# Predictors of Medical Destination Intention to Visit: The Role of Culture of Destination-Iraqi patients as an example

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Supervisor: Professor Astrid Dickinger

Student name: Dr. Abdulla AlNAKSHABANDI

Student number :61904156

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## ABSTRACT

Medical tourism is an emerging field, and it is attracting researchers and practitioners. Studies that have dealt with this topic in developing and emerging economies is still limited. The purpose of this study is to examine the predictors of medical destination (MD) intention to visit. Based on theory of planned behavior(TPB) and theory of reasoned actioned (TRA), this study proposed that the medical tourism expenses, medical staff service quality, and product belief will affect the attitude (AT) toward medical tourism. In addition, homophily and destination belief will affect the subjective norms (SN). The AT, SN, and medical tourism infrastructure are proposed to affect the MD intention to visit. Destination culture is proposed to moderate the effect of AT and SN on MD intention to visit. The population of this study is the Iraqi medical tourists, and the destination is set to be Dubai. Due to the lack of database of these respondents, connivance sampling technique was deployed in this study. Using a questionnaire, the data was collected. A validation process was conducted as well as a pilot study to ensure that the measurement of the variables is reliable. A total of 315 complete and usable responses were collected in this study. The data was analyzed using SPSS and smart partial least square (Smart PLS). The data was analyzed for missing values, outliers, normality, and multicollinearity. The Smart PLS was deployed to assess the measurement and structural model. The findings of this study showed that the effect of medical staff service quality and medical tourism expenses on AT were significant. Homophily and destination belief affected the SN. In addition, AT, SN, and medical tourism infrastructure affected the MD intention to visit. Destination culture did not moderate the effect of AT or SN on MD intention to visit. Decision makers were advised to develop packages that suit all type of medical tourist and to hire high quality medical and non-medical staff.

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## ABBREVIATION

| | |
|---|---|
| Agree | A |
| Actual Behaviour | AB |
| Attitude | AT |
| Average variance extracted | AVE |
| Behavioural Intention | BI |
| Cronbach's Alpha | CA |
| Composite reliability | CR |
| Disagree | D |
| Dependent Variable | D.V |
| Destination belief | DB |
| Destination culture | DC |
| Facilitating condition | FC |
| Gross domestic product | GDP |
| Homophily | HOM |
| Information and Communication technology | ICT |
| Information System Success | IS success |
| Independent Variable | IV |
| Medical Destination | MD |
| Medical destination intention to visit | MDIT |
| Medical staff service quality | MSSQ |
| Medical tourism | MT |
| Medical tourism expense | MTE |
| Medical tourism infrastructure | MTI |
| Neutral | N |
| Product belief | PB |
| Strongly Agree | SA |
| Strongly Disagree | SD |
| Subjective norms | SN |
| Technology Acceptance Model | TAM |
| Theory of planned behaviour | TPB |
| Theory of Reasoned Action | TRA |
| Unified Theory of Acceptance and Use of Technology | UTAUT |

# CHAPTER 1

# INTRODUCTION

## 1.1 Background of the Study

Tourism is an important sector, and it is one of the source of the foreign currency in most countries. The tourism sector has multiple effects on the economic growth of a country and can contribute to the prosperity of several other sectors such as food industry, transportation, and hospitability (Nikoli & Lazakidou, 2019). The contribution of tourism to the gross domestic product (GDP) varied among countries. According to a research conducted by Oxford Economics, the direct and indirect contribution of travel and tourism in 2017 reached $9.3 trillion for the GDP of the world which form 10.4% of the GDP and contributed to employment by 313 million jobs worldwide (Oxford Economics, 2017).

Newly emerged branch of tourism is the medical tourism (MT), and it is defined as travel undertaken largely for the aim of obtaining medical treatment (Gaines & Lee, 2019). Medical tourists may travel for a range of operations, including some that are innovative or experimental, and they may go to either developing or industrialized nations for medical care.Global the number of medical tourist varied between 16 to 20 million yearly(Dalen & Alpert, 2019; Matiza & Slabbert, 2020; Ridderstaat et al., 2019). In term of the market value, the MT market value has reached US$ 635 billion in 2017 (Dalen & Alpert, 2019; Matiza & Slabbert, 2020; Ridderstaat et al., 2019).

Competition among countries is high to attract more medical tourists because it is a profitable business and include medical and wellness tourism (Nasab et al., 2018). Several studies attempt to understand the factors that can affect the decision of destination selection and choice. For example, the cost of MT, medical service quality, accessibility, and word of mouth were among the most important factors in determining the destination choice (Gill & Singh, 2011; Moghimehfar & Nasr-Esfahani, 2011; Sultana et al., 2014). Other studies are into the image of the country

and the tourism attraction (de la Hoz-Correa & Muñoz-Leiva, 2019; Ghosh & Mandal, 2019; Zarei & Maleki, 2019a).

The review of the literature as shown in Table 2.1 indicated that there are no specific theories that have been used to support the development of MT choice. However, one of the theory that is used to determine the behaviour of individual is the theory of planned behaviour (TPB) by Ajzen (1991) who indicated that the behavioural intention (BI) of individual is related to their attitude (AT) toward the behaviour, SN, and perceived behavioural control (PBC). The TPB was developed based on the theory of reasoned actioned (TRA) by Fishbein and Ajzen (1980). Few studies deployed TRA and TPB to explain the MT destination choice. For example, the theory was deployed by previous studies and found to explain the MT destination choice (Boguszewicz-Kreft et al., 2020; Seow et al., 2017a).

Medical tourists come from all countries. However, larger number are from developing countries due to poor medical service and infrastructure. In Iraq, the country has suffered instability since 1980s and this has affected the capability of the country for medical treatment. Large number of citizens travel abroad for MT. However, the factors that affect their choice is still not clearly understood. Therefore, the purpose of this study is to identify the factors that affect the Iraqi MT destination choice and their preference to visit Dubai as the destination for MT. Dubai is one of the leading city in the region of Middle East that provide medical and unique tourism activities. The state is the second largest state in United Arab Emirates and it has several landmarks that can attract the tourist from all over the world. In addition, the number of Iraqi tourist to Dubai is in increasing trend.

## 1.2 Problem Statement

Iraq is a country in the Middle East that is considered upper middle income with gross domestic product (GDP) of $234.1 billion in 2020. The life expectancy reached 70 years with weak human capital at 0.4 out of one (1)(The World Bank, 2022). The country has been in instability since 1980s and this has affected the infrastructure and medical facilities which has increased the demand for medical treatment in the

country (Cetorelli & Shabila, 2014). The determinant of MTdesignation choice is not known due to the lack of studies in this topic in Iraq.

Based on the review of studies in Table 2.1, which presents a matrix of studies from global perspective, researchers are not in agreement regarding the determinants. Researchers related the decision of choosing a MT destination to country specific aspect such as security and safety, accessibility (visa), facilities, cost, tourism attraction (Çapar & Aslan, 2020; Cham et al., 2021; Collins et al., 2019; Matiza & Slabbert, 2020). Other researchers are into the medical service quality and word of mouth (Ghosh & Mandal, 2019; Rosenbusch et al., 2018).

In term of using theoretical framework, few studies deployed a theory. The TPB is a theory that can explain the behaviour intention of individual and it has been used by few studies to explain the MT destination choice (Boguszewicz-Kreft et al., 2020; Seow et al., 2017a). The TPB was developed based on TRA and these two theories are deployed in this study. The study proposes that AT toward the destination is affected by cost and service quality. In addition, the subjective norm is affected by the social media generated content while the PBC is affected by the knowledge. AT,SN, and PBC will affect the destination choice. Further, cultural similarity between countries might play a role in the selection(Ghosh & Mandal, 2019; Matiza & Slabbert, 2020). Therefore, this study is deploying culture as a moderating variable.

By understanding the predictors or MT destination choice, this study will provide individual and decision makers with a reference that can be used to make policy and international agreement that facilitate the MT of citizens.

## 1.3 Research Questions

The research questions of this study are as follows:

1- What are the effect of MT expense,medical staff service quality and product belief on attitude toward MT destination choice?
2- What is the effect of homophily and destination belief on subjective norms to choose a MT destination?

3- What is the effect of attitude, subjective norms, and MT infrastructure on tomedical destination (MD) intention to visit?
4- Does destination culture moderate the effect of attitude and subjective norms on MD intention to visit?

## 1.4 Research Objectives

The general objective of this study is to understand the predictors of MT destination choice by Iraqi. Specifically, this study aims to fulfill the following objectives:

1- To examine the effect of MT expense, medical staff service quality and product belief on attitude toward MT destination choice.
2- To investigate the effect of homophily and destination belief on subjective norms to choose a MT destination.
3- To identify the effect of attitude, subjective norms, and MT infrastructure on toMD intention to visit.
4- To determine the moderating role of destination culture between attitude and subjective norms, and MD intention to visit.

## 1.5 Significance of the Study

This study is significant because it contributes to the knowledge regarding the selection of MT in developing countries. The study is important because it identifies the predictors of the MT and it also important because it deploys the theories of TRA and TPB and extend the theories to examine its capability in explain the MD intention to visit.

From practical perspective, the study is important because it identifies the most critical predictors of MD intention to visit. The study also is important because it enhances the understanding of decision makes regarding the significance of this sector and the importance of selecting a MT destination by citizens. It contributes to the individual by enhancing the understanding of MT and the most important predictor in selecting a destination.

## 1.6 Scope of the Study

This study focuses on the MT. The population of this study is the Iraqi medical tourists. The study will deploy a purposive sampling technique due to the lack of information about the medical tourist in Iraq which limited the capability of using random sampling. The study examines the predictors that affect the MT destination choice. Further, the study deploys TRA and TPB as a theoretical frameworks and will collect the data using an online questionnaire. The destination in this study is set to be Dubai in United Arab Emirates (UAE). The choice of Dubai because it is a known destination for MT in the Middle East.

## 1.7 Definition of Terms

The terms that are used in this study are defined to provide the reader (s) with clarify regarding the terms in this study.

**Medical destination intention to visit**

MD intention to visit is defined as the process of choosing destinations between competitive alternative (Barišić & Nejašmić, 2021). In this study, it is defined as the process of selection a country for medical treatment and tourism.

**Attitude**

Attitude is a “positive or negative perception of the intended behaviour" (Abadi et al., 2012). In this study, it is defined as the general tendency toward selection a destination by people from Iraq to do medical treatment and tourism.

**Subjective norms**

SN is defined as “the perception of others who are important and think that this particular individual should perform the intended behaviour”(Ajzen, 1985). In this study, it is defined as the influence of others such as friends, relatives, family members, and word of mouth on the decision of individual to select a destination for their tourism and medical treatment.

**Medical Tourism Expense**

MT expense is defined as "the cost that will medical tourist will pay while doing MT in the selected destination"(Collins et al., 1995). In this study, it is defined as the amount of money that medical tourist need to pay for medical treatment and tourism.

**Medical Staff Service quality**

Medical staff service quality is defined as the evaluation of the service provided to the customers" (Zeithaml, 1988). In this study, medical staff service quality is defined as the quality of medical care provided by medical staff that medical tourist received in the destination country.

**Product belief**

Product belief is defined as "a state of understanding obtained through experience and analysis of collected information"(Deveaux et al., 2021). In this study, it refers to the understanding of individual of the process and procedures of doing MT and selecting the destination.

**Homophily**

Homophily is defined as the tendency for people to seek out or be drawn to others who are similar to themselves (Khanam et al., 2022). In this study, it refers to the similarity between Iraq and Dubai in term of language, tradition, and cultural background.

**Destination belief**

Destination belief is the knowledge about the destination obtained from several sources such as social media, experience, relatives, and acquaintances.

**Medical Tourism Infrastructure**

MT infrastructure is defined as "the extent to which a person feels that the necessary organizational and technological infrastructure is in place to facilitate their usage of the technology of MT(Keong et al., 2012). In this study, it is defined as the technological availability of MT in the destination.

## 1.8 Organization of the Research

This study is divided into five chapters. A brief description of the content of each chapter is given in the following section.

**Chapter 1: Introduction**

This chapter introduces the topic of MT destination choice. The chapter provides a background of the MT industry and formulated the problem which is related to the weak academic literature in Iraq regarding the MT destination choice and the mixed findings in the literature. The research questions and objectives were stated followed by the significance of the study as well as the scope of the study. The definition of terms was given in this chapter as well as the structure of this research.

**Chapter 2: Literature Review**

The purpose of this chapter is to conduct a literature review on the subject of the destination selection for MT. Both the TRA and the TPB are broken down and discussed in this chapter. Following a discussion of the previous research on MT destination selection, a gap analysis, a suggested model, and this study's hypotheses are presented.

**Chapter 3: Research Methodology**

This chapter describes the research design that was used for this study as well as the study population. In this chapter, the processes for sampling are addressed, along with the instrument for data collection, the validity, and the reliability of the data. In this chapter, both the data analysis and the techniques for collecting the data are covered.

**Chapter 4: Data Analysis and Findings**

This chapter contains the findings of this research, as well as the analysis of the data. There is a presentation of the respondents' descriptive information in this chapter. Discussion centers on the analysis of the data in terms of missing value, outliers, normality, and multicollinearity. The analysis of the data is carried out utilizing the smart partial least square method (Smart PLS). This is the method through which the hypotheses are examined.

**Chapter 5: Discussion and Conclusion**

The results and conclusions drawn from this study are the primary emphasis of this chapter. In this chapter, a discussion of the findings of this study and a comparison to earlier studies are included. After that, the implications of this study are discussed, taking into account both the theoretical and the practical aspects. The conclusions of the study are summed up in this section's last subsection, which also contains the concluding remarks.

## 1.9 Chapter Summary

Medical tourism is increasing becoming one of the leading industry for nations and economies. This chapter serves as the introduction of this study. The chapter discussed the MT destination choice. Problem statement of this study was discussed followed by the research questions and research objectives. The significance of the study as well as the scope of this study were discussed. The definition and the organization of the research were elaborated. Lastly, a summary of the chapter was given.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 Introduction

This chapter discusses the literature related to the MT destination choice. The chapter is divided into five section. The first section discusses the MT destination choice as well as the background of Iraqi MT choice. In the second section, the TRA and TPB are discussed. The third section discusses the existing models of MT destination choice. The fourth section presents the conceptual framework of this study as well as the hypotheses development. In the last section, a summary of the chapter is provided.

## 2.2 Medical Tourism Destination

MT is an emerging field in term of economic and literature perspectives. Several countries have launched strategies to make their countries a hub for MT. Effort has been made to reduce the restriction and promote the MT in countries such as European union (Hodzic & Paleka, 2018; Virani et al., 2020), Turkey (Cavmak & Cavmak, 2020), Malaysia (Cham et al., 2021; Chandran et al., 2018), and Southeast Asia (Chandran et al., 2018; Pavli & Maltezou, 2021; Zarei & Maleki, 2019b).

There is variation in the number of tourist based on countries. Based on report of Organization for Economic Co-operation and Development (OECD), when customers choose to travel across international boundaries in order to get medical care, this is known as MT. This therapy may involve a broad range of medical procedures; however, it is most typically connected with dental work, cosmetic surgery, elective surgery, and fertility treatment. Patients from richer, more developed nations are increasingly going to less developed countries to acquire health care, due to the cheaper cost of treatments given in the latter and the

availability of affordable flights and internet sources of information (Lunt et al., 2011).

OCED also referred to the importance of governmental support and policy in promoting the MT. Beyond national strategy, national policy may actively support the domestic MT business in a variety of ways. Here are several examples: Since 2009, hospitals in South Korea have been permitted to freely promote health services to international patients. Supporting trade fairs: the UAE, Dubai, Turkey, Cyprus, and Malta all have government assistance (via tourism, airlines, or health). In certain situations, governments have actively aided the process by promoting their hospitals to get international accreditation, like in Singapore and UAE(Lunt et al., 2011).

Numerous research in the subject of determining factors on MT destination selection have lately been conducted (Çapar & Aslan, 2020; Cham et al., 2021; Matiza & Slabbert, 2020). Some studies cover a wide range of illness, while others are more narrowly focused on specific illnesses and disorders (Collins et al., 2019; Moghimehfar & Nasr-Esfahani, 2011). The distance between the patients' home country and their MD influences both the expense and the ease of their transit (Sultana et al., 2014; Zolfagharian et al., 2018). Many medical travelers choose for a renowned tourism location while in the target country so that they may enjoy their vacation and treatment (Moghimehfar & Nasr-Esfahani, 2011).

Therefore, it can be understood that the choice of destination can be affected by several factors out of which cost, service quality, and procedures of obtaining the document and information about the destination country. In this study, the Iraqi patients or medical tourist are targeted to understand the factor that determine their choice of destination.

### 2.2.1 Iraqi Medical Tourist

Iraq is a country in the Middle East with population of almost 40 million and weak medical and general infrastructure. The country has been through several wars since 1980s which weakened the medical infrastructure. Basic medical treatment were not available and people of Iraq sought alternatives by travelling to other countries for medical treatment (Al-Bdairi et al., 2020). During the American invasion in 2003 and

afterward, most Iraqi go to neighboring countries as refugees and for medical treatment (Dewachi et al., 2014; Mowafi & Spiegel, 2008).

Al-Bdairi et al. (2020) conducted a study and referred to the notion that Iran is one of the top selection of Iraqi for MT. This could be due to religious background and cultural link. In line with the study of Al-Bdairi et al. (2020), the study of Soltani et al. (2021) indicated that Iraqi is one of the top visitors of Iran for medical treatment. Qasim et al. (2020) pointed out that the Iraqi MT is affected by economic, political, availability and accessibility of medical destination. The study also noted that instability in the country is one of the main reason for travelling aboard for MT.

Not much studies have been conducted on the predictors of MT destination choice among Iraqis. This study contributes to the country by examining the predictors of choosing a MT destination.

### 2.2.2 Medical Tourism in UAE

United Arab Emirates (UAE) is a federation consists of seven states or also called emirate. Dubai is one of the most important and attractive state for tourism. Over the past years, the UAE has consolidated its position among the best medical tourism destinations in the world thanks to the growing international confidence in its health sector, which has succeeded in attracting major medical institutions of prestigious international standing(Papadopoulou, 2022; Saberi et al., 2018). The UAE ranks first in the Arab Gulf states in the list of the best medical tourism destinations globally according to the index of the US-based Medical Tourism Association, while Dubai ranks first in the Arab world and sixth globally in the “Global Index of Medical Tourism” issued by the International Center for Health Care Research (IHRC)(Shukla & Kulshreshtha, 2020).

A vast network of hospitals and medical institutions stretches throughout the nation, delivering the highest quality medical care(Khudhair & Mardani, 2021). Aside from standard operations and aesthetic treatments, the UAE has specialist clinics for superior dental, plastic, and elective surgeries, general check-ups and diagnostics,

tumors, cancer, and diabetes care. As of January 2016, the UAE was the first country to include a number of medical institutions that have received the Joint Commission International (JCI) for accreditation certificate. Dubai Healthcare City, Sharjah Healthcare City, Sheikh Khalifa Medical City (Abu Dhabi), and Sheikh Shakhbout Medical City (SSMC) are examples of government-built medical complexes where people may have access to a range of medical and cosmetic treatments(EL-Baiomy et al., 2020; Souilamas et al., 2022).

The UAE ranks first in the Gulf as the best destinations for medical tourism, and the medical tourism index depends on a wide range of factors, for example, the experiences of patients and the traditional destinations of tourism in the country, as well as the level of tourism.In this context, UAE media revealed the components of medical tourism in the country. The media emphasized that the index for evaluating the distinguished treatment destination depends on many factors, including the interface's environment, patients' experiences, and the many means of tourism in the UAE, which cannot be compared to any other destination, where international hospitals and medical centres are located(Kim & Hyun, 2022; Michael & Fotiadis, 2022).

The medical tourism sector in Dubai is preparing to receive tourists. The UAE is a regional centre for medical tourism and aesthetic medicine. The UAE is an ideal destination as hospitals and medical centres are spread all over the UAE and provide the best treatment services, as the UAE hosts specialized healthcare services in the following areas

- Oncology and Cancer
- Physiotherapy and paralysis
- Dentist
- Diabetes
- Medical examinations and diagnosis
- Plastic and elective surgeries
- Brain and nerve diseases
- Treatment of fertility problems and delayed childbearing

The UAE also includes a large group of medical complexes such as "Dubai Healthcare City and Sharjah Healthcare City. Therefore, the UAE is one of the best destinations for medical tourism in the world and the Middle East."Medical tourism in the UAE has become very booming for those looking for health care outside their home countries(Shukla & Kulshreshtha, 2020; Souilamas et al., 2022).

It is not just medical health care, medical tourism combines experience, skill and amenities, as well as an exciting tourism opportunity that attracts the attention of patients and those wishing to recover.The medical tourism sector in the UAE has begun to recover from the effects of the Corona pandemic, as some have begun to travel to it to get hospitalization, andthe UAE is applying the highest methods and means of protection from the Corona virus, so there is no need to worry, as Dubai has become a centre for medical tourism enjoying international confidence(Kim & Hyun, 2022; Michael & Fotiadis, 2022).

The UAE enjoys a distinguished geographical location in the east of the Arabian Peninsula, where the Gulf climate is relatively mild compared to other destinations in the Gulf, with many other factors such as the authentic Arab heritage, as well as fun, entertainment and culture. It is a wonderful country by all international standards, worthy of the title of the best medical tourism destination(Ennab et al., 2022; Hosseini & Mirzaei, 2021).

The UAE has been keen on the necessity of having an infrastructure that matches international standards in the medical field and has worked continuously to achieve this goal in a short time, which made it one of the best international destinations, and medical tourism in Dubai is one of the most popular types of tourism within it, the field of plastic surgery in Dubai, where many different tourists from different countries come to the emirate for cosmetic operations(Abu-Gheida et al., 2021; Zainal & Salloum, 2021).

### 2.2.3 Overview of Dubai

Dubai is a city in the UAE famed for its ultramodern architecture and high-end shopping. It is situated on the Arabian Gulf at the southern extremity of the Arabian Peninsula. The UAE is a federation of seven emirates or sheikdoms with a population of more than 9.4 million people, with Abu Dhabi as its capital. With the exception of Dubai's sheikdom, the UAE's economy is the 31$^{st}$ biggest by nominal gross domestic product (GDP) and remains heavily dependent on oil. Tourism is very important to the economy of the UAE, with annual visitor numbers exceeding 10 million and Dubai having the biggest tourism share of all the emirates. The healthcare system is a combination of public and private, with the public system providing a more complete service that addresses all of a patient's requirements. Meanwhile, the private sector continues to create cutting-edge institutions and caters to medical tourists(Abu-Gheida et al., 2021; Bulatovic & Iankova, 2021; Hosseini & Mirzaei, 2021).

Dubai's dry summers and hot. Summer and winter are the two different seasons of Dubai. Summer in Dubai starts in late April and lasts until the beginning of October. Hot temperatures, warm breezes, and high humidity define this time period. Dubai's summer temperatures are lower than those in other Gulf cities such as Kuwait City and Riyadh, because to the city's closeness to the sea(Kharrufa & Noori, 2022; Murtagh et al., 2022).

### 2.2.4 Overview of Medical Tourism in Dubai

In April 2014, Crown Prince of Dubai and Chairman of the Executive Council, launched the Dubai Medical Tourism Strategy Initiative, where he indicated that the Dubai Health Authority would be responsible for providing various medical services and facilities to international patients.It is noteworthy that the Emirate of Dubai includes a wide range of government and private hospitals, which are considered the best and are distinguished by their high-level medical staff, which confirms the efficiency that Dubai has achieved, as this was a key factor in attracting more than 500,000 tourists to Dubai in search of the best possible health and treatment care(Bulatovic & Iankova, 2021; Momeni et al., 2021).

The Emirate of Dubai has been able to make a special imprint for it and compete with the developed countries in the quality of services provided to those seeking treatment, patients and those looking for plastic surgery, fitness and slimming, and in various fields, such as heart diseases, gynaecology, neurosurgery, as well as cancer, lung diseases, liver diseases and many other medical specialties. Service at the highest level can be found in Dubai, as many Dubai hospitals provide advanced medical services by using the latest devices that match the devices available in international medical centres(AlKetbi et al., 2021; Bulatovic & Iankova, 2021; Murtagh et al., 2022; Zainal & Salloum, 2021).

Dubai offers health care packages that suit all patients, with low-cost care solutions, follow-up visas, and medical insurance that covers any medical complications that may occur to patients during the treatment period. Tourists can inquire about the services of the Dubai Health Portal (DXH) launched by the Health Authority for Medical Tourism in Dubai, and they can enter the portal through the Dubai Health Experience application(Abu-Gheida et al., 2021; Hosseini & Mirzaei, 2021; Kharrufa & Noori, 2022; Momeni et al., 2021).

Among the factors that contributed to the development of the field of medical tourism in Dubai is the directive of His Highness Sheikh Mohammed bin Rashid Al Maktoum, and his keenness to support and establish a strong infrastructure to suit international medical standards, thus achieving the goal and achieving progress year after year, making Dubai one of the best distinguished destinations for many of patients in all medical fields, as those looking for medical tourism are making Dubai their destination instead of other countries, because of its advanced medical technologies, and reasonable prices when compared to other countries in the world, and it is also considered one of the most advanced countries in the medical field, health and tourism(Ennab et al., 2022; Kim & Hyun, 2022).

The Emirate of Dubai is one of the most famous tourist destinations in the world, because of its distinctive tourist attractions and recreational places, and great interest in human health. Medical tourism in Dubai is one of the most popular types of tourism in the emirate, because it includes many hospitals, health centers and clinics

equipped with world-class facilities. At the highest level with the latest technology, in addition to having a world-class medical staff(Bulatovic & Iankova, 2021; Kharrufa & Noori, 2022).

Dubai is considered one of the best international cities that provide the best services in medical tourism in Dubai, and the UAE in general provides the best services in the field of medical tourism, and the Dubai Health Authority is keen to provide facilities for patients coming for treatment in the emirate, and the emirate includes many medical centers and high-level governmental clinics and hospitals, and this is what attracted thousands of tourists to Dubai; with the aim of obtaining excellent health care within the emirate(AlKetbi et al., 2021; Momeni et al., 2021).

When the patients desire to receive treatment outside their countries, theysearch for the best hospitals that provide the best medical services. Providing all support to the medical field in general, whether: neurosurgery, cardiology, gynecology, pediatrics, and many other medical specialties. Medical centers and government hospitals are also keen to use the latest technologies and devices in the medical field(Abu-Gheida et al., 2021; Hosseini & Mirzaei, 2021).

One of the advantages of medical tourism in Dubai is that the emirate includes the best hospitals of international standards, which fit international standards, in addition to the diversity of medical specialties in government and private hospitals in Dubai, and access to high-quality health care at reasonable prices, and the quality of services provided in government or private hospitals is better than other places.All hospitals and health centers have the best trained doctors at the highest level(AlKetbi et al., 2021; Momeni et al., 2021; Zainal & Salloum, 2021).

While residing in Dubai in order to receive health care, residents combine treatment and entertainment by visiting for months. A government report on medical tourism showed that Dubai received 630,000 international health tourists during 2021.The medical expenses of international patients amounted to nearly 730 million UAE's dirhams (Almost $200 million USD), which are record numbers if they are calculated and estimated according to the conditions of the global Covid-19 pandemic, which

during the past two years has caused a state of international stagnation for this type of tourism(Zawya, 2022).

The report indicated that most of the tourists who came to Dubai for treatment and hospitalization were from Asian countries with 38%, followed by Europe and the Commonwealth States with 24% and the Arab countries and the Gulf Cooperation Council countries with 22%.The report showed that 55% of international health tourists were male, and 45% were female, and that most of the medical facilities that received them were multi-specialty clinics with 70%, then specialized clinics by 16%, then hospitals and one-day surgery centers by 14%.The three medical specialties that attract health tourists the most, are dermatology 43%, dentistry 18%, and gynecology 16%.Tourists who came to Dubai from three continents "Asia, Europe and Africa" also conducted other medical treatment at varying rates, namely: orthopedics, plastic surgery, ophthalmology, fertility treatments, health and hospitalization(Zawya, 2022).

A. Dubai Health Portal DXH

By entering the application, tourists can book and obtain medical insurance and many other services that they will learn about when entering the portal. The portal also gives the possibility of direct communication with hospitals and doctors who will follow up the patient's treatment, as well as booking and travel procedures, and tourists can search for health care facilities in the UAE(Murtagh et al., 2022).

Dubai has a wide spectrum and tourist oases that attract millions, and it is the capital of Asian tourism. Recent studies indicate that the Middle East region is witnessing a large increase in the number of those seeking treatment and patients seeking hospitalization, and for various diseases, whether physical injuries or plastic surgeries and operations(Bulatovic & Iankova, 2021).

## 2.3 Theoretical Framework

This study examines the MT destination choice. The study deploys the TRA and TPB because they are the theories that can explain the behavior of individuals. Before discussing the Theory of Planned Behaviour (TPB), it is worthwhile to

understand the Theory of Reasoned Action (TRA) since TPB is an improvement of the TRA. TRA has been widely used by social psychologists to explain human behaviour towards a particular action (Fishbein & Ajzen, 1980). The TRA was introduced by Fishbein in 1967. The theory implies that people do consider the implication of their behaviour before acting. This theory was developed to harmonize and give wider picture of the relationship between attitudinal beliefs, normative beliefs, intentions and behaviours.

The theory has also been used in determining if an individual will excel in a particular behaviour he or she is involved. A predictor, which is known as "intention", was developed by Fishbein and Ajzen (1980) to evaluate the action. To determine the intention to do an action, the theory of TRA proposed that the intention is affected by the AT and the SN. According to Fishbein and Ajzen (1980), actions are performed by some individuals after positive evaluation of the action and perceived that it will attract positive reaction by others. Ajzen and Fishbein (1977) postulate that the stronger the intention and willingness of a person to perform behaviour, the greater it becomes on the likelihood of succeeding in changing the behaviour.

BI is affected by an individual's AT towards behaviour and SN, which influence the actual behaviour. TRA also suggests that a person's behaviour can be determined through his or her intention to perform a particular action, which implies that the action in which he or she intends to perform is portrayed by his or her AT towards a particular behaviour and SN. Intention has been used as a predictor in measuring behaviour action. It is also a cognitive representation of a person's readiness to perform a given action, which is then considered as the immediate antecedent of behaviour. The other important assumption in TRA is based on full volition control. This implies that every individual has total freedom in choosing his or her line of behaviour.

This suggests that both intentions and behaviour must completely abide by this violation in order to be effective in the TRA. Furthermore, it has been asserted in the TRA that there are no external variables with direct influence on individual behaviour as argued by Ajzen (1991), who argued that the external variables are only

related on intentions and behaviour (Ajzen, 1991). This argument has been countered in subsequent studies, which have disputed this claim through the demonstration of external variables that influences behaviour (Ajzen, 2010). The TRA is conceptualized in Figure 2.1.

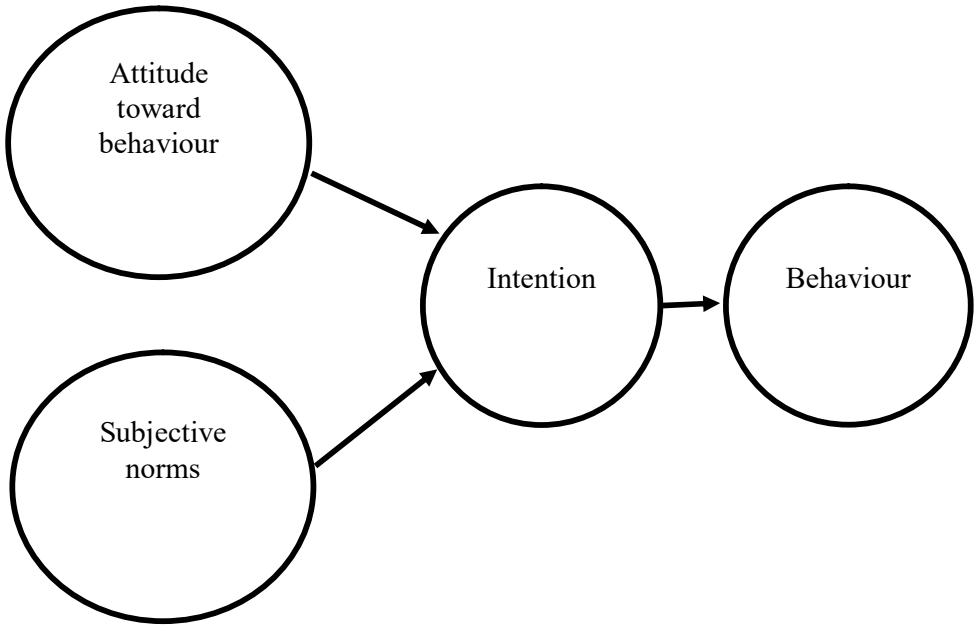


Figure 2. 1: Theory of Reasoned Action

Source: Ajzen and Fishbein (1980).

The validity of the TRA was confirmed in a number of meta-analysis studies. Cullis and Lewis (1997)conducted a meta-analysis to determine the effect sizes of (a) AT towards the behaviour and SN on BIs, and (b) BIs on actual behaviour, in the aggregate, and for each of the four subgroups. Several sources were used to procure studies from each of the four subgroups. The findings indicated that AT and BI link has significant exploratory power to explain the actual behaviour, it also indicated

that the theory is able to explain the variance and predict the behaviour. Hagger et al., (2012)conducted a meta-analysis study on 72 studies and the findings showed that the TRA is valid to predict the behaviour of individual.

TRA has been criticized for ignoring the relevance of social dynamics, which might influence individual behaviour life (Grandon & Mykytyn Jr, 2004; Werner, 2011). All impacts of the environment around the person (such as norms) that may affect the individual's behaviour are referred to as social factors (Ajzen 1991). Ajzen (1991) offered an extra component in influencing individual behaviour in TPB, which is PBC, to avoid TRA's weakness.

Ajzen (1991) developed the TPB to encounter the problem of volitional control in the TRA. The TPB was developed to measure how human actions are guided. The theory predicts how particular behaviour occurred with provision that behaviour is intentional. The TPB has been described by Ajzen (1991) as a BI (BI), which can be predicted through behavioural AT, subjective norm (SN) and PBC (PBC).The TPB has been applied in studying different behaviours, which make it one of the best theories adopted by psychologists in prediction of behaviours (Armitage & Conner, 2001). The TPBmodel is illustrated in Figure 2.2.

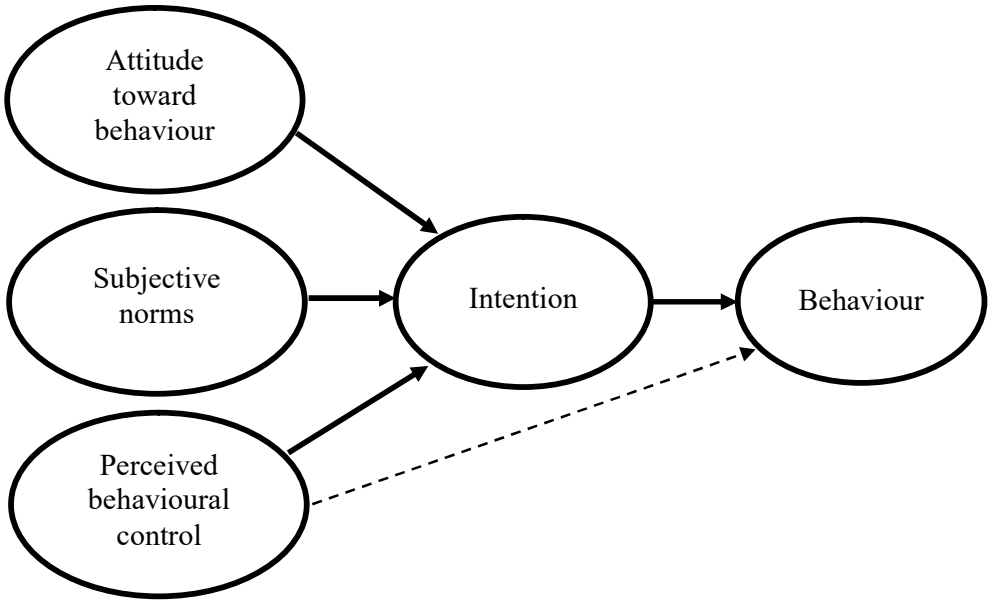


Figure 2. 2: Theory of Planned Behavior

Source: Ajzen (1991, p. 182).

As depicted in Figure 2.2, the model consists of three variables, which are AT, subjective norm, and PBC, together with intention predict behaviour. Intention, which is defined as the evaluation of an intended behaviour by individuals (Ajzen, 1991). Intention also entails consideration of behavioural performance outcomes. This refers to the preference of a behaviour (Ajzen, 1991). It is based on AT toward the behaviour, SN and PBC, with each predictor weighted for its importance in relation to the behaviour and population of interest.

Similar to TRA, Ajzen (1991) defined AT as individual's feelings either positive or negative towards performing an action. SN are defined as perceived social pressure that gives signal whether an action should be performed or not (Ajzen, 1991). PBC is the third determinant factor for TPB (Ajzen, 1991) which is a value added from TRA.

The TPB has been applied in the study of different aspect of knowledge such as medical, education and other fields. This is possibly because TPB allows other variable to be included in the theory(Armitage and Conner, 2001). Greaves et al. (2013) for instance, used TPB in the exploration of environmental BI of workers in their workplace and the result shows the effectiveness of the theory in the study of environment. Similar to this was the study by Lin and Chen (2011) where they also used TPB to study the behavioural of workers towards workplace dishonesty in Taiwan.

Knabe (2012) in the educational field also used the TPB; the author used the theory to study the effectiveness of faculty of public relations in their online teaching program. The TPB has also been used in the medical field. Kelly et al. (2011) for example, used TPB in their pharmaceutical study where it was used to examine the impacts of behavioural AT of clients towards future patronizing of pharmacists because of alcoholic intoxication. Steingold (2008) has also used TPB to study the behavioural health risk of tobacco usage and alcoholic consumption by student of University of Cape Town.

Jones et al. (2007) have used TPB in examining the demographic, medical and social cognitive determinants of exercising intention of primary brain cancer tumour patients. Another similar study was conducted by Andrykowski et al. (2006) where they examine the changes in mental health patients upon the changes of some specific behaviours. Darker (2008) has also used TPB in the medical field for the intervention of walking behaviour. Hagger et al. (2007) also used TPB in examining the health behavioural pattern towards exercise, diet and binge drinking.McEachan et al. (2011) investigated the productivity of the TPB in health related behaviour using meta-analysis. The findings indicated that TPB has strong predictive power of behaviour and intention in health related behaviour.

Based on the above discussion, it can be seen that the theory of TPB has been tested in different context including pharmaceutical studies, customers' preferences, worker's adoption of new technology, and consumer's acceptance of video games. This indicates that the theory is capable to explain the variation in the dependent variables in many areas. In addition, the theory of TPB has covered the gaps in the TRA and added additional variable which is the PBC. The TPB also limits the difficulty found in TRA as it can clarify the reason why an individual is holding unto a particular conduct. This is practical as the inability of an individual to successfully make edge in a conduct diminishes his morality in going on with the conduct. This is the reason why TPB is called "behavioural control". Overall, there is strong support demonstrated for the TPB in predicting intentions and behaviour.

However, there is still a significant amount of the variation that cannot be explained, which has prompted academics to suggest the inclusion of other factors in order to enhance the TPB's capacity for predicting the BI. The TPB is, in theory, amenable to the incorporation of new predictors so long as there is a robust theoretical basis for their inclusion and so long as those predictors capture a sizeable percentage of the distinct variation in intentions or behaviour. However, the inclusion of additional predictors is contingent on these two requirements being met (Ajzen, 1991).

Researchers criticize the TPB and its ability to explain the behaviour of individual. Several studies criticized the limited predictive validity of the TPB. However, Ajzen (2010) replied to the criticism of TPB and its limited predictive validity by pointing

out that the context of the study might affect the measurement error of the validity of the theory to explain the behaviour. The author also refers to the incapability of other variables such as willingness to replace the BI.

The TPB is a behavioural theory that is capable of explaining the BI and the use behaviour, which is selecting a medical toursim destination in the context of this study. The theory has been used by few studies in the context of selecting a medical toursim destination and its validity as well as applicability in the context of toursim in developing country need to be tested. The theory of TPB has been proven to explain almost 40% of the BI and use behaviour (Venkatesh et al., 2003). The theory allows for additional variables, and thus, this study incorporated additional variables to explain more variation in the BI. Accordingly, this study deploys mainly the TPB to understand and explain the factors that affect the medical toursim destination choice.

## 2.4 Existing Model of Medical Tourism Destination Choice

This section reviews the literature related to the MT. Studies that have examined the MT destination choice are reviewed. In a study that is pertaining to the fertility, Moghimehfar and Nasr-Esfahani (2011) examined the intention of couple to select Iran as a medical destination. The finding referred to the importance of religiosity as the critical factors to select the country. In US, the study of Gill and Singh (2011) indicated that there are several factors that affect the choice of destination for MT, and these include competent doctors, high quality medical treatment facilities, promotion of medical treatment are the most important factors for US citizens when deciding to travel aboard for medical treatment.

Interaction and service quality were also proposed as critical factors that determine the attractiveness and the satisfaction with the destination either in India (Sultana et al., 2014) or in Germany (Rosenbusch et al., 2018). Another important factor is the medical cost. In the study of Zolfagharian et al. (2018) in US, the Medical cost, patient privacy, medical restrictions, destination desirability affected the MT consideration. In addition, service quality, medical cost, and tourist attraction

affected the destination desirability. Similar findings regarding the role of cost was derived by Nasab et al. (2018).

Intention to visit among six countries was examined by De la Hoz-Correa and Muñoz-Leiva (2019). The findings indicated that important predictors are related to information sources, cognitive and affective image which affected the overall image and intention to visit. In the study of Rezaei (2019) found that there is a mediation effect of tangible and intangible attributes between consumers' needs and acceptance of MT. According to the findings of Collins et al. (2019), the choice of destination is influenced by factors such as the environment of the host country, the location of the tourist destination, the expenses associated with MT, and the availability of MT facilities and services.

Zarei and Maleki (2019a) conducted a literature study on the topic of the attractiveness of Asian countries as destinations for MT. According to the results, the perceived service quality and overall satisfaction are the two most essential aspects to consider. The most critical obstacles are effective rules, coordination among medical market parties, high-quality medical services, and enough insurance coverage. These are the most essential obstacles. A study conducted in South Africa by Matiza and Slabbert (2020) discovered that socio-cultural factors have a significant impact on MT. On the other hand, a study conducted in Turkey by Capar and Aslan (2020) discovered that the most important factors in determining the destination choice are accessibility, level of security and safety, quality of health care service, level of hygiene, potential of saving cost, and tourism opportunity.

According to research conducted by Cham et al. (2021) in Malaysia, factors such as country knowledge, safety and security, accessibility, and price reasonability, as well as word-of-mouth (WOM) communication and user-generated social media, all had an impact on the image of the destination as a place for MT. On the other hand, the image of the destination as a place for MT had an effect on the perceived value and the desire to return. The perceived value was another factor that influenced the intention to return.In Table 2.1, a summary of the reviewed studies can be seen. It includes the name of author, country, theory, independent variable (IV), dependent variable (DV) sample, data analysis, and findings.

Table 2. 1: Summary of Review Studies

| Author/ year | Country | Theory | I.V. | D.V | Sample | Data analysis | Findings |
|---|---|---|---|---|---|---|---|
| (Moghimehfar & Nasr-Esfahani, 2011) | Iran | Nil | • Distance<br>• Cost<br>• Lack of experience<br>• Legal or moral restrictions<br>• Tourist attractions<br>• Medical service<br>• Religiosity<br>• Perception of traveling to non-Muslim | • Destination choice for assisted reproductive technology (ART) | 67 interview with couples | Content analysis and SPSS for frequency | Religiosity has the greatest effect for traveling to Iran for fertility. |
| (Gill & Singh, 2011) | US | Nil | • Exploratory | • Choice of destination for MT. | 194 students | SPSS | Important factors that determine the decision of American citizens to travel for medical treatment are the competency of doctors, quality of treatment facilities, and promotion of the medical treatment. |
| (Sultana et al., 2014) | India | Nil | • Destination competitiveness<br>• Service quality<br>• Tourist AT<br>• Cost | • Attractiveness of MT destination | 202 respondents | AMOS | Service quality and cost followed by destination competitiveness. AT has less effect on the attractiveness of MT destination. |
| (Rosenbusch et al., 2018) | Germany | Nil | • Interaction quality doctors<br>• Interaction quality nurses<br>• Environmental quality<br>• Outcome quality | • Patient satisfaction<br>• Recommendation intention | 1281 patients | Smart PLS | The quality of interaction along with the environmental and outcome quality has a positive significant effect on patient satisfaction and recommendation intention. |
| (Zolfagharian et | US | Nil | • Medical restrictions | • MT consideration | 539 | AMOS | Medical cost, patient privacy, medical |

| Author/ year | Country | Theory | I.V. | D.V | Sample | Data analysis | Findings |
|---|---|---|---|---|---|---|---|
| al., 2018) | | | • Patient privacy<br>• Domestic medical costs<br>• Tourist attractions<br>• Service quality assurance<br>• Destination desirability | | respondents | | restrictions, destination desirability affected the MT consideration. In addition, service quality, medical cost, and tourist attraction affected the destination desirability. |
| (Nasab et al., 2018) | Iran | Pull and push factor theory | • Policies<br>• Capacities treatment<br>• Destination characteristic<br>• Marketing<br>• Cost | • MT attraction | 384 respondents visiting private hospital in Iran. | Smart PLS | The most important factor is the cost followed by capacity treatment, destination characteristic, marketing, and policies. |
| (de la Hoz-Correa & Muñoz-Leiva, 2019) | Six countries (France, Sweden, Switzerland, US, Peru, Ecuador) | Nil | • Information sources<br>• eWOM<br>• Cognitive image<br>• Affective image<br>• Medical cognitive image | • Overall image<br>• Intention | 534 respondents | AMOS | Important predictors are related to information sources, cognitive and affective image which affected the overall image and intention to visit. |
| (Rezaei, 2019) | Several countries | Nil | • Consumer needs for MT<br>• Tangible attributes<br>• Intangible attributes | • Consumer acceptance of MT | 486 respondents | AMOS | There is a mediation effect of tangible and intangible attributes between consumers' needs and acceptance. |
| (Ghosh & Mandal, 2019) | India | Nil | • Treatment quality<br>• Medical service quality<br>• MT expenses<br>• MT infrastructure<br>• Destination appeal<br>• Destination culture<br>• Communication | • Tourist satisfaction<br>• Destination loyalty | 649 and 451 respondents | AMOS | The proposed independent variables affected the satisfaction and loyalty of medical tourist.<br>. |

| Author/ year | Country | Theory | I.V. | D.V | Sample | Data analysis | Findings |
|---|---|---|---|---|---|---|---|
| | | | convenience | | | | |
| (Collins et al., 2019) | US | Nil | • Outbound USA medical tourist | • Host country environment<br>• Tourism destination<br>• Medial tourism costs<br>• MT facilities and service | 541 respondents | AMOS | The choice of destination is influenced by a number of factors, including the environment of the host country, popular tourist destinations, the cost of MT, and the availability of MT facilities and services. |
| (Zarei & Maleki, 2019a) | Asian countries | Nil | • Review | • MT attraction | Review of articles between 2000-2017 | Frequency | The perceived quality of the service and the level of satisfaction provided by it are the most crucial elements. The most critical obstacles are effective rules, coordination among medical market parties, high-quality medical services, and enough insurance coverage. These are the most essential obstacles. |
| (Matiza & Slabbert, 2020) | South Africa | Nil | • Governance influence<br>• Marketing influence<br>• Tourism influence<br>• Negative event influence<br>• Socio-culture<br>• Competitive advantage | • MT | 233 respondents | AMOS | Socio-cultural has the only significant effect on MT in South Africa. |
| (Çapar & Aslan, 2020) | Turkey | Nil | • Quality of care<br>• Safety and security<br>• Potential for saving<br>• Tourism opportunity<br>• Hygiene level<br>• Accessibility | • Destination choice | 317 | AMOS | Accessibility, level of security and safety, quality of health care service, level of hygiene, and potential of saving cost, and tourism opportunity are the most critical factors in determining the destination choice. |
| (Stoney et al., 2021) | US | Nil | • Descriptive study | • MT | 93,493 | Nil | People in US travel abroad for trips as well as dentistry. |

| Author/ year | Country | Theory | I.V. | D.V | Sample | Data analysis | Findings |
|---|---|---|---|---|---|---|---|
| (Cham et al., 2021) | Malaysia | Nil | Country specific aspect<br>• Country Knowledge<br>• Safety and security<br>• Accessibility<br>• Price reasonableness<br>Social Aspect<br>• Word of mouth<br>• Country created social media<br>• User generated social media | • MT destination image<br>• Perceived value of medical trip<br>• Intention to revisit | | AMOS | The image of the destination as a place for MT was impacted in a variety of ways, including knowledge of the country, safety and security, accessibility, and prices that were reasonable, as well as word of mouth communication and user-generated social media. On the other hand, the image of the site as a place for MT had an effect on the perceived value and the desire to return. The perceived value was another factor that influenced the propensity to return. |
| (Chaulagain et al., 2021a) | US-Cuba | Utility theory | Country image<br>• Safety and security<br>• Economic environment<br>• Technological environment<br>• Political environment<br>Destination image<br>• Local attraction<br>• Hospitality services<br>• Perceived value of tourism<br>• Perceived MT cost<br>• Perceived MT quality | • Intention to visit a MT destination. | 353 tourist | AMOS | According to the findings, the country's image and the perceived quality of MT services had the largest positive effect on the desire of United States citizens to come to Cuba for medical reasons as a kind of MT. |

It can be seen that in Table 2.1, most of the study focused on the perception of American and European countries (Collins et al., 2019; de la Hoz-Correa & Muñoz-Leiva, 2019; Gill & Singh, 2011; Rosenbusch et al., 2018; Stoney et al., 2021; Zolfagharian et al., 2018)while few examined the predictors from the perspective of developing countries. Therefore, this study examines the predictors of MT destination based on the perception of individual from Iraq who have visited or intent to visit Dubai for MT purposes.

In term of using theory to explain the choice of MT destination, few of the previous studies deployed a theory. To fill this gap, this study deploys the TPB theory to explain the MT destination choice. In addition, prior literature did not agree on a specific factor to affect the MT destination choice. For instance, studies focus on religiosity (Moghimehfar & Nasr-Esfahani, 2011), while other focused on the service quality of medical treatment (Gill & Singh, 2011; Sultana et al., 2014). Cost also was among the important factors (Nasab et al., 2018; Zolfagharian et al., 2018).

## 2.5 Proposed Conceptual Framework

Based on the theory of planned behavior (TPB) and the review of the literature, this study proposed that ATwill be affected by MT expenses, product belief, and medical staff service quality. The SN will be affected by destination belief and homophily, AT, SN, and MT infrastructure will affect the MD intention to visit. Culture of destination is expected to moderate the effect of AT and SN on MD intention to visit. Figure 2.3 shows the proposed conceptual framework.

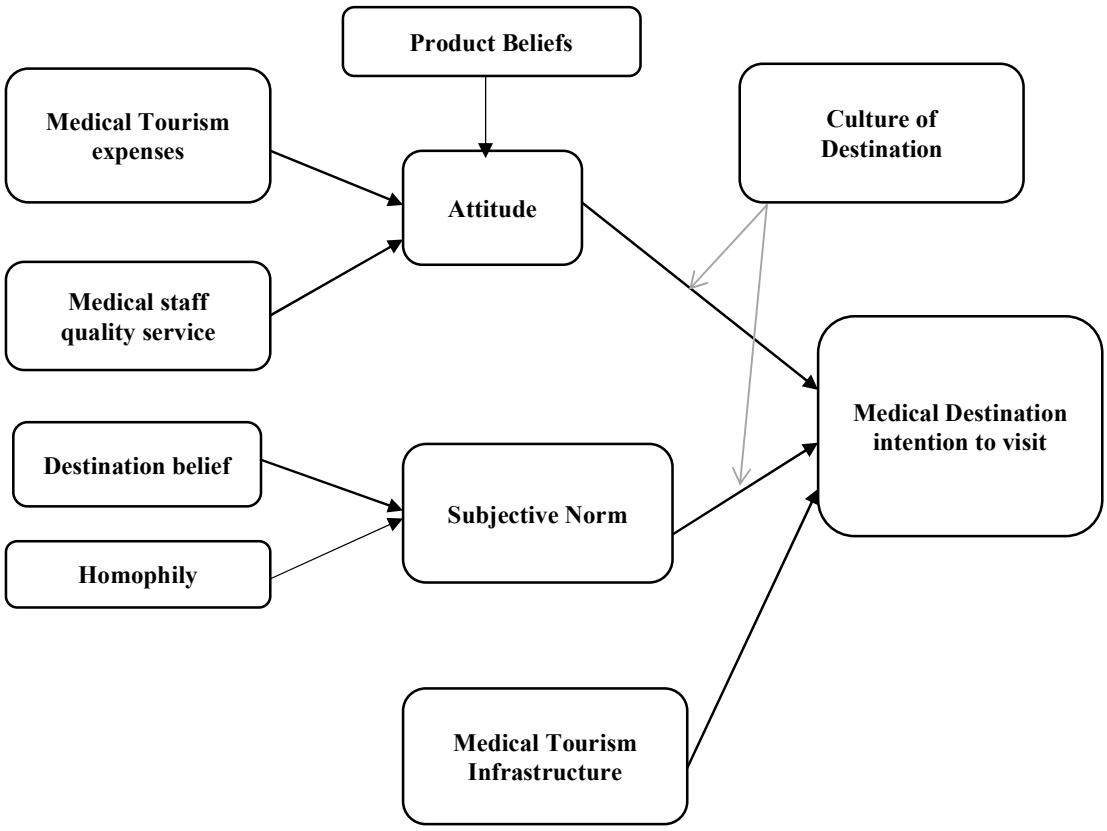


Figure 2. 3: Conceptual Framework

### 2.5.1 Medical Tourism expense and Attitude

MT expense is an essential factor in determining the AT toward a destination. Cost of MTwas found the most important factor for MT attraction (Nasab et al., 2018). MT destination choice is affected by the cost (Çapar & Aslan, 2020). Zolfagharian et al. (2018) also found that cost is a critical factor. In this study, cost of medical treatment is expected to have a significant negative effect on choice of MT destination. A high cost will lead tourist to find alternative destination. Accordingly, the following is hypothesized:

H1: MT expenseaffects negatively the AT.

### 2.5.2 Medical staff Service Quality and Attitude

Medical staff service quality (MSSQ) of medical treatment is important for choosing a MT destination. Service quality was found as important factor that affect the attractiveness and the patient satisfaction (Rosenbusch et al., 2018; Sultana et al.,

2014). Service quality was also found to affect the destination choice (Moghimehfar & Nasr-Esfahani, 2011). Ghosh and Mandal (2019) and Zarei and Maleki (2019) found that service quality affected the tourist satisfaction. Therefore, this study proposes that high service quality will affect the AT of tourist toward selecting the MT destination. Accordingly, the following is hypothesized:

H2: Medical staff service quality affects positively the AT.

### 2.5.3 Product belief and Attitude

Product belief comes from the knowledge that individual have regarding the destination. Several sources of knowledge are existed and among which the social media is essential in shaping the belief about destination (Ahani et al., 2019). Cham et al. (2021) found that country generated information and user generated information about the country affected positively the MT destination image. De la Hoz-Correa & Muñoz-Leiva (2019) found that electronic word of mouth affected the overall image of countries. In this study, product belief is expected to have an effect on the AT of tourist. Accordingly, the following is hypothesized:

H3: Product belief affects the AT of tourists.

### 2.5.4 Destination Belief and Subjective Norms

Destination belief is defined as a state of understanding obtained through experience and analysis of collected information (Deveaux et al., 2021). Having adequate knowledge enables the medical tourist to make informed decision. It also eases the selection of the destination. Cham et al. (2021) found that knowledge about the country of destination is important and affect the MT destination image. Destination desirability affected positively the MT consideration in the study of Zolfagharian et al. (2018) in US.Collins et al. (2019) found that tourism destination affected the choice of destination. In this study, destination belief is expected to affect the SN. Accordingly, the following is hypothesized:

H4: Destination belief affects the SN of tourists.

### 2.5.5 Homophily and Subjective Norms

Homophily is defined as the tendency for people to seek out or be drawn to others who are similar to themselves (Khanam et al., 2022). Several studies linked the homophily to online environment where people meet those who are similar to them. In the context of MT, few studies examined this variable. However, the literature found that homophily has a positive significant effect on the SN(Fogel & Shraybman-Buynova, 2021; Hotter, 2018; Ro & Ha, 2019; Rogers & Bhowmik, 1970; Thwe, 2019). Thus, the following is hypothesized:

H5: Homophily affected positively the SN.

### 2.5.6 Attitude and Medical Destination Intention to Visit

AT is one of the main variable of TPB. The theory proposed that AT affect the BI (Ajzen, 1991). Studies referred to the importance of positive AT of tourist to form their selection of a MT destination (Çapar & Aslan, 2020; Sultana et al., 2014). Other studies found a positive link between positive AT and MT destination choice (Lee et al., 2012; Suki et al., 2017). Thus, in this research, the AT is anticipated to have an important impact on the MD choice.

H6: AT affect positively the MD intention to visit.

### 2.5.7 Subjective Norms and Medical Destination Intention to Visit

Subjective norm is one of the variable of TPB and it is proposed to affect the BI (Ajzen, 1991). Cham et al. (2021) found that word of mouth which is part of the subjective norm affected the medical torusim desintion image which in turn affected the intention to revisit. On the other hand, Matiza and Slabbert (2020) found that marketing influence and toursim influence affected the medical toursim. In this study, SN is expected to affect the medical toursim destination choice. Accordingly, the following is hypothesized:

H7: SN affect the MD intention to visit.

### 2.5.8 Medical Toursim Infrastructure and Medical Destination Intention to Visit

MT infrastructure is similar to facilitating condition in adoption theory such as unified theory of acceptance and use of technology (UTAUT) (Venkatesh et al., 2003). The variable is expected to affect the behaviour intention to perform an action (Ajzen, 1991).MT infrastructuresuch as the availability of technology was found in several studies to have a significant positive effect on MT destination choice (Jalilvand & Samiei, 2012; Seow et al., 2017b; Soliman, 2021). Gill and Singh (2011) found that high quality medical treatment facilities are one of the most important factors for US citizens when deciding to travel aboard for medical treatment. In this study, MT infrastructure is expected to have a significant effect on the MT destination choice. Accordingly, the following is hypothesized:

H8: MT infrastructure affects positively MD intention to visit

### 2.5.9 Moderating role of destination culture

Culture and values of the hosted countries or the destination countries is important. Studies found that when there is similarity in term of religion, tourist tend to have higher intention to travel to a country with similar religion (Moghimehfar & Nasr-Esfahani, 2011). Destination culture have a significant effect on the tourist satisfaction (Ghosh & Mandal, 2019). In addition, the tourist destination characteristic has significant impact on the MT attraction (Nasab et al., 2018). Socio-culture factors has the strongest impact on the destination choice (Matiza & Slabbert, 2020).

The moderating role of culture destination has been examined by limited number of studies. Culture of destination is examined in this study as a moderator. Chahal and Devi (2015)suggested for future research to examine the moderating role of culture of destination. Culture of destination moderated the effect of tourist's satisfaction on BI(Hung et al., 2019). Accordingly, this study proposes that culture of destination will have a moderating effect between the variables of TPB such as AT andSN, and the MD intention to visit. Thus, the following is hypothesized:

H9: Culture of destination moderates the effects of AT andSN on MD intention to visit

## 2.6 Summary

This chapter reviewed the literature of MT destination choice. The chapter reviewed the theory of TPB and TRA and deployed these theories. In addition, the existence studies that are related to the topic of this study were reviewed. The gaps in the literature were identified. Based on the literature, theories, and model, this study proposed the conceptual framework and developed the hypotheses of this study.

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3.1 Introduction

This is the third chapter, and its focus is on the several approaches that may be used in order to carry out the research for this study. There are nine different sections included in this chapter. The chapter's introduction as well as its structure are provided in this section of the chapter. The study design is presented in the second section, and then the research population and the research sampling procedure are detailed in the sections that follow. The discussion then proceeds on to the instrument's validity and reliability before moving on to the procedure of data collecting and data analysis are discussed in this chapter followed by the summary of the chapter.

## 3.2 Research Design

A quantitative methodology was used in the development of this study's research design. In this case, the survey method is used for the design. The conceptual framework is developed by the research based on the several theories and models that have previously been developed. Following the development of the framework, the population is determined and specified. The participants in this research are Iraqi tourists seeking medical treatment. However, due to time and cost consideration, the area of Baghdad, the capital of Iraq and the majority of the population are living in this city, is chosen. Sample technique is convenience sampling technique. This is because there is no database for the medical tourists in Iraq and it is difficult to collect the contact information of the respondents. Thus, connivance snow balling technique is deployed in this study in which, the questionnaire is sent to respondents and they are asked to forward the questionnaire to those in their network that match the inclusion criteria. This sampling is more suitable because the lack of respondents details (Sekaran & Bougie, 2016).

The data is acquired by means of a questionnaire. The measurements that are used in the questionnaire were taken from previously conducted research. A validation and reliability processes were undertaken prior to field data gathering. The data needed for the research came from the tourists. Two different programs are used in the analysis of the data. In order to conduct preliminary analyses and perform data screening, the SPSS is used. This included the missing value, the outliers, the normality, and the multicollinearity. The Smart PLS is the second piece of software available. This software application is used in the process of evaluating the model and testing the hypotheses. In order to evaluate the measurement model, the factor loading, validity, and reliability of the measurements are all analyzed. The R-square, F-square, and Q-square measures, in addition to the hypotheses posed by this research, are evaluated with the assistance of the structural model. The suggestions, recommendations, as well as the theoretical and practical implications for theory and decision makers, are delivered and debated based on the results. The steps involved in conducting this research are shown in Figure 3.1.

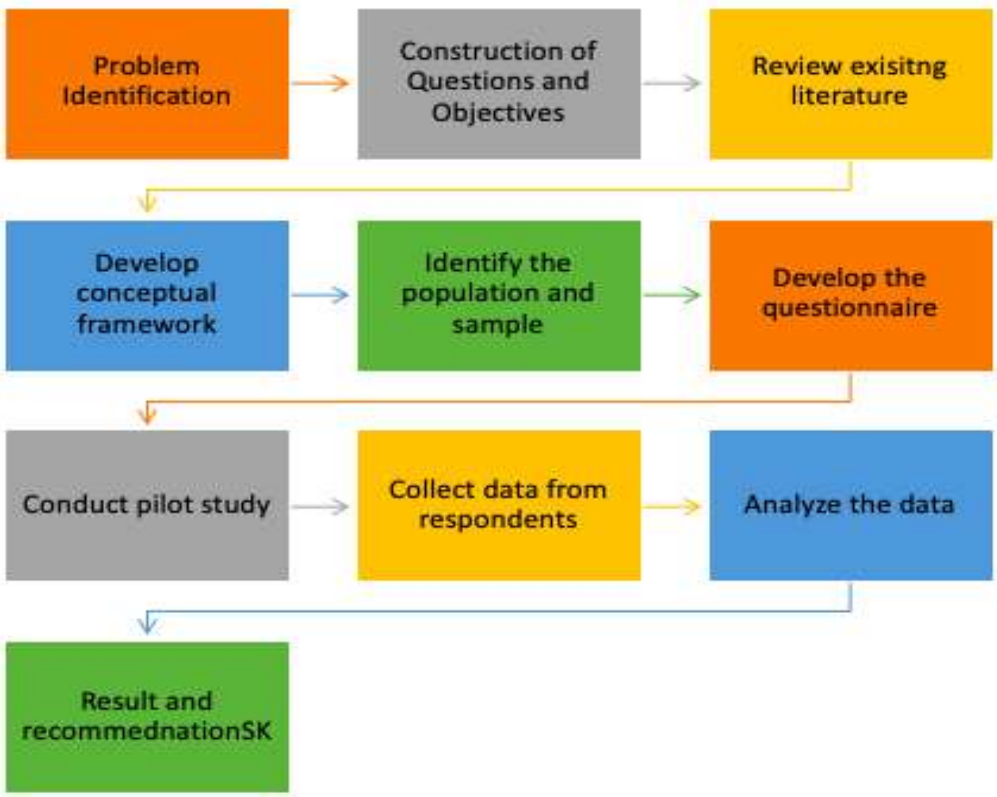


Figure 3. 1: Processes of Conducting this Research

## 3.3 Research Population

Population refers to the group of individuals the researcher is interested in studying (Fraenkel & Wallen, 2005). The population of this study is the medical tourist in Iraq and in particular in the Baghdad, the capital of Iraq. In Baghdad, there are several travel agencies which helps in the data collection.

## 3.4 Sampling

Sampling is defined as the act of selecting a representative sample of respondents from a broader population (Fraenkel & Wallen, 2005). In this study, the population is anIraqi's medical tourists. In order to represent these tourists, this study deploys connivance sampling technique. The use of this technique enables the use of snowballing in which the respondents are asked to forward the questionnaire to those who are Iraqi medical tourists in Baghdad. This technique is preferable compared with other sampling techniques such as random and stratified sampling. This is because it allows for collecting the data that is relevant to the topic of this study and due to the absence of database, this sampling technique is more feasible for the data collection(Fraenkel & Wallen, 2005; Sekaran & Bougie 2016).

When choosing the size of the sample to use with the Structural Equation Model (SEM), there are several general guidelines that should be taken into consideration. According to the findings of Hair et al. (2017), a sample size of eighty is regarded as the minimum sample size for the use of smart partial least square (PLS). Kline (2013) carried out an analysis of the previous research that had made use of SEM and came to the conclusion that a sample size of 200 responses is considered to be standard. To comply with the general rule of thumb for using Smart PLS, the sample size for this research is planned to be more than 200 responses.

## 3.5 Instrument of the study

An online survey was used to obtain the answers necessary for this research from Iraqi medical tourists. The survey has a structured format with close-ended questions. The measures of the variables were taken from prior research that had been

conducted on the topic of MT destination choice or other disciplines that are comparable. The questionnaire is broken up into sections, the first of which is an introduction that explains the objective of the questionnaire, elucidates the role of the respondents, and guarantees the confidentiality of the data. The questionnaire also includessections to ask about the variables of this study and the last section asks about the background information. Table 3.1 shows the measurement, number of items and source of the measurement.

Table 3. 1: Measurements of Variables

| **Variables** | **Items** | **Source of measurement** |
|---|---|---|
| Medical Staff Service Quality | 1. Dubai has well trained doctors | Chaulagain et al., (2021) |
| | 2. Dubai has experienced doctors | |
| | 3. Dubai has reputable doctors | |
| | 4. Dubai has doctors that speak my language | |
| MT Expenses | 1. Dubai offers a lower price for treatments | Chaulagain et al., (2021) |
| | 2. In Dubai treatment is affordable | |
| | 3. Dubai offers advanced treatments at competitive prices | |
| | 4. The food is affordable | |
| | 5. The lodging (hotel) is affordable | |
| | 6. The traveling is affordable | |
| MT Infrastructure | 1. Dubai has a high quality of healthcare | Chaulagain et al., (2021) |
| | 2. Dubai has internationally certified doctors | |
| | 3. Dubai has reputable hospitals/medical facilities | |
| | 4. Dubai has internationally accredited hospitals/medical facilities | |
| | 5. Dubai has a high-quality standard in medical services | |
| Attitude | 1. Traveling to Dubai for medical treatment would be a good idea. | Lee et al. (2019) |
| | 2. I like the idea of traveling to Dubai to receive my medical treatment. | |
| | 3. Traveling to Dubai to receive medical treatment would be a pleasant experience. | |
| Product Beliefs | 1. Dubai's medical services are good | Lee et al. (2019) |
| | 2. Dubai's medical services are good value for money | |
| | 3. Going to Dubai for medical treatment conveys high status. | |
| | 4. Dubai's medical services are a good alternative. | |
| MD Intention to visit | 1. My willingness to visit Dubai for medical treatment is high. | Chaulagain et al., (2021) |
| | 2. My willingness to recommend this MD to others is high. | |
| | 3. I plan on going to Dubai for medical treatment in the future. | |
| | 4. If I have the resources, I would go to Dubai for medical treatment. | |

| Variables | Items | Source of measurement |
|---|---|---|
| Homophily | 1. Dubai has a similar moral system as my home country | (Lin & Guan, 2002) |
| | 2. Dubai has a similar value system as my home country. | |
| | 3. Social views are similar in Dubai | |
| | 4. In Dubai interpersonal norms are similar. | |
| Destination Culture | 1. The destination offers several opportunities to explore the local way of life | (Chaulagain et al., 2021b; R. Lee et al., 2019) |
| | 2. There are several programs to learn local history | |
| | 3. The local people are open to welcome people from other cultures | |
| | 4. The destination offers several ways to exchange cultural thoughts | |
| | 5. Dubai has rich cultural heritage. | |
| Destination Beliefs | 1. Dubai is a good place for beaches | (Chaulagain et al., 2021b; R. Lee et al., 2019) |
| | 2. Dubai has a variety of restaurants. | |
| | 3. Dubai has appealing local food | |
| | 4. Dubai has good shopping facilities. | |
| | 5. Dubai is safe and secure | |
| | 6. Dubai offers exciting and interesting places to visit | |
| | 7. Dubai has beautiful scenery and natural attractions. | |
| | 8. Dubai has a pleasant climate. | |
| | 9. As a tourism destination Dubai offers good value for money. | |

In appendix A and B, a copy of the English and Arabic questionnaire are given respectively.

### 3.6 Validity and Reliability

In order to improve the precision of the measurement, one of the most important aspects of research is validating the instrument and determining its level of reliability (Sekaran & Bougie, 2019). Validation of the data collection instrument was accomplished in this research, and a pilot study was conducted to ensure that the measurement of the variables is reliable. One commonly used and reliable method to determine the reliability is the Cronbach's Alpha (CA). CA according to several researchers are one of the established analysis in the literature to examine the reliability of a set of items in which the items should show internal consistency (Hair et al., 2017; Sekaran & Bougie, 2019). A value of less than 0.70 is considered to have a poor reliability, despite the fact that the accepted value of CA is more than 0.70.

Respondents who are active in MT were invited to participate in the pilot study. A total of 35 respondents participated. These responses are sufficient for the purpose of a pilot study because Sekaran and Bougie (2013) suggested that a number of response greater than 30 is sufficient for any academic research. Table 3.3 shows the results of the pilot study. It shows that all the measurements have CA greater than 0.70 indicating that the measurements are reliable.

Table 3. 2: Result of Pilot Study

| Variable | Number of items | CA>0.70 |
|---|---|---|
| Medical Staff Service Quality | 4 | 0.792 |
| MT Expenses | 6 | 0.832 |
| MT Infrastructure | 5 | 0.841 |
| Attitude | 3 | 0.733 |
| Product belief | 4 | 0.802 |
| MD | 4 | 0.871 |
| Homophily | 4 | 0.772 |
| Destination Culture | 5 | 0.781 |
| Destination Beliefs | 9 | 0.763 |

### 3.7 Data Collection

Data collection of this study was conducted using an online questionnaire. Deploying the Google applications, the questionnaire wascreated. English and Arabic languages wereused in the questionnaire. A request for help in distributing the questionnaire wasmade to the travel agencies in Baghdad. Respondents are asked to forward the questionnaire to those who match the inclusion criteria i.e., to be a medical tourist from Iraq or intend to do MT. The travel agency forwarded the questionnaire into WhatsApp groups and direct emails. In addition, network referral and friends were asked for help in the data collection. This has resulted in 344 responses after a follow up procedures which wasconducted to increase the response rate. These 344 responses are considered in this study for further analysis as shown in Chapter 4.

### 3.8 Data Analysis

The SPSS version 25.0 and the Smart PLS version 3.3.3 statistical programs were used to perform the data analysis for this research. The preliminary analysis that

were carried out using SPSS and contained discussions of the missing value, outliers, normality, and multicollinearity. Description of the analysis are discussed in the next section. In addition, the main analysis, which makes use of Smart PLS and incorporates both a measurement model and a structural model, is presented in the following sections.

### 3.8.1 Preliminary Analysis

SPSS was used in order to carry out the analyses included in this section. Before continuing with the analysis, it is necessary to determine whether or not the data that should be utilized are of a high enough quality. Researchers (Hair et al., 2017; Hair et al., 2017; Pallant, 2020)highlighted the need of evaluating the data to determine whether or not it is reliable and whether or not it is ready to be used in subsequent analysis. There are a number of different analysis that are carried out in order to check, clean, and prepare the data. The replacement of missing values, outliers, normality, and multicollinearity are all included in this study.

The first analysis that is carried out is to make use of the frequency analysis provided by SPSS in order to examine the missing value. According to Hair et al. (2017), the mean should be used to replace missing values that account for less than 15 percent of the total response. However, researchers are required to discard responses that missed more than 15 percent of the questions in the survey.

Researchers were advised by Pallant (2020) and Hair et al. (2017) to evaluate the data for outliers by looking at the boxplot of the outliers so that they could identify any anomalies in the data. The boxplots of all of the variables are going to be looked at in this research. George and Mallery (2008) and Pallant (2016) highlighted that there are two ways to test for a normal distribution. The first method is to examine the form of the histograms, and the second method is to evaluate the value of the skewness and kurtosis statistics. A skewness value and a kurtosis value that are both less than two are regarded to be indicative of normal distribution. In addition, the bell-shaped histograms are an example of a normal distribution shape (George & Mallery, 2008; Pallant, 2016).

The word "multicollinearity" describes a situation in which there is a strong connection between many independent variables. Researchers recommended looking at variation inflation factors (VIF) and tolerance as a way to investigate multicollinearity. In order to get the conclusion that there are no multicollinearity problems with the variables, VIF have to be smaller than 5 and tolerance larger than 0.20. Within the scope of this research, these analyses are carried out to check for the absence of multicollinearity in the data.

### 3.8.2 Smart PLS

In SEM, there are several software that can be used. In this study the PLS is deployed. Researchers suggested to use PLS when the model is well-established and include a new path (Henseler et al., 2009; Henseler & Chin, 2010; Lowry & Gaskin, 2014; Vinzi et al., 2010). In this research, a well-established baseline model served as the foundation; however, additional factors such as MT expenses, medical staff service quality, and homophily were included as variables. As a result, the use of PLS is an acceptable practice. In addition, when testing a continuous moderator such as destination culture (measured using Likert scale), PLS is more suitable (Lowry & Gaskin, 2014). When working with PLS, there are two primary levels to consider. The first model is referred to as the measurement model, while the second model is referred to as the structural model. The evaluation of the two different models is going to be covered in the following parts.

#### 3.8.2.1 Assessment of the Measurement Model

There are five separate evaluations that go into the evaluation of the measuring model. The factor loading of the items is the first thing that has to be evaluated and looked at in this study. In the second part of the evaluation, the reliabilities which includes the CA is investigated, and in the third part of the evaluation, the composite reliability (CR) is examined. The investigation of convergent validity is part of the fourth part of the overall evaluation. In the last step of the measurement model, it is necessary to evaluate the discriminant validity (Hair et al., 2011; Henseler et al.,

2009). In order for the value to be considered valid for factor loading, in addition to the composite reliability, and CA, it must be larger than 0.70. (Hair et al., 2011).

When the value of the Average Variance Extracted (AVE) is larger than 0.50, convergent validity has been established. On the other hand, in order to draw the conclusion that the discriminant validity has been attained, the value of the square root of AVE should be bigger than the cross loading (Fornell & Larcker, 1981; Lowry & Gaskin, 2014).

#### 3.8.2.2 Assessment of the Structural Model

According to Hair et al. (2011), there are four factors that need to be looked at in order to properly understand the structural model. The R-square ($R^2$) is the first criterion to consider, then the predictive relevance ($Q^2$), the path coefficient (B), and finally the effect size ($f^2$). If the $R^2$ value is more than 0.25, then the level of explanatory power is considered to be moderate. If the value of the Q-square is larger than zero, it suggests that the independent variables can accurately predict the dependent variable.

The evaluation of the path coefficients of the structural model is one of the criteria that is considered to be among the most essential in evaluating the structural model. The path coefficient shows the degree to which the independent variables can impact the dependent variables of the study. In the evaluation, the size of the path coefficient, the degree of significance, and both the positive and negative signs of the coefficient should be included (Henseler et al., 2009; Hair et al., 2017).

#### 3.8.2.3 Moderator Testing

Lowry and Gaskin (2014) did a comparison between data analysis software and concluded that when the model includes a continuous moderator, PLS is advantageous. This study includes a continuous moderator such as the destination culture, thus, the use of PLS is a justifiable move. Using Smart PLS, researchers such as Hair et al. (2017) indicated that the moderator can be tested by multiplying the

indicators of the independent variable (IV) with the indicator of the moderator (M) to create a new variable called moderating effect or interaction effect (IV*M).In this research, the destination culture (DC) was multiplied by AT and SN to create a new variable DC*AT and DC*SN.

## 3.9 Summary

The research methodologies that were used for this study have been detailed and proved throughout this chapter. Due to the fact that a questionnaire is used to gather data for this research, the kind of research being conducted here may be classified as quantitative. Both the study's target population and its methodology for collecting samples are broken out below. The data for the research will be collected via the use of an online questionnaire. Due to the fact that Arabic is the most commonly spoken language in Iraq, the document will first be translated into that language. Before beginning the data collecting process, the instrument will first be verified, and then a reliability study will be carried out. In this chapter, there was a discussion of the collecting of data as well as the analysis of this data using SPSS and Smart PLS.

# CHAPTER IV

# DATA ANALYSIS AND RESULTS

## 4.1 Introduction

This chapter covers the findings of this investigation, including an analysis of the data. There are six different parts included in this chapter. The first part provides an overview of the material covered in this chapter. The missing value, outliers, normality, and multicollinearity are all presented in the data screening that is covered in the second part of this chapter. The descriptive information on the respondents and the variables is presented in the third part. The evaluation of the measurement model and the structural model of this investigation is carried out in the fourth part of the chapter. The hypotheses testingof this research are investigated in the sixth part. The chapter's main ideas are summed up in the last section.

## 4.2 Data Screening

In this part of the process, the screening of the data takes place. Before moving on to do additional types of analyses, Hair et al. (2017) and Pallant (2016) state that the data must first be cleaned. Checking for missing values, outliers, normality, and multicollinearity are all part of this procedure. The discussion of these analyses will continue in the next section.

### 4.2.1 Missing Value

This study's data were examined to see whether there were any missing values. According to research carried out by Hair et al. (2017), a response need to be discarded if it is deficient in more than 15 percent of the available replies. It is recommended that the mean score be used in lieu of responses that have less than 15

percent. A total of 344 responses were obtained for this investigation, and all of these responses were comprehensive with the exception of 17 responses that were missing more than 15 percent of the information. For the nine replies that were missing less than 5 percent of the total, the treatment consisted of substituting the mean score for the missing value. Therefore, a total of 327 responses were considered complete (344-17=327).

### 4.2.2 Outliers

Outliers are values that are significantly different from the response's average or center, and Hair et al. (2017) noted that the boxplot is a useful tool for identifying and analyzing outliers. According to the boxplot, there are a total of 12 replies that are regarded to be outliers because of their extreme distance from the mean. These 12 replies have been removed from consideration. After removing 12 replies from consideration, the total number of full and acceptable responses is now 315. The complete results of this research, which include 315 replies, are presented in Table 4.1. These replies are examined, and their findings are included into the subsequent studies as well. Boxplots of the variables are shown in Appendix C.

### 4.2.3 Normality

According to George and Mallery (2008) and Pallant (2016), normality may be determined by one of two different ways. The first method uses a numerical representation of the value of skewness and kurtosis, both of which are anticipated to be lower than two (2) in order to characterize the data as normally distributed. The second approach is more visual, and it involves looking at the histograms of the variables. The fact that both the skewness value and the kurtosis value in Table 4.1 are less than two indicates that the data follow a normal distribution.

Table 4. 1: Analysis of Normality of the Data

| **Descriptive Statistics** | | | | | | |
|---|---|---|---|---|---|---|
| | N | Mean | Skewness | | Kurtosis | |
| | Statistic | Statistic | Statistic | Std. Error | Statistic | Std. Error |
| Medical staff service quality | 315 | 3.256 | -.210 | .137 | -.295 | .274 |
| Product belief | 315 | 3.414 | -.263 | .137 | -.389 | .274 |

| | | | | | | |
|---|---|---|---|---|---|---|
| MT Expenses | 315 | 3.172 | -.364 | .137 | -.080 | .274 |
| MT infrastructure | 315 | 3.201 | -.375 | .137 | -.505 | .274 |
| MD intention to visit | 315 | 3.184 | -.397 | .137 | -.092 | .274 |
| Subjective norms | 315 | 3.376 | -.417 | .137 | -.567 | .274 |
| Homophily | 315 | 3.343 | -.387 | .137 | -.389 | .274 |
| Destination belief | 315 | 3.292 | -.302 | .137 | -.725 | .274 |
| Attitude | 315 | 3.288 | -.648 | .137 | -.156 | .274 |
| Culture destination | 315 | 3.497 | -.359 | .137 | -.546 | .274 |

For the histograms, in Appendix D, the shape of the histogram shows a bell-shaped curve indicating that the data is normally distributed.

### 4.2.4 Multicollinearity

The existence of collinearity is not preferred in data analysis. It is a situation when the correlation between two or more IV is higher than 0.90 (Hair et al., 2017). To confirm that the data is free from collinearity, the VIF have to be smaller than 5 while the tolerance have to be larger than 0.20. In other words, to arrive at the conclusion that the variable does not exhibit multicollinearity, the value of the VIF must be less than 5, and the tolerance must be more than 0.20. The value of tolerance as well as the VIF for each of the variables is shown in Table 4.2. This study does not have a problem with multicollinearity since the VIF is less than 5, and the tolerance is larger than 0.20, as seen in the results of this research.

Table 4. 2: Multicollinearity

| **Coefficients[a]** | | | |
|---|---|---|---|
| Model | | Collinearity Statistics | |
| | | Tolerance | VIF |
| 1 | Medical staff service quality | .617 | 1.621 |
| | Product belief | .656 | 1.524 |
| | MT Expenses | .634 | 1.577 |
| | MT infrastructure | .579 | 1.727 |
| | Subjective norms | .693 | 1.442 |
| | Homophily | .798 | 1.253 |
| | Destination belief | .698 | 1.433 |
| | Attitude | .588 | 1.700 |
| | Culture destination | .915 | 1.093 |
| a. Dependent Variable: MD intention to visit | | | |

## 4.3 Descriptive Information of Respondents

In this part of the report, the background of the respondents is discussed, along with the descriptive information of the respondents. The demographic information for the respondents is shown in Table 4.3. The respondents' ages, income, education levels, levels of acquaintance, marital status, and number of children are detailed below.

Table 4. 3: Background of the Respondents

| Variable | Label | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| **Familiarity** | Very Familiar | 24 | 7.6 | 7.6 | 7.6 |
| | Familiar | 164 | 52.06 | 52.1 | 59.7 |
| | Neutral | 89 | 28.3 | 28.3 | 87.9 |
| | Not familiar | 34 | 10.8 | 10.8 | 98.7 |
| | Total unfamiliar | 4 | 1.3 | 1.3 | 100.0 |
| | Total | 315 | 100.0 | 100.0 | |
| **Gender** | Male | 205 | 65.1 | 65.1 | 65.1 |
| | Female | 110 | 34.9 | 34.9 | 100.0 |
| | Total | 315 | 100.0 | 100.0 | |
| **Marital Status** | Married | 169 | 53.7 | 53.7 | 53.7 |
| | Divorced | 92 | 29.2 | 29.2 | 82.9 |
| | Widowed | 39 | 12.4 | 12.4 | 95.2 |
| | Never married | 15 | 4.8 | 4.8 | 100.0 |
| | Total | 315 | 100.0 | 100.0 | |
| **Income** | Less than 3,000 | 171 | 54.3 | 54.3 | 54.3 |
| | Between 3,000-6,000 | 48 | 15.2 | 15.2 | 69.5 |
| | 6,000-9,000 | 22 | 7.0 | 7.0 | 76.5 |
| | 9,000-12,000 | 16 | 5.1 | 5.1 | 81.6 |
| | 12,000-15,000 | 28 | 8.9 | 8.9 | 90.5 |
| | More than 15,000 | 30 | 9.5 | 9.5 | 100.0 |
| | Total | 315 | 100.0 | 100.0 | |
| **Education** | High school | 4 | 1.3 | 1.3 | 1.3 |
| | Associate degree | 3 | 1.0 | 1.0 | 2.2 |
| | College | 43 | 13.7 | 13.7 | 15.9 |
| | Bachelor’s degree | 193 | 61.3 | 61.3 | 77.1 |
| | Master’s degree | 49 | 15.6 | 15.6 | 92.7 |
| | PhD | 23 | 7.3 | 7.3 | 100.0 |
| | Total | 315 | 100.0 | 100.0 | |
| **Age** | 25-34 | 8 | 2.5 | 2.5 | 2.5 |

| Variable | Label | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| | 35-44 | 89 | 28.3 | 28.3 | 30.8 |
| | 45-54 | 108 | 34.3 | 34.3 | 65.1 |
| | 55-65 | 39 | 12.4 | 12.4 | 77.5 |
| | 65-74 | 69 | 21.9 | 21.9 | 99.4 |
| | 75 and older | 2 | .6 | .6 | 100.0 |
| | Total | 315 | 100.0 | 100.0 | |

### 4.3.1 Familiarity

In terms of familiarity, the highest percentage of 52.06% or 164 of the respondents are familiar with the MT in Dubai. This is followed by 28.3% or 89 who were neutral. A total of 10.8% or 34 are not familiar and 7.6% or 24 are very familiar. 1.3% or 4 of the respondents are totally unfamiliar with the MT in Dubai. Figure 4.1 shows the distribution of respondents based on their familiarity.

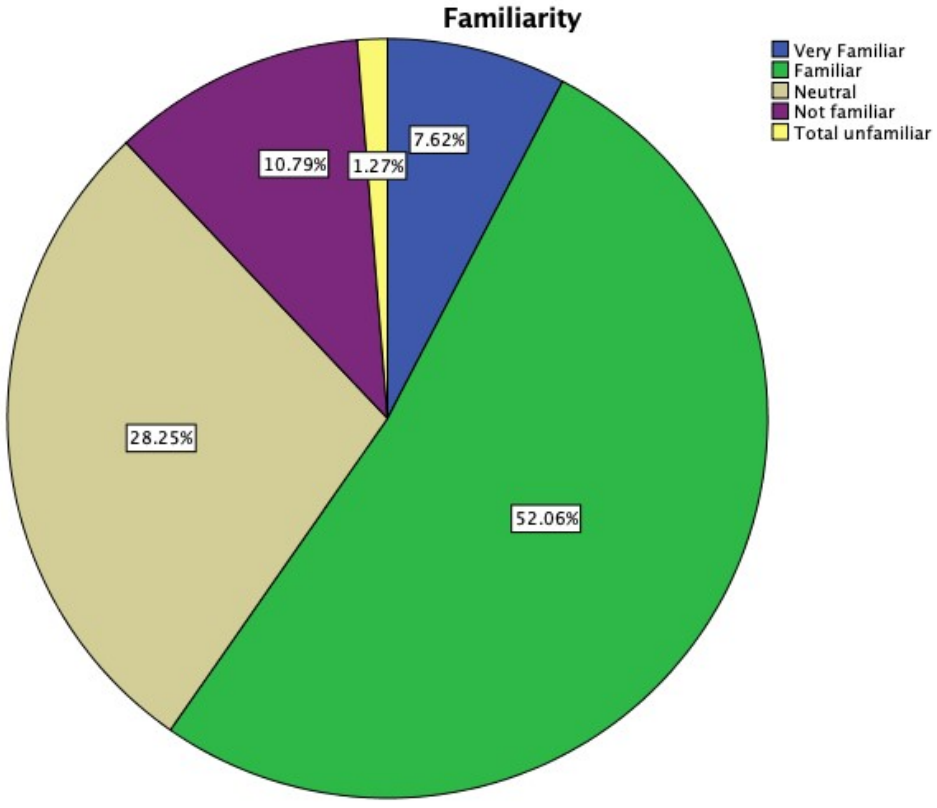


Figure 4. 1: Familiarity

### 4.3.2 Gender

Gender of the respondents was given in Table 4.3. It shows that 205 or 65.1% of the respondents are males while female accounted for 34.9% or 110 of the respondents. Figure 4.2 shows the distribution of gender.

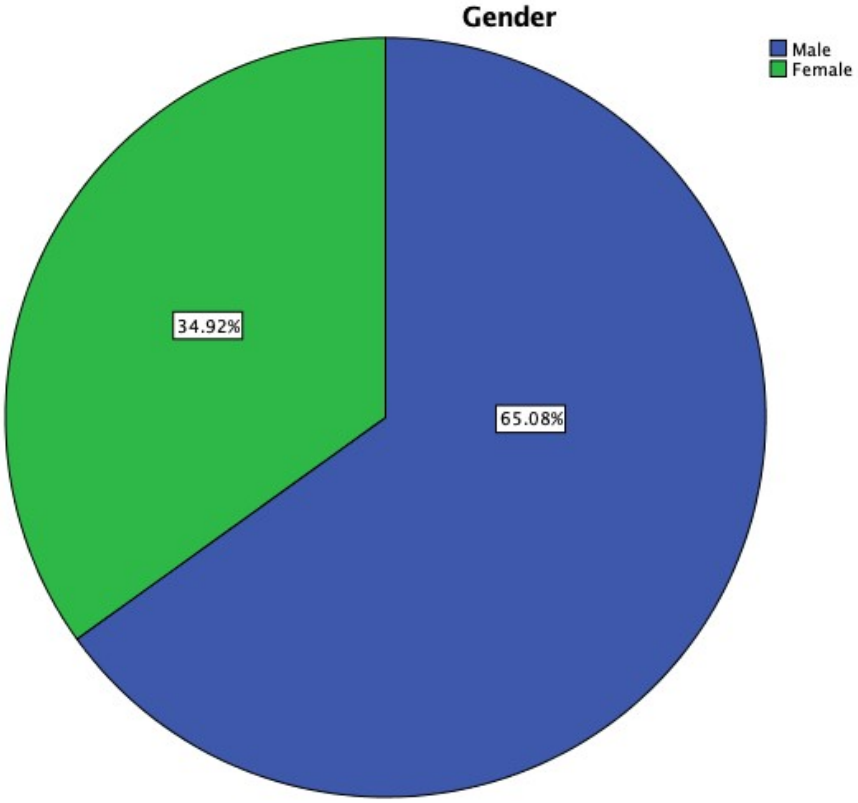


Figure 4. 2: Distribution of respondents based on gender

### 4.3.3 Marital Status

Marital status of the respondents is shown in Table 4.3 and Figure 4.3. It shows that the highest percentage of 53.7% are married followed by 29.2% or 92 of the respondents are divorced. Widowed accounted to 12.4% or 39 of the respondents. A total of 15 or 4.8% of the respondents are singles (never married). Figure 4.3 shows the martial status of the participants in this study.

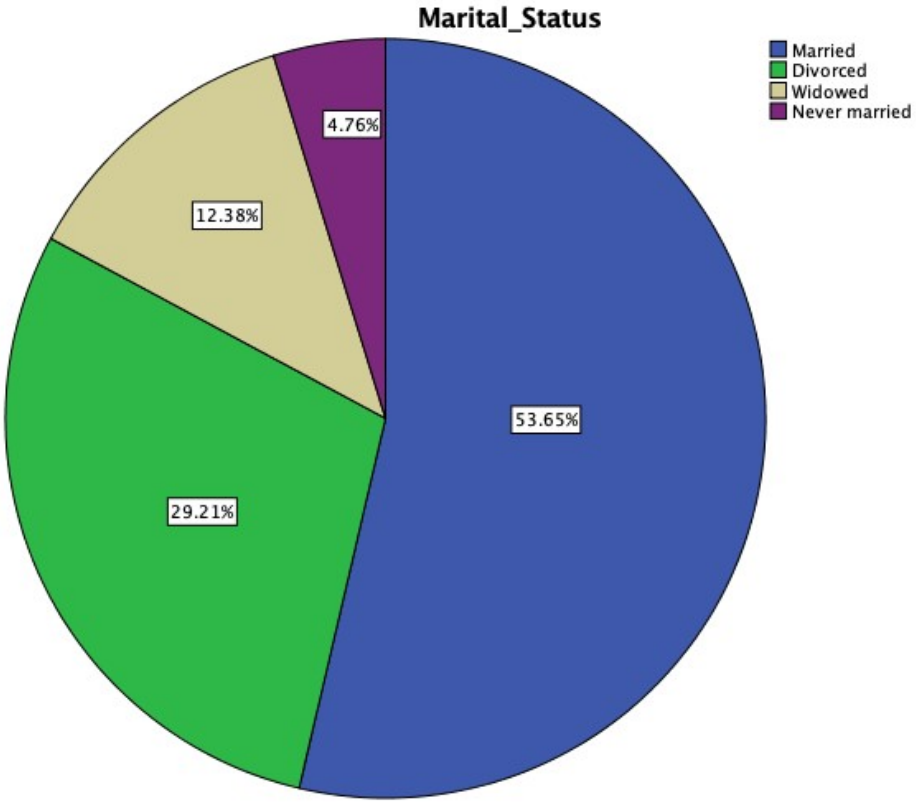

Figure 4. 3: Marital Status

### 4.3.4 Income of the respondents

The income of the respondents is given in Table 4.3 and graphically presented in Figure 4.4. The highest percentage of the respondents 54.3% are earning less than $3,000 monthly followed by 48 or 15.2% are earning between $3,000 and $6,000. Those who earn more than $15,000 account to 30 or 9.5%, while those with monthly income between $12,000 and $15,000 accounted to 8.9%. respondents who have income of more than $6,000 and less than $9,000 accounted to 22 or 7%. Lastly, those with income between $9,000 and $12,000 accounted to 5.1%. The respondents are considered high income individual, and this could be due to the sampling method which focused on those who are involved in MT. Figure 4.4 shows the distribution of respondents based on their income.

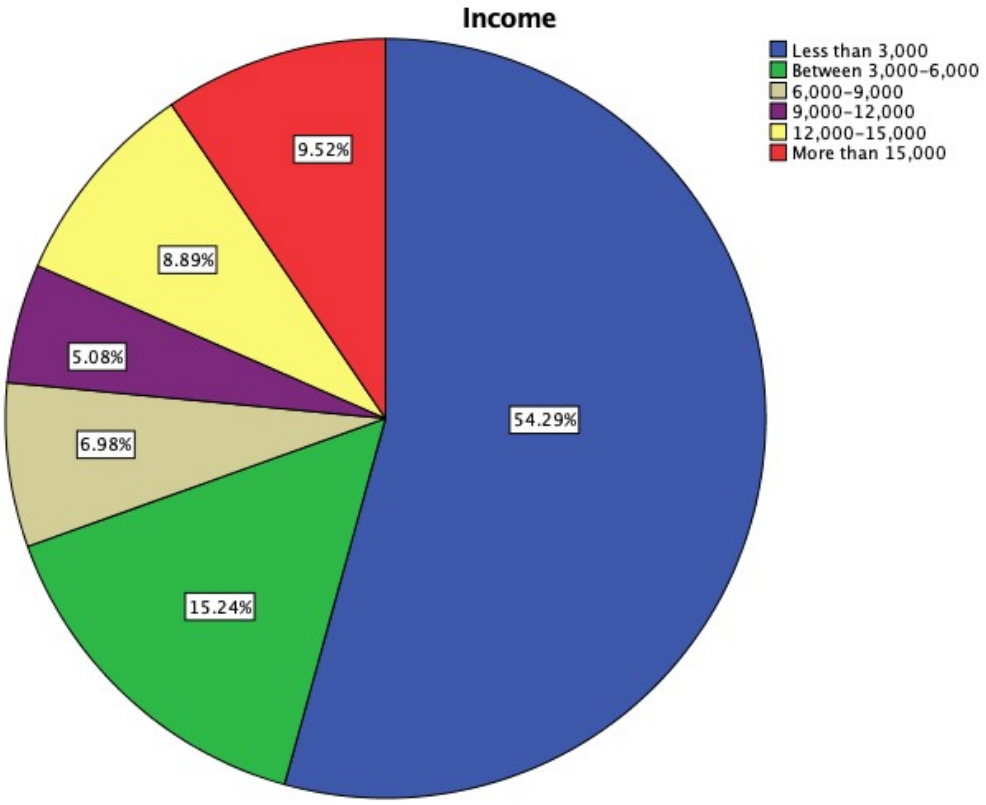


Figure 4. 4: Distribution of Respondents based on Income

### 4.3.5 Education

The education of respondents is shown in Figure 4.5. Based on the findings in Table 4.3, the highest percentage of 61.3% of the respondents are holders of bachelor's degree followed by 15.6% holders of master's degrees. Those with college education accounted to 13.7% followed by 23 or 7.3% are holders of PhD degree. Figure 4.5 shows the educational level of the respondents.

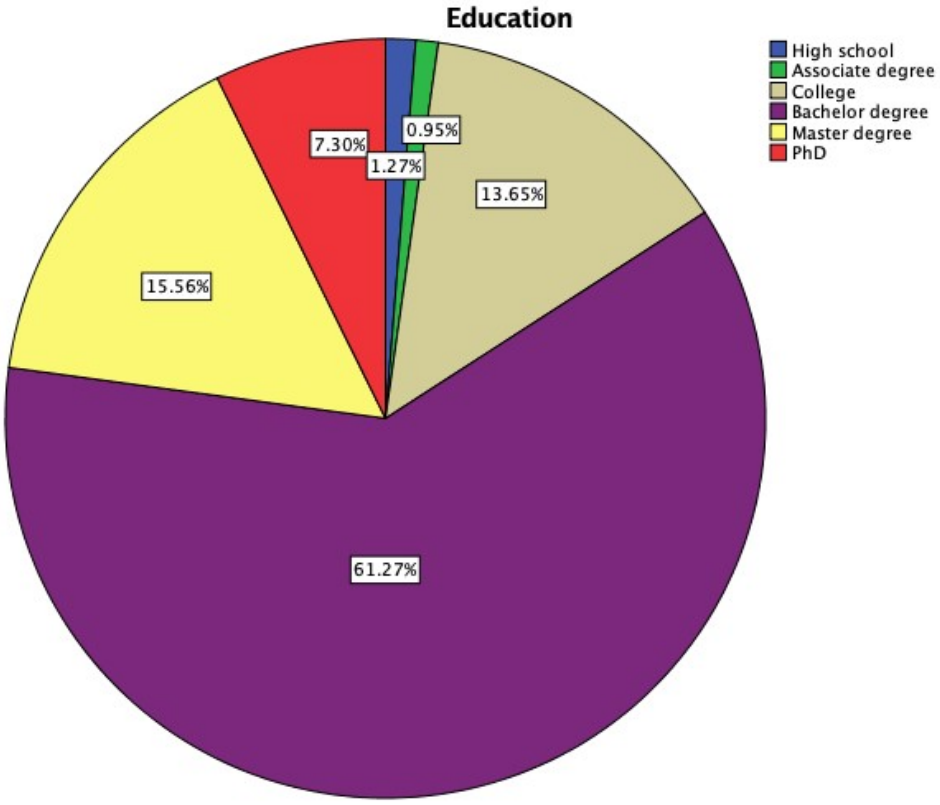


Figure 4. 5: Distribution of Respondents based on Education

### 4.3.6 Age of Respondents

Figure 4.6 shows the distribution of respondents based on their age. The highest percentage of the respondents are in the age group of 45-54 with percentage of 34.3% followed by 28.3% in the age group between 35-44 years. Those who are in the age between 65 and 74 years accounted to 21.9% while those who are young between 25 and 34 years accounted to 2.5%. respondents who are older than 75 years accounted to 0.6% or two of the respondents. Figure 4.6 shows age of respondents based on the groups that have been assigned in the questionnaire.

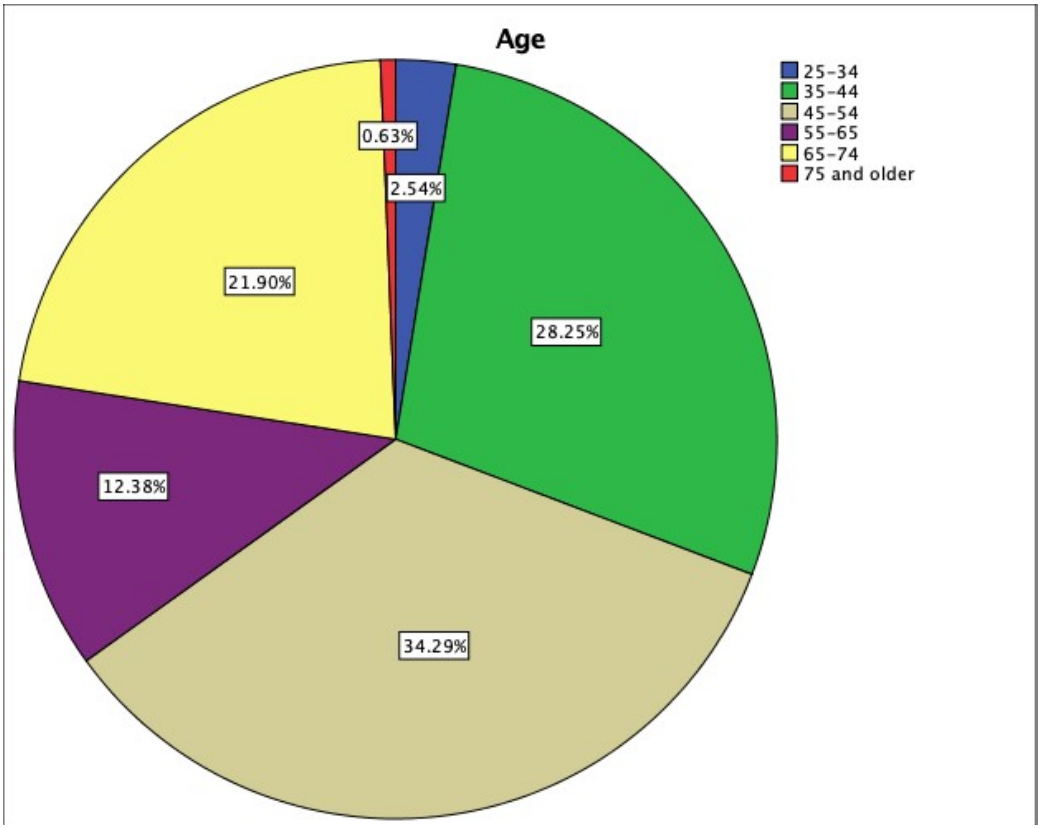

Figure 4. 6: Age of the Respondents

## 4.4 Descriptive Statistics

Descriptive information of variables is presented in the form of mean score which is interpreted based on the value as shown in Table 4.4. Researchers have come to a standard description and interpretation of the mean when using five score Likert scales. These researcher such as Siron and Tasripan (2012) and Qawasmeh, Darqal and Qawasmeh (2013) concluded that value less than 1.49 are considered as strong disagreement and can be interpreted as very low in terms of the level. Very high level occurs when the mean is larger than 4.5. Table 4.4gives the interpretation of the mean score of the variables.

Table 4. 4: Value of Mean Score and Their Interpretations

| **Scale Index** | **Answer** | **Interpretation** |
|---|---|---|
| 1-1.49 | Strongly Disagree | Very Low |
| 1.5-2.49 | Disagree | Low |
| 2.5-3.49 | Neutral | Moderate |
| 3.5-4.49 | Agree | High |
| 4.5-5 | Strongly Agree | Very High |

The mean score values of the variables are shown in Table 4.5. the table shows the minimum (min), maximum (max), mean, standard deviation (Std.). It shows that all the variables have moderate level indicating that the respondents have shown their agreement level on the items of the variables.

Table 4. 5: Mean Score Value of Variables

| Variables | Min | Max | Mean | Std. | Level |
|---|---|---|---|---|---|
| Medical staff service quality | 1.40 | 4.80 | 3.25 | .70 | Moderate |
| Product belief | 1.50 | 5.00 | 3.41 | .71 | Moderate |
| MT Expenses | 1.60 | 4.40 | 3.17 | .57 | Moderate |
| MT infrastructure | 1.60 | 4.80 | 3.20 | .68 | Moderate |
| MD intention to visit | 1.25 | 4.50 | 3.18 | .67 | Moderate |
| Subjective norms | 1.33 | 4.50 | 3.37 | .77 | Moderate |
| Homophily | 1.25 | 4.75 | 3.34 | .71 | Moderate |
| Destination belief | 1.40 | 4.80 | 3.29 | .78 | Moderate |
| Attitude | 2.00 | 4.25 | 3.28 | .57 | Moderate |
| Culture destination | 1.44 | 5.00 | 3.49 | .92 | Moderate |

Table 4.5 shows that the mean score of medical staff service quality is 3.25 and this level is moderate indicating that the respondents have agreed on the statement of the medical staff service quality. The mean score for other variables is also moderate. As shown in Table 4.5, the mean score of product belief is 3.41, for MT expense is 3.17, MT infrastructure is 3.20, MD intention to visit is 3.18, SN is 3.37, homophily is 3.34, destination belief is3.29, AT is 3.28, and culture destination is 3.49.

## 4.5 Structural Equation Modeling

Smart PLS is used to analyze the data in this research. Measurement and structural models are both considered while evaluating the model using PLS. The assessments are detailed in the following sections.

### 4.5.1 Measurement Model

It is necessary to examine the factor loading and the reliabilities and validities of each component of the model. Any item having a factor loading of less than 0.70 should be eliminated from consideration.

#### 4.5.1.1 Factor Loading

All of the items' factor loadings (FL) were examined. Item with FL of less than 0.70 should be deleted, as stated by Hair et al (2017) All items' FL is shown in Table 4.6. FL for all items is greater than 0.70 except for some items which were deleted due to low factor loadings. Table 4.6 shows the finalized measurement model after removing items for destination belief, MT expense, MT infrastructure, homophily, and product belief.

Table 4. 6: Factor Loading of Items

| | AT | DB | DC | HOM | MDIV | MSSQ | MTE | MTI | PB | SN |
|---|---|---|---|---|---|---|---|---|---|---|
| AT1 | 0.913 | | | | | | | | | |
| AT2 | 0.888 | | | | | | | | | |
| AT3 | 0.891 | | | | | | | | | |
| DB1 | | 0.826 | | | | | | | | |
| DB2 | | 0.791 | | | | | | | | |
| DB3 | | 0.789 | | | | | | | | |
| DB4 | | 0.807 | | | | | | | | |
| DB6 | | 0.785 | | | | | | | | |
| DB7 | | 0.725 | | | | | | | | |
| DB9 | | 0.755 | | | | | | | | |
| DC1 | | | 0.853 | | | | | | | |
| DC2 | | | 0.883 | | | | | | | |
| DC3 | | | 0.893 | | | | | | | |
| DC4 | | | 0.731 | | | | | | | |
| HOM1 | | | | 0.890 | | | | | | |
| HOM2 | | | | 0.906 | | | | | | |
| HOM3 | | | | 0.876 | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| HOM4 | | | | 0.886 | | | | | | |
| MDI1 | | | | | 0.920 | | | | | |
| MDI2 | | | | | 0.893 | | | | | |
| MDI3 | | | | | 0.905 | | | | | |
| MSSQ1 | | | | | | 0.873 | | | | |
| MSSQ2 | | | | | | 0.860 | | | | |
| MSSQ3 | | | | | | 0.886 | | | | |
| MSSQ4 | | | | | | 0.855 | | | | |
| MTE2 | | | | | | | 0.833 | | | |
| MTE3 | | | | | | | 0.909 | | | |
| MTE5 | | | | | | | 0.915 | | | |
| MTI2 | | | | | | | | 0.898 | | |
| MTI4 | | | | | | | | 0.781 | | |
| MTI5 | | | | | | | | 0.906 | | |
| PB1 | | | | | | | | | 0.952 | |
| PB2 | | | | | | | | | 0.864 | |
| PB4 | | | | | | | | | 0.897 | |
| SN6 | | | | | | | | | | 0.903 |
| SN1 | | | | | | | | | | 0.875 |
| SN2 | | | | | | | | | | 0.877 |
| SN3 | | | | | | | | | | 0.887 |
| SN4 | | | | | | | | | | 0.876 |

#### 4.5.1.2 Reliabilities and Validities

The reliability and validity of the measurement model are considered in the evaluation of the model. CA and composite reliability (CR) are two measures of reliabilities that should both be larger than or equal to 0.70. (Hair et al., 2017). When the CA and CR are both larger than 0.70, it is clear that the data is accurate, as shown in Table 4.7. It is predicted that the average variance extracted (AVE) will be more than 0.50 when assessing the convergent validity (Hair et al., 2017). AVE larger than 0.50means that the items of each variable explain more than 0.50 of the variations in the measurement. Reliabilities and validity were achieved as shown in Table 4.7.

Table 4. 7: Reliabilities and Validities

| | CA | CR | AVE |
|---|---|---|---|
| **Attitude** | 0.879 | 0.925 | 0.805 |
| **Destination Belief** | 0.842 | 0.879 | 0.514 |
| **Destination Culture** | 0.861 | 0.907 | 0.710 |
| **Homophily** | 0.912 | 0.938 | 0.791 |
| **MD intention to visit** | 0.891 | 0.932 | 0.821 |
| **Medical Staff Service Quality** | 0.891 | 0.925 | 0.754 |
| **MT Expenses** | 0.863 | 0.917 | 0.786 |
| **MT infrastructure** | 0.777 | 0.872 | 0.697 |
| **Product belief** | 0.896 | 0.931 | 0.819 |
| **Subjective Norms** | 0.930 | 0.947 | 0.781 |

One of the criteria to be assessed for the measurement model, is the discriminant validity. It can be safely concluded that the discriminant validity occurs when the square root of AVE is larger than the row and column or the cross loading on other variables. In Table 4.8, the square root of AVE is given in bold and underlined, and it is greater than the cross loading (rows and columns).

Table 4. 8: Discriminant Validity

| | AT | DB | DC | HOM | MDIV | MSSQ | MTE | MTI | PB | SN |
|---|---|---|---|---|---|---|---|---|---|---|
| **Attitude** | **0.897** | | | | | | | | | |
| **Destination Belief** | 0.621 | **0.717** | | | | | | | | |
| **Destination Culture** | 0.502 | 0.497 | **0.843** | | | | | | | |
| **Homophily** | 0.431 | 0.403 | 0.431 | **0.889** | | | | | | |
| **MD intention to visit** | 0.605 | 0.688 | 0.557 | 0.302 | **0.906** | | | | | |
| **Medical Staff Service Quality** | 0.481 | 0.450 | 0.554 | 0.304 | 0.530 | **0.869** | | | | |
| **MT Expenses** | 0.040 | 0.222 | 0.477 | 0.231 | 0.172 | 0.303 | **0.886** | | | |
| **MT infrastructure** | 0.556 | 0.610 | 0.557 | 0.287 | 0.690 | 0.438 | 0.230 | **0.835** | | |
| **Product belief** | 0.173 | 0.254 | 0.431 | 0.180 | 0.224 | 0.386 | 0.744 | 0.284 | **0.905** | |
| **Subjective Norms** | 0.432 | 0.454 | 0.413 | 0.354 | 0.483 | 0.329 | 0.295 | 0.430 | 0.249 | **0.884** |

Other two methods to confirms the discriminant validity is the cross loading and the HTMT which is the Heterotrait-Monotrait Ratio (HTMT). In cross loading, the loading of the items on their variable should be greater than loading on other variables. Table 4.9 shows the cross loading.

Table 4. 9: Cross Loading

| | AT | DB | DC | HOM | MDIV | MSSQ | MTE | MTI | PB | SN |
|---|---|---|---|---|---|---|---|---|---|---|
| AT1 | 0.91 | 0.59 | 0.49 | 0.40 | 0.58 | 0.44 | -0.04 | 0.52 | 0.10 | 0.40 |
| AT2 | 0.89 | 0.52 | 0.44 | 0.40 | 0.52 | 0.42 | 0.06 | 0.47 | 0.18 | 0.38 |
| AT3 | 0.89 | 0.56 | 0.42 | 0.36 | 0.53 | 0.43 | 0.09 | 0.51 | 0.19 | 0.39 |
| DB1 | 0.47 | 0.83 | 0.43 | 0.29 | 0.59 | 0.38 | 0.21 | 0.53 | 0.23 | 0.41 |
| DB2 | 0.50 | 0.71 | 0.39 | 0.30 | 0.53 | 0.33 | 0.13 | 0.53 | 0.17 | 0.34 |
| DB3 | 0.53 | 0.79 | 0.45 | 0.29 | 0.63 | 0.41 | 0.22 | 0.57 | 0.28 | 0.37 |
| DB4 | 0.49 | 0.81 | 0.39 | 0.34 | 0.59 | 0.35 | 0.19 | 0.56 | 0.20 | 0.35 |
| DB6 | 0.38 | 0.71 | 0.23 | 0.30 | 0.31 | 0.24 | 0.07 | 0.22 | 0.09 | 0.27 |
| DB7 | 0.34 | 0.70 | 0.33 | 0.26 | 0.33 | 0.29 | 0.14 | 0.26 | 0.16 | 0.22 |
| DB9 | 0.36 | 0.76 | 0.23 | 0.25 | 0.37 | 0.23 | 0.11 | 0.25 | 0.10 | 0.27 |
| DC1 | 0.42 | 0.41 | 0.85 | 0.41 | 0.46 | 0.45 | 0.41 | 0.47 | 0.40 | 0.41 |
| DC2 | 0.42 | 0.39 | 0.73 | 0.25 | 0.45 | 0.39 | 0.28 | 0.48 | 0.28 | 0.31 |
| DC3 | 0.45 | 0.44 | 0.88 | 0.43 | 0.47 | 0.53 | 0.49 | 0.46 | 0.40 | 0.36 |
| DC4 | 0.41 | 0.43 | 0.89 | 0.36 | 0.49 | 0.50 | 0.43 | 0.46 | 0.37 | 0.32 |
| HOM1 | 0.37 | 0.33 | 0.37 | 0.89 | 0.27 | 0.29 | 0.21 | 0.28 | 0.17 | 0.31 |
| HOM2 | 0.42 | 0.36 | 0.39 | 0.91 | 0.28 | 0.27 | 0.20 | 0.25 | 0.17 | 0.30 |
| HOM3 | 0.39 | 0.37 | 0.40 | 0.88 | 0.27 | 0.28 | 0.23 | 0.24 | 0.18 | 0.31 |
| HOM4 | 0.36 | 0.37 | 0.38 | 0.89 | 0.25 | 0.25 | 0.19 | 0.25 | 0.13 | 0.33 |
| MDI1 | 0.56 | 0.63 | 0.52 | 0.29 | 0.92 | 0.53 | 0.13 | 0.65 | 0.17 | 0.45 |
| MDI2 | 0.52 | 0.59 | 0.50 | 0.27 | 0.89 | 0.44 | 0.20 | 0.61 | 0.24 | 0.42 |
| MDI3 | 0.56 | 0.65 | 0.50 | 0.26 | 0.90 | 0.47 | 0.15 | 0.61 | 0.19 | 0.44 |
| MSSQ1 | 0.44 | 0.43 | 0.54 | 0.28 | 0.47 | 0.87 | 0.31 | 0.42 | 0.40 | 0.32 |
| MSSQ2 | 0.42 | 0.39 | 0.49 | 0.28 | 0.44 | 0.86 | 0.30 | 0.39 | 0.38 | 0.27 |
| MSSQ3 | 0.42 | 0.41 | 0.47 | 0.24 | 0.49 | 0.89 | 0.22 | 0.40 | 0.30 | 0.32 |
| MSSQ4 | 0.40 | 0.33 | 0.43 | 0.25 | 0.44 | 0.85 | 0.21 | 0.31 | 0.26 | 0.23 |
| MTE2 | 0.03 | 0.18 | 0.27 | 0.13 | 0.10 | 0.25 | 0.83 | 0.19 | 0.69 | 0.23 |
| MTE3 | 0.04 | 0.19 | 0.53 | 0.25 | 0.17 | 0.28 | 0.91 | 0.21 | 0.59 | 0.28 |
| MTE5 | 0.04 | 0.22 | 0.46 | 0.23 | 0.19 | 0.28 | 0.92 | 0.21 | 0.61 | 0.28 |
| MTI2 | 0.50 | 0.55 | 0.48 | 0.25 | 0.63 | 0.40 | 0.22 | 0.90 | 0.27 | 0.38 |
| MTI4 | 0.43 | 0.35 | 0.41 | 0.18 | 0.44 | 0.29 | 0.12 | 0.71 | 0.16 | 0.32 |
| MTI5 | 0.46 | 0.59 | 0.51 | 0.29 | 0.63 | 0.39 | 0.22 | 0.91 | 0.27 | 0.38 |
| PB1 | 0.21 | 0.28 | 0.42 | 0.19 | 0.25 | 0.39 | 0.67 | 0.28 | 0.95 | 0.27 |
| PB2 | 0.10 | 0.17 | 0.37 | 0.10 | 0.16 | 0.35 | 0.70 | 0.23 | 0.86 | 0.20 |
| PB4 | 0.12 | 0.20 | 0.37 | 0.16 | 0.16 | 0.29 | 0.70 | 0.24 | 0.90 | 0.17 |
| SN1 | 0.44 | 0.41 | 0.37 | 0.37 | 0.43 | 0.31 | 0.27 | 0.39 | 0.21 | 0.87 |
| SN2 | 0.38 | 0.41 | 0.36 | 0.30 | 0.44 | 0.30 | 0.22 | 0.35 | 0.19 | 0.88 |
| SN3 | 0.35 | 0.39 | 0.35 | 0.29 | 0.40 | 0.28 | 0.26 | 0.36 | 0.20 | 0.89 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| SN4 | 0.34 | 0.38 | 0.34 | 0.29 | 0.43 | 0.27 | 0.27 | 0.39 | 0.23 | 0.88 |
| SN6 | 0.40 | 0.42 | 0.40 | 0.32 | 0.43 | 0.29 | 0.29 | 0.40 | 0.27 | 0.90 |

The last method according to Hair et al. (2017), is the HTMT which supposed not to have values greater than 0.85. the existence of values greater than 0.85 indicate that the correlation among the variables is high. As shown in Table 4.10, the values are all less than 0.85.

Table 4. 10: Heterotrait-Monotrait Ratio (HTMT)

| | AT | DB | DC | HOM | MDIV | MSSQ | MTE | MTI | PB | SN |
|---|---|---|---|---|---|---|---|---|---|---|
| AT | | | | | | | | | | |
| DB | 0.71 | | | | | | | | | |
| DC | 0.58 | 0.57 | | | | | | | | |
| HOM | 0.48 | 0.46 | 0.49 | | | | | | | |
| MDIV | 0.68 | 0.77 | 0.64 | 0.34 | | | | | | |
| MSSQ | 0.54 | 0.51 | 0.63 | 0.34 | 0.59 | | | | | |
| MTE | 0.08 | 0.25 | 0.55 | 0.26 | 0.20 | 0.34 | | | | |
| MTI | 0.68 | 0.71 | 0.68 | 0.34 | 0.82 | 0.52 | 0.27 | | | |
| PB | 0.18 | 0.26 | 0.48 | 0.19 | 0.24 | 0.42 | 0.86 | 0.33 | | |
| SN | 0.48 | 0.50 | 0.46 | 0.38 | 0.53 | 0.36 | 0.33 | 0.51 | 0.26 | |

### 4.5.2 Structural Model

The process of evaluating the structural model was given in Chapter 3. In which, the assessment has to include the explanatory power which known as R-square. The predictive relevancy of the cross redundancy (Q-square) also should be examined. The f-square or the effect size as well as the path coefficient are other criteria that should be evaluated when examining the structural model. For the R-square, the R-square of MD intention to visit is 0.567. This indicates that 56.7% of the variation in MD intention to visit can be explained by the variables of the study such as AT, SN, and MT infrastructure. In addition, the R-square of AT and SN are 0.252 and 0.241indicating that expense, service quality and product belief can explain 25.2% of AT while destination belief and homophily can explain 24.1% of SN. Q-square or also known as the predictive relevance which explain the predictability of the IV on the DV showed values greater than zero which indications that there is predictive relevance among the IV and the DV. The value of Q-square for medication destination intention to visit is 0.576 and the predictive relevance of AT and SN are 0.312 and 0.291 respectively.

The path coefficient of the models is presented in Figure 4.7. In this study, there are two models. The first model is testing the direct effect of thevariable while the second model is testing the moderating effect of culture destination. Figure 4.7 shows the structural model of the direct effect.

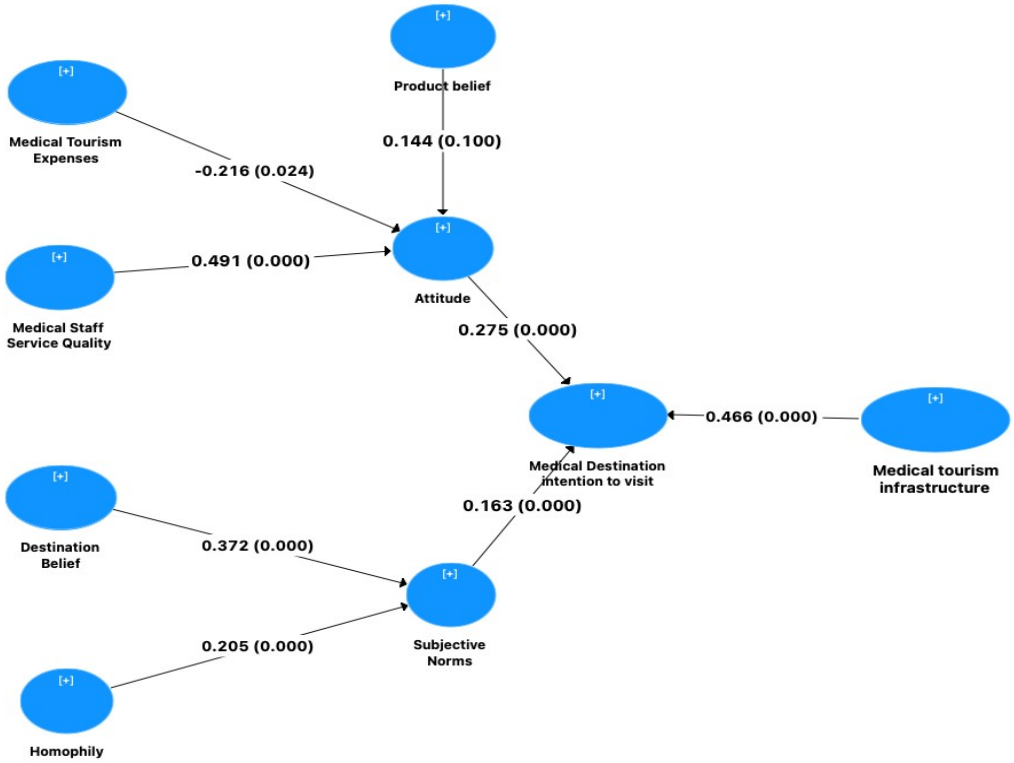


Figure 4. 7: Structural Model of Direct Effect

Table 4.9 provides information on the F-square and the path coefficient, both of which represent the results of testing the hypotheses. Table 4.11 reveals that every effect size, as measured by f-square, is more than 0.02, indicating that the effect size meets the criteria for being considered acceptable. The hypotheses (H), the path, the path coefficient (B), the standard deviation (Std.), the T-value (T), and the F-square are shown in Table 4.9.

Table 4. 11: Result of Hypotheses Testing

| H | Path | B | Std | T | P | $f^2$ | Conclusion |
|---|---|---|---|---|---|---|---|
| **H1** | **MT Expenses -> Attitude** | -0.216 | 0.095 | 2.269 | **0.024** | **0.11** | **Supported** |
| **H2** | **Medical Staff Service Quality -> Attitude** | 0.491 | 0.055 | 8.979 | **0.000** | **0.34** | **Supported** |
| **H3** | **Product belief -> Attitude** | 0.144 | 0.087 | 1.648 | **0.100** | **0.01** | **Rejected** |

| H | Path | B | Std | T | P | $f^2$ | Conclusion |
|---|---|---|---|---|---|---|---|
| **H4** | **Destination Belief -> Subjective Norms** | 0.372 | 0.046 | 8.009 | **0.000** | **0.32** | **Supported** |
| **H5** | **Homophily -> Subjective Norms** | 0.205 | 0.051 | 4.034 | **0.000** | **0.10** | **Supported** |
| **H6** | **Attitude ->MD intention to visit** | 0.275 | 0.054 | 5.052 | **0.000** | **0.21** | **Supported** |
| **H7** | **Subjective Norms ->MD intention to visit** | 0.163 | 0.046 | 3.519 | **0.000** | | **Supported** |
| **H8** | **MT infrastructure -> Medical Destination intention to visit** | 0.466 | 0.043 | 10.954 | **0.000** | **0.29** | **Supported** |

## 4.6 Hypotheses Testing

The hypotheses of this study consists of two types. Firs the direct effect which include the effect of variables on AT, SN, and MD intention to visit. The second type include the moderating role of destination culture. In the following section, the analysis of the hypotheses is discussed.

### 4.6.1 Attitude

In terms of AT, it included three hypotheses for predictors of AT. The first of which is the MT expense and its link with AT. The hypothesis was predicted to be negative. The effect of MT expense on ATwas proposed to be negative. The findings showed that this effect is negative at coefficient (B) of -0.216 and p-value of less than 0.05. Thus, H1 is supported. The increase in expense of MT will lead to a decrease in the AT toward destination.

For the second hypothesis, it is proposed that the effect of medical staff service quality will have a positive effect on AT. The proposition is true. Medical staff service quality has a positive and significant effect on AT(B=0.491, P-value<0.05). Thus, H2 is supported. The increase in the level of service quality of medical staff will lead to an increase in the positive AT toward the destination.

For the third hypotheses, the effect of product belief on AT was found insignificant. This indicates that product belief is not critical for the AT of a destination (B=0.144, P-value>0.05). Thus, H3 is rejected.

### 4.6.2 Subjective Norms

The fourth hypotheses of this study proposed that the effect of destination belief on subjective norm is positive and significant. The findings showed that the effect of destination belief on SN is positive and significant with a coefficient of 0.372 and p-value of less than 0.05. The increase in the level of destination belief will lead to an increase in the SN of a destination.

The fifth hypothesis indicated that the effect of homophily on the SN is positive and significant. The findings showed that this effect is positive at B= 0.205 and P-value equals to 0.000 which is less than 0.05. This led to accepting the hypothesis (H5) and concluding that the increase in the level of homophily will lead to an increase in the SN toward the destination.

### 4.6.3 Medical Destination intention to visit

Three variables were expected to affect the MD intention to visit. The findings as shown in Table 4.11 indicate that the effect of AT on MD intention to visit is positive and significant at B=0.275 and P-value of less than 0.05. this indicates that once AT toward the destination increases, the MD intention to visit will increase. Accordingly, H6 is supported.

For H7, the SN affected positively the MD intention to visit at B=0.163 and P-value less than 0.05. This has led to supporting the seventh hypothesis of this study and lead to a conclusion that the increase in the level of SN will affect positively the MD intention to visit.

The eighth hypothesis of this study is related to the effect of MT infrastructure on MD intention to visit. The findings in Table 4.11 support this claim and indicated that the increase in the level of MT infrastructure will lead to an increase in the MD intention to visit. Thus, H8 is supported.

### 4.6.4 Destination Culture as Moderator

The ninth hypothesis of this study proposed destination culture to play a moderating role between AT and SN with MD intention to visit. To test the moderating effect, the product indicators of AT and SN were multiplied by the product indicators of the destination culture. This has resulted in creating two new variables that are the moderating effects as shown in Figure 4.8 (AT*DC and SN*DC). The new paths were examined, and Figure 4.8 shows the moderating effect of destination culture.

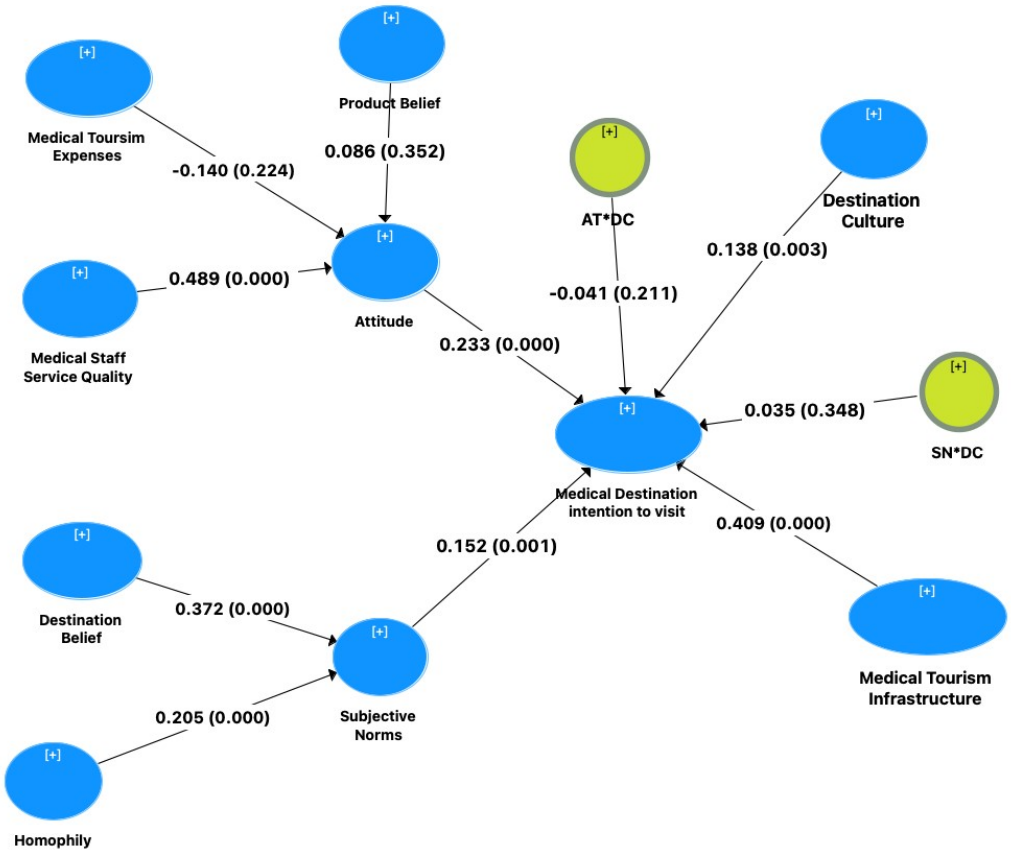


Figure 4. 8: Moderating Effect of Destination Culture

In Table 4.12, the result of testing the moderating role of destination culture is shown.

Table 4. 12: Results of Testing the Moderator

| H | Path | B | Std | T | P | Conclusion |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| H9 | AT*DC -> Medical Destination intention to visit | -0.041 | 0.033 | 1.253 | 0.211 | Rejected |
| | SN*DC -> Medical Destination intention to visit | 0.035 | 0.037 | 0.940 | 0.348 | Rejected |

As shown in the Table, the moderating effect of destination culture between AT and MD intention to visit (AT*DC) is not significant because the P-value is greater than 0.05. Similarly, the moderating effect of destination culture between SN and MD intention to visit is not significant due to the fact that p-value is greater than 0.05. thus, it can be concluded that destination culture is not a moderator but is the direct predictors of the MD intention to visit. This is because the effect of destination culture on MD intention to visit is positive at B= 0.138 and P-value less than 0.05 as shown in Figure 4.8.

## 4.7 Summary

The results and data analysis of this research have been reported in this chapter. For the sake of further analysis, the data were screened. There was an investigation of missing values, outliers, normality and multicollinearity. Descriptive analysis was also carried out on the respondents and the variables in this research. The hypotheses of this study were tested using the Smart PLS. All the hypotheses were accepted except for the product belief and moderating role of destination culture.

# CHAPTER 5

# DISCUSSION AND CONCLUSION

## 5.1 Introduction

The results of the research are discussed in this section of the study. The chapter is broken up into five different parts. Following the presentation of a summary of the material covered in this chapter in the first part, the subsequent part focuses on discussing the results. The results of this research are analyzed and compared to the findings of other studies. In the third part, it addresses both the theoretical and practical implications of the findings. Following a discussion of the limitations imposed by this study in the fourth part, the fifth part describes the direction for future research. The results of this research are presented in their entirety in the last section.

## 5.2 Discussion

This study was conducted to examine the predictors of MD intention to visit as well as the moderating role of destination culture. In particular, the objectives of this study were stated as follows:

1- To examine the effect of MT expense, medical staff service quality and product belief on attitude toward MT destination choice.
2- To investigate the effect of homophily and destination belief on subjective norms to choose a MT destination.
3- To identify the effect of attitude, subjective norms, and MT infrastructure on toMD intention to visit.
4- To determine the moderating role of destination culture between attitude and subjective norms, and MD intention to visit.

To fulfill the objectives, a framework was developed based on existing theories and models. The data was collected from medical tourist in Iraq who have visited or intended to do MT in Dubai.

### 5.2.1 Attitude

The first objective of this study sought to find the effect of MT expenses, medical staff service quality, and product belief on the MDintention to visit. The findings showed that the effect of MT expense is negative while the effect of medical staff service quality is positive. Product belief has insignificant effect. The high expense is a major reason for not selecting a MT while the service quality of the medical staff is critical.

In line with these findings, previous studies showed the cost of MT is one of the most important factors (Çapar & Aslan, 2020; Nasab et al., 2018; Zolfagharian et al., 2018). In addition, prior literature agreed that the medical staff service quality is essential for promoting the MD intention to visit and to improve the AT toward the destination (Rosenbusch et al., 2018; Sultana et al., 2014). Medical staff service quality is also critical for the satisfaction of tourists and for their decision making to travel to MD (Moghimehfar & Nasr-Esfahani, 2011; Ghosh & Mandal, 2019; Zarei & Maleki, 2019).

For product belief, it has no effect. This finding contradict with the fining of other previous studies which found that product belief is critical for the AT and the selection of a MD (Ahani et al., 2019; Cham et al., 2021). However, the insignificant effect could be related to the notion that cost of MT in Dubai which might be considered high for the respondents. In addition, the familiarity withMT in Dubai where more than 28% who indicated that they are neutral and 12% of the respondents indicated that they are not familiar with MD.

### 5.2.2 Subjective Norms

The second objective aimed to find the effect of homophily and destination belief on SN. The findings showed that homophily and destination belief have a significant effect on SN. These findings indicated that the increase in the level of homophily and destination belief will lead to an increase in the SN toward the MT destination.

The findings of this study are in line with the findings of the previous studies. Researchers found that homophily is critical for the SN and the selection of a destination (Fogel & Shraybman-Buynova, 2021; Hotter, 2018; Ro & Ha, 2019; Rogers & Bhowmik, 1970; Thwe, 2019). This could be due to the similarity between Dubai and Iraqi in term of language, background, and tradition. The effect of destination belief is also significant. This finding is in line with the findings of other researcher (Zolfagharian et al. 2018; Collins et al., 2019).

### 5.2.3 MD Intention to Visit

The third research objective sought to find the effect of AT, SN and MT infrastructure on the medication destination intention to visit. The effect of AT and SN as well as the MT infrastructure have significant effect on the medial destination intention to visit. This indicates that the increase in the level of AT, SN, and MT infrastructure will increase the MD intention to visit.

In line with the TPB, AT and SN are critical for the behavior and intention to do an action (Ajzen, 1991). Findings of prior literature also showed that the AT and SN are important for the MD intention to visit (Lee et al., 2012; Suki et al., 2017; Cham et al. 2021). In term of MT infrastructure, the positive effect is in line with the findings of studies such as Gill and Singh (2011) who found that medical treatment facilities are important for deciding to travel aboard for medical treatment.

### 5.2.4 Destination Culture as a Moderator

The fourth research objective aimed to find the moderating role of destination culture between AT and SN, and MD intention to visit. The finding indicated that destination culture has no moderating effect between AT and SN with medication destination

intention to visit. The finding of prior literature is inconsistent with the findings of this study. Destination culture moderated the effect of tourist's satisfaction on BI in the study of Hung et al. (2019).

This insignificant moderator could be related to the similarity between the two cultures which makes the variation among the two cultures small. Nevertheless, the findings showed that the direct effect of destination culture is significant. This finding is in line with other researchers who found direct link between destination culture and satisfaction or destination culture and intention to visit and revisits (Ghosh & Mandal, 2019; Matiza & Slabbert, 2020; Nasab et al., 2018).

## 5.3 Implications

The results of this research give rise to two distinct kinds of implications as a direct result of their findings. The first inference is one with theoretical connotations, whereas the second one has connotations of an applied kind. The implications of this are shown in the following sections.

### 5.3.1 Theoretical implication

This research has added to the body of knowledge and literature about MD intention to visit and its predictors. The study examined the effect of predictors of MD intention to visit in the context of Middle Eastern countries which received less attention in the literature. The study also contributed to the literature by examining the moderating role of destination culture between AT and SN, and MD intention to visit.

This study deployed the TRA and TPB in the context of MT. The study confirmed the validity of TRA and TPB to explain the link between predictors and intention to do MT among Iraqis and their destination is Dubai. The study has explained more than 56% of the variation in the MD intention to visit. Lastly, the study contributed to the literature by examining the hypotheses using the Smart PLS as embedded in structural equation modeling while prior literature has used SPSS.

### 5.3.2 Practical Implications

The study's practical implications are derived from the results. This research found that MT expense has a negative effect on AT. Tourism industry decision makers are recommended to create package in which the total cost can be customized to suit the need of medical tourist. Therefore, their AT will improve. The findings also showed that medical staff service quality is important for AT. Thus, decision makers are recommended to hire high quality staff who are able to provide excellent service either in the receptions or in the medical field.

The findings also showed that homophily and destination belief are critical for the SN. Decision makes are recommended to customize the services by including those who understand the tradition and the small details of other culture so that they can increase the SN about the destination. AT and SN as well as the MD infrastructure are important for the MD intention to visit. Therefore, the decision makers are recommended to enhance the AT of MT and to deploy social media application to improve the online word of mouth. In addition, the infrastructure should be up to date and convenient for the usage of the medical tourist.

The moderating effect of destination culture was not confirmed in this study. However, the direct effect of destination culture was confirmed. A guider is recommended to be always with the medical tourist and an orientation day should be provided for tourist to understand the culture of the destination.

## 5.4 Limitations

This study was conducted in Iraq among medical tourists. The study deployed a connivance sampling technique which limit the generalization of the findings. However, the findings can be generalized on the sample of this study and those who share similar characteristic with the sample. The findings are limited to the perception the respondents who have participated in this study.

## 5.5 Direction for Future Work

In light of the results and the limitations placed by this study, it is advised that more research be conducted to duplicate this study. Future studies can examine the predictors of MT using a random sampling technique. A database of medical tourists should be existed to use this kind of sampling. Future studies are recommended to examine the role of religiosity as a moderator in the process of selecting a medical destination. Other variables can be included such as the hospitability of the citizens of the destination and the level of understanding and tolerance with foreigners. Visa application and the easiness of obtaining visa should be a direction for future work. Lastly, future studies are recommended to increase the sample size so that the findings can be more generalizable.

## 5.6 Conclusion

This study was conducted to examine the predictors of MD intention to visit. The study also aimed to find the moderating roe of destination culture. The study deployed the TPB and TRA as well as the existing frameworks to develop the conceptual model. Based on the literature, the related hypotheses were developed. The population of this study included the medical tourists in Iraq. A total of 315 respondents participated in this study.

SPSS and Smart PLS were used throughout the process of carrying out the data analysis. For the purpose of analyzing missing data, outliers, normality, multicollinearity, and descriptive information on the respondents and the variables, the SPSS was used. Following the completion of the data screening, the Smart PLS was put into action in order to investigate the reliability and validity of the measurement. In addition, the Smart PLS was used to confirm the status of the hypotheses of this research.

The findings showed that the effect of MT expenses has negative effect on AT while medical staff service quality has positive effect. The SN was affected by homophily and destination belief. The findings also showed that AT, SN, and MT infrastructure affected the MD intention to visit. Destination culture did not moderate the effect of AT and subjective norm on MD intention to visit.

Based on the findings, the study suggested that decision makers to focus on reducing cost and improving service quality of medical staff. The suggestions also include the spread of a positive word of mouth and customization of the MT to suit more tourists.

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**Appendix A: Questionnaire**

Dear Respondents
I am ABDULLA SAMI ESMAIL AL NAKSHABANDI a master's degree student at MODUL UNIVERSITY-VIENNA; my supervisor and I are working on a study project titled “Predictors of Medical Tourism Destination Choice: The Role of Culture of Destination". Since you are doing medical tourism, we are asking for your kind cooperation in answering this questionnaire. The purpose of the questionnaire is to collect data about the choice of destination for medical tourism. Participation in the survey is voluntary, no personal data will be collected in the questionnaire, and all the information provided will be used for statistical purposes. Furthermore, the information provided will be kept confidential, and no one except the researcher will have access to them. The time estimated to complete this questionnaire is 10 to 15 minutes. Furthermore, you have the right to withdraw from your participation in the study before using the data.

If you have any further questions or inquiry about the research, please do not hesitate to contact me through email: abdullasami@hotmail.com

Your cooperation is highly appreciated.

**Consent form**
After reading the information sheet, please tick marks the following:

I have read the information sheet and fully understood the purpose of the data collection.

I understand that my participation in the study is voluntary, and I can withdraw from the study at any stage before usage of the data.

I understand the information provided by me will remain fully confidential and only used for the purpose stated in information sheet.

I understand that I will not be asked any personal information in the questionnaire and any additional information given by me will be voluntarily.

Please evaluate the following statement where:

(1) Strongly disagree (SD)
(2) Disagree (D)
(3) Neutral (N)
(4) Agree (A)
(5) Strongly agree (SA)

| | | | | | | |
|---|---|---|---|---|---|---|
| Medical Staff Service Quality | Dubai has well trained doctors | SD | D | N | A | SA |
| | Dubai has experienced doctors | | | | | |
| | Dubai has reputable doctors | | | | | |
| | Dubai has doctors that speak my language | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Medical Tourism Expenses | Dubai offers a lower price for treatments | | | | | |
| | In Dubai treatment is affordable | | | | | |
| | Dubai offers advanced treatments at competitive prices | | | | | |
| | The food is affordable | | | | | |
| | The lodging (hotel) is affordable | | | | | |
| | The traveling is affordable | | | | | |
| Medical Tourism Infrastructure | Dubai has a high quality of healthcare | | | | | |
| | Dubai has internationally certified doctors | | | | | |
| | Dubai has reputable hospitals/medical facilities | | | | | |
| | Dubai has internationally accredited hospitals/medical facilities | | | | | |
| | Dubai has a high-quality standard in medical services | | | | | |
| Attitude | Traveling to Dubai for medical treatment would be a good idea. | | | | | |
| | I like the idea of traveling to Dubai to receive my medical treatment. | | | | | |
| | Traveling to Dubai to receive medical treatment would be a pleasant experience. | | | | | |
| Product Beliefs | Dubai's medical services are good | | | | | |
| | Dubai's medical services are good value for money | | | | | |
| | Going to Dubai for medical treatment conveys high status. | | | | | |
| | Dubai's medical services are a good alternative. | | | | | |
| MD Intention to visit | My willingness to visit Dubai for medical treatment is high. | | | | | |
| | My willingness to recommend this MD to others is high. | | | | | |
| | I plan on going to Dubai for medical treatment in the future. | | | | | |
| | If I have the resources, I would go to Dubai for medical treatment. | | | | | |
| Homophily | Dubai has a similar moral system as my home country | | | | | |
| | Dubai has a similar value system as my home country. | | | | | |
| | Social views are similar in Dubai | | | | | |
| | In Dubai interpersonal norms are similar. | | | | | |
| Destination Culture | The destination offers several opportunities to explore the local way of life | | | | | |
| | There are several programs to learn local history | | | | | |
| | The local people are open to welcome people from other cultures | | | | | |
| | The destination offers several ways to exchange cultural thoughts | | | | | |
| | Dubai has rich cultural heritage. | | | | | |
| Destination Beliefs | Dubai is a good place for beaches | | | | | |
| | Dubai has a variety of restaurants. | | | | | |
| | Dubai has appealing local food | | | | | |
| | Dubai has good shopping facilities. | | | | | |
| | Dubai is safe and secure | | | | | |
| | Dubai offers exciting and interesting places to visit | | | | | |
| | Dubai has beautiful scenery and natural attractions. | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Dubai has a pleasant climate. | | | | | |
| | As a tourism destination Dubai offers good value for money. | | | | | |
| Familiarity | How familiar are you with Dubai's medical services?<br>Very familiar<br>Familiar<br>Neutral<br>Unfamiliar<br>Total unfamiliar | | | | | |
| Gender | Male | | | | | |
| | Female | | | | | |
| Marital Status | Married | | | | | |
| | Living with partner | | | | | |
| | Divorced, | | | | | |
| | Widowed | | | | | |
| | Never Married | | | | | |
| What is your disposable income per month? (i.e., after paying al bills)<br>Please specify | | | | | | |
| Education | High school | | | | | |
| | Associate degree | | | | | |
| | College | | | | | |
| | Bachelor's degree | | | | | |
| | Master's degree | | | | | |
| | PhD | | | | | |
| Age | 18-24 | | | | | |
| | 25-34 | | | | | |
| | 35-44 | | | | | |
| | 45-54 | | | | | |
| | 55-65 | | | | | |
| | 65-74 | | | | | |
| | 75 and older | | | | | |

## Appendix B: Arabic Questionnaire

أعزائي المستجيبين
أنا عبد اللهالنقشبندي طالب ماجستير في جامعة مودول -فيينا؛ أنا ومشرفي نعمل على مشروع دراسة بعنوان "اسباب اختيار وجهة السياحة العلاجية: دور ثقافة الوجهة". بما أنكم تقومون بالسياحة العلاجية، فنحن نطلب تعاونكم في الإجابة على هذا الاستبيان. الغرض من الاستبيان هو جمع بيانات حول اختيار وجهة السياحة العلاجية. المشاركة في الاستبيان تطوعية، ولن يتم جمع أي بيانات شخصية في الاستبيان، وسيتم استخدام جميع المعلومات المقدمة للأغراض الإحصائية. علاوة على ذلك، ستكون المعلومات المقدمة سرية ولن يتمكن أحد غير الباحثين من الوصول إليها، والوقت المقدر لإكمال هذا الاستبيان هو من 10 إلى 15 دقيقة، كما يحق لكم الانسحاب من مشاركتكم في الدراسة قبل استخدام البيانات.

إذا كان لديك أي أسئلة أو استفسارات أخرى حول البحث، فيرجى عدم التردد في الاتصال بنا عبر البريد الإلكتروني
abdullasami@hotmail.com:

نقدر تعاونكم كثيرا.

نموذج الموافقة:
بعد قراءة ورقة المعلومات، يرجى وضع علامة على ما يلي:
لقد قرأت ورقة المعلومات وفهمت تمامًا الغرض من جمع البيانات.
أفهم أن مشاركتي في الدراسة تطوعية ويمكنني الانسحاب من الدراسة في أي مرحلة قبل استخدام البيانات.
أفهم أن المعلومات التي قدمتها ستظل سرية تمامًا وستستخدم فقط للغرض المذكور في ورقة المعلومات.
أفهم أنه لن يتم سؤالي عن أي معلومات شخصية في الاستبيان وأي معلومات إضافية قدمتها ستكون طواعية.

| | غير موافق بشدة | غير موافق | محايد | موافق | موافق بشدة |
|---|---|---|---|---|---|
| جودة خدمة الطاقم الطبي | | | | | |
| 1. دبي لديها أطباء مدربون تدريباً جيداً | | | | | |
| 2. دبي لديها أطباء ذوي خبرة | | | | | |
| 3. يوجد في دبي أطباء مرموقون | | | | | |
| 4. يوجد في دبي أطباء يتحدثون لغتي | | | | | |
| تكلفة الخدمات الطبية | | | | | |
| 1. تقدم نفقات السياحة العلاجية في دبي سعرًا أقل للعلاجات | | | | | |
| 2. العلاج في دبي ميسور التكلفة | | | | | |
| 3. تقدم دبي علاجات متقدمة بأسعار تنافسية | | | | | |
| 4. الغذاء بأسعار معقولة | | | | | |
| 5. السكن (فندق) ميسور التكلفة | | | | | |
| 6. السفر بأسعار معقولة | | | | | |
| البنية التحتية للسياحة العلاجية | | | | | |
| 1. دبي تتمتع بجودة عالية في الرعاية الصحية | | | | | |
| 2. يوجد في دبي أطباء معتمدين دوليًا | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | 3. يوجد في دبي مستشفيات / مرافق طبية مرموقة |
| | | | | | 4. يوجد في دبي مستشفيات / منشآت طبية معتمدة دوليًا |
| | | | | | 5. تتمتع دبي بمعايير عالية الجودة في الخدمات الطبية |
| | | | | | الموقف من السفر |
| | | | | | 1. السفر إلى دبي لتلقي العلاج الطبي سيكون فكرة جيدة. |
| | | | | | 2. تعجبني فكرة السفر إلى دبي لتلقي علاجي الطبي. |
| | | | | | 3. السفر إلى دبي لتلقي العلاج الطبي سيكون تجربة ممتعة. |
| | | | | | معتقدات المنتج |
| | | | | | 1. المنتج المعتقدات الخدمات الطبية في دبي جيدة |
| | | | | | 2. تعتبر الخدمات الطبية في دبي ذات قيمة جيدة مقابل المال |
| | | | | | 3. الذهاب إلى دبي لتلقي العلاج الطبي ينقل مكانة عالية. |
| | | | | | 4. تعتبر الخدمات الطبية في دبي بديلاً جيدًا. |
| | | | | | الوجهة الطبية لزيارة دبي |
| | | | | | 1. رغبتي في زيارة دبي لتلقي العلاج الطبي عالية. |
| | | | | | 2. رغبتي في التوصية بهذه الوجهة الطبية للآخرين عالية. |
| | | | | | 3. أخطط للذهاب إلى دبي لتلقي العلاج الطبي في المستقبل. |
| | | | | | 4. إذا كانت لدي الموارد فسوف أذهب إلى دبي لتلقي العلاج الطبي. |
| | | | | | الشبه مع البلد الام |
| | | | | | 1. دبي لديها نظام أخلاقي مماثل لبلدي الأم |
| | | | | | 2. لدى دبي نظام قيم مماثل لبلدي الأم. |
| | | | | | 3. الآراء الاجتماعية متشابهة في دبي |
| | | | | | 4. المعايير الشخصية في دبي متشابهة. |
| | | | | | ثقافة الوجهة |
| | | | | | 1. توفر الوجهة العديد من الفرص لاستكشاف طريقة الحياة المحلية |
| | | | | | 2. هناك العديد من البرامج لتعلم التاريخ المحلي |
| | | | | | 3. السكان المحليون منفتحون على الترحيب بالناس من الثقافات الأخرى |
| | | | | | 4. توفر الوجهة عدة طرق لتبادل الأفكار الثقافية |
| | | | | | 5. تتمتع دبي بتراث ثقافي غني. |
| | | | | | وجهة معتقدات |
| | | | | | 1. دبي هي مكان جيد للشواطئ |
| | | | | | 2. يوجد في دبي مجموعة متنوعة من المطاعم. |
| | | | | | 3. دبي لديها طعام محلي جذاب |
| | | | | | 4. دبي لديها مرافق تسوق جيدة. |
| | | | | | 5. دبي آمنة ومأمونة |
| | | | | | 6. تقدم دبي أماكن مثيرة ومثيرة للاهتمام للزيارة |
| | | | | | 7. تتمتع دبي بمناظر طبيعية جميلة ومناطق جذب طبيعية. |
| | | | | | 8. تتمتع دبي بمناخ لطيف. |

| | | | | | |
|---|---|---|---|---|---|
| 9. كوجهة سياحية تقدم دبي قيمة جيدة مقابل المال. | | | | | |
| | | | | | |
| الإلمام ما مدى معرفتك بالخدمات الطبية في دبي؟ | | | | | |

الجنس

ذكر

أنثى

الحالة الاجتماعية:

متزوج

اعيش مع شريك

مُطلّق،

الأرامل

لم اتزوج قط

ما هو دخلك المتاح في الشهر؟ (أي بعد دفع الفواتير)

ارجو التحديد ()

التعليم

تعليم ثانوية

درجة الزمالة

كلية

درجة البكالوريوس

ماجستير

دكتوراه

العمر

24-18

25-34

35-44

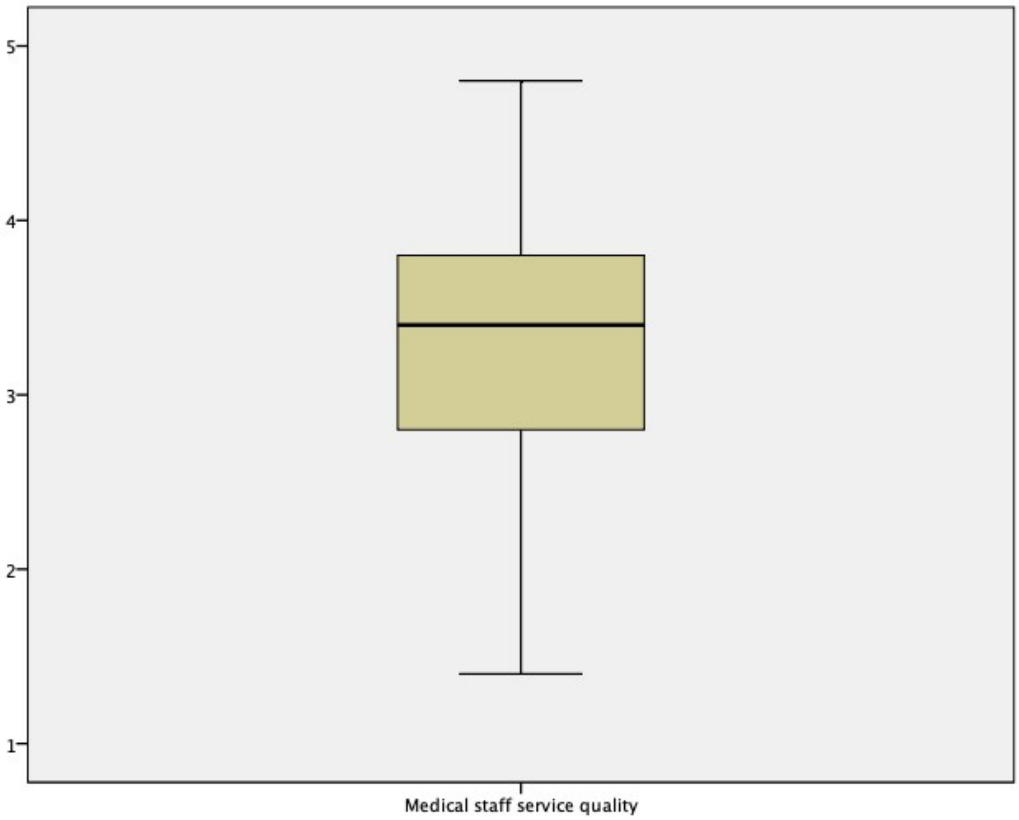
45-54

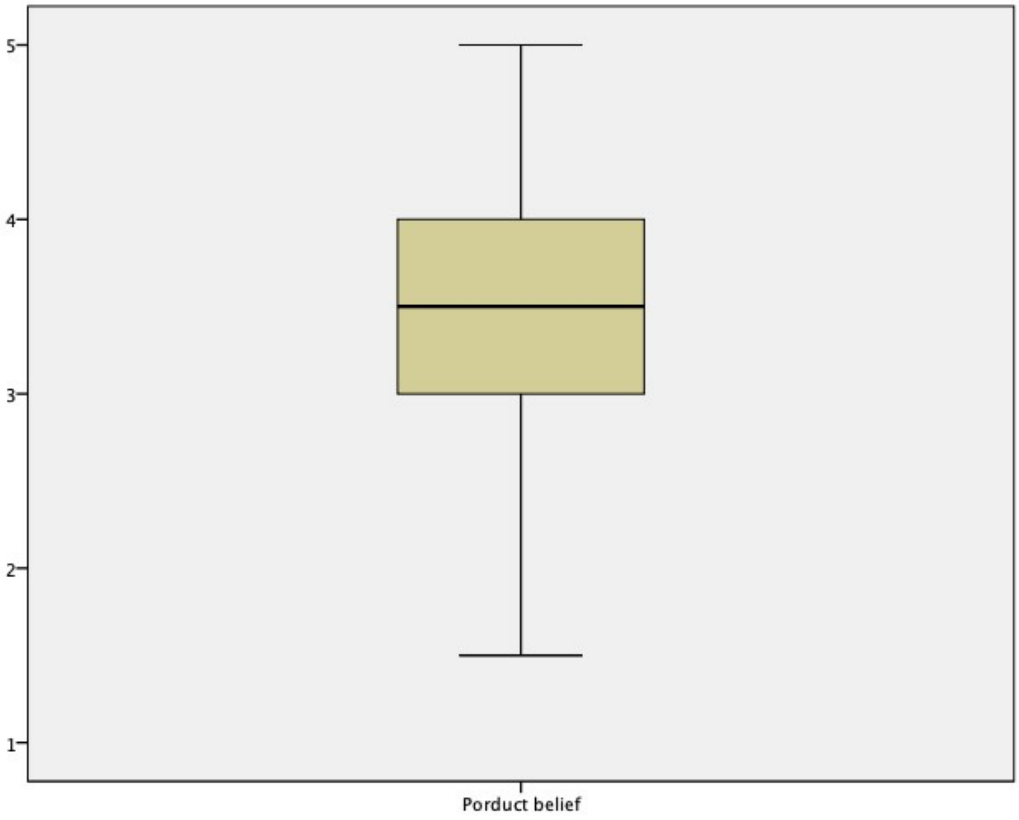
55-65

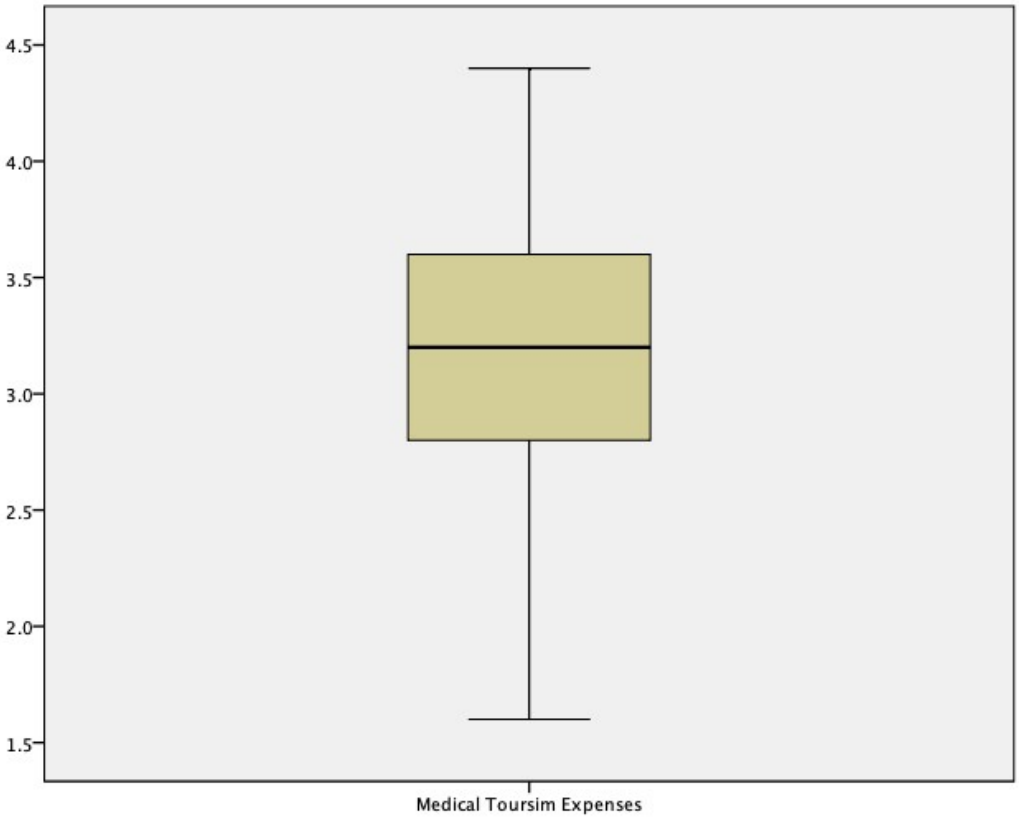
65-74

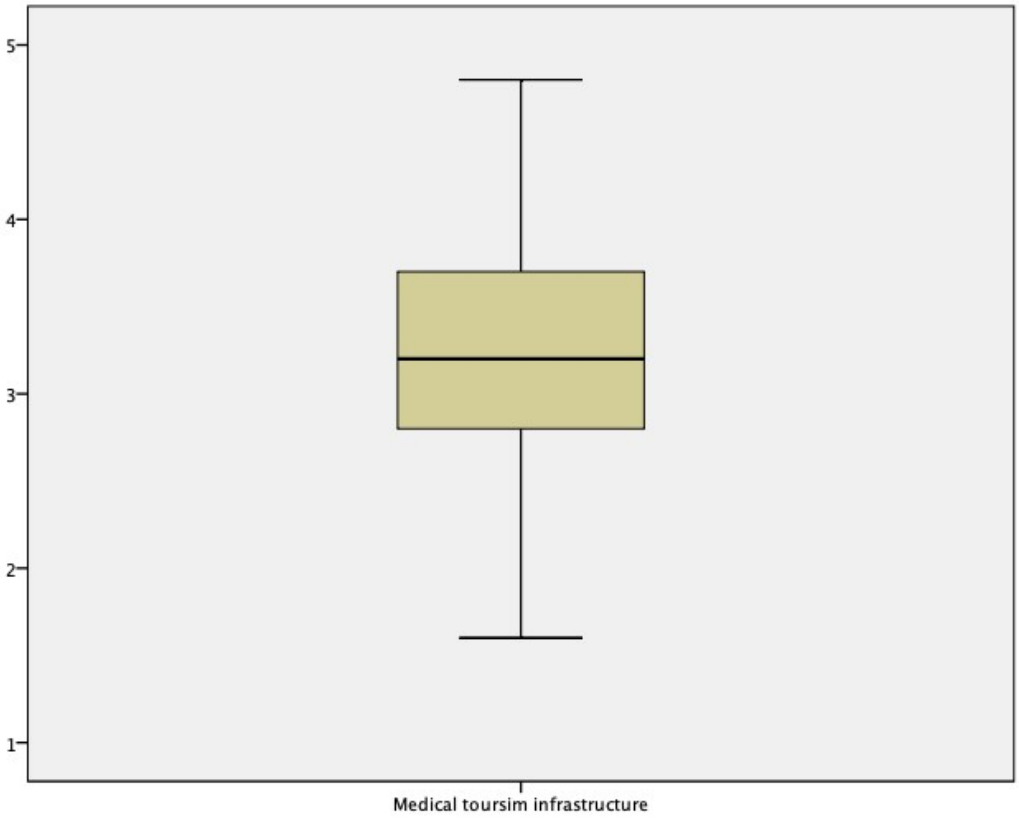
75وما فوق

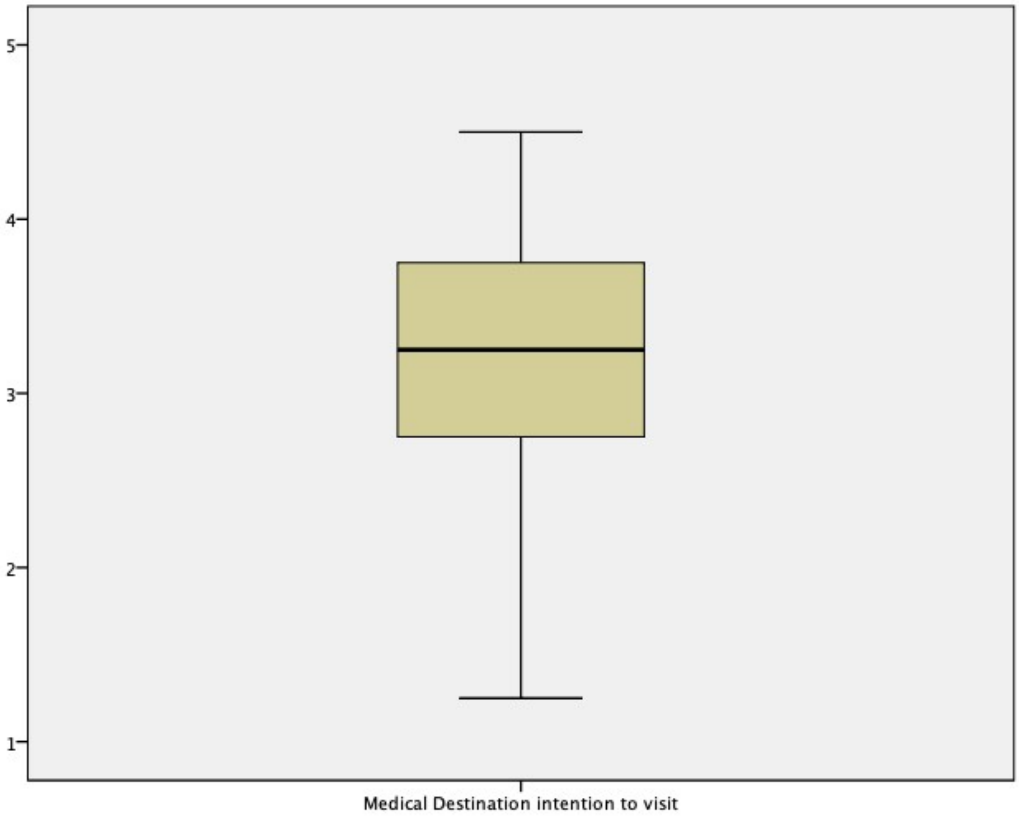
**Appendix C: Boxplot of Outliers**

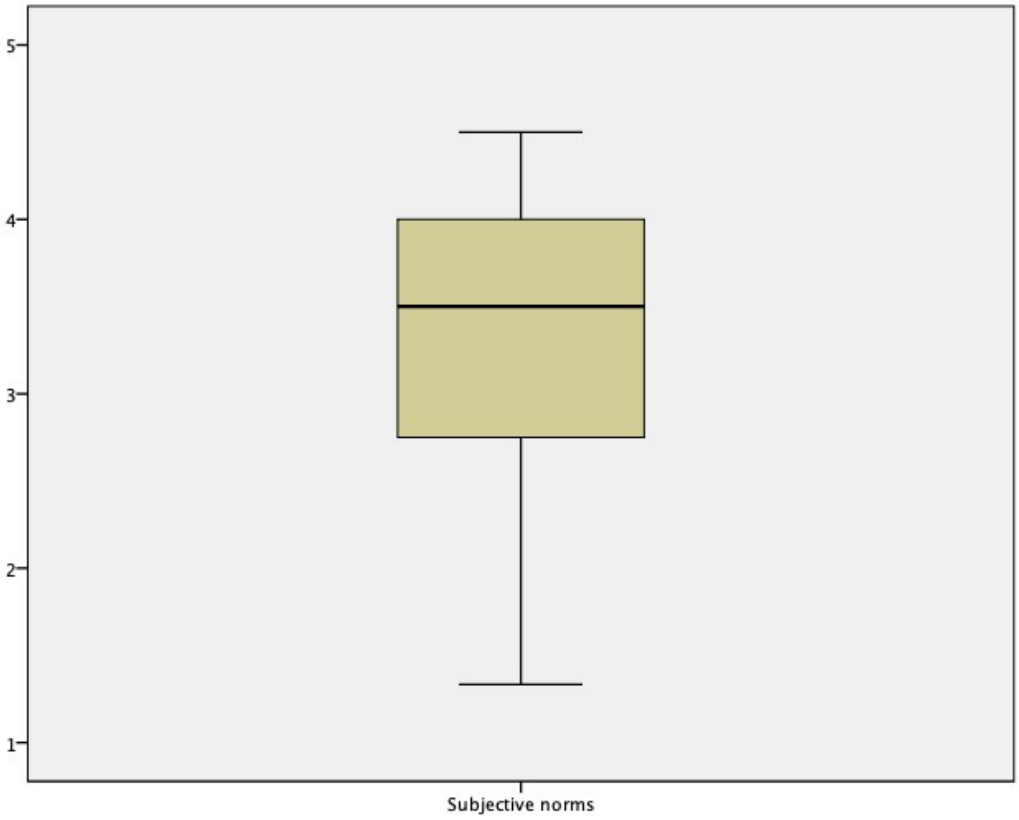


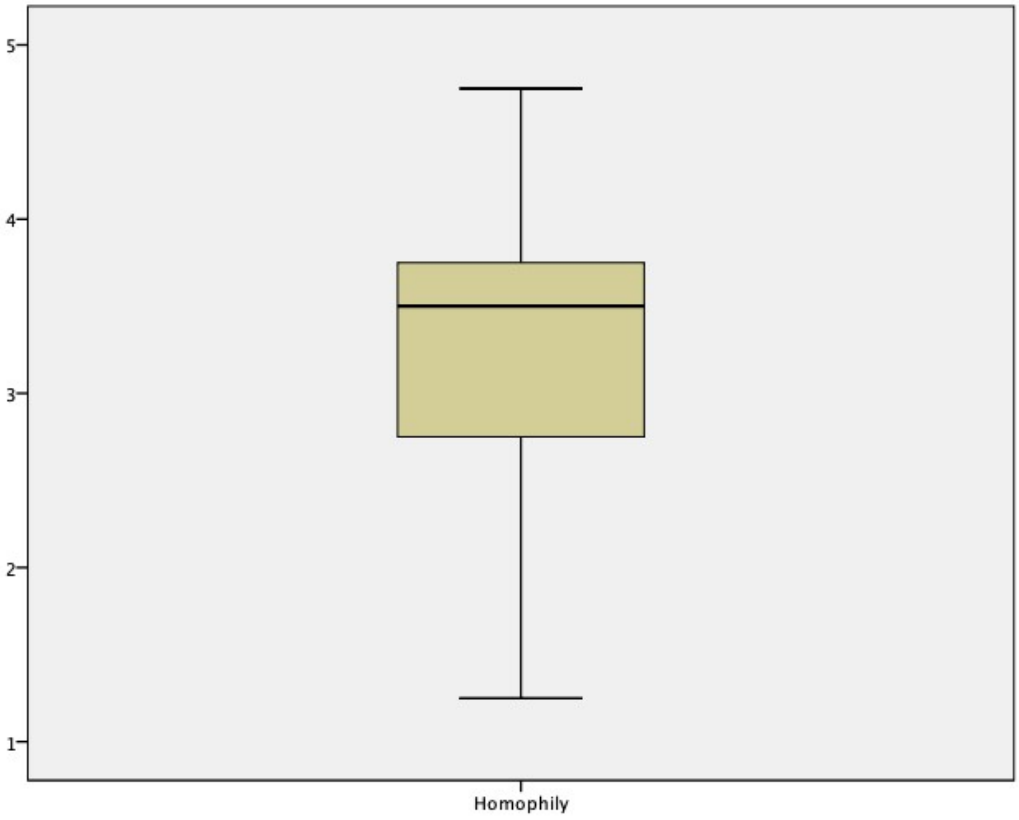

5
4
3
2
1
Porduct belief

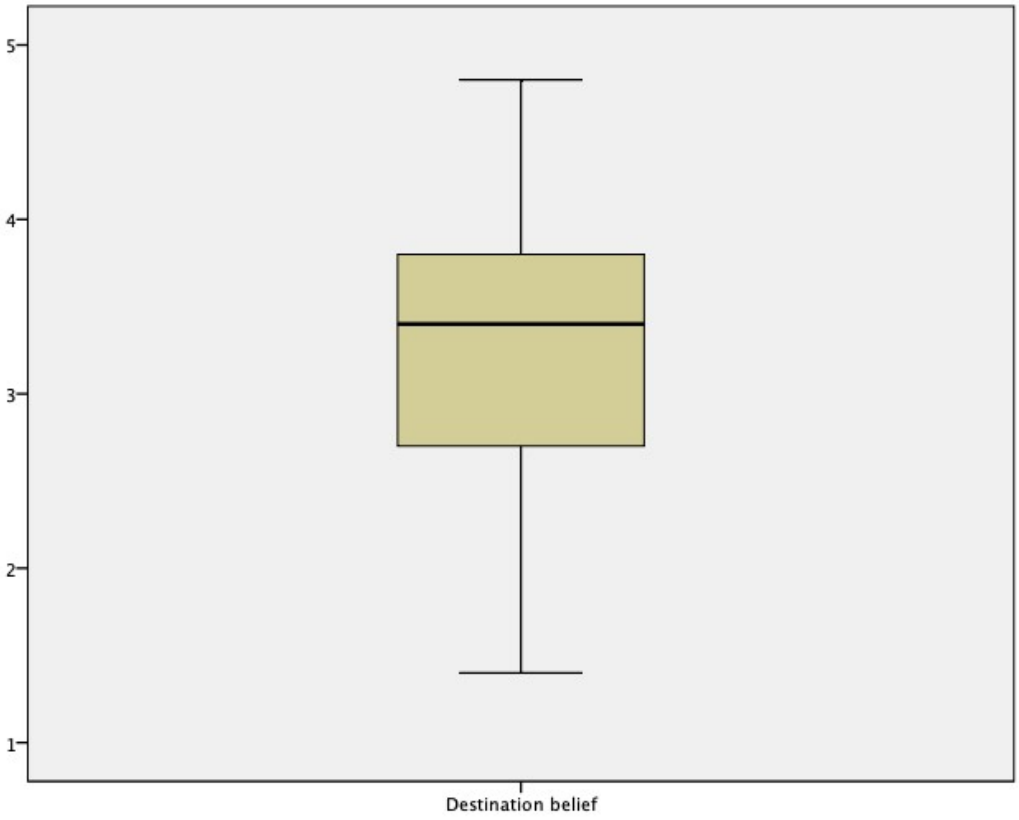

4.5
4.0
3.5
3.0
2.5
2.0
1.5
Medical Toursim Expenses

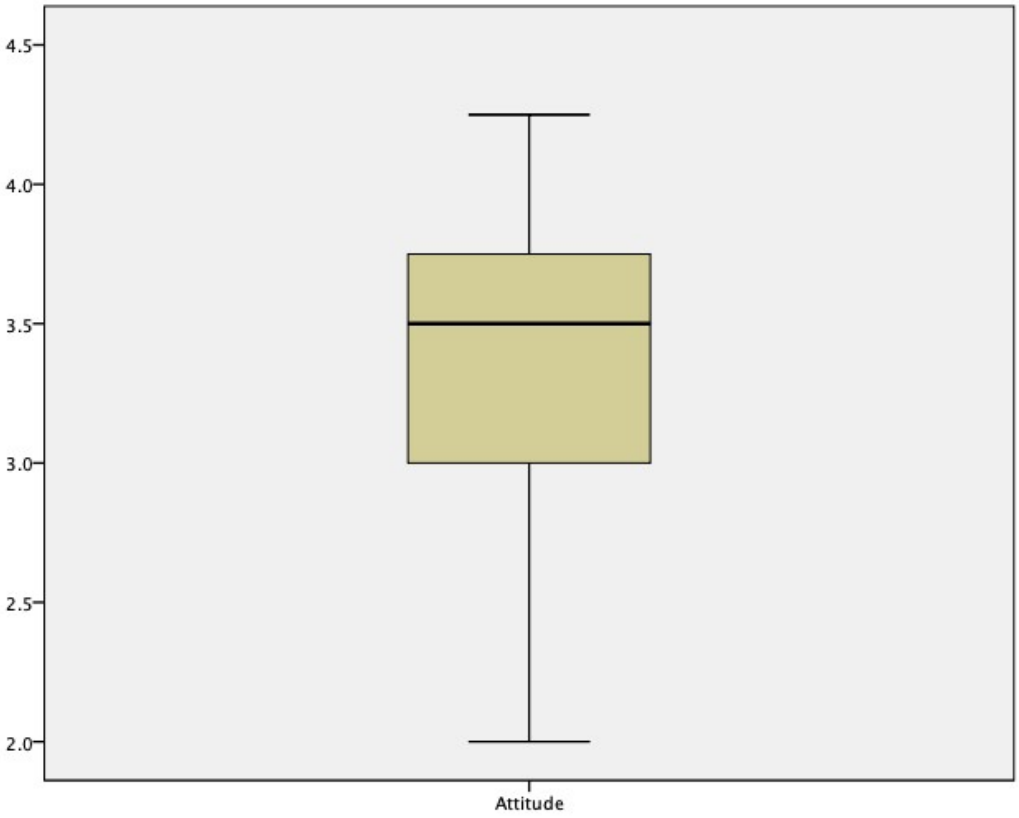

5
4
3
2
1
Medical toursim infrastructure

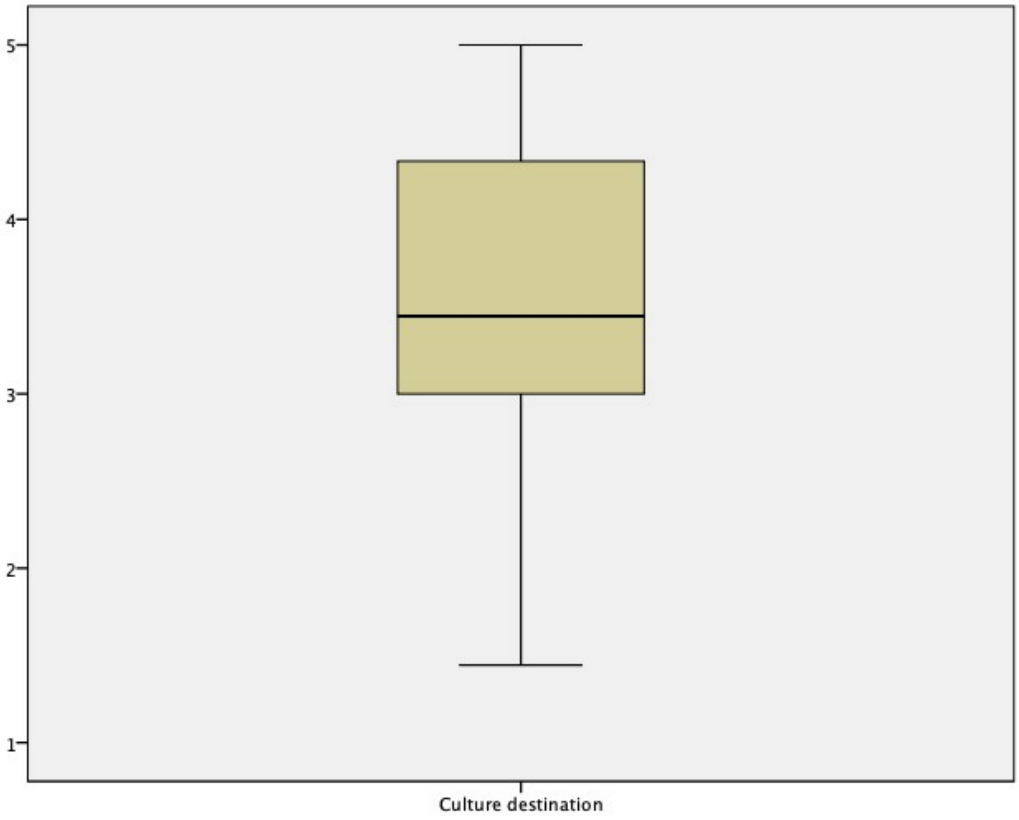

5
4
3
2
1
Medical Destination intention to visit


5
4
3
2
1
Subjective norms

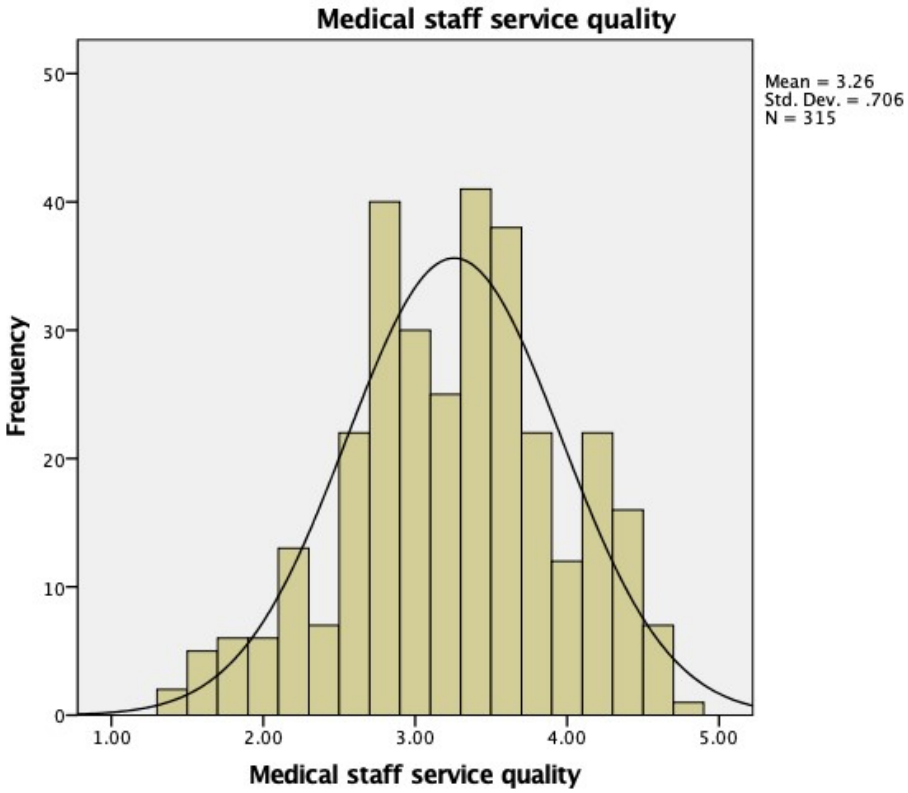

5
4
3
2
1
Homophily

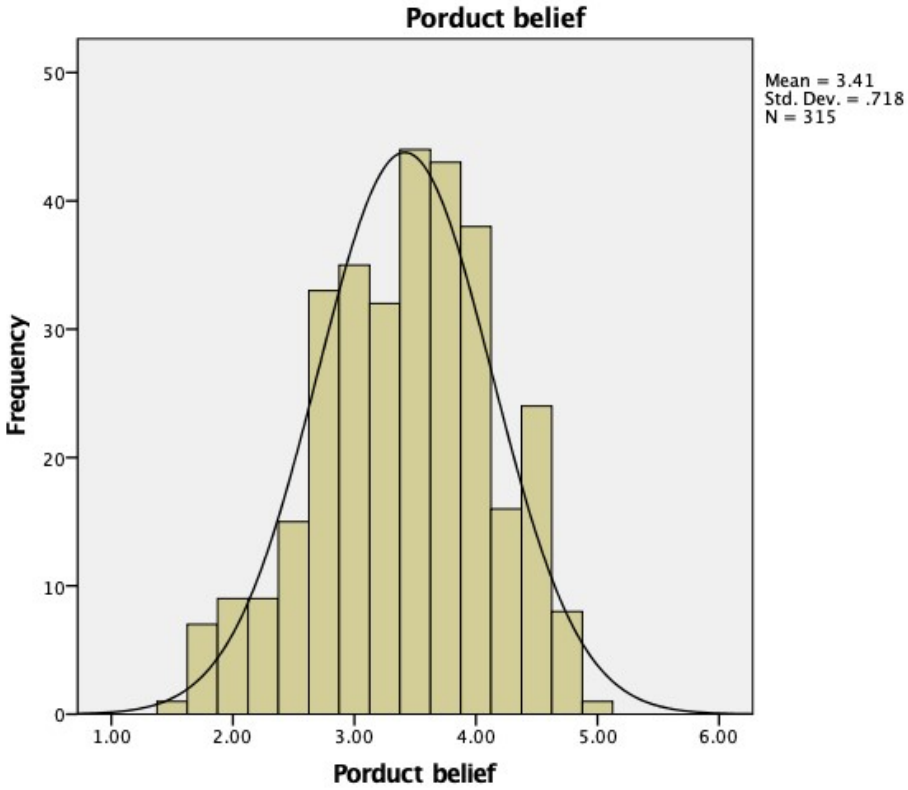

5
4
3
2
1
Destination belief

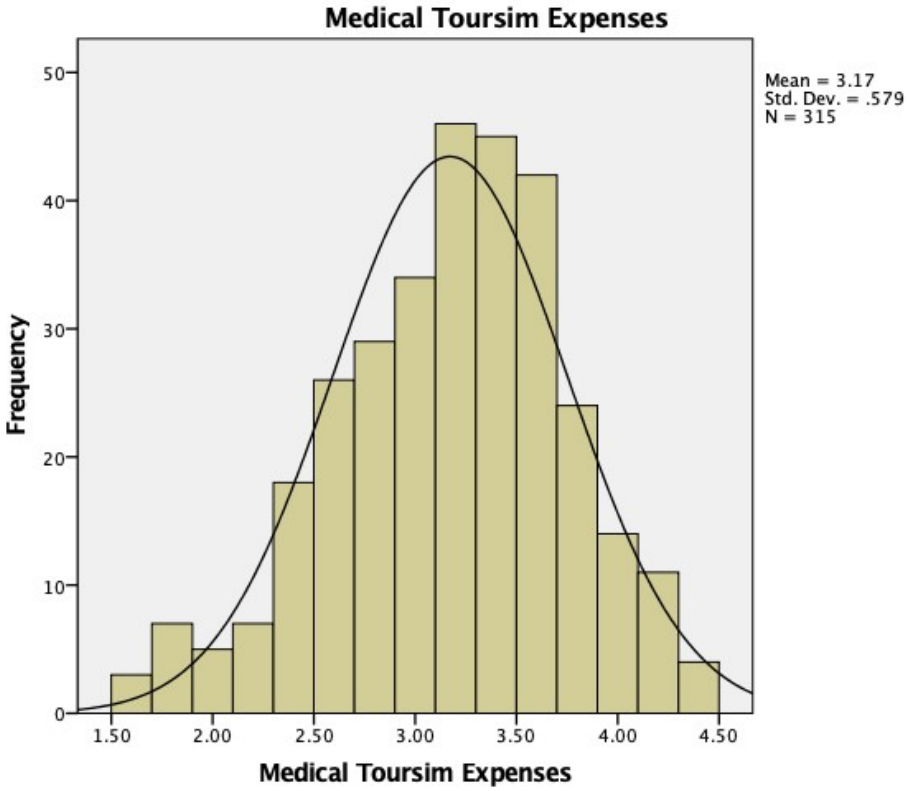

4.5
4.0
3.5
3.0
2.5
2.0
Attitude

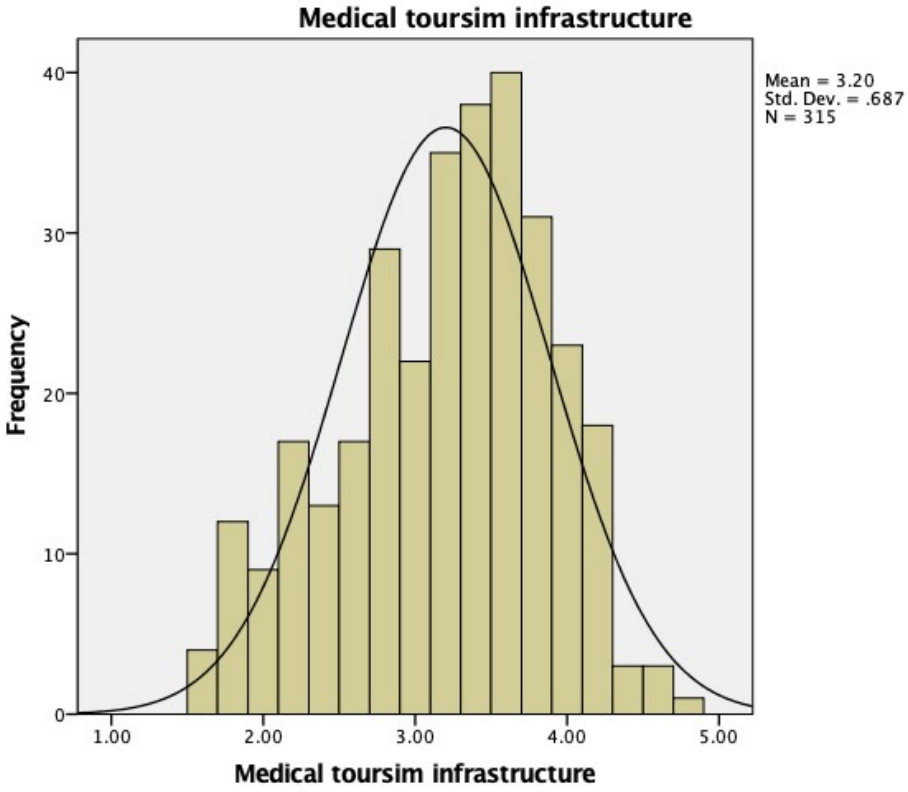

5
4
3
2
1
Culture destination

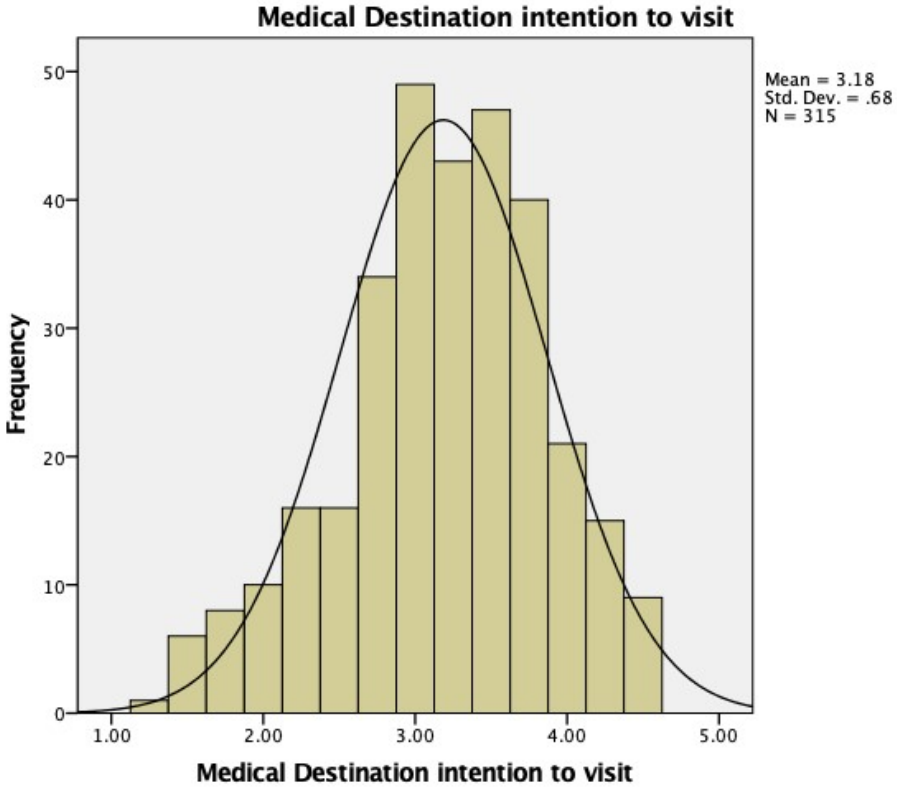
**Appendix D: Histograms of Normality**

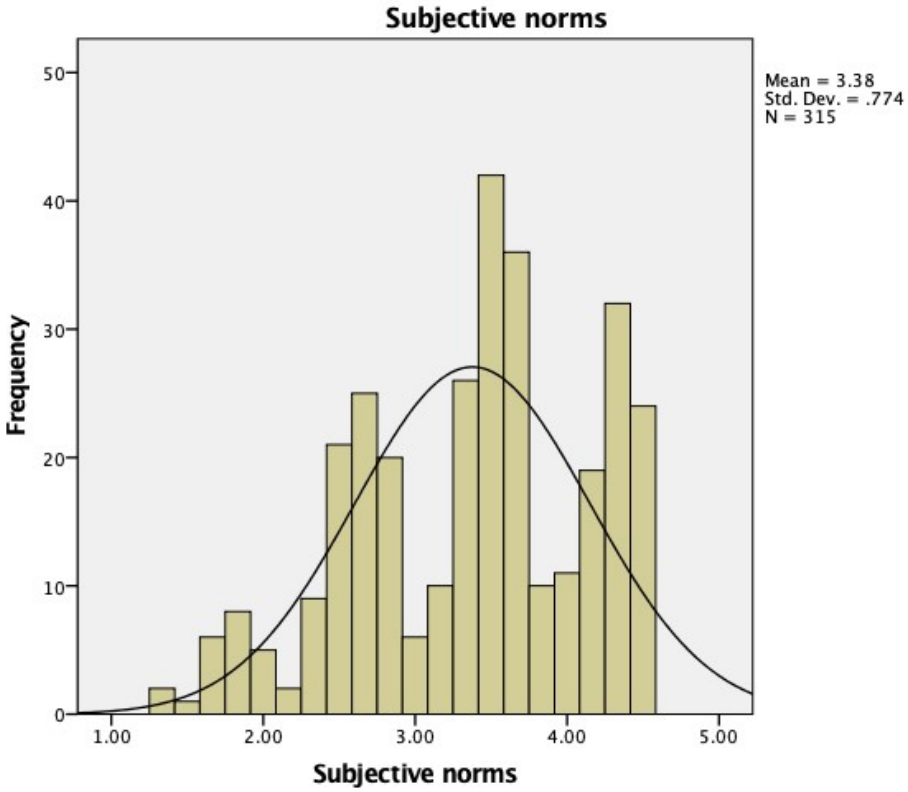


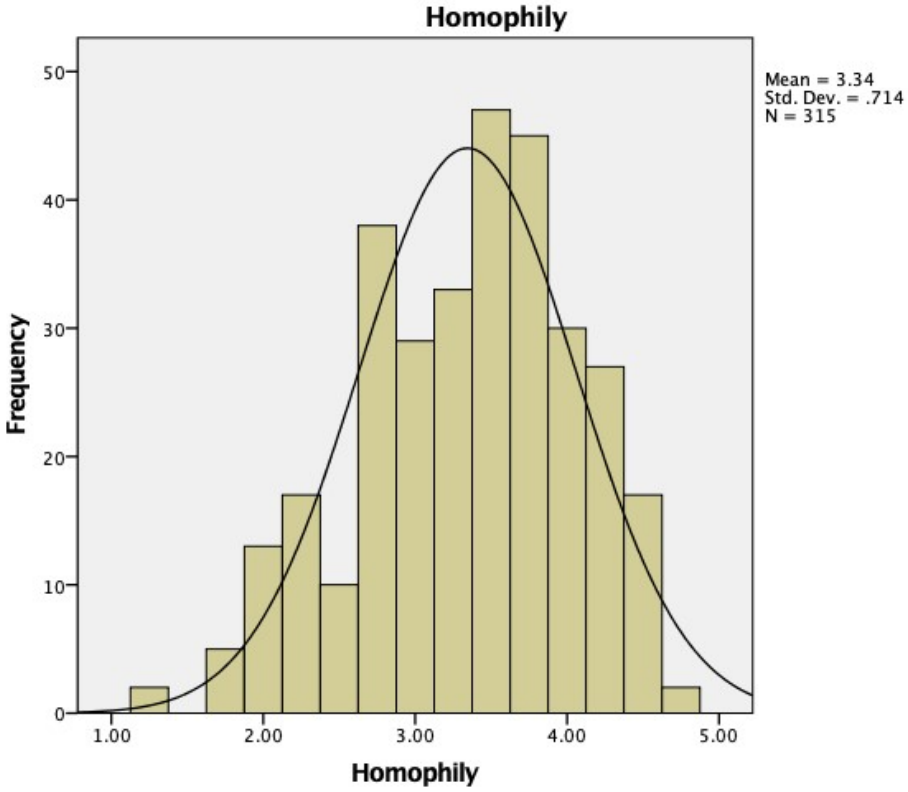

Porduct belief
Mean = 3.41
Std. Dev. = .718
N = 315
Frequency
0
10
20
30
40
50
1.00
2.00
3.00
4.00
5.00
6.00
Porduct belief

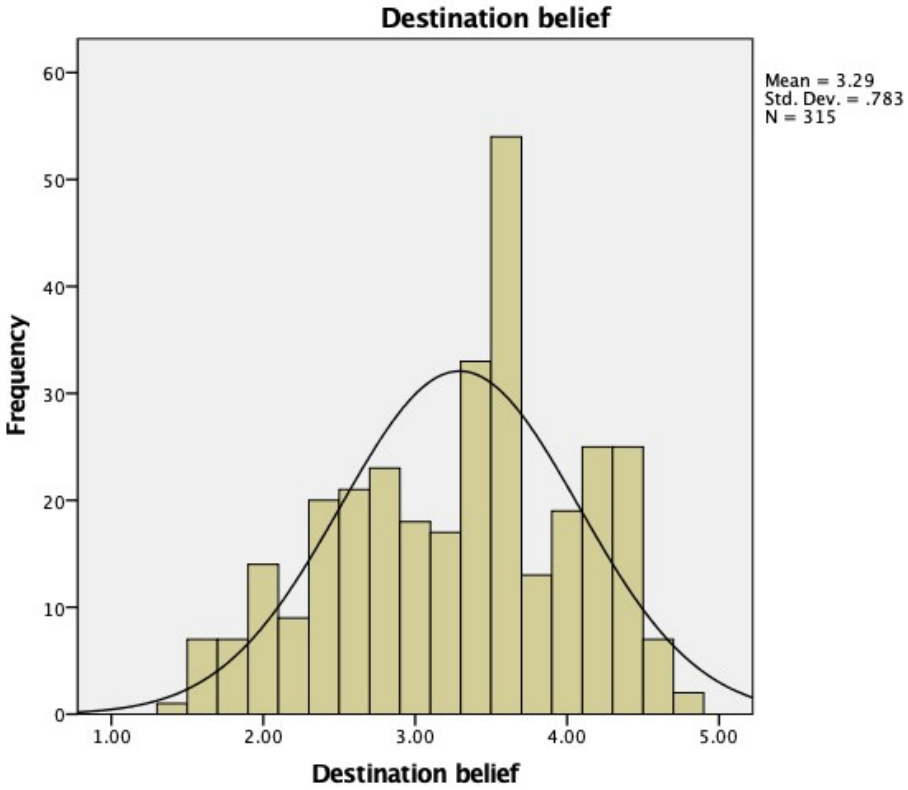

Medical Toursim Expenses
Mean = 3.17
Std. Dev. = .579
N = 315
Frequency
0
10
20
30
40
50
1.50
2.00
2.50
3.00
3.50
4.00
4.50
Medical Toursim Expenses

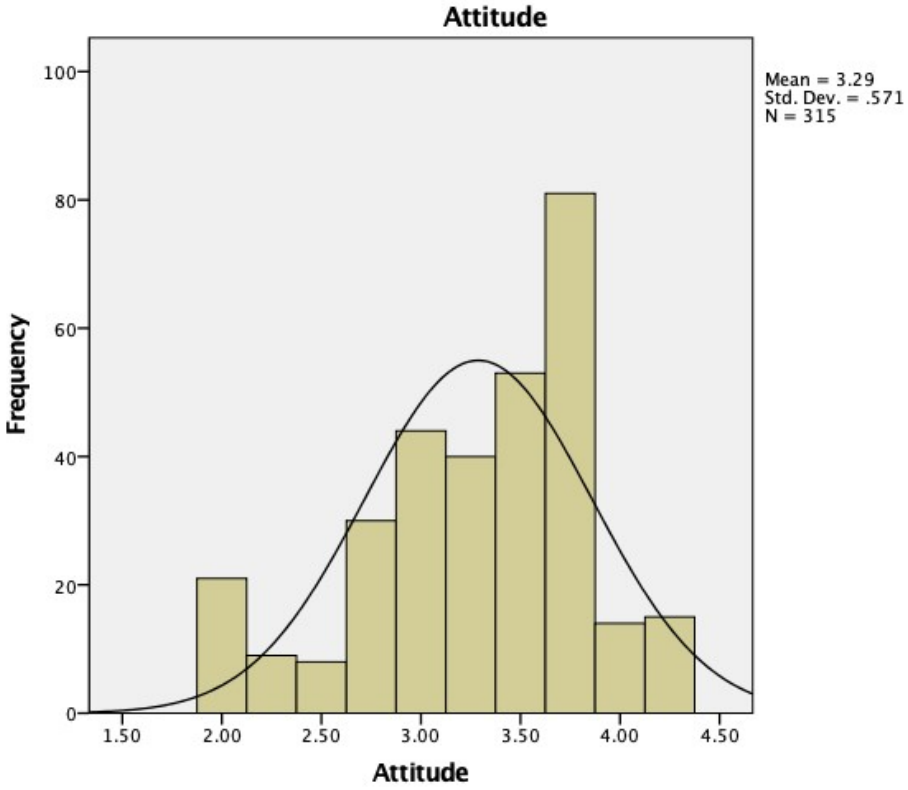

Medical toursim infrastructure
Mean = 3.20
Std. Dev. = .687
N = 315
Frequency
0
10
20
30
40
1.00
2.00
3.00
4.00
5.00
Medical toursim infrastructure

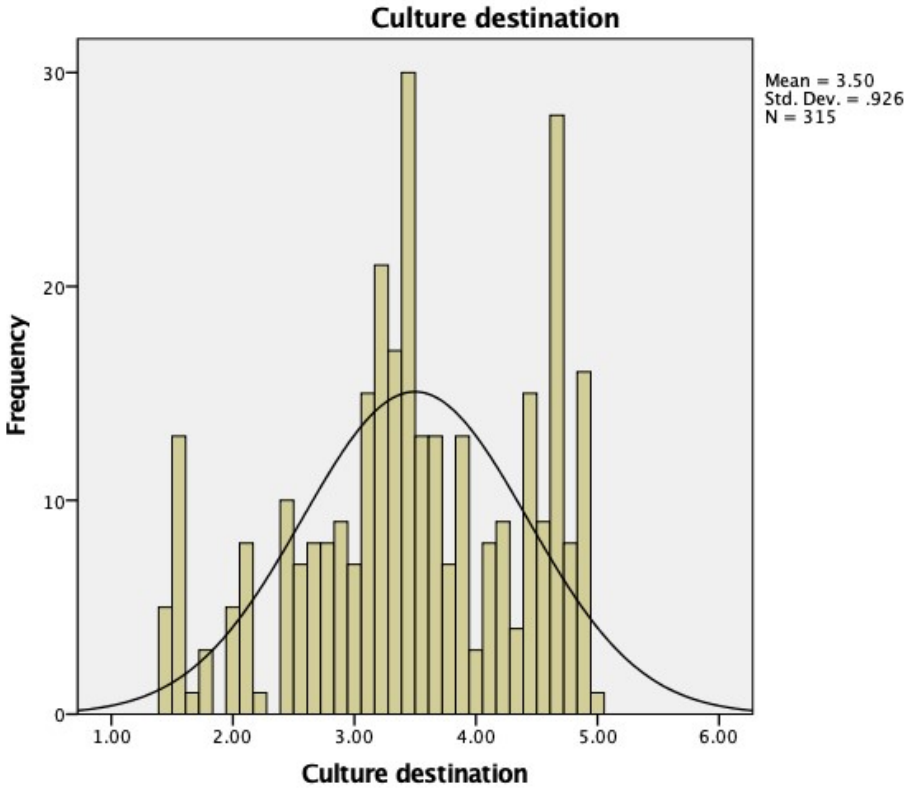

Medical Destination intention to visit
Mean = 3.18
Std. Dev. = .68
N = 315
Frequency
0
10
20
30
40
50
1.00
2.00
3.00
4.00
5.00
Medical Destination intention to visit


Subjective norms
Mean = 3.38
Std. Dev. = .774
N = 315
Frequency
0
10
20
30
40
50
1.00
2.00
3.00
4.00
5.00
Subjective norms


Homophily
Mean = 3.34
Std. Dev. = .714
N = 315
Frequency
0
10
20
30
40
50
1.00
2.00
3.00
4.00
5.00
Homophily


Destination belief
Mean = 3.29
Std. Dev. = .783
N = 315
Frequency
60
50
40
30
20
10
0
1.00
2.00
3.00
4.00
5.00
Destination belief


Attitude
Mean = 3.29
Std. Dev. = .571
N = 315
Frequency
100
80
60
40
20
0
1.50
2.00
2.50
3.00
3.50
4.00
4.50
Attitude


Culture destination
Mean = 3.50
Std. Dev. = .926
N = 315
Frequency
30
20
10
0
1.00
2.00
3.00
4.00
5.00
6.00
Culture destination