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The salient place brand factor(s) influencing medical tourism to South Africa

Abstract

Regardless of its importance to the global tourism economy, there is still limited academic inquiry relating to Africa within the context of non-traditional tourism typologies, such as medical tourism. This article contributes to the broader understanding of the potential factors influencing medical tourism by extending place branding theory to the decision-making process of tourists within the South African medical tourism context. The present study examines the place brand - medical tourism nexus using data generated from a sample of n=233 conveniently sampled inbound tourists. Exploratory Factor and Multiple Regression Analyses were applied to the data. It emerged that South Africa's socio-cultural place brand was found to be a statistically significant heuristic cue, positively influencing medical tourism to the country, pivoting aspects such as the country's cultural practices and colonial heritage, as some of the key considerations in the decision making the process of tourists when considering South Africa as a medical tourism destination. Critically, the results associate medical tourism with the socio-cultural profile of South Africa, through the place brand as a heuristic cue for information symmetry. The study enriches both place branding and medical tourism discourse by providing empirical evidence of the nexus between the two constructs. Practically, destination marketers are provided with critical insights into tourist perspectives, and it is recommended that African governments and medical tourism facilitators collaborate to develop a nation branding theory-based framework as a decision support model for proactively managing and communicating the image of South Africa as a medical tourism destination.

Key words: medical tourism; place brand; socio-cultural factors; South Africa

1. Introduction

Medical Tourism (MT) is considered a niche form of tourism (Mathijsen, 2019; Schalber & Peters, 2012; Suess, Baloglu, & Busser, 2018), particularly within the African context. A key characteristic of MT as a tourism typology is that, in the broadest sense, it involves the consumer (the tourist) travelling outside [of] their "natural health care jurisdiction" (Cook, 2010, p. 140), in order to consume healthcare services abroad (Kušen, 2011; Suess et al., 2018). Globally, an estimated 16 million people travelled abroad for MT purposes in 2017, resulting in up to US$72 billion in tourist spending (Dalen & Aplert, 2019). In total, the global MT industry is worth between an estimated US$439 billion and US$635 billion (Dalen & Aplert, 2019; Ridderstaat, Singh, & DeMicco, 2019), contributing immensely to the socio-economic growth of MT destinations through Gross Domestic Product (GDP) growth, employment creation and infrastructure development (Bacus, 2010; Beladi, Chao, Ee, & Hollas, 2019). Due to the palpable fiscal benefits associated with MT for major medical services, export countries such as India, Malaysia, Dubai, Mexico, Korea and Brazil have stimulated intensified competition for medical tourists (MTs) within the global tourism market (Beladi et al., 2019; Cook, 2010; Dalen & Aplert, 2019; Heung, Kucukista, & Song, 2010; Lee, Han, & Lockyer, 2012).

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As competitive forces within the MT market intensify, MT destinations are increasingly acknowledging the value of proactively promoting their countries as attractive MT destinations (Ebrahim & Ganguli, 2019). This suggests that tourists are subjected to vast amounts of information about MT destinations, making them more circumspect in their decisions (Hwang, Lee, & Kang, 2018; Iajevardi, 2016). Thus, insights into how tourists assimilate and synthesise information about MT destinations within the context of their decision-making process have become critical to both the competitiveness of MT destinations and the success of the marketing communications efforts of destination marketers (Ebrahim & Ganguli, 2019; Han & Hyun, 2014; Lunt et al., 2012). One global marketing communication strategy, place branding, is increasingly being applied to build competitiveness within the tourism context. Place branding is a highly specialised marketing communication approach that has become synonymous with contemporary tourism marketing (Browning & de Oliveira, 2017; Foroudi, Gupta, Kitchen, Foroudi, & Nguyen, 2016). To this end, a proliferation of studies (Almeyda-Ibáñez & George, 2017a; Saberi, Paris, & Marochi, 2018; Zenker, Braun, & Petersen, 2017) has been examining the role of the place brand (PB) in tourist decision-making.

However, while studies on tourism and PB proliferate, there is a distinct scarcity of studies relating to MTs. A distinct paucity of academic inquiry exists concerning the general MT discourse within the African context, particularly when comparisons are made with empirical evidence from Asia, Latin America and Europe. The literature (Suess et al., 2018; Ye, Yuen, Qiu, & Zhang, 2008; Zolfagharian, Rajamma, Naderi, & Torkzadeh, 2018) seems to acknowledge that a significant proportion of previous studies has also primarily focused on the demand-side factors motivating MTs to seek medical services abroad. Although the country-specific supply-side factors related to MT have been the subject of limited academic inquiry (Connell, 2013; Lee et al., 2012; Smith & Forgione, 2007), there has been far less empirical research into the influence of broader generic PB factors.

There is some complexity associated with exploring the decision-making process of tourists and MTs in particular (Mathijsen, 2019). To this end, Connell (2013) argues for more concerted efforts to understand the decision-making process associated with MT - critiquing some studies for attempting to model MTs' behaviour based on anecdotal evidence and sweeping assumptions about causal relationships, while omitting critical variables. Pedagogically, there is an observable skewness of contemporary studies concerning developed countries, implying a natural pivoting of MT theory from that perspective (Connell, 2013; Cook, 2010). Relatedly, Ridderstaat et al. (2019) point to a significant deficiency in inferential research within the MT discourse, critiquing the abundance of descriptive studies, while highlighting the dearth of studies examining cause and effect relationships in particular. This holds in the case of South Africa, where an extensive review of MT literature related to MT in Africa observes the prevalence of qualitative cases, reviews and secondary data-based studies (Mogaka, Mupara, Mashaba-Thompson, & Tsoka-Gwengweni, 2017). Thus, this study aimed to consider the potential relationship between the cognitive (South Africa's PB in the minds of tourists) and the conative (intention to (re) visit South Africa) behaviour of tourists relating to South Africa as a MT destination.

To the best of the researchers' knowledge, this is a first attempt at exploring the relationship between the PB and MT within the African context. With this in mind, this study seeks to make three key contributions. First, it seeks to enrich the extent of the literature by conducting inferential research, which examines the PB-MT nexus within the South African context. Secondly, the present study supplements the contemporary literature by extending the PB theory to MT-related decision-making behaviour, thereby contributing to theory development within the general tourism discourse. Thirdly, by investigating the case of South Africa, it presents a unique African perspective on MT, thus generating Afro-centric empirical evidence to support MT theory.

2. Review of the literature

2.1. Medical tourism in South Africa

South Africa is an emerging and highly reputable MT destination within the global tourism market (Lunt et al., 2012; PwC, 2018), and is synonymous with world-class medical procedures in cosmetic surgery (breast augmentations), invasive medical procedures such as organ transplants and for conditions such as cancer (Bacus, 2010; Crush, Chikanda, & Maswikwa, 2012; Haarhof & Mokoena, 2017; PwC, 2018). According to a Forbes Africa report, South Africa is a Top 20 MT destination, offering MTs cost savings of between 25% and 40% on specific procedures. Ironically, South African Tourism (2018) estimates that MTs accounted for an average of only 1.63% of the total estimated 35.2 million tourist arrivals in South Africa between 2015 and 2017 – with the most substantial proportion originating from African countries (Zimbabwe, Botswana, Lesotho).

South Africa is considered an archetypical MT destination, offering the discerning MTs various world-class medical services in conjunction with leisure tourism-oriented products, such as game parks, blue flag beaches and unique flora and fauna as well as an inimitable African cultural richness (Crush et al., 2012; Haarhof & Mokoena, 2017; Hemana, 2014). South Africa attracts MTs from Britain, Western Europe and the United States of America. They benefit from cost savings of up to 800% for some procedures, due in part to currency exchange rates (Nicolaides, 2011). PwC (2018) reports that within the BRICS group of nations, the average Chinese MT spends up to 65.9 days in South Africa, while the average Indian MT spends up to 31 days in South Africa, taking advantage of both South Africa's affordable medical services and leisure activities.

Research on MT within the South African context is still at the embryonic stage. A detailed online search found limited evidence-based studies that are related to MT in South Africa. Most MT studies relating to South Africa focus on specific MT services, offering specialised medical procedures (Mogaka et al., 2017). For the present study, research on MT within the South African context was undertaken from the supply-side perspective. The research was based on affordability and availability of services as well as the legal, technological, quality and reputational aspects of MT in South Africa.

2.2. The characterisation and motivational factors associated with medical tourism

The literature consulted (Connell, 2013; Cook, 2010; Gosh & Mandal, 2018) acknowledges the lack of census regarding a universal definition of MT. Voigt et al. (2010, p. 36) posit that MT involves tourists whose "…primary motive is to treat or cure a medical condition by taking advantage of medical intervention services away from their usual place of residence while typically combining this journey with a vacation or tourism elements in the conventional sense." Relatedly, the World Tourism Organization and European Travel Commission (WTO/ETC, 2018, page or paragraph or section - because you are quoting) characterise medical tourism as "…a type of tourism activity which involves the use of evidence-based medical healing resources and services (both invasive and non-invasive). This may include diagnosis, treatment, cure, prevention and rehabilitation." While the definition of MT may be wide-ranging within the contemporary literature, the preceding characterisations, highlight some generic elements that may be associated with characterising MT:

- MT relates to tourist activities motivated by the need to cure, treat, rehabilitate or prevent against medical conditions

- MT involves the consumption of medical services in a foreign location

- MT encompasses wellness-related activities that may not necessarily or exclusively be for remedy purposes

- MT may also involve vacation or tourist activities on the same visit.

Recent tourism trends suggest that developing countries are becoming key exporters of medical care services, with developed countries being the primary source markets for Asian and South American MT destinations (Alsharif, Labonté, & Lu, 2010; Connell, 2013; Iajevardi, 2016; Lee et al., 2012). Contemporary literature suggests that tourists are influenced and motivated by a myriad of factors when engaging in medical tourism activities. The demand-side factors include: associated cost savings of medical treatment outside the home country (Mathijsen, 2019), the expediency of receiving treatment abroad compared their own country (Vashua, Masrib, & Hueic, 2018), limited insurance coverage (Dalen & Aplert, 2019) and the unavailability of expertise in the home country (Rokni, Avci, & Park, 2017). The supply-side factors include the facilitation of affordable medical services (Lee et al., 2012); availability of world-class health facilities (Smith & Forgione, 2007); amenable health-related laws (Hemana, 2014); technologically advanced health systems (Iajevardi, 2016); availability of high-quality medical services (Heung et al., 2010) and reputable medical staff (Musa, Doshi, Wong, & Thirumoorthy, 2012). The present study focuses on the broader extrinsic location-specific (supply-side) PB factors considered by tourists when deciding to engage in MT activities. This has mostly been a neglected area of academic inquiry within the MT context (Vashua et al., 2018).

2.3. Place brands within the medical tourism context

Place brands are a heuristic cue that tourists utilise to derive meaning, surmise destination information and create a perception of a tourism destination (Almeyda-Ibáñez & George, 2017a; Kim & Lee, 2018; Stiglitz, 2017). To this end, the subsequent image(s) arising from the tourists' interaction with the brand of a place has /have been found to exert substantial influence on the cognitive, affective and conative behaviour of tourists (Byon & Zhang, 2009; Lindblom, Lindblom, Lehtonen, & Wechtler, 2017; Sharma & Nayak, 2019). Place branding and the influence of PBs on the decision-making process of tourists is grounded in Nation Branding Theory (NBT). The key tenants of NBT suggest that national governments manage their images and reputations amongst external stakeholders, such as tourists (Browning & de Oliveira, 2017; Dinnie, 2012; Kotsi, Balakrishnan, Michael, & Ramsoy, 2018), by communicating and interacting through the six distinct channels of governance, people, exports, investment and immigration, culture and heritage and tourism dimensions of PB (Dinnie, 2008).

By interacting with one or more of these brand dimensions, consumers of a place and its outputs, form their perceptions of the place, which in turn influence their cognitive and affective behaviour (Dinnie, 2008; Kavaratzis & Kalandides, 2015). The PB may thus be characterised as,

> "…a network of associations in the place consumers' mind based on the visual, verbal, and behavioural expression of a place, which is embodied through the aims, communication, values, and the general culture of the place's stakeholders and the overall place design," (Zenker & Braun, 2010, p.4).

As evidenced by definition, the distinction between place and destination brands lies in the pervasiveness of their respective scopes (Zenker et al., 2017). While destination brands are a specialised tourism-oriented construct, PBs supersede destination brands as they are broader in scope, encompassing and communicating myriad pieces of information focused on the overall image of the place (Browning & de Oliveira, 2017; Saberi et al., 2018). To this end, Smith and Forgione (2007) argue that MT destinations are susceptible to the influence of country-specific subjective factors and that the first step in

the decision-making process for the MTs is the selection of the destination followed by the medical and touristic considerations. However, in the absence of data to support this assertion, subsequent studies cited by Connell (2013) have, to a larger extent disputed the notion that the destination of the MT is a primary consideration. For instance, Heung et al., (2010) observe that some MT models (Caballero-Danell & Mugomba, 2007) consider distribution channels (operators, intermediaries and the word-of-mouth) as being paramount to MT decision-making, while some models (Ye, Yuen, Qiu, & Zhang, 2008) view medical factors as taking precedence to destination factors within the decision-making process of MTs.

However, Rokni et al. (2017) point to the lack of a specific brand as being detrimental to attractiveness and promotion of MT destinations. To this end, some studies have found strong correlations between destination brands and MT. For instance, in the case of Iran, Iajevardi (2016) found that the destination brand image had the most significant influence on the perceived quality of the country as a MT destination. In the case of Malaysia, Vashua et al. (2018) observed a nexus between the behaviour (based on cognitive and affective attributes) of MTs and the brand image of the MT destination, advancing the notion that MTs utilise destination brand images as heuristic cues in their evaluations of MT destinations. No empirical evidence-based study exploring the influence of South Africa's PB on the decision-making process of MTs or the PB-MT nexus seems to be readily available. Despite the admittedly sparse evidence of the influence of destination brands within the MT context, it is reasonable to hypothesise the potential effect of South Africa's PB on MT to South Africa.

2.4. Hypothesis formulation

It was hypothesised that the potential PB factors influencing MT to South Africa included five of the traditional NBT elements (*Tourism, Governance, Immigration, Culture and Heritage and People*) but excluded *Exports*. The influence of two novel factors: *Marketing* and *Negative Events,* was also taken into consideration within the South African MT context. For the present study, the PB factors are operationalised as follows (Dinnie, 2008; Matiza & Oni, 2014; Žugić & Konatar, 2017):

• *Tourism*: the attractiveness of the country to visitors based on its profile of tourism offerings

• *Governance*: pervasive perceptions of the government of the country and its actions

• *Immigration*: perceptions of the country's socio-economic conditions, its openness to foreign visitors, as well as its attractiveness as a place to live, work or study

• *Culture and heritage*: perceptions of the country based on its traditions, history, values and achievements

• *People*: the stereotypical views held of the citizens of a country as individuals or employees

• *Marketing*: the perceptions of the country based on the proactive information symmetry of the comparative and competitive advantages associated with the country

• *Negative events*: contemporary events that may occur and have a deleterious effect on how the country is perceived

Each PB factor is briefly discussed and hypothesised in the context of MT. As with other conventional forms of tourism, the manner of governance of a country/place influences tourist decision-making. To this end, Smith and Forgione (2007) posit that some country-specific factors, such as regulatory policy-making, political climate and economic conditions, influence choice of country for MT. Citing the case of Malaysia, Seow, Choong, Moorthy, and Chan (2017) identify law enforcement as a governance factor that is a critical antecedent for tourists to the country in order to mitigate the

perceived risk when considering Malaysia for MT. Marketing has also traditionally been an aspect of destination promotion within the MT context, by providing information symmetry for tourists on value for money, product spectrum and competitive advantages to mitigate risk aversion within the MT context (Ebrahim & Ganguli, 2019; Njiru, 2016). Countries such as Hong Kong[1], South Africa and Singapore have been identified as cases where marketing plays an increasingly important role in attracting tourists to these countries for MT. Marketing aspects, such as value for money of tourism products and a positive perception of the place (Lee et al., 2012), attractive uniqueness of the place for tourism (Heung et al., 2010), sufficient information (Rokni et al., 2017), as well as positive marketing/advertising of the place (Han & Hyun, 2014) are critical marketing-oriented place brand elements within the MT context. Therefore, the following hypotheses were formulated,

H_1: *South Africa's Governance influences medical tourism to South Africa*

H_2: *South Africa's Marketing influences medical tourism to South Africa*

MT is typically associated with a combination of medical interventions and conventional leisure tourism activities (Cook, 2010; Schalber & Peters, 2012). To this end, Heung et al., (2010) and Kušen (2011) importantly describe MT within the integrated context of both medical and leisure tourism aspects. Lee et al. (2012) support this view, positing that MT involves the integration of tourism-oriented activities within the medical treatment context. Tourism aspects such as leisure, fun and relaxation are characteristic of MT as well as a significant factor in the competitiveness of MT destinations (Gosh & Mandal, 2018; Loubeau, 2009; Zolfagharian et al., 2018). Relatedly, the perceived risks associated with the tourism destination are critical to the destination choice of MTs. Negative events, such as social unrest (Connell, 2013) and perennial droughts, such as experienced in Cape Town South Africa (Caboz, 2017) have been found to influence decision-making by MTs. Therefore, the following hypotheses were formulated,

H_3: *South Africa's Tourism influences medical tourism to South Africa*

H_4: *South Africa's Negative events influence medical tourism to South Africa*

The WTO/ETC (2018) identify the native cultural traditions and heritage of MT destinations as key demand and motivation factors for MTs. Relatedly, Mathijsen (2019) recognises tourist affinity to the cultural norms of the MT destination as being influential to tourist decision-making. While Connell (2013) suggests that potential cultural barriers (language, tolerance, values, religion) influence the mobility of MTs. He also suggests that the entrepreneurial nature and innovativeness of the people involved in MT may be critical to MTs' decision-making (Connell, 2013). Additionally, Heung et al., (2010) observe that the preservation of cultural practices, such as the use of traditional medicines, also impacts on MT to particular countries. Relatedly, Rokni et al. (2017) concede that while the cultural tolerance of the local population to cultural diversity and change also influences the decision-making process of MTs, it is even more so the friendliness and helpfulness of the people of the MT destination that draws these visitors (Das & Mukherjee, 2016). Governments are also increasingly becoming involved in the improvement of the quality of life of their citizens by providing critical public resources such a health-related infrastructure, albeit for the additional benefit of tourists (Beladi et al., 2019; Han & Hyun, 2014). Visa policy and the ease of immigration visa procedures in granting MT-related visas to MTs are also considered to be critical to the facilitation of MT (Cook, 2010). Therefore, the following hypotheses were formulated,

H_5: *South Africa's Culture and Heritage influences medical tourism to South Africa*

H_6: *South Africa's People influence medical tourism to South Africa*

H_7: *South Africa's Immigration policy influences medical tourism to South Africa*

3. Methodology

3.1. Sample and method

The primary data for the present study were generated from a broad survey conducted in South Africa between the 6th and the 9th of November 2018. Survey participants were drawn from a non-probable convenient sample of inbound tourists who had visited one of South Africa's major tourist attractions, Table Mountain, in Cape Town. A team of 4 trained fieldworkers approached tourists awaiting to ascend in the aerial cable car (at the bottom station) and to descend (at the top station) of Table Mountain. They were invited to complete the survey on the PB factors influencing their perceptions of South Africa as a tourism destination. The survey also solicited information on tourists' current and future travel motives across four tourism typologies – business, leisure, nature-based and medical tourism, respectively. Of the 400 self-administered surveys distributed and completed, *n*=233 were suitable for analysis within the context of the present study. The respondent profile was made up of respondents who: were mostly male (55.1%); aged between the 20 and 40 years of age (57%); possessed a bachelor's degree (39.4%); were employed in the private sector (54.9%) and were first-time visitors to South Africa (75.0%). Most of the respondents originated from the United Kingdom (19.4%), Germany (15.4%), the United States of America (11.6%) and the Netherlands (7.1%), respectively.

The survey instrument measured the operationalised latent PB factors based on observed variables from previous studies summarised in Table 1.

Table 1
Observed variables literature sources

Latent variable	Previous study sources of the items
Tourism	Jeuring & Haartsen (2017); Reitsamer & Brunner-Sperdin (2017); Yang, Fik, & Zhang (2013); Stepchenkova, Schichkova, Kim, & Rykhtik (2018)
Governance	Biagi & Detotto (2014); Lv & Xu (2017); Moyo & Zirambi (2013); Poprawe (2015); Steyn & van Vuuren (2016)
Immigration	Moufakkir (2014); Reitsamer & Brunner-Sperdin (2017); Stepchenkova et al. (2018)
Culture and heritage	Das & Mukherjee (2016); Shaw, Saayman & Saayman (2012); Wang, Kim, & Agrusa, (2018)
People	Das and Mukherjee (2016); Shaw et al. (2012); Vengesayi, Mavondo, and Reisinger (2009); Wang, Kim, and Agrusa (2018)
Marketing	Albu (2013); Huong & Lee (2017); McCabe (2014); Reitsamer & Brunner-Sperdin (2017); Saayman, Krugell, & Saayman (2016)
Negative events	Buckley & Mossaz (2015); Ferreira & Perks (2016); Fuchs & Reichel (2006); Muboko, Gandwi, Muposhi, & Tarakani (2016); Park & Reisinger (2010)

Table 1 summarises the literature sources for the items included in the questionnaire. The independent variable items are provided in Appendix 1. The influence of the items was measured on a 5-point Likert scale with responses ranging from 1 ("not at all influential") to 5 ("extremely influential"). The dependant variable, MT, was measured on a scale that solicited the current travel and future travel motives of tourists across four tourism typologies. For MT, travel motives were measured by the following items:

access to affordable medical treatment (Mathijsen, 2019); availability of world-class health facilities (Smith & Forgione, 2007); relatively relaxed health laws (Hemana, 2014); possession of technologically advanced health systems (Iajevardi, 2016); access to high-quality medical services (Nicolaides, 2011); and the availability of reputable medical doctors in South Africa (Musa et al., 2012). The factors constituting the MT construct were measured on a 5-point Likert scale with responses ranging from 1 ("strongly disagree") to 5 ("strongly agree").

3.2. Data analyses

The results of the Kaiser-Meyer-Olkin (KMO) (>.50) and Bartlett's Test of Sphericity (p<.001) respectively confirmed the factorability of the data. The data related to the factors influencing MT to South Africa reported a KMO of .854, and a statistically significant Bartlett's Test of Sphericity (χ^2 (946) = 4,919.853, p<.001). Relatedly, data for MT within the South African context reported a KMO of .854, and a statistically significant Bartlett's Test of Sphericity (χ^2 (210) = 2,979.398, p<.001). The following lower limits were applied to the data to achieve practical statistical significance based on the recommendation of Hair, Black, Babin, Anderson, and Tatham (2014):

- Principle Components Analysis (PCA) at Eigenvalue (EV) >1 and Exploratory Factor Analysis (EFA) at factor loading coefficient of >.40 (recommended for samples of $n \geq 200$) were employed as a data reduction approach aimed at identifying the underlying structure of the latent (PB factors) influencing MT to South Africa, as well as the MT construct within the South African context.

- The reliability of resultant sub-scales was measured utilising Cronbach's alpha (α>.650). At the same time, Pearson product-moment correlations were calculated to determine the linear relationships between the PB factors and the MT construct.

- Multiple Regression Analysis (MRA) was then employed to model the PB-MT nexus at p<.001 and p<.05.

4. Empirical results

This section presents the empirical results of the descriptive and inferential statistical analysis conducted for the study.

4.1. Validity and reliability analyses

Table 2 presents the findings of the PCA (EV), EFA, Cronbach's alpha (α), means ($\bar{x}$) and standard deviation (σ) tests respectively, for the PB factors influencing MT to visit South Africa, as well as the antecedent factors of MT to the country.

Table 2
Results of the EFA, PCA, Cronbach's alpha, mean and standard deviation tests for the PB factors influencing MT to South Africa and the MT construct

Latent variable	Items (> .40)			EV	Var (%)	α	x̄	σ
		Min	Max					
Governance (GOV)	GOV1, GOV2, GOV4, GOV5, GOV6	.669	.786	3.17	7.20	.860	3.12	.977
Marketing (MKT)	PEO7, MKT3, MKT4, MKT5, MKT6, MKT7	.499	.806	2.74	6.23	.885	3.62	.816
Tourism (TOR)	TOU3, TOU5, TOU6, TOU7, GOV3	.519	.693	2.35	5.35	.659	2.97	.950
Negative events (NEV)	NEV1, NEV2, NEV3, NEV4, NEV5, NEV6	.457	.751	1.92	4.36	.864	3.18	.883
Socio-cultural (SCU)	IMM3, IMM4, IMM5, CLH1, CLH2, CLH3, CLH4, CLH5, PEO1, PEO2, PEO3, PEO4	.478	.789	13.01	29.58	.918	3.42	.756

Table 2 **Continued**

Latent variable	Items (> .40)			EV	Var (%)	α	x̄	σ
		Min	Max					
Competitive advantages (CAV)	TOU2, TOU4, TOU7, IMM1, IMM2	.507	.659	1.47	3.34	.682	3.86	.696
Medical tourism (MT)	MT1, MT2, MT3, MT4, MT5	.782	.917	7.266	34.60	.949	3.16	.854

Key: GOV- Governance; PEO - People; MKT – Marketing; TOR – Tourism; NEG – Negative events; IMM – Immigration; CLH – Culture & heritage; MT – Medical tourism

Table 2 indicates that after the PCA (EV>1) and EFA (Oblimin with Kaiser Normalisation) a total of 39 items were retained, constituting the PB factors influencing MT to South Africa, with factor loading coefficients of >.40. Six valid PB factors were extrapolated, accounting for a cumulative 56.06% of the variance in the data. The *Governance* (EV=3.17, Var%=7.20, α=.860); *Marketing* (EV=2.74, Var%=6.23, α=.885); *Tourism* (EV=2.35, Var%=5.35, α=.659); *Negative Events* (EV=1.92, Var% = 4.36, α=.864) factors were retained from the a *priori* hypotheses. Two new factors emerged from the EFA, the *Socio-cultural* (EV=13.01, Var%=29.58, α=.918) and *Competitive Advantages* (EV=1.47, Var%=3.34, α=.682) factors. The new *Socio-cultural* factor consisted of five items (CLH1, CLH2, CLH3, CLH4, CLH5) from the *Culture and Heritage* factor, as well as four items (PEO1, PEO2, PEO3, PEO4) from the *People* factor, and three items (IMM3, IMM4, IMM5) from the *Immigration* factor. The novel *Competitive Advantages* factor consisted of three items (TOR2, TOR4, TOR7) from the *Tourism* factor and two items (IMM1, IMM2) from the *Immigration* factor.

Therefore, the following revised hypotheses were formulated:

H_1: *South Africa's Governance influences medical tourism to South Africa*

H_2: *South Africa's Marketing influences medical tourism to South Africa*

H_3: *South Africa's Tourism influences medical tourism to South Africa*

H_4: *South Africa's Negative events influence medical tourism to South Africa*

H_5: *South Africa's Socio-Cultural elements influence medical tourism to South Africa*

H_6: *South Africa's Competitive Advantages influence medical tourism to South Africa*

The Cronbach's alpha for each PB factor was α > .650, suggesting that all the sub-scales were deemed reliable (Hair et al., 2014). The *Competitive Advantages* factor reported the highest mean tending towards 4 on the Likert scale (x̄=3.86, σ=.756), suggesting that tourists found the *Competitive Advantages* to be quite influential. The *Tourism* factor reported the lowest mean tending towards 3 on the Likert scale (x̄ = 2.97, σ =.950), suggesting tourists found the *Tourism* to be somewhat influential as a place brand factor. The standard deviations for the dimensions ranged between σ = .696 and σ = .977 suggesting little variation (<1) in the responses of tourists.

The PCA and EFA (Oblimin with Kaiser Normalisation) validated the antecedents of MT within the South African context at minimum factor loading coefficient of .40. Six items loaded onto the South African MT construct as the dependent variable (EV=7.266; Var%=34.60%): facilitates access to affordable medical treatment (.782); has world-class health facilities (.894); has relatively relaxed health laws (.895); possesses technologically advanced health systems (.917); allows access to high quality of medical services (.913) and; has reputable medical doctors (.880). The MT sub-scale was deemed reliable (α > .949). MT also reported a mean tending towards 3 on the Likert scale (x̄=3.16, σ=.854), suggesting respondents were neutral.

4.2. Results of the correlation analysis

Table 3 presents the results of the Pearson product-moment correlational analysis.

Table 3
The Pearson product-moment correlation matrix of South Africa's PB factors and MT

Variables	MT	SCU	GOV	MKT	TOR	NEV	CAV
Medical tourism (MT)	**1.000**						
Socio-cultural (SCU)	.284*	**1.000**					
Governance (GOV)	.118	.420*	**1.000**				
Marketing (MKT)	.212*	.521*	.338*	**1.000**			
Tourism (TOR)	.202*	.328*	.387*	.274*	**1.000**		
Negative events (NEV)	.214*	.554*	.411*	.542*	.390*	**1.000**	
Competitive advantages (CAV)	.132	.437*	.328*	.493*	.345*	.358*	**1.000**

*Correlation is significant at the .001 level (2-tailed).

Squared inter-factor correlations were reported between *MT* and the *Socio-cultural* (r = .284, p< .001); *Marketing* (r = .212, p< .001); *Negative events* (r = .214, p< .001), and; *Tourism* (r = .202, p< .001) PB factors associated with South Africa. Non-significant correlations of .132 (p = n.s), and .018 (p = n.s) were observed between *MT* and the *Competitive Advantages* and *Governance* PB factors, respectively.

4.3. Multiple regression analysis results

Table 4 records the results of the MRA. The preliminary Multi-collinearity test reported Tolerance values ranging between .527 and .755 and VIF values ranging between 1.234 and 1.787, suggesting the absence of collinearity and the viability of MRA.

Table 4
Summary of the results of the multiple regression analysis: Medical tourism

	Dependent variable: Medical tourism			Collinearity statistics		
Independent variables (R^2= .102)	β	t-value	Sig. (p)	Tolerance	VIF	Hypo-thesis
Governance	-.052	-.658	.511	.723	1.383	H$_1$
Marketing	.082	.931	.353	.527	1.750	H$_2$
Tourism	.129	1.681	.094	.755	1.324	H$_3$
Negative events	.033	.369	.713	.559	1.787	H$_4$
Socio-cultural	.222	2.515	.013**	.573	1.744	H$_5$
Competitive advantages	-.045	-.554	.880	.676	1.478	H$_6$

* p<.001 **p<.05.

The results of the regression in Table 4 indicated that one PB factor influenced *MT*, explaining 10.02% of the variance (R^2=.102, F(6,201)=3.79, p<.001). The PB factor, *Socio-cultural* (β=.222, p<.05) significantly influenced *MT* to South Africa. Additionally, the t-value for the *Socio-cultural* PB factor reported a critical value of t = 2.515, which is between the recommended 1.96 and 3.09 at p<.05 (Mugenda & Mugenda, 2003), thus hypothesis H$_5$ was accepted. The *Governance, Marketing, Tourism, Negative Events* and *Competitive Advantages* factors reported statistically insignificant (*p*>.001, *p*>.05) relationships with *MT,* suggesting that they did not influence MT to South Africa. Therefore, hypotheses H$_1$, H$_2$, H$_3$, H$_4$ and H$_6$ were rejected, respectively.

5. Discussion of the results

The empirical evidence from the present study suggests that South Africa's *Socio-cultural* PB influences MT to the country and this assertion is supported by the strongest correlation being found as existing between *MT* and the *Socio-cultural* PB factor. The NBT submits that the consumer may be influenced by one or more PB factors in their decision-making, thus supporting the unidimensional influence of the *Socio-cultural* factor on MT to South Africa (Dinnie, 2008; Kavaratzis & Kalandides, 2015; Schalber & Peters, 2012). More pertinently, Almeyda-Ibáñez and George (2017b) and Foroudi et al. (2016) submit that PBs represent the underpinning culture(s) of the place/country, thereby impacting on and influencing the perceptions and decision-making process of consumers. Johnson and Delgado (2013) support this view, arguing that despite the cost, quality and access considerations, social and cultural factors are equally influential in the decision-making process of tourists within the MT context. In addition, Henson, Guy, and Dotson (2015) found that the pervasive culture of the MT destination was a crucially influential supply-side factor in MT.

In the case of South Africa, some of the socio-cultural sub-factors, including the friendliness and help-fulness of the people; availability of public resources; the preservation of cultural practices and heritage; tolerance and ability adapt to cultural diversity; and South Africa's colonial heritage, are perceived to be influential on MT to the country. These assertions find support within the literature. For instance, Das and Mukherjee, (2016) suggest that soft cultural issues such as the friendliness and helpfulness of the people of the MT destination influence the perceptions of MTs. Nicolaides (2011) observes that MTs are particularly sensitive to being accepted (the friendliness and openness) by the local population, particularly given South Africa's racial past, while Signé (2018) advances that the availability of public resources such as health services are a critical antecedent for the development of low-income countries as tourism destinations. More pertinently, public resources are inextricably linked to the growth and development of MT in Asia (Beladi et al., 2019).

In the case of China, Chinese traditional medicine has been harnessed as a critical differentiation aspect in the marketing of the country as a competitive MT destination, highlighting the role of cultural aspects in the promotion of MT to China (Heung et al., 2010). While Lunt et al. (2012) submit that cultural heritage is a significant element in the decision-making process of MTs, Hwang et al. (2018) highlight that MTs consider the availability of cultural activities in the host MT destination as part of their decision-making process. In the case of South Korea, the inability of health professionals in the country to tolerate and adapt to cultural diversity and change constitutes a significant barrier to MT to the country (Rokni et al., 2017). The British colonial heritage of India has been considered as a critical underlying factor in the lucrative MT market between India and England (Lunt et al., 2012).

Conversely, it is interesting to observe from the empirical findings that critical PB factors, such as *Governance* and *Marketing,* were not found to be influential to MT to South Africa. This finding contradicts the evidence of the emerging role of national governments and DMOs proactively marketing and promoting their countries as MT destinations (Ebrahim & Ganguli, 2019; Smith & Puczkó, 2008; Suess et al., 2018). For instance, in the case of India, the international marketing of the country as a tourism destination contributed to the growth of the MT market in the country (Alsharif et al., 2010). It would also be reasonable to assume that *Immigration* factors, such as the ease of visa procedures when travelling to South Africa would be an influential factor to tourists given the country's controversial and stringent immigration policy (Tourism Business Council of South Africa, 2015). Alsharif et al. (2010) support this notion attributing part of the success of India as a MT destination to the country's facilitation of special visas for MTs to travel to the country. More significantly,

while the literature (Connell, 2013; Loubeau, 2009; Zolfagharian et al., 2018) associates MT with auxiliary leisure tourism activities such as natural and man-made tourist attractions, climate and other entertainment-oriented attractions, this appears not to be the case for South Africa, which is a premier African leisure tourism destination.

6. Conclusions and recommendations

The purpose of this novel study was to explore the PB-MT nexus within the South African context, in order to model the potential influence of South Africa's PB on MT to the country. The study makes some significant contributions. First, the results confirm the PB-MT nexus, suggesting a potential causal relationship between South Africa's PB and MT to the country - thereby further enriching the extent of the MT literature. Thus, the study provides empirical evidence supporting and compliment-ing the growing body of literature exploring the increasingly important role of PBs in MT from a uniquely African perspective. Second, from a theoretical perspective, the present study contributes to the emerging body of inferential studies within the MT discourse by extending PB theory to tourist decision-making within the MT context. Hence, the study provides critical insights that improve the understanding of the extrinsic factors that may influence medical tourists when they consider African destinations for MT purposes. Third, MT is a burgeoning field of study within the tourism discourse, and the present study contributes to the breadth and depth of academic inquiry into the supply-side of MT by presenting research from an often-overlooked African perspective. Critically, the results associate tourism (MT) with the socio-cultural profile of South Africa, through the PB as a heuristic cue (communication platform). Therefore, the study is a catalyst for broader inquires that may explore the contribution of African country's generic PBs to their perceived positioning as MT destinations.

Practically, the results point to a crucial need for African destination marketers that are active within the MT market to be cognisant of the role and influence of PBs in the attraction of MT to their countries. While significant demand-side factors such as the inherent cost savings associated with MT in Africa may motivate MTs, it is evident that within an increasingly competitive global MT market, supply-side factors such as the PB must be evaluated and pro-actively managed by national governments and related enterprises; for instance, medical tourism services facilitators. One approach would be the development of an NBT-based framework as an evaluative framework to periodically determine the factors influencing MT to South Africa. Relatedly, the same framework would also act as a decision support model in a concerted multi-stakeholder global communication (place branding) strategy for MT to South Africa, aiding in the management of South Africa's global image as a MT destination.

This study acknowledges two limitations. First, obtaining a representative sample of tourists to South Africa remains a challenge for novel studies (within the African context) in fields such as medical tourism. As a result, it is essential to note that the data analysed for this study were generated as part of a broad study that generally targeted inbound tourists without distinguishing their motives for visiting South Africa at the time of the survey. However, this challenge was mitigated by soliciting present and future travel motives, which included MT. Hence, the findings are relevant to the potential inference of the influence of South Africa's PB on MT to the country in general. Due to the novelty of the measuring instrument utilised by the present exploratory study, the second potential limitation of the study may be that of potential measurement misspecification (reflective versus formative) of some of the items within the context of the study. This has been identified as a growing challenge in the social sciences, including tourism (see Cheah et al., 2018; Mikulić, 2018; Mikulić & Ryan, 2018). It is, therefore, recommended that the present study be considered as a primer to more incisive, future studies to be

based on an adapted and refined measuring instrument amongst MTs with a specific focus on MT to South Africa. It is also recommended that longitudinal research be conducted into the influence of South Africa's PB on MT travel motives in order to ascertain the influence of South Africa's PB within a dynamic global environment over time and to extrapolate trends. A cross-cultural study across various regions (Africa, Asia, Europe and the Americas) is also recommended in order to definitively compare tourist perceptions of South Africa as a MT destination from various source market perspectives.

Note:

[1] In view of present civil upheavals in Hong Kong it is not clear how MT will be affected in short term and long term

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Appendix 1

List of Items/statements and Factor loadings

Code	Statement	SCU	GOV	MKT	TOR	NEV	CAV
IMM3	Quality of life in South Africa	0.478					
IMM4	South Africa's public resources (health and education)	0.453					
IMM5	Availability of efficient basic service utilities in South Africa (water, electricity)	0.596					
CLH1	Equal opportunities for all who live in South Africa	0.773					
CLH2	Commonality of cultural values with South Africans	0.747					
CLH3	Societal equality in South Africa	0.789					
CLH4	The colonial heritage of South Africa	0.735					
CLH5	Entrepreneurial nature and innovativeness of South Africans	0.729					
PEO1	Tolerance/openness to cultural diversity/change of South Africa	0.664					
PEO2	Preservation of South Africa's cultural practices and heritage	0.482					
PEO3	South Africa's friendly trade policy	0.569					
PEO4	The friendliness/helpfulness of South Africans	0.509					
GOV1	The political instability in South Africa		0.716				
GOV2	Lack of safety from crime in South Africa		0.679				
GOV4	High risk of terrorist attacks in South Africa		0.669				
GOV5	Lack of control of corruption by the South African government		0.786				
GOV6	Absence of visible policing in South Africa		0.723				
PEO7	Acceptance of tourists by South Africans			0.499			
MKT3	Sufficient information about South Africa as a tourism destination country			0.616			
MKT4	The value for money that I receive from South African tourism products			0.656			
MKT5	The attractive uniqueness of South Africa compared to other destinations			0.702			
MKT6	Positive marketing advertisements/promotions related to South Africa			0.776			
MKT7	Perception of South Africa as a tourism destination of choice			0.806			
TOR3	The closeness of South Africa to my country				0.634		
TOR5	South Africa's sports attractions				0.693		
TOR6	South Africa's entertainment attractions				0.644		
TOR7	Closeness of South Africa to other African tourist destination countries				0.519		
GOV3	The relations between South Africa and my own country				0.584		
NEV1	Intermittent drought in water-scarce South Africa (the drought in Cape Town and the Eastern Cape region)					0.457	
NEV2	Lack of food safety (Listeria outbreak in South Africa)					0.551	
NEV3	Prevalence of illegal poaching of wildlife in South Africa					0.715	
NEV4	South Africa's economic growth					0.572	
NEV5	The association of South Africa with the illicit trade in animal parts (such as lion bones, rhino horn, elephant tusk)					0.751	
NEV6	Prevalence of social unrest					0.653	
TOU2	South Africa's climate						0.529
TOU4	The scenic beauty of South Africa						0.659
TOU7	South Africa's man-made tourism attractions						0.532
IMM1	Ease of immigration visa procedures when travelling to South Africa						0.507
IMM2	Visa policy of South Africa towards my home country						0.597

EFA at >.40 (Oblimin with Kaiser Normalisation).
Key: GOV - Governance; PEO - People; MKT – Marketing; TOR – Tourism; NEV – Negative events; IMM – Immigration; CLH – Culture & Heritage.