godwin et al., 2001), and the ability of CC can potentially lead to positive outcomes (Saha et al., 2013). Therefore focusing on the healthcare workforce and increasing their CC is likely to be essential due to focusing on personal characteristics, supporting and training.

Chapter 6

CONCLUSION

This chapter presents the final conclusion on the previous chapters, including the aim of the study and how the results could address the aim; also it shows how comparing the results with other studies and facts could lead to the contribution of study.

The determinants of cultural competence were examined based on two categories of being delivered appropriately and effectively. The former was examined through the qualitative procedure, while the latter was tested by quantitative methodology. Accordingly, the conclusion of each section is presented and afterward, the general conclusion is provided on the whole gathered results and discussion.

6.1 Conclusion on the Qualitative Phase

In order to address the aim of exploring the determinant of CC delivery in MT, systematic literature review and semi structured interview was conducted in Seoul, South Korea.

The determinants of cultural competence delivery, from healthcare practitioners to foreign patients, were categorized into three main themes of internal factors, external factors, and skillfulness. A new dimension of commitment and hard work emerged based on the medical tourism novelty, in addition to knowledge, attitude, motivation, and desire. External factors namely, training system and organizational support were introduced as key determinant factors due to their impacts on the provider's

skillfulness for delivering their cultural competency, also improving their knowledge and awareness.

Acknowledging that MT is a new arena with a wide range of ambiguities, adding the determinant of "commitment and hard work" makes sense because it implies that an appropriate CC could not be achieved unless being committed to the general path suggested by the institution or government at large. It is likely that although "being acknowledged, having a positive attitude and being motivated" are efficient determinants that one should have to be culturally competent in the healthcare sector and medical tourism domain as well, it is essential to be hard-working specifically in the scope of medical tourism.

Doctors involved in medical tourism are required to either possess or gain initial characteristic mentioned in internal factors, but due to the uncertainty in this arena, training system and organizational support should facilitate a particular path to be followed by its providers who have a direct interaction with foreign patients. It is likely that adopting such a procedure could enable healthcare practitioners to improve their abilities to deliver cultural competence, appropriately. Moreover, appropriate and effective CC neither can be set individually nor achieved, and external factors are required in order to clarify the unfamiliar aspects in MT.

Based upon, in the scope of MT, the internal abilities of individuals are not the only significant determiner, but the role of external support is significant as well and without that personal awareness would not respond adequately to lead to successful skills; following this path, health practitioners should be committed to the designed policy and procedure, also work hard to enable themselves with the basics of CC.

Taking all these factors into account, it is likely that the healthcare practitioners involved in MT would be skillful enough to deliver CC appropriately.

6.2 Conclusion on Quantitative Phase

In general, the developed framework on delivering CC was supported; it means that for delivering an effective cultural competency for the doctors-patient interaction, it is suggested that providers should be knowledgeable enough, have positive attitude to other cultures and motivation to improve their abilities, also they are required to attempt more than the normal situation for health care because they need special abilities, these characteristics could not be achieved for those who are working for medical tourism industry, except by having special training and external supports.

The internal characteristics of health care practitioners are determinant in delivering an effective CC, for instance, it is likely that personal attempt is essential in medical tourism, besides knowledge and positive attitude to other cultures are essential. It might be due to the novelty of MT which resulted in a confusing arena for the workforce in regard to being culturally competence and a direction to deliver their CC. Therefore although the internal characteristics are essential to CC; revision is needed in order to solve the problem of model fit for some of them.

Nevertheless, it can be highly confirmed that training and external support are determinants of an effective CC delivery in MT. Although we did not test the level of variables' impression, the accuracy of the model implies on the importance of these variables on CC delivery. Also, the specific skillfulness is likely to play a key role in this process.

6.3 Integrated Conclusion

The results suggest that Korea is among the top destinations for MT since it provides high-quality infrastructure and medicine which is designed based on newly emerged technologies. Moreover, designing an accurate comprehensive plan, in advance, supports the details. Nevertheless, it seems that the number of foreign patients coming to Korea is facing a decreasing trend. The factors that hinder the development of MT in South Korea were identified. Among the identified barriers, "the lack of specialist on cross cultural communication" was one of the key factors, with centralized governmental support. It is likely that the government is moving forward to solve the barriers through "training" and providing some "encouraging plan". Yet, there is a shortage of cultural factors' consideration, while it is worthy enough to invest on this issue owing to the positive outcomes that will be provided. Also, it is likely that investment into cultural competence training and improvement programs will potentially act as an asset in South Korea, for both organizations and individuals involved in medical tourism.

Acknowledging the differences between the healthcare sector and medical tourism requirements, it was hypothesized that the determinants of CC demand for a specific revision for MT; and that an appropriate and effective way of communication will not occur unless all the requirements are carefully taken into account, in advance.

Similar to cross cultural communication in the healthcare sector, the level of knowledge and awareness about other cultures and the way of communication is essential in MT. It was developed in this study as "knowledge and attitude". Moreover, it seems that it is essential for healthcare providers to have personal

motivation and commitment, desire and hardworking. Since there might be new paths and directions for MT improvement, the providers should be motivated enough for that improvement, also the goal might not be addressed unless being committed to follow a right path and provide hard working for adapting and adopting those directions.

In this regards, although personal ability is exponentially essential in order to manage the situation individually, it regards to the MT ambiguities the demand for external factors seems logical. It does not imply to providing a clear path to be followed, instead training system will increase the awareness on the importance of cross cultural communication in MT and organizational will provide both financial and non-financial support to enable their doctors with CC or improve it.

Provided that the service will be offered through face to face interaction, the ability of healthcare providers is vital, to adopt those directions provided by training system and organization guidance, with the help of their own characteristics.

6.4 Implication

The implications of this thesis are categorized in two sections, similar to other research. These implications, including theoretical and practical, can be followed or adopted by the scholars and authorities, respectively; specifically those how are conducting their research regarding the supply side of medical tourism, the role of manpower in health care sector and cultural factor in medicine domain, also those researchers working on tourist services for MT, such as facilitators who are offering MT as a package to patients-customers; also the practical implications can assist those authorities who are leading a team of healthcare practitioners involved in MT,

managing medical institution and organizations offering service to foreign patient-customers, managers of a MT facilitator organization.

6.4.1 Theoretical Implication

Theoretically, this study contributes to a new classification of cultural competency dimensions and introduces "commitment and hard work" as a required dimension in the scope of medical tourism. Also, other determinants of CC are presented with unique items for MT.

The importance of external factors in achieving and enhancing CC resulted in considering training and organizational support as the key factors in delivering CC appropriately and effectively. Although training has been considered previously as the main determinants, it is first time to introduce external factors as the main contributor.

In terms of framework, this study contributes to the literature by introducing a model to deliver cultural competence in the scope of medical tourism. It represents the new dimensions and categorization to the knowledge of CC in tourism, healthcare, Madison and communication domains of research.

Finally, it is important to notion that "social cognitive theory" is likely to be applicable regarding cultural competence in medical tourism. It represents a well stablished classification or procedure in terms of offering service in a both side interaction, those researchers working in tourism service, healthcare service or communication can adopt this theory in their research to represent the delivery of cultural services in a supply and demand side interaction.

6.4.1 Practical Implication

In the current situation of South Korea, the most urgent requirement seems to be investments into workforce improvement in the scope of non-clinical abilities. It implies on the tourism service side of the MT rather than medicine. In order to offer and deliver an appropriate and effective CC to foreign patients, medical abilities and skills seems not to be enough by their own, instead it is required for the managers and authorities to consider the cross cultural communication in their planning.

The policy making and reconfiguring the goals could not be addressed successfully, unless conducting a research on the issue that what/how competitive advantage is being offered by the competitors. Several strategies are required in order to address and combat the mentioned barriers, such as governmental support for cultural training, cooperative efforts to encourage health practitioners to enhance their cultural and linguistic competence in international scale. Therefore, government should reconfigure the policy and planning, especially in terms of promotional supports. These kind of supports can take place in different domains of tourism services, medical services and those organizations working specifically on communication.

Practical implications mostly contribute to current situation of MT industry in South Korea. Nevertheless, the results enabled the authors to generalize the implications to a wider context and other countries as well. The authorities involved in MT are called to focus on the adequate strategies of CC training and support, it would assist the health practitioners to get familiar with their abilities and try to adopt the best strategies to interact with foreign patients-customers. Accordingly, health educators

should be willing to select effective communication and use multicultural and appropriate strategies.

From the tourism domain perspective, it is essential for the authorities to consider cross cultural communication skills in their planning. Although this study focused on the interaction between doctor and patients, it is essential to note that medical tourism is being offered as a package and is considered as an ecosystem, therefore this package could not be delivered/offered successfully unless with a comprehensive planning in both tourism and medicine side of this package. For instance it the responsibility of the facilitators to introduce the best doctor to their customers, not only based on their medical capabilities, but also the facilitator companies are required to find a doctor who is highly compatible with the cultural background of their patient-customers. It is also implies on those hotels or agencies in which the package of MT is being offered to the customers. The managers of such organizations are called to consider the importance of culturally appropriate service in their planning, since ignorance on this issue might potentially lead to dissatisfaction, also they can improve their service and distinguish their product with a competitive advantage, called cultural competency.

6.5 Limitation and Future Studies

Although determinants of CC delivery in medical tourism have been identified in this study, certain limitations should be noted. The small number of participants in qualitative phase was due to the difficulty to make an appointment and their busy schedules.

The process of conceptualization in this study was based on qualitative content analysis, which has a high risk of bias. However, it was theoretically grounded on previously mentioned models and two associated theories. Also, the inclusion of multiple dimensions enabled this study to capture a broad conceptualization of CC. Nevertheless, always there are other factors which play a key role and are ignored or forgotten from that particular study.

Since a novel framework of CC delivery was developed for MT, and not a single study has mentioned to these determinants, the results demand for more practical support. Although the construct validity of the measurement was established, it might only imply on the healthcare practitioners with Korean cultural background and test these measurements on other ethnic groups might provide a different result.

In addition, the finding that which characteristics will construct the internal factors is likely to demand being re-tested again. Nevertheless, the result of the construct validity shows that this framework with its suggested constructs is likely to address the goal of delivering an effective and appropriate CC in medical tourism.

It is noteworthy to mention that this study was at the risk of social desirability bias, because of a self-administered questionnaire on the data collection phase. On the other hand for data analysis procedure, some revision was suggested on the model which the second data collection did not perform due to time limitation.

Acknowledging these limitations, further studies are required to re-test the validity and reliability of the developed framework. Totally 6 characteristics were identified as the determinants of CC in MT. Other researchers are called to test this framework

in varying degrees of effectiveness and different combinations. Also, it is suggested to test the framework in other destinations of MT to evaluate whether any differences would be revealed due to geographical and cultural background variations. Due to ethical considerations, the opinion of foreign patients as the demand side has not been investigated in this study. However, further studies are required to reveal the cultural needs from the demand side perspective and it would also be beneficial to provide a comparison and to determine their basic needs.

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APPENDICES

Appendix A: Expert Opinion

Dear prof. .....,
I am conducting my research on "*Cultural Competence in Medical tourism*". In this context, I aimed to investigate on "*a framework that represents the entire contributors to deliver cultural competence in medical tourism*".
Follows are Table 1 and Figure 1, which have been developed based on a deep literature review and interviewing (the result has been submitted). A brief description is provided here:

> "*Cultural factors are introduced as highly influential in the context of medical tourism, but due to the novelty of medical tourism, the cultural competency would be achieved neither individually nor by external factors solely. However, a system with entire introduced factors is required to deliver an appropriate and effective cultural competence*"

Since my research is going to be continued in this context**, <u>at this phase I need the expert opinion</u>** involved academically in medical tourism (Social science and Healthcare).
Accordingly, I would like to cordially solicit you to review and comment on the survey developed in the first phase of my study. **<u>I would like to ask you to confirm or comment on its clarity and relevance; If the items adhere to the attributed subcategory and its theme.</u>**
I appreciate your input very much; your invaluable cooperation would be of high importance for me to reach my goals.

Ladan Rokni

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Figure. 1: A framework for delivering cultural competence in medical tourism service

Table 1: recognized effective factors and dimensions to deliver a cultural competence in medical tourism

Theme	Sub-categories	Items
Internal factors	Knowledge	• Being familiar with the culture, beliefs and needs of the targeted group of patients • Being aware of the importance of cultural factors in MT • Familiarity with cultural factors, both verbal and non-verbal • Considering CC as an ongoing process
	Attitude	• Being open mind about the differences • Respecting the beliefs of patient from different culture • Considering culture as a strength not barrier • Having a positive attitude beyond the discrimination • Ability to understand the issues with the 'Lenz' of patients
	Motivation and Desire	• Passion for learning and enhancing the abilities • Motivated to be a specialist in MT • Motivated to interact with foreign patients • Try to control any feeling of discrimination
	Commitment and Hardworking	• Being committed to follow the procedure • Ability to put a concerted effort • Ability to understand the difficulties (as a new-stablished arena)
External factors	Training System	• To provide specific training in the scope of MT • To provide cultural diversity training • Verbal and non-verbal training for interacting with overseas patients • To provide practical training, including workshops
	Organization Support	• Encouraging the employees to improve their CC abilities • Commitment to provide facilities for achieving their goal in practice • To provide the opportunity of training to their employees • To design a comprehensive system for raising the awareness, motivation and skill
Surefire factors	Skill and Experience	• Ability to react properly at the time of cultural conflict • Ability to learn and analyze the situation individually for every patient / avoid generalization • Ability to apply a blend of their knowledge and immediately faced situation to provide an appropriate service • Ability for being involved beyond the only clinical service • Being comfortable and adoptability

Comments:

Appendix B: Questionnaire

Questionnaire	**QR. No: ……. Hospt. Code** …

Dear respondent

I am conducting a survey for my research on "*Cultural Competence in Medical Tourism";* I would greatly appreciate if you could assist me by answering this questionnaire.

This survey will take less than 15 minutes and the information will be used only for academic purposes. The results will be kept strictly confidential and your identity will not be revealed.

I appreciate your input very much; your invaluable cooperation would be of high importance for me to reach my goals.

Ladan Rokni
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……
…

Please read the following statements and check the box that best describes how you feel about the statement.

1- I believe that there are personal differences for people within a specific cultural group (Coming from other countries).

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

2- Patients coming from a specific country will think and act alike.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

3- I believe that it **is essential** to consider **personal differences** rather than cross-cultural differences while working with the patient coming from another country for treatment.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

4- I think that I am familiar with the **verbal and non-verbal expression** when interacting with foreign patients coming from other countries.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

5- I intend to understand or assess the cultures of patients during the consultation.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

6- I know it is important **NOT** to have stereotype to a certain cultural group, if I want to improve my ability on working with foreign patients.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

7- I try to **withhold** judgment about the patients coming from a different cultural background.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

8- I believe that all patients should be treated **with respect**, regardless their cultural background.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

9- I think that we should **value** the personal differences and belief of patient from a different culture.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

10- I think that I should address the specific needs of patients, no matter if it is unfamiliar to me.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

11- Considering the personal needs of each patient, enable me to offer better service to the patient based on their preference.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

12- I do not have stereotypes regarding a certain cultural group.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

13- I am motivated by the desire to interact with patients from culturally diverse groups.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

14- I am keen on interacting with non-Korean patients and in any other language.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

15- I am motivated by the desire for being called as "an experienced doctor in medical tourism".

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

16- I am keen on learning about the cultural background of my foreign patients.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

17- I have a desire to enhance my skills and abilities to interact with foreign patients.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

18- I seek out new training for interacting with foreign patients from a different cultural group.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

19- I think that I have the commitment to care for patients from a culturally diverse group.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

20- I feel committed to follow the procedure and policy presented by the organization I am working for (in the case that it is available).

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

21- I think that I am capable enough to invest my time and effort into **gaining/improving knowledge and skills** for an effective interaction with foreign patients.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

22- I feel that in order to improve my "non-clinical service skills" for effective interaction with foreign patients, I need to learn more and more continuously.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

23- I feel that I have **personal commitment** to learn from each patient's cultural background and assess their case accordingly.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

24- There is an end-position to be an expert in interaction with foreign patients.

Strongly agree ☐ Agree ☐ Average ☐ Disagree ☐ Strongly disagree ☐

1- No matter how I am skillful in my field, I need to be trained for interaction with a new trend of incoming foreign patients.

Strongly agree Agree Average Disagree Strongly disagree

2- I feel that by attending training courses related to "medical tourism" I will gain more knowledge.

Strongly agree Agree Average Disagree Strongly disagree

3- I feel that attending training courses will improve my verbal and non-verbal skills for interaction with foreign patients.

Strongly agree Agree Average Disagree Strongly disagree

4- Training workshops can, generally, improve my awareness of the **cultural needs** of foreign patients.

Strongly agree Agree Average Disagree Strongly disagree

5- I need to be trained about the constructive methods that in accordance I can understand and realize the **non-clinical** preferences of foreign patients.

Strongly agree Agree Average Disagree Strongly disagree

6- Attending informative courses about non-clinical service can direct my work better for interacting with patients from a different culture.

Strongly agree Agree Average Disagree Strongly disagree

7- I feel more motivated to improve my cultural competency if I feel that I am being encouraged by the hospital/organization I am working in.

Strongly agree Agree Average Disagree Strongly disagree

8- I think that I **cannot** develop my cultural competency **if there is not** any clear policy provided by the organization I am working in.

Strongly agree Agree Average Disagree Strongly disagree

9- If I am being supported by my organization, both financially and non-financially, I will attend the training courses to improve my non-clinical service skills, in the case that I am being supported,.

Strongly agree Agree Average Disagree Strongly disagree

10- If I feel that there is a path (provided by my hospital) for treating foreign patients, I will follow those procedures because I feel it will improve my skills.

Strongly agree Agree Average Disagree Strongly disagree

11- **Being encouraged** by the hospital or organization I am working for, I will put more effort to improve my non-clinical service skills.

Strongly agree Agree Average Disagree Strongly disagree

The following personal information will be kept confidential

Year of birth	….....
Gender	Female Male
Which language(s) can you talk in?	Korean English Chinese Japanese Russian Other….
Do you have experience of studding out of Korea?	Yes No
Do you have experience of working out of Korea?	Yes No
How many years do you have experience in this position?	For how long ……
Type of institution you working in	Hospital or Clinic // governmental or private
Do you have experience of training in Medical Tourism?	-No -Yes
Do you have experience of non-clinical training in Medical tourism?	- No -Yes

1- I try to avoid generalization to a specific stereotype when I interact with a patient coming from a different culture.

Strongly agree Agree Average Disagree Strongly disagree

2- I generally tend to address the cultural and personal needs of my foreign patients, **no matter** if it seems unfamiliar to me.

Strongly agree Agree Average Disagree Strongly disagree

3- I think that I have the ability to provide a service accordingly with patients' preferences.

Strongly agree Agree Average Disagree Strongly disagree

4- If I face a cultural clash problem with my patient, I feel that **I can easily solve it**.

Strongly agree Agree Average Disagree Strongly disagree

5- I can **adapt** myself to a new and unfamiliar situation that I might be faced when interacting with patients from a culturally different background.

Strongly agree Agree Average Disagree Strongly disagree

6- I have the ability to **apply** my previously learnt knowledge (non-clinical) in order to understand patients' preferences.

Strongly agree Agree Average Disagree Strongly disagree

7- I have the ability to learn from, evaluate and analyze the situation **for each patient**, separately.

Strongly agree Agree Average Disagree Strongly disagree

8- I tend to get involved with the **personal preferences** of patients coming from a different cultural background.

Strongly agree Agree Average Disagree Strongly disagree

9- I have the ability to provide a service which is a mix of both **clinical and non-clinical skills**.

Strongly agree Agree Average Disagree Strongly disagree

10- I am able to understand the personal attitudes of patients immediately and **provide them a service accordingly**.

Strongly agree Agree Average Disagree Strongly disagree

* I believe that there is an association between culture and medicine.

Yes Somehow yes I have no idea No Somehow no

**I think that I have cultural competence for interaction with foreign patients.

Yes Somehow yes I have no idea No Somehow no

Thank You for your Valuable Contribution