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Health Service Quality and Patient Communication In Medical Tourism

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Abstract

This study investigates the perceptions of patient communication and medical service quality in relation to the demographic and occupational characteristics of medical staff working in Alanya. A significant relationship was found between perceptions of patient communication and the field of expertise of the staff and the foreign language they speak. This indicates that, in medical tourism contexts, the patient communication perceptions of medical staff affect first-hand perceptions of health service quality. To increase health service quality and patient communication motivation, it is recommended that revenues from patients or insurance companies be distributed to all staff involved with medical tourists. Furthermore, apart from doctors and nurses, staff believe health service quality and communication are low. Therefore, it is recommended to provide in-service training for this area.

Keywords

Medical tourism, Medical staff, Health care, Communication, Quality

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Introduction

Tourism is a rapidly developing and diversifying industry that is a prominent field in international commerce and a key source of revenue for developing countries (UNWTO, 2021). The inflow of foreign currency has benefited developing economies by reducing unemployment and increasing economic prosperity. As a developing country, Turkey's tourism industry has recently seen an increase in the number of visitors and gross tourism earnings (Bulut and Yalçın, 2015: 102). Turkey is regarded as one of the leading tourism destinations in the Mediterranean basin owing to its geographical characteristics, ancient sites, natural beauty, and climate conditions (Edinsel and Adıgüzel, 2014: 175). Because of the varied terrain across the country's seven geographical regions, tourists can experience all four seasons. As a peninsula, Turkey offers diverse tourism alternatives (Evci and Tezcan, 2005: 100).

Beyond being a recreational activity, tourism has become a consumer industry meeting individual needs worldwide. The sustainability of tourism as a service industry depends on several factors: providing high-quality products; ensuring tourists enjoy good experiences with these products; attaching importance to domestic residents; ensuring the sustainability of native culture; and preserving natural resources, and the historical and cultural heritage for future generations (Kervankıran, 2014: 151).

Tourists pass through various decision stages before, during, and after their holiday travel. During the planning stage, they focus on transportation opportunities, potential routes, accommodation capabilities, attractive locations, and activities. The latest developments in communication and transportation infrastructure have eliminated accessibility impediments in tourism. The perceptions gained during this process directly affect their future decisions (Emir and Avan, 2010: 206).

In medical tourism, defined as travel for treatment and care conducted in different areas from where individuals live (Anvekar, 2012: 109), individuals requiring medical treatment can compare services in their home countries with those in other countries. For host countries, medical tourism yields higher income than conventional tourism, a fact which has encouraged countries to concentrate on this sector. Meanwhile, developed countries have outsourced medical care through mutual agreements with other countries offering superior medical services to provide health services for their citizens. Accordingly, countries competing in the medical tourism sector emphasize their superior medical services advances in technological and medical training (Kördeve, 2016: 52). Prominent countries in medical tourism, including India, Singapore, Thailand, Philippines, Hungary, and Turkey, have introduced novel policies and strategies to sustain their competitive leverage in the global market (Aktepe, 2013: 175-176).

Turkey's up-to-date and well-qualified medical institutions and physicians have attracted increasing numbers of medical tourists. The Ministry of Health has identified three core medical tourism service domains: *Advanced Age and Handicapped Tourism, Thermal Medical Tourism and Spa-Wellness,* and *Medical Tourism* (Kaya et al., 2013: 5). Turkey offers various advanced treatments, including cardiovascular surgery, radiotherapy, robot surgery, transplants, infertility treatments (e.g., in-vitro fertilization), plastic surgery, dental treatments, and dialysis (Türkiye Sağlık Turizmi Derneği, 2021).

Medical services are generally cheaper in developing than developed countries. Medical tourists also usually prefer developing countries since transportation is more convenient and there is no waiting time, while the infrastructure, technology, and professionalism are adequate (Karagülle, 2021). Medical tourism requires a multi-stakeholder approach due to the many stakeholder sectors, including transportation, tourism, communication and information, travel, finance, construction (for new investments), private and public medical institutions, mediating institutions, assisting and consulting companies, and insurance companies. To ensure robust medical tourism, every stakeholder, at every level, must contribute effectively (Kaya et al., 2013).

Alanya Province is an important medical tourism destination in Turkey. Besides being a well-known coastal tourism destination for Europe, the Balkans, the Middle East, Central Asia, and Siberia, Alanya is known for its high-quality dental, optometric, cardiovascular, cosmetic, infertility, and surgical treatments. (Alanya Turizm Tanıtma Vakfı, 2022). Alanya received 1.5 million foreign visitors in the first eight months of 2021, which exceeded the yearly total for 2020 (Yılmaz, 2021) despite the Covid-19 pandemic conditions. Table 1, which shows the number of public and private health institutions working under the Ministry of Health, indicates the importance given to health tourism in Alanya.

Table 1
Medical Institutions in Alanya Under the Province Ministry of Health (Ministry of Health, 2022)

Alanya Medical Centers			
Medical Centers	**n**	**Medical Centers**	**n**
➢ Public Hospitals	1	➢ Private Polyclinics	5
➢ Private Hospitals	2	➢ Private Practices	51
➢ Family Health Centers	72	➢ Physical Therapy Units	1
➢ Private Dental Clinics	32	➢ Health Cabinets	1
➢ Private Dental Practices	77	➢ Private Dialysis Centers	1
➢ Oral and Dental Health Hospitals	1	➢ Alcohol and Drug Addiction Treatment Clinics	1
➢ Private Eye Hospitals	1	➢ Healthy Life Centers	1
➢ Private Medical Centers	1	TOTAL	248

A number of studies have evaluated the quality of services at medical tourism destinations (Gilson et al., 1994; Zerenler and Öğüt, 2007; Eleuch, 2011; Fullerton and McCullough, 2014; Taqdees et al., 2017; Bilgin and Göral, 2017; Kondasani, Panda, and Basu; 2019). These studies focus on measuring the patients' perceptions of communication, service quality, and satisfaction. In contrast, few studies have evaluated the perceptions of medical staff in health tourism destinations regarding patient communication and the quality of medical services (Canver, 2015). Accordingly, the present study offers a unique perspective by investigating the relationship between patient communication and medical staff's perceptions of medical tourism service quality and comparing these perceptions in terms of demographic and professional variables.

A quantitative survey was used as the data collection method. The survey had two scales and another section to record the respondents' demographic and professional details. Before further analysis, the survey data were tested for reliability using Cronbach's alpha. Based on the reference values of $\alpha>0.600$, reported by Akgül and Çevik (2003: 430) and Ural and Kılıç (2006: 290), data were reliable.

Confirmatory factor analysis and validity analysis were conducted on the scale questions (Canver, 2015). Regression analysis was then used to determine the effect of the medical staff's perceptions of patient communication on their perceptions of medical service quality and how these perceptions were affected by their demographic and professional characteristics. The relationships between the variables were tested using correlation analysis. The novel findings of this study make an important contribution to the literature.

Literature Review

Communication and Communication in Medical Services

As part of the interaction between individuals and/or institutions within a society, communication is a significant phenomenon existing for interaction among individuals and/or institutions within society. Communication could take place person-to-person, person-to-institution, and institution-to-society for information exchange. Individuals need communication so that they can perceive all phenomena outside themselves and gather information (Vardarlıer and Öztürk, 2020: 2). Communication within the scope of medical services assists medical staff to understand the needs of patients and their families; learning how to manage their chronic health conditions; and gaining healing results with the treatment (Arnold and Boggs, 2016: 6). The ways care, courtesy, compassion, and understanding are shown to patients and the usage of knowledge and skill relax patients and allow them to be more cooperative and adopt a more participative attitude (Tanşu, 2021: 19). Accurate communication established with

the patient and patient's relatives during the medical services is directly effective on medical service satisfaction (Kaya et al., 2017: 65).

Service and Quality Concepts and Medical Service Quality

Service is regarded as a product in which production and consumption take place simultaneously by both humans and machines for the ultimate benefit of human beings (Kesmez and Savaş, 2014: 2). That is to say, each service produced has its own unique characteristics. The fact that the service has an intangible feature causes the perception of quality during consumption to be quite high (Güven and Sarıışık 2014: 22-23). When the quality concept is compared with other industries, it is rather difficult to explain from the dimension of the service industry. In the service industry, quality is a concept ensuring the provision of service matching customer needs and demands, maintaining a stable success level, without any flaw or defect. It can be measured and evaluated, and is expected to be directly related to customer satisfaction (Murat and Çelik, 2007: 2). In a study conducted by Parasuraman et al. (1988), the service quality concept is considered and five fundamental concepts effective on service quality are suggested: *physical (concrete) characteristics*: physical resources, equipment outfitting of personnel; *reliability*: provision of services promptly, constant format and without any defect; *eagerness*: personnel's readiness and eagerness for providing service; *trust*: keeping service provision away from danger, risk, and suspicion; *empathy*: significance attached to customers, personal care, and being sensitive to customers. For medical services, several studies have suggested seven key dimensions (Sevimli, 2006: 48; Korkmaz and Çuhadar, 2017: 74):

- Efficiency: the effort exerted to treat health conditions
- Effectiveness: Successful medical outcomes
- Productivity: Minimizing costs during the treatment period
- Optimality: Sustaining the balance between cost and healing
- Reasonability: Communication between patient and medical staff, and meeting the patient's needs
- Legitimacy: Appropriateness to the patient's social preferences
- Impartiality: Justice in the provision of medical services

Like other industries, the health industry continuously evolves due to technological advances. Therefore, service quality is considered particularly important in the medical industry. It can be defined as the difference between patient expectations and their post-service perceptions. That is, satisfaction levels increase if the provided medical services meet the patient's expectation. This in turn determines the patient's preference for that medical institution (Temizkan, 2018: 148).

Medical Tourism Concept and Medical Tourism in Turkey

By combining medical treatment and entertainment activities – depending on individuals' health status – medical tourism has significant potential as a style of tourism (Dunets et al., 2020: 2215). Medical tourism facilities include hotels with spas and hospitals and clinics specializing in thermal springs (TÜROFED, 2021: 71). Until the 20th century, medical tourism primarily involved citizens from underdeveloped countries travelling because their countries lacked proper treatments. In the 21st century, however, this trend has reversed, with medical tourists from developed countries choosing developing countries for their cheaper and better quality medical services (Kantar and Işık, 2014: 17). Medical services in developed countries steer citizens of these countries to tourist destinations to access low-cost yet well-equipped medical services. Tourists needing treatment prefer destinations offering high-quality services in institutions equipped with modern and advanced medical devices and well-educated specialists (Horowitz and Rosensweig, 2007: 28). Medical tourism activities make a significant contribution to the economy by exporting services and developing the health industry (Tontuş, 2018: 69). Given this importance, Turkey has worked to enhance its international reputation in this field. Figure 1 shows the number of health tourists visiting Turkey from 2012 to 2019, gross medical tourism revenue, and per capita medical tourism spending.

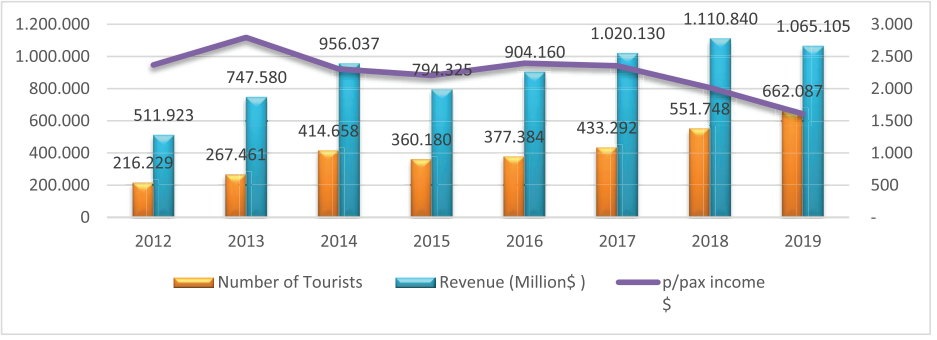

Figure 1. Health Tourist Arrivals in Turkey, Health Tourism Revenue, Health Tourist Spending, 2012-2019 (USHAS, 2021)

Both the number of medical tourists and gross medical tourism income increased, although per capita spending decreased. Thus, revenues from medical tourism contribute to the economic welfare of the host countries and provide a competitive advantage. International medical tourism has grown due to increasing international information exchange, domestic and global strategic partnerships, and international technology and knowledge transfers. Moreover, countries accepting international patients foster the exchange of social and cultural values, and the development of international relationships (Soysal, 2017: 171-172).

Research Questions

Based on this literature review, this study addresses two main research questions:

1. Do the patient communication perceptions of medical staff affect their perceptions of health service quality?

2. Is there a significant correlation between medical staff's perceptions of patient communication and the perceptions of medical service quality?

Methodology

Study Design

This was a descriptive study.

Study model and hypotheses

The study investigated the perceptions of medical staff regarding patient communication and medical service quality in medical institutions in Alanya Province, Turkey. The study focused on personnel from three private and one public medical institution that accept patients for medical tourism and that wished to improve their service quality.

The study hypotheses were based on various previous studies. Taqdees et al. (2017) investigated medical service quality, patient satisfaction, and patient loyalty in six private hospitals in Pakistan, while Ahmed et al. (2017) studied 204 patients from medical institutions across Bangladesh, to compare the appropriateness of medical services, service quality, patient satisfaction, and patient loyalty in relation to demographic variables. Meesala and Paul (2018) used a comparative service quality scale to measure patient satisfaction and loyalty in 40 private hospitals in Hyderabad, India. Lee et al. (2012) measured service quality, patient satisfaction and loyalty, and employment performance for 196 medical staff and 196 patients receiving medical service from four hospitals with capacities of at least 500 beds. Finally, Aljumah et al. (2017) interviewed 389 medical tourists in Malaysia to measure patient loyalty, trust, and perceived value.

From these studies, the following two hypotheses were developed regarding the objectives of the present study.

H_1: Medical staff's perceptions of patient communication affect their perceptions of medical service quality.

H_2: Medical staff's perceptions of patient communication correlates significantly with their perceptions of medical service quality.

Figure 2 shows the model developed in line with the study's objectives, and the position in the model of the two main hypotheses.

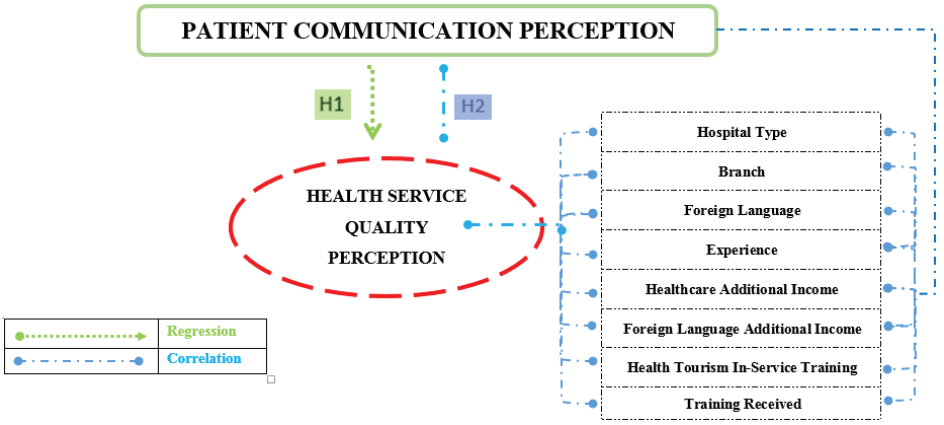

Figure 2. Study Model

Study Group

Field research was conducted in the city of Antalya in Alanya Province during 2020. Regarding the universe of the study, there were a total of 1,855 medical staff across public and private medical institutions in Alanya Province, as detailed in Table 2.

Table 2

Distribution of Healthcare Professionals across Institutions in Alanya Province

STAFF TITLES	Specialist Physician (Prof, Doc., Asst. Doc.)	Specialist Physician (Exp.)	Family Physician (Exp).	General Practitioner	Dentist	Nurse	Midwife	Health Officer (Community Health + ATT + X-ray + Lab. + Medical Sector + ..)	Biologist	Pharmacist	Other Health Personnel (Anesthetist + Prm + Dental Tech. + Dialysis Tech. + Dietician + FTR + Psik. + Perf. + Audio....)	Officer	Technician (Elec.+Eletr. Etc.)	Crew	TOTAL
Public Health Centers	54	123	1	34	43	329	76	98	4	7	249	6	14	36	1074
Private Health Centers	23	117	4	27	4	169	8	161	11	3	108	13	10	123	781
Total	77	240	5	61	47	498	84	259	15	10	357	19	24	159	**1855**

Alanya's 1,855 medical staff serve a local population of 350,000 residents. In addition, the hospitals serve medical tourists, which limited the time available for medical staff to respond to the survey. Thus, not all medical staff at these institutions could be accessed because the hospital administrations wanted to avoid any disruption in the provision of their medical services.

Random sampling was adopted as the most appropriate method to represent the universe for meeting the study objectives. This involved interviewing any medical staff encountered in the hospital for data collection purposes (Özdamar, 2001; Arıkan, 2004; Kılıç, 2013). The required sample size was determined using the following formula (Özdamar, 2001; Ural ve Kılıç, 2006; Şahin, 2007; Köroğlu, 2011).

FORMULA

$$\text{Sample Size} = \frac{2500.\mathbf{N}.(1.96)^2}{[25(\mathbf{N}\text{-}1)] + [2500*(1.96)^2]} = ?$$

RESULT

$$\text{Sample Size} = \frac{2500.\mathbf{1855}.(1.96)^2}{[25(\mathbf{1855}\text{-}1)] + [2500*(1.96)^2]} = 318.39$$

Applying this formula indicated a required sampling size of at least 318.39 participants. Accordingly, 400 survey forms were distributed. However, only 177 valid forms were returned. The low response rate was probably because medical workers faced intense work pressure during the Covid-19 pandemic. In short, it was not possible to reach the calculated sample size in this study.

Data Collection Tools

The data collection tool, a survey, was limited to two scales and some demographic questions due to the long working hours of healthcare workers during the Covid-19 pandemic. Both scales were obtained from Canver (2015). The participants responded to the items concerning patient communication and medical service quality using a five-point Likert-type scale.

KMO and Barlett tests were conducted to perform factor analysis and determine the accuracy of this decision on the scale items used to measure perceived patient communication and perceived medical service quality. Tables 3 and 4 summarize the analyses for perceived communication and perceived medical service quality, respectively.

Table 3
Validity Analysis of Perceived Patient Communication

FACTOR ANALYSIS	Factor Load	$\bar{x}$	α
PCP7 - Concerning the limited medical service provided	0.787	2.21	0.833
PCP6 - On applying hospital rules	0.724		
PCP8 - Regarding Additional Treatment and Procedures	0.717		
PCP9 - Monitoring treatment outcome	0.715		
PCP3 - From patients recovering from their cultures	0.661		
PCP2 - Communication with patient relatives	0.648		
PCP1 - Communication with the patient	0.629		
PCP5 - Concerning the physics of the hospital	0.567		
PCP10 - Treatment related	0.480		
PCP4 - Meals served to the patients at the hospital	0.458		

For the perceived patient communication scale, the KMO test value was 0.784. Since this value was greater than 0.500 (p>0.500), the selected sample size was valid for explaining the items of the work satisfaction scale. The chi-square value for Bartlett's test was 684.101, while the degrees of freedom and asymptotic significance value were p:0.000/ and p<0.050. This indicated that the communication scale could be subjected to factor analysis. Finally, the Cronbach's Alpha value (α) was 0.833, which indicated acceptable reliability.

Table 4
Validity Analysis of Perceived Health Service Quality

FACTOR ANALYSIS	Factor Load	x̄	α
HSQP9 – Hospital's implementation of international standards	0.830	4.16	0.899
HSQP8 - Medical staff of the hospital	0.826		
HSQP7 - Good technical equipment of the hospital	0.824		
HSQP11 - Impact of quality accreditation certificate	0.787		
HSQP6 - Short, effective, and fast service delivery	0.765		
HSQP10 - Referral of intermediary institutions	0.706		
HSQP2 - Providing a high standard of healthcare	0.703		
HSQP4 - Being in a cheap country for accommodation and transportation issues	0.671		
HSQP3 - Geographically close to the patient's home country	0.626		
HSQP5 - Turkey has many touristic features	0.569		
HSQP1 - Low cost of treatment	0.515		

For the perceived medical services quality scale, the KMO test value was 0.873. Since this value was greater than p>0.500, the selected sample size was valid to explain the scale items. The chi-square value for Bartlett's test was 1110.282 while the degrees of freedom and asymptotic significance values were p:0.000 and p<0.050. This indicated that the perceived medical service quality scale could be subjected to factor analysis. Finally, the Cronbach's Alpha value (α) was 0.899, which indicated acceptable reliability.

The factor analysis results indicated that there were two valid factors. These factor loadings were reasonably distributed within the dimensions of communication and quality.

Results

Table 5
Participants' Demographic and Professional Characteristics

Hospital Type		
	n	**%**
Public	91	51.4
Private	86	48.6
Profession		
	n	**%**
Doctor	21	11.9
Nurse	75	42.4
Health Officer	3	1.7
Technician	51	28.8
Medical secretary	11	6.2
Patient Consultant (Guide)	16	9
Professional Experience (years)		
	n	**%**
1-5	84	47.5
6-10	55	31.1
11-15	21	11.9
16-20	7	4
21+	10	5.6

Do You Require Side Payment for the Medical Services Provided within to Medical Tourists?		
	n	**%**
Yes	103	58.2
No	39	22
Partially	35	19.8
Do You Require Side Payment for Your Foreign Language Skills?		
	n	**%**
Yes	92	52
No	57	32.2
Partially	28	15.8
In-Service Training		
	n	**%**
Yes	49	28.7
No	97	54.8
Partially	31	17.5
Foreign Languages		
	n	**%**
English	90	52
German	18	10
Russian	11	6.2
None	58	33

Table 6 summarizes the respondents' scores for the perceived communication scale items.

Table 6
Mean Scores for Patient Communication Scale Items and Normality Test Results

	$\bar{X}$	S.S.	$\bar{X}$	Normality Test (Shapiro Wilk)a	Chosen Test Type
PCP1 - I have trouble communicating with the patient.	2.39	0.840			
PCP2 - I have problems communicating with patients' relatives.	2.36	0.835			
PCP3 - I have problems with patients' cultural behaviors.	2.33	0.849			
PCP4 - I have problems with the meals served to the patients in the hospital.	2.44	1.054			
PCP5 - I have problems with the hospital's physical facilities.	2.24	0.846			
PCP6 - I have problems with applying hospital rules.	2.22	0.918	2.21	0.006	Non-Parametric
PCP7 - I have problems implementing the health service provided to the patient.	2.01	0.765			
PCP8 - I have problems with additional treatment and procedures.	2.02	0.812			
PCP9 - I have problems monitoring patients' treatment results.	1.86	0.796			
CP10 - I have problems with patients regarding treatment costs.	2.20	0.875			

Table 7 summarizes the responses to the perceived communication scale items.

Table 7
Mean Scores for Perceived Medical Service Quality Scale Items and Normality Test Results

	$\bar{X}$	S.S.	$\bar{X}$	Normality Test (Shapiro-Wilk) a	Chosen Test Type
HSQP1 - Low cost of treatment	4.24	2.21	4.16	0.000	Non-Parametric
HSQP2 - Providing a high standard of healthcare	3.88	1.280			
HSQP3 - Geographically close to the patient's own country	4.25	1.117			
HSQP4 - Being in a cheap country for accommodation and transportation	4.01	1.017			
HSQP5 - Turkey having many touristic features	4.33	0.938			
HSQP6 Short, effective, and fast service delivery	4.25	0.968			
HSQP7 - Good technology in the hospital	4.20	0.995			
HSQP8 - Good medical staff in the hospital	4.28	0.987			
HSQP9 – Hospital implements international standards	3.97	1.175			
HSQP10 - Referral of intermediary institutions	4.08	1.081			
HSQP11 - Quality accreditation certificate positively affects service	4.24	1.023			

The medical staff's perceptions of patient communication and medical service quality were analyzed in terms of their demographic and professional characteristics. First, a normality test was conducted, which indicated that the data collected were non-parametric. Given that there were at least two groups to be compared, the Mann Whitney-U test, one of the gap analyses, was used, while the Kruskal Wallis test was used when the number of groups was at least three. Tables 8 and 9 summarize the analysis results.

Table 8 compares the perceptions of public and private hospital medical staff. While there was no significant difference between sectors for perception of patient communication, there was a significant difference between sectors for perception of medical service quality.

Table 8
Comparative Analysis of Perceptions in Public and Private Hospitals

MANN WHITNEY-U	PCP			HSQP		
HOSPITAL SECTOR	n	Mean Rank	p	n	Mean Rank	p
Public Hospital Health	91	88.88	0.975	91	64.24	0.000
Private Hospital Health	86	89.12		86	115.20	

PCP : Patients' Communication Perception. HSQP : Health Service Quality Perception

Table 9 compares the medical staff in terms of various demographic and professional characteristics. Profession had a significant effect on the medical staff's perceptions of patient communication, but not on their perceptions of medical service quality.

Table 9
Comparative Analysis of Perceptions based on Demographic and Professional Characteristics

KRUSKAL-WALLIS			**PCP**			**HSQP**		
Profession		**n**	**Mean Rank**	**p**	**df**	**Mean Rank**	**p**	**df**
Doctor	a	21	78.60		b	88.40		
Nurse	b	75	98.84		a,e,f	93.54		
Health Officer	c	3	83.67		-	89.33		
Health Technician	d	51	98.34	0.002	e,f	92.94	0.193	N/A
Medical secretary	e	11	47.77		a,e	50.50		
Patient Consultant (Guide)	f	16	56.09		b,d	82.34		
Language		**n**	**Mean Rank**	**p**	**df**	**Mean Rank**	**p**	**df**
English	a	90	59.92		d	55.23		b
German	b	18	57.31	0.047	d	77.53	0.048	a,d
Russian	c	11	65.05		-	70.36		-
No Foreign Language	d	58	104.22		a,b	83.48		b
Occupational Experience (years)		**n**	**Mean Rank**	**p**	**df**	**Mean Rank**	**p**	**df**
1-5	a	84	92.64			87.26		
6-9	b	55	95.51			103.43		
11-14	c	21	59.40	0.062	N/A	77.95	0.180	N/A
16-19	d	7	75.21			83.79		
21+	e	10	94.40			51.10		
Medical Tourism Service Side Income		**n**	**Mean Rank**	**p**	**df**	**Mean Rank**	**p**	**df**
Yes	a	103	87.16		b	95.51		
No	b	39	105.36	0.040	a	85.44	0.084	N/A
Partially Payment	c	35	76.19		b	73.81		
Foreign Language Side Income		**n**	**Mean Rank**	**p**	**df**	**Mean Rank**	**p**	**df**
Yes	a	92	84.511			100.24		b,c
No	b	57	90.474	0.469	N/A	72.56	0.005	a
Partially Payment	c	28	97.446			82.79		a
Medical Tourism In-Service Training		**n**	**Mean Rank**	**p**	**df**	**Mean Rank**	**p**	**df**
Yes	a	49	82.89			99.36		
No	b	97	92.35	0.570	N/A	85.15	0.249	N/A
Partially Time	c	31	88.19			84.68		

PCP : Patients' Communication Perception. HSQP : Health Service Quality Perception

Foreign language knowledge had a significant effect on medical staff's perceptions of patient communication but not on service quality. Length of experience had no significant effect on perceptions for either scale. Receiving additional payment for treating medical tourists had a significant effect on perceptions of patient communication but not on service quality. Conversely, the staff's language skills had no significant effect on perceptions of patient communication but a significant effect on perceptions of medical service quality. Finally, the respondents' medical tourism training had no significant effect on perceptions for either scale.

A simple linear regression analysis was conducted to analyze the effect of hospital medical staff's perceptions of patient communication and perception of medical care quality. As Table 10 shows, perceived patient communication significantly affected perceived medical care quality (p:0.002-p<0.05).

Table 10
Regression Analysis Results for Effect of Perceived Patient Communication on Perceived Medical Care Quality

Size	Unstandardized Coefficients		Standardized Coefficients	t	p	Tolerance
	B	Standard Error	β			
Constant	3.443	0.232		14.841	< .001	1.000
PCP	0.323	0.102	0.233	3.163	0.002	1.000
			Dependent Variable: HSQP			
R = 0.233	R^2 = 0.054		ΔR^2= 0.049		Durbin-Watson= 1.270	
	$F_{(2,1003)}$= 10.003; p<0.000					

More specifically, the two variables were positively correlated (R= 0.233), with perceived patient communication explaining 5.4% of the variance in perceived medical care quality (R^2 = 0.054). In other words, a 1% increase in medical staff's perception of patient communication resulted in a 0.323% increase in perception of quality. Based on these results, H_1 (Medical staff's perception of patient communication is effective on medical service quality) was accepted (F=10.003; p<0.05). The Durbin Watson value was 1.270, which indicated no autocorrelation, while the t-test results for the regression coefficients were significant (t=3.163; p<0.05).

Table 11 shows the correlations between the demographic and professional variables and the respondents' perceptions of patient communication and medical care quality.

Table 11
Correlations between Demographic and Professional Variables and Perceived Communication with Patients and Perceived Health Care Quality

	PCP		HSQP	
	r	p	r	p
Hospital Type	-0.006	0.937	.453**	0.000
Profession	-.187*	0.013	-0.083	0.27
Foreign Language	.211**	0.005	-0.033	0.66
Experience	-0.099	0.188	-0.065	0.387
Medical Service Side Income	-0.096	0.205	-.233**	0.002
Foreign Language Side Income	0.029	0.705	-.166*	0.027
Medical Tourism Service Training	0.077	0.311	-0.097	0.197
Training	-0.118	0.117	.229**	0.002
PCP			.233**	0.002
HSQP	.233**	0.002		

There was a significant correlation between perceived patient communication and perceived service quality (r=.233; p:0.002). There was a significant negative correlation between profession and perceived patient communication (r=-.187; p:0.013). A significant correlation was determined between medical staff's foreign language skill and their perception of patient communication (r=.211; p:0.005). A positive correlation was determined among variables. Based on the analysis findings, the correlation level was estimated as 21.1%. A positive and significant correlation was determined between the hospital type of medical staff (Public-Private Hospital) and their perception of medical tourism quality (r=.453; p:0.000), due to analysis findings, the correlation level was estimated the correlation level was estimated as 45.3%. The main purpose of public hospitals is to provide public health services without paying any fee. Private hospitals do not have such a basic purpose other than just emergency health services. In this respect, it is thought that private hospitals give more importance to health tourism and the quality of the service provided in health tourism. In this context, it can be said that the findings obtained have significant results. A negative significant correlation was determined between medical staff's request for additional payment for medical services given under the scope of medical tourism and their perception of medical tourism quality (r=-.233; p:0.002).

Discussion and Conclusions

In medical health tourism, the perceptions of a destination can be damaged if its health professionals lack sufficient knowledge, skills, and equipment to provide good quality medical care. Therefore, both the host country and those working in the specific destination need to have high levels of knowledge, skills, and awareness (Acar and Turan, 2016: 18). Focusing on medical tourism in Turkey, the present study investigated medical staff's perceptions of patient communication and medical service quality in medical institutions located in Alanya City. Given that interaction, relationships, and differences between medical staff's perceptions of patient communication and medical service quality are crucial in medical tourism, this study used survey scales to measure these perceptions in relation to key professional and demographic variables.

Regarding the professional and demographic characteristics of the sample, most of the participants were medical staff, primarily nurses and medical technicians. A majority of the medical staff know English, although a third cannot speak any foreign language. The participants all had at least five years' experience in their profession. A majority of medical staff requested additional payment for providing medical tourism services and believed that they deserved additional compensation for their foreign language skills. Finally, a majority had not received any extra medical tourism

training. This suggests that there is a training deficiency that could be remedied by offering in-service training activities.

There were several significant findings regarding the relationship between the medical staff's perceptions of patient communication and medical service quality and the demographic and professional variables. First, medical staff in private hospitals had higher perceptions of medical service quality.

This is important because a previous study (ESCAP, 2009) reported a significant correlation between medical service quality and patient satisfaction while the institution's medical service quality was the most fundamental requirement for patient satisfaction. Similarly, Nazem and Mohammed (2015: 105-108) reported a significant correlation between medical service quality and satisfaction among international patients at private hospitals in Penang, Malaysia, as did Abd Manaf et al. (2015: 54) for patients in Malaysia

Second, in the present study, medical staff's perceptions of patient communication were not affected by working in private or public hospitals, although the perceived level was slightly higher among private hospital employees. The importance of this is emphasized by Aljumah et al. (2017: 585), who concluded that "[the] behaviour, approach and attitude showed to patients are important in forming the stable relationship between medical institutions and patients."

Third, the medical staff's professions had no effect on their perceptions of medical service quality, although perceived levels were higher for nurses and medical technicians whereas they were particularly low for medical secretaries. Conversely, profession did have a significant effect on medical staff's perception of service quality, with perceived levels being higher for nurses and medical technicians' perceptions and lower for medical secretaries and patient consultants. As Wu (2011: 4877-4880) reports, medical staff must exhibit perfect professionalism, technical competency, effectiveness, and courtesy to gain patients' confidence, which means that their professions emphasize social skills such as empathy, personal attention, understanding patients' needs, and giving care.

Finally, a fundamental communication factor in medical care is rapid responses to patients' requests. The present results relate closely to previous research. For instance, Buzcu and Birdir (2019: 322-324) argue that interventions and treatment in medical tourism need to be implemented quickly. However, this may sometimes be hindered due to patient communication difficulties. Accordingly, timely interventions with significant decisions would introduce positive results.

In the present study, medical staff's foreign language skills significantly influenced their perceptions of both patient communication and medical service quality in that

medical staff with no foreign language skills had higher perceptions. This may because these staff were particularly aware of their language deficiencies and paid close attention to their communication with patients. Our findings support Acar and Turan (2016: 34), who noted the significance of awareness for medical staff providing medical tourism services, identified deficiencies with in-service training in the medical tourism industry, and suggested further projects to eliminate these deficiencies. Sarwar et. al. (2012) concluded that medical tourism service perceptions depend on quality accreditation certificates as well as low-cost treatments, high standards of medical service, accommodation, cheap transport, and attractive touristic characteristics in the destination. The findings also suggest that medical staff should develop their language skills based on the nationalities of medical tourist visitors. In the case of Alanya, these are predominantly Russian.

Regarding compensation, medical staff's perceptions of patient communication were unrelated to receiving additional compensation for their foreign language skills, whereas perceptions of service quality were higher among medical staff who requested additional compensation for their foreign language skills. Similarly, Özdemir and Kervankıran (2011: 15) emphasize the importance of offering material benefits to medical tourism personnel for their foreign language skills.

There were also significant differences in medical staff's perceptions based on their requests for extra compensation for providing medical tourism services. More specifically, personnel who responded "yes" or "partially." This indicates that medical staff want to receive their share of the revenue provided by medical insurance companies for treating medical tourists in both public and private hospitals. Similarly, Erigüç et al. (2018) claim that medical institutions have higher employment costs than other industries because of the higher competency of and specialization of medical staff.

Medical tourists visiting Turkey come particularly from those countries where Turkey has a positive reputation regarding medical tourism services. Indeed, both public and private medical institutions have made substantial investments to provide high-quality medical services, especially in Istanbul, Antalya, Ankara, and Izmir (Aydın, 2012: 94). The 11th Development Plan issued by the Republic of Turkey Presidency Department of Strategy and Budget prioritizes promotion and investment activities to develop medical tourism, improve Turkey's reputation, strengthen its competitiveness, increase the quantity and quality of its medical service capacity, and establish the necessary legal infrastructure, accreditation, and auditing processes.

Due to the profitability of medical tourism and its contribution to the country's economy, awareness of medical tourism has increased. There are many signs of this. For example, seminars, symposiums, and congresses have been organized and

attended by both local and international participants. The Ministry of Health and the Ministry of Culture and Tourism have both supported congresses to help medical tourism develop to the desired level (Aydın, 2012: 92-94). The Ministry of Health has established the Department of Medical Tourism to promote Turkey's international medical services. USHAŞ (International Medical Services A.Ş.) was established to support public and private industries' activities in medical tourism, while the Republic of Turkey Department of Strategy and Budget set concrete targets for medical tourism within its development plans. Public hospitals operating under the Ministry of Health have established international patient departments while private medical institutions increasingly offer treatment to foreign medical tourists.

In providing medical services to health tourists, it is critical to develop the appropriate accreditation and quality concepts and procedures (Kayral, 2018; Hoş, 2016). The standards of accredited medical institutions should conform to international codes, so accreditation should be cascaded across all medical institutions by achieving the required levels of patient communication and medical service quality. As Aydın (2012) notes, it is essential for both private and public hospitals to obtain and then maintain international accreditation to enhance the place of medical tourism in a country's development. In short, it is crucial for medical institutions to maintain quality certification and continuously meet quality accreditation criteria.

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