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Perceived impacts of medical tourism development on community wellbeing

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ABSTRACT

Community leaders and tourism authorities in Las Vegas have suggested the promotion and development of medical tourism to improve the economy and quality of life for residents. The present study uses social exchange theory with spillover theory as the conceptual framework to examine factors of economic performance of medical tourism, overall community satisfaction, health care satisfaction and attitudes toward medical tourism; these factors influence on residents' perceptions of medical tourism's impact on community wellbeing, which in turn affects willingness to pay higher taxes and support for medical tourism development. The findings revealed that the greater the economic performance of medical tourism, the more positive the impact of medical tourism to community wellbeing was perceived. Similarly, attitudes toward medical tourism and overall community satisfaction positively influenced the perceived impact of medical tourism on community wellbeing. Finally, community wellbeing positively influenced residents' willingness to pay higher taxes and support medical tourism development.

1. Introduction

Over the past decade, community leaders and tourism authorities have increasingly viewed medical tourism as an important industry with the potential to diversify existing forms of tourism, improve the economy, enhance local health care systems, create employment, and increase tax revenues. Medical tourism is a niche tourism resulting from the rapid rise of domestic and international travelers in search of medical surgery and therapies for various conditions (Cormany & Baloglu, 2011). Medical tourism—where travel is linked to both wellness and direct medical intervention—is quite new and is satisfying the needs of people who are patients and travelers, from a range of countries, benefiting themselves and a growing number of destinations (Connell, 2011).

Particularly, the US faces an aging population, soaring health care service expenses, decreasing insurance coverage, and caregiver numbers shrinking in relation to the population size, while expectations surrounding holistic care and maintenance of good health are increasing (Cormany, 2013). Furthermore, as the disproportionate increase of private medical costs in other countries and the long waiting lists for some treatments in public hospitals in countries with socialized medicine increases outbound travel to the US for medical services (Gray & Poland, 2008), the ability to attract travelers for health care services becomes a distinct advantage.

In general, tourism's impact on a community in which its developed—both positive and negative—dynamically changes quality of life (QOL), and many studies have focused on understanding residents' perceptions of its impact (Allen, Hafer, Long, & Perdue, 1993; Choi & Sirakaya, 2006; Deccio & Baloglu, 1999; Jurowski & Gursoy, 2004; Jurowski, 1994; Lankford & Howard, 1994; Perdue, Long, & Allen, 1990; Pizam, 1978; Vincent & Thompson, 2002). Residents' perceptions imply that their beliefs about tourism vary widely (Dogan, 1989; Doxey, 1975), and that their relationships on the effects of tourism may be linear or nonlinear (Allen, Long, Perdue, & Kieselbach, 1988; Milman & Pizam, 1988). While previous research has investigated the effects from a variety of tourism types (e.g., eco-tourism, nature-tourism, adventure tourism, recreation-based tourism, cruiseship tourism, historic/heritage tourism, cultural tourism, event tourism; sports tourism, and gaming tourism) on a community, there is a limited understanding of the role medical tourism would play on community QOL (Kim, Woo, & Uysal, 2015).

QOL is a complex concept, wherein multidimensional and interactive domains encompass many aspects of people's lives and environments in different ways (Sirgy, Rahtz, Cicic, & Underwood, 2000). As residents and their external environments change, so too may their perceptions of a community QOL (Sirgy et al., 2000). In this regard, QOL can be expressed by five factors: economic health, subjective wellbeing of locals, unspoiled nature and the protection of resources, healthy culture, and satisfaction (Müller, 1994). These interacting factors are not equal in importance, however. Müller (1994) places a

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particular emphasis on the wellbeing of local residents. Concomitantly, Uysal, Sirgy, Woo, and Kim (2016) recognize that community wellbeing is an important emotional and psychological dimension that involves residents' living experiences within a community and principles of reciprocity applied to residents and regional tourism development.

Particularly, Epley and Menon's (2008) representative group of living experiences include (1) enjoyment and livability of a community; (2) desirability of a community; and (3) satisfaction with overall community QOL. However, while some studies in the area of tourism and residents' support for tourism development have introduced the idea that residents' perceptions of tourism's impact affect their community QOL and their support for incremental tourism development, tourism's influence on community wellbeing has not been associated with the attainment of particular tourism development goals (Andereck & Nyaupane, 2011; McCabe & Johnson, 2013).

Thus, the question remains: Do residents perceive that tourism impacts community wellbeing (i.e. desirability and enjoyment of living in the community, and overall QOL)?

Furthermore, residents in tourism destinations may expect better community wellbeing through medical tourism nested in their communities. The potential effect of medical tourism on community wellbeing can be attributed to its ability to create significant economic benefits and jobs in the health sector in the community (Connell, 2013b). Further increases in jobs should play a significant role in increasing the economic and consumer wellbeing of the residents. Increases in jobs and sales should also generate more tax revenues for the community, which in turn allows increases in public sector spending. Economic, consumer wellbeing, and public sector spending enhance the community's desirability, enjoyment of living in the community and overall quality of life for residents (Epley & Menon, 2008).

This is particularly important in the study's context of the greater Las Vegas area. Las Vegas was hard-hit by the recession in 2008 and endured a slow economic recovery. Gaming revenue suffered a two-year decline (Bush, 2013). The initial phase of the financial crisis caused a $5.2 billion swing from profitability to loss for the top twenty-two performing Las Vegas Strip properties between peak fiscal year 2007 and 2009 (Macomber, 2012). Unemployment rates remained the highest in the nation, reaching 14%and pointing to the deepest economic slide since the Great Depression (Nagourney, 2010). Las Vegas became known as the unofficial foreclosure capital of the U.S, its median home values declined more than 60% between 2008 and 2011 (Bush, 2013; Hanscom, 2014). The region's lack of economic diversity and heavy reliance on gaming, tourism, and construction, was cited as its single-greatest vulnerability.

Consequently, close to a decade post recession, regional stakeholders are underway diversifying the economic base beyond these industries and have recently embraced the potential of promoting Las Vegas as a medical tourism destination. The need for a medical tourism industry is echoed by residents, who advocate serious efforts to extend the economy beyond gaming to create a sustainable Las Vegas region as well as improve the local health care system which is currently ranked poorly in the U.S. national health care ratings (SNMIC, 2013). Distressed local health care services, senior communities, businesses, casinos, resorts, hotels, and other community facilities would benefit from planning as those entities attempt to introduce innovative medical and wellness amenities to attract additional tourism. Important spillover effects from medical tourism planning may include increased desirability of living in the community for residents due to the expanded employment opportunities, stronger tax revenue, and an improved health care system that would benefit the locals as well (LVCVA, 2013).

In 2014, a coalition including the Las Vegas Convention and Visitors Authority (LVCVA), the Las Vegas Global Economic Alliance (LVGEA), the Southern Nevada Medical Industry Coalition, the Las Vegas Health Education Advocacy Leadership of Southern Nevada (Las Vegas HEALS), and the University of Nevada Las Vegas (UNLV) developed a strategic plan for medical tourism. It outlined several existing features for promotion by tourism facilitators to tourists interested in receiving health care services in the entertainment capital of the world—cosmetic surgery, physical therapy, managed and senior care, rehabilitation, diagnostic services, dental services, and holistic treatments, to name a few (LVCVA, 2013).

The Cleveland Clinic center in Las Vegas, for example, is world-renowned for its program on brain health, which offers the diagnosis and treatment of patients with cognitive disorders. The LVCVA also identifies the potential for widespread promotion of medical tourism extending to Las Vegas's world-class wellness travel features, including the spas located in the luxury hotels. In fact, casino resort-hotels have already started developing innovative "healthy-hospitality," including, for example, the MGM Grand's 171 Stay Well rooms and suites, which feature in-room wellness amenities and technology. Furthermore, due to the cost of real estate and state laws allowing research and procedures outlawed in other states, Southern Nevada has seen in recent years a large expansion of medical conventions, training facilities, stem-cell research labs, biotechnology, and pharmaceutical manufacturing—all of which attract physicians and specialists who then set up practice in the area, expanding the medical offerings (NGOED, 2012). With dozens of spas and ample hotel rooms for travelers, combined with growth of state-of-the-art medical facilities and knowledgeable professionals, Las Vegas has the potential to become a sought-out medical tourism destination for patients who seek medical or specialized wellness care and who are interested in a healthy lifestyle (Haugen, 2015).

However, medical tourism could result in traditional health care services for locals turning into commercial opportunism, resulting in varied and paradoxical effects such as tourist overcrowding, higher costs of services, diversion of public funds, decreased accessibility to health care services, and negative relationships between residents and tourists (Connell, 2013a), which reduce enjoyment and quality of living for residents in the community.

Thus, there is a demonstrable need for health care improvement and continued economic revitalization within the Las Vegas metropolitan area, and answers to questions about medical tourism's impact on residents' community wellbeing are important to both community leaders and tourism officials. Medical tourism formulated to enhance residents' enjoyment of living in a community, desirability of a community and overall QOL for residents is also necessary to maintain resident support for tourism. Furthermore, how residents perceive these effects on community wellbeing may be a useful concept for evaluation of not only their support but also their personal investment in tourism development in the form of paying taxes.

To answer these questions, a conceptual model that describes how residents' perceptions of medical tourism's impact on community wellbeing influences their support for development and their taxpaying behaviors was developed and tested.

2. Literature review

2.1. The impact of tourism on local communities

Tourism is critical to both urban and rural development programs around the world, and many disciplines have recognized tourism as a formidable means of economic diversification and social development (Archer, 1978; Cohen, 1978; Farrell, 1977; Inskeep, 1988; Ioannides, 1995; Keogh, 1990; Marcouiller, 1997; Murphy, 1981; Peters, 1969; Turner & Ash, 1975). Previous research has identified that tourism contributes to both benefits and costs to a community (García, Vázquez, & Macías, 2015) and tourism's positive or negative impacts dynamically change community quality of life (QOL) (Allen et al., 1988; Bramwell & Lane, 1993; Haywood, 1988; Johnson, Snepenger, & Akis, 1994; Liu & Var, 1986; Liu, Sheldon, & Var, 1987; McCool & Martin, 1994; Pearce, 2009; Perdue et al., 1990; Sharpley, 2000). Studies have adopted multidimensional approaches to studying tourism's impact on QOL

incorporating economic health (e.g. community infrastructure and standard of living); social resources (e.g. public service provisions, social support network); environmental resources (e.g. unspoiled nature and protection of natural resources); healthy culture (e.g. neighborhood conditions, physical amenities, community commitment); political factors (e.g. confidence in local institutions, power in influencing local institutions); and subjective wellbeing of local residents (e.g. community living experiences and community satisfaction) (Andereck & Nyaupane, 2011; Filkins, Allen, & Cordes, 2000; Gee, Mackens, & Choy, 1997; Goudy, 1990; Grzeskowiak, Sirgy, & Widgery, 2003; Gunn, 1988; Kasarda & Janowitz, 1974; McGehee & Andereck, 2004; Müller, 1994; Nunkoo & Ramkisson, 2012; Sirgy & Cornwell, 2001; Sirgy et al., 2000; Weaver, 2006).

However, Müller (1994) places a particular emphasis on the subjective wellbeing of local residents. Concomitantly, Uysal et al. (2016) recognized that community wellbeing is an important emotional and psychological dimension that involves living experiences within a community and should be studied with principles of reciprocity applied to residents and regional tourism development. In this regard, subjective wellbeing of local residents is considered the pinnacle of a QOL hierarchy and associated with overarching living experiences and community satisfaction as a result of tourism. Sirgy and Cornwell (2001) noted that community wellbeing is comprised of living experiences including the happiness and joy of living in a community, and overall life satisfaction. Thus, the more living in a community is desirable and enjoyable, along with overall satisfaction with quality of life, the greater the community wellbeing overall. However, there are limited studies that specifically investigated residents' evaluation of tourism's impact on community wellbeing (McCabe & Johnson, 2013).

2.2. Social exchange theory with spillover theory and residents perceptions

Among the theories and models that could be used to explain the relationships between residents' perceptions of tourism's impact on community wellbeing, social exchange theory (SET) may have the most utility. SET has been used in myriad studies to explain residents' reactions to tourism's impact to a community and factors influencing those perceptions (Teye, Sirakaya, & Sonmez, 2002).

SET posits that an individual or group will either be receptive towards something or willing to engage in an exchange depending on the perceived benefits and costs. Thus, the central tenets of SET are that a basic form of human interaction is the exchange of either social or material resources; that people want to maximize the value of their exchange outcome; and that propositions of behavioral psychology apply (Kelley & Thibaut, 1978). Exchange theory brings sociology together with economics: economics as an exchange that is carried out by people under special circumstances with built-in value measures (Kivisto, 2011) and social exchange as a basic assumption that people establish social associations because they expect them to be rewarding. Thus, people will enter into an exchange if they feel the transaction results in a "reward" (Kivisto, 2011) such as money, information, and tangible products, along with nonmaterial benefits such as approval, esteem, compliance, love, joy, and affection (Turner & Ash, 1975).

Thibaut and Kelley (1959) first assumed a theoretical standpoint from which to understand the larger group or community as a dyad, a point implied by individual interactions. The implications of this are based on the assumption that if the determinants of the individual's attitude toward an exchange can be explained, a community reaction to an exchange can be understood as well. Fishbein and Ajzen (1975) also noted that the individual's social association has a strong relationship with belief, attitudes, and behavioral intentions under certain conditions and concluded that these relationships can be examined at the individual and collective level.

Thus, an understanding of social exchange will elucidate the interaction between the factors that influence residents' perceptions of tourism's impact on community wellbeing and the implicit 'reward' of benefits to the community provided by its development (Jurowski, 1994). However, in a study, Deccio and Baloglu (2002) highlighted the limitations of SET in understanding tourism's impact on a community, and presented the case for using SET when studying spillover impacts of a mega event.

Spillover Theory, as an economic and social theory, attempts to explain how the events or developments in one area (primary effects) stimulate improvements or satisfaction in a related or unrelated area (secondary effects), and has been applied to QOL studies by Sirgy, Effraty, Siegel, and Lee (2001). Despite this research and what is known about the spillover effect of tourism development on communities and residents' perceptions, there is yet a limited understanding of the nature of spillover from tourism to specific community wellbeing dimensions. Further, Mason and Cheyne (2000) indicated the need for studies on tourism to the examine dynamic and complex nature of a community and the basis on which residents draw conclusions about future tourism. There is also a limited understanding of the role that positive versus negative spillover effects associated with specific types of additional tourism would play on the community (Kim et al., 2015).

Thus, the type of tourism is key to understanding the potential impacts on community wellbeing (Jurowski, 1994), in addition to type of facilities developed (Andereck & Vogt, 2000), level of development (Allen et al., 1988), state of the local economy (Gursoy & Rutherford, 2004), geographic region (Milman & Pizam, 1988), and resident characteristics (Gursoy, Chi, & Dyer, 2009). While previous research has investigated the perceived spillover effects from additional eco-tourism; nature-tourism; adventure tourism; recreation-based tourism; cruiseship tourism; historic/heritage tourism; cultural tourism; event tourism; sports tourism; and gaming tourism development in a community, health tourism - including wellness and medical tourism- is an area that has not been investigated in the residents' attitudes literature.

2.3. Medical tourism and spillover effects

Medical tourism initially emerged from "health tourism" that involves travel outside one's natural health care jurisdiction for the enhancement or restoration of the individual's health through wellness and medical treatments (Connell, 2011). While wellness refers to changes in an individual's health through bodies and minds without surgical or invasive procedures, medical typically refers to restoration of an individual's health through medical intervention (Carrera & Bridges, 2006). In recent decades, however, an increasing importance placed on biophysical processes linked to psychological elements (Nahrstedt, 2004), has caused a convergence of wellness and medicine. Wellness, (i.e. alternative or holistic therapies), may be associated with primary medical treatments, though little or no medical intervention is involved with procedures. The positive resulting health outcomes are nevertheless said to be medical outcomes (Connell, 2011).

Thus, "medical tourism" has been conceptualized as something of an umbrella term which many promoters of tourism have uncritically accepted and associated with travelers in search of better health inclusive of not only necessary and elective medical (surgical and non-surgical) procedures, but also wellness therapies bundled with services for lodging, entertainment, food and beverage, and touring or exploring the attractions of a destination (Hall, 2011). The lack of distinction between health, wellness, and medical tourism is not unusual (Connell, 2011).

Medical tourism is also the outcome of media promoting the concept alongside the convergence of biotechnological development in medicine, mobility, and the evolution of the airline industry. Governments have played a role in further destination marketing and effectively linked medical tourism into broader health tourism that connects invasive medical procedures to rejuvenation, healthy living, and the accommodation for recuperation (Smith and Puczkó, 2008) Despite questionable use of medical terminology, medical tourism describes a niche form of sustainable tourism and has its own segmented-marketing

mechanisms for health services and tourism activities in which travelers are intended to engage upon travel to a particular destination (Robinson, 2005).

Because medical tourism has the propensity to dynamically change the health care and tourism industries, medical tourism may contribute to community wellbeing through processes of spillover effects of commodification and consumption (Connell, 2013a,b; Smith & Puczko, 2008). For example, if medical tourism generates positive effects in relation to improved health care availability, accessibility, and quality, it may then contribute to the desirability and enjoyment of living in a community. Employment opportunities and an improved economy from expanded health care and hospitality systems and additional tax revenues for governments, among community benefits associated with medical tourism, may improve overall QOL for residents.

Thus, Spillover Theory provides an underpinning to understand residents' perceptions of medical tourism's effect on community wellbeing. Furthermore, exchange strategy suggests that SET provides a suitable framework for analyzing not only residents' reactions to medical tourism, but also behaviorist approaches. Medical tourism studied as a social exchange system is focused on the community component of the model where the unit of analysis is the community's residents. The spillover element includes improved community wellbeing from medical tourism. An understanding of the exchange made in this category is critical to explaining the interaction between factors that may influence residents' perceptions of medical tourism's impact on community wellbeing and the ultimate outcome of the exchange, residents' behavior related to its development.

2.4. Residents' behavioral intentions

According to Sharpley (2014), one of the limitations of the research on residents' perceptions is that it does not consider residents' behavioral responses. While it is important to understand how residents' perceptions of medical tourism result in the formation of positive or negative conceptions of its impact on community wellbeing, the extent to which these perceptions are subsequently reflected in residents' behavioral responses is equally critical.

Community wellbeing can be considered as an antecedent of residents' behavioral intentions; expressed support for tourism development is based on the premise that residents in communities would embrace tourism because they expect the spillover effects to then improve community wellbeing. Conversely, it can be expected that residents would be less supportive of tourism if they felt it would eventually detract from their community wellbeing (Woo, Kim, & Uysal, 2015). Therefore, the aim of this study is to focus on the community wellbeing (i.e. desirability, enjoyment of living in a community, and overall QOL) associated with medical tourism in order to explain residents' behavioral intentions. Additional benefits from tourism's development may influence not only resident's support but also investment in tourism (Snaith & Haley, 1999; Turco, 1997) and thus social exchange (Dickinson & Dickinson, 2006; Weaver & Lawton, 2013).

2.5. Theoretical model based on the social exchange theory

As highlighted by Fredline and Faulkner (2000), "developing more general theory concerning the interface between communities and tourism and events … requires a more thorough investigation of variables such as sociopolitical values which may influence residents' perceptions, and also exploration of perception development and transmission" (p. 780). Thus the authors used the tenets of the theories to link variables that impact residents' perceptions of medical tourism's impact on community wellbeing for inclusion in the model (Fig. 1). The principal multi-variable constructs shaping resident perceptions have been classified as "intrinsic" and "extrinsic" factors (Sharpley, 2014). Social exchange theory points to the importance of intrinsic factors—economic performance of tourism (Fredline & Faulkner, 2000), and social and political factors affected by tourism relevant to an individual resident (Zhang, Inbakaran, & Jackson, 2006). Moreover, extrinsic factors represent macro-environmental influences that affect satisfaction with the community as a whole; specifically, inclusion of satisfaction with community health care attributes would be important, as variables of interest, in social exchange studies that examine community settings and medical tourism's spillover effect on the nature of existing health care resources in the community (see Fig. 1).

The model describes (1) factors thought to influence residents' perceptions of how medical tourism impacts community wellbeing, including overall community satisfaction, perceptions of economic performance of tourism; attitudes toward medical tourism;, and (2) how residents' perceptions about the influence of tourism on community wellbeing affect their support for medical tourism development and taxpaying behavior.

2.6. Overall community satisfaction

It has been posited that community satisfaction should be included in the tourism development framework (Ko & Stewart, 2002). Few studies, however, have explicitly investigated the relationships between satisfaction with community and residents' perceptions of tourism impacts (Kim, Uysal, & Sirgy, 2013). Kaplanidou et al. (2013) linked positive effects of tourism and residents' overall satisfaction with QOL. Similar results indicating tourism's positive influence on residents' satisfaction with QOL were found by Kim et al. (2013) and Nawijn and Mitas (2012). In other studies, the focus has been on residents' satisfaction with QOL as the dependent variable influenced by tourism (e.g., Andereck and Nyaupane (2011).

Vargas-Sanchez et al., (2009) argued that residents' levels of satisfaction with their community become a factor affecting their perceptions of tourism's impact on QOL when they are not satisfied. This argument and social exchange provides a lens through which a destination's tourism can be examined. Spillover Theory is indicative of tourism's relevance to the destination involved in the social exchange; where the improvement to a community (a community with which residents may or may not be satisfied, overall) is anticipated.

Therefore, the current study involves investigating residents' satisfaction with community as an antecedent of perceptions of an improved community wellbeing from medical tourism, keeping in mind that resident satisfaction with community is expected to influence perceived improvement in a community from future medical tourism development. The following hypothesis was developed:

H1. Higher community satisfaction leads to more favorable perceptions of medical tourism's positive impacts on community wellbeing.

2.7. Satisfaction with health care

Previous studies have also investigated residents' perceptions of their community as influenced by the importance and satisfaction placed on various community services and attributes (Epley & Menon, 2008); including public services and civic institutions, formal education, environment, recreation opportunities, economics, citizen involvement, government, social opportunities, and medical services (Allen & Beattie, 1984; Allen et al., 1988). Ko and Stewart (2002) investigated resident's satisfaction with hospitals, doctors/dentists, and other services including both composite indicators of individual health care services as well as overall satisfaction with health care. The study supports the notion that satisfaction with community health care attributes may play a significant role in the way improvement to a community's wellbeing from medical tourism is perceived by residents. In other words, residents will perceive improvement to the enjoyment and desirability of living in their community and overall quality of life from medical tourism when they are satisfied with their community health care services (Vargas-Sanchez, et al., 2011). It is reasonable to

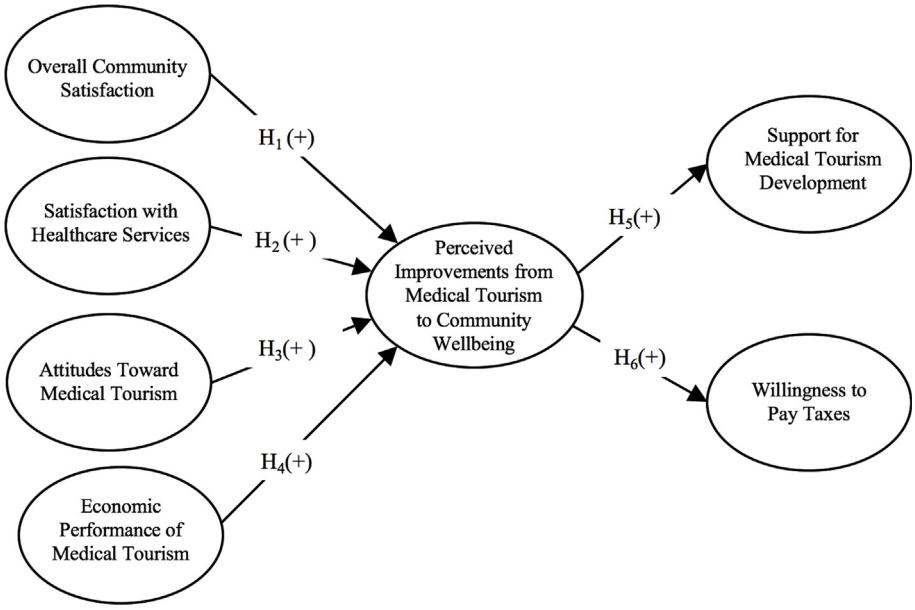

Fig. 1. Conceptual model of residents' responses to medical tourism and hypothesized linkages.

hypothesize the following:

H2. Higher levels of health care services satisfaction lead to more favorable perceptions of medical tourism's positive impacts on community wellbeing.

2.8. Attitudes toward medical tourism

The third variable addresses the "values" component of the intrinsic factors involved in a framework of social exchange theory. Values are often used to construct meanings for what is considered the reward involved in the exchange process. Deery, Jago, and Fredline (2012) indicated that residents with varying social, political and economic values would hold different representations of tourism's impact. Thus, residents' attitudes toward medical tourism are an appropriate measure to explore the relationships between residents and tourism in a community. Attitudes represent residents' feelings towards tourism's potential to achieve the community's long-term political and social goals and measure adaptation to tourism on an embracement-withdrawal continuum for economic planning (McGehee and Andereck, 2004). Measurement of resident attitudes include indicators of tourism growth, community image, role of government and authorities in promoting tourism, and anticipated economic performance of tourism and the basis on which residents draw conclusions of the impacts from tourism on quality of life (Nunkoo & Ramkisson, 2012; Nunkoo et al., 2012). Conceptually, attitudes toward medical tourism relate to individual resident's values, with residents holding different value perceptions of medical tourism's ability to benefit their community wellbeing. Based on this discussion, the additional hypothesis was proposed:

H3. Higher advocacy attitudes toward medical tourism lead to more favorable perceptions of medical tourism's positive impacts on community wellbeing.

2.9. Economic performance of medical tourism

The fourth extrinsic factor is economic performance. It has been widely recognized that positive community economic impact is consistently related to residents' perceptions of tourism (Allen et al., 1993; Deccio & Baloglu, 2002; Jurowski, 1994; Jurowski, Uysal, & Williams, 1997; Lindberg & Johnson, 1997; Liu & Var, 1986; Pizam, 1978 Sharpley, 2014; Sheldon & Var, 1984; Suess & Mody, 2016). Kuvan and Akan (2005) found that residents who indicate they are economically dependent on the tourism industry not only perceive more positive impacts from tourism but also are less disapproving of its negative impacts. Improvement in the economy through tourism is a strong motivation for multiple forms of community tourism development (Nunkoo & Ramkission, 2012). The more positively medical tourism's potential economic performance is perceived, the more positive residents' perceptions of medical tourism's influence on community wellbeing. Thus the authors hypothesize:

H4. Higher perceived economic performance of medical tourism leads to more favorable perceptions of medical tourism's positive impacts on community wellbeing.

2.10. Support for medical tourism development

The second part of the model is based on extensive tourism literature on the relationships between residents' perceptions of impacts and their subsequent support for tourism development. Stylidis (2015) found that residents in Kavala, Greece who perceived higher economic and sociocultural impacts from tourism held a more positive opinion of future tourism development. In a study of the Sunshine Coast in Australia, Dyer, Gursoy, Sharma, and Carter (2007) found that locals were likely to support future tourism development mainly because of the perceived economic and sustainable benefits. In a more rural context, Park, Nunkoo, and Yoon (2015) found the residents' perceptions of positive socioeconomic and environmental impacts predicted their support for tourism. Similarly, while framing the effects of tourism as positive or negative, other researchers such as Lee (2013) and Nunkoo and So (2015) found that a greater perception of tourism's positive impacts influences residents' support for tourism development.

While the relationships between tourism's impacts and residents' support are important in themselves, Pearce, Moscardo, and Ross (1991) add that extant impact and equity should be considered among various forms of tourism development. Thus, an assessment of residents' perceptions of impacts and their support level for different types of development may be necessary to maintain the sustainability of the tourism industry (Gursoy, Chi, & Dyer, 2010; Nunkoo, Smith, & Ramkisson, 2013; Ribeiro, Pinto, Silva, & Woosnam, 2017). Suess and Mody (2016) conducted such an assessment in Las Vegas in which they

examined the different influences of residents' perceptions of tourism effects on their support for seven types of tourism, e.g., alternative tourism, defined as attractions with nature-based, culture and history-based, and outdoor recreation-based themes. In addition, medical tourism, gaming tourism, and event tourism were tested. The assessment found that while some factors influence attitudes toward all forms of alternative tourism, attitudes toward each form of development (i.e., gaming vs. medical tourism) are likely to be formed based on the perceptions of different economic and social factors. Recognizing the need to specify the type of tourism development against which the perceptions of the residents are measured (Gursoy et al., 2009; Vargas-Sanchez, Porras-Bueno, & Plaza-Mejía, 2011) the authors hypothesize:

H5. Residents who perceive higher positive impacts from medical tourism on community wellbeing will more likely support medical tourism development.

2.11. Willingness to pay taxes

A section of literature has examined the impacts of tourism-related taxation on residents' support for tourism development. Krannich and Luloff (1991) noted residents' willingness to pay higher taxes in response to modernization and industrialization in the 1960s, a 1970s population resurgence in rural areas and industrial expansion, and a shift back to economic decline and population loss in the 1980s. Research by Suess and Mody (2016) argued that for many residents in tourism communities, the primary drivers to invest in a community's development and pay higher taxes include community changes from tourism, as well as enhanced QOL through community conditions including expanded infrastructure, higher living standards, increased resources, and improved residential community services. Such economic and lifestyle opportunities represent potential influences on enjoyment and desirability of living in a community and resident personal investment patterns (Gursoy, Jurowski, & Uysal, 2002). Therefore, this study operationalizes residents' behavioral intentions in a manner that most effectively captures individual investment in tourism—that is, residents' willingness to pay higher taxes to support tourism development (Turco, 1997). This assessment leads to the following hypothesis:

H6. Residents who perceive higher positive impacts from medical tourism for community wellbeing are willing to pay higher taxes to support medical tourism development.

3. Methodology

3.1. Survey development

The study used survey research design, and a questionnaire was developed based on previous work in related literature. In the first section of the questionnaire, three statements regarding tourism impacts on community living experiences were adapted on the basis of face validity from a survey by Yu (2011). Respondents were asked to indicate to what extent each of the items on a five-point Likert-type scale (wherein 1 = Much Worse; 5 = Much Better) would either improve or worsen as a result of medical tourism developed in the community. Next, the survey asked respondents, to rate on a five-point Likert-type scale (1 = Strongly Oppose; 5 = Strongly Support) how they personally felt about proposed medical tourism development in Las Vegas. In the second section, three items based on a study by Nunkoo and Ramkissoon (2012) on a five-point Likert Scale (wherein 1 = Strongly Disagree; 5 = Strongly Agree) measured residents' perceptions of medical tourism's potential economic performance.

In addition, five items regarding overall community satisfaction and three items regarding health care satisfaction (1 = Very Unsatisfied; 5 = Very Satisfied) were also included. Both the community and health care satisfaction constructs were adapted from Rahtz and Sirgy (2000) and Ko and Stewart (2002). Another section included a medical tourism attitude scale aimed at determining residents' feelings about medical tourism's future in the community, the importance placed on promoting medical tourism, and beliefs that medical tourism would improve the community's overall image. A series of attitude statements, measured on a five-point Likert-type scale (1 = Strongly Agree; 5 = Strongly Disagree), was utilized, adapted from McGehee and Andereck (2004). Finally, demographic questions, including age, gender, education, ethnicity, household, income, length of residence, and occupation were included in the last section of the survey.

3.2. Sample and data collection

The population of the study was residents of Las Vegas who were eighteen years of age or older. A stratified random sample of residents was taken in the forty-eight zip codes throughout Las Vegas areas delineated as urban in order to gain representative data from residents who would be affected by medical tourism development. Although a sample size of 200 is suggested for structural equation modeling analysis, the model complexity should also be taken into consideration. The sample size was determined based on 5–10 cases per parameter estimate as recommended by Kline (2011) and Bentler and Chou (1987).

The primary means of data collection were telephone interviews conducted by the UNLV Cannon Survey Center. The sample was purchased from Survey Sampling, Inc. (SSI). This company maintains a database of “working blocks,” a set of 100 contiguous numbers identified by the first two digits of the last four digits of a telephone number. After blocks were verified to contain residential phone numbers, telephone numbers were randomly generated from each block, allowing for the inclusion of unlisted numbers and newly listed numbers not included in the most recently published telephone directories. This RDD methodology was augmented with a cellular telephone frame to include approximately 25% of the 18- to 34-year-old demographic. Telephone interviewers placed calls to the randomly selected numbers on various days of the week, including weekends, between 9:00 a.m. and 9:00 p.m. Interviewers made up to seven attempts to contact the individual at each number, placing these calls on different days of the week. All respondents were given the opportunity to complete the survey at another time by scheduling a time convenient for them. Each interview lasted between 15 and 20 min. The proportion of interviews from the cell phone sampling frame was 38% of all completed interviews. Of the 4323 calls eligible for completion, 314 (7.3%) resulted in a completed interview.

3.3. Data analysis

Data analysis consisted of several stages. First, descriptive statistics and distributions were assessed. Twenty-three of the 314 completed interviews had extensive missing data. These cases were deleted, which resulted in a total of 291 cases for further analysis (n = 291). Next, underlying constructs in the proposed model were validated using confirmatory factor analysis (CFA). Finally, structural equation modeling (SEM), using Stata 13.0 (maximum likelihood method), was conducted to test the proposed model. Multiple measures were used to assess both the fit of the measurement and fit of the structural models, including normed chi-square (chi-square/df), critical function index (CFI), Tucker Lewis Index (TLI), root-mean-square error approximation (RMSEA), and standardized root mean squared (SRMR). These indices have been suggested for single group analysis (Browne & Cudeck, 1993; Hair, Black, Babin, & Anderson, 2010).

4. Results

4.1. Profile of respondents

Demographic data collected for each respondent consisted of

Table 1
Demographic profile of respondents.

Demographic		*f*	% (*n* = 291)
Gender	Male	129	44.33
	Female	162	55.67
Age (years)	Older than 75	18	6.2
	60–75	81	27.8
	45–59	56	19.2
	30–44	82	28.2
	18–29	35	12.0
	Refused to respond	11	3.8
Household	Single adult living alone or with other single adult	94	32.30
	Single adult living with children	37	12.71
	Married couple living without children	65	22.34
	Married couple living with children	88	30.24
	Refused to respond	7	2.41
Length of residence	Less than a year	12	4.12
	1–3 years	36	12.37
	4–6 years	29	9.97
	7–9 years	25	8.59
	9–12 years	27	9.28
	More than 12 years	135	53.61
	Refused to respond	27	9.28
Employment status	Employed full-time	110	40.29
	Employed part-time	28	10.26
	Unemployed	20	7.33
	Temporarily laid off	3	1.10
	Retired	96	35.16
	Other	10	3.66
	Refused to respond	6	2.0
Occupation	Utilities	1	.73
	Construction	5	3.65
	Manufacturing	2	1.46
	Transportation/ warehousing	4	2.92
	Information	1	.73
	Finance or insurance	4	2.92
	Real estate, rental, leasing	6	4.38
	Professional, scientific, or technical	28	20.44
	Management of companies, enterprises	3	2.19
	Administration, support, waste management	5	3.65
	Educational services	15	10.95
	Healthcare, social assistance	17	12.41
	Arts, entertainment, or recreation	8	5.84
	Accommodation or food services	12	8.76
	Other	25	18.25
	Refused to respond	1	.73
Income (yearly)	Less than $15,000	46	15.81
	$15,000– less than $30,000	39	13.40
	$30,000-–less than $45,000	52	17.87
	$45,000-–less than $60,000	28	9.62
	$60,000-–less than $75,000	22	7.56
	$75,000–less than $90,000	14	4.81
	$90,000 or more	47	16.15
	Refused to respond	39	13.40
	Don't know	4	1.37
Education	Grade school	4	1.38
	High school	76	26.30
	Some college	96	33.22
	College	72	24.91
	Graduate school	41	14.19
	Refused to respond	0	0
Ethnicity	White/Caucasian	175	60.14
	Black/African American	34	11.68
	Asian/Pacific Islander	25	8.59
	Native American/Alaskan Native	2	.69
	Multiracial	22	7.56
	None of these	30	10.31
	Refused to respond	3	1.03
Hispanic background	Yes	48	9.97
	No	243	87.71
Willingness to pay higher taxes for medical tourism development	Strongly agree	55	18.9
	Agree	104	35.75
	Neither agree nor disagree	47	16.15
	Disagree	79	26.12
	Strongly disagree	9	3.09
Support for Medical Tourism Development	Strongly support	43	14.78
	Support	120	41.24
	Neither support nor oppose	114	39.18
	Oppose	11	3.78
	Strongly oppose	3	1.03

gender, age, household, length of residence, employment status, occupation, income, education, ethnicity, and willingness to pay higher taxes. The demographic characteristics of respondents are shown in Table 1. In terms of gender, 44.33% of the respondents were male; 55.67% were female. The majority of respondents were middle aged or older. The largest percentage of households reported was single adult living alone (32.30%), followed by married couples with children (30.24%) and married couples without children (22.34%). The majority of the respondents (53.61%) had lived in Las Vegas more than twelve years; only 4% had lived there less than one year. In terms of employment status, 40.29% of the respondents indicated they were employed full-time, 35.16% were retired, and 7.33% were unemployed. Respondents represented a wide range of occupations, with the largest group (20.44%) engaged in professional, scientific, or technical occupations. The question concerning income received the highest number of respondents refusing to answer (13.40%). The majority of respondents were represented in one of three income brackets: less than $15,000 per year (15.81%), $30,000–$45,000 per year (17.87%), and over $90,000 per year (16.5%). The majority of the respondents (72.32%) had either attended or graduated from college or had completed graduate degrees; 27.68% had high school educations or less. Ethnically, the majority of respondents (60.14%) were White/Caucasian. Only 9.97% had Hispanic or Latino backgrounds. The majority of respondents (54.66%) also indicated they were willing to pay higher taxes to bring more medical tourism development to Las Vegas. However, 16.15% of the respondents neither agreed nor disagreed with that statement. Fifty-six percent of the respondents have supported medical tourism development. The respondent profile is consistent with the demographics of Clark County and the state of Nevada ("Clark County, Nevada," 2015; Waddoups, 2013).

Table 2 shows the statistics concerning the respondents' perceptions of the impacts of medical tourism on community wellbeing, willingness to pay higher taxes, support for medical tourism development, overall community satisfaction, satisfaction with health care, economic performance of medical tourism, and attitudes toward medical tourism. The majority of respondents indicated medical tourism will impact the following indicators positively: (a) the desirability of living in Las Vegas ($M = 3.64$; $SD = 0.84$), (b) the overall QOL in Las Vegas ($M = 3.62$; $SD = 0.78$), and (c) the enjoyment of living in Las Vegas ($M = 3.59$; $SD = 0.75$). The majority of respondents were willing to pay higher taxes to bring medical tourism development to Las Vegas ($M = 3.20$; $SD = 1.10$) and were supportive of medical tourism development ($M = 3.65$; $SD = 0.81$). Respondents also indicated they were satisfied with the overall QOL in Las Vegas ($M = 3.90$; $SD = 0.97$) and found Las

Table 2
Means and Standard Deviations for Survey Measures.

Topic	Survey item	*M*	*SD*
Perceived improvements from medical tourism (Epley & Menon, 2008; Yu, 2011)			
• Community wellbeing	Desirability of living in Las Vegas	3.64	.84
	The quality of life in Las Vegas	3.62	.78
	Enjoyment of living in Las Vegas	3.59	.75
Willingness to pay taxes (Gursoy & Rutherford, 2004)	I would be willing to pay higher taxes/assessments if it would bring more medical tourism development to Las Vegas.	3.20	1.10
Support for medical tourism development (Jurowski, 1994)	How much do you support or oppose medical tourism development in this community?	3.65	.81
Overall community satisfaction (Rahtz & Sirgy, 2000)	How would you rate Las Vegas as a desirable place to live?	3.85	.99
	To what extent do you enjoy living in Las Vegas?	4.09	.87
	When thinking about conditions in Las Vegas, are they getting worse/about the same/or getting better?	3.09	.92
	In the years to come do you think conditions in Las Vegas, will be getting worse/about the same/or getting better?	3.34	.90
	Overall, how satisfied are you with the quality of life in Las Vegas?	3.90	.97
Satisfaction with healthcare (Ko & Stewart, 2002; Rahtz & Sirgy, 2000)	In general, how satisfied are you with the overall quality of healthcare available in Las Vegas?	3.29	1.22
	How satisfied are you with the overall quality of healthcare that you personally have received in Las Vegas?	3.70	1.11
	How satisfied, would you say, most of your friends, neighbors, and other family members living in the area are with the overall quality of healthcare available in Las Vegas?	3.13	1.10
Attitudes towards medical tourism (McGehee & Andereck, 2004)	Medical tourism could be one of the most important industries for Las Vegas.	3.49	.95
	Additional Medical tourism would help Las Vegas grow in the right direction.	3.70	.83
	The medical tourism industry could play a major economic role in Las Vegas.	3.69	.88
	I would be happy and proud to see medical tourists coming to see what Las Vegas has to offer.	3.78	.84
	I support medical tourism having a vital role in Las Vegas.	3.81	.81
	Medical tourism holds great promise for Las Vegas's future.	3.63	.85
	The tourism organizations of Las Vegas and governments should do more to promote medical tourism.	3.57	.86
	I favor building new medical tourism facilities which will attract tourists.	3.61	.86
	Las Vegas should plan and manage the growth of medical tourism.	3.66	.84
Economic performance of medical tourism (Nunkoo & Ramkisson, 2012)	Medical tourism will help deal with Las Vegas's current economic challenges.	3.50	.88
	Medical tourism will help deal with Las Vegas's future economic challenges.	3.64	.83
	Medical tourism will help deal with unemployment in Las Vegas.	3.72	.86

Table 3
Comparison of AVE and squared correlations of paired constructs[a].

Constructs	Economic performance	Attitudes toward medical tourism	Overall community Satisfaction	Satisfaction with healthcare	Community wellbeing
Economic performance	.61[a]				
Attitudes toward medical tourism	0.6534	.57[a]			
Overall community satisfaction	0.1909	0.1583	.61[a]		
Satisfaction with healthcare	0.2046	0.1770	0.3474	.58[a]	
Community wellbeing	0.4923	0.5620	0.3240	0.1896	.72[a]

Notes: [a]AVE is on the diagonal. Squared correlations of paired constructs are on the off-diagonal.

Vegas to be both an enjoyable (M = 4.09; SD = 0.87) and a desirable place to live (M = 3.85; SD = 0.99). Although respondents did not perceive either the improving or worsening of overall community conditions at present (M = 3.09; SD = 0.92), they did anticipate marginal improvement in community conditions in the future (M = 3.34; SD = 0.90). The majority of respondents indicated overall satisfaction with the health care available in Las Vegas and believed their friends and family members were generally satisfied as well: (a) general quality of health care (M = 3.29; SD = 1.22), (b) availability of health care (M = 3.70; SD = 1.11), and (c) satisfaction of friends and family with health care (M = 3.13; SD = 1.10).

Respondents perceived medical tourism positively in terms of helping with current economic challenges (M = 3.50; SD = 0.88), future economic challenges (M = 3.64; SD = 0.84), and unemployment (M = 3.72, SD = 0.86). They also expressed positive attitudes toward medical tourism, with the most positive attitudes being the vital role medical tourism may play in Las Vegas' future (M = 3.81; SD = 0.81) as well as happiness and pride regarding the influx of medical tourists coming to see what Las Vegas has to offer (M = 3.81; SD = 0.81).

4.2. Confirmatory factor analysis

The scales used to measure constructs in the model— overall community satisfaction, satisfaction with healthcare, attitudes toward medical tourism, and economic performance of medical tourism—have been validated in previous studies, while residents' support for medical tourism development and their willingness to pay taxes were assessed using single-item measures. A confirmatory analysis was conducted on the hypothesized model. Simple model modification was necessary after an examination of standardized residual covariance showed high collinearity), among construct items (a) "When thinking about conditions in Las Vegas, are they getting worse/about the same/or getting better?; " and (b) "In the years to come, do you think conditions in Las Vegas will be getting worse/about the same/or better?" The items were removed and the model was then retested. All measurement model paths were significant without any offending estimates (Table 3). The respecified model fit indices indicated an acceptable range based on the suggested threshold values: RMSEA = 0.040; SRMR = 0.028; CFI = 0.97; TLI = 0.99; $\chi 2(414) = 861.388$; Normed $\chi 2 = 2.08$ (861/414) (Acock, 2013; Hair et al., 2010). The chi-square test for the measurement models was significant. However, chi-square statistical results tend to be significant in large sample sizes and complex models

Table 4
Confirmatory factor analysis.

Constructs and indicators	Loadings[a]	Indicator reliability	Error variance[b]
Overall community satisfaction (α = .80; ρ = .83; AVE = .61)			
●How would you rate Las Vegas as a desirable place to live?	.76	.58	.42
●To what extent do you find Las Vegas to be an enjoyable place to live?	.81	.66	.34
●Overall, how satisfied are you with the quality of life in Las Vegas?	.78	.60	.39
Satisfaction with healthcare (α = .80; ρ = .80; AVE = .58)			
●In general, how satisfied are you with the overall quality of healthcare available in Las Vegas?	.86	.74	.26
●How satisfied are you with the overall quality of healthcare you personally have received in Las Vegas?	.76	.58	.42
●How satisfied, would you say, most of your friends, neighbors and other family members living in the area are with the overall quality of healthcare available in Las Vegas?	.64	.41	.59
Attitudes toward medical tourism (α = .90; ρ = .92; AVE = .57)			
●Medical tourism could be one of the most important industries for Las Vegas	.66	.44	.56
●Additional medical tourism would help Las Vegas grow in the right direction.	.73	.53	.47
●The Medical tourism industry could play a major economic role in Las Vegas	.79	.62	.38
●I would be happy and proud to see medical tourists coming to see what Las Vegas has to offer.	.69	.48	.52
●I support Medical tourism having a vital role in Las Vegas	.81	.66	.34
●Medical holds great promise for Las Vegas' future	.80	.64	.36
●The tourism organizations of Las Vegas and government should do more to promote medical tourism.	.78	.61	.39
●I favor building new medical tourism facilities which will attract tourists.	.81	.66	.34
●Las Vegas should plan and manage the growth of medical tourism.	.74	.55	.45
Economic performance of medical tourism (α = .81; ρ = .82; AVE = .61)[c]			
●Medical tourism will help deal with current economic challenges facing Las Vegas.	.74	.55	.45
●Medical tourism will help deal with future economic challenges facing Las Vegas.	.89	.79	.21
●Medical tourism will help deal with unemployment in Las Vegas.	.69	.48	.52
Perceived improvements from medical tourism to community wellbeing (α = .82; ρ = .83; AVE = .72)			
●The desirability of living in Las Vegas	.92	.85	.25
●The quality of life in Las Vegas	.81	.66	.34
●The enjoyment of living in Las Vegas	.82	.67	.33

[a] Entries are standardized values; all statistically significant ($p < .01$).
[b] Error variance entries are standardized.
[c] α = Cronbach's alpha of reliability; ρ = composite construct reliability; AVE = amount of variance extracted. The average variance estimates (AVEs) ranged between 0.58 and 0.61.

(Liu & Jang, 2009).

The authors used several measures to check the reliability and the validity of the CFA model (Liu & Jang, 2009). Cronbach's α and composite reliability values were computed to check the measurement's reliability. Reliabilities were over 0.70 as recommended by Hair et al. (2010). Convergent validity and discriminate validity were also tested by checking factor loadings and average variance extracted (AVE). All composite reliabilities were above 0.70 and exceeded the squared correlations between pairs of constructs, indicating high internal consistency between the items measuring the various constructs and providing support for the discriminant validity of the measures (Acock, 2013). A comparison of AVE and squared correlations of paired constructs is shown in Table 3.

Convergent validity was satisfied in this study in that all items had high (values ranged from 0.64 to 0.92), significant, $p = .000$, standardized factor loadings on their underlying constructs. The values for both the reliability and validity measures indicated that the models. Table 4 represents the measurement model that was tested in the present study.

4.3. Structural equation modeling

Based on the measurement fit, the structural model (Fig. 2) was tested. The model achieved acceptable fit indices based on the suggested threshold values RMSEA = 0.05; SRMR = 0.05; CFI = 0.93; TLI = 0.92; $\chi2(220) = 425.15$; Normed $\chi2 = 1.93$ (425/220) (Acock, 2013; Hair et al., 2010). The model relationships are summarized in Table 5.

The analysis explained several relationships specified in the model. Cohen's Rule was used to assess the strength of the relationships based on coefficients falling in the range of weak (less than 0.30), moderate (greater than 0.30 but less than 0.50) and strong (greater than 0.50) (Deccio & Baloglu, 2002). The path from overall community satisfaction to perceived improvements from medical tourism to community wellbeing (H1) was weak, standardized coefficient = 0.27, and significant, $p < .05$. This suggests that resident satisfaction levels with the existing conditions of the community influence whether or not the residents believe that medical tourism will improve living experiences essential to community wellbeing. However, the path from satisfaction with healthcare to perceived improvements from medical tourism to community wellbeing (H2) was not significant. The path from attitudes toward medical tourism to perceived improvements from medical tourism to community wellbeing (H3) was strong, standardized coefficient = 0.47, and significant, $p < .01$. This relationship indicated that favorable attitudes toward medical tourism lead to more positive perceptions of community wellbeing improvement as a result of medical tourism. The path from economic performance of medical tourism to perceived improvements from medical tourism to community wellbeing (H4) was weak, standardized coefficient = 0.17, and significant, $p < .10$. This indicates that there is a positive relationship between perceived economic performance of medical tourism and perceived improvement from medical tourism to community wellbeing. Finally, residents' perceived improvements to community wellbeing from medical tourism was positively associated with their support for medical tourism development (H5) as indicated by the moderate (0.37) and significant path ($p < .01$). Moreover, the path from perceived improvement to community wellbeing from medical tourism to residents' willingness to pay higher taxes (H6) was weak (0.17) and significant ($p < .01$).

5. Discussion

This study developed a working model to investigate resident perceptions of medical tourism effects from a community quality of life (QOL) wellbeing perspective. From the literature, community wellbeing—including living experiences in Las Vegas, as impacted by medical tourism—was evaluated to determine residents' behavior. Overall, the results showed the interplay among numerous factors like residents' attitudes toward medical tourism, economic performance of

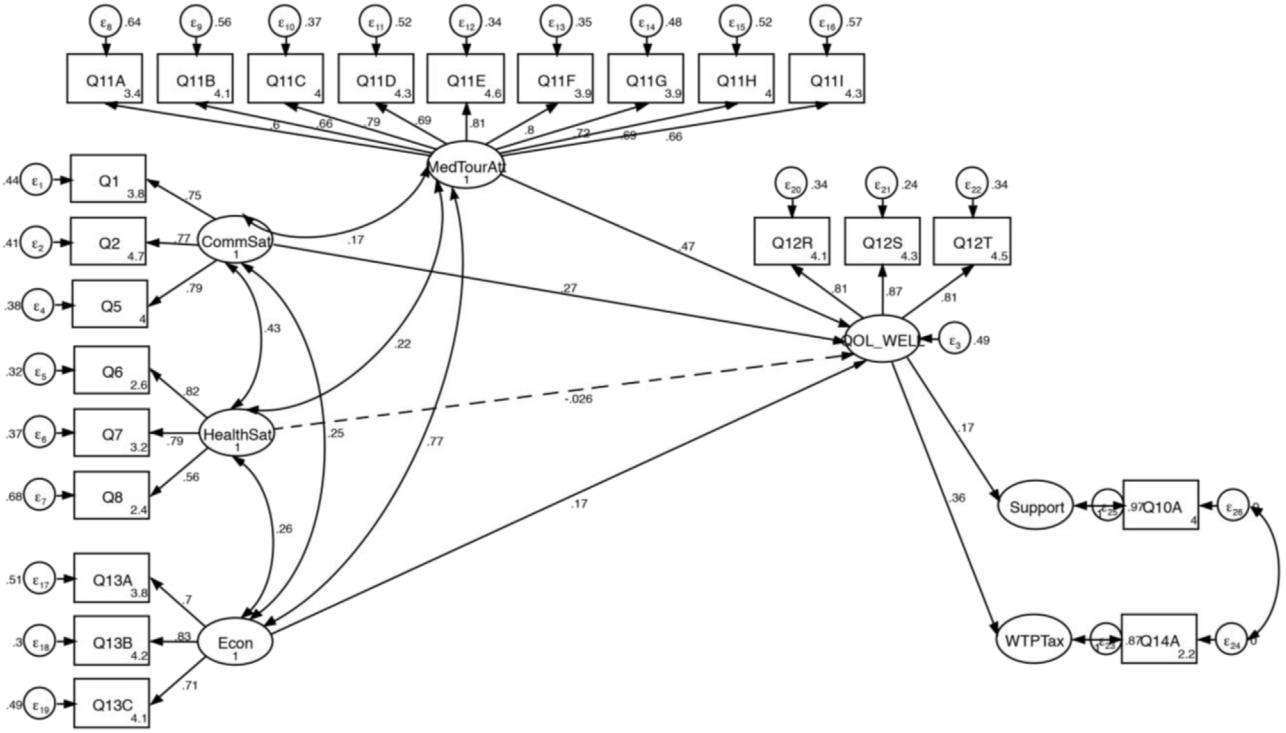

Fig. 2. Model as operationalized in Stata 13.0.

medical tourism, overall satisfaction with the community and satisfaction with health care services, residents' perceptions of medical tourism's impact on community wellbeing, and support for medical tourism development and willingness to pay taxes. Residents ultimately perceived that medical tourism would enhance community wellbeing. This finding indicates that residents do not see medical tourism as a development that creates problems in the overall QOL in a community and is a testament to the importance placed on the enjoyment and desirability of living in a community.

Overall satisfaction with a community positively influenced the way in which residents perceived improvements to community living experiences due to medical tourism. This finding confirms the proposition made by both Ko and Stewart (2002) and Uysal (2012) that community satisfaction could be a critical factor influencing how residents perceive positive and negative impacts of tourism development. However, the study did not find any significant relationship between residents' levels of satisfaction with health care services in the community and their perception of medical tourism impacts on community wellbeing, which was surprising given study results of Nunkoo and Ramkisson's (2009) study that indicated residents' satisfaction with community services are important in determining a community's attitude towards tourism's impact.

The support for the relationship between resident attitudes toward medical tourism and medical tourism's perceived improvement to community wellbeing is consistent with the long history of research on residents' attitudes confirming correlations between attitudes toward tourism and positive or negative perceptions of impacts from tourism. Likewise, this finding of the positive relationship between perceived economic performance of medical tourism and its perceived improvements to community wellbeing is in line with previous research that has found perceived economic improvement from tourism influences the way that residents perceive tourism to positively or negatively affect various community conditions (Deccio & Baloglu, 2002; Sharpley, 2014; Suess & Mody, 2016). In fact, improvement to the economy has been regarded as one of the most visible and powerful motivations for influencing residents' perceptions of the impacts of any tourism development in a community (Kotler, Bowen, Makens, & Baloglu, 2016).

Medical tourism's perceived improvement to community wellbeing is associated with resident support for development. This has been supported by the data, as evidenced by the significant and positive path relationship from perceived improvements to wellbeing to support for medical tourism development. These positive relationships indicate that residents who perceive medical tourism's spillover improvements to the desirability and enjoyment of living in a community and overall QOL (i.e., wellbeing) will support medical tourism development in the community. Several studies have found evidence confirming the direct

Table 5
Structural equation model relationships.

Path	Path coefficient[a]	$p > z$
Overall community satisfaction - > Percieved improvements from medical tourism to community wellbeing (H1)	.27 (.05)	.02**
Satisfaction with healthcare → Perceived improvements from medical tourism to community wellbeing (H2)	-.02(.06)	.68[ns]
Attitudes toward medical tourism → Perceived improvements from medical tourism to community wellbeing (H3)	.47(.09)	.00***
Economic performance of medical tourism → Perceived improvements from medical tourism to community wellbeing (H4)	.17(.10)	.09*
Perceived improvements from medical tourism to community wellbeing → Support for medical tourism development (H5)	.36(.05)	.00***
Perceived improvements from medical tourism to community wellbeing → Willingness to pay higher taxes (H6)	.17(.06)	.00***

*** = $p < .01$; ** = $p < .05$ * = $p < .10$.
[ns] = $p > .10$.
[a] Entries are standardized estimates (standard errors).

and indirect relationships between the perceived positive or negative tourism impacts on a community and residents' subsequent support for tourism development (Choi & Murray, 2010; Dyer et al., 2007; Gursoy et al., 2002, 2009; Sharpley, 2014; Suess & Mody, 2016).

Residents are more willing to pay higher taxes if their perceptions of improvement to community living experiences due to medical tourism are more favorable. A strong support for medical tourism development evidenced when indicators of enhanced enjoyment of living in a community, desirability of a community, and overall QOL were associated with medical tourism. Therefore, this study explained tourism QOL in a context of medical tourism's impact on a representative group of community living experiences and its influence on residents' behavioral intentions.

5.1. Theoretical and practical implications

This study utilized social exchange and spillover theory to develop and test a model underlying destination community residents' behavioral responses to medical tourism development. In so doing, the authors sought to consider a broader conceptual foundation for understanding residents' perceptions of tourism's impacts on community QOL and wellbeing. Constructs were identified to achieve this consideration and hypothesize the relationships based on spillover effects of medical tourism to community wellbeing, support and willingness to pay more taxes for tourism development.

By including two behavioral dimensions in the model—i.e., support for medical tourism development and residents' willingness to pay higher taxes—the present study also addressed the "value-action gap," which is limited in studies on resident perceptions (Blake, 1999). As highlighted by Sharpley (2014), in many contemporary contexts, particularly those of tourism, there exists a value- or intent-action gap in that attitudes are expressed, but not necessarily reflective of what resident's would actually do. Behavioral intention, by contrast, can be a strong indicator of actual behaviors. Suess and Mody (2016) found that residents in the Las Vegas metropolitan area indicated a willingness to pay higher taxes in addition to their attitudinal support for diverse forms of tourism development in their community. Moreover, in the present study's context, residents were more likely to show support and pay higher taxes if they perceived medical tourism as way to improve their community wellbeing. Thus, the residents in this study appear to adopt medical tourism as a positive development tool for their community. One reason would be that the local health care system has poor scores in national health care rankings. Most destinations that target the medical or health tourism markets have world-class health care facilities. Las Vegas has seen an economic opportunity and unveiled a strategic plan and mission to position itself as a medical tourism center despite the weaknesses in its health care facilities and services. Residents might have viewed medical tourism as a way to improve health care facilities and services. Communities recognize the need to capitalize on the fast-changing political and economic landscapes, appreciating that Las Vegas is an attractive destination for tourists and residents because of its gaming and hospitality, ease of access, affordable cost of living, and opportunities for new tourism development products. Thus, medical tourism as a sustainable holistic development paradigm necessitates a supportive local community, which will likely only be possible if its improved community attributes are accounted for. Social exchange and spillover effects refute the argument that medical tourism, with its great potential for health care improvement and thus social benefit marketing acceptability, represents the way forward for the greater Las Vegas metropolitan area.

In the present study, residents indicated that they believe medical tourism would positively improve community wellbeing, consistent with a study by Gursoy et al. (2009), which found higher support for tourism development among residents of the Sunshine Coast as a result of tourism's perceived improvement to cultural and socioeconomic QOL community dimensions. For tourism planners in the Las Vegas metropolitan area, these findings represent significant opportunities for development in the region. Securing resident support for medical tourism—both attitudinally and in terms of their personal investment in the form of higher taxes, among other options—is likely to strengthen the probability of government authorities' permissions for land use with zoning for new health care institutional development and medical licensure, since they are assured that residents feel there is something in it for them, in exchange. The economic gain from an expanded health care industry and its ability to allow residents to capitalize on the improved medical opportunities afforded by the medial tourism development agenda represents the focal idea that tourism planners can disseminate.

Medical tourism development provides some opportunities for economic diversification as well. For example, in another case about Las Vegas, Suess and Mody (2016) highlighted that the use of alternative tourism development options as a tool for improving the income and employment benefits of tourism from the core to the periphery represents a realistic tourism development policy. As opposed to relying solely on gaming and casino development options to stimulate economic and social regeneration, Las Vegas can instead leverage the synergistic long-term financial and technical support benefits of medical tourism inclusive of an expanded health care system and diversified hospitality and tourism offerings.

There is extensive research in tourism regarding resident attitudes, but little that specifically addresses QOL and community wellbeing (Uysal et al., 2016) and even sparser research investigating the impact of medical tourism on residents and communities (Genç, 2012). This study thus contributes to the literature by creating a foundational structural model to describe residents' perceptions of medical tourism's impact on these areas and to evaluate its antecedents and effects on residents' behavioral intentions. The model broadens the scope of Jurowski (1994), Deccio and Baloglu (2002), and Gursoy and Rutherford's (2004) social exchange and spillover models by showing how impacts from tourism affect residents' community wellbeing and taxpaying behaviors.

Medical tourism may be perceived as beneficial by residents if its development results in a fulfillment of improved living experiences. Tourism and development in general may not be beneficial, but if residents perceive that medical tourism benefits outweigh the costs, then they may be more likely to support it.

Consequently, the results can be used to address planning and development issues. Understanding of residents' opinions, how medical tourism impacts community wellbeing, and favorable endorsement of medical tourism and taxpaying behavior will help tourism stakeholders predict behavioral outcomes, thus shaping more successful strategies for community development (Guiry & Vequist, 2011). Too often, development planning in destinations is undertaken without thought to community QOL. This research, therefore, was designed to explore many questions associated with medical tourism effects on local communities and suggests that medical tourism will, from the residents' perspectives, positively enhance desirability and enjoyment of living in a community and perceptions of QOL.

Medical tourism is a rapidly expanding niche industry driven by the growing number of aging and affluent patients at rates that surpass the availability of quality health care resources. With the great variation in the complexity, delivery, accreditation, and overall quality of experience in medical facilities abroad, along with the increasing popularity of domestic health and wellness travel within the United States for consumers seeking alternative therapies and second opinions from qualified United States providers, it should be noted that more countries and medical providers recognize the potential for new business in the US; and Las Vegas is one of the first markets positioned to attract medical tourism to consumers. Residents' willingness to pay higher taxes in exchange for medical tourism gives state officials who have pledged to promote economic development in the medical industries is a strong indication for potential return on investment for expenditures

on incentives that will attract medical and wellness industry businesses to Las Vegas.

6. Limitations and future research

One of the limitations of this study is low response rate, which is relatively lower than other studies on resident attitudes appearing in the literature that have employed mail-survey methods. Therefore, results might not be representative of the whole population because of hard-to-reach respondents and lack of a nonresponse bias check. In addition, the sample profile is consistent with the demographics of Clark Country and the state of Nevada, the representation of Hispanic residents in the present study (9.97%) was lower than the figures for the region (27–30%); the survey instrument was administered in English only, which would have resulted in a lower sample size for this category. Because the study was conducted in the context of Las Vegas, the results may not be generalizable over other tourism destinations. Based on the studies by Snaith and Haley (1999) and Turco (1997), the authors captured residents' behavioral intention as their willingness to pay higher taxes to support tourism development. However, actual behaviors may be different from self-expressed intentions. While it may not be feasible or even useful to capture residents' actual tax paying behavior, since taxes are mandated and residents have no choice but to pay them, the use of a ratio variable that captures a percentage increase in residents' willingness to pay higher taxes would provide more nuanced and behaviorally representative information.

The theoretical model used in the study is a broad overview of medical tourism's impact and does not discern between the impact on the community associated with specific forms of medical tourism development (e.g., cosmetic procedures, dental services, senior care, etc.).

It would be also useful to compare models across medical tourism's different segments where residents might vary in terms of their support for various forms of medical tourism development). Another potential moderator that may carry important practical implications is the satisfaction with specific community health care attributes. The ability to distinguish between satisfactory and unsatisfactory health care services would enable an explanation of how medical tourism influences the dynamics of community wellbeing and behavioral intentions. It is likely in the next decade more research and advances in medical and wellness fields will create new services in the health care industries, influencing both supply and demand for medical tourism. Thus future researchers are encouraged to develop detailed frameworks for critically analyzing medical tourism and its development's impact on the QOL of individuals as tourists and providers alike, including employees of the health care and tourism industries.

Further research should also focus on articulating pertinent objective and subjective indicators in future tourism studies to better capture QOL domains of both community residents and tourists (Uysal et al., 2016). QOL is usually measured with either objective or subjective indicators. Research may benefit from conjoining objective and subjective indicators to better develop conceptualizations and measures of QOL for tourism and community residents that can address the nuances of complexity in medical tourism. Doing so may enhance the predictive utility of QOL measures in empirical research. This implies that research on medical tourism should be contextualized to reflect the uniqueness of health care services and tourism activities in the destination. In addition, QOL can be assessed at different levels of analysis: individual, family, community, and destination levels (Sirgy et al., 2001). Finally, it may be beneficial to understand how resident attitudes are conditioned by the level and type of tourism interaction (Sharpley, 2014; Weaver & Lawton, 2001), personality and ethnicity (Zhang, Inbakaran, & Jackson, 2006), and resident demographics (Yoo, Zhou, Lu, & Kim, 2014). Another potential moderator that may carry important practical implications is the frequency of use of specific resources by residents including spa/wellness and medical services intended for inclusion in medical tourism offerings.

Appendix A. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.tourman.2018.06.006.

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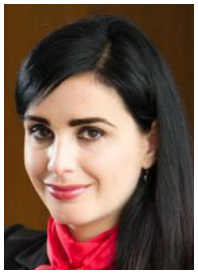

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