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MEDICAL TOURISM: DOES CONSUMER ETHNOCENTRISM IMPACT ATTITUDE AND INTENTIONS?

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Abstract

Medical Tourism, though growing in popularity, is still not considered as an option by many. This has been found to be the case even though there is a general agreement that the medical care system in developed countries has shortcomings such as high costs and limited availability. Medical tourism can offer a solution, but it has not taken off as expected. This research looks at some of the reasons behind consumers' concerns and explores if consumer ethnocentrism influences consumers' attitudes and intentions towards medical tourism. This research follows a quantitative approach and uses structural equation modelling with AMOS to create a model predicting intentions. 537 respondents were surveyed to measure their consumer ethnocentrism, attitude towards medical tourism, and their behavioural intentions towards the same. Also included in the model were the observed variables "travelled overseas", "gender," and "trust in primary care physician." SPSS is utilized to study mediation effects in the model. The empirical results demonstrate that consumer ethnocentrism does influence attitude and together they do influence behavioural intentions towards medical tourism. Furthermore, consumer ethnocentrism was found to mediate the effect of attitude on behavioural intentions. However, the effect of consumer ethnocentrism on intentions was found to be much smaller than its effect on attitude indicating that consumers were guided more by pragmatism than ideology when it came to healthcare decisions. The study closes with a discussion of the theoretical and managerial implications of this research.

Keywords: *Medical Tourism, Consumer Ethnocentrism, Attitude, Behavioural Intentions*

Introduction

Consumer ethnocentrism is known to influence consumption of several goods as consumers may shy away from buying products not manufactured in their home country. Most research on consumer ethnocentrism has focused on products, not services. This is because of the inseparability aspect of services which means services are produced and consumed in the same location, which is usually the home country of the consumer. Medical tourism, by its very nature is a service that is consumed outside of the home country which makes consumer ethnocentrism especially relevant to its popularity or unpopularity.

The cost of healthcare has consistently been rising in the United States. An analysis of government data estimated that Americans owe at least $220 billion in medical debt with around 14 million people owing more than $1000 and about 6 million owing more than $10,000 (Rakshit et al., 2024). As a result, many Americans are unable to save for retirement, their children's education or buy a house. Not only that, but medical debt has also led to 1 in 7 people with debt being denied access to medical care because of previous unpaid bills. Almost two-thirds of people with debt reported that they delayed medical care that they or a family member needed because of the expected expense.

Medical tourism sounds like it has the potential to be the solution for many of those patients. But despite the many benefits, medical tourism, at least in the US has not taken off as expected. The primary concern of Americans considering medical care overseas is the quality of medical care. Even as hospitals overseas try to assuage these fears by going in for accreditation through the Joint Commission and hiring physicians and staff trained in the US, Americans mentioned uncertain quality as the topmost apprehension (Dalen & Alpert, 2019).

This research looks at the reasons behind the fears expressed by potential consumers. Specifically, it explores if ethnocentrism may be playing a role in the discomfort felt by Americans when it comes to considering medical care in a country other than their own. We propose a theoretical framework that conceptualizes the link between consumer ethnocentrism, attitude towards medical tourism, and behavioural intentions. We hypothesize that consumers who measure higher on the consumer ethnocentrism scale will show a more

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negative attitude towards medical tourism and lower behavioural intentions towards medical tourism. In this research, we design our empirical study to test three questions: 1. Does consumer ethnocentrism influence attitude towards medical tourism? 2. Does attitude determine behavioural intentions towards medical tourism consumption? 3. Does attitude towards medical tourism mediate the relationship between consumer ethnocentrism and behavioural intentions? We also examine if trust in physician, experience with overseas travel, and satisfaction with medical insurance influence behavioural intentions towards medical tourism.

This research makes contributions to the field of medical tourism as well as consumer ethnocentrism. First, it creates a theoretical framework that explains the variables influencing medical tourism. Second, it examines the impact of consumer ethnocentrism on attitude and behavioural intentions. The findings are interesting with consumers showing a distinct difference in their attitude and behavioural intentions. Consumers who were high on the consumer ethnocentrism scale showed more negative attitudes towards medical tourism, but surprisingly, were open to using medical tourism as an option, if required. Needless to say, this has profound managerial implications since it indicates that consumers may choose to be pragmatic when it comes to their purchase behaviour, notwithstanding their attitudes towards a specific provider.

Theoretical Framework and Hypotheses

Medical tourism refers to the practice of patients traveling abroad for medical treatments. Unlike previous trends of patients traveling from developing nations to developed countries for what was expected to be more advanced treatment options, medical tourism today refers to residents of highly developed nations bypassing the healthcare offered in their own countries and traveling to less developed parts of the world to receive a variety of medical services. They usually pay out-of-pocket and enjoy a vacation at the same time. Some of the reasons cited for the growth of this trend are cost savings for uninsured or underinsured patients, no waiting period or the procedure not being available in their home country.

Medical tourism combines two purposes: receiving medical services and visiting a popular destination. Medical tourism can be described as the offering of affordable medical services to patients through a partnership with the tourism industry (Gupta, 2004).

Consumer Ethnocentrism

The concept of ethnocentrism has been part of sociological literature for over a hundred years. Sumner (1906) defined it as a viewpoint where one's group is the centre of everything and is used as the benchmark for all others to be scaled and rated against. Research in psychology has found prevalence of a strong individual predisposition towards bias in favour of in-groups.

While ethnocentrism has a generally negative connotation due to its implication in ethnic conflict, instability of democratic institutions, war, and voting, its effect on consumer choice cannot be ignored (Hammond & Axelrod, 2006). Consumer ethnocentricity is the economic form of ethnocentrism, and it refers to "the beliefs held by consumers about the appropriateness, indeed morality, of purchasing foreign made products" (Shimp & Sharma, 1987). Consumer ethnocentricity has the following characteristics: It stems from a deep love and concern for one's country, along with apprehension about the potential negative impacts of imports. The second aspect involves the deliberate decision to avoid purchasing foreign goods. This introduces a moral dimension, motivating consumers to choose domestic products, even if their quality may be inferior to imported goods. Hence, refraining from buying foreign products is seen as fitting, commendable, and patriotic, whereas purchasing them is viewed as negative, unfitting, undesirable, and irresponsible. Third, it refers to an individual bias against imports (Sharma et al., 1995). On the other hand, nonethnocentric individuals evaluate products more objectively, regardless of country of origin (Netemeyer et al., 1991). This can be very important in the case of medical tourism since ethnocentric consumers may be more resistant to the idea of acquiring medical services in foreign countries.

A literature search for the effect of consumer ethnocentrism on attitude or intentions to purchase medical services overseas did not yield any results. Shankarmahesh (2004) in a meta-analytical study listed previous research and the product categories covered, and found auto, apparel, TV, food, PCs, toys, home appliances, alcohol, consumer goods and more. A later study by (Kock et al., 2019) proposed the concept of tourism ethnocentrism and proposed that "both domestic tourists and residents may harbour such a systematic in-group bias that manifests in the prescriptive belief, and felt moral obligation, that the domestic tourism economy should be supported." However medical tourism is not exactly like tourism and is guided by different considerations. Tourists select destinations based on different factors such as self-congruity, which is the match between the destination visitor image and tourists' self-concept (Sirgy & Su, 2000) or destination personality, the idea that tourists ascribe

traits such as sincerity, excitement, and conviviality to locations (Ekinci & Hosany, 2006). In more recent times, some tourists also pick their destination based on social return, or the amount of positive social feedback that one's social media posts of travel generate (Boley et al., 2018). On the other hand, medical tourists make their choices based on perceived quality of medical care, ease of travel, difficulty of obtaining post operative care, besides other factors. Naturally, the effect of ethnocentrism on perception of these factors is very different. This is the gap that this study is trying to fill.

Attitudes

A good understanding of consumers' attitudes towards medical tourism is important to be able to predict their purchase behaviour, should the need for certain medical services arise. Attitude is a concept extensively researched in psychology, marketing, and social sciences literature. One of the most widely accepted definitions of attitude is by Fishbein and Ajzen (1975) who referred to it as "a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object." Indeed, attitude is one of the two determinants of intentions, the other being subjective norms according to Fishbein and Ajzen's theory of reasoned action. According to the theory of reasoned action (TRA), an individual's actions are guided by their behavioral intention, which is, in turn, influenced by their attitude toward the behavior and subjective norms (Fishbein & Ajzen, 1975).

Behavioural Intentions

Intentions are self-instructions to perform certain behaviours or to obtain certain outcomes. Since intentions are seen as the end of the deliberation about what one will do, they are considered to capture the motivational factors that influence a behaviour. Ideally, purchase behaviour is the variable to be studied but due to difficulties associated with measuring real behaviour, behavioural intentions are used as an indicator of consumer behaviour. Real behaviour and behavioural intentions have been found to be highly correlated (Sheppard et al., 1988; Srivastava, Mishra, Srivastava et al., 2024; Venkatesh & Davis, 2000). TRA also proposes that behavioural intention is the proximal determinant of behaviour and mediates the influence of the theory's predictors (attitude) and external variables such as demographic characteristics (Webb & Sheeran, 2006). An attitude has been noted in prior research as an evaluative appraisal (Bagozzi, 1992). If an individual makes favourable (unfavourable) evaluative judgments, then attitudes will lead to intentions to perform (or not) the behaviour.

Existing and Proposed Models

Research efforts have been made to develop models that explain the dynamics of the medical tourism industry. Smith and Forgione (2007) proposed a two-stage model highlighting the factors influencing patients' decisions to seek healthcare services abroad. Their model suggests that no single factor predominates; instead, multiple factors play an equally significant role. In the first stage, the model identifies factors influencing the choice of a destination, while the second stage evaluates those affecting the selection of a healthcare facility. They concluded that consumers typically decide on a destination first, followed by consideration of the medical and tourism facilities available there. Similarly, Ye et al. (2008) conducted a case study on potential tourists in Hong Kong, exploring their motivations and barriers to medical tourism. Using the push-and-pull motivation theory, they developed a framework illustrating the unique motivations of medical tourists, which differ significantly from those of traditional tourists.

Sharma et al. (1995) found that consumers with strong consumer ethnocentrism tendencies may overestimate the attributes and overall quality of domestic products while underestimating the quality of foreign products. CETSCALE measures the tendency of consumers to act consistently towards foreign and domestic products. Such tendencies may precede attitudes but are not equivalent of attitudes which tend to be object specific (Watson & Wright, 2000). Consumer ethnocentrism serves as a powerful determinant of general attitudes toward foreign products relative to domestic offerings (Biljana & Anthony, 1998). Highly ethnocentric consumers often exhibit negative evaluations of imported products, citing concerns about potential negative impacts on the domestic economy (Shimp & Sharma, 1987). In contrast, consumers with lower levels of ethnocentrism may display positive attitudes toward imported products solely based on their foreign provenance. It stands to reason that like attitudes towards products, attitudes towards services will follow the same pattern. Therefore, we propose the first hypothesis as follows:

Hypothesis 1: Consumer ethnocentrism will influence attitude towards medical tourism.

Fishbein and Ajzen's theory of reasoned action proposes that a person's behaviour is determined by behavioural intentions which in turn are

influenced by attitude towards the behaviour. Behavioural intentions in this case are regarding the purchase of medical services overseas, should the need arise. There is a significant body of research showing the strong relationship between attitudes and intentions (Ajzen & Fishbein, 1980; Fazio, 1990; Srivastava et al., 2023). However, there is also research which talks about the gap between the positive attitude of consumers and their actual purchase behaviour (Mittal, 1988; Vermeir & Verbeike, 2006). This gap might arise because of habit, or temporary situational factors like promotions, or personal factors like the consumer's values, knowledge and perceived behavioural control, among others (Jager, 2000, Minteer et al., 2004). Indeed, consumer behaviour, when it comes to the pathway from attitude to behaviour often has complex motivations influencing it, including the type of product/service (for example, environmentally sustainable products show a wide gap between attitude and behaviour) and moderating effect of other variables at play (Jana et al., 2024; Srivastava et al., 2024). Clearly, more research is called for to clarify this relationship. Therefore, the second hypothesis is presented as follows:

Hypothesis 2: Attitude towards medical tourism will predict behavioural intentions.

This study primarily deals with the relationships between consumer ethnocentrism, attitude, and behavioural intentions. Consumer ethnocentrism gauges consumers' perceptions regarding the ethical and moral aspects of buying products made in foreign countries. They are also believed to precede attitudes. Attitudes are believed to be cognitive and affective evaluations of an object, issue, or a person. In this study, the attitudes towards medical tourism are the focus. Behavioural intentions refer to the intentions of performing the behaviour explored in the survey, namely, buying or using medical services overseas, should the need arise. Past research has shown that attitudes positively affect behavioural intentions. Furthermore, the principle of cognitive consistency suggests that consumers seek harmony between thoughts, feelings, and actions with the instinctive goal being to ensure consistency (Hawkins et al., 1997). Therefore, positive attitudes lead to positive behavioural intentions. Putting these together, we propose that:

Hypothesis 3: Attitude towards medical tourism will mediate the relationship between consumer ethnocentrism and behavioural intentions.

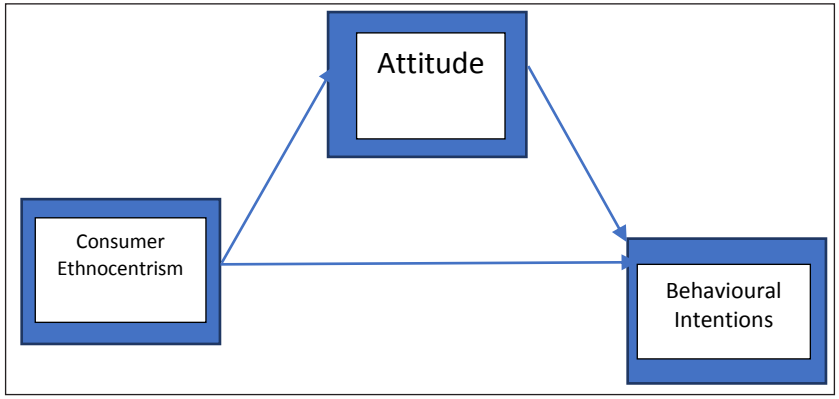

Fig. 1: Attitude will Mediate the Relationship Between Consumer Ethnocentrism and Behavioural Intentions

Past research has indicated that comfort of the patient plays an important part in the efficiency of their treatment. Patients have been found to be more comfortable when culture shock can be minimized. For instance, British medical tourists preferred to travel to India for treatment whereas for Americans, receiving medical treatment in India brought greater culture shock than receiving treatment in Mexico (Ferguson & Candib, 2002). Medical tourists may already be in a vulnerable position and medical tourism can have an impact on mental emotions. Therefore, sociocultural dimensions are an important part of medical tourism (Liu & Chen, 2013). Individuals who have travelled overseas are less likely to be as taken aback by culture shock as compared to those who have never travelled outside their home country. Therefore, we hypothesize the following:

Hypothesis 4: Respondents who have travelled abroad will be more likely to have positive attitude towards Medical Tourism and demonstrate positive behavioural intentions.

Past research on consumer ethnocentrism identified the following demographic antecedents of consumer ethnocentrism: age, gender, education. (De Ruyter et al., 1998). The relationship between consumer ethnocentrism and willingness to buy is moderated by age and gender (Josiassen et al., 2011). Similarly, Akbarov found that the effect of consumer ethnocentrism on purchasing behaviour is moderated by gender, marital status, and personal income (Akbarov, 2021). Other research has found contradicting results with gender not being a determinant of consumer ethnocentrism (Correa & Parente-Laverde, 2017; Spillan et al., 2011). Clearly, further research is called for here

to confirm the effect of gender on ethnocentrism. Extrapolating from that, and since ethnocentrism has an impact on attitude towards medical tourism, we hypothesize that a similar effect will be seen in attitude towards medical tourism.

Hypothesis 5: Gender will influence attitude towards medical tourism.

Lack of satisfaction with current medical insurance has been cited by multiple authors as the primary reason for considering medical tourism. For example, one of the reasons cited for the growth of medical tourism is cost savings for uninsured or underinsured patients (Levary, 2011). Based on this, it can be hypothesized that potential patients who are dissatisfied with their current medical insurance are more likely to explore the option of getting medical treatment overseas where it will be more affordable. Likewise, candidates who believe they are well insured are less likely to look into medical treatment as they are confident about having their medical needs covered by their insurance. Therefore, the next hypothesis can be stated as:

Hypothesis 6: Satisfaction with health insurance will have a negative relationship to behavioural intentions towards Medical Tourism.

Trust in the physician has been known to be a predictor of positive outcomes such as reducing anxiety and providing a sense of being cared for. This improves the patient's sense of well-being and improves functioning (Thom & Campbell, 1997). Not surprisingly, trust has been found to be highly correlated with patient satisfaction (Anderson & Dedrick, 1990). Based on this and the previous hypothesis, it can be expected that patients who trust their physicians and are more satisfied with their medical care are going to be less likely to be interested in medical treatment overseas.

Hypothesis 7: Trust in the physician will have an inverse relationship to behavioural intentions towards Medical Tourism.

Methodology

Measures

CETSCALE

This research heavily relies on the CETSCALE designed by Shimp and Sharma (1987). Even though the original scale utilizes 17 items to measure consumer ethnocentrism, following researchers have had success using the

10-item or even 6-item scales. This research uses the shortened 10-item scale. Even the original creators of the scale acknowledge that "the reduced-form measure's nomological validity is supported" (Shimp & Sharma 1987, p. 286). Other researchers recommend the shortened scale in favour of greater parsimony and to avoid respondent fatigue (Klein et al., 2006, Netemeyer et al 1991). Given that CETSCALE measures a relatively straightforward unidimensional construct, the belief that it is wrong to purchase foreign products and services, the use of the 10-item CETSCALE here is justifiable.

Attitude Towards Medical Tourism

Attitude towards Medical Tourism is measured using an 11-item scale from MEDTOUR (Martin et al., 2011). Measured on a seven-point semantic differential scale, respondents answered questions such as "High-quality (overseas) medical care is worth the search (Agree/Disagree)." This scale consisted of three components – the belief of quality of overseas medical care (four questions), the attitude towards overseas medical treatment (four questions), and the belief in the value of medical treatment overseas (three questions).

Behavioural Intention

Behavioural Intention is measured using the three-item scale developed in MEDTOUR. It is derived from the ''generalized intention'' method suggested by Francis et al. (2004). Generalized Intention has demonstrated internal consistency and is the most used measure of intention.

Data Collection

A Qualtrics-based online questionnaire was administered to a total of 537 students at a state university in Texas, USA. These students, enrolled in online graduate and undergraduate programs, reflected a broad diversity in terms of age, race, and income. About 24% of the respondents were in the 18-24 years age group, 41% in the 25-34 years group, 21% in the 35-44 years group, 7% in the 45-54 years group, 4% in the 65-74 years group and 3% were in the 75 years and above age group. 37% of the respondents were male, 62% were female and less than 1% identified as non-binary/other. 484 respondents completed the survey. These are all online students and most of them are working full or part time. Respondents were from a wide range of income categories (please see Table 1) which makes this study more generalizable than full time students.

Table 1: Income of Respondents

	Annual Household Income	%
1	Less than $10,000	4.01%
2	$10,000 to $19,999	2.11%
3	$20,000 to $29,999	7.81%
4	$30,000 to $39,999	9.70%
5	$40,000 to $49,999	10.13%
6	$50,000 to $59,999	8.65%
7	$60,000 to $69,999	9.70%
8	$70,000 to $79,999	6.33%
9	$80,000 to $89,999	7.59%
10	$90,000 to $99,999	4.43%
11	$100,000 to $149,999	17.51%
12	$150,000 or more	12.03%
	Total	100%

The first section of the questionnaire measured ethnocentrism. The second section checked for their medical insurance availability and their satisfaction with their current medical care. Section three measured their attitudes towards medical tourism in general. The last sections measured behavioural intentions and demographic information. Most of the questions were measured using 7-point Likert scales though there were a couple of multiple response questions such as "In your opinion, what might be the top three concerns a person might have about going overseas for medical care?"

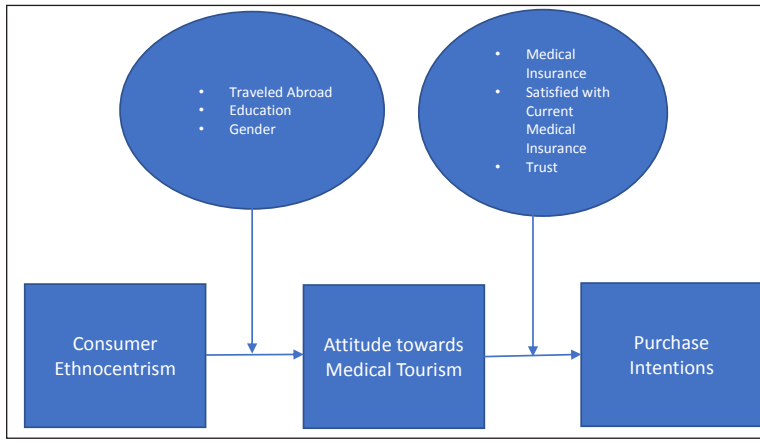

Fig. 2: Proposed Conceptual Model of Medical Tourism

Results

Respondents were asked to select their top three reasons for opting for medical tourism and top three concerns about it out of a list of six factors each and the results aligned well with previous literature findings. When it came to reasons for selecting medical tourism, financial reasons were the top three. Even though most respondents had medical insurance, they could still anticipate needing to opt for medical tourism to save money on procedures not fully covered or maybe not covered at all by their insurance. As expected, uncertain quality of medical care and safety issues were the top concerns. There were also fears about post operative care and legal liability issues.

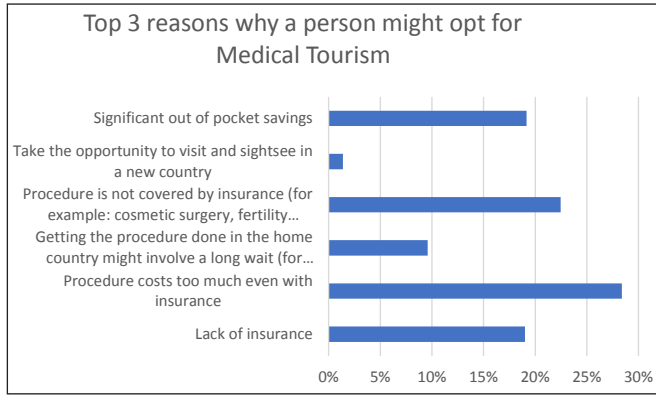

Fig. 3: Reasons for Selecting Medical Tourism

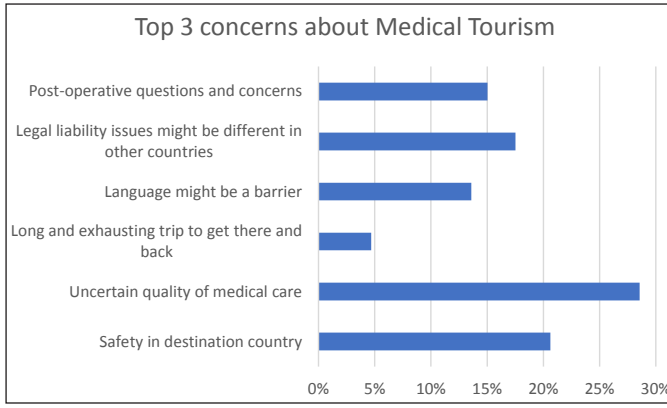

Fig. 4: Concerns About Medical Tourism

The measurement model was developed to test the hypotheses in the study. AMOS 27.0 was used for Confirmatory Factor Analysis and path analysis. We checked the model fit by several goodness of fit statistics, including Chi-square, The Minimum Sample of Discrepancy Function with Degree of Freedom (CMIN/DF), Root Mean Square Error of Approximation (RMSEA), Adjusted Goodness of Fit Index (AGFI), Goodness of-Fit Index (GFI) and Comparative Fit Index (CFI).

We followed Anderson and Gerbing's (1988) two-step approach and started by conducting a confirmatory factor analysis (CFA) to establish confidence in the measurement model, which specifies the posited relationships on the observed variables to the underlying constructs. The model fit well according to all measures. CMIN/DF was 2.141 and the p value was .095. RMSEA value was 0.36 which is significantly lower than the generally accepted cutoff of 0.80. Tucker Lewis Index was .942 and CFI was .979 both above the commonly used cutoff of .90.

We evaluated the reliability of each item by analyzing their loadings on the corresponding latent construct; loadings below 0.50 may indicate poorly worded or unsuitable items. All measurement items exceeded this threshold and loaded significantly on the expected constructs (ranging from .704 to .959).

Structural Model and Hypothesis Testing

After satisfactory results from the CFA testing, a structural equation model was created to determine if the hypothesized theoretical model aligns with the collected data. The model includes exogenous as well as endogenous variables. Endogenous variables were Purchase Intentions, Attitude towards Medical Tourism, and CETSCALE. The exogenous variables were Satisfied with Health Insurance, How many times seen the Primary Physician, Trust Primary Physician's judgement and Have You ever travelled Outside the USA.

Hypothesis Testing

Based on the results of SEM analysis, the following results were obtained:

Hypothesis 1: Consumer ethnocentrism will influence attitude towards medical tourism.

The p value of the consumer ethnocentrism variable on medical tourism is very significant (p =***) with c.r. at -3.762. Because the p value obtained is

<0.05 and C.R. is greater than +-1.96, H1 is accepted, and it is concluded that consumer ethnocentrism has a significant and negative effect on the attitude variable, the higher the consumer ethnocentricity, lower the (positive) attitude towards medical tourism and vice versa.

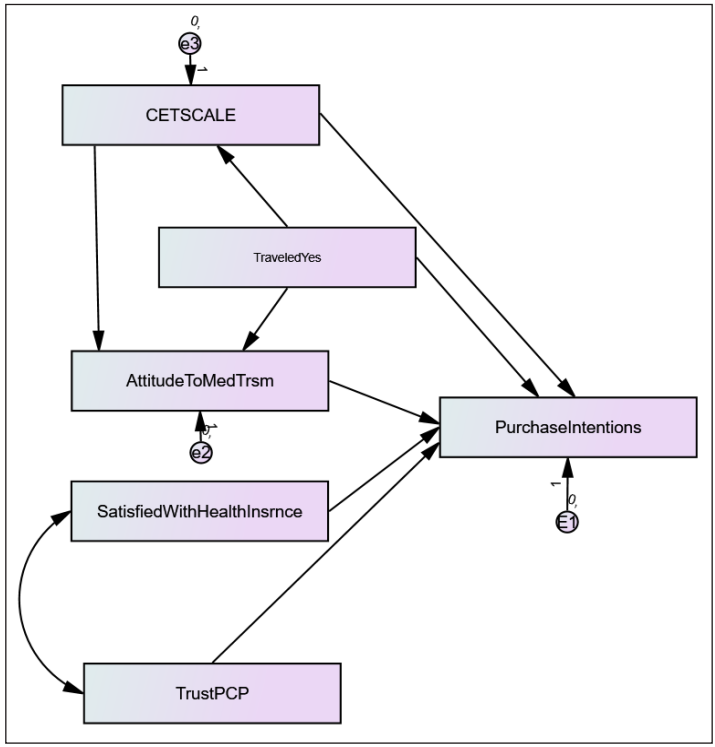

Fig. 5: Comprehensive Model of Medical Tourism

Hypothesis 2: Attitude towards medical tourism will predict behavioural intentions.

P value of attitude towards medical tourism on behavioural intentions is highly significant (p =***) and CR value is 15.418 which is greater than the t-table value of 1.96. Therefore, H2 is accepted.

Hypothesis 3: Attitude towards medical tourism will mediate the relationship between consumer ethnocentrism and behavioural intentions.

The mediation effect was tested using (Hayes, 2013) PROCESS macro for SPSS. Model 4 was used to test the basic mediation model. The results of

the estimation are given below. The effects and their significance of each path between each of the model variables are reported in Table 2.

Table 2: Total Effect of Attitude on Behavioural Intentions

Total Effect of Attitude on Behavioural Intentions					
Effect	se	t	*p*	LLCI	ULCI
.9207	.0582	15.8311	.0000	.8064	1.0349
Direct effect of Attitude on Behavioural Intentions					
Effect	se	t	*p*	LLCI	ULCI
.9574	.0584	16.3935	.0000	.8426	1.0721
Indirect effects of Attitude on Behavioural Intentions					
	Effect	BootSE		BootLLCI	BootULCI
CETSCALE	-.0367	.0152		-.0704	-.0111

Table 1 reports the indirect effects of the independents on the dependents, through the mediation role of CETSCALE. When a confidence interval does not contain zero, the indicated indirect effect is statistically significant ($p < 0.05$). As that is the case here, it is accepted that consumer ethnocentrism does mediate the effect between attitude and behavioural intentions.

Hypothesis 4: Respondents who have travelled abroad will be more likely to have positive attitude towards Medical Tourism and demonstrate positive behavioural intentions.

Since we wanted to examine the relation between the dependent variables CETSCALE, Attitude towards medical tourism, and Behavioural Intentions, and the nominal interval variable, Travelled Abroad, we use the single factor ANOVA. 76.7 percent of the respondents had travelled abroad at least once. Since the groups are unequal, Levene's test for homogeneity of variances was carried out first. The test criterion for Levene's test of homogeneity of variance was calculated such that the p-values were greater than the significance level at which the test was conducted (i.e., $\alpha = 0.05$, or 5%). Therefore, we can confirm the homogeneity of variance and move on to ANOVA testing. ANOVA testing however resulted in p-values over 0.05 and F values ranging from 0.073 to 3.016 for the three variables. This hypothesis is therefore rejected.

Hypothesis 5: Gender will influence consumer ethnocentrism, attitude towards medical tourism, and behavioural intentions.

179 of the respondents identified themselves as male, 302 as female and 3 responded as other/do not wish to answer. Since the sample sizes were unequal,

Table 3: Summary of Results

Hypotheses				β	S.E.	t	P	Results
H1	AttitudeToMedTrsm	<---	CETSCALE	-.162	.044	-3.672	***	Supported
H2	Purchase Intentions	<---	AttitudeToMedTrsm	.938	.061	15.431	***	Supported
H3	Purchase Intentions	<---	CETSCALE	.189	.057	3.332	***	Supported
H4 (a)	Purchase Intentions	<---	TraveledYes	.173	.155	1.114	.265	Not supported
H4 (b)	CETSCALE	<---	TraveledYes	.232	.132	1.763	.078	Not Supported
H4 (c)	AttitudeToMedTrsm	<---	TraveledYes	.024	.122	.196	.844	Not Supported
H5	Purchase Intentions	<---	Gender			*(F2,434) =.407*	.666	Not Supported
H6	Purchase Intentions	<---	SatisfiedWithHealthInsrnce	-.093	.042	-2.205	.027	Supported
H7	PurchaseIntentions	<---	TrustPCPJudgement	-.074	.084	-.881	.379	Not Supported

Levene's test of homogeneity of variances was carried out. The p-value for CETSCALE, Attitude and Intentions were .726, .912 and .236 respectively. Since all values were well above the threshold of p = .05, the data meets the assumption of homogeneity of variances and therefore one-way ANOVA is an appropriate test for comparing means. The difference between groups for attitude was not statistically significant as determined by one-way ANOVA (F (2,434) =.589, p =.556. The difference between groups for CETSCALE was also not statistically significant (F (2,434) =.041, p =.960. Likewise, the difference between groups for intentions was not statistically significant (F2,434) =.407 and p =.666. This hypothesis is rejected.

Hypothesis 6: Satisfaction with health insurance will have a negative relationship to behavioural intentions towards Medical Tourism.

P value was found to be 0.027 and CR value was -2.205 so this hypothesis is accepted. As the respondents' satisfaction with their health insurance goes up, their intentions to purchasing medical tourism go down.

Hypothesis 7: Trust in the physician will have an inverse relationship to behavioural intentions towards Medical Tourism.

There was indeed an inverse relationship between trust in the physician and behavioural intentions towards medical tourism, but it was not significant. P-value was .379 and CR value was -.881. This hypothesis was not supported.

Conclusion

As expected, attitude towards medical tourism was the primary predictor of purchase intentions. Also as expected, consumer ethnocentrism had a negative relation to attitude towards medical tourism. However, the surprising part was that consumer ethnocentrism did not seem to have a large effect on purchase intentions directly. Perhaps this is because consumers may be viewing this scenario with a sense of pragmatism rather than ideologically. This sense of pragmatism was seen in some of the responses given to questions that were asked as part of CETSCALE. Even as the Cronbach's alpha for the items on the scale showed a robust value of .920, there were significant differences in how respondents answered different questions. For instance, when asked, "I support American products and services first and foremost (1-Strongly Agree, 7-Strongly Disagree), the mean was 2.87 with a standard deviation of 1.550. On the other hand, when asked "A real American should only buy American services and products (1-Strongly agree, 7-Strongly Disagree), the mean was 5.63 with a standard deviation of 1.438. This indicates that even as consumers

have feelings of consumer ethnocentrism which translate into their attitude, when it came to purchase intentions, they were open to foreign products and services. This could be because of the widespread presence of products manufactured overseas in the stores. As a respondent said in a follow-up call, "It is harder to find a product 'Made in America' in USA. Everything I pick up in a store says, 'Made in China.'" So, consumers may have readjusted their expectations. Even while they still believe that American products are the best or being a good American includes supporting American products which in turn, are responsible for American jobs, they have realized they may have to buy foreign manufactured products because that is their only option. There is some theoretical support for this in psychology and sociology research where it has been found that the predisposition to favour in-groups is not necessarily predictive of observed behaviour and can be trumped by more complex behaviour (Kurzban et al., 2001). This could have implications for CETSCALE and how it is interpreted as well.

There was a small negative effect between 'Satisfied with their health insurance' and 'purchase intentions'. This was also expected. Most medical tourism providers target uninsured or underinsured consumers. So, respondents who are satisfied with their health insurance may not see any need for medical tourism either now or in the future. It is possible that some respondents may be underinsured and not be aware of it if they have not encountered any medical emergencies. Therefore, there is a possibility that the actual market for medical tourism may be larger than indicated by many market surveys.

Along the same lines, respondents who saw their physician more often showed lower purchase intentions than those who did not. This also appears to be intuitively logical that respondents who see their physician are likely to have a sense of comfort that their medical care is assured within the country, and they may not need to explore medical tourism options. Trust in their primary care physician was another variable explored and that also showed a negative correlation with purchase intentions of medical tourism. Interestingly, when it came to correlations, satisfaction with health insurance was negatively correlated to how many times they saw their PCP in the last year. On the other hand, satisfaction with health insurance was positively correlated to their trust in the PCP. All correlations were significant at 0.01 level (2-tailed).

Intuitively, this may be explained as follows: healthier individuals may need to see their PCP less often. These are also the individuals who may have less reason to be dissatisfied with their insurance as their medical expenses may be predictable and covered by insurance. This may also explain the positive

correlation between satisfaction with insurance and trust in the physician. Individuals who are generally satisfied with their medical care reported high scores for trust in PCP as well as insurance.

Limitations

While this model expands on our understanding of medical tourism, other variables can be included in the next round of research on the topic. For instance, current health of the respondents may be an important factor on how they view healthcare. Respondents who have been faced with serious health issues and medical bills may be in a different frame of mind when it comes to their attitude towards medical tourism.

Implications

This research has practical implications for public policy and medical tourism proponents. To begin with, respondents were unequivocal in their concerns about medical tourism. Their top concern was the quality of care they may receive overseas. This is clearly what providers of medical tourism need to focus their efforts on addressing as a top priority. When it comes to something as serious as their health, consumers are not going to be willing to take a chance with an unknown provider in an unfamiliar country even if it means saving money. On a positive note, the number of Americans holding a passport has gone up from around 30% in 2008 to 51% in 2024[1]. This does indicate an openness to traveling outside of the country even though our research did not show a connection between past travel and positive attitude towards medical tourism. So, improving attitudes towards medical tourism will need to be a multi-pronged effort with investments in not just medical services but also tourism, travel, marketing, advertising and promotions. Many hospitals are striving to earn accreditation through international bodies, few of which are Global Healthcare Accreditation (GHA), Joint Commission International (JCI), International Society for Quality in Health Care (ISQua), Accreditation Canada, and Australian Council on Healthcare Standards International (ACHSI)[2]. Receiving accreditation from these independent and respected organizations can assure possible customers about the quality of care they will receive at these hospitals.

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[1] https://www.usatoday.com/story/travel/news/2024/10/23/state-department-issues-record-us-passports/75794556007/

[2] https://www.magazine.medicaltourism.com/article/navigating-excellence-a-comprehensive-guide-to-the-top-5-hospital-accreditation-bodies-globally

Previous research by Kumar and Hussian (2016) found that geography, specifically, the location and its natural beauty and weather can be an important determinant of patients' satisfaction. This can be another way for healthcare providers to distinguish themselves from the competition. Tourism ministries in countries interested in promoting medical tourism can look into tie-ups with airlines, hotels and travel agents to emphasize the ease of the process from beginning to end. Families should be included in the planning process so that they are also on-board with it.

Overall, this research improves understanding of attitude and behavioural intention towards medical tourism and how consumer ethnocentrism can influence those. The most interesting take away from this research has been that even individuals who rated high on the ethnocentric scale were willing to set aside those feelings when it comes to purchase intentions. This can be very relevant to service providers based overseas.

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