

**CONSUMERS' DECISION TO VISIT A RISKY DESTINATION COUNTRY:  
AN ANALYSIS OF TOURISTS' RISK TAKING**

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## **ABSTRACT**

### **“Consumers’ Decision to Visit a Risky Destination Country: An Analysis of Tourists’ Risk-Taking”**

This study examines the risk-related predictors of destination decisions in a series of models across two types of tourism services: leisure and medical tourism. Data come from a survey of 1,024 Australian respondents across states who evaluated both tourism services in Indonesia (n=511) and Singapore (n=513). The comparison of attitudinal and behavioural responses towards the two types of tourism services draws on the differences in experience and credence services (Mitra et al., 1999) which assumes that a credence service (i.e., medical tourism) is considered as riskier than an experience service (i.e., leisure tourism).

Results of the study are presented in four papers. In the first paper, the domain of willingness to take risks (WTR) construct was tested in destination decision models across leisure and medical tourism settings. The results suggested WTR is better measured as a behaviour than as an attitude. In the second paper, the combined effects of visitors’ experience and cultural distance on the likelihood of destination decisions were explored. In the third paper, the combined effects of visitors’ experience along with risk aversion also increase the likelihood of destination decisions. In the fourth paper, risk reduction strategies were incorporated into a destination decision model. The results provide evidence that risk reduction strategies can be distinguished into both risk relief (RRT) and risk mitigation tactics (RMT). The choice of RRT is a more favoured approach to WTR than RMT.

Overall, the results show the importance of risk-related factors and risk reduction strategies across both leisure and medical tourism and in a range of tourist destinations. The (mediating) destination decision model fits across leisure and medical tourism settings and the risk-related predictors, in general, are able to distinguish destination decisions in both settings.

## **STATEMENT OF CANDIDATE**

I certify that the work in this thesis entitled “Consumer Decision to Visit a Risky Tourist Destination – An Analysis of Tourists’ Risk Taking” has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree at any other university or institution other than Macquarie University.

I also certify that the thesis is an original piece of research and it has been written by me. Any help and assistance that I have received in my research work and the preparation of the thesis itself have been appropriately acknowledged. The additional authors included in Chapters 2, 3, 4 and 5 were involved in the research at a supervisory level.

In addition, I certify that all information sources and literature used are indicated in the thesis.

The research presented in this thesis was approved by Macquarie University Ethics Review Committee, reference number: 5201200636 on the 17 September 2012.

Albert Nugraha (Student ID 42090512)

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# **CHAPTER 1**

## **INTRODUCTION**

## **1.1 The Role of Risk in Tourist Destination Decision Making**

The tourism sector is generally vulnerable to a number of problems that can result in fluctuating demand among international travellers. In terms of security, different types of events, both local and international, can impact tourists' intentions to visit a country, such as natural disasters (e.g., the Indian Ocean tsunami of 2008 and the 1999 earthquake in Taiwan); outbreaks of disease (e.g., severe acute respiratory syndrome (SARS) in Hong Kong in 2003, the foot and mouth epidemic in Britain in 2001, and H1N1 avian flu in Hong Kong in 1997); and man-made disasters (e.g., the 2010 bomb attack in the Moscow subway, the bomb attacks in India in 2008, and the September 11, 2001 terrorist attacks on the World Trade Centre and the Pentagon in the US) (Reisinger & Mavondo, 2005). Such risk factors become sensitive matters due to their influence on tourism demand. Raymond A. Bauer introduced the concept that consumer behaviour involves risks and that every consumer must face the consequences of his/her decisions, some of which are unpleasant (Stone & Grønhaug, 1993). In particular, Wahab et al. – reproduced from Sirakaya and Woodside (2005:p.818) – indicated that “tourism purchase decisions are risky, require extensive problem solving, and need advanced planning”.

Against this background, the present study aims to investigate consumers' international tourism decisions, particularly as they relate to decisions concerning whether to visit a destination country that is perceived as risky. This study investigates several risk-related predictors of destination decisions that are consistent with the nature of risk embedded in the tourism service (Sirakaya & Woodside, 2005). This study is constructed on the premise that consumers' perceptions of risk associated with prospective tourism destinations are at the heart of their travel and tourism decisions. Consumers' perceptions of risk vary significantly, and how they make risk-related decisions depends on both their perceptions of risk and their willingness to take calculated risks. Risk is particularly salient

with respect to purchase and consumption decisions because it is fundamentally intertwined with uncertainty and its consequences.

The degree to which consumers are more likely to undertake a risk is likely to depend on several key variables. This thesis focuses on the research problem of developing an understanding of consumers' willingness to take risks in travel and tourism decisions, with particular reference to the decision to visit a particular destination country. This thesis focuses on testing the destination decision model in a country with a weak image, such as Indonesia, and in a country with a strong image, such as Singapore. In this sense, consumers' perceptions of a country's image can be viewed as crucial to country competitiveness in the travel and tourism sector. However, if possible, developing a general destination decision model regardless of the strength of a country's image is important as the basis for tourism marketers developing improved global tourism marketing strategies.

Indonesia is chosen as the context of this study due to the potential of its tourism sector that is coupled with the challenges it faces in attempting to strengthen its tourism competitiveness. Indonesia is considered as a high-risk country destination (Lovelock, 2004). Various incidents such as the Bali bombings (Hitchcock & Darma Putra, 2005); airplane crashes (Henderson, 2009); and the Aceh tsunami (Sharpley, 2005) have contributed to depicting Indonesia as a risky destination. Meanwhile, Singapore is chosen due to its position as a benchmark of a highly competitive tourist destination in Southeast Asia. Singapore was ranked 1st in Southeast Asia and 11th in the world in terms of tourism competitiveness (World Economic Forum, 2015). In addition, Singapore is also considered as a low-risk country of destination (Enright & Newton, 2004).

The aim of this thesis is to provide a destination decision model that involves several risk-related factors. The service typology proposed by Mitra et al. (1999) is employed. This study investigates differences in destination decisions in two settings,

leisure and medical tourism services. Leisure and medical tourism can be positioned on a continuum that is based on the level of potential outcome uncertainty. In this sense, leisure tourism is more likely to generate less outcome uncertainty compared with medical tourism because of the difficulty in judging the outcome of medical treatment. Therefore, leisure tourism is considered an experience service, whereas medical tourism is considered a credence service. This chapter contains a comprehensive review of previous tourism studies on predictors of destination decisions, which are presented in the framework of the experience-credence service typology.

## **1.2 Predictors of Destination Decisions**

Understanding the factors that influence tourists' decisions to visit a country might be an important issue for many countries worldwide, especially those heavily dependent on tourism. The global tourism sector is a major economic engine and ranked fourth in global exports, following fuels, chemicals and food (UNWTO, 2015). By 2012, the total annual value of global exports in the tourism sector had reached USD1,243 billion or 5.4% of total exports. Furthermore, in the same year, the contribution of the tourism sector to the world's gross domestic product was estimated at 9.3%, and the contribution of the tourism sector in creating jobs, both directly and indirectly, was 8.7% (WTTC, 2013). These data clearly indicate that the tourism industry has become an important, or potentially important, economic driver for most countries in the world, and particularly for developing countries (Eilat & Einav, 2004). Given the importance of tourism in economic development and this sector's vulnerability in terms of risk issues, it is important for marketers to understand the factors that influence tourists' destination decisions.

This section reviews the literature on the predictors of destination decisions that supports the research problem and questions. It consists of the following subsections, as shown in Figure 1.1.

1. **Risk Properties in the Tourism Service.** This subsection provides a discussion on the source of risk properties embedded in the tourism service as a result of negative country image and the nature of experience and credence services. These two variables are the endpoints of a continuum that distinguishes the level of risk associated with visiting a particular destination.
2. **Mapping Predictors of Destination Decisions.** This subsection discusses the general map of the predictors of destination decisions from the tourism literature and includes a discussion about two themes in tourism studies; namely, prominent predictors of destination decisions and various domains of predictors in the model

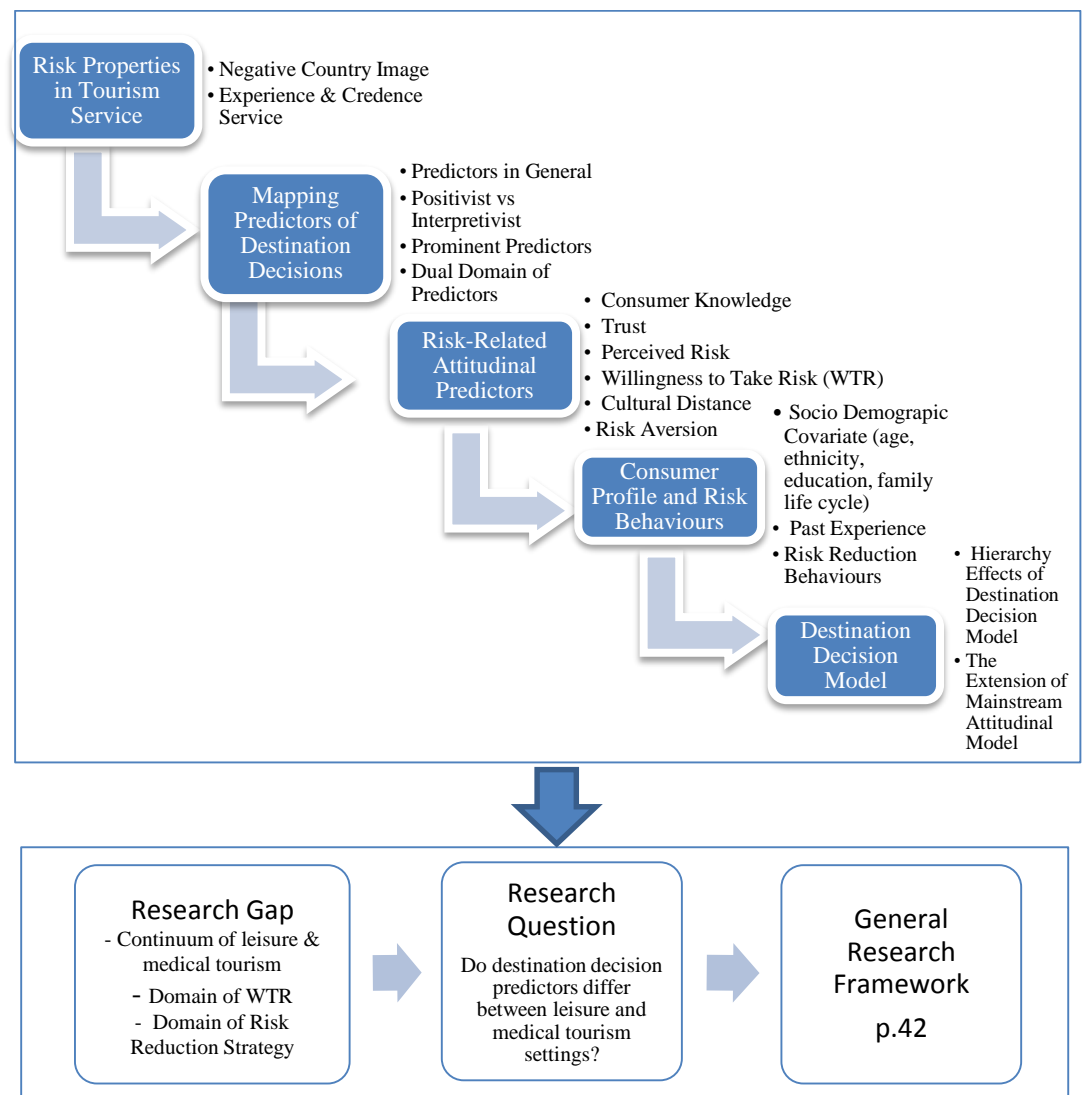


Figure 1.1. Literature Review Map

3. **Risk-Related Attitudinal Predictors.** This subsection describes several attitudinal predictors of destination decisions that relate to the nature of risks that are attached to a tourism purchase. The discussion includes predictors such as consumer knowledge, trust, perceived risk, willingness to take risk (WTR), cultural distance, and risk aversion. In particular, the dual domains of the WTR construct are reviewed.
4. **Consumer Profile and Risk Behaviours.** This subsection details how demographic covariates (e.g., gender, age, education, and income) and past experience relate to the cognitive processes of risk-taking behaviour. This subsection also explains how consumers manage risk to reduce their vulnerability in decision making.
5. **Destination Decision Model.** This subsection covers the sequence of cognitive processes in the destination decision model and the application of well-established attitude theories – such as the theory of reasoned action and the theory of planned behaviour – in tourism studies.
6. **General Research Framework.** This subsection describes the proposed general research framework employed in this thesis. The framework is based on the “reasoned action” and risk theory frameworks.

### **1.3 Risk Properties in the Tourism Service**

#### *1.3.1 Negative Country of Origin Effect/Country Image*

In international marketing, a common challenge is managing a product/service that is associated with an unfavourable country image, particularly when the product has not yet been well-established. This situation refers to the interchangeable concept of negative country image (Tse & Wei-na, 1993), negative country of origin effects/stereotypes (Lotz & Hu, 2001) or weak country of origin (COO) (Martin, 2010). In such circumstances,

marketers are typically concerned with developing strategies to overcome negative country images because of their potential to seriously, perhaps even fatally, affect the brand image of products/services (Thakor & Katsanis, 1997).

In this context, less developed or industrializing nations that produce products/services at low costs typically have an unfavourable country image (Lotz & Hu, 2001; Tse & Wei-na, 1993). Stereotypes emerge, and developing countries are typically associated with a negative country image and/or negative country of origin effect. Several studies have indicated a hierarchy of bias that is influenced by the level of economic development in a country, the source of the country's culture and its political climate (Bilkey & Nes, 1982). Thus, products from advanced countries are perceived to be of higher quality than products from developing countries (Al-Sulaiti & Baker, 1998; Gaedeke, 1973). The hierarchy of bias is not consistently in line with the facts, as the products of less developed countries/industrializing nations are frequently able to succeed in the marketplace and compete against the products of developed countries (Tse & Wei-na, 1993). China is perhaps the most conspicuous example of this success, although it can plausibly be argued that the low-cost manufacturing advantage of China is clearly sufficient to overcome any potential negative COO bias.

A managerial question arises as to whether marketers can successfully communicate a country's strengths when promoting a country with a negative image. Consumers' perceptions of a negative country image might fatally influence their product/service evaluation and behaviour. They might consider that there is a higher risk when purchasing a product/service that originates from a country with a negative country image and believe that they are assuming some risk when deciding to purchase such a product/service. Therefore, it is important for marketers to understand the dynamics of consumer behaviour in the context of risk taking, particularly in relation to products from countries with a negative country image. Some researchers have explored the issues



associated with solving the problem of negative country image (Martin, 2010; Tse & Wei-na, 1993). Martin (2010) suggests the use of a well-designated targeted marketing campaign via print ads or the Internet. The content of a message should be associated with imagery that allows consumers to imagine a positive experience of using the product. Furthermore, branding and product experience can reduce negative COO effects (Tse & Wei-na, 1993). The construct of country image is related to the “destination image” construct in the tourism field, i.e., a destination image resembles the product country image concept (Mossberg & Kleppe, 2005).

### *1.3.2 Experience vs. Credence Service Typology: The Contexts of Leisure and Medical Tourism*

They are three types of services in this regard, and these are based on the availability of information (Mitra et al., 1999) and the ability to process information prior to purchase (Alford & Sherrell, 1996). These services include search, experience, and credence services. Nelson was the first scholar to introduce the classification of a product/service based on search and experience attributes, and Darby & Karni (1973) suggested an additional “credence” product/service. A search service refers to a service that consists of attributes that consumers can relatively easily retrieve and evaluate prior to purchase (Klein, 1998). For example, consumers can access information and make evaluations concerning airline service offers before purchase through an information search on the Internet. An experience service refers to a service that consumers cannot evaluate prior to purchase and consumption. As an example, tourists cannot evaluate the quality of a leisure tourism service in one country before they visit the country. A credence service refers to a service that consumers face difficulties in evaluating, even after having purchased and/or consumed it. An example of this service is a medical tourism service. Consumers cannot immediately evaluate the success of its delivery even after its purchase and consumption.

These three types of services, which fall along a continuum, are based primarily on the difficulty of obtaining pre-purchase information and knowledge (Mitra et al., 1999). The sequence on a continuum from less to more difficult acquisition of information and knowledge is a search service, followed by an experience service and then a credence service. In a search service, consumers find it easier to acquire information prior to the purchase and are more knowledgeable about the service due to its standardized nature (Mitra et al., 1999). In this sense, consumers are more likely to associate the outcome of a search service as being more certain and, in turn, as having a lower risk (Mitra et al., 1999). By contrast, a credence service is associated with uncertainty due to a lack of knowledge and information, even after consumption, which results in a credence service being perceived of as riskier than a search service.

To date, a comparison of the destination decision-making process and the role of risk in leisure and medical tourism have not been conducted in the tourism literature. The basis for this comparison is in the continuum of the experience-credence service framework, in which leisure tourism represents an experience service and medical tourism represents a credence service. A segmentation profile based on the framework assumes that there may be differences due to variations in the extent of risk along the continuum. Some scholars have investigated differences in tourist attitudes and behaviours toward visiting a destination based on the main purpose of their visit, e.g., a honeymoon or leisure (Mok & Iverson, 2000); visiting friends or relatives (Feng & Page, 2000); a religious ritual (Chaudhary, 2000); or commerce, conference attendance, matters related to employment, or educational studies (Collins & Tisdell, 2002). Notably, however, they did not include visiting a destination for a medical purpose in the segmentation profile. The basis for the comparison also did not specifically cover the issue of the risk properties that are attached to the purchase of a tourism service. In this sense, different purposes of a visit may create

different levels of risk that tourists might experience as a consequence of their destination decisions.

## **1.4 Mapping Predictors of Destination Decisions**

### *1.4.1 Predictors of Destination Decisions in General*

Among the various topics discussed in previous tourism studies, tourism marketers might be especially concerned to understand the predictors of destination decisions. These predictors are crucial due to their influence in consumers' decisions to visit a country of destination. Therefore, tourism marketers should be concerned with understanding strategies that are effective in managing or influencing such predictors. Table 1.1 indicates the predictors of destination decisions discussed in the prior research on tourism based on the purposes of travel. Most predictors are studied in the context of general leisure, which is logical given the importance of leisure to enhancing individuals' level of well-being (Trenberth, 2005) and the economic importance of leisure travel. Many of these predictors, however, have not been discussed in other tourism settings such as medical or education tourism. Of the various travel purposes, visiting a destination for leisure and/or medical purposes seems consistent with the experience-credence dichotomy of services. The distinction is based on the degree of difficulty in accessing information prior to the purchase and evaluating the outcome of the service. The nature of visiting a destination for medical purposes is considered riskier than for leisure. Predictors of destination decisions, therefore, can be arguably distinguished based on their relation to the risk properties embedded in a tourism service.

The tourism literature has established predictors of international travel decisions that can be categorized into the two broad sources of internal and external factors. Internal factors refer to the personal characteristics of the traveller (e.g., beliefs, attitudes, socio-

demographic characteristics, personality, and lifestyle), and external factors generally refer to the marketing activities of tourism operators and destination country characteristics (e.g., reference group, family, and marketing communication). For both types of predictors, internal factors dominate the discussion of the predictors of destination decisions because tourism scholars give greater attention to a managerial approach (i.e., that is more micro and cognitive in nature) when seeking to understand tourist behaviour (see Assael, 2005). In terms of methodology, as shown in Table 1.1, a quantitative approach remains the dominant, mainstream approach in understanding the predictors of destination decisions. In terms of model development, the studies have typically applied an attitudinal-behaviour model to explain the impact of each predictor examined.

Table 1.1.  
*Predictors of Destination Decisions*

Predictor	Leisure	Medical	Education
<b>Internal</b>			
Affect		Han, 2013	
Attitude toward Destination	Fakharyan et al., 2012; Jalilvand et al., 2012; Van der Veen & Song, 2014		
Attitude toward Visiting Destination	Han et al., 2011; Hsu & Huang, 2010; Hsu & Huang, 2012; Lam & Hsu, 2004, 2006; Ziadat, 2014	Hall et al., 2011; Lee, Han, et al., 2012; Reddy et al., 2010	Chen & Zimitat, 2006
Congruity	Wang & Wu, 2011		
Cultural Distance	Crotts, 2004; Ng et al., 2007		
Cultural Proximity	Huang et al., 2013		
Desire	Lee, Song, et al., 2012		
Destination Attribute Preferences	Lehto et al., 2002		
Destination Awareness	Ferns & Walls, 2012		
Destination Brand Personality		Guiry & Vequist, 2014	
Destination Familiarity	Chen & Lin, 2012		
Destination Image	Assaker et al., 2011; Campo-Martínez et al., 2010; Chew & Jahari, 2014; Hallmann et al., 2013; Jalilvand et al., 2012; Lee et al., 2002; Lin et al., 2007; Morais & Lin, 2010; Noh & Vogt, 2012; Phau et al., 2010; Sirakaya et al., 2001		Cubillo et al., 2006
Destination Loyalty	Ferns & Walls, 2012; Oppermann, 2000		
Disconfirmation	Wang & Wu, 2011		
Expectation	Oom do Valle et al., 2008		
Evoked Fear	Hem et al., 2003		
Health Status	Zimmer et al., 1995		
Involvement	Clements & Dongling, 1996; Shen et al., 2009	Lee, 2013	
Likelihood of Crisis	Pennington-Gray et al., 2011		
Locus of Control	Zimmer et al., 1995		
Motivation	Hsu & Huang, 2012; Huang & Hsu, 2005; Oom do Valle et al., 2008; Prayag, 2012	Hall & Laesser, 2011	Nyaupane et al., 2011
Novelty Seeking	Jang & Feng, 2007		
Perceived Attractiveness	Um et al., 2006		

<b>Predictor</b>	<b>Leisure</b>	<b>Medical</b>	<b>Education</b>
Perceived Behavioural Control	Han et al., 2011; Hsu & Huang, 2010; Hsu & Huang, 2012; Lam & Hsu, 2004, 2006; Lee, Song, et al., 2012; Shen et al., 2009	Hall et al., 2011; Lee, Han, et al., 2012	Chen & Zimitat, 2006
Perceived Risk	Chew & Jahari, 2014; Floyd et al., 2004; Kozak et al., 2007; Qi et al., 2009		
Perceived Value	Petrack et al., 2001; Um et al., 2006	Wang, 2012	
Political Ideology	Legg et al., 2012		
Psychographic Segmentation	Waryszak & Kim, 1995		
Quality	Baker & Crompton, 2000; Žabkar et al., 2010	Ferrer & Medhekar, 2011; Zhang et al., 2013	
Regret	Sánchez-García et al., 2012		
Risk Aversion	Decrop & Snelders, 2005		
Satisfaction	Assaker & Hallak, 2013; Assaker et al., 2011; Baker & Crompton, 2000; Campo-Martínez et al., 2010; Chen & Tsai, 2007; Jang & Feng, 2007; Kim, Han, et al., 2009; Kozak, 2001; Lee, 2009b; Petrack et al., 2001; Tavitiyaman & Qu, 2013; Tian-Cole & Crompton, 2003; Um et al., 2006; Žabkar et al., 2010	Aliman & Mohamad, 2013	
Sensation Seeking	Assaker et al., 2011; Lepp & Gibson, 2008		
Social Ties			Nyaupane et al., 2011
Socio-demographic	Abuamoud et al., 2014; Clements & Josiam, 1995; Floyd et al., 2004; Oom do Valle et al., 2008; Zimmer et al., 1995		
Subjective Norm	Han et al., 2011; Hsu & Huang, 2010; Hsu & Huang, 2012; Lam & Hsu, 2006	Hall et al., 2011; Lee, Han, et al., 2012; Reddy et al., 2010	Chen & Zimitat, 2006
Travel Benefit Sought	Lehto et al., 2002		
Travel Philosophies	Lehto et al., 2002		
Trust	Wen, 2009	Han, 2013; Han & Hyun, 2015	
Variety-Seeking Tendencies	Sánchez-García et al., 2012		
Value - Psychographics	Pizam & Calantone, 1987		
Visit Experience	Campo-Martínez et al., 2010; Floyd et al., 2004; Kaplanidou & Vogt, 2006; Kozak, 2001; Lam & Hsu, 2004, 2006; Oom do Valle et al., 2008; Pennington-Gray et al., 2011; Petrack et al., 2001; Aarts et al., 1998; Shen et al., 2009; Sönmez & Graefe, 1998a		
Willingness to Take Risk	Aro et al., 2009)		

Predictor	Leisure	Medical	Education
<i>External</i>			
Advertising Awareness	Hennessey et al., 2010		
Ad Photo	Hem et al., 2003		
Destination Characteristics	Oom do Valle et al., 2008; Vassiliadis, 2008		
Time Constraints	Thill & Horowitz, 1997		
Product Information	Rewtrakunphaiboon & Oppewal, 2008		
Electronic Word of Mouth	Fakharyan et al., 2012; Jalilvand et al., 2012		
Destination Websites	Kaplanidou & Vogt, 2006		
Web Information Search	Pennington-Gray et al., 2011		
Family Member	Madrigal, 1994		
Media Form	Hennessey et al., 2010		
Perceived Image of Celebrity Endorsers	Van der Veen & Song, 2014		
Price	Abuamoud et al., 2014; Lord & Yeoman, 2012	Ferrer & Medhekar, 2011	
Service Image and Attributes			Cubillo et al., 2006
Service Quality	Somphaiphithak et al., 2011		
Visa Exemptions	Han et al., 2011		

#### *1.4.2 Positivist (Quantitative) Approach vs. Interpretivist (Qualitative) Approach*

Various approaches and methodologies have been applied to understand the tourist decision-making process. Previous tourism studies focused on the use of a managerial approach to understand tourist behaviour. This focus is understandable given that marketers can apply the findings of this approach to design marketing strategies (see Assael, 2005). A managerial approach and quantitative method remain the dominant paradigms in understanding the predictors of destination decisions, which is consistent with tourism marketers' efforts to determine the significant predictors of visiting a destination country and with attempts to intervene with respect to those predictors to increase the likelihood of destination visits (see Table 1.1). In contrast, other scholars have applied a qualitative method to understanding the predictors of destination decisions (e.g., Corey, 1997; Decrop & Snelders, 2004; Woodside & King, 2001). A qualitative approach is considered as a means of addressing certain issues faced in quantitative research, such as a lack of explanation for "why" questions and an inability to accommodate particular respondents due to the particular method of data collection (Clifton & Handy, 2001).

However, a quantitative method and positivist approach remains the mainstream approach in tourism research (see Decrop, 1999; Riley & Love, 2000). The positivist approach argues that a qualitative method produces less rigorous and valid results, including the lack of justification for a particular research method (Decrop, 1999). However, Cohen (1988) claims that substantial seminal studies in the tourism field have come through qualitative method-based research. Regardless of the debates about approaches and methods, the findings in tourism studies are important for countries worldwide, given that the tourism sector has become a significant source of revenue in the current state of development of the global economy. The present thesis attempts to identify the predictors of destination decisions through a quantitative approach by employing the advantages of generalization and prediction (Decrop, 1999).



### *1.4.3 Prominent Predictors of Destination Decisions*

It is notable that satisfaction and visit experience are dominant concerns in tourism scholarship, particularly with respect to leisure tourism. (See Table 1.1). In addition, destination image contributes as a predictor of destination decisions. Satisfaction and visit experience are relevant predictors of destination decisions, and tourism marketers are interested in strengthening these predictors in order to sustain tourism demand. Scholarly attention to these predictors demonstrates that tourism researchers are concerned with the importance of post-tourism purchase evaluation. Despite this fact, other scholars have questioned the relevance of satisfaction as a predictor of destination decisions and proposed other predictors such as novelty seeking, market offerings from competitors, and weather. Tourism scholars generally assume that a tourist is a rational individual who attempts to determine the choice that will provide the greatest satisfaction. Satisfaction is believed to increase individuals' likelihood of repurchasing the same product or service (Patterson & Spreng, 1997). Thus, not surprisingly, some tourism studies have examined the influence of satisfaction on revisit intentions (e.g., Assaker & Hallak, 2013; Petrick et al., 2001; Um et al., 2006).

A number of established theories/models, such as satisfaction (e.g., Kozak, 2001), the theory of planned behaviour (e.g., Aarts et al., 1998), disconfirmation of expectations theory (e.g., Pizam & Milman, 1993), cognitive dissonance theory (e.g., Chhetri et al., 2004), and SERVQUAL (e.g., Campo-Martínez et al., 2010) have all established that visit experience is argued to critically influence tourist behaviour. Most studies hypothesize that a satisfactory visit experience tends to increase individuals' likelihood of making a tourism purchase, and empirical evidence supports this hypothesis. In previous tourism studies, visit experience has been treated both as an independent direct predictor (e.g., Kozak, 2001; Lam & Hsu, 2004, 2006; Pennington-Gray et al., 2011; Shen et al., 2009) and as a moderating variable (e.g., Kozak, 2001; Sönmez & Graefe, 1998a). As a moderating

variable, however, visit experience did not interact with the other potential moderating variables. The relative paucity of studies of simultaneous effects of moderating variables in previous tourism studies provides the impetus for this thesis to examine the importance of visit experience and other moderating variables, such as cultural distance and risk aversion. This thesis assumes that future tourist behaviour is the outcome of a learning process in which tourists are more likely to adjust their current beliefs and attitudes as a result of their visit experience to a particular destination.

#### *1.4.4 Dual Domain of Predictors of Destination Decisions*

In previous destination decision model, there are commonly combinations of direct, and mediating, predictors. A particular predictor can also act as both a direct and mediating predictor in some studies. Destination predictors that serve as mediating variables, in addition to direct predictors, include satisfaction (Lee, 2009a; Lee, 2009b; Tavitiyaman & Qu, 2013), destination image (Moon et al., 2013), involvement (Wang & Wu, 2011), and trust (Han, 2013; Han & Hyun, 2015). Regardless of the position, theoretical and empirical support is necessary to justify the position of a particular construct in a model. The Baron and Kenny (1986) procedure is a commonly used, and accepted, approach to determine whether a particular predictor serves as a mediating variable in a model.

### **1.5 Risk-Related Attitudinal Predictors**

The purchase of a tourism service is arguably a detailed, complex, and risky decision (Clements & Josiam, 1995; Sirakaya & Woodside, 2005). From that perspective, the predictors of destination decisions can be categorized based on their relation to the risk factors embedded in a product or service, which can be labelled “risk-related predictors of destination decisions”. One category of risk-related predictors in tourism studies consists of attitude variables, which are conventionally defined as a learned predisposition to

respond to an object or class of objects in a consistently favourable or unfavourable manner (Assael, 2005). In the theory of reasoned action, attitudes are, in part, a function of behavioural beliefs about the outcome of the behaviour (Ajzen & Fishbein, 1980). Some risk-related attitudes that have been examined in tourism include consumer knowledge (e.g., Biswas et al., 2006), cultural distance (e.g., Ng et al., 2007), destination image (e.g., Assaker et al., 2011), trust (e.g., Clancy, 1998), risk perception (e.g., Reisinger & Mavondo, 2005), risk aversion (e.g., Decrop & Snelders, 2005), and willingness to take a risk (WTR) (e.g., Aro et al., 2009).

Table 1.2.  
*Risk-Related Predictors of Destination Decisions*

Domain	Predictor	Tourism Setting	
		Leisure	Medical
Attitude	Consumer Knowledge	Ferns & Walls, 2012	
	Cultural Distance	Crotts, 2004; Ng et al., 2007	
	Destination Image	Lin et al. 2007 (Assaker et al., 2011; Campo-Martínez et al., 2010; Chew & Jahari, 2014; Hallmann et al., 2013; Jalilvand et al., 2012; Lee et al., 2002; 2007; Morais & Lin, 2010; Noh & Vogt, 2012; Phau et al., 2010; Sirakaya et al., 2001	,
	Evoked Fear	Hem et al., 2003	
	Perceived Risk	Chew & Jahari, 2014; Floyd et al., 2004; Kozak et al., 2007; Qi et al., 2009	
	Regret	Sánchez-García et al., 2012	
	Risk Aversion	Decrop & Snelders, 2005	
	Sensation Seeking	Assaker et al., 2011	
	Trust	Wen, 2009	Han, 2013; Han & Hyun, 2015
	Willingness to Take Risks	Aro et al., 2009	
Tourist Characteristics	Socio-demographic Factors	Abuamoud et al., 2014; Clements & Josiam, 1995; Floyd et al., 2004; Oom do Valle et al., 2008; Zimmer et al., 1995	
Tourist Behaviour	Visit Experience	Aarts et al., 1998; Campo-Martínez et al., 2010; Floyd et al., 2004; Kaplanidou & Vogt, 2006; Kozak, 2001; Lam & Hsu, 2004, 2006; Pennington-Gray et al., 2011; Petrick et al., 2001; Shen et al., 2009; Sönmez & Graefe, 1998a	

### *1.5.1 Consumer Knowledge*

Consumer knowledge forms the cognitive component of attitudes (Goldschmidt et al., 2003). Lake (2009, p. 99) has stated that “attitudes encompass the consumer’s knowledge of that something, her liking or disliking of it, and the strength of her feelings regarding it”. Consumers’ product knowledge is thus a key factor in understanding consumer behaviour (Klerck & Sweeney, 2007; Long-Yi & Chun-Shuo, 2006; Park et al., 1994). It has been argued that there are three types of consumer knowledge, namely, subjective knowledge/perceived knowledge, objective knowledge, and experience-based knowledge (Long-Yi & Chun-Shuo, 2006). The definition of subjective knowledge or perceived knowledge is a person’s perception of the extent to which they know about a product class (Brucks, 1985; Park et al., 1994). Objective knowledge is accurate information about the product class that is stored in long-term memory (Brucks, 1985; Park et al., 1994). Experience knowledge is the amount of purchasing or usage experience with the product (Brucks, 1985).

Consumer knowledge regarding a tourism service plays an important role in travel decision making (Chorus et al., 2006; Zalatan, 1996) and becomes a starting point for making a travel decision (Chorus et al., 2006; Zalatan, 1996). The extent of consumer knowledge (i.e., prior purchase knowledge) might differ between experience services (i.e., leisure tourism) and credence services (i.e., medical tourism). Mitra et al. (1999) posited that the level of consumer knowledge prior to a service purchase is high for an experience service and low for a credence service. As a result, the degree of consumer knowledge influences the level of risk perception that is associated with a product or service (e.g., Klerck & Sweeney, 2007). Consumers are predicted to perceive a credence service as being riskier than an experience service because there is only limited knowledge that can be gleaned regarding the credence service. Similarly, a lack of knowledge of new product

features leads to uncertainty about what the product can deliver to consumers, such as space tourism (Crouch et al., 2009).

Limited knowledge about a product or service potentially reduces individuals' likelihood of making a purchase decision. In the context of a tourism service, prior knowledge is related to information search behaviour in a tourism purchase (e.g., Dodd et al., 2005; Kerstetter & Cho, 2004), particularly when tourists are highly involved with a tourism product or service (Gursoy & McCleary, 2004). Furthermore, consumer knowledge and product involvement positively influence consumer decision making (Famularo et al., 2010). Product complexity has a negative association with consumer knowledge and differs across product class (Öörni, 2004). Therefore, the present study assumes that medical tourism is more complex with lower consumer knowledge than leisure tourism offered by a tourism provider in a particular country of destination.

### *1.5.2 Trust*

Earlier scholars argued that "trust" is an attitude. In this sense, the reasoned action theoretical framework views trust as an attitude toward an action. Trust can be viewed as an attitude to place oneself under the control of other persons or objects that might harm oneself in a particular situation (Donaldson et al., 2008; Hoffman, 2006). McKnight et al., in Franke (2002), extend the concept of trust to include not only an attitude but also a behaviour, an expectation, a structured variable contingency, a social agency variable, and an interpersonal variable.

When consumers face a risky choice, they will commonly rely on trust to manage the uncertainty and make a decision. In this sense, trust refers to an attitude in which an individual places the fate of his/her interest under the control of others in a particular context (Alba & Hutchinson, 1987). Trust is confidence in an exchange partner's reliability and integrity (Park et al., 1994). Thus, the party in whom consumers entrust their fate

should be trustworthy. In this sense, trust and trustworthiness cannot be separated.

Consumers place their trust in a product/service because they believe and feel that the product/service can meet their expectations.

Trust has frequently been discussed in the context of tourism; however, comparatively few tourism studies have investigated its influence, specifically on destination decisions. Their discussions have focused on various issues such as the influence of the following: trust in e-commerce on tourism products and service loyalty (Kim et al., 2011), trust on rural tourism loyalty (Loureiro & González, 2008), trust on relationship commitment to a nature-based tourism provider (Zillifro & Morais, 2004), the predictors of trust in an online travel site (Chen, 2006), trust on e-commerce relationships among travel agencies (Wu & Chang, 2006), trust on an online accommodation booking relationship (Fam et al., 2004); trust between cultures (Hunter, 2001), intra-firm trust on the international travel trade (Crotts & Turner, 1999), and online reviews of trust perceptions for hotel bookings (Sparks & Browning, 2011). Some studies, however, have discussed the role of trust as a predictor of a tourism purchase, such as the purchase of a product from a tour agency (Lin & Lu, 2010) and quality trust on the revisit intentions of upscale hotels (Kim, et al., 2009). The aforementioned studies mostly focused on leisure tourism, and therefore, future studies could usefully examine the role of trust in the medical tourism context.

### *1.5.3 Perceived Risk*

Perception is also understood as an attitude. In this sense, perception is the first phase of the actual formation of an attitude (Sherif & Cantril, 1947). Fronda (2010) states that perception is an attitude of the real; therefore, it follows that perceived risk (risk perception) can be categorized as an attitude (e.g., Cossens & Gin, 1995). Consumers make decisions based on their expectations. These expectations are based on the evaluation of

product attributes that are relevant to consumers. In this sense, consumers are likely to confirm their expectations after they purchase and consume the product/service; however, there is always an element of uncertainty and the possibility of a discrepancy. This uncertainty of *a priori* probabilities of specific outcomes associated with a choice leads to ‘perceived risk’ in consumers’ minds (Kim et al., 2008). Perceived risk refers to the consumers’ perceptions of uncertainty and the adverse consequences of buying a product or service (Murray, 1991). Perceived (subjective) risk differs to “real world” (objective) risk in which objective risk attaches a probability or “statistical expectation value of outcome severity” (Hansson, 2010, p.232) and assumes that each individual may assign a probability of negative consequences. Conversely, perceived (subjective) risk assumes that an individual “has limited information, a reduced number of trials to consider and a semi-reliable memory” (Mitchell, 1999, p.164) and therefore that the individual has difficulty in calculating the real probability of the occurrence of events.

The previous discussion of perceived risk suggests that consumers commonly believe that a product/service from a developing country is riskier than the equivalent product from a developed country (Cordell, 1992). The perception is that products that derive from less-developed countries are less preferred than products from developed countries (Laroche et al., 2005).

Some scholars have investigated the components of perceived risk, such as performance, psychological aspects, financial matters, social factors, and physical risk (Kaplan et al., 1974). A related article also found that time-related risk contributes to perceived risk (Stone & Grønhaug, 1993). These six components form overall perceived risk. Previous research on country of origin shows the relationship between country of origin and performance risk (e.g., Agarwal & Teas, 2004; Alden & Hoyer, 1993; Cordell, 1992), financial risk (e.g., Hulland et al., 1996; Quester et al., 2000; Wall et al., 1991), physical risk, time-related risk, and psycho-social risk (e.g., Chakraborty & Allred, 1996).

In the previous literature, the dominant focus and the main object of study on risk perception has been tangible goods rather than services. The various products covered by such studies include toothpaste (Alden & Hoyer, 1993), knit/polo shirts, leather wallets, telephones (Wall et al., 1991), personal computers and televisions (Soo-Jiuan & Wai-Ying, 1999). Other products include calculators, wristwatches, running shoes, CD players, sunglasses, ski-jackets (Agarwal & Teas, 2004), auto parts (Chakraborty & Allred, 1996), watches, shoes (Cordell, 1992), toys (Kabadayi & Lerman, 2011), and software products (Reuber & Fischer, 2011). Subsequently, the small number of articles that are based on services in consumer risk perception studies cover mobile telecommunication providers, insurance companies (Michaelis et al., 2008), and tourism (Eilat & Einav, 2004).

In the tourism context, perceived risk is an aspect of a destination's image (Lepp et al., 2011). A visit to a risky destination might be associated with particular issues such as war (Fuchs & Reichel, 2006b), terrorism (e.g., Floyd et al., 2004; Pizam & Smith, 2000; Sönmez & Graefe, 1998b), criminal conduct (e.g., Ferreira & Harmse, 2000; George, 2010), AIDS (e.g., Cossens & Gin, 1995; Forsythe et al., 1998), political turmoil (e.g., Brown, 2000), and natural disasters (e.g., Bird et al., 2010). In addition to destination image, the choice of a tourist's role such as a backpacker (e.g., Hunter-Jones et al., 2008; Reichel et al., 2007), the choice of tourism activities such as adventure tourism (e.g., Bentley & Page, 2008; Cater, 2006), and personality traits such as sensation seeking (Lepp & Gibson, 2008) contribute to the perceived risk embedded in tourist destination decisions. Perceived risk determines the extent of risk reduction (Maser & Weiermair, 1998), and the ultimate objective is to influence perceptions of risk associated with destination decisions (Kozak et al., 2007; Reisinger & Mavondo, 2005; Sönmez & Graefe, 1998a). Most of the tourism studies on perceived risk, however, examine leisure tourism rather than medical tourism contexts; however, a few studies have discussed the role of perceived risk in the context of medical tourism context. For instance, Brown (2000) scrutinizes the role of



medical tourism in communicating the benefits and risks that are associated with certain medical procedures. Moreover, tourists perceive a medical tourism service as having a high level of risk (Brown, 2000).

#### *1.5.4 Willingness to Take Risk*

In previous works, behavioural intention has been used to express the concept of purchase intention (Prendergast et al., 2010) and intention to buy (Nadiri & Tümer, 2010). Furthermore, the concept is also used as willingness to buy (Champion et al., 2010), willingness to pay (Schnettler et al., 2009), and WTR (Bohnet et al., 2008). The concept of WTR differs from the concept of perceived risk. As a perception, perceived risk is an attitude component because perception is the first stage in the actual formation of an attitude (Sherif & Cantril, 1947). Moreover, perception is an attitude itself (Fronza, 2010). In contrast, WTR is within the domain of behavioural intentions (Cho & Lee, 2006), which is arguably the culmination of consumer decision making (Conchar et al., 2004; Constant et al., 2011; Forlani & Mullins, 2000; Simon et al., 1999). A behavioural intention is a function of salient information or beliefs about the likelihood that performing a behaviour will lead to a specific outcome (Darby & Karni, 1973). Behavioural intention is the immediate antecedent to behaviour.

WTR is a term and construct that is commonly used in research on financial investment decisions (Valor et al., 2009), alliances (Becerra et al., 2008), innovation (Wan et al., 2005), and strategic management (Fink & Kessler, 2010; Hornsby et al., 2002). The concept of financial risk is also frequently used in research on entrepreneurship (Caliendo et al., 2009; Kreiser et al., 2010; Morales-Gualdrón & Roig, 2005; Simon et al., 1999), migration (Balaz & Williams, 2011; Constant et al., 2011) and international business (Datta et al., 2009).

By contrast, few researchers in the marketing field have investigated WTR in the context of tourism studies, in particular. Previous articles have focused on perceived risk as a stimulus for product evaluation. The next significant step in consumer behaviour is to measure the extent to which the consumer is willing to subsequently purchase (or not) based on perceived risk (Conchar et al., 2004). As consumers are rational in their decisions, they are usually willing to purchase a service when its risk perception is low. Consumers are likely to make a purchase even if the service has a high risk when they perceive its potential benefit (Wandel, 1994) or if they experience cognitive biases that lead to less risk perception (Simon et al., 1999). WTR may be seen as embedded in variables such as willingness to buy, willingness to pay, and intention to buy. However, it is often difficult to decompose these concepts into sub-components, such as WTR, because the measurements of these variables do not usually cover the indicators of WTR, and WTR is more likely to influence consumer decisions and the resulting economic outcomes (Constant et al., 2011).

There are two conceptualizations regarding the concept of WTR. First, WTR can be seen as constituting an attitude toward risk (Bonin et al., 2009; Bonin et al., 2007). As with other attitude measurements, consumers express WTR through a continuum between negative and positive, which is conveyed from low to high WTR. The object of WTR might be either the risk in general – which is similar to a risk aversion construct (see Mandrik & Bao, 2005) – or the risk property embedded in a particular object, setting, or behaviour, such as holding stocks, becoming self-employed, being involved in sports, or smoking (Dohmen et al., 2011). WTR with respect to the latter object (i.e., an object, setting, or behaviour) corresponds with the principles of the theory of reasoned action (Ajzen, 1988).

The second perspective of WTR, is as a generalized behavioural tendency, independent of a particular construct domain. Instead, WTR is seen as an attitudinal and

behavioural construct, both in terms of its definition and measurement. WTR is defined as “a combination of emotional coolness, toughness, activity, and a tendency for casualness about control and rules” (Nicholson et al., 2005, p.171). This definition implies a behavioural component, i.e., a tendency for actions demonstrating casualness about control and rules. Furthermore, the measurement of WTR also includes both attitudes and behaviours (e.g. Grable & Lytton, 1999).

Given the broad and loose scope in the definition and measurement of WTR, a procedure to more clearly delineate the construct of the WTR domain is necessary in tourist behaviour research. Moreover, this issue arises in the current study when the framework of the theory of reasoned action is applied in developing the proposed research model. The theory of reasoned action treats attitudes and behaviour (i.e., behavioural intention) as two separate constructs, although some scholars have suggested that behavioural intention is a component of attitudes (Bagozzi, 1978; Breckler, 1984; Ostrom, 1969). Of the three components of attitudes, cognitive (belief), affective (product evaluation), and conative (purchase decision), brand or product evaluation is the focal point of the study of attitudes. Therefore, consumer researchers equate product evaluation with attitudes (Assael, 2005). Nevertheless, this thesis follows the framework of the theory of reasoned action, which clearly distinguishes attitudes and behavioural intentions.

Furthermore, WTR corresponds to the concept of willingness to act (Stern et al., 1995), which relates to the notion that "risk-taking behaviour" is an "action" (Lyng, 1990). In addition, previous studies have applied “intention” and “willingness” to act as interchangeable terms (MacIntyre et al., 1998; Tobler et al., 2012). In relation to risk-taking behaviour, scholars use WTR interchangeably with constructs such as “risk propensity”, “willingness to accept a risk”, “risk tolerance”, and “willingness to bear a risk” (Grable & Roszkowski, 2008). WTR, as with other risk-related variables (i.e., consumer knowledge, trust, and perceived risk), is discussed in tourism studies (e.g. Aro et

al., 2009); however, few studies of this nature have occurred within the medical tourism context. The present thesis compares the domain of WTR in both leisure and medical tourism and examines whether the construct domain differs between the two contexts.

#### *1.5.5 Cultural Distance*

Culture is the broadest environmental factor influencing consumer behaviour (Assael, 2005; Schwartz, 2006) and consists of values, morals, symbols, physical manifestations, and behaviours ruled by characteristic of a particular world view (Gnoth & Zins, 2013). Consumers tend to refer to the norms and values of their society to evaluate their decisions, and these norms and values differ across countries. A term that is commonly used to capture this notion is cultural distance, which refers to the extent to which the home culture is similar to or different than the host country (Clark & Pugh, 2001; McKercher & So-Ming, 2001; Shenkar, 2001). This concept is frequently discussed in the context of entry mode choice (Drogendijk & Slangen, 2006; Meschi, 1997; Tihanyi et al., 2005), international HRM (Boyacigiller, 1990), foreign investment expansion (Shenkar, 2001), and international entrepreneurship (Thomas & Mueller, 2000). In addition, cultural distance relates to the choice of risk reduction strategies (Crotts, 2004), an informal source of uncertainty (López-Duarte & Vidal-Suárez, 2010), and information asymmetry (Colakoglu & Caligiuri, 2008). Consumer behaviour is also considered a function of cultural distance (see De Mooij & Hofstede, 2002). Cultural distance is particularly salient with respect to intercultural contact (Ye et al., 2012). Furthermore, Davidson (1982) stated that cultural distance is positively related to uncertainty or risk (Zhao & Zhu, 1998).

In the context of the tourism industry, some studies have discussed the issue of culture such as cultural heritage sites (Abuamoud et al., 2014; Scherrer et al., 2011), religion (Fakharyan et al., 2012), and consumer cultural attractions (Ramkissoon & Uysal,

2010). In regards to the issue of cultural distance, Crotts (2004) has investigated the relationship between cultural distance and risk reduction on travel behaviour. Ng et al. (2007) has compared several cultural distance measurements and related them to tourists' behaviour to visit a country. Gnoth & Zins (2010) investigated the differences in tourists' cultural values based on the choice of travel destination. Cultural distance influences individuals' participation in cultural tourism (McKercher & So-Ming, 2001), the intention to visit a destination country (Ng et al., 2007), trip information processing (Litvin et al., 2004), and travel behaviours (Crotts, 2004). Furthermore, risk factors in a tourism product differ among cultures (Reisinger & Mavondo, 2006), suggesting a relationship between cultural distance and risk issues in a tourism purchase service.

Notwithstanding this previous research, only a limited number of tourism studies have specifically examined the role of cultural distance as a predictor of destination decisions, particularly in the context of medical tourism. This suggests a research opportunity to which this research study responds. Some findings on the role of cultural distance in medical tourism include that medical tourists perceive foreign language skills as a problem in communicating with health providers in Iran (Azadi et al., 2012). In addition, cultural distance reduces the ability to determine legal conduct regarding the issue of malpractice in a host country (Turner, 2007), Religious affinity determines the preference for reproductive medical tourism (Moghimehfar & Nasr-Esfahani, 2011), and migrants prefer medical services in their respective home countries because the care matches their culture (Sobo, 2009). Differences in cultural aspects (e.g., language and social norms) are also more likely to reduce the quality of interactions, leading to potential discrimination regarding medical tourists (Ye et al., 2012). For instance, Ye, et al. (2012) found that medical tourists from Mainland China felt discriminated against, as they experienced less sharing of information from the nurse(s) in a Hong Kong hospital as a result of language barriers.

Nevertheless, responses to cultural differences vary among tourists. Cultural distance seems to be a “double-edged sword” because its influence spreads in both directions. On the one hand, cultural attractiveness as an outcome of cultural differences may result in a positive evaluation of a destination decision. On the other hand, cultural distance might be associated with an increased level of uncertainty, which might result in negative perceptions of tourist destinations and/or outcomes. Based on the distance decay theory, tourists tend to prefer a distinctive destination, as long as no risks of unexpected events affect them during their visit (Cohen, 1979). In general, however, tourists prefer a destination country that has cultural similarities with the culture of their home country (Basala & Klenosky, 2001; Henderson, 2003; Yavas, 1990).

The present thesis, however, assumes the position that cultural distance is more likely to produce a negative evaluation of a tourism service because of the risks inherent in a tourism purchase. Furthermore, there is a possible continuum in tourist evaluations among different types of tourism services, such as between leisure and medical tourism services. Previous tourism studies have not compared the consistency of cultural distance in determining destination decisions between leisure and medical tourism. The present thesis therefore examines the impact of cultural distance in influencing destination leisure and medical tourism decisions. Moreover, the present thesis attempts to simultaneously combine the effects of cultural distance with predictors of destination decisions such as prior visit experience.

#### *1.5.6 Risk Aversion*

Risk aversion refers to “an individual’s degree of negative attitude toward risk arising from outcome uncertainty” (Mandrik & Bao, 2005). This definition implies that an individual is “risk averse” and places more concern on downside risk (i.e., negative consequence) than on an upside risk (i.e., positive consequence) that is attached to a

particular object or behaviour. Risk aversion is applied as an interchangeable (but contrary) construct with sensation seeking, which refers to a personality trait that is associated with the need for novelty (Lepp & Gibson, 2008; Pizam et al., 2004) and an individual's attempts to adopt the behaviour for the sake of experience (Zuckerman, 1990). Although both constructs respond to the same risk property (i.e., downside risk), their evaluations differ in that risk aversion measures the extent of an individual's avoidance of risk associated with a particular object or behaviour (Grinblatt & Keloharju, 2009).

In relation to a construct domain, risk aversion can be considered in the domain of general human traits, in the domain of individual traits, or as a response to a context (March, 1996). Risk aversion is among the various prominent factors in a consumer's rational choice and decision-making processes (March, 1996), particularly in relation to destination decisions and the decision-making process of rational tourists (Decrop & Snelders, 2005). The manifestation of risk aversion is most measurable when consumers are more involved with the product/service, conduct more information searches, avoid conflicts, and prefer safer choices (Decrop & Snelders, 2005). A psychocentric individual (i.e., a risk-averse tourist) tends to choose safe destinations, whereas an allocentric individual (i.e., a risk-taking tourist) is more likely to choose a less safe destination (Plog, 1974).

Tourism studies have discussed the risk aversion construct as it relates to issues such as predicting destination decisions (Ryan, 1995), segmenting risk perceptions of non-institutionalized tourists (Reichel et al., 2007), and segmenting tourist perceptions of an information source (Alvarez & Asugman, 2006). To date, a range of scholars have discussed risk aversion in the setting of leisure tourism; however, this construct has been only rarely addressed in the context of medical tourism (e.g., Lu et al., 2014). In addition, numerous studies have focused on risk aversion as a stand-alone construct rather than combining its effects with other predictors of destination decisions. Therefore, the present

thesis examines the effects of risk aversion in combination with other constructs – such as visit experience and cultural distance to compare leisure and medical tourism. Visit experience is among the dominant predictors of destination decisions (see Table 1.1). The present thesis examines whether risk aversion influences destination decisions and has simultaneous effects with visit experience in affecting destination decisions for both the leisure and medical tourism.

## **1.6 Consumer Profile and Risk Behaviour**

### *1.6.1 Socio-Demographic Factors*

Published research has found that WTR depends on variables such as culture and demographic covariates. Individuals from low uncertainty avoidance cultures are more willing to take risks than individuals from high uncertainty avoidance cultures (Hoppe, 1993; Jaeger, 1986; Riefler et al., 2011; Somkiat et al., 1993; Tse et al., 1997). Cosmopolitan consumers are more likely to be risk takers than non-cosmopolitan consumers (Riefler et al., 2011), and younger individuals are more willing to take risk than older individuals (Bonin et al., 2009; Geiger & Hürzeler, 2003; MacCrimmon & Wehrung, 1990). Women are less willing to take risk than men (Balaz & Williams, 2011; Bernasek & Shwiff, 2001), and individuals with a higher education level are less likely to take risk than those of lower education levels (Bernasek & Shwiff, 2001). WTR has a strong influence on making decisions that result in economic outcomes (Constant et al., 2011).

### *1.6.2 Prior Experience*

Satisfaction and prior experience (i.e., visit experience) are, rather unsurprisingly, among the most frequently discussed predictors of destination decisions, particularly in the context of leisure tourism (see Table 1.1). These two constructs are interrelated because



they both operate in the post-tourism purchase evaluation stage. Following the principles of the expectation-disconfirmation theory (Oliver, 1980), prior experience potentially increases or decreases the likelihood of destination decisions as a result of product/service evaluation (e.g., tourism service). It has been suggested that prior experience is an expression of consumer knowledge – along with subjective and objective knowledge – that is measured and evaluated through actual purchases and/or the usage of a product/service (Bettman & Park, 1980; Brucks, 1985; Raju, 1995).

However, Dolnicar, et al. (2013) argue that satisfaction, in the context of a tourism service, is not necessarily a salient predictor of intention to return, which implies they do not follow the principles of the expectation-disconfirmation theory (see Oliver, 1980). This argument is based on the consideration of more salient predictors instead of satisfaction, such as novelty seeking, a competitor's offering, and extraordinary events (e.g., weather) (McKercher & Prideaux, 2014). Interestingly, Dolnicar, et al.'s argument applies to the context of leisure tourism in general and has not provided any evidence in the context of medical tourism. In addition, Jang and Feng (2007) found that satisfaction resulting from previous positive visit experience is still a relevant predictor of revisit intentions, though in the short-term only. Arnould and Price (1993) also found that tourists still have minimal expectations as a reference in evaluating their travel decisions (e.g., inexperienced tourists still have a desire for comfort and safety).

Prior experience might be considered as a flexible construct that has been expressed in at least three ways. First, some scholars use the following terms to refer to prior experience: “past experience” (San Martin et al., 2012), “prior behaviour” (Bentler & Speckart, 1981), “familiarity” (Alba & Hutchinson, 1987), and “prior involvement” (Lehto et al., 2004). Second, measurements of prior experience include single binomial measures (Lam & Hsu, 2004; Perdue, 1985; Sönmez & Graefe, 1998a) and seven-point scale measures (Raju, 1995). Third, the position of prior experience in model development

varies either as a moderating factor (Bennett et al., 2005; Mangleburg et al., 1998; Murray, 1991; Park & Jang, 2014; Vogt & Andereck, 2003) or as an independent variable (Dodd et al., 2005; Lam & Hsu, 2004, 2006; Tax et al., 1998).

Some studies indicate that prior experience has significant effects on behaviour (e.g., Lam & Hsu, 2004; Sönmez & Graefe, 1998a), whereas other studies present mixed results (e.g., Lehto et al., 2004; Perdue, 1985). Although there are differences in terminology, measurements, and construct domain, prior experience is considered a salient predictor of consumer behaviour (Bentler & Speckart, 1981). Prior experience reduces the uncertainty attached to high involvement products or services (Smith & Swinyard, 1982) through elevating an individual's confidence level when engaging in risky behaviour (Sitkin & Pablo, 1992). Prior experience, therefore, increases the predictability of behavioural intentions or future behaviour (Park & Jang, 2014).

In the setting of a tourism service, some studies have examined the importance of prior experience (i.e., visit experience) for activity participation and expenditure patterns (Lehto et al., 2004), consumer enjoyment (Ma et al., 2013), destination preferences (Raitz & Dakhil, 1989), future destination decisions (Mazursky, 1989), segmenting travel information inquirers (Perdue, 1985), travel behaviour (Sönmez & Graefe, 1998a), and travel cancellations (Park & Jang, 2014). The consistency of prior experience in influencing destination decisions across various travel purposes has not been examined in previous tourism studies, however. In addition, the previous tourism literature has not examined the interactive effects of prior experience (i.e., visit experience) and other predictors of destination decisions.

### *1.6.3 Risk Reduction Behaviour*

Destination decisions require risk reduction strategies due to the risky nature of a tourism service (Sirakaya & Woodside, 2005). Tourism studies have examined the role of

risk reduction tactics in various settings. For instance, Fuchs and Reichel (2011) examined the differences in applying risk reduction tactics based on the level of tourists' prior experience (i.e., visit experience). Loet et al. (2011) examined the preference for the adoption of risk reduction tactics based on tourists' travel-related and socio-demographic characteristics. Mitchell and Vassos (1998) investigated the influence of culture and gender on risk reduction tactics. Fuchs and Reichel (2006a) examined the relation between destination risk perception and risk reduction tactics. Tourists engage in risk reduction tactics in response to the risky nature of a tourism service (see Maser & Weiermair, 1998). Mitchell et al. (1999) provide a list of 43 risk factors that are associated with a tourism service, and these factors indicate that risk reduction tactics are even more important when tourists need to make a travel decision.

The typology of risk reduction tactics may be presented based on the approaches that logically flow from the components of perceived risk, i.e., uncertainty and consequences (Bauer, 1967). Based on these components, risk reduction tactics aim to increase the certainty of the (positive) outcome or reduce the consequences of potential loss resulting from a particular behaviour (e.g., Lo et al., 2011). Mitchell and McGoldrick (1996) provide an intensive review of this construct. Various expressions refer to the general term "risk reduction tactic", including risk relief tactic (RRT) and risk mitigation tactic (RMT). The RRT refers to "a piece of information that increases the likelihood of product success" (McCarthy & Henson, 2005). In this sense, information becomes valuable to tourists due to its ability to reduce uncertainty when arranging a travel plan (Gursoy & McCleary, 2004). Some strategies to gather necessary information are through family members and friends, a travel agent, and the media (Lo et al., 2011) and, increasingly, the internet.

An additional term that is used as an expression for a risk reduction tactic is "risk mitigation tactic (RMT)", which refers to the use of a conscious process to limit the

consequences of potential loss resulting from particular behaviour (Manuj & Mentzer, 2008; Norrman & Jansson, 2004; Sjoberg, 1999). Some initiatives for risk mitigation include purchasing insurance, choosing to travel in a group, planning a larger travel budget, and notating emergency hotlines for tourists (Lo et al., 2011). In the context of tourist behaviour, however, scholars are more concerned with investigating the influence of RRT than RMT (e.g., Alegre & Juaneda, 2006; Andereck, 2005; Fuchs & Reichel, 2011; Gursoy & McCleary, 2004). RMT has been studied separately for tourism marketers and authorities in addressing tourism seasonality (Jang, 2004) and handling terrorism threats (Paraskevas & Arendell, 2007).

To date, the tourism literature has not considered both types of risk reduction tactics (i.e., RRT and RMT) simultaneously in one destination decision model. For example, Lo et al. (2011) categorized the two types of tactics, RRT and RMT, without comparing the two. Only one study (Cho & Lee, 2006) attempted to incorporate and separate the role of RRT and that of RMT in the case of household investment decisions (Cho & Lee, 2006). Their study, however, did not present theoretical and empirical justification for including RRT and RMT as separate constructs in the model. The study also did not clearly indicate the degree of model fit when the two interrelated constructs are treated as separate constructs. These issues reflect the issue that providing both theoretical and empirical explanation is a necessary methodological concern.

An alternative perspective that explains the notion of separating RRT and RMT is the distinction between the concepts of *genus proximum* and *differentia specifica* (Brante, 2011). *Genus proximum* refers to a ‘general concept’, and *differentia specifica* refers to a ‘subclass of the *genus proximum*’ (Bunt, Jones, & Bedient, 2012, p.135), that unique properties are inherent into each subclass (Heink & Kowarik, 2010).

RRT and RMT are the subclasses of risk reduction tactics but they differ in their unique properties. RRT is concerned with an increase in outcome certainty, and RMT is

concerned with the reduced consequences of a potential loss. A discriminant validity test may be applicable to test whether the two constructs can be distinguished into two interrelated constructs. Assuming that the result of a discriminant validity test provides support for RRT and RMT as separate constructs, a problem regarding the possibility of a poor model fit due to a high correlation between the two constructs remains. Therefore, error covariance is used to resolve this issue.

## **1.7 Destination Decision Model**

### *1.7.1 Hierarchy Effects of Destination Decision Models and the Role of Involvement*

Purchasing a product can be seen as satisfying ‘utilitarian’ or ‘non-utilitarian needs’ (Qu & Qu, 2015, p.389). People commonly purchase tourism services in order to meet utilitarian needs such as “relaxation, comfort, safety, security, convenience, and accessibility” (Ahn, Ekinci, & Li, 2013, p.720), while other tourists are also motivated to meet ‘non-utilitarian needs’. Such “non-utilitarian needs may be fulfilled through ‘hedonic consumption’ and ‘value-expressive consumption’ (Qu & Qu, 2015, p.389). *“Hedonic consumption designates those facets of consumer behaviour that relate to the multi-sensory, fantasy and emotive aspects of one's experience with products.”* (Hirschman & Holbrook, 1982, p. 92). Similarly, value-expressive consumption refers to *“the phenomena that products bought may serve as a positive demonstration of one's central values, self-concept, role position or group membership”* (Qu & Qu, 2015, p.389). In brief, the latter perspective is described as an “experiential view” given that the focus of consumption is on the element of fantasies, feelings, and fun” (Holbrook & Hirschman, 1982, p.132). Some examples of ‘non-utilitarian needs’ are aesthetic, symbolic and variety-seeking needs (Qu & Qu, 2015, p.389).

Previous destination decision models generally assume that tourists are rational in their decision-making (Song et al., 2003). Tourists will prioritise fulfilling ‘utilitarian needs’ and looking for the tangible benefits offered by tourism service, e.g., food quality, service quality, accommodation quality, entertainment facilities, organized social, and cultural events (Ahn et al., 2013). They are more likely to follow a rational decision making sequence of cognitive, affective, and behaviour (see Assael, 2005) and concentrate on verbal stimuli during information acquisition (see Holbrook & Hirschman, 1982). In addition, tourists typically refine many alternatives into a smaller set of alternatives before making their decisions (Crompton, 1992; Sirakaya & Woodside, 2005). Tourists typically evaluate and choose tourism products through engagement of cognitive decision making (see Holbrook & Hirschman, 1982).

The dominant paradigm in understanding tourist behaviour as rational, however, has also given rise to a contrary perspective that tourists are not necessarily rational in their decision making (Okumus et al., 2007) and, consequently, that they frequently engage in imprudent or impulsive planning (Kah & Lee, 2014). As an example, tourist shoppers are generally not as rational as visitors whose main purpose is to shop (Sundström et al., 2011). Another example is that unplanned visits to tourist attractions are an important part of leisure travel (Hwang & Fesenmaier, 2011). Tourists attempt to fulfil ‘non-utilitarian needs’ through symbolic meaning attached to tourism services (Ahn et al., 2013). Tourists focus on non-verbal stimuli that “*must be seen, heard, tasted, felt, or smelled to be appreciated properly*” (Holbrook & Hirschman, 1982, p.134). Tourists are involved with tourism services when they exhibit attention, interest, and excitement towards the tourism service (see Holbrook & Hirschman, 1982).

In general, a tourism purchase decision is a complex and multi-faceted decision process (Dellaert et al., 1998). This principle suggests the possibility that tourists may apply a unique decision process. The hierarchy of effects that are applied when choosing a

particular country destination to visit might differ from those applied when selecting souvenirs or culinary items in a destination country. Various attitudes and behaviours regarding tourist attitudes and behaviours might result from the differences in the extent of tourists' involvement. For instance, different tourist involvement leads to different information preferences (Cai et al., 2004). For example, shopping enthusiasts (i.e., high involvement) allocate more shopping expenditures for craft souvenirs than indifferent shoppers (i.e., low involvement) (Hu & Yu, 2007). Tourism marketers can utilize consumer involvement as a segmentation tool in understanding tourist differences in attitudes and behaviours (Dimanche et al., 1993; Fesenmaier & Johnson, 1989; Josiam et al., 2005).

#### *1.7.2 Extending the Theory of Planned Behaviour in a Destination Decision Model*

Some scholars have applied well-established theoretical frameworks to develop their destination decision models. For instance, Han et al. (2011) attempted to compare three destination models derived from the theory of reasoned action and the theory of planned behaviour. Their study proposed a destination decision model by extending the theory of planned behaviour, in which visa exemptions were chosen as an additional predictor. The extended theory of planned behaviour, which incorporates attitude, subjective norm, perceived behavioural control and expectation of a tourist visa exemption, provides better predictability than either the original theory of reasoned action or the theory of planned behaviour. Another destination decision model extended the theory of planned behaviour by including cultural tour involvement (Shen et al., 2009) and motivation (Hsu & Huang, 2012; Huang & Hsu, 2005). A comparison between the theory of reasoned action and the theory of planned behaviour was also undertaken in a study by Lee, Song, et al. (2012), which was extended by including past behaviour as a predictor of behavioural intention within the framework of the theory of reasoned action (Ryu & Han,

2010). Given the wide acceptance of this mainstream theory, the present thesis applies an attitude-behaviour model in the proposed model.

## **1.8 Research Gaps and the Purpose of the Thesis**

The above review reveals a range of issues that have not been adequately addressed in the tourism literature. This thesis focuses on the following issues:

1. Most predictors of destination decisions have been examined in the setting of leisure tourism, although their roles and effects in the context of medical tourism have rarely been discussed. For instance, previous tourism studies have discussed topics regarding health issues following overseas travel (Ryan et al., 2002), a medicine festival (Song et al., 2014), tourists' quality perceptions of medical facilities in their destinations (Tambi et al., 2013), pre-travel health consultation (Provost & Soto, 2001), and ethical transplant procedures (Biggins et al., 2009). In addition, previous tourism studies have raised topics from the earlier scope of medical tourism, such as the influence of destination attractiveness on the frequency of visiting hot springs destinations (Lee et al., 2009); the influence of destination personality (Lin, 2013), self-health perception (Lin, 2014), cuisine experience and psychological well-being (Lin, 2013, 2014) on tourists' revisit intentions to a hot springs destination; and the role of functional and wellness values in tourists' evaluations of spa experiences (Choi et al., 2014). This issue offers a starting point for examining the predictors of destination decisions in a medical tourism setting and conducting a comparison with the predictors in a leisure tourism setting. This comparison is also consistent with the principles of an experience-credence service typology, which considers the type of service based on the extent of inherent risk properties. This thesis argues that medical tourism is



riskier than leisure tourism due to the high uncertainty outcome involved with medical procedures.

2. Consistent with the principle that a tourism purchase is a risky decision (Maser & Weiermair, 1998), this thesis focuses on examining risk-related predictors of destination decisions. WTR is one risk-related predictor of a destination decision that is associated with a dual domain in terms of its conceptualization. Some scholars argue that it is an attitudinal construct, whereas others position this construct as behavioural. To date, WTR has not been extensively discussed in the tourism literature as a significant risk-related predictor of destination decisions. It is, therefore, necessary to examine the status of this construct in tourism service settings. As a consequence, this thesis applies the theory of reasoned action as a framework for the procedure of testing WTR as a mediating variable.
3. Visit experience is a dominant predictor of destination decisions in the tourism literature. The previous literature, however, has not tested the combined effects of visit experience and other predictors of destination decisions. Furthermore, a comparison of the combined effects in the two settings of leisure and medical tourism has not yet been made. For instance, Sönmez and Graefe (1998a) only distinguish the plan to travel to a region based on whether tourists have had a prior visit experience to the region. Kozak (2001) has examined the differences of revisit intentions to the same destination for first-time and repeat visitors. Furthermore, other studies have examined visit experience as a direct predictor of destination decisions and other variables (e.g., Campo-Martínez et al., 2010; Lam & Hsu, 2004, 2006; Pennington-Gray et al., 2011). Although Shen et al. (2009) hypothesized relationships between visit experience and other predictors (i.e., perceived control attitude, and cultural tour involvement), they did not test the combined (interaction) effects of those predictors on destination decisions. The

present thesis, therefore, examines the combined effects of visit experience as one of the prominent predictors of destination decisions and two risk-related attitude variables, namely, cultural distance and risk aversion, in the settings of leisure and medical tourism.

4. To varying degrees, tourists initiate efforts to reduce the potential risk of a tourism purchase. In general, there are two types of risk reduction strategies following the components of risk perception (Murray, 1991); namely, initiatives to increase the certainty of positive destination decision outcomes (i.e., RRT) and initiatives to reduce the negative consequence of failure as a result of destination decisions (i.e., RMT). To date, tourism scholars have generally examined risk reduction tactics in general without distinguishing the unique characteristics of each tactic (see Heink & Kowarik, 2010). The present thesis provides theoretical and empirical evidence to support the distinction of RRT and RMT in the proposed model.

## **1.9 General Research Questions**

Based on reviews of the previous literature and identification of the research gaps, the present thesis strives to answer the following main research question:

*Do destination decision predictors differ between leisure and medical tourism settings?*

This thesis focuses on the investigation of several risk-related predictors of destination decisions and addresses the following issues:

1. The domain position of the WTR construct in tourism settings as either an attitude or behavioural construct.
2. The extent of the combined effects of visit experience and other risk-related predictors of destination decisions, such as cultural distance and risk aversion.

3. The impact of two types of risk reduction tactics (i.e., RRT and RMT) as mediating variables between attitudes and willingness to take a travel risk.

## 1.10 General Research Overview

Based on the previous discussion of the tourism industry context and the previous literature overview, the present study follows a general research overview, as shown in Figure 1.2. This research framework is the basis for the logic and direction of the research.

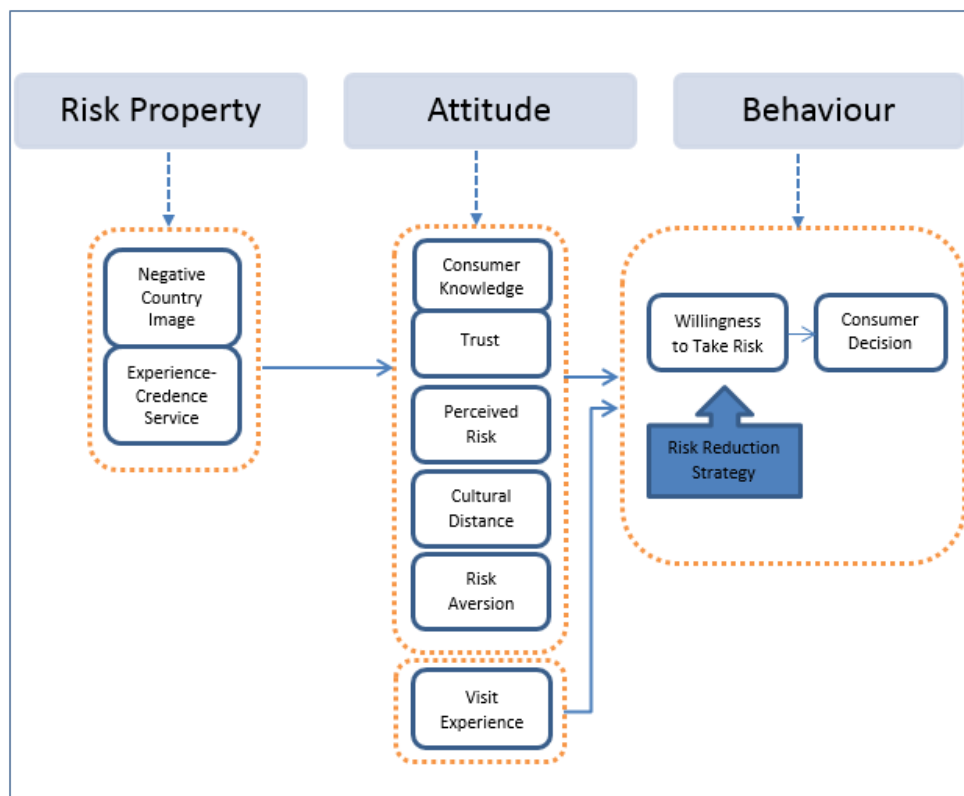


Figure 1.2. General Research Overview

### 1.10.1 The Underlying Assumptions of the General Research Framework

To generate a better understanding of the pattern of tourist behaviour in relation to tourists' decision-making process, several assumptions have been made in developing the model framework. These principles are concerned with risk properties inherent in tourism services, regardless of the main purpose of visiting a particular tourism setting. The following constitute the three main underlying principles of the model framework:

1. *A tourism purchase is a risky decision.* In general, risk is inherent in a tourism service, and this risk may determine tourist attitudes and behaviour. Such risks include physical, financial, performance, socio-psychology, and time. However, there is also a possible continuum within a tourism service that allows for different tourist attitudes and behaviours in various tourism settings, such as leisure and medical tourism. The proposed model examines the experience-credence service typology.
2. *A tourist destination decision is a high involvement decision* that requires a sequence of attitude-behaviour relationships. Although some scholars argue that tourists are not entirely rational in their decision making (Okumus et al., 2007), the present thesis assumes that many tourists are rational and that choosing a tourism destination is a high involvement decision. Choosing a destination country to visit is a facet of a destination decision that requires more careful planning than other tourist decisions such as purchasing gifts, choosing restaurants, , or selecting cultural events during the visit.
3. *Tourists are risk averse by nature* (Eugenio-Martín et al., 2004). This assumption implies that risk factors are important when tourists consider visiting a destination country. Sirakaya and Woodside (2015, p.823) suggest that “*Travel-related decisions involve high risks due to the very nature of tourism services .....*” For instance, some risk factors in tourism include physical risks (Raza & Jawaid, 2013); health risks (Larsen et al., 2007); and financial risks (Um et al, 2006). Tourists are more likely to express hesitation in visiting a risky destination country, and a risky country has an unfavourable country image (e.g., Lepp et al., 2011). Therefore, destination image is a function of consumers’ perceptions of the degree to which a particular destination country is considered to be risky.

## **CHAPTER 2**

### **DESTINATION DECISIONS IN EXPERIENCE AND CREDENCE SERVICES**

## **2.1 Abstract**

Previous studies have investigated the predictors of travel destination decisions for various purposes. However, to date, the predictors of two types of specialized tourism types, leisure (“experience”) and medical (“credence”) tourism, remain unexplored. The purpose of this study is to investigate the relative importance of destination choice predictors in leisure and medical tourism by following the framework of the experience-credence service typology. The results suggest that willingness to take risk is better measured as behaviour than as an attitude in destination decision models in the contexts of leisure and medical tourism.

## **2.2 Introduction**

This paper attempts to understand consumers' cognitive processes in deciding to travel, particularly in terms of the choice of destination. Within the tourism destination literature, the issues related to predicting tourists' intentions to travel and particular choices of destination have been discussed extensively (e.g., Floyd et al., 2004; Lin et al., 2007; Rewtrakunphaiboon & Oppewal, 2008). However, tourism decisions are complex and risky (Sirakaya & Woodside, 2005), with distinct predictors reflecting the inherent uncertainty and risk.

The main focus of this study is the role of 'willingness to take risk' (WTR) in this rather complex consumer process. There is an active debate in the literature concerning whether WTR is an attitude (Bonin et al., 2007) based on its cognitive nature (e.g., "thinking about it") or an expression of willingness to act and thus a behavioural intention (Stern et al., 1995). The latter understanding is based on the notion that an individual's willingness constitutes a conscious choice or a form of desire, i.e., "willing to do it" or "willing to act" (MacIntyre et al., 1998). The present study provides empirical evidence based on competitive hierarchical regression modelling and sheds light on the two contrasting understandings of the role of WTR in consumer choice.

This study models WTR in the context of alternative modes of tourism based on the dichotomy of experience and credence services. Beyond the tourism literature, a number of typologies of services have been proposed in the marketing and services literatures (Mitra et al., 1999). Mitra et al. (1999) developed a service typology that is based on Nelson (1970), who divided services into two categories, "search" and "experience" services. Darby and Karni (1973) extended Nelson's typology by adding the category of 'credence' services. In this context, leisure tourism can be regarded as an experience service, and medical tourism as a credence service. Credence services are services characterized by attributes that a consumer has difficulty in evaluating, even after having purchased and consumed the service

(Mitra et al., 1999). For instance, it might be difficult to evaluate the outcome of medical surgery, even after the surgical procedure has been completed. In this context, credence services rely on trust in, and the competence of, the service provider, including various aspects of the extended service package (e.g., airlines, hotel, travel agent, and adventure travel). In previous studies, health care was commonly selected as an example of credence services (e.g., Chen et al., 2008; Patterson & Smith, 2001; Shemwell et al., 1998). The present study also follows this categorization.

A number of studies have examined comparisons of consumer evaluations in the experience-credence context (Mitra et al., 1999; Patterson & Smith, 2001). Leisure and medical tourism are characterized by an added complexity, compared with simple ‘search’ services (e.g., Weathers et al., 2007). As a first-time tourist, whether for leisure or medical purposes, an exposure or experience is typically required for proper evaluation. However, previous research outside of the tourism field frequently falls short of incorporating such post-experience evaluations. The present study is designed to fill this gap and focuses explicitly on experience services (leisure tourism) and credence services (medical tourism) in identifying significant differences between the two modes in tourists’ decision making.

## **2.3 Literature Review**

Services have been categorized into three types based on the availability of information (Mitra et al., 1999) and the ability to process information prior to purchase (Alford & Sherrell, 1996). Nelson (1970) introduced the classification of product/services based on “search” and “experience” attributes, and Darby and Karni (1973) suggested the addition of the “credence” category.

- Search attributes: Consumers evaluate information or attributes before a purchase through direct inspection or readily available sources (Nelson, 1970, 1974). For



example, prior to purchase, a consumer can access information and evaluate an airline's offerings posted on its website, based on price, timetable and availability.

- Experience attributes: Consumers can only evaluate the service attributes after purchase and consumption (Nelson, 1970, 1974). The example in the current study is leisure tourism because the outcome of leisure tourism can only be discerned after visiting a destination.
- Credence attributes: Consumers are not able to evaluate the service confidently even after purchase and consumption (Darby & Karni, 1973). In the context of the present study, an example of a credence service is medical tourism, which refers to the activity of traveling to a foreign country for the primary purpose of obtaining healthcare services (Heung et al., 2010). Such services are difficult for the consumer to judge immediately after the service and often even in the longer term.

The World Tourism Organization defines tourism travel as the activity of a traveller in visiting countries or places outside their ordinary environment, mainly for leisure purposes (UNWTO, 2014). The history of tourism reveals that leisure tourism was originally a pastime of upper class society during ancient Greek and Roman times (Towner, 1995). Wealthy Greeks and Romans travelled to the Bay of Naples (Towner & Wall, 1991) to enjoy the hot springs at purposely designed spas that included luxurious rest and relaxation areas and a variety of pampering services (Altin et al., 2011). In such circumstances, the overarching purpose of tourism was to achieve pleasure and relaxation, including an increase in well-being and health (Connell, 2006). The activity of tourism is assumed to improve one's subjective well-being, which refers to *"experiencing a high level of positive affect, a low level of negative affect, and a high degree of satisfaction with one's life"* (Deci & Ryan, 2008, p.1). Subjective well-being has been commonly associated as "happiness" (Deci & Ryan, 2008) which provides a perspective on the way to promote, evaluate, and measure destination experiences (Filep, 2012). Little has changed in principle since Greek and Roman

times. Consumers are more likely to evaluate the purchase of experience services, such as leisure tourism, as relatively predictable and, in turn, as involving less risk than credence services (Mitra et al., 1999).

Conversely, medical tourism is defined as “patients leaving their country of residence outside of established cross-border care arrangements made with the intent of accessing medical care, often surgery, abroad” (Johnston et al., 2010, p.1). In typical medical tourism services, consumers cannot immediately evaluate the quality or success of service delivery even after purchase and consumption. Beyond the difficulties in evaluating the quality of medical services even when received in the home country, with respect to international medical tourism, there are additional financial, time and physical risks that accompany complications or side effects from the medical treatment. To further complicate the matter, medical services are frequently offered in emerging markets – such as Thailand, Eastern Europe or Indonesia, that often are characterized by minimal government or legal protection (Hume & Demicco, 2007). In addition, consumers may doubt the qualifications of medical staff, such as doctors and nurses, in such locations.

The historical roots of medical tourism date back to the Sumerian, Greek and even earlier civilizations and resemble in many respects the early development of leisure tourism (Altin et al., 2011). With respect to travel to health spas, the leisure and medical aspects were (and remain) inseparable. Currently, medical tourism involves “actual medical treatment” beyond the earlier concept of medical tourism as involving simple spa treatments, although they share the common purpose of improved health (Connell, 2006). Actual medical treatment includes, for example, cosmetic and dental surgery, cardio, orthopaedic and bariatric surgery, organ and tissue transplantation (Lunt & Carrera, 2010) and, more recently, fertility and parental surrogacy procedures. Such treatments involve risks that are over and above those associated with visiting a destination merely to utilize hot springs and spas.

Medical tourism is considered a niche market in the tourism industry overall (Altin et al., 2011). People with specific health issues have long travelled overseas to obtain medical treatment. Since the 1990s, however, the market for medical tourism has shifted from developed countries to developing countries, resulting in a new understanding of “medical tourism” as “people from developed countries travelling to emerging economies with the intention of combining health care with holidaying” (Altin et al, 2011, p. 2). Paradoxically, such reverse trends are in strong contrast to the generally negative perception of healthcare in developing countries (Pafford, 2009). Clearly, the cost savings that are associated with having surgery in lower-cost countries, as opposed to the home country, is the dominant consideration. Medical treatment is risky, particularly when received in developing countries. Thus, the recent growth in medical tourism merits investigation into the differences in consumer evaluations and decision making between mainstream leisure tourism and the niche market of medical tourism in the context of an emerging market such as Indonesia and a more developed neighbouring tourism market such as Singapore.

### *2.3.1 Predictors of Travel Decisions*

It has been established in the literature that the predictors of international travel decisions can be categorized into two broad sources; namely, internal factors and external factors. Internal factors refer to the personal characteristics of the traveller, and external factors generally refer to the marketing activities of tourism operators and destination country characteristics. Internal factors include psychological and psychographic factors and consumer perceptions such as destination image (Lin et al., 2007), consumer knowledge, trust (Wen, 2009), risk perception (Floyd et al., 2004), destination loyalty (Oppermann, 2000), and socio-demographic factors (Zimmer et al., 1995). External factors include predictors such as destination product characteristics (Vassiliadis, 2008), time constraints

(Thill & Horowitz, 1997) and package holiday information (Rewtrakunphaiboon & Oppewal, 2008).

The purchase of a tourism service is typically a detailed, complex and risky decision (Sirakaya & Woodside, 2005). Previous scholars have identified several risk-related factors in tourism, including consumer knowledge (Biswas et al., 2006), trust (Clancy, 1998), risk perception (Reisinger & Mavondo, 2005) and WTR (Aro et al., 2009). Previous scholars have also argued that the levels or the importance of the four internal factors of consumer knowledge and risk perception (Mitra et al., 1999), trust (Wiedenfels, 2009), and WTR differ based on the differences in the levels of risk along the continuum of experience-credence services. Therefore, in the present study, all four factors are included as potential predictors in explaining leisure (i.e., experience service) and medical tourism (i.e., credence service) decisions.

### 2.3.2 *Consumer Knowledge*

The marketing literature has extensively investigated consumer knowledge as a fundamental aspect of consumers' purchase decisions (Dodd et al., 2005). Consumer knowledge is a necessary stage or component of consumer learning (Hung & Yiyan Li, 2007; Moschis, 1981), and the effects of this prior knowledge on other consumer variables have been examined by numerous scholars (Hutchinson & Alba, 1991). Consumer knowledge is also one of the key constructs investigated in tourism research (Baloglu, 2001; Kerstetter & Cho, 2004). Consumer knowledge of tourism services is an important indicator for predicting travel decisions (Chorus et al., 2006; Zalatan, 1996).

Given that consumer knowledge is a cognitive construct that reflects a product-related experience in a consumer's memory (Schaefer, 1997), the salience of this construct is likely to depend on the service context. Dabholkar (1995) argued that a particular service situation emphasizes specific mental processes, either cognitive (a factual judgment) or

affective (an evaluative judgment). In the context of the experience-credence services distinction, it has also been argued that an individual is more likely to consider cognitive factors in the context of experience services and affective factors in credence services (Shemwell et al., 1998). It follows that consumer knowledge, as a cognitive factor, might be more influential in the consumer's leisure travel decision than in the medical tourism decision. The current study applies subjective knowledge as a reflection of attitudes (Phillips, 1993). The measurement of subjective knowledge in the current study borrows indicators from Brucks (1985).

### *2.3.3 Trust*

In previous studies, trust has been understood as an important predictor of travel decisions. A number of scholars have investigated the role of trust in the tourist decision-making process in different settings, such as online travel booking decisions (Kim et al., 2011; Wen, 2009), travel information search (Cox et al., 2009), international travel trade in business to business markets (Crotts & Turner, 1999), and group decision processes (Decrop, 2005). Some scholars have argued that "trust" is an attitude (Donaldson et al., 2008) and, therefore, that trust can be treated within the framework of the theory of reasoned action (Ajzen & Fishbein, 1980) as an attitude toward action. When consumers face a risky choice, they require a certain level of trust to address the uncertainty (Chaudhuri & Holbrook, 2001) and to make a decision (Matzler et al., 2008). Trust is considered an effective mental shortcut (Matzler et al., 2008) in conducting a product or service evaluation, particularly in complex decision-making processes such as leisure and medical tourism.

Trust is also an indicator that has been used to evaluate the extent of service quality (Chen et al., 2006). The established SERVQUAL model encompasses the quality of a service with respect to facets of tangibility, reliability, responsiveness, assurance and empathy (Parasuraman et al., 1988), and trust is particularly important in evaluating service in terms

of the dimensions of reliability (Kim et al., 2011) and assurance (Fick & Ritchie, 1991). The SERVQUAL dimensions have been probed for their role in evaluating services. Such research has found that empathy is a predictor of willingness to recommend and long-term intentions and that responsiveness significantly explains short-term behavioural intentions (Baumann et al., 2007). Trust is not always a key driver of customer loyalty, for example, because it is often overpowered by satisfaction measures, especially in “experience” services. In contrast, trust is likely to be far more influential in “credence services”. Nonetheless, trust is likely to be correlated with consumer choice decisions in the contexts of both leisure and medical tourism.

The importance of trust is also a function of the purchasing context, such as the type of product or service purchased (Wiedenfels, 2009). Following Mayer et al. (1995), the risk that is associated with a particular product or service might distinguish the relevance of trust as a predictor of purchasing behaviour. Wiedenfels (2009) argues that a ‘credence’ service is riskier than an ‘experience’ good or service; therefore, the effect of trust is stronger for ‘credence’ than for ‘experience’ goods or services. The same principle also applies in the context of leisure and medical tourism, in which it is more difficult to evaluate the outcome and quality of medical tourism than leisure tourism. It follows that trust is likely to be more important in the uncertain circumstances that typically characterize medical tourism. For instance, some issues of post-surgery procedures have been found to increase the outcome uncertainty of medical tourism services (Herrick, 2007). The trust measurement in the current study applied items that were used in Kim et al. (2011), Dahlstrom and Nygaard (1995), and Doney and Cannon (1997).

#### *2.3.4 Risk Perception*

In 1960, Bauer introduced the concept that consumer behaviour involves some degree of risk and that every consumer must face the consequences of their decisions (Stone

& Grønhaug, 1993). Risk perception arises from the uncertainty of *a priori* probabilities of specific outcomes that are associated with a choice (Kim, 2008) and the adverse consequences of buying a product or service (Murray, 1991). In consumer behaviour, risk perception focuses on the negative consequences of buying decisions (Stone & Grønhaug, 1993). Negative consequences from the purchase lead to unrealized expected satisfaction (Stone & Grønhaug, 1993).

Risk perception has been investigated in comparisons between various types of experience-credence services (Mitra et al., 1999). By applying the measurement from Murray & Schlacter (1990), Mitra et al. (1999) found that risk perception increases in the case of credence services compared with experience services. Notwithstanding this distinction, there has been little investigation to date of the risk perceptions involved in experience services (e.g., leisure tourism) compared with those of credence services (e.g., medical tourism) in the tourism literature.

#### 2.3.5 *Willingness to Take Risk (WTR)*

As previously outlined, this study sheds light on the scholarly debate concerning whether WTR is more properly viewed as an attitude or as a behavioural intention. According to the first perspective, the construct is positioned as an attitude toward risk (Bonin et al., 2007). This view assumes that consumers objectively evaluate risk as an attitude along a continuum, either positively or negatively, and express high or low WTR when they are in favour, or not in favour, of risk. In this sense, WTR is viewed as a predisposition to risk. This view considers WTR in general without relating it to the specific context in which the risk occurs. The second view of WTR involves viewing or considering attitudes toward risk in specific behavioural contexts, such as the decision to hold shares, become self-employed, participate in sports, or smoke (Dohmen et al., 2011). The second perspective considers WTR to be an attitude toward behaviour and a reliable predictor of

corresponding specific risk-taking behaviour (Dohmen et al., 2011). This latter view is consistent with the principle of attitude toward behaviour expressed in the theory of reasoned action (Ajzen, 1988).

However, a contrasting view is that of WTR as a behavioural construct rather than as an attitude. Nicholson et al. (2005, p.171) proposed a definition of WTR as “a combination of emotional coolness, toughness, activity and a tendency to casualness about control and rules.” This definition views WTR in a behavioural domain (i.e., an activity and tendency to casualness about control and rules). Furthermore, Grable and Roszkowski (2008) applied Grable and Lytton’s (1999) 13 indicators that covered both attitudes and behaviour to measure the construct. The notion of WTR as a behavioural construct arises from the principle that WTR can be positioned in the domain of willingness or preparedness to act (Stern et al., 1995). Goffman (1967, p.ix) suggests gambling is an example of risk taking behaviour as an “action” in which “*activities that are consequential, problematic, and (are) undertaken for what is felt to be their own sake*” (Goffman, 1967, p.185). Some scholars use the construct interchangeably with other constructs such as “risk propensity”, “willingness to accept risk”, “risk tolerance” and “willingness to bear risk” (Grable & Roszkowski, 2008). Among the various possible domains of WTR, the present study treats WTR as a behavioural intention. This latter position is examined through the following model development.

Based on the aforementioned literature review, the present study employs two models of WTR. These models are followed by the formulation of respective hypotheses for each model. The first model treats WTR as an independent variable in a hierarchical model of attitudes. In line with the theory of the reasoned action framework (Ajzen & Fishbein, 1980), the second model treats WTR as a mediating variable and as an expression of behavioural intention. Thus, this study tests competing models of WTR, i.e., the (attitudinal) hierarchical and (behavioural) mediating models.



### 2.3.6 Stage 1 – Hierarchical Model Testing

The hierarchical model (Figure 2.1) assumes that consumer knowledge, trust, risk perceptions, and WTR are found in the attitude domain and are direct predictors of destination decisions concerning leisure and medical tourism. The current study applies a hierarchical multiple regression analysis to measure the contribution of each independent variable in explaining the variance in the dependent variable, destination decisions. Hierarchical multiple regression analysis accommodates an alternative method, in addition to comparing beta coefficients, that assesses the importance of independent variables through an increase in R-square when an independent variable is inserted into a regression equation (Ho, 2006). The order of entry for each independent variable should follow logical or theoretical considerations (Boo & Busser, 2005).

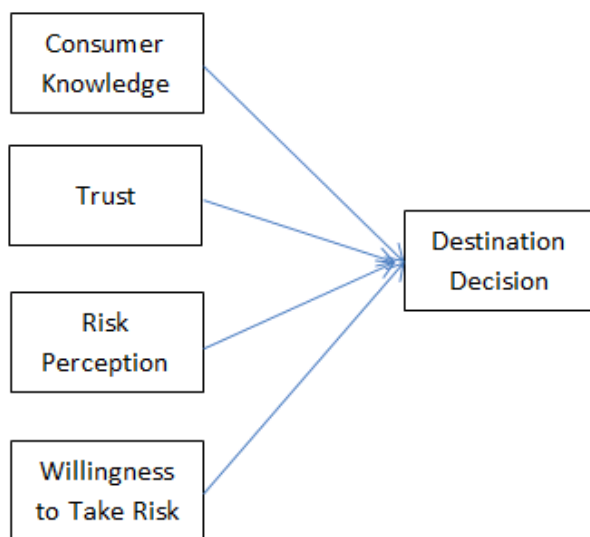


Figure 2.1. Hierarchical Model Framework with Four Direct Predictors

This study follows Baron and Kenny (1986) and McCullough et al. (1997), who suggest identifying the potential existence of a mediating variable by using hierarchical model testing. To demonstrate a mediating relationship, three steps are required when using hierarchical regression analysis. First, a causal model that examines the independent

variables of the three attitude variables and the mediating variable of WTR is tested. Second, a regression model of the direct relationship between attitude variables and the criterion variable of destination decisions is expected to be significant. Finally, a test of the mediation effect of WTR on the regression model between attitude variables and destination decisions is required to demonstrate evidence of significant relationships.

### 2.3.7 Stage 2 – Mediating Model Testing

The subsequent model (Figure 2.2) tests WTR as a mediating variable. Although there is a lack of rigorous consensus regarding the domain of WTR, the present study tests alternative views of the WTR construct, namely, as an attitude or as a behaviour (Grable & Roszkowski, 2008). Following the theory of reasoned action framework, Hypothesis 1 examines the possibility that WTR is better conceptualized as an expression of “behavioural intention”. In this test, the effects of the independent variables on destination decisions are hypothesized as follows.

*Hypothesis 1:* WTR is better measured as a behaviour than as an attitude in destination decision models in leisure and medical tourism settings.

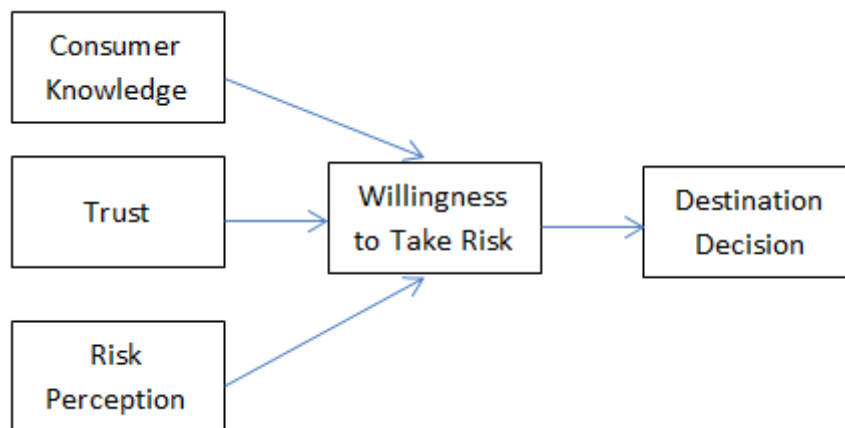


Figure 2.2. Mediating Model Framework with WTR as a Mediator

## 2.4 Method

This study focuses on the antecedents of consumers' tourism decision making, which involves perception and attitude constructs. To explore tourists' decision making and to test the above hypotheses, an online survey was conducted in Australia in February 2013 using a national consumer panel. In total, 511 respondents evaluated leisure and medical tourism in Indonesia and a separate 513 respondents evaluated leisure and medical tourism in Singapore. The consumer panel was facilitated by GMI (Global Market Insite, Inc.) and included respondents from the general population across states in Australia. The on-line survey design and methodology prompted respondents to fill out all the answers. Therefore, there were no missing values. Prior to further data analysis, outliers were checked by using a box and whisker plot analysis. As a result, the outliers were omitted and excluded from further analysis. Data were also checked for the issues of autocorrelation and multicollinearity (see Tables 2.1 and 2.2). A Durbin-Watson statistic test was applied to indicate whether the issue of autocorrelation exists in the regression analysis. The results of the Durbin-Watson 'd' across the settings of leisure and medical tourism in Indonesia and Singapore range from 1.967 to 2.159 (see Tables 2.1 and 2.2). Given that the range is between two critical values of  $1.5 < d < 2.5$  (Ho, 2014), it can be assumed that there is no issue of autocorrelation (i.e., independence of residuals) across all the tourism settings. In addition, the multicollinearity issue occurred in the hierarchical model when the fourth predictor (i.e., willingness to take a risk) was included in the model ( $CI > 15$ ), providing an early indication of the need for a better model alternative instead of the hierarchical model.

Table 2.1  
*Testing on the Assumptions of Independence of Error Terms and Multicollinearity - Indonesia*

Predictor	Condition Index (CI)	Durbin Watson
<i>Hierarchical leisure model - Indonesia<sup>a</sup></i>		
Constant	1.000	
Consumer Knowledge	4.165	
Trust	6.585	
Perceived Risk	9.114	
Willingness to Take Risk	<b>17.289</b>	2.103
<i>Hierarchical Medical Model - Indonesia<sup>a</sup></i>		
Constant	1.000	
Consumer Knowledge	4.575	
Trust	5.745	
Perceived Risk	7.469	
Willingness to Take Risk	<b>18.928</b>	2.038

a. Dependent variable: destination decisions

Table 2.2  
*Testing on the Assumptions of Independence of Error Terms and Multicollinearity - Singapore*

Predictor	Condition Index (CI)	Durbin Watson
<i>Hierarchical leisure model - Singapore<sup>a</sup></i>		
Constant	1.000	
Consumer Knowledge	4.658	
Trust	7.634	
Perceived Risk	10.133	
Willingness to Take Risk	<b>17.371</b>	2.159
<i>Hierarchical Medical Model - Singapore<sup>a</sup></i>		
Constant	1.000	
Consumer Knowledge	5.167	
Trust	5.992	
Perceived Risk	8.352	
Willingness to Take Risk	<b>15.981</b>	1.967

a. Dependent variable: destination decisions

An online or internet survey design is a popular tool for data collection (Tierney, 2000), especially because they are commonly regarded as convenient and efficient in terms of time and cost (Buchanan & Hvizdak, 2009). However, there are some potential research ethics issues regarding online surveys including “...privacy, informed consent, ownership, recruitment, public versus private spaces, and research and scientific integrity itself” (Buchanan & Hvizdak, 2009, p.37). Other issues are non-response bias and low response rates (Tierney, 2000). Interestingly, the online survey design has become popular in tourism

research (Dolnicar, Laesser, & Matus, 2009). Having considered all the aforementioned benefits and potential problems, this study applied an online survey design due to the benefits of short time, low cost, and timely results when considered with some of the response and error issues associated with other types of survey designs.

In order to provide more insight into the predictors, the current study collected qualitative responses through open ended questions before respondents filled out the complete questionnaires. The respondents answered the questions “What are the first things that come to your mind when you think about Indonesia or Singapore as a travel destination? What are the advantages and drawbacks of Singapore or Indonesia as a travel destination?” The responses are categorised based on whether they fit into a particular predictor.

The measures and scales were taken from previous studies; however, several were modified for purposes of the current research (See Appendix 2.1). The structure of the questionnaire included two items of consumer knowledge (Brucks, 1985), three items of trust (Dahlstrom & Nygaard, 1995; Doney & Cannon, 1997; Kim et al., 2011), nine items of risk perception (Fuchs & Reichel, 2006), one item of WTR (Dohmen et al., 2011) and three items of consumer decision (Hanzaee & Khosrozadeh, 2011). All items were adapted from the original sources to fit the tourism context. The responses for each variable were measured using a 5-point Likert scale (1=Strongly disagree; 5=Strongly agree).

Each variable in the model has a different number of constituent items; however, a hierarchical multiple regression analysis requires only one composite or an average score for each variable under investigation. Previous studies have also tested variables in their models with various numbers of measurement items (Boo & Busser, 2005). Specifically, a variable with a single item of measurement such as WTR was applied in previous research and generated behavioural validity (Dohmen et al., 2011).

Prior to conducting the hierarchical regression, validity and reliability were tested by using factor analysis and Cronbach’s alpha test (reliability). Table 2.3 shows the results of

the validity and reliability tests for each predictor. The Kaiser-Meyer-Olkin values are between 0.871 to 0.917 and a significant probability level ( $p < 0.001$ ) for the Bartlett's test of all constructs across both types of tourism service. These indicate that the correlation is sufficient within the correlation matrix for the factor analysis to proceed.

Table 2.3

*Convergent Validity and Reliability Test for Predictors of Destination Decisions*

Factor	Load Factor 1	Load Factor 2	Load Factor 3	Load Factor 4	Cronbach's $\alpha$
<b>LEISURE TOURISM</b>					
Factor 1 - Consumer Knowledge <ul style="list-style-type: none"> <li>I am familiar with leisure tourism.</li> <li>I have had experience with leisure tourism.</li> </ul>			0.821 0.852		0.743
Factor 2 - Trust <ul style="list-style-type: none"> <li>In general, leisure tourism is reliable.</li> <li>I generally trust leisure tourism.</li> <li>I believe the information regarding leisure tourism.</li> </ul>		0.865 0.868 0.861			0.952
Factor 3 - Risk Perception <ul style="list-style-type: none"> <li>I worry that I would not receive good value for my money.</li> <li>I worry that accommodations would be unsatisfactory.</li> <li>I worry that the facilities would not be acceptable.</li> <li>I worry that employees in leisure tourism would not be courteous.</li> <li>I worry that employees in leisure tourism would not be professional.</li> <li>I worry that I might not be personally satisfied with a trip to Singapore/Indonesia.</li> <li>I worry that preparation for visiting Singapore/Indonesia for leisure would take too much time.</li> </ul>	0.804  0.857 0.864  0.846  0.853  0.780  0.806				0.944
Factor 4 - Willingness to Take Risk <ul style="list-style-type: none"> <li>I am willing to take a risk visiting Singapore/Indonesia for leisure purposes.</li> </ul>				0.856	
<b>MEDICAL TOURISM</b>					
Factor 1: Consumer Knowledge <ul style="list-style-type: none"> <li>I am familiar with medical tourism.</li> <li>I have had experience with medical tourism.</li> </ul>			0.877 0.816		0.651
Factor 2: Trust <ul style="list-style-type: none"> <li>In general, medical tourism is reliable.</li> <li>I generally trust medical tourism.</li> <li>I believe the information regarding medical tourism.</li> </ul>		0.887 0.914 0.880			0.950
Factor 3 - Risk Perception <ul style="list-style-type: none"> <li>I worry that I would not receive good value for my money.</li> <li>I worry that accommodations would be unsatisfactory.</li> <li>I worry that the facilities would not be acceptable.</li> <li>I worry that employees in medical tourism would not be courteous.</li> <li>I worry that employees in medical tourism would not be professional.</li> <li>I worry that I might not be personally satisfied with a trip to Singapore/Indonesia.</li> <li>I worry that preparation for visiting Singapore/Indonesia for medical treatment would take too much time.</li> </ul>	0.769  0.829 0.812  0.771  0.786  0.778  0.769				0.917
Factor 4 - Willingness to Take Risk I am willing to take a risk visiting Singapore/Indonesia for medical purposes.				0.857	



## 2.5. Results

The respondents of this study were first divided into two groups that evaluated leisure and medical tourism in Indonesia (n=511) and Singapore (n=513). Details of the participants' socio-demographic profiles are shown in Table 2.4, offering evidence of a reasonably balanced sample with no evidence of extreme cases.

Table 2.4  
*Socio-Demographic Profiles of Respondents*

No	Variable	Category	Indonesia	%	Singapore	%
1	Gender	Male	202	39.5	191	37.2
		Female	309	60.5	322	62.8
2	Age	18-30	54	10.6	50	9.7
		31-43	98	19.2	94	18.3
		44-56	139	27.2	138	26.9
		57-69	152	29.7	178	34.7
		>70	68	13.3	53	10.3
3	Education	Primary School	5	1.0	5	1.0
		High School or Equivalent	183	35.8	178	34.7
		Vocational College	153	29.9	174	33.9
		Bachelor's Degree	138	27.0	107	20.9
		Master's Degree or Above	32	6.3	49	9.6
4	Income	Under \$20,000	63	12.3	52	10.1
		\$20,000 to less than \$40,000	114	22.3	129	25.1
		\$40,000 to less than \$60,000	94	18.4	101	19.7
		\$60,000 to less than \$80,000	88	17.2	77	15.0
		\$80,000 to less than \$100,000	50	9.8	71	13.8
		\$100,000 and over	102	20.0	83	16.2

### *2.5.1. Hierarchical Model Testing*

The following analyses and discussion focus on the individual contributions of attitude variables in explaining choices in leisure and medical tourism destinations. Following hierarchical regression, as exhibited in Table 2.5 for Indonesia and Table 2.6 for Singapore (models 1 to 4), the measure of contribution is determined by the coefficient of determination of each independent variable. The hierarchical model encompasses the process of inclusion for each predictor: column  $\Delta R^2$  shows the r-squared contribution for each independent variable of destination decisions. Each predictor was entered into the equation based on the following logic, and the process was identical for both Indonesia and Singapore:

1. Consumer knowledge (Model 1): Existing knowledge about the travel destination is the basis for the regression analysis. In essence, this is the consumer's knowledge regarding the destination country.
2. Trust (Model 2): After the consumer has 'digested' the knowledge, a level of trust is established. Therefore, this variable was entered next.
3. Risk perception (Model 3): After trust formation, a shadow of doubt may emerge in the consumer's perception of the country destination, resulting in a perception of risk. This was entered next.
4. Willingness to take risks (Model 4): A reflection of the respondent's preparedness to take risks associated with the country destination was entered as the final variable in the hierarchical regression.

The results indicate that when WTR is included in Model 4, the contribution of risk perception for destination decisions becomes non-significant. This result implies the

possible existence of a mediating variable or relationship. Further mediating model testing was conducted using the three-stage procedure of Baron and Kenny (1986).

Table 2.5

*Hierarchical Model for Destination Decisions Regarding Leisure and Medical Tourism in Indonesia*

Predictor	Model 1	Model 2	Model 3	Model 4	$\Delta R^2$
	Beta (Sig.)	Beta (Sig.)	Beta (Sig.)	Beta (Sig.)	
Hierarchical leisure model - Indonesia <sup>a</sup>					
Consumer Knowledge	0.508 ( $<.001$ )	0.248 ( $<.001$ )	0.231 ( $<.001$ )	0.132 ( $<.001$ )	0.258 ( $<.001$ )
Trust		0.494 ( $<.001$ )	0.430 ( $<.001$ )	0.189 ( $<.001$ )	0.177 ( $<.001$ )
Perceived Risk			-0.131 (.001)	-0.041 (.220)	0.012 ( $<.001$ )
Willingness to Take Risk				0.567 ( $<.001$ )	0.190 ( $<.001$ )
R2	0.258	0.435	0.446	0.636	
Adj. R2	0.257	0.432	0.443	0.633	
F	176.966 ( $<.001$ )	195.227 ( $<.001$ )	136.163 ( $<.001$ )	220.917 ( $<.001$ )	
df1	1	1	1	1	
df2	509	508	507	506	
Hierarchical Medical Model - Indonesia <sup>a</sup>					
Consumer Knowledge	0.339 ( $<.001$ )	0.180 ( $<.001$ )	0.183 ( $<.001$ )	0.086 (.006)	0.115 ( $<.001$ )
Trust		0.485 ( $<.001$ )	0.434 ( $<.001$ )	0.204 ( $<.001$ )	0.210 ( $<.001$ )
Perceived Risk			-0.095 (0.027)	-0.020 (0.559)	0.007 (0.027)
Willingness to Take Risk				0.583 ( $<.001$ )	0.237 ( $<.001$ )
R2	0.115	0.325	0.331	0.569	
Adj. R2	0.113	0.322	0.327	0.565	
F	65.947 ( $<.001$ )	122.133 ( $<.001$ )	83.705 ( $<.001$ )	166.799 ( $<.001$ )	
df1	1	1	1	1	
df2	509	508	507	506	

a. Dependent variable: destination decisions

Table 2.6  
*Hierarchical Model for Destination Decisions Regarding Leisure and Medical Tourism in Singapore*

Predictor	Model 1 Beta (Sig.)	Model 2 Beta (Sig.)	Model 3 Beta (Sig.)	Model 4 Beta (Sig.)	$\Delta R^2$
Hierarchical Leisure Model - Singapore <sup>a</sup>					
Consumer Knowledge	0.483 ( $<.001$ )	0.196 ( $<.001$ )	0.199 ( $<.001$ )	0.102 (0.013)	0.233 ( $<.001$ )
Trust		0.471 ( $<.001$ )	0.42 ( $<.001$ )	0.294 ( $<.001$ )	0.140 ( $<.001$ )
Perceived Risk			-0.109 (0.006)	-0.064 (0.073)	0.009 (0.006)
Willingness to Take Risk				0.401 ( $<.001$ )	0.111 ( $<.001$ )
R2	.233	.373	.383	.494	
Adj. R2	.231	.371	.379	.490	
F	155.109 ( $<.001$ )	151.820 ( $<.001$ )	105.107 ( $<.001$ )	123.902 ( $<.001$ )	
df1	1	1	1	1	
df2	511	510	509	508	
Hierarchical Medical Model - Singapore <sup>a</sup>					
Consumer Knowledge	0.315 ( $<.001$ )	0.166 ( $<.001$ )	0.177 ( $<.001$ )	0.069 (0.041)	0.099 ( $<.001$ )
Trust		0.465 ( $<.001$ )	0.438 ( $<.001$ )	0.247 ( $<.001$ )	0.194 ( $<.001$ )
Perceived Risk			-0.071 (0.073)	0.023 (0.486)	0.004 (0.073)
Willingness to Take Risk				0.557 ( $<.001$ )	0.229 ( $<.001$ )
R2	.099	.293	.298	.526	
Adj. R2	.098	.290	.293	.523	
F	56.354 ( $<.001$ )	105.736 ( $<.001$ )	71.870 ( $<.001$ )	141.159 ( $<.001$ )	
df1	1	1	1	1	
df2	511	510	509	508	

a. Dependent variable: destination decisions

### 2.5.2 *Mediating Model Testing*

Following Baron and Kenny (1986), three steps were executed to test the mediating variable (WTR) (Tables 2.7 and 2.8). The first stage examined the causal relationship between the independent variables and the destination decisions. The results reveal that consumer knowledge, trust, and risk perception significantly influence destination decisions to visit Indonesia and Singapore for leisure and medical tourism. The next stage involved testing whether all independent variables significantly influence WTR. The results demonstrate that consumer knowledge, trust, and risk perception significantly influence WTR for leisure and medical tourism in Indonesia and Singapore. The last stage was to provide evidence that the mediating variable remains significant when controlling for each independent variable. The findings indicate that WTR significantly influences destination decisions. The results of testing the three regression equations indicate that all the predictors in question significantly influence the dependent variables, thus confirming the validity of WTR as a mediating variable. Therefore, Hypothesis 1 is supported.

Table 2.7

*Mediating Model for Destination Decisions Regarding Leisure and Medical Tourism in Indonesia*

Predictor	Beta (Sig.)		R <sup>2</sup>
Mediating Leisure Model - Indonesia			
Consumer Knowledge	0.231 <sup>a</sup> ( $<.001$ )	0.174 <sup>b</sup> ( $<.001$ )	0.411
Trust	0.430 <sup>a</sup> ( $<.001$ )	0.425 <sup>b</sup> ( $<.001$ )	
Perceived Risk	-0.131 <sup>a</sup> (0.001)	-0.159 <sup>b</sup> ( $<.001$ )	
Willingness to Take Risk		0.761 <sup>a</sup> (0.000)	0.580
Mediating Medical Model - Indonesia			
Consumer Knowledge	0.183 <sup>a</sup> ( $<.001$ )	0.166 <sup>b</sup> ( $<.001$ )	0.301
Trust	0.434 <sup>a</sup> ( $<.001$ )	0.394 <sup>b</sup> ( $<.001$ )	
Perceived Risk	-0.095 <sup>a</sup> (0.027)	-0.128 <sup>b</sup> (0.003)	
Willingness to Take Risk		0.723 <sup>a</sup> ( $<.001$ )	0.522

a. Dependent variable: destination decisions

b. Dependent variable: willingness to take risk

Table 2.8

*Mediating Model for Destination Decisions Regarding Leisure and Medical Tourism in Singapore*

Predictor	Beta (Sig.)		R <sup>2</sup>
Mediating Leisure Model - Singapore			
Consumer Knowledge	0.199 <sup>a</sup> ( $<.001$ )	0.242 <sup>b</sup> ( $<.001$ )	0.308
Trust	0.42 <sup>a</sup> ( $<.001$ )	0.314 <sup>b</sup> ( $<.001$ )	
Perceived Risk	-0.109 <sup>a</sup> (0.006)	-0.111 <sup>b</sup> (0.008)	
Willingness to Take Risk		0.619 <sup>a</sup> ( $<.001$ )	0.383
Mediating Medical Model - Singapore			
Consumer Knowledge	0.177 <sup>a</sup> ( $<.001$ )	0.195 <sup>b</sup> ( $<.001$ )	0.263
Trust	0.438 <sup>a</sup> ( $<.001$ )	0.343 <sup>b</sup> ( $<.001$ )	
Perceived Risk	-0.071 <sup>a</sup> (0.073)	-0.170 <sup>b</sup> ( $<.001$ )	
Willingness to Take Risk		0.685 <sup>a</sup> ( $<.001$ )	0.469

a. Dependent variable: destination decisions

b. Dependent variable: willingness to take risk

## 2.6. Discussion

This study's objective is to contribute to the debate on the role of WTR in the choice regarding the country of destination. To summarize, there is no clear agreement in the literature regarding whether WTR should be treated as an attitude (Bonin et al., 2007) or as a behavioural intention (Stern et al., 1995). The present study sheds light on this important issue and concludes, after testing both versions, that WTR is better treated and measured as a behavioural intention. This finding makes an important contribution to theory because future research can now more comfortably model WTR as a behavioural intention, resulting in stronger predictive models of country of destination choice.

The present finding also has practical implications. If WTR was an attitude, as has been proposed by Bonin et al. (2007), then the link to consumer choice would be immediate because there is no intervening variable. However, that is not the case, and WTR is better viewed as a behavioural intention. In addition, the association between consumer knowledge, trust and risk perception is mediated by WTR regarding destination decisions. This framework thus sees WTR intervening prior to action (e.g., booking the trip). Consumers are more hesitant to act fast and book their journey to perceived risky destinations such as Indonesia and Singapore.

This study analysed the degree of mediation (presented in Appendix 2.2) for the WTR construct and provides evidence that the effect is rather strong for Indonesia. This result indicates that Australian consumers are hesitant in regards to Indonesian tourism, including (and possibly in particular) medical tourism. However, the mediating effect was not as strong in the case of Singapore leisure tourism, which indicates that Singapore is considered a less risky destination.

This study chose Indonesia and Singapore as destination countries based on the assumption that they are geographically close but have distinct characteristics. Indonesia is a much larger country than the city-state of Singapore. Singapore is an exciting East meets West metropolis, but Indonesia has much more variety, particularly in regards to its attractiveness for leisure tourism, with its 13,466 islands (Menkokesra, 2012). In addition, Singapore is considered a benchmark for tourism competitiveness in the Southeast Asia region (World Economic Forum, 2015). For credence, or medical tourism, Singapore was expected to enjoy a strong advantage given that the country has reached a highly advanced stage of economic development and offers a world-class medical and tourism infrastructure. The country is also clean and orderly. Indonesia, by contrast, is an emerging market and is perceived to be a 'risky' country in the eyes of the Australian consumers sampled here.



This study found that Australian consumers display only modest consumer knowledge about the two countries of destination, coupled with great scepticism (regarding terrorism, hygiene, safety and security, and infrastructure), resulting in an overpowering dependence on trust. This study did not test whether a more positive perception occurs for Western countries, such as the US.

For the tourism sector, this study suggests that the key focus for emerging markets such as Indonesia should be establishing and growing trust. Consumers may have a biased view based on the largely negative media coverage about such markets; however, the potential for leisure tourism is substantial. Notwithstanding, the limitations of medical tourism are substantial. Although Singapore may have world-class infrastructure and medical services, these features do not substantially differentiate Singapore from Indonesia in the perceptions of Australian consumers. Future research should explore the extent to which this finding is also true for other markets with a strong focus on medical tourism such as Thailand, South Korea, China and India. It is also acknowledged, however, that Singapore is likely to rank high among consumers who are actively considering medical tourism.

As shown in Tables 2.7 and 2.8, consumer knowledge, trust and risk perception are significant predictors of destination decisions based on the mediating model. Consumer knowledge significantly influences destination decisions, although respondents stated that they have little knowledge of tourism in Indonesia or Singapore. The respondents have a certain amount of knowledge regarding Indonesia or Singapore, which has generally been acquired through their friends, relatives and possibly some limited exposure when in airport transfer. Indonesia is well known, but mostly because Bali is a dominant popular tourism destination with leisure activities, shopping, food, and cultural products. However, knowledge of Indonesian medical tourism is negligible. By contrast, the respondents associate Singapore with shopping, food and leisure tourism icons. As is the case with respect to Indonesian medical tourism services, respondents have limited knowledge about

medical tourism in Singapore. In turn, the limited knowledge about tourism services might reduce the importance of consumer knowledge in influencing destination decisions for both leisure and medical purposes.

The predictor of trust is a key determinant in consumers' travel decisions for both leisure and medical purposes. Trust displays the greatest effects (i.e., the greatest beta) on destination decisions in both leisure and medical tourism contexts through WTR as a mediating variable. Although the experience-credence typology suggests that medical tourism is riskier than leisure tourism, the results suggest that both types of tourism services are regarded as high involvement services (see Assael, 2005). In particular, trust occupies the same prominent role in destination decisions when respondents have limited knowledge of both leisure and medical tourism services (Clancy, 1998). In the context of Indonesian tourism, a small proportion of respondents were concerned with the reliability of Indonesian government officials and law enforcement. They were also concerned with the availability and reliability of basic services and facilities, such as safe food and water. In relation to medical tourism, the findings indicate that respondents were concerned with the reliability of medical services. Similarly, a small percentage of respondents raised issues about tourism in Singapore, such as the reliability of government officials, product delivery and the availability of basic needs, such as food and water.

Mitra et al. (1999) suggest that credence services, such as medical tourism, involve more uncertainty (due to higher levels of customization, personal intervention of providers, and uncertainties regarding actual cost and performance, which all lead to less knowledge of, and confidence in, medical tourism services). It is hardly surprising that respondents rely on trust in such circumstances, particularly when they are not familiar with the medical tourism service. It is important for the individual to trust that a medical service in a foreign country is of high quality and that the information available regarding medical tourism is reliable because trust rises in importance when an individual faces uncertainty and a lack of

information in evaluating the service or when the consequences of a poor service outcome are potentially serious.

The third predictor, risk perception, significantly influences destination decisions for leisure and medical purposes. Respondents evaluated both Indonesia and Singapore using several facets of risk perception. In the context of Indonesia, respondents were concerned with the issue of personal health and safety due to potential terrorist attacks, natural disasters, petty theft, and food and water hygiene (physical risk). In terms of performance risk, responses were mixed in that respondents have positive views toward Indonesian hospitality, cultural uniqueness and cuisine. By contrast, they perceived that Indonesia, as a destination, lacked cleanliness and had uncomfortable weather (hot and humid) and traffic jams. Australian respondents have positive perceptions regarding minimal travel time and distance and low financial risk in the affordable prices for transportation, accommodation and food. The results indicate that respondents perceived a low physical risk in Singapore as a travel destination due to a limited number of issues of safety and security. As with Indonesia, respondents provided mixed responses concerning the performance risk of Singapore tourism. They appreciated the cleanliness, the quality of public transport and accommodation and local hospitality. However, they are not attracted to the hot and humid weather, overcrowding, and limited tourism attractions. As with Indonesia, the respondents regarded Singapore as convenient in time and distance, although they believe that shopping and accommodation in Singapore are expensive.

This study has broken new ground by comparing leisure and medical tourism from an Australian consumer perspective. Hierarchical model testing confirmed the role of WTR as an expression of “behavioural intention” rather than as an “attitude”. For leisure and medical tourism, trust is a main driver when mediated by WTR. Trust overpowers consumer knowledge when consumers make a decision regarding their leisure destination. At the same

time, this finding is not true for medical tourism, where trust is the key predictor of destination decisions.

Trust is such an important factor because Australian consumers generally know little about Indonesia and Singapore tourism, in terms of both leisure and medical services. In other words, when consumer knowledge is low, trust becomes crucial. Roughly three-quarters (60%) of the sample had not had exposure to Indonesia or Singapore. Such lack of familiarity may explain the importance of trust, at least in part, because knowledge is consequentially limited due to such low exposure. Simultaneously, this lack of familiarity or experience is likely to explain respondents' inability to differentiate between Indonesia and Singapore.

The respondents' limited knowledge or experience may have resulted in an equalizing effect for the experience and credence service decision, leading consumers to view the clearly more risky medical service on par with the clearly less risky leisure tourism. It appears that these consumers are ultimately unable to grasp the different risks associated with such different types of services. Consumer knowledge (or lack of it) counteracts the effects of risk on destination decisions for both leisure and medical tourism. This situation is also potentially caused by the issue of the low value of construct reliability and is one limitation of this study.

Another limitation of this study is that the information was collected from only one country (i.e., Australia). Although the sample was broadly representative, it is possible that respondents from different countries may yield different results. Therefore, the generalizability of the findings must be examined in future studies. However, other Western markets might be expected to reveal similar results, given the global convergence of media (e.g., CNN, BBC), such that viewers worldwide hear/see the same news about Indonesia or Singapore. In addition, two contexts (leisure and medical tourism) were chosen to represent experience and credence services. The additional context of "search" services could also be

applied based on consumers' use of online travel search and booking systems for airline, resort or hotel services. It is also worthwhile to test the variety of responses based on visit experiences, cultural factors and specific risk-taking behaviours to better understand segment attitudes and behaviour.

A further possible extension is to choose tourism services from countries or destinations with similar and competitive images, for example, Bali (Indonesia), Penang (Malaysia) and Phuket (Thailand) to test whether similar differences might occur in similar competitive situations. Indeed, the work can also be extended by a comparison with markets at different levels of competitiveness. For example, a new key player is the Middle East, which has substantial resources (e.g., Dubai, where religion could be explored as a factor); Thailand, which is an early provider of medical services and, therefore, well established; and Korea, which is a new provider of medical tourism but typically has high product and service quality as a result of a rather competitive market orientation. China could also be examined in a comparison study, as it is the strongest emerging market and has one of the strongest growing tourism sectors (both in- and out-bound).

As tourism services for both leisure and medical services are increasingly important for many countries such as Indonesia and Singapore, the results of this study may provide interesting and useful input for government and private tourism management organizations. Given the low perceptions of Indonesia and Singapore as medical tourism destinations and the fact that there was little differentiation evident in the data, there is a substantial need for improved branding at both the national and micro (e.g., firm, hospital, doctor, and beauty clinic) levels in both Indonesia and Singapore. This is particularly true given the competitive nature of the market with the aforementioned globally established and emerging key players.

## APPENDIX 2.1 - Questionnaires

### Consumer knowledge

1. I am familiar with [leisure/medical tourism] in [Singapore/Indonesia].
2. I have had experience with [leisure/medical tourism] in [Singapore/Indonesia].

### Trust

1. In general, [leisure/medical tourism] in [Singapore/Indonesia] is reliable.
2. I generally trust [leisure/medical tourism] in [Singapore/Indonesia].
3. I believe the information regarding [leisure/medical tourism] in [Singapore/Indonesia].

### Risk Perception

1. I worry that I would not receive good value for my money when I visit [Singapore/Indonesia] for [leisure/medical purposes].
2. I worry that accommodation for [leisure/medical tourism] in [Singapore/Indonesia] would be unsatisfactory.
3. I worry that the facilities for [leisure/medical tourism] in [Singapore/Indonesia] would not be acceptable.
4. I worry that [Singapore/Indonesia] employees in [leisure/medical tourism] would not be courteous to international tourists.
5. I worry that [Singapore/Indonesia] employees in [leisure/medical tourism] would not be professional in doing their jobs.
6. I worry that I might not be personally satisfied with a trip to [Singapore/Indonesia] for [leisure/medical purposes].
7. I worry that preparation for visiting [Singapore/Indonesia] for [leisure/medical purposes] would take too much time.

### Willingness to Take Risk

1. I am willing to take risk visiting [Singapore/Indonesia] for [leisure/medical purposes].

### Destination Decisions

1. In the future I will seriously consider visiting [Singapore/Indonesia] for [leisure/medical purposes].
2. I would visit [Singapore/Indonesia] in the foreseeable future for [leisure/medical purposes].
3. I expect that I would recommend [Singapore/Indonesia] to other people who want to travel for [leisure/medical purposes].

### Country Destination Image

What are the first things that come to mind when you think about [Singapore/Indonesia] as a travel destination? What are the advantages and drawbacks about [Singapore/Indonesia] as a travel destination?

## APPENDIX 2.2 - An Elaboration of Degree of Mediation

To identify the degree of mediation of WTR, two hierarchical regressions were conducted. In the first hierarchical regression, three attitude variables of consumer knowledge, trust, and perceived risk were block entered. These variables accounted for 44.6% ( $p < 0.000$ ) and 33.1% ( $p < 0.000$ ) of the variance in destination decisions concerning Indonesia leisure and medical tourism, respectively. In the second step, after attitude variables had been controlled, WTR explained the variance of destination decisions by 19% ( $p < 0.000$ ) for leisure tourism and 23.7% ( $p < 0.000$ ) for medical tourism settings in Indonesia. In the second hierarchical regression, which was conducted in a reverse manner from the previous hierarchical regression, WTR was controlled and accounted for 58% and 52.2% of the variance in destination decisions with respect to Singapore leisure and medical

tourism, respectively. The three attitude variables accounted for 5.6% ( $p < 0.000$ ) and 4.6% ( $p < 0.000$ ) of the variance in destination decisions with respect to Singapore leisure and medical tourism, respectively.

The results of the two hierarchical regressions show that all  $R^2$  changes are significant. Because the unique contributions of attitude toward destination decisions (5.6% and 4.6% for Indonesia leisure and medical tourism, respectively) are smaller than the unique contributions of WTR for destination decisions (19% and 23.7% for Indonesia leisure and medical tourism, respectively), the WTR partially mediated the effects of attitude on destination decisions.

Using the same procedure for the setting of Singapore tourism, WTR partially mediated the effects of attitude on the decision to visit Singapore particularly for medical tourism, whereas the mediating effect of WTR was minimal for leisure tourism. All  $R^2$  changes for Singapore leisure and medical tourism hierarchical regressions are significant. The unique contributions of attitude toward destination decisions (11% and 5.7% for Singapore leisure and medical tourism, respectively) are smaller than the unique contributions of WTR for destination decisions (11.1% and 22.9% for Singapore leisure and medical tourism, respectively).



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## **CHAPTER 3**

### **THE EFFECTS OF CULTURAL DISTANCE AND VISIT EXPERIENCE ON DESTINATION DECISIONS**



### **3.1 Abstract**

This study examines the effects of the combination of cultural distance and visit experience on tourists' destination decisions. To date, this combination has not been examined in the tourism literature. The present study tests the differential effects of cultural distance and visit experience on travellers' destination decisions in leisure and medical tourism contexts in Indonesia and Singapore. Consumers with low and high cultural distance are unlikely to travel to Indonesia for both leisure and medical tourism. Conversely, the study reveals that consumers with low and high cultural distance are likely to travel to Singapore for leisure tourism but unlikely to visit Singapore for medical tourism. Furthermore, visit experience significantly distinguishes destination decisions for each cultural distance group. Consumers with visit experience are more likely to visit Indonesia for leisure than for medical tourism.

### **3.2 Introduction**

Cultural distance has frequently been discussed in the field of international business (Shenkar, 2001). Scholars have typically investigated the role of cultural distance with respect to foreign investment decisions, mode of entry preference, and foreign affiliation performance (Shenkar, 2001). In the tourism literature, cultural distance is a prominent cultural element influencing tourists' destination decisions (Ng et al., 2007). Some measures of cultural distance have been developed and examined, although the consistency of the measures in predicting tourists' destination decisions varies (Ng et al., 2007).

Previous tourism studies have also examined the importance of visit experience in determining travel decisions (Decrop, 2000; Oppermann, 2000; Perdue, 1985; Sönmez & Graefe, 1998). As a facet of consumer knowledge, visit experience is a predictor of tourists' decisions under certain circumstances, particularly when visit experience might influence risk attitudes and behaviour (Sitkin & Weingart, 1995), such as in the purchase of tourism services (Sirakaya & Woodside, 2005). Furthermore, visit experience improves tourists' willingness to take risks (Pearce & Foster, 2007). Visit experience is considered to be a more influential factor in tourism decisions than information from external factors (Mazursky, 1989), such as marketing communications.

The present study compares the differential effects of cultural distance and visit experience in leisure and medical tourism settings. The combination of various levels of risk-related variables, such as cultural distance and visit experience might distinguish tourists' destination decisions for leisure and medical tourism, which have different risk properties. To date, there have been no studies in the tourism field that specifically aim at a comparison of the combined effects of the two constructs in these two contexts.

A further contribution of this study is that its findings may help tourism organizations better understand how tourist profiles might differ based on cultural distance and visit experience. In this sense, tourism organizations can apply different marketing

strategies for each group, which in turn, is likely to boost their tourist sector performance. International data reveal that tourism contributes 6% of world exports. It accounts for 9% of the world's GDP; and involves 1 out of every 11 jobs (UNWTO, 2015). Clearly, the tourism sector is important, particularly for developing countries (Eilat & Einav, 2004).

The following sections will cover a brief literature review on leisure and medical tourism, the issue of cultural distance and visit experience in consumer decisions, the research method employed in the current study, and the findings. Finally, the conclusion will also present some limitations and recommendations.

### **3.3 Literature Review**

#### *3.3.1 Leisure and Medical Tourism*

Leisure tourism and medical tourism are as old as ancient Greek, Sumerian, and Roman civilizations, whose privileged members travelled for spa, general rest, and relaxation purposes (Altin et al., 2011). Originally, leisure and medical tourism involved similar activities; however, the scope of medical tourism has recently evolved beyond recuperative or preventative treatments to cover more complex treatments, such as surgery (both cosmetic and non-cosmetic) and dental care (Altin et al., 2011; Connell, 2006). Leisure and medical tourism can be distinguished based on the main purpose of the overseas travel, i.e., for leisure/recreational purposes or to obtain health care. The classification of these tourism services can also be based on the service typology proposed by Mitra et al. (1999). Following their typology, leisure tourism can be regarded as an “experience” service, whereas medical tourism is a “credence” service.

An experience service refers to a service that allows consumers to confidently judge the quality of a service after experiencing its purchase and consumption, such as is the case with a salon, travel agency, or retail bank (Patterson & Smith, 2001). A credence service is

a type of service for which consumers have difficulty judging the quality, even after purchase and consumption. Leisure and medical tourism are positioned along a continuum, with the assumption that tourists have limited information and knowledge and perceive a higher risk in medical tourism (a credence service) than in leisure tourism (an experience service). Tourists perceive greater risk in undergoing medical procedures overseas than in traveling for leisure. Such risks are related to those involving contracting infections, flying home after surgery, and potentially experiencing malpractice (Crooks et al., 2010).

### *3.3.2 Effect of Cultural Distance on Destination Decisions*

Hofstede (1980, p.23) defined culture as “the collective programming of the human mind that distinguishes the members of one human group from those of another”. In Hofstede (1980), Kluckhohn detailed the thought processes in the human mind by referring to culture as a cognitive, affective, and conative scheme. The role of culture is argued to influence individual decision making (Schwartz, 2006) such as tourist destination choice (Ng et al., 2007). Based on Hofstede’s definition of culture, consumer behaviour is likely to vary based on the extent of cultural differences (De Mooij & Hofstede, 2002), which implies that consumers might have different attitudes and behaviours when they are exposed to different settings.

Cultural distance refers to the extent of differences between the culture of the home country and that of a foreign country (Clark & Pugh, 2001; McKercher & So-Ming, 2001). This construct is one of the various risk-related variables that can distinguish consumer attitudes and behaviours. For instance, cultural distance has been linked to choice of risk reduction strategies (Crotts, 2004); the informal source of uncertainty (López-Duarte & Vidal-Suárez, 2010); and information asymmetry (Colakoglu & Caligiuri, 2008). Cultural distance has been extensively studied in relation to international business issues such as mode of entry, international diversification, and performance of multi-national enterprises

(Tihanyi et al., 2005). In terms of concept measurement, Ng et al. (2007) examined various measures of cultural distance and found perceived cultural distance to be among the best predictors of intention to visit a destination country. Perceived cultural distance is critical for intercultural contact (Ye et al., 2012), which is important in service delivery.

Subsequently, tourism studies have specifically investigated the differential effects of cultural distance, such as the intention to visit a destination country (Ng et al., 2007), trip information processing (Litvin et al., 2004), and travel behaviours (Crotts, 2004). To date, however, no studies have examined the differential effects of cultural distance on destination decisions in the two settings of leisure and medical tourism. In a general leisure tourism setting, cultural distance might encourage participation in cultural tourism (McKercher & So-Ming, 2001). In this sense, tourists might prefer to visit a country of destination that offers cultural attractions that are distinct from what they might find in their home country. However, following the principles of the distance decay theory, tourists are more likely to maintain preferences for a distinct tourist destination as long as they assume that they will not be threatened during their travel (Cohen, 1979). Conversely, tourists might also prefer a country of destination that has cultural similarities with the culture of their home country (Basala & Klenosky, 2001; Henderson, 2003; Yavas, 1990).

Cultural distance is understood as an important factor in the process of evaluation and decision making regarding a medical tourism service. Cultural distance is a barrier when an individual must learn about the legal system in the host country, particularly with respect to addressing potential malpractice (Turner, 2007). The cultural aspect of religion also influences a tourist's decision to travel to a country of destination for a medical purpose. For instance, religious affinity is frequently an important factor for Muslim couples traveling to Iran for reproductive medical tourism (Moghimehfar & Nasr-Esfahani, 2011). In addition to foreign tourists, migrants might prefer to return to their home country to receive medical care because the care received may be important to their culture (Sobo,

2009). Cultural distance, such as distance in language and social norms, also reduces the quality of interaction, which in turn increases the potential discrimination that medical tourists might experience (Ye et al., 2012). The settings in the current study allow for the investigation of whether cultural distance generates consistent differential effects in tourists' travel intentions and leads to the first hypothesis:

*Hypothesis 1: "Low cultural distance" groups are more likely than "high cultural distance" groups to visit a country of destination for leisure and medical purposes.*

### *3.3.3 Effect of Visit Experience on Destination Decisions*

Visit experience can be regarded as a facet of consumer knowledge. Based on previous studies, Brucks (1985) classified consumer knowledge into the following three categories: subjective knowledge, objective knowledge, and the amount of purchasing or usage experience. Subjective knowledge refers to the level of perception of an individual's knowledge regarding a product or service; objective knowledge refers to the ability to identify or recognize actual characteristics of a product or service; and experience relates to the actual behaviour of purchasing or using a product or service (Brucks, 1985).

Despite the interrelation of these three facets of consumer knowledge, they differ in terms of measurement (Raju, 1995). Subjective knowledge is typically measured through self-evaluation of the extent of an individual's knowledge about a product or service. Objective knowledge is captured through objective tests about a product or service. Visit experience, by contrast, is typically measured through a self-report regarding the experience of using a product or service (Bettman & Park, 1980).

The notion of visit experience has been extensively discussed in tourism research, as it is the most influential source of information in destination preferences (Raitz & Dakhil, 1989). Previous studies have investigated the importance of visit experience on

travel behaviour (Sönmez & Graefe, 1998), on segmenting travel information inquirers (Perdue, 1985), on activity participation and expenditure patterns (Lehto et al., 2004), and on travel cancellations (Park & Jang, 2014). Although previous studies have provided mixed results, they have generally indicated that visit experience is a significant predictor of tourist behaviour.

There are two possible mechanisms or explanations for how visit experience can significantly differentiate consumer evaluations and decisions. Following the principles of the “expectation-disconfirmation” theory (Oliver, 1980), visit experience can lead to positive (satisfaction) or negative (dissatisfaction) disconfirmation. Satisfaction as a result of positive disconfirmation, for example, leads to an increased likelihood of revisiting Singapore (Hui et al., 2007). In addition to satisfaction, some other factors, however, may also be considered as relevant predictors of intention to revisit a destination; such as the interest in novelty seeking, competitors' offers, and extraordinary events (e.g., weather) (McKercher & Prideaux, 2014). In regard to the time frame, satisfaction is a significant predictor of short-term revisit intentions, instead of mid-term and long-term revisit intentions (Jang & Feng, 2007). Therefore, based on the broad findings that visit experience is a salient predictor of tourist behaviour and, consistent with the argument of the expectation-disconfirmation theory, the second hypothesis is expressed as follows:

*Hypothesis 2: “Experienced” groups are more likely than “non-experienced” groups to visit a country of destination for leisure and medical tourism.*

#### *3.3.4 The Relation between Cultural Distance and Visit Experience*

Culture and experience variables have previously been applied to create a cultural tourism typology (McKercher & du Cros, 2003), which has resulted in a matrix of tourist segments that differ in terms of trip characteristics and other variables, including cultural

distance (McKercher & du Cros, 2003). The present study provides an impetus to apply other aspects of experience and culture to tourism; in particular, cultural distance and visit experience. The relationship between cultural distance and visit experience was proposed by Weiermair & Fuchs (2000), who argued that cultural distance might influence the destination image and that visit experience plays a role in varying the importance of the image. Notably, these authors examined the two variables separately rather than investigating the differential effects of cultural distance and visit experience simultaneously (Weiermair & Fuchs, 2000). The third hypothesis examines the relationship between cultural distance and visit experience and is expressed in two parts as follows:

*Hypothesis 3a:* Respondents with “low cultural distance and visit experience” have the highest likelihood of traveling for leisure and medical tourism.

*Hypothesis 3b:* Respondents with “high cultural distance and no visit experience” have the lowest likelihood of traveling for leisure and medical tourism.

### **3.4 Method**

In this study, Australian respondents participated in an online survey of their opinions on overseas tourism. The data were collected using a national consumer panel in February 2013. A total of 1,024 respondents reported their visit experiences to a foreign country, their perceptions about the cultural distance between their home country and a particular country of destination, and their destination decisions. These respondents were divided into two groups that evaluated Indonesia (511) and Singapore (513). In this study, Indonesia and Singapore were chosen as the countries of destination because they are located in the same region (i.e., Southeast Asia region) and because they differ in terms of tourism competitiveness.



Indonesia is positioned as 50<sup>th</sup> in the world ranking of tourism competitiveness, whereas Singapore is the benchmark of tourism competitiveness in the Southeast Asia region and in Asia Pacific in general, with a world ranking of 11<sup>th</sup> (World Economic Forum, 2015). In addition, Indonesia and Singapore may also be considered “neighbours” due to their relatively close distance from one another; i.e., the distance between Australia and the two countries is 2,150.76 miles (Indonesia) and 2,722.52 miles (Singapore) (<http://www.distancefromto.net>). Thus, broader participation in the survey may be achieved because of transport cost considerations, since Australia is not particularly far from the two countries.

The questionnaires were designed to incorporate items that have been used in previous studies and were suitably modified for the present study. The questionnaires included one item of cultural distance (Ng et al., 2007) and visit experience (De Rojas & Camarero, 2008), which was identified using a binomial Yes or No response; and three items of consumer tourism decisions (Hanzaee & Khosrozadeh, 2011). Cultural distance was measured with an item that was used in a study by Ng, et al. (2007). In particular, cultural distance was expressed in the single question item, “How large do you believe are the national cultural differences between Australia and Indonesia (Singapore)?” Lam and Hsu (2004) applied a single binomial item to measure visit experience. The present study modified the question item to, “Have you ever visited Indonesia (Singapore)?” Finally, the item measurement for destination decisions is a composite measure of items, as follows: “In the future, I will seriously consider visiting Indonesia (Singapore) for leisure (medical) purposes”; “I would visit Indonesia (Singapore) in the foreseeable future for leisure (medical) purposes”; “I expect that I would recommend Indonesia (Singapore) to other people who want to travel for leisure (medical) purposes”. The measurement of cultural distance and destination decisions applied a five-point Likert scale that ranged from 1=strongly disagree to 5=strongly agree. This study distinguished the respondents into two

groups (i.e., low and high cultural distance) through the use of the mean score as a cut-off value.

The subsequent stage involved an analysis using t-tests and analysis of variance (ANOVAs) that aimed to identify the differential effects of cultural distance and visit experience on destination decisions. The data analysis entailed three steps. First, the mean score differences of destination decisions based solely on respondents' visit experiences were examined. Second, a procedure similar to the first step was applied, but the distinction was based on perceived cultural distance between the respondents' home country (Australia) and the country of destination. Finally, the four cell-matrices formed by the visit experience and cultural distance profiles were used to depict the mean scores of the destination decisions. The first two steps involved the use of t-test analyses, and the final step was analysed using ANOVA tests. The four-cell matrices thus consisted of four sub-groups, namely, "experienced, low cultural distance"; "experienced, high cultural distance"; "non-experienced, high cultural distance"; and "non-experienced, low cultural distance".

### **3.5 Results**

#### *3.5.1 Respondent Profiles*

The data were collected from Australian respondents through a national consumer panel that consisted of 1,024 respondents who completed the online survey in February 2013. The respondents evaluated leisure and medical tourism in two groups, namely, for Indonesia and Singapore. Table 3.1. displays the characteristics of the respondents based on socio-demographic factors. The sample is dominated by the following categories: females, the 57-69 age group, those who have completed a high school education, and those with annual incomes from \$20,000 to \$40,000. Furthermore, the sample comprises

mostly participants with “high cultural distance with no visit experience” for Singapore and those with “low cultural distance with no visit experience” for Indonesia.

Table 3.1  
*Profiles of Respondents*

No	Variable	Category	Indonesia	%	Singapore	%
1	Gender	Male	202	39.5	191	37.2
		Female	309	60.5	322	62.8
2	Age	18-30	54	10.6	50	9.7
		31-43	98	19.2	94	18.3
		44-56	139	27.2	138	26.9
		57-69	152	29.7	178	34.7
		>70	68	13.3	53	10.3
3	Education	Primary School	5	1.0	5	1.0
		High School or Equivalent	183	35.8	178	34.7
		Vocational College	153	29.9	174	33.9
		Bachelor's Degree	138	27.0	107	20.9
		Master's Degree or Above	32	6.3	49	9.6
4	Income	Under \$20,000	63	12.3	52	10.1
		\$20,000 to less than \$40,000	114	22.3	129	25.1
		\$40,000 to less than \$60,000	94	18.4	101	19.7
		\$60,000 to less than \$80,000	88	17.2	77	15.0
		\$80,000 to less than \$100,000	50	9.8	71	13.8
		\$100,000 and over	102	20.0	83	16.2
5	Cultural distance and visit experience	Low cultural distance with visit experience	94	18.4	129	25.1
		High cultural distance with visit experience	35	6.8	84	16.4
		High cultural distance with no visit experience	127	24.9	167	32.6
		Low cultural distance with no visit experience	255	49.9	133	25.9

### 3.5.2 Differential Effects of Cultural Distance on Destination Decisions

This section consists of an analysis of the differential effects of cultural distance on leisure and medical tourism in Indonesia and Singapore based on the results of a t-test analysis. In general, the findings in Table 3.2. indicate significant differences in terms of destination decisions between the “low cultural distance” and “high cultural distance” groups. The “low cultural distance” and “high cultural distance” respondent groups are distinguished based on the mean score of cultural distance as a cut-off value. The mean score of cultural distance between Australia and Indonesia is 4.05, while the cultural

distance between Australia and Singapore is 3.55. Respondents in the “low cultural distance” group gave a score below the mean, and the “high cultural distance” group received a score above the mean score for each cultural distance.

The respondents are unlikely to visit Indonesia for both leisure and medical purposes, regardless of whether they are perceived as “low cultural distance” or “high cultural distance” groups. However, respondents with “high cultural distance” have a greater likelihood of not visiting Indonesia than those with “low cultural distance”. Notably, both groups are more likely to visit Singapore for leisure tourism than medical tourism; however, the “low cultural distance” group has a higher likelihood of visiting Singapore than the “high cultural distance” group. The results, therefore, partially support Hypothesis 1.

Table 3.2  
*Mean Differences of Destination Decisions based on Cultural Distance Category*

Variable	Type of Tourism Service					
	Leisure		Sig.	Medical		Sig.
Country of Destination	Low Cultural Distance	High Cultural Distance		Low Cultural Distance	High Cultural Distance	
Indonesia (n=511) <sup>a</sup>	2.827	2.152	<.001*	2.037	1.560	<.001*
Singapore (n=513) <sup>b</sup>	3.281	3.080	0.032*	2.462	2.274	0.039*
Sig.						
*Significant ** ‘Destination decision’ is a composite measure comprising the average score for the following variables: “to consider visiting a country”, “would visit a country”, and “would recommend to others to visit a country” for leisure and medical tourism. a. Low cultural distance = 349 (68.3%); high cultural distance = 162 (31.7%) b. Low cultural distance = 262 (51.1%); high cultural distance = 251(48.9%)						

### 3.5.3 Differential Effects of Visit Experience on Destination Decisions

The subsequent analysis tests the comparison between the “experienced” and “non-experienced” groups in leisure and medical tourism at the destination country level. Table

3.3. reveals that differential effects occur between leisure and medical tourism for Indonesia and Singapore. The groups with experience are more likely to travel to both Indonesia and Singapore for leisure purposes. However, both experienced and non-experienced groups tend to display a lower likelihood of visiting either Indonesia or Singapore for medical purposes. These results thus partially support Hypothesis 2.

Table 3.3

*Mean Differences of Destination based on Visit Experience Category*

Variable	Type of Tourism Service					
	Leisure		Sig.	Medical		Sig.
Country of Destination	Visit experience	No visit experience		Visit experience	No visit experience	
Indonesia (n=511) <sup>a</sup>	3.401	2.347	<.001*	2.083	1.819	<.001*
Singapore (n=513) <sup>b</sup>	3.565	2.911	<.001*	2.571	2.227	<.001*
*Significant ** A 'Destination Decision' is a composite measure comprising the average score for the following variables: "to consider visiting a country", "would visit a country", and "would recommend to others to visit a country" for leisure and medical tourism. a. Visit experience = 129 (25.2%); no visit experience = 382 (74.8%) b. Visit experience = 213 (41.5%); no visit experience = 300 (58.5%)						

#### 3.5.4 Combined Effects of Cultural Distance and Visit Experience on Destination

##### *Decisions*

A further analysis was conducted by examining the combined effects of cultural distance and visit experience on the destination decisions of respondents with various levels of cultural distance based on ANOVA test results. This analysis examined whether the differential effects of cultural distance and visit experience significantly distinguished destination decisions for leisure and medical tourism in Indonesia and Singapore.

In general, the ANOVA test results show the significant combined effects of visit experience along with cultural distance toward destination decisions to Indonesia for leisure,  $F(3,507) = 44.046, p < .001$ , and medical purposes,  $F(3,507) = 12.313, p < .001$ ,

across four conditions. The results of the ANOVA tests also generally indicate there was significant combined effects of visit experience and cultural distance on destination decisions to Singapore at the  $p < .05$  level for both leisure purposes,  $F(3,509) = 18.370$ ,  $p < .001$ , and for medical purposes,  $F(3,509) = 5.612$ ,  $p < .001$ . The mean confidence intervals for each condition based on the level of visit experience and cultural distance are presented in Table 3.4.

Table 3.4

*Descriptive Statistics with Confidence Intervals for Mean – The Combined Effects of Visit Experience and Cultural Distance*

Visit Experience	Cultural Distance	Indonesia			
		Leisure		Medical	
		M(SD)	95% CI	M(SD)	95% CI
Yes	Low	3.54 (.97)	[3.35,3.74]	2.28(1.07)	[2.06,2.50]
Yes	High	3.01(1.32)	[2.56,3.46]	1.56(.87)	[1.26,1.86]
No	Low	2.56(1.05)	[2.43,2.69]	1.95(.91)	[1.84,2.06]
No	High	1.92(1.09)	[1.72,2.11]	1.56(.90)	[1.40,1.72]

Visit Experience	Cultural Distance	Singapore			
		Leisure		Medical	
		M(SD)	95% CI	M(SD)	95% CI
Yes	Low	3.54 (.82)	[3.40,3.69]	2.60(.88)	[2.45,2.75]
Yes	High	3.59(1.12)	[3.35,3.84]	2.53(1.10)	[2.29,2.77]
No	Low	3.02(1.05)	[2.84,3.20]	2.33(1.10)	[2.14,2.52]
No	High	2.82(1.06)	[2.66,2.98]	2.14(1.01)	[1.99,2.30]

Note: M=Mean; SD=Standard Deviation; CI=Confidence Intervals

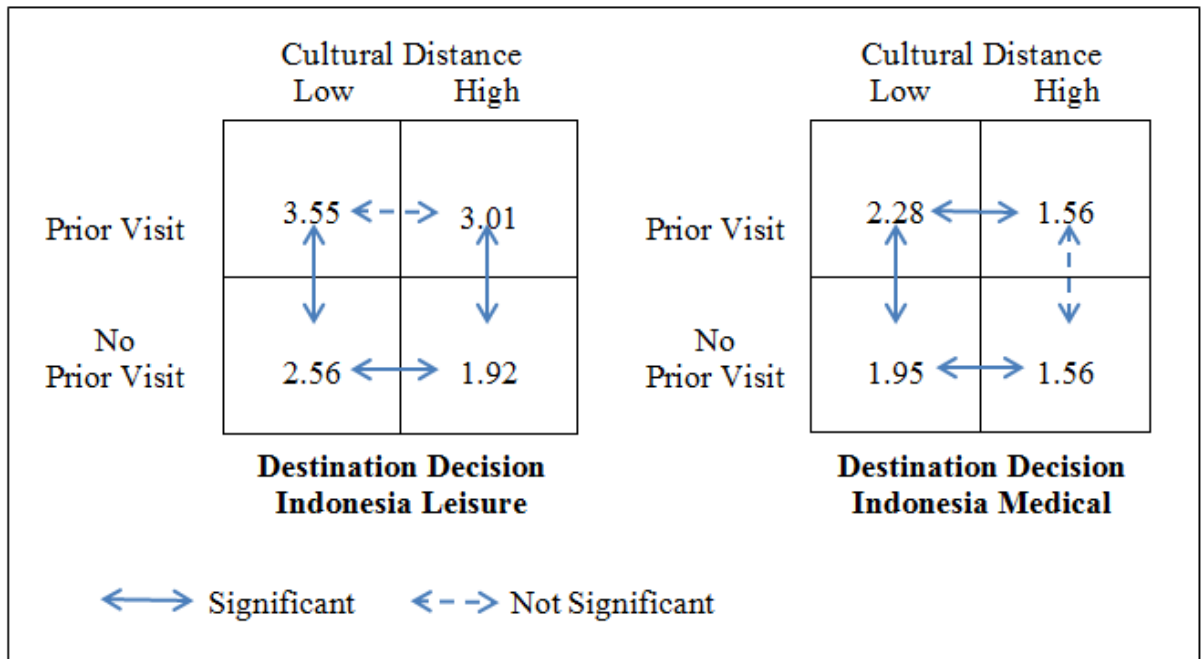
#### 3.5.4.1 Indonesian Tourism

Figure 3.1a. shows that visit experience significantly differentiates destination decisions regarding leisure tourism in Indonesia. “Experienced” groups, regardless of the level of cultural distance, have a higher likelihood of visiting Indonesia for leisure purposes compared with “non-experienced” groups. The “low cultural distance and experienced” group is the most likely to visit Indonesia for leisure purposes (3.55). By

contrast, the “high cultural distance and non-experienced” group is the least likely to visit Indonesia for leisure purposes (1.92). Furthermore, the “high cultural distance and experienced” and the “low cultural distance and non-experienced” groups fall in the range between the “low cultural distance and experienced” and the “high cultural distance and non-experienced” groups.

Although the “non-experienced” groups are unlikely to visit Indonesia for leisure (<3), their destination decisions differ based on the level of their cultural distance. The “high cultural distance and non-experienced” group is more reluctant to visit Indonesia for leisure purposes than the “low cultural distance and non-experienced” group. In summary, for leisure tourism, the level of cultural distance and visit experience differentiates consumer decisions; however, the level of cultural distance does not distinguish between consumer decisions among “experienced” groups.

By contrast, Figure 3.1b shows that all sub-groups are generally unlikely to visit Indonesia for medical purposes, regardless of their level of cultural distance from Indonesia and visit experience (<3). However, the “low cultural distance and experienced” group expresses the least reluctance to visit Indonesia for medical purposes compared with the other three sub-groups. The “high cultural distance” groups are least likely to visit Indonesia for medical tourism. The level of cultural distance and experience distinguishes among consumer decisions; however, the level of experience does not significantly differentiate consumer decisions among “high cultural distance” groups. As a result, the findings for Indonesian tourism partially support Hypotheses 3a and 3b.



*Figure 3.1* Mean score differences of consumer decision regarding tourism services in Indonesia based on the combined effects of cultural distance and visit experience.

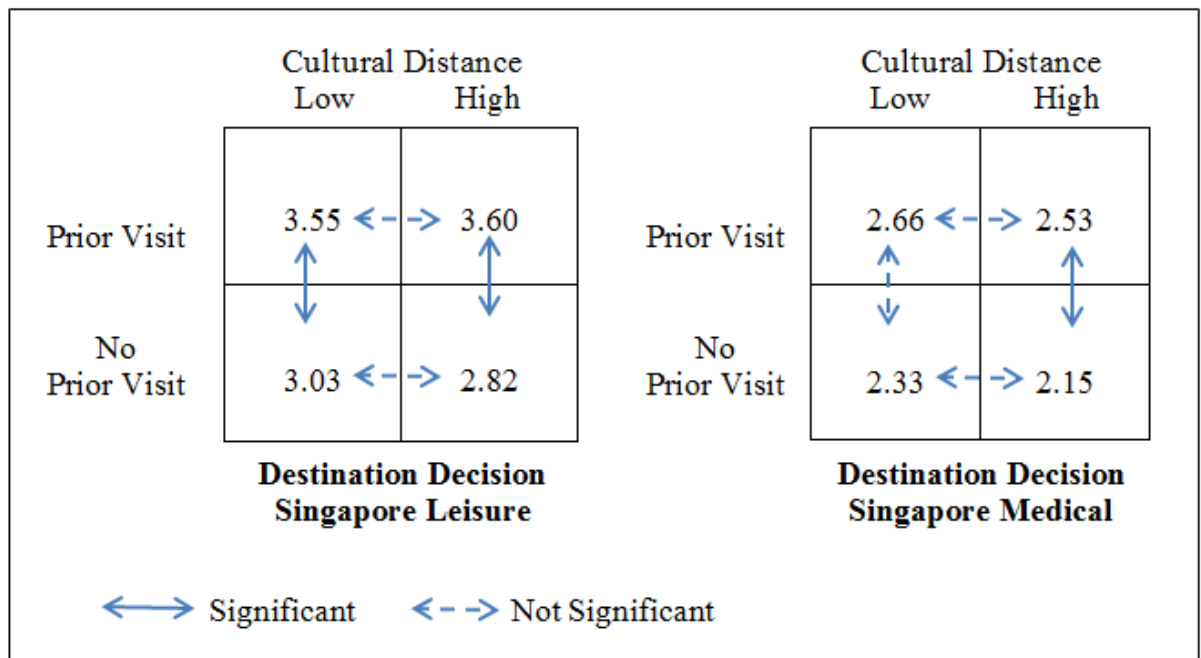
#### 3.5.4.2 Singapore Tourism

Figure 3.2a shows that “experienced” respondents, regardless of their levels of cultural distance, are more likely to visit Singapore for leisure purposes (3.55-3.60). The “high cultural distance and non-experienced” group is the least likely to visit Singapore for leisure purposes (2.82). However, the “low cultural distance and non-experienced” group is marginally likely to visit Singapore for leisure (>3). This result is significantly different from the “low cultural distance and experienced” group but not significantly different from the “high cultural distance and non-experienced” group. Hence, the level of experience distinguishes leisure tourism decisions, regardless of the level of cultural distance. By contrast, cultural distance does not distinguish between consumer decisions with respect to leisure tourism, regardless of the experience level.

Furthermore, Figure 3.2b indicates that all sub-groups are unlikely to visit Singapore for medical purposes, regardless of the level of their cultural distance and visit experience with Singapore tourism (<3). The level of visit experience and cultural distance



does not differentiate between consumer decisions, except that the level of experience distinguishes consumer decisions among “high cultural distance” groups. Hence, the Singapore tourism results partially support Hypotheses 3a and 3b.



*Figure 3.2* Mean score differences of consumer decisions with respect to tourism services in Singapore based on the combined effects of cultural distance and visit experience.

### 3.6 Discussion

These findings demonstrate that cultural distance distinguishes destination decisions for leisure and medical tourism in both Indonesia and Singapore. In general, respondents are unlikely to visit Indonesia for leisure and medical purposes; however, the “low cultural distance” group is less reluctant to visit Indonesia for both purposes than the “high cultural distance” group. Furthermore, regardless of the level of their cultural distance, respondents are only likely to visit Singapore for leisure purposes. Medical tourism is assumed to be riskier than leisure tourism and results in a lower likelihood of visiting Indonesia and Singapore for medical purposes. Thus, the current research findings

contribute to research evidence about the influence of cultural distance on tourist behaviour (Ng et al., 2007). The findings demonstrate a consistent pattern in which destination decisions differ significantly between high and low cultural distance groups. As an informal source of uncertainty (López-Duarte & Vidal-Suárez, 2010), cultural distance can significantly influence an individual's likelihood of visiting a country of destination.

Considering the findings collectively, it is clear that destination decisions can be distinguished based on visit experience for purposes of both leisure and medical tourism. In the case of the sample for each country of destination, differences in destination decisions are significant. Furthermore, consumers with experience are more likely to travel to a country of destination, although consumers are generally unlikely to visit Singapore or Indonesia for medical purposes. This result indicates a consistent pattern in the importance of experience in distinguishing consumer destination decisions. Clearly, visit experience provides respondents with better knowledge of tourism, which significantly influences consumers' evaluations, willingness to travel, and subsequent destination decisions. This notion is consistent with the expectation-disconfirmation theory, which suggests that positive disconfirmation, through experience, leads to a positive evaluation and decisions regarding leisure and medical tourism. Clearly, experienced travellers are more confident and willing to take risks than inexperienced travellers.

In general, respondents are more favourably disposed to leisure tourism than medical tourism, regardless of their visit experience. In addition to being more enjoyable, leisure tourism, as an experience service, is easier to evaluate than medical tourism (Nelson, 1974). Medical tourism is a credence service whose outcome is difficult for consumers to evaluate, even after purchase and consumption (Darby & Karni, 1973). The consequence is that respondents might be more reluctant to take a potentially higher risk (Wahab et al. reproduced from Sirakaya & Woodside, 2005) and less likely to travel for medical purposes. However, the "experienced" group expressed a higher likelihood of

travel for medical purpose compared with the “non-experienced” group. This argument follows the principle that country of origin image might be applied as a “summary cue” used by consumers to encapsulate other product information in a way that reduces cognitive effort” (Knight & Calantone, 2000, p.129). This argument is in line the modified summary construct model proposed by Johansson (1989) in which country image may serve as a summary cue for the set of beliefs formed from prior visit experience. In this context, the country image cue acts to increase the likelihood of travel decision more for leisure than medical purposes.

The combined effects of cultural distance and visit experience were examined in a matrix, but the results were inconsistent and inconclusive. In general, however, cultural distance is less important in distinguishing destination decisions in relation to leisure tourism in Indonesia and Singapore, whereas visit experience significantly differentiates destination decisions. These results suggest that visit experience produces more positive disconfirmation expectations, which result in more objective evaluations of the tourism services in a country of destination. Furthermore, the findings provide mixed results in relation to medical tourism.

Although all the respondents are reluctant to visit either Indonesia or Singapore for medical purposes, respondents with visit experience are more likely to visit those countries than respondents with no visit experience. However, this result is not salient in all “cultural distance” groups. Concurrently, cultural distance is an important variable in distinguishing destination decisions for medical tourism in Indonesia, but it is not relevant in Singapore. The finding for medical tourism in Indonesia is consistent with the principle of similarity-attraction (Ng et al., 2007), in which the “low cultural distance” group is more likely to visit a country of destination.

In conclusion, cultural distance and visit experience significantly distinguish all consumer decisions in both leisure and medical tourism settings when tested individually.

Following the principle of similarity-attraction, the levels of perceived cultural distance distinguish the destination decisions for leisure and medical tourism in both Singapore and Indonesia. Furthermore, visit experience significantly distinguishes the destination decisions for Indonesia and Singapore tourism. These findings correspond with the view that positive disconfirmation experiences lead to more positive travel and destination evaluation decisions for both leisure and medical tourism. In the context of leisure tourism, the “experienced” group is more likely to visit Indonesia and Singapore than the “non-experienced” group. Meanwhile, all groups are unlikely to visit Indonesia and Singapore for medical purposes, although they provide better evaluations of Singapore than Indonesia.

The differential effects of both variables on the destination decision provide mixed results. In general, however, visit experience plays a more important role than cultural distance in distinguishing destination decisions for leisure tourism in Indonesia and Singapore. Furthermore, cultural distance is a more important variable in differentiating destination decisions for medical tourism in Indonesia than in Singapore. These results follow the principle of similarity-attraction, in which a group of respondents who express “low cultural distance” express a higher likelihood to visit Indonesia for medical purposes than a group with “high cultural distance”. Notably, this finding is not repeated in the results for medical tourism in Singapore.

The current study suffers from familiar limitations in research of this type. It includes only Australian respondents who evaluated leisure and medical tourism for two specific countries, Singapore and Indonesia. Thus, the generalizations of these findings may be questionable. As a consequence, future studies might extend the scope of respondents to different countries. Furthermore, Australian respondents might evaluate leisure and medical tourism in countries with more similar images, such as, for example, Malaysia and Indonesia. The current study also has certain managerial implications. Given

the clear importance of visit experience, this study suggests increased opportunities for foreign tourists to visit a country of destination in the long term. The results indicate that experienced tourists have better evaluations and a greater likelihood of visiting a country for both leisure and medical tourism. In the short term, tourism providers in Indonesia or Singapore should, therefore, target experienced tourists. In the longer term, tourism organizations might provide incentives to encourage first-time visitors. In addition, tourism providers in Indonesia, in particular, must pay attention to cultural distance issues with respect to medical tourism by engaging in various strategies to reduce perceived cultural distance.

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## **CHAPTER 4**

### **TOURISM DESTINATION DECISIONS: THE IMPACT OF RISK AVERSION AND PRIOR EXPERIENCE**

#### **4.1 Abstract**

The aim of this study is to explore the differences in individuals' tourism destination decisions based on risk aversion measures. In the tourism literature, there is little or no research regarding the influence of risk aversion on tourists' destination decisions when comparing leisure and medical tourism. The results of this study indicate that risk aversion significantly distinguishes destination decisions in the context of both leisure and medical tourism in Indonesia but not in Singapore. All risk-averse groups are less likely to visit Indonesia than Singapore for leisure and medical purposes. By contrast, all risk-averse groups are likely to visit Singapore for leisure purposes, although they remain unlikely to travel to Singapore for purposes of medical tourism. Furthermore, prior experience significantly distinguishes the likelihood that the two risk-averse groups will travel to Indonesia and Singapore for leisure. Conversely, the effects of prior experience on medical tourism generally do not significantly differ between the two countries.

## 4.2 Introduction

This study explores tourism in two contexts, leisure and medical tourism. In the tourism literature, the overwhelming majority of studies have focused on leisure tourism (see Towner, 1995). In fact, few or no comparative studies have been conducted involving leisure tourism and other tourism settings, such as medical tourism. The justification for comparing these two tourism services is mainly that they can be regarded as exemplars of different categories in the typology of experience-credence services (Darby & Karni, 1973; Nelson, 1970). This typology provides a continuum that classifies each service primarily based on differences in the degree of uncertainty and risk that are associated with the service outcome. In this sense, the risk property is arguably a central consideration in destination decisions for both leisure and medical tourism services.

The current study aims to contribute to tourism research by undertaking a comparison of destination decisions based on consumers' risk aversion and prior experience profiles in the service settings of leisure and medical tourism. To date, such a comparison has not been undertaken in the tourism literature. In addition, the present study compares prior experience and risk-related variables in the context of two destination countries, namely, Indonesia and Singapore. These two countries are geographically adjacent, although they differ in terms of tourism competitiveness. In recent decades, Singapore has become a benchmark for tourism competitiveness in Southeast Asia, whereas Indonesia aspires to improve its competitiveness relative to Singapore, Thailand, and Malaysia (World Economic Forum, 2015).

Utilizing a tourism service is generally considered to be a risky decision (Sirakaya & Woodside, 2005), and the nature of risk in a tourism service can potentially alter a destination decision (Sönmez & Graefe, 1998a). Previous tourism studies have investigated risk-related variables, such as risk aversion, that predict tourists' behaviour (Alvarez & Asugman, 2006; Drakos & Kutan, 2003; Reichel et al., 2007). The domain of risk aversion

may be regarded as a general human trait, an individual trait, or a behavioural or psychological response to context (March, 1996); however, mainstream tourists are generally risk-averse by nature (Fuchs et al., 2013).

Prior experience is another potential predictor of tourists' attitudes toward risk and of tourists' associated behaviour (Reichel et al., 2007; Sitkin & Weingart, 1995), and previous tourism studies have examined the influence of experience on travel decisions (Decrop, 2000; Oppermann, 2000; Perdue, 1985). Prior experience is likely to increase confidence in making future international travel decisions (Sönmez & Graefe, 1998b). Thus, a positive international travel experience typically leads to a higher likelihood of traveling abroad for tourism purposes. Other scholars argue that prior experience can negate the influence of risk factors in consumer decisions (March, 1996). As a result, people are likely to modify their tendencies toward the same choice based on experience. Thus, although tourists resemble one another in the extent of their risk aversion, consumers may nonetheless differ in their tourism choices based on prior experience. Thus, although conceptually linked, the effects of risk aversion and prior experience are likely to be independent. Following this argument, an exploration of the combination of risk aversion and prior experience may provide additional insights into tourists' destination choices and more detailed tourist profile segmentation.

Against this background, exploring the differential and combined effects of risk aversion and prior experience across different respondent groups is potentially worthwhile. Tourism marketers can utilize the findings from the present study for market segmentation, customization of marketing communications and communicating the tourism experience. The current study is structured as follows. It begins with a literature review, which covers risk aversion and prior experience in relation to consumer decisions. This review is followed by formulation of the hypotheses and a discussion of leisure and medical tourism service in relation to risk attitudes and behaviour. Next, the research method, including the

sampling method, research instrument, and analytical tools, is presented. Lastly, a discussion of the findings and conclusions, limitations, and recommendations is provided in the final section.

### **4.3 Literature review**

Within the tourism literature, a number of studies have explored differences in tourists' attitudes and behaviours concerning visiting a destination country for different travel purposes. For instance, previous studies compared tourist behaviours based on whether the tourists travelled on a honeymoon or for pleasure (Mok & Iverson, 2000), to visit friends or relatives (Feng & Page, 2000), to go on a holiday, to go on a business trip, to attend a convention/conference, for employment reasons or for educational purposes (Collins & Tisdell, 2002). However, these studies did not consider the issue of the risk properties that are associated with the purchase of a tourism service. In general, purchasing a tourism service can be regarded as an inherently risky decision (Sirakaya & Woodside, 2005). As a consequence, the question arises as to the likely differential effects of risk properties based on travel purposes. In particular, the continuum of risk properties that are associated with different purposes of travel might result in different tourism service evaluations and decisions. For instance, traveling to a country of destination for leisure purposes might be less risky than traveling to the same country for medical treatment (Johnston et al., 2010). This assumption is consistent with the proposed service typology of Mitra et al. (1999), who classified types of service based on the extent of prior knowledge and perceived risks. Following their typology, the current study positions leisure tourism as an "experience" service and medical tourism as a "credence" service.

#### 4.3.1 *Leisure and Medical Tourism*

Leisure tourism and medical tourism arguably share common historical origins. The phenomena were first recognized in the histories of Greece and other ancient civilizations such as those of the Sumerians and the Romans (Altin et al., 2011; Towner, 1995). Initially, there was no clear distinction between the concepts due to the similar scope of their activities. The upper classes of society – the only recreational travellers – enjoyed spas and general relaxation as their main travel purposes (Altin et al., 2011).

For this study, it is useful to distinguish the main purposes of travel – apart from business – as for either leisure or medical reasons. Leisure tourism refers to overseas travel for recreational or leisure purposes, for example, visiting a resort or a city for relaxation, sightseeing, entertainment, or to visit tourist attractions. By contrast, medical tourism refers to the rapidly growing practice of traveling across international borders to obtain (purchase) health care. The recent growth in medical tourism has been driven not merely by recuperative treatment such as health resorts, spas, and hot springs but also by more complex medical procedures such as cosmetic surgery, oral and dental treatment, internal medicine, eye surgery, reproductive procedures and others.

Medical tourism has attracted tremendous interest in the tourism industry since the late 1990s, and many tourists have travelled to India, Thailand, and Mexico for medical treatment (Connell, 2013). Before the 1990s, it was common for affluent people to visit developed countries such as the US and UK to receive high-quality medical treatment and facilities. However, the opposite trend has occurred since the 1990s, with tourists visiting less developed countries for purposes of medical treatment (Altin et al., 2011). The motivations to engage in a medical tourism program include Procedure-Travel-Cost (PTC) motivations (Crooks et al., 2010), such as reduced waiting time, convenient access, and/or cost savings. There is also often an opportunity to include a leisure component, either before or after the medical procedure, as an added attraction.



As discussed briefly above, leisure and medical tourism can be located in the framework of the service typology proposed by Mitra, Reiss, and Capella (1999), which was developed from Nelson (1974) and Darby and Karni (1973). The service typology comprises search, experience, and credence services. The framework of search-experience-credence is well developed mainly for tangible products; however, its application to services is more recent (e.g., Mitra et al., 1999; Ostrom & Iacobucci, 1995). Search service refers to a service for which consumers have no difficulties in collecting information and evaluating its attributes prior to purchasing it, such as in the case of evaluating a mail delivery service (Mitra et al., 1999). An experience service is a service type for which consumers are confident in their judgment of the service only after actual purchase and consumption, such as in the case of hotels, restaurants, and hair salons (Ostrom & Iacobucci, 1995). A credence service is a service for which consumers lack confidence in their judgment of the service, even after their own purchase and consumption. For instance, it is frequently difficult to judge the success or quality of chemotherapy treatment or invasive surgery, even after the patient has undergone the procedure. All three types of services are positioned along a continuum based on the availability of information and knowledge prior to, and after, purchase and consumption. This continuum represents varying levels of uncertainty that, in turn, lead to varying levels of perceived risk (Mitra et al., 1999).

Experience and credence properties tend to be embedded in a service more than in a tangible product, which has more search attributes (Zeithaml, 1981). In accordance with the principles of the service typology of Mitra, Reiss, & Capella, it has been plausibly argued that leisure tourism is an example of an experience service and that medical tourism is a credence service. Thus, it is relatively easy for visitors to a country of destination for leisure tourism to evaluate the service based on their experiences on the accommodations and tourist facilities, foods, destination attractions, and gifts. By contrast, it is more

difficult to access relevant, comprehensive and trustworthy information concerning traveling to a country of destination for medical treatment because medical tourists are likely to evaluate the service experience based on the outcome of the medical treatment (i.e., success rate of the medical procedure) and where the outcome itself may be difficult to judge objectively.

Medical tourism is thus assumed to be associated with more limited prior, and 'post', knowledge and higher perceived risks than leisure tourism. This assumption reflects the additional risk elements that are associated with medical tourism services, such as having post-operative infections in the country of destination, returning to the home country following surgery, and having potential malpractice issues after surgery (Crooks et al., 2010). In addition, the risk elements in medical tourism such as bio-security risks may be salient considerations for some medical tourism destination countries (Hall & James, 2011). Such issues position medical tourism as significantly riskier than leisure tourism.

#### *4.3.2 The Role of Risk-Seeking Behaviour in Destination Decisions*

Risk aversion is a major construct that can apply when considering consumers' decision-making when they pursue rational choices (March, 1996). The mainstream theories of risk aversion were developed from an economic model (Mandrik & Bao, 2005), although risk aversion also has clear psychological explanations (Lopes, 1994). Risk aversion is defined as 'an individual's degree of negative attitude toward risk arising from outcome uncertainty' (Mandrik & Bao, 2005). Qualls & Puto (1989) define risk aversion as 'a preference for a guaranteed outcome over a probabilistic one having an equal expected value'. Risk aversion has also been formulated as a general human trait, as an individual trait, and as a response to a specific context (March, 1996).

Risk aversion has been discussed in many tourism studies (Lepp & Gibson, 2008; Reichel et al., 2007) and is a recognized predictor of destination decisions (Ryan, 1995).

The concept of “sensation seeking” is also employed in explaining tourist behaviour and can be regarded as a proxy for risk taking (Lepp & Gibson, 2008), although some scholars argue that the constructs differ (Grinblatt & Keloharju, 2009), i.e., that it is the opposite of risk aversion. Sensation seeking is generally considered to be a personality trait (Pizam et al., 2004) that refers to an individual’s need for any form of variation, novelty, complexity of sensation, and experience, including willingness to take risks, particularly physical and social risks, merely for the sake of an experience (Zuckerman, 1990). Nonetheless, the basic principle is that a “risk-averse” group tends to prefer a less risky choice and that a “risk-taker” group is willing to make a riskier choice for the same expected value (e.g., visiting a high-risk country destination). Purchasing a tourism service is a risky decision (Sirakaya & Woodside, 2005), particularly when the destination country is perceived to be risky due to associations with war, terrorism, or corruption (Lovelock, 2004). By applying this principle, Hypothesis 1 is formulated as follows:

*Hypothesis 1:* Risk-takers are more likely to visit a country of destination than risk-averse.

Although risk aversion can be regarded as a generalized personality trait, its impact may vary according to the circumstances of the decision. A relevant service typology was proposed by Mitra et al. (1999). This typology considers the extent of pre-purchase knowledge and perceived risk. Following the service typology, leisure tourism can be regarded as an “experience” service because tourists are likely to be more confident in judging the quality of a service when they have direct experience (e.g., prior visit experience). By contrast, medical tourism can be regarded as a “credence” service based on the assumption that tourists are more likely to have difficulties in evaluating the service outcome, even following the service experience. This claim is based on the assumption that

visitors are likely to be less confident in evaluating the success of a medical procedure (e.g., surgery) that is conducted by a health provider in a country of destination even after they have returned to their home country. These additional risk properties imply that medical tourism is riskier than leisure tourism.

Therefore, risk aversion might differ based on the context of the tourism. Although a “risk taker” is generally more likely to take a risk than a “risk-averse” person, the decision might differ based on the different types of service. Following the principle of risk aversion and the service typology proposed by Mitra et al. (1999), Hypothesis 2 is proposed as follows:

*Hypothesis 2:* The likelihood that both “risk-taker” and “risk-averse” groups visit a destination country is higher for leisure than for medical tourism.

#### *4.3.3 The Role of Prior Experience in Risk Seeking Behaviour*

Similar to subjective and objective knowledge, prior experience is generally understood as a facet of consumer knowledge (Brucks, 1985). However, these types of knowledge differ in terms of measurement (Raju et al., 1995). Prior experience is measured through actual purchases and/or usage of a product/service, whereas subjective and objective knowledge are measured through the self-assessment of an individual’s perception of knowledge and an objective test of a product/service, respectively.

In previous studies, prior experience has been expressed in terms such as “past experience” (San Martin et al., 2012), “prior behaviour” (Bentler & Speckart, 1981), and “familiarity” (Alba & Hutchinson, 1987). Regardless of the term or expression, prior experience is an important predictor of behaviour (Bentler & Speckart, 1981) and an important variable for increasing the predictability of consumers’ attitudes on behaviour (Fazio et al., 1978; San Martin et al., 2012). Furthermore, prior experience facilitates the

formation of consumer expectations as a function of consumer satisfaction (Huang et al., 2012). In previous studies, prior experience has been treated both as a moderating (Bennett et al., 2005; Mangleburg et al., 1998; Murray, 1991; Vogt & Andereck, 2003) and as an independent variable (Dodd et al., 2005; Tax et al., 1998).

Furthermore, consumers may apply prior experience as a tool to reduce uncertainty in a high-involvement product or service (Smith & Swinyard, 1982). Slovic et al. in Sitkin & Pablo (1992) argue that prior experience increases the extent of confidence in risk-associated behaviours. In this sense, a high-involvement product/service is important to consumers and typically involves one's ego, self-image and a certain amount of performance, in addition to financial, social, and/or personal risk (Assael, 2005). High involvement also requires more information and deliberation (Assael, 2005), which commonly applies to consumers' tourism decisions (Sirakaya & Woodside, 2005). Prior experience has been studied extensively in tourism studies (Lehto et al., 2004; Ma et al., 2013; Park & Jang, 2014; Perdue, 1985; Sönmez & Graefe, 1998a). Although these studies have provided mixed results, prior experience is considered to be an important variable in understanding and predicting tourists' behaviour.

Although prior experience and risk aversion may have important independent effects, their interactive effects are less predictable. For example, prior experience might reinforce the extent to which risk aversion influences a destination decision. The differential effects of prior experience likely depend on whether the experience is favourable. A favourable prior experience results in a more positive reinforcement of destination decisions. Therefore, the combination of "risk taker and experience" should lead to the highest likelihood of visiting a country of destination. By contrast, the combination of "risk-averse and no experience" should result in the lowest likelihood that an individual would visit a country of destination. An unfavourable prior experience results in negative reinforcement in making a destination decision. These two effects follow the

principles of the expectation-disconfirmation theory (Oliver, 1980), in which prior experience may lead to either positive or negative judgments regarding a product or service, such as a tourism destination. These judgments, in turn, increase or decrease the likelihood of a destination decision. For example, satisfaction as a function of positive disconfirmation increases the likelihood that tourists revisit Singapore (Hui et al., 2007).

Although they are interrelated, risk aversion and prior experience stem from different theoretical explanations regarding individual choices (March, 1996). The former construct, risk aversion, is derived from theories of rational choice. By contrast, the latter construct, prior experience, derives from theories of experiential learning. However, combining these two perspectives (March, 1996) and following the principles of the expectation-disconfirmation theory and learning from experience, Hypothesis 3 can be expressed as follows:

*Hypothesis 3: Destination decisions of “risk-taker” and “risk-averse” consumers differ with respect to prior visit experiences.*

#### **4.4 Method**

The present study evaluated the relevance and consistency of risk aversion and tourists' prior experiences in distinguishing destination decisions regarding two countries of destination, Indonesia and Singapore. These countries were chosen because they differ in terms of tourism competitiveness but are located in the same region (i.e., Southeast Asia). The 2015 Travel & Tourism Competitiveness Report reported that Indonesia was ranked 50<sup>th</sup>, whereas Singapore is among the leading countries in tourism, ranked 11<sup>th</sup> in the world in the same report (World Economic Forum, 2015). Indonesian inbound tourism in 2013 contributed to 9.3% of international tourist arrivals in the Southeast Asia market, whereas Singapore tourism generated 12.6% of that same market share (UNWTO, 2015).

In addition, Indonesian inbound tourism in the same year accounted for revenues of 8.4% of the Southeast Asia market, whereas Singapore contributed to 17.8% of that same market (UNWTO, 2015). In terms of the medical tourism infrastructure, Indonesia has 16 internationally accredited hospitals, whereas Singapore has 10 internationally accredited hospitals (Joint Commission International, 2015). Notably, Indonesian tourists are important contributors to the medical tourism sector in Singapore (Connell, 2013). Based on the proposed hypotheses, destination decisions concerning leisure and medical tourism might differ based on risk aversion and prior experience with respect to the destination country.

The current study provides empirical evidence that Singapore is perceived as having a better country image than Indonesia, as shown in Table 4.1. The current measurement of country image borrowed and modified factors of country image from previous studies (Maheswaran, 1994; Martínez & Alvarez, 2010). The factors of country image include economic development, political stability, social conditions, and the quality of products and the specific tourism service. Country image is argued to influence the risk evaluation of products (Liefeld, 1993), such that products from less-developed countries are perceived to be riskier than products from more developed countries (Laroche et al., 2005). In the context of the tourism industry, Indonesia is considered among high-risk country destinations (e.g., Lovelock, 2004); conversely, Singapore is considered among low-risk destinations (Enright & Newton, 2004). Based on the 2013 Travel and Tourism Competitiveness Index, Singapore is considered a low-risk country in terms of safety, security, health, and hygiene indicators compared with Indonesia (World Economic Forum, 2015).

Table 4.1

*Country Image Comparison between Indonesia and Singapore*

No	Country Image	Mean score		
		Indonesia	Singapore	p-value
1	Economic development	1.96	3.07	0.000
2	Political stability	1.96	2.82	0.000
3	Social conditions	1.89	2.67	0.000
4	Quality of products	2.35	2.93	0.000
5	Quality of tourism services	2.62	3.20	0.000

To test the research hypotheses, a sample survey was conducted using an online self-report survey in February 2013. The respondents were recruited through a national consumer panel. Australian respondents were asked their opinions and intentions to visit Indonesia or Singapore for leisure and medical purposes. The questionnaire included items from previous studies, with some necessary modifications. The questionnaire, as shown in Appendix 4.1, consisted of four demographic items (gender, age, education, income); five items of risk aversion (Mandrik & Bao, 2005); one binomial item of prior experience (Lam & Hsu, 2004); and three items of consumer tourism decisions (Hanzaee & Khosrozadeh, 2011). A Likert scale that ranged from 1 = strongly disagree to 5 = strongly agree was applied for the response items of risk aversion and destination decisions.

Subsequently, the data were analysed using t-tests and analysis of variance (ANOVA) to examine the differences in destination decisions for leisure and medical tourism in Indonesia and Singapore. The first stage of analysis used a t-test to examine the differences in destination decisions based on a risk aversion measurement. The subsequent analysis extended the comparison of destination decisions by adding prior experience. The results are shown in two matrices that represent destination decisions regarding leisure and medical tourism for both Indonesia and Singapore as destination countries. The matrices form four cells that indicate the following four respondent categories: “risk taker and experienced”, “risk-averse and experienced”, “risk-averse and non-experienced” and “risk taker and non-experienced”.



## **4.5 Results**

### *4.5.1 Respondents' Characteristics*

This study involved the participation of a sample of Australian respondents who completed self-report surveys through a national online consumer panel. The study included two respondent groups that evaluated leisure and medical tourism in Indonesia and Singapore. The first group consisted of 511 respondents who evaluated tourism services in Indonesia, and the second group included 513 respondents who evaluated tourism services in Singapore. A total of 1,024 respondents completed the survey in February 2013.

Table 4.2 shows that the highest proportion of the sample for both groups was female, was in the 57-69 age group, had completed a high school education, and had an income from \$20,000 to \$40,000. The respondents in both groups fell mostly in the category of “risk-averse with no experience”

Table 4.2  
*Socio-Demographic Profiles of Respondents*

No	Variable	Category	Singapore	%	Indonesia	%
1	Gender	Male	191	37.2	202	39.5
		Female	322	62.8	309	60.5
2	Age	18-30	50	9.7	54	10.6
		31-43	94	18.3	98	19.2
		44-56	138	26.9	139	27.2
		57-69	178	34.7	152	29.7
		>70	53	10.3	68	13.3
3	Education	Primary School	5	1.0	5	1.0
		High School or Equivalent	178	34.7	183	35.8
		Vocational College	174	33.9	153	29.9
		Bachelor's Degree	107	20.9	138	27.0
		Master's Degree or Above	49	9.6	32	6.3
4	Income	Under \$20,000	52	10.1	63	12.3
		\$20,000 to less than \$40,000	129	25.1	114	22.3
		\$40,000 to less than \$60,000	101	19.7	94	18.4
		\$60,000 to less than \$80,000	77	15.0	88	17.2
		\$80,000 to less than \$100,000	71	13.8	50	9.8
		\$100,000 and over	83	16.2	102	20.0
5	Risk aversion and prior experience	Risk Takers with Prior Experience	105	20.5	75	14.7
		Risk Averse with Prior Experience	108	21.1	54	10.6
		Risk Averse with No Prior Experience	176	34.3	214	41.9
		Risk Takers with No Prior Experience	124	24.2	168	32.9

#### 4.5.2 Test 1: Risk-Seeking Behaviour Comparison

The purpose of Test 1 was to examine the differential effects of risk-seeking behaviour on destination decisions. In addition, the differential effects of the service type (i.e., leisure (“search”) and medical (“credence”)) on destination decisions were examined for each risk-seeking behaviour category. At this stage, a t-test analysis was applied for the leisure and medical tourism categories.

#### *4.5.2.1 Differential Effects of Risk-Seeking Behaviour*

This section presents the differences in destination decisions based on the risk-seeking behaviour category for two types of services, leisure and medical tourism. The differences were tested using independent samples and a t-test analysis. Table 4.3 shows significant differences between the risk-taker and risk-averse groups in regard to travel decisions to Indonesia for both leisure and medical purposes. The mean score for risk aversion was applied as a cut-off value to categorise respondents into the risk-taker and risk-averse groups. The mean scores of risk aversion are 3.57 and 3.44 for respondents who evaluate Indonesia and Singapore respectively. The “risk-taker” groups gave a score below the mean score, and the “risk-averse” group conversely scored above the mean.

Although the respondents were less likely to visit Indonesia, the risk-averse group expressed a significantly lower willingness than the risk-taker group to visit Indonesia for both leisure and medical purposes. By contrast, no significant differences were found between the risk-taker and risk-averse groups regarding travel decisions to Singapore for both leisure and medical purposes. However, regardless of their levels of risk aversion, respondents were generally more likely to visit Singapore for leisure than for medical purposes. These results, therefore, generally support Hypothesis 1, particularly in terms of Indonesian tourism.

Table 4.3

*Mean Differences of Destination Decisions Regarding Tourism Services based on the Risk Aversion Category*

Variable	Type of Tourism Service				
	Leisure		Sig.	Medical	
Country of Destination	Risk Taker	Risk Averse		Risk Taker	Risk Averse
Indonesia (n=511) <sup>a</sup>	2.982	2.279	<.001*	2.043	1.744
Singapore (n=513) <sup>b</sup>	3.224	3.149	0.418	2.402	2.344
*Significant ** ‘Consumer Decision’ is a composite measure comprising the average score for the following variables: “to consider visiting a country”, “would visit a country”, and “would recommend to others to visit a country” for leisure and medical tourism. c. Risk taker = 243 (47.6%); risk averse = 268 (52.4%) d. Risk taker = 229 (44.6%); risk averse = 284 (55.4%)					

#### 4.5.2.2 Differential Effects of a Tourism Service

The following results reveal the differences for each risk aversion group when evaluating leisure and medical tourism. Table 4.4 shows that each risk-averse group is reluctant to visit Indonesia for either purpose. However, the results clearly indicate significant differences between destination decisions concerning leisure and medical tourism in Indonesia. All risk-averse groups are more reluctant to visit Indonesia for medical than for leisure purposes. A similar result is shown in the context of tourism services in Singapore, for which there are significant differences between travel decisions to Singapore for leisure and medical purposes, in that both risk-taker and risk-averse groups are more likely to visit Singapore for leisure than for medical purposes. The findings, therefore, support Hypothesis 2.

Table 4.4

*Mean Differences of Destination Decisions among Risk-Averse Groups based on Type of Tourism Service*

Variable	Risk Aversion Group					
	Risk Taker		Sig.	Risk Averse		Sig.
Country of Destination	Leisure	Medical		Leisure	Medical	
Indonesia (n=511) <sup>a</sup>	2.982	2.043	<.001*	2.279	1.744	<.001*
Singapore (n=513) <sup>b</sup>	3.224	2.402	<.001*	3.149	2.344	<.001*
*Significant						
** A ‘Consumer Decision’ is a composite measure comprising the average score for the following variables: “to consider visiting a country”, “would visit a country”, and “would recommend to others to visit a country” for leisure and medical tourism.						
c. Risk taker =243 (47.6%); risk averse=268 (52.4%)						
d. Risk taker =229 (44.6%); risk averse=284 (55.4%)						

#### 4.5.3 Test 2: Risk-Seeking Behaviour vis-à-vis Prior Experience Matrix

Test 2 extends the findings of Test 1. In this section, ANOVA was applied to "risk-averse" consumers. The results are presented in Figures 1 and 2 for tourism in Indonesia and Singapore, respectively. In general, the results of the ANOVA test indicate significant combined effects of visit experience and risk aversion toward destination decision to Indonesia for leisure purposes,  $F(3,507) = 44.983, p < .001$ , and medical purposes,  $F(3,507) = 5.940, p < .001$ . In addition, the combined effects of visit experience and risk aversion on destination decisions to Singapore in general were statistically significant at the  $p < .05$  level for both leisure purposes,  $F(3,509) = 18.722, p < .001$ , and for medical purposes,  $F(3,509) = 6.207, p < .001$ , across the four conditions. The following descriptive statistics across four conditions with confidence intervals for mean are presented in Table 4.5.

Table 4.5

*Descriptive Statistics with Confidence Intervals for Mean – The Combined Effects of Visit Experience and Risk Aversion*

Visit Experience	Risk Aversion	Indonesia			
		Leisure		Medical	
		M(SD)	95% CI	M(SD)	95% CI
Yes	Risk Taker	3.67 (.87)	[3.47,3.87]	2.22(1.05)	[1.98,2.46]
Yes	Risk Aversive	3.02(1.27)	[2.68,3.37]	1.89(1.07)	[1.60,2.18]
No	Risk Taker	2.67(1.10)	[2.51,2.84]	1.96(0.97)	[1.81,2.11]
No	Risk Aversive	2.09(1.03)	[1.95,2.23]	1.71(0.88)	[1.59,1.82]

Visit Experience	Risk Aversion	Singapore			
		Leisure		Medical	
		M(SD)	95% CI	M(SD)	95% CI
Yes	Risk Taker	3.47 (.91)	[3.29,3.64]	2.48(.86)	[2.31,2.64]
Yes	Risk Aversive	3.66(.98)	[3.47,3.84]	2.66(1.06)	[2.46,2.87]
No	Risk Taker	3.02(.95)	[2.85,3.18]	2.34(1.02)	[2.16,2.52]
No	Risk Aversive	2.84(1.12)	[2.67,3.00]	2.15(1.07)	[1.99,2.31]

Note: M=Mean; SD=Standard Deviation; CI=Confidence Intervals

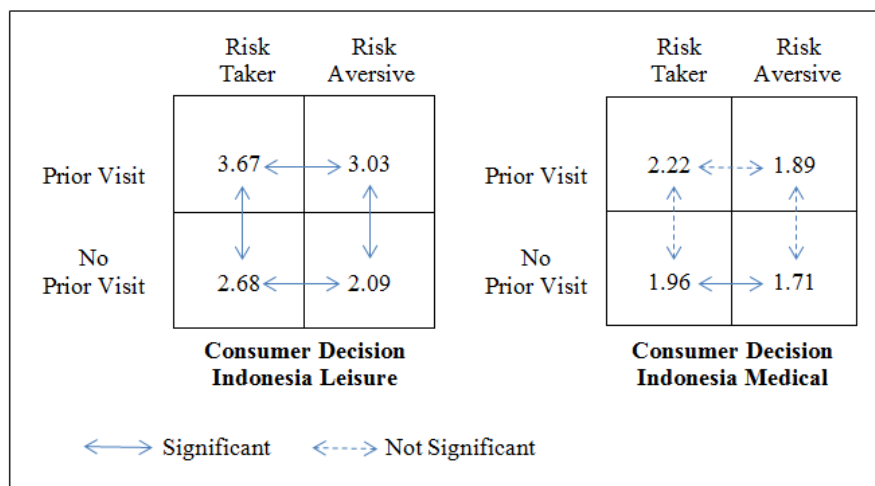
#### 4.5.3.1 Indonesian Tourism Context

Along with risk aversion, further analysis examined the effect of prior tourism experience. Considering risk aversion and prior experience, Figure 4.1 below shows two matrices that consist of four cells for Indonesia. A bold arrow indicates that the destination decisions of the two sub-groups are significantly different; conversely, a dotted arrow shows that the difference between two sub-groups is not significant.

Based on the extent of risk aversion and prior experience, the “risk-taker and experienced” group is the most likely to visit Indonesia for leisure purposes (3.67). Conversely, the “risk-averse and non-experienced” group is the least likely to visit Indonesia for leisure purposes (2.09). Regardless of the extent of risk aversion, the respondents are more likely to visit Indonesia for leisure purposes as long as they are in the “experienced” group ( $>3$ ). Although the “non-experienced” groups are unlikely to visit Indonesia for leisure ( $<3$ ), their decisions differ based on their level of risk aversion. The “risk-averse and non-experienced” group is more reluctant than the “risk-taker and non-

experienced” group to visit Indonesia for leisure. Overall, the extent of risk aversion with prior experience distinguishes respondents’ destination decisions concerning leisure tourism in Indonesia.

A different result is shown in the context of medical tourism in Indonesia. In general, the extent of risk aversion and prior experience does not significantly distinguish a destination decision among the sub-groups, except for the “non-experienced” groups. In addition, all sub-groups are unlikely to visit Indonesia for medical purposes regardless of the level of their risk aversion and prior experience (<3). Overall, the findings in the context of Indonesian tourism, as shown in Figure 1, support Hypothesis 3, particularly with respect to leisure tourism.



*Figure 4.1* Mean Differences of Destination Decisions Regarding Indonesian Tourism Services based on Risk Aversion and Prior Experience.

#### 4.5.3.2 Singapore tourism context

The findings for Singapore tourism support Hypothesis 3, particularly with respect to leisure tourism. Figure 4.2 shows that respondents are most likely to visit Singapore for leisure purposes if they are in the “experienced” group (3.47-3.66). The “risk-averse and non-experienced” group expresses the lowest likelihood to visit Singapore for leisure purposes (2.84). Although the “risk-taker and non-experienced” group is likely to visit

Singapore for leisure ( $>3$ ), the decision is significantly different from the “risk-taker and experienced” group decision and not significantly different from the decision of the “risk-averse and non-experienced” group. In the Singapore leisure tourism setting, risk aversion does not distinguish between destination decisions across sub-groups regardless of their prior experience. By contrast, evidence shows that prior experience distinguishes between consumer decisions across sub-groups for all levels of risk attitudes.

A similar result for the relevance of risk aversion and prior experience is shown in the Singapore medical tourism context in that the level of risk aversion does not significantly distinguish the destination decisions in any prior experience situation. Furthermore, prior experience distinguishes the destination decisions between the “risk-averse” sub-groups but not the “risk-taker” sub-groups. Overall, all sub-groups are unlikely to visit Singapore for medical purposes regardless of their level of experience and risk aversion ( $<3$ ). This situation is similar to the Indonesia medical tourism results, in which all the sub-groups have a low likelihood of traveling for medical purposes. However, destination decisions regarding Singapore medical tourism differ among “risk-averse” groups, whereas the decisions concerning Indonesia medical tourism are different among “non-experienced” groups.

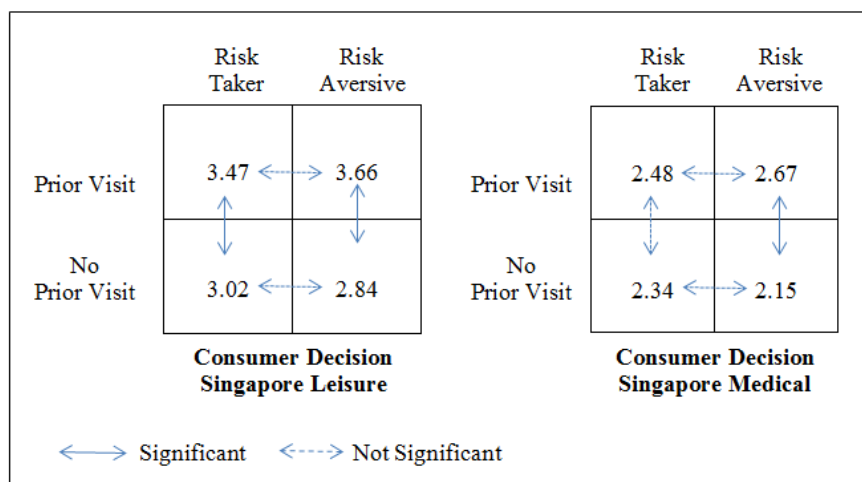


Figure 4.2 Mean Differences of Destination Decisions Regarding Singapore Tourism Services based on Risk Aversion and Prior Experience.



## 4.6 Discussion

The findings in Table 4.3 reveal that destination decisions based on the profile of risk seeking behaviour for tourism services provide mixed results with respect to the two destination countries. In the context of leisure and medical tourism in Indonesia, it is clear that risk-seeking behaviour significantly differentiates respondent behaviours. “Risk-averse” respondents are less likely to travel to Indonesia (i.e., high-risk country) for both leisure and medical purposes than “risk-taker” respondents. Surprisingly, there is no difference across the “risk-taker” and “risk-averse” groups in terms of visiting Singapore either for leisure or medical purposes. These mixed results lead to the possibility that there might be other potential moderating variables that contribute to this inconsistency. One plausible explanation is that the image of the destination country is a contributor and suggests that the images of Indonesia and Singapore differ significantly. A further examination using a t-test shows that Singapore is perceived to be significantly better than Indonesia in terms of country image. “Risk-averse” respondents, therefore, likely utilize the destination country image to compensate for their lack of information about leisure and medical tourism in Singapore (i.e., a low-risk country).

The results shown in Table 4.4 reveal a consistent pattern in which a specific context significantly distinguishes the respondents’ behaviour regardless of the respondents’ risk attitude. In the present study, the destination decisions regarding leisure and medical tourism are significantly different for Singapore and Indonesia. The respondents are less likely to visit Singapore for medical than for leisure purposes, regardless of whether they are “risk takers” or “risk averse”. These results are consistent with the credence properties of medical tourism (Darby & Karni, 1973). In this sense, a credence service is associated with a lack of pre-purchase knowledge and a higher perceived risk (Mitra et al., 1999). A medical tourism service, as a credence service, is presumably associated with limited prior purchase information and perceptions of high

risk. Following this principle, the findings indicate similar evidence in the context of Indonesia. Both “risk-taker” and “risk-averse” people are generally reluctant to visit Indonesia for either purpose (<3). However, all the respondents are less likely to visit Indonesia for medical than leisure purposes. In this context, the destination country image may be significant, as was found in the context of Singapore tourism services. In general, therefore, the results provide general evidence that particular tourism destination countries may differentiate destination decisions regardless of whether the respondents are “risk takers” or “risk averse”.

A further breakdown is presented by dividing respondents into sub-groups based on their risk aversion and prior experience. This study employed ANOVAs to examine the differences in destination decisions across sub-groups. Figures 4.1 and 4.2 show that the “risk-taker and experienced” and “risk-averse and non-experienced” groups lie at the two ends of the continuum of destination decisions. The “risk-taker and experienced” respondents have the highest likelihood of visiting Indonesia and Singapore for leisure, and the “risk-averse and non-experienced” respondents are the least likely to visit Indonesia and Singapore for the same purpose. These results demonstrate that the greatest combined effects of risk aversion and prior experience concerning destination decisions occur when they are at the same ends of the spectrum (i.e., high, high and low, low). However, prior experience generally contributes more to the combined effects than risk aversion in leisure tourism settings. All respondents are more likely to travel for leisure purposes as long as they are within “experienced” groups. This result demonstrates the importance of prior experience in enhancing the likelihood that an individual travels to Indonesia and Singapore for leisure purposes.

Notably, very few of the mean scores of destination decisions concerning medical tourism across the sub-groups are significantly different. The exceptions, displaying significant differences, were the “non-experienced” medical tourism groups for Indonesia

and the “risk-averse” medical tourism groups for Singapore. In general, however, respondents in all groups are unlikely to visit Indonesia or Singapore for medical purposes (<3). Risk aversion and prior experience seem to be irrelevant in differentiating their behaviour in regard to making decisions concerning medical tourism. Thus, the nature of a credence service, which is perceived as more risky, presumably overpowers the willingness to take risks, even if respondents are “risk takers”. This conclusion supports the notion that the influence of risk aversion characteristics might vary significantly, depending on the context of the decision. Alternatively, the absolute magnitude of the perceived risk of medical tourism in both countries may “overpower” the differential effects of risk aversion.

In summary, risk aversion plays an important role in destination decisions for both leisure and medical tourism. The “risk-taker” group is more likely to visit Indonesia and Singapore for leisure and medical purposes; however, there is no difference between the risk-averse groups in the Singapore context. This latter finding is consistent with the argument that a more positive image of a destination country leads the “risk-averse” group to be more confident in utilizing the cue as a summary of service quality compared with when the image is more negative, which is the case for Indonesian tourism. In this sense, a positive country image may “overpower” the influence of risk aversion.

A further breakdown based on the level of risk aversion and prior experience shows that the two variables distinguish destination decisions concerning leisure tourism in Indonesia and Singapore, except that risk aversion does not differentiate significantly in the context of Singapore. In addition, risk aversion and prior experience are important variables in contrasting destination decisions. Thus, “risk-taker and experienced” respondents express more favourable destination evaluations than “risk-averse and non-experienced” respondents.

By contrast with the leisure tourism results, the mean score comparisons of destination decisions across the four groups are generally not significantly different in the context of medical tourism. As an example of a credence service, it appears that all respondents lack the necessary information to evaluate medical tourism and, in turn, lack confidence in their evaluations. Therefore, regardless of being “risk takers” or “risk averse”, respondents presumably consider medical tourism to be a high-risk product that requires complex decision making. Consequently, all groups, regardless of prior tourism experience, are unlikely to visit Indonesia or Singapore for medical purposes.

This study has a number of limitations. It covers only Australian respondents who evaluated leisure and medical tourism in Indonesia and Singapore. Thus, adding respondents from different countries might increase the robustness of the general conclusions. In addition, further studies should compare destination decisions for leisure and medical tourism in countries with a similar country image, such as Indonesia and Malaysia. A further possibility is to examine the differences in destination decisions in groups with the same risk and prior experience profiles between different countries.

An additional issue in this study is that the “experienced” group profile is not well distributed in terms of travel purposes. In practice, it was difficult to recruit respondents who had visited either Indonesia or Singapore for medical purposes. This group clearly represents a small, albeit increasing, proportion of the Australian tourist population. The respondents who had visited the countries had nearly universally visited Indonesia or Singapore for leisure, with only minimal numbers having visited either country for medical purposes. This finding suggests that travellers’ prior experience is only minimally relevant in the aggregate decisions regarding medical tourism, although experienced medical tourists undoubtedly have an important influence on the decisions of other medical tourists. Therefore, a future study might address this issue by increasing the sample proportion of respondents who have visited a destination country for medical purposes in different

destination countries. As medical tourism is currently rapidly growing, this is a significant problem that may be more feasible to address in the future.

A future study can also examine other similar risk evaluation measurements such as the willingness to take risks, which is familiar in tourism research. Risk aversion is arguably a generalized personality trait, whereas willingness to take risks can be expressed in various levels of generality and may be situation-dependent. Despite the consensus that this construct domain is not yet extensively researched, these results indicate that the construct is an important factor that can influence a destination decision. In this sense, a future study can investigate whether the predictability of willingness to take risks is significantly different when it is expressed as either a general or specific construct such as in a tourism context. Furthermore, a further question is whether various expressions of the willingness to take risks (general to specific) are uni-dimensional or multi-dimensional.

From a managerial perspective, these results reinforce the notion that it is worthwhile to provide an incentive for first-time visitors to a destination country, given the importance of prior experience in forming a better evaluation and higher likelihood of visiting a destination country in the future. Tourism operators and marketers might develop “visitor loyalty programs” to reward those who make frequent trips to a destination country. For instance, an incentive might be implemented through a service package that includes discounted prices for future trips to different locations in the country of destination. Such incentives may be particularly important for Indonesian tourism, as foreign tourists may only have knowledge of Bali and Jakarta and may have limited knowledge of other tourism destinations in the country.

## Appendix 4.1 – Questionnaires

### 1. Prior Experience

Have you ever visited [Singapore/Indonesia]? Yes / No

### 2. Risk aversion

No	Question/Statement	Response
1	I prefer situations that have foreseeable outcomes.	Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>
2	Before I make a decision, I like to be sure how things will turn out.	Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>
3	I avoid situations that have uncertain outcomes.	Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>
4	I feel nervous when I have to make decisions in uncertain situations.	Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>

### 3. Destination Decisions

No	Leisure Tourism	Medical Tourism
1	In the future I will seriously consider visiting [Singapore/Indonesia] for <b>leisure purposes</b> .  Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>	In the future I will seriously consider visiting [Singapore/Indonesia] for <b>medical purposes</b> .  Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>
2	I would visit [Singapore/Indonesia] in the foreseeable future for <b>leisure purposes</b> .  Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>	I would visit [Singapore/Indonesia] in the foreseeable future for <b>medical purposes</b> .  Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>
3	I expect that I would recommend [Singapore/Indonesia] to other people who want to travel for <b>leisure purposes</b> .  Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>	I expect that I would recommend [Singapore/Indonesia] to other people who want to travel for <b>medical purposes</b> .  Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/>

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## **CHAPTER 5**

### **THE ROLE AND IMPACT OF RISK REDUCTION BEHAVIOURS IN LEISURE AND MEDICAL TOURISM**

## **5.1 Abstract**

Scholars have extensively studied the role of risk reduction tactics in the process of consumer decision making, although these studies have not specifically articulated a comparative typology of risk reduction tactics, particularly with respect to tourism studies. This study contributes to this knowledge gap in tourism studies by simultaneously examining the role of risk relief and risk mitigation in a destination decision model. The use of risk relief is a tactic employed to increase the certainty of product success; whereas risk mitigation is used to reduce the consequences of potential loss resulting from the purchase of a product or service. The results indicate that the risk relief tactic significantly increases individuals' willingness to take risks to visit a destination country for leisure and medical tourism. By contrast, risk mitigation significantly decreases individuals' willingness to take risks in both tourism service settings. This study contributes to the literature by providing theoretical and empirical support for the use of risk relief and risk mitigation tactics as separate constructs.

## 5.2 Introduction

Risk reduction tactics are important tools that are employed to increase the likelihood of success and/or to minimize the risks or consequences of making a wrong or sub-optimal product or service purchase. Various typologies of risk reduction tactics have been developed to identify the differences among tactics that distinguish consumer purchase decisions (see Mitchell and McGoldrick 1996). Such typologies are commonly based on the two generic risk reduction tactics of increasing certainty, on the one hand, or mitigating consequences, on the other. In this context, the former tactic of risk reduction has characterized the mainstream approach of previous studies (Mitchell & McGoldrick, 1996). This approach, in practice, implies that an individual is basically reluctant to accept risk though they cognitively manage it. In contrast, an individual make use of risk mitigation as a tool to accept inherent loss. This classification implicitly suggests that there are two distinctive natures inherent in risk reduction tactics and that any risk reduction tactic can thus be classified based on its main purpose, which is logical because these tactics differ in terms of how perceived risks are minimized.

While these two approaches to risk are conceptually unambiguous, convincing empirical evidence which rigorously examines the distinctions between the two types of risk reduction tactics is, however, lacking. Previous studies have treated risk reduction as a general construct (e.g.(Roselius, 1971) but have not classified tactics based on their main purpose. Some scholars have positioned risk reduction tactic as a tool to increase certainty (e.g.,(Brown & Gentry, 1975), whereas other studies have focused on the role of the risk reduction tactic in reducing the consequences of purchase decisions (e.g.,(Manuj & Mentzer, 2008). To date, however, only the household investment decision model developed by Cho & Lee (2006) distinguishes between these types of risk reduction tactics. Although Lo et al. (2011) attempt to classify two forms of risk reduction in the leisure travel of Hong Kong residents (i.e., to increase certainty and to reduce consequences), that

study did not specifically compare the differences between the two forms of risk reduction tactics.

Based on the studies and issues discussed above, a further question arises as to whether the risk reduction should be considered as two-components construct in tourism destination decision models. While it may be argued that there are multiple sources and kinds of risk and that, consequently, risk reduction is likely to be multi-dimensional, there is little published empirical evidence to support the claim. A further methodological issue may also arise when two forms of risk reduction (i.e., risk relief and risk mitigation) are treated as separate constructs and incorporated into a structural equation model. This treatment potentially creates an issue of possible multicollinearity which, if present, will lead to a decreased model fit.

The current study contributes to the literature in several ways. First, a proposed destination decision model simultaneously considers both types of risk reduction (i.e., risk relief and risk mitigation). Previous tourism studies have not tested the magnitude or direction of influence for each type of tactic simultaneously. In particular, this study tests the influence of risk reduction tactics on individuals' willingness to take risk. In addition, this study provides theoretical and empirical support when addressing the problem of separating one construct into two sub-constructs. The recursive model procedure, discussed later, is a solution that can be applied to solve the issue. Finally, previous tourism studies have not compared the role of risk relief and risk mitigation within the settings of leisure and medical tourism. In this study, however, an experience-credence service typology is applied to support the notion that experience service (i.e., leisure tourism) and credence service (i.e., medical tourism) might differ based on the number of risk properties that are embedded in each service.



## 5.3 Literature Review

### 5.3.1 *Risk Reduction: Risk Relief and Risk Mitigation*

Consumers face a dilemma when purchasing a product that involves a perceived potential downside risk (Roselius, 1971). To manage the inherent risks, consumers may take one of four basic actions, namely, purchase the product and absorb the accompanying risks, postpone or forego the purchase, reduce the perceived magnitude of purchase failure, or increase the perceived certainty of the purchase outcome (Brown & Gentry, 1975).

There are numerous tactics for reducing risks. Mitchell and McGoldrick (1996) list 37 tactics that consumers can use to reduce risks, including consulting with family members and friends, seeking information from TV commercials and print advertisements, obtaining price information, and inquiring with salespeople in the country of origin, among others. The two generic approaches to risk reduction are to increase the probability of product success, and to reduce the consequences of product failure (Lo, Cheung, et al., 2011). These approaches are derived from the two components of perceived risk, namely, the uncertainty of product success and the consequences of product failure (Bauer, 1967).

Consumers can utilize a combination of risk reduction tactics to reduce the uncertainty component of perceived risk and the potential consequences of physical, financial, performance, social, psychological, and/or time risks. The chosen risk reduction tactic will commonly depend on its aim. For instance, in the case of leisure tourism, consumers can make use of the advice of family, friends, and travel agents to increase their certainty or confidence (Lo, Cheung, et al., 2011). In the case of reducing the consequences of risks, consumers can, for example, buy travel insurance or travel in tour groups (Lo, Cheung, et al., 2011).

Kahneman and Tversky (1979) examined the issue of risk and proposed “prospect theory” to explain the way humans behave in risky situations. They conducted experiments

in which subjects were presented with the options as sure gains or sure losses. Their results indicated that the subjects tend to take riskier options when presented with ‘losses’, and in contrast, prefer less risky options when they are presented with ‘gains’. This cognitive bias leads to the conclusion of ‘human irrationality’ (i.e., fast, automatic, intuitive and unconscious) because they are less likely to maximise utilities (Holt, 2011), although Kahneman more recently accommodated human rationality (i.e., slow, deliberate, analytical and conscious) by proposing a dual mode of human cognitive processing (Holt, 2011). Following prospect theory, and applying it to tourists’ decision-making, in the situation when tourists are exposed only to ‘gains’ for each tourism offer, they will opt for the offer with highest ‘gains’ (e.g., the destination attractiveness, the excitement of experience, and the healthiness). In order to increase the success of ‘gains’, tourists are more likely to apply risk reduction approaches that increase the occurrence of ‘gains’ which implies that tourists do not take into account losses associated with the option although they might be aware of it.

Conversely, tourists may not choose the tourism option with high chance of ‘gains’ when a high chance of ‘loss’ (e.g., physical, financial, time loss) is framed in the options. As a result, they are more likely to consider other tourism option with lower chance of ‘loss’ despite the chance of ‘gains’ is lower. Otherwise, tourists will accept inherent loss though they, at least, will still apply a risk reduction approach that reduces the consequence of loss.

Although previous studies generally apply the term “risk reduction strategy”, specific terms are typically associated with a risk reduction tactic. McCarthy & Henson (2005) use the term “risk reliever”, which refers to “a piece of information that increases the likelihood of product success”. This concept has been applied interchangeably with risk reduction tactic (Angulo & Gil, 2007; Yeung & Morris, 2001) or “risk relief tactic (RRT)” (Kunze & Mai, 2007). The definition of RRT involves the importance of information to

increase confidence in the expected outcome. RRT plays the same role as information search in the decision-making process (see Assael, 2005). Some forms of RRT that are used to increase the certainty of an expected outcome include gathering information from family members and friends, acquiring information from a travel agent, searching for updated information from the media (e.g., brochures, advertisements in newspapers or travel magazines, TV shows, radio broadcasts, or information on the Internet), and learning the language and culture of the destination country (Lo, Cheung, et al., 2011). The current study posits that information search is a RRT, regardless of whether the concept is expressed as specific or general in scope.

In addition, some studies specifically apply the term “risk mitigation” in lieu of the general term “risk reduction tactic”. Risk mitigation tactic (RMT) refers to individual efforts to reduce the consequences of unexpected outcomes (Manuj & Mentzer, 2008; Norrman & Jansson, 2004; Sjöberg, 1999) and will frequently take the form of purchasing insurance, traveling in tour groups, allocating larger travel budgets, and taking note of government emergency hotlines for tourists (Lo, Cheung, et al., 2011). Based on previous studies, the current study defines risk mitigation as a tool to reduce the consequences of unexpected outcomes resulting from tourism purchase decisions.

It is interesting to note that previous studies commonly use the term “risk reduction strategy(ies)” without a clear justification of applying the term “strategy(ies)”. While any efforts to reduce any potential risk applied in the studies may seem more appropriately as implementation of strategy (i.e., tactics), the use of the term "strategy(ies)" persists. This argument applies in the marketing field which consider marketing tactics as more operational in nature than marketing strategy (Webster, 1992). In the context of strategic management, strategy and tactics differ based on their level of operationalisation and flexibility (Casadesus-Masanell & Ricart, 2010). Accepting this argument, the current

study adopts risk reduction tactic(s) rather than risk reduction strategy(ies) to any action taken to reduce risk.

Previous studies in areas such as consumer behaviour and management have attempted to differentiate between specific types of risk reduction tactics, i.e., RRT (e.g., Brown & Gentry, 1975; Locander & Hermann, 1979) and risk mitigation (e.g., Manuj & Mentzer, 2008; Martin et al., 2009; Ostrom & Iacobucci, 1998; Sjoberg, 1999). Furthermore, other studies treat the risk reduction tactic as a general construct (e.g., Cases, 2002; Dowling & Staelin, 1994; Greatedorex & Mitchell, 1994; Mitchell & McGoldrick, 1996; Roselius, 1971). The current study argues that the various possible risk reduction tactics (i.e., general or specific risk reduction tactics) allow a comparison of the two types of risk reduction (i.e., RRT and RMT) in risk reduction models for destination decisions involving leisure and medical tourism. Furthermore, previous tourism studies generally have not distinguished between RRT and RMT in their analyses. An exception is Lo, Cheung et al. (2011) who classified risk reduction tactics as RRT and RMT but they did not examine the differences.

Although risk reduction strategies can be divided into two different but related constructs (e.g., Cho & Lee, 2006), tourism studies have not yet compared the use of RRT and RMT. Most tourism scholars have focused on the use of the RRT, which increases the certainty of the outcome (e.g., Alegre & Juaneda, 2006; Andereck, 2005; Fuchs & Reichel, 2011; Gursoy & McCleary, 2004; Kunze & Mai, 2007). Other scholars have studied risk mitigation separately from RRT (e.g., Jang, 2004; Paraskevas & Arendell, 2007), and some scholars have examined risk reduction as a general construct (e.g., Ahmed & Krohn, 1993; Lo, Cheung, et al., 2011; Lo, McKercher, et al., 2011; Mitchell et al., 1999). Moreover, previous tourism studies have not compared the use of RRT and RMT in two different types of settings, such as leisure tourism and medical tourism. For instance, Lo, Cheung, et al. (2011) measured preferences regarding risk reduction tactics and found that

purchasing travel insurance, allocating extra cash, and searching for the most recent information about the destination are the main risk reduction tools when making travel decisions for leisure purposes. Fuchs & Reichel (2006a) examined tourist characteristics based on the type of risk reduction, and Fuchs & Reichel (2011) examined the differences in the use of risk reduction tactics between first-time and repeat visitors.

### 5.3.2 *Attitude Predictors of the Risk Reduction Tactic*

Attitude variables might influence the use of RRT and RMT. In particular, consumer knowledge as an attitude variable (Phillips, 1993) is likely to influence the use of RRT. Given that the content of RRT often involves an information search (see Lo, Cheung, et al., 2011), the extent to which consumer knowledge influences the use of RRT might depend on factors such as product involvement, the informational inadequacy of alternatives, insufficient information regarding the product or service under consideration, conflicts between existing beliefs about a product or service and information from external sources, and expectations regarding product or service performance prior to the purchase (Assael, 2005). Greater consumer knowledge (i.e., subjective knowledge) has been found to provide an impetus for individuals to be more confident in their evaluation skills and, in turn, to reduce information search (Brucks, 1985). However, Schmidt & Spreng (1996) proposed that consumer knowledge has a positive influence on searching for external information, implying that more knowledgeable consumers will seek further information. Furthermore, Martin et al. (2009) proposed a model that relates consumer knowledge (i.e., subjective knowledge) and risk reduction behaviours (i.e., risk mitigation).

The variable of “trust” is an attitude variable (Donaldson et al., 2008) that is also considered an antecedent of risk reduction tactics. Trust is “generated as a result of knowledge accumulation” (Flavián, Guinalú, & Gurrea, 2006, p.3) and therefore the degree of knowledge may influence the degree of trust towards a subject. Brand loyalty as

a risk reduction tactic (Yeung & Morris, 2001) is influenced by brand trust (Matzler et al., 2008). The extent of trust determines control (Inkpen, 2004), which has a role that resembles a risk reduction tactic (i.e., confirming expected outcome) (Das & Teng, 2001). The specific risk reduction behaviour of employing a RRT (i.e., information search behaviour) is determined by trust in product/service information (e.g., Menon et al., 2003). Although the influence is marginal, trust determines the demand for risk mitigation (e.g., Sjöberg, 1999).

The study of perceived risks in the tourism field is relatively recent, although the construct has been discussed for four decades (Fuchs & Reichel, 2006a). Perceived risks are considered to influence the extent of risk reduction utilization. Greater perceived risk is predicted to increase the likelihood that a risk reduction tactic will be applied (Fuchs & Reichel, 2006a). The nature of a perceived risk encompasses a certain level of uncertainty (Kim, 2008) and involves the consequences of a potential loss (Murray, 1991). Much of the literature on risks outside of the marketing field distinguishes perceived risks from uncertainty such that perceived risks attach a known probability of consequences, whereas uncertainty entails an unknown probability of consequences (Stone & Grønhaug, 1993). Nevertheless, perceived risk and uncertainty are frequently used interchangeably in marketing research (Peter & Tarpey, 1975). Regardless of the classification issue of the perceived risk construct, the current study examines the influence of perceived risk on the extent of risk reduction utilization. The causal relation is supported by previous studies that propose that perceived risk is an antecedent of the use of RRTs (Derbaix, 1983) and RMT (Martin et al., 2009).

### 5.3.3 *Willingness to Take Risk, Attitude Predictors, and Decision Making*

Willingness to take risk (WTR) is understood to influence behaviour (Constant et al., 2011). However, the construct domain of WTR is not strictly defined with respect to

whether it is an attitudinal (Bonin et al., 2007) or a behavioural construct. The notion of WTR as a behavioural construct arises from its definition (Nicholson et al., 2005) and measurement (Grable & Roszkowski, 2008). Nicholson et al. (2005) and Grable and Roszkowski (2008) mix both attitudinal and behavioural properties in the definition and measurement of WTR. In addition, WTR can be positioned as “willingness to act” (MacIntyre et al., 1998), particularly with respect to a specific action or decision, i.e., “risk taking”. “Willingness to act” is considered to be an element of behaviour intention (McKnight et al., 2002). Therefore, the current study positions WTR as behaviour (i.e., behavioural intention) regardless of the construct domain. Following the theory of reasoned action (Ajzen, 1988), WTR acts as a mediating variable between attitudinal variables (i.e., consumer knowledge, trust, and perceived risk) and behaviour (i.e., destination decisions). Several scholars have argued that consumer knowledge (Yao et al., 2005), trust (Becerra et al., 2008), and perceived risk (Conchar et al., 2004) are antecedents of WTR. Furthermore, the current study applies multiple mediating variables, i.e., RRT and RMT) to mediate the relation between attitudinal variables and WTR. Previous tourism studies have not specifically examined risk reduction tactics in the framework of multiple mediating variables (i.e., RRT and RMT). Risk reduction tactics can be considered an antecedent of WTR (Mitchell, 1998), in which the tendency to apply a particular type of risk reduction tactic may determine the level of WTR among individuals.

#### *5.3.4 Model Development*

As shown in Figure 5.1, the current model is developed based on an attitude–behaviour framework that assumes that various attitudinal variables are predictors of destination decisions (Bentler & Speckart, 1979). In particular, the proposed model is developed from the well-established theory of reasoned action, which treats behavioural intention as a mediating variable (i.e., WTR) (Ajzen, 1988). Based on the literature review,

consumer knowledge, perceived risks, and trust are important attitudinal variables that influence destination decisions directly or possibly through WTR as a mediating variable.

The proposed model was tested in two tourism settings, leisure tourism and medical tourism. Leisure tourism is defined as the activity of travellers visiting countries or places outside of their usual environment, mainly for purposes of leisure (UNWTO, 2014). Meanwhile, medical tourism is defined as “patients leaving their country of residence outside of established cross-border care arrangements made with the intent of accessing medical care, often surgery, abroad” (Johnston et al., 2010), p.1). The distinction between leisure and medical tourism follows the experience-credence service framework, which originated with Nelson (1970) and was extended by Darby & Karni (1973). The distinctions between experience service (e.g., leisure tourism) and credence service (e.g., medical tourism) are based on the availability of information prior to the purchase (Mitra et al., 1999) and the ability to evaluate the outcome of a service (Alford & Sherrell, 1996).

The proposed model assumes that individuals are more likely to have more knowledge and to more easily evaluate the outcome of an experience service (i.e., leisure tourism) than a credence service (i.e., medical tourism). As a consequence, medical tourism is considered riskier than leisure tourism due to the nature of risk associated with the medical treatment performed in the destination country. For instance, it is more difficult to judge the outcome of a surgical procedure performed in the destination country even after return to the home country. Overall, tourists who spend time in a destination country for leisure purposes can more easily evaluate their visit experiences than those whose main travel purpose is to undergo a medical procedure.

Mitra et al. (1999) argue that the extent of some cognitive factors such as knowledge and perceived risk might differ between search, experience and credence services. These authors hypothesize that individuals are more likely to express less knowledge and higher perceived risks concerning credence services than search and



experience services. Furthermore, Wiedenfels (2009) argues that the role of trust in a product or service evaluation differs with the purchasing context. Specifically, differences in the amount of risk that is involved in the consumption of a service might distinguish the role of trust in a service purchase decision (Mayer et al., 1995). Following the principles of instrumental conditioning theory that tourists are rational and attempt to maximize their satisfaction (Assael, 2005), tourists might attach less trust to a credence service than an experience service. Tourists prefer narrow discrepancies between their expectations and actual experiences (i.e., low perceived risk). These principles provide the rationale for testing whether the pattern of the role of the risk reduction strategy differs based on the setting, i.e., between an experience service (i.e., leisure tourism) and a credence service (i.e., medical tourism).

The proposed destination decision model proposes that risk reduction tactics (i.e., RRT and RMT) serve as mediating variables between attitudinal variables. However, the inclusion of RRT and RMT in the proposed model may lead to problems of multicollinearity because, as discussed, RRT and RMT are closely related constructs. The two constructs are in the same domain of risk reduction tactics but differ in terms of their objectives. The consequence of the potential multicollinearity is that model testing using a structural equation model (SEM), as in the current case, might generate poor model fit, which must be resolved by modifying the general SEM through the use of error covariance between mediating variables. There are two approaches in treating error covariance in the case of multi-mediating variables. Some studies have applied zero error covariance (e.g., Holbert & Stephenson, 2003; Rutter & Hine, 2005), whereas other studies have correlated errors between mediating variables (e.g., Gudmundsdottir et al., 2004). The former approach assumes that firm distinctions occur between mediating variables, and the latter approach assumes that there is a certain amount of error correlation between mediating variables due to their position in the same construct domain. Preacher & Hayes

(2008) raise a potential issue of model misspecification in the former approach when there is error correlation between mediating variables. They suggest applying error covariance between mediating variables when inserting them into a path analysis or SEM, as in the current approach.

Following this theoretical discussion, the current study tests the risk reduction model shown in Figure 5.1. The proposed model presents the evaluations and decisions of the respondents to capture the relevance of risk reduction strategies in respondents' decision-making process. Note that RRTs and RMT are shown as mediating variables between attitudinal variables of perceived risk, consumer knowledge and trust and WTR (i.e., a "behavioural intention" variable).

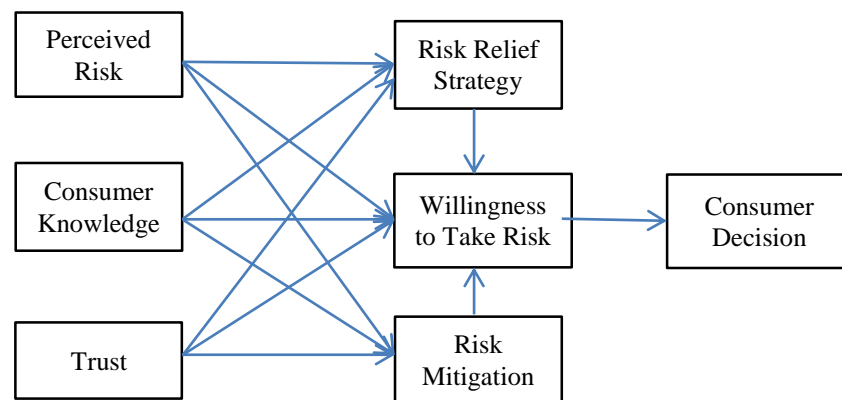


Figure 5.1 Destination Decision Model

## 5.4 Method

Treating RRT and RMT as separate constructs in the proposed model requires both a theoretical and empirical basis. From a theoretical perspective, a good construct or definition consists of *genus proximum* and *differentia specifica* (Brante, 2011). An Aristotelean theory of definition proposes that “every concept is defined as a subclass of a more general concept. This general concept is called the *genus proximum*. Each special subclass of the genus proximum is characterized by special features called the *differentiae*

*specificae*” (Bunt et al., 2012, p.135). Following the principles of the genus-differentia definition, RRT and RMT are subclass of more general concept (i.e., risk reduction tactic), but they have unique properties or *differentia specifica*. RRT is a risk reduction tool that focuses on increasing outcome certainty, and risk mitigation is concerned with reducing the consequences of a negative outcome. However, empirical evidence is required to confirm the differences between RRT and RMT through construct validity testing. The current study applied two techniques for testing discriminant validity, namely, factor analysis (Hair et al., 2006) and the nested model procedure proposed by Bagozzi et al. (1991). The main purpose of applying both tools is to compare the sensitivity of each tool to distinguish constructs in the same class category (i.e., the same *genus proximum*) but with their unique *differentia specifica*. Furthermore, a minimum value of Cronbach’s alpha is required to justify the reliability of each construct. Following Nunnally, et al. (1967, p.226), the minimum scores for reliability measures are 0.5 – 0.6 (in preliminary research); 0.8 (in basic research) and 0.9 – 0.95 (in applied research). The results of the empirical evidence are expected to support two types of risk reduction tactics in the proposed model.

Testing the proposed hypotheses involved a series of stages, including the choice of respondents, research instrument design, data collection procedure, and data analysis. The respondents were Australians who evaluated two types of tourism services - leisure and medical tourism. The questionnaires were developed by applying measurement of seven relevant constructs that were modified from previous studies. The questionnaire included two items relating to consumer knowledge (Brucks, 1985; Sharon & Smith, 1987; Sharon & Talpade, 1994), three items relating to trust (Anderson & Barton, 1992; Crosby et al., 1990; Dahlstrom & Nygaard, 1995; Doney & Cannon, 1997; Ganesan, 1994; Kim et al., 2011; Moorman et al., 1992; Schurr & Ozanne, 1985; Syed Saad, 1996), nine items relating to perceived risk (Fuchs & Reichel, 2006b), five items relating to risk relief (Lo, Cheung, et al., 2011), four items relating to risk mitigation (Lo, Cheung, et al., 2011), one

item relating to WTR (Dohmen et al., 2011), and three items relating to destination decision (Hanzaee & Khosrozadeh, 2011). WTR is the only construct that applies a single item measurement.

Although it might carry with it a potential problem of internal consistency reliability (Wanous et al., 1997), a single item measurement is acceptable given that it has benefits that are both ‘psychometric’ (Fuchs & Diamantopoulos, 2009) and ‘non-psychometric’ (Nagy, 2002). Some ‘psychometric’ benefits include the inclusion of any aspects in the construct under consideration, while ‘non-psychometric’ benefits such as short (Nagy, 2002) and efficient (Gardner, et al., 1998) allow higher levels of questionnaire completion (Wanous, et al., 1997). Another ‘non-psychometric’ benefit is the ability to measure an unexplored facet/attribute (Nagy, 2002). Dohmen, et al. (2011) also applied a single-item measurement of WTR which also has demonstrated behavioural validity. Another view also suggests that many of the attributes in marketing are concrete or singular (e.g., likability, quality of a brand, price perception, and buying intention) which indicates that it is neither necessary nor desirable to measure the attributes through multiple items (Rossiter, 2002). This view is consistent with the use of a WTR as a single-item construct in the current study.

The current study thus tested the destination model based on an Australian tourists’ perspective of leisure and medical tourism. Indonesia and Singapore were selected as representative Southeast Asian countries. Singapore is a benchmark for tourism competitiveness, as it is among the top ten leading countries in the world in the tourism sector. By contrast, Indonesia is ranked 50<sup>th</sup> in the world in tourism competitiveness (World Economic Forum, 2015). Although it has much potential in the tourism sector, increasing the competitiveness of Indonesia’s tourism sector among the Southeast Asian countries involves many challenges. In 2013, Indonesia generated a 9.3% market share for international tourist arrivals in the Southeast Asian market, with revenue equal to 8.4% of

that market share. Singapore surpassed the performance of the Indonesia tourism sector under the same measure by generating a 12.6% market share of international tourist arrivals and 17.8% of tourism revenue (UNWTO, 2015).

The questionnaires for the current study were distributed via an online consumer panel and completed in February 2013. In total, there were 1,024 Australian respondents from different Australian states. Table 1 shows the demographic profiles of respondents based on gender, age, education, and income. The overall samples evaluated both leisure and medical tourism in Indonesia and Singapore. Table 2 shows that the overall sample was dominated by females (61.62%), by respondents in the 57-69 age category (32.23%), by respondents who completed their high school education (35.25%), and by respondents with an income ranging from \$20,000 to \$40,000 (23.73%).

Table 5.1  
*Socio-Demographic Profiles of Respondents*

No	Variable	Category	Frequency	%
1	Gender	Male	393	38.38
		Female	631	61.62
2	Age	18-30	104	10.16
		31-43	192	18.75
		44-56	277	27.05
		57-69	330	32.23
		>70	121	11.82
3	Education	Primary School	10	0.98
		High School (or equivalent)	361	35.25
		Vocational College	327	31.93
		Bachelor's Degree	245	23.93
		Master's Degree (or above)	81	7.91
4	Income	Under \$20,000	115	11.23
		\$20,000 to less than \$40,000	243	23.73
		\$40,000 to less than \$60,000	195	19.04
		\$60,000 to less than \$80,000	165	16.11
		\$80,000 to less than \$100,000	121	11.82
		\$100,000 and over	185	18.07

Source: Primary data, 2013

The following data collection and analysis stages were employed:

1. First, the collected data were screened for missing data, and unnecessary outliers were removed. The procedure was conducted using descriptive statistics, including a box plot procedure provided by SPSS software. Following this procedure, construct validity testing, as previously discussed in the developed model section, was performed. Next, the result of the Cronbach's  $\alpha$  test (see Appendix 5.1a and 5.1b) indicated that all the constructs in the proposed model were reliable ( $>0.6$ ).
2. Secondly, the Australian respondents from different groups were required to conceptualise the constructs in the same way when they evaluated tourism services from different country of destination. Therefore, this study applied one model of measurement invariance test (i.e., configural invariance) to identify measure equivalence across two groups. The results indicate that all the constructs meet the requirement for configural invariance (Steenkamp & Baumgartner, 1998) (see Appendix 5.3, p. 179).
3. Thirdly, risk reduction was tested to determine if it is a uni-dimensional or multi-dimensional construct. Two statistical tools were applied for the discriminant validity test in this stage, namely, factor analysis and a nested model test.

#### *5.4.1 Discriminant Validity Testing Using Factor Analysis*

Factor analysis was applied to examine whether all the constructs in the risk reduction model differ from one another, as shown in Appendix 5.1a and 5.1b. The range of the Kaiser-Meyer-Olkin values are between 0.857 and 0.894 with a significant probability level ( $p < 0.001$ ) for the Bartlett's test of all constructs in the settings of leisure and medical tourism. These sufficient correlations within the correlation matrix allow the factor analysis to proceed. In general, all the items applied to measure each attitudinal variable (i.e., consumer knowledge, trust, and perceived risk) produce convergent (i.e.,

factor loading exceeds 0.5) and discriminant validity (i.e., one measurement item is assigned to measure one construct only). However, the same results do not hold with respect to other constructs in the model. Importantly, RRT and RMT are positioned in the same factor, which implies that they are in the same class category (i.e., risk reduction tactic). An alternative validity test was applied by following the principle from Gaski and Nevin (1985) that discriminant validity occurs when the factor correlation is lower than their respective reliability estimates. The results based on Gaski and Nevin's principle is consistent with the results from the factor analysis (see Appendix 5.1a, 5.1b, 5.2, p.177-179).

The results of the factor analysis and Gaski and Nevin's procedure therefore did not seem to provide an acceptable justification for separating RRT and RMT in the proposed model. A subsequent construct validity test (i.e., nested model and average variance extracted test) were therefore applied to determine if might be more sensitive in distinguishing the two constructs, particularly when they are in the same class category.

#### *5.4.2 Discriminant Validity Using a Nested Model Test and Average Variance*

##### *Extracted*

The nested model test aims to test whether RRT is distinct from RMT, even when they are in the same class category (i.e., risk reduction. The overall destination decision model reduces the risk reduction tactic to two constructs, namely, RRT and RMT. The procedure in a nested model test is conducted to compare fit measures of an unconstrained and a constrained model. The current unconstrained model examines the correlation between RRT and RMT because the two constructs are strongly correlated (i.e., risk reduction strategy as a uni-dimensional construct). The constrained model assumes that RRT has a strong correlation with RMT (i.e.,  $r=1$ ),

which indicates that the two constructs are inseparable. As a rule of thumb, RRT would be considered distinct from RMT when the model fit for the constrained model is significantly worse than for the unconstrained model. Table 5.2 shows the support for the proposition that RRT is distinct from risk mitigation, although they are in the same domain of risk reduction tactics.

Table 5.2  
*Nested Model for RRT and RMT*

	LEISURE		MEDICAL	
	Unconstrained	Constrained	Unconstrained	Constrained
Chi-square	32.18	132.446	19.76	48.29
DF	8	9	6	7
<i>p</i> -value	0.00	0.00	0.00	0.00
Chi-square/DF	4.02	14.72	3.29	6.90
GFI	0.98	0.94	0.99	0.98
AGFI	0.96	0.87	0.96	0.93
CFI	0.98	0.91	0.99	0.98
NFI	0.98	0.90	0.99	0.98
TLI	0.97	0.85	0.99	0.96
RMSEA	0.69	0.15	0.06	0.10
RMR	0.02	0.37	0.02	0.27

Note: Δ Chi-square in Leisure=100.27(*p*=0.00); Δ Chi-square in Medical=28.53(*p*=0.00)  
DF=degree of freedom; GFI=Goodness of Fit Index; AGFI=Adjusted Goodness of Fit Index; CFI=Comparative Fit Index; NFI=Normed-fit Index; TLI=Tucker Lewis Index; RMSEA=Root Mean Square Error of Approximation; RMR=Root Mean Square Residual.

Hair et al. (2006) suggest that discriminant validity holds when average variance extracted (AVE) is higher than both maximum shared variance (MSV) and average shared squared variance (ASV). This study found that AVEs are less than MSVs except ASVs for RRT and RMT in the settings of leisure and medical tourism. These results indicate partial support of discriminant validity for RRT and RMT (see Appendix 5.2, p.179).

4. The discriminant validity testing (i.e., nested model) results therefore indicate that risk reduction can be decomposed into separate variables, i.e., RRT and RMT. However, because both are risk reduction tactics, potential model fit issues might arise. The



proposed model is more likely to generate a poor fit due to the potential high error correlation between RRT and RMT. Therefore, assuming that the pre-modified model generates a poor fit, a modified SEM is necessary through a modified recursive model. The modified recursive model procedure is conducted by applying a disturbance error correlation (i.e., error covariance) between a construct error resulting from both RRT and RMT.

5. The final stage is to test the overall model in both leisure and medical tourism settings. An SEM procedure was applied using AMOS software. The two main outputs of the SEM procedure are the direction and significance of causal relations (paths) among the constructs (as shown in Figure 5.1) and model fit measures. The direction and significance of causal paths are presented as a beta coefficient regression value and a probability value (i.e.,  $p$ -value  $< 0.05$ ). The evaluation of acceptable model fit is judged by applying the fit measures that are shown in Table 5.3.

## **5.5 Results**

### *5.5.1 Structural Equation Modelling*

Further analysis indicates that both models of leisure and medical tourism meet the minimum model fit, as shown in Table 5.3. In general, the modified recursive model generates better fit measures than the pre-modified recursive model. Some fit measures of the pre-modified recursive model do not meet acceptable cut-off values, such as  $p$ -values, AGFI, and RMR in the leisure tourism model, whereas none of the fit measures (except CFI) meets acceptable minimum fit measures in the medical model. However, the modified recursive model in both leisure and medical models achieved acceptable cut-off values for nearly all indices except the  $p$ -value for the Chi-square. More generally, it is difficult to obtain a perfect model fit for all measures with such a complex model.

Table 5.3  
*Model Fit Measures for the Risk Reduction Model*

Fit Measures	Acceptable Cut-off Value	Source	LEISURE		MEDICAL	
			Pre-modified	Modified	Pre-modified	Modified
Chi-square			818.371	485.02	1066.73	494.66
DF			183	182	179	178
p-value	$\geq 0.05$	Barrett, 2007	0.00	0.00	0.00	0.000
Chi square/DF	$\leq 5.00$	Wheaton, 1977	4.47	2.67	5.96	2.78
GFI	$\geq 0.90$	Hooper et al., 2008	0.90	0.94	0.88	0.93
AGFI	$\geq 0.90$	Hooper et al., 2008	0.86	0.91	0.84	0.90
CFI	$\geq 0.90$	Hooper et al., 2008	0.93	0.97	0.90	0.97
NFI	$\geq 0.90$	Bentler & Bonett, 1980	0.91	0.95	0.89	0.95
TLI	$\geq 0.80$	Hooper et al., 2008	0.91	0.96	0.88	0.96
RMSEA	$\leq 0.08$	Hooper et al., 2008	0.07	0.05	0.09	0.05
RMR	$\leq 0.08$	Hu & Bentler, 1999	0.09	0.05	0.14	0.05

*Causal Relationships in the Risk Reduction Model*

After examining the model fit, the next stage is to analyse the causal relationships between the constructs in the model (Table 5.4). In the leisure tourism model, all causal relationships are significant except that between consumer knowledge and RRT and RMT. In addition, trust does not significantly influence the use of RRT and RMT. In the medical tourism model, all independent variables are significant predictors of dependent variables except the causal relation between trust and RRT.

Table 5.4 shows that consumer knowledge and trust significantly increase WTR, whereas perceived risk significantly reduces WTR in both leisure and medical tourism. Moreover, perceived risk significantly decreases the use of RRT and RMT in leisure tourism but increases the use of both risk reduction strategies in medical tourism. Furthermore, RRT significantly increases WTR to visit a destination country in both leisure and medical models; whereas risk mitigation yields significant converse results in both models.

Table 5.4  
*Risk Reduction Model in Leisure and Medical Tourism*

Causal Path	LEISURE		MEDICAL	
	Beta	Prob.	Beta	Prob.
CKnow → WRisk	0.168	0.000	0.448	0.000
PRisk → WRisk	-0.160	0.002	-0.316	0.000
Trust → WRisk	0.326	0.000	0.527	0.000
CKnow → Rrelief	0.027	0.539 <sup>ns</sup>	-0.236	0.002
PRisk → Rrelief	-0.324	0.000	0.166	0.047
Trust → Rrelief	0.083	0.228 <sup>ns</sup>	0.135	0.054 <sup>ns</sup>
CKnow → RMitigation	0.032	0.540 <sup>ns</sup>	-0.373	0.000
PRisk → Rmitigation	-0.340	0.000	0.284	0.003
Trust → Rmitigation	-0.025	0.764 <sup>ns</sup>	0.138	0.082 <sup>ns</sup>
RRelief → WRisk	0.534	0.003	0.450	0.005
RMitigation → WRisk	-0.406	0.009	-0.368	0.004
WRisk → Cdecision	1.109	0.000	1.029	0.000

Note: CKnow=Consumer Knowledge; PRisk=Perceived Risk; WRisk=Willingness to Take Risk; RRelief=Risk Relief; RMitigation=Risk Mitigation; CDecision=Consumer Decision.

## 5.6 Discussion

The findings of the current study provide theoretical and empirical support for the argument that RRT and RMT serve different purposes in terms of reducing the risk of leisure and medical tourism decisions. The findings support the argument that the risk reduction tactic can be decomposed into RRT and RMT. A factor analysis provides evidence that RRT and RMT are in the same class category or *genus proximum* (i.e., of a risk reduction tactic), and the nested model test supports the principles of *differentia specifica*. In other words, there are specific properties of RRT (i.e., “increased certainty”) and “reduced consequence” for RMT.

The findings provide empirical evidence that RRT and RMT have the same influence across both types of tourism services. RRT significantly increases WTR to visit a country of destination for both leisure and medical tourism. These results indicate that respondents express an increased WTR to visit a country of destination when they choose RRT as a tool for risk reduction. These results highlight the importance of information to

respondents when they evaluate a tourism service in a particular destination country. Perhaps unsurprisingly, respondents tend to be less willing to take risk when they do not have sufficient information. They may search for additional information through a travel agent as a general source of information about a tourism service. They may also use updates with the most recent information about the country of destination through brochures, advertisements in newspapers or travel magazines, TV shows, radio broadcasts, or information on the Internet. Interestingly, they also consider that understanding the culture of the destination country increases their certainty that the tourism service offered by that country is likely to meet their expectations.

By contrast, the choice of risk mitigation expresses respondents' hesitation to take risks when traveling overseas. Risk mitigation operates as a compensating tactic when respondents are less willing to take risks in either leisure or medical travel. In tourism, the probability of a potential loss due to service failure is considered high; therefore, travellers will understandably seek to reduce the consequences of such potential loss. Tourists may, therefore, attempt to mitigate such loss by, for instance, purchasing travel insurance, allocating larger budgets for unexpected expenses, and/or taking note of the government emergency hotline number for tourists.

The likelihood of applying either RRT or RMT also depends on several initial cognitive evaluations that precede the tourism purchase. The current study examined three cognitive factors: the extent of consumer knowledge, perceived risk, and trust. The findings provide evidence that perceived risk is the only significant predictor of RRT and RMT in leisure tourism and that consumer knowledge and trust are not relevant predictors for either risk reduction tactic. While the relationships were in the anticipated direction, they were not statistically significant. These results seem to contradict the logic that individuals are more likely to apply a risk reduction tactic when they perceive that the tourism service offered in the country of destination involves higher risk. Such anomalies

may occur when individuals believe that the continuum of the risk level in a leisure tourism service is within their acceptable risk threshold. Simultaneously, individuals might believe that they do not need any additional resources (e.g., time and money) to manage the potential of the uncertainty and the consequences that are embedded in leisure tourism, especially to a relatively familiar country such as Indonesia or Singapore.

Consumer knowledge and perceived risks are significant predictors of RRT and RMT in medical tourism; however trust does not have an impact on the use of either risk reduction tactic. As the knowledge of medical tourism increases, the extent of RRT declines significantly. RRT generally means gathering additional information during a service evaluation, and thus individuals are more likely to search for additional information when they feel that the existing information about a product or service is insufficient for an adequate evaluation, when there is conflict between existing knowledge and knowledge received from a reference group, or when they need to confirm an expected service performance (Assael, 2005). These findings indicate that respondents might feel confident with their existing knowledge during the process of evaluating a medical tourism service and are, therefore, more likely to reduce the influence of RRT. In addition, increased knowledge reduces the likelihood that individuals will apply risk mitigation because they might believe that they can manage the consequences of a travel decision without such mitigation.

Perceived risk significantly influences the use of RRT and RMT in medical tourism. A medical tourism service is more likely to require extensive and reliable information about its providers than a leisure tourism service. In general, personal health is considered an important issue that requires prudence, particularly concerning a healthcare provider. Health issues involve high levels of uncertainty with regard to the service outcome, particularly for complex medical procedures such as surgery. Therefore, individuals tend to increase their information search through mainstream sources of

tourism information (e.g., travel agents and personal sources (WOM)) and non-personal media (e.g., newspapers, magazines, the Internet, etc.) as various RRT. Learning about culture is also an important response to understand and resolve potential conflicts in service delivery. Previous studies have found that cultural issues are critical in the setting of medical tourism, such as in the context of potential malpractice (Turner, 2007) and religious affinity (Moghimehfar & Nasr-Esfahani, 2011). In addition, as a result of the potentially high uncertainty that can result from undergoing medical procedures in a foreign country, respondents are likely to increase their risk mitigation efforts. Purchasing travel insurance and allocating larger budgets are common forms of risk mitigation in which travellers can engage.

The use of RRT and RMT reflect the degree to which respondents tend are willing to take risks in either leisure or medical travel decisions. Given that respondents focus more on RRT, these results indicate that they manage these risks by searching for additional information (and perhaps accepting the minimal residual risks). Furthermore, RRTs are more effective in reducing costs than risk mitigation tactics. Information access through mainstream and social media is convenient. Moreover, the development of information technology (e.g., increased social media exposure) encourages and empowers consumers to obtain the information they consider necessary.

The current study provides empirical evidence that different construct validity tests may have different sensitivities in examining discriminant validity. The combination of factor analysis and a nested model test was shown to be a suitable confirmatory tool when distinguishing constructs that have the same *genus proximum* but unique *differentia specifica*. In this sense, factor analysis focuses on whether two constructs have the same *genus proximum*, and the nested model test can be applied to examine the uniqueness of each construct in the same class category.

As a consequence of the separation of RRT and RMT, the proposed model tested multi-mediating variables that produce an unexpected model fit as the result of high error correlation between the two constructs. In these circumstances, it would have been difficult to improve the model fit without making modifications to the model. The solution for this issue is to add the error correlation between RRT and RMT. The results indicate that the modified model produced better model fit.

The findings indicate that RRT has a more positive impact on WTR for both leisure and medical travel. As a consequence, it is important for tourism destination countries to focus on providing reliable information on a regular basis (i.e., updated information) about their leisure and medical tourism services. In addition to traditional media (e.g., television, radio, print media), greater interest in access to information through the use of the Internet allows for the instant diffusion of information, which enables tourism marketers to disseminate information quickly such that potential tourists worldwide can readily access it.

Promoting leisure and medical tourism can also involve the role of travel agents. Tourism marketers can cooperate with institutions to provide reliable and clear information regarding tourism services in their respective countries. Travel agents are a mainstream source of information about tourism, and people seem to continue to rely on them in planning their itineraries. In addition, tourism marketers can assist people in learning more about the culture in the country of destination. In this task, tourism marketers would be well advised to update continuously their knowledge of medical tourism services.

The use of risk mitigation might express a low WTR. Respondents assume a significant degree of uncertainty as a result of their decisions; therefore, they anticipate uncertainty through risk mitigation efforts such as purchasing insurance and allocating larger budgets for unexpected expenses.

The modified recursive model produced a sufficient model fit for nearly all measures, except for the Chi-square  $p$ -value but the latter result is common in SEM (e.g. Beerli & Martín, 2004; Bélanger & Carter, 2008; Han et al., 2011). However, the modified recursive model adequately represents the cognitive processes in individual risk reduction strategies, and particularly the extent to which RRT and RMT serve as mediating variables between attitudinal variables and WTR. Using only one item to measure WTR might also raise questions regarding internal consistency reliability; however, the use of a single item measurement is now widely accepted, given its advantages (Bergkvist & Rossiter, 2007; Nagy, 2002).

Notwithstanding these largely confirmatory results, the generalizability of the current study's findings in its evaluation of leisure and medical tourism is limited, particularly as only two Southeast Asian countries were considered as destinations, and all the respondents were Australian. Clearly, a broader sample may increase the generalizability of the model's application in the Southeast Asia region and beyond. Future studies should examine consumer evaluations and decisions in leisure and medical tourism services across countries such as Thailand, Malaysia, and Vietnam. Alternatively, respondents from various countries of origin might evaluate leisure and medical tourism in one particular country.

The current study also suggests that future research should identify individuals' preferences for the two types of risk reduction tactics (i.e., RRT and RMT) and measure whether their tendencies to take risk and, thus, their destination decisions differ based on their risk reduction strategy preference. In addition, future research might relate the preferences between RRT and RMT with individual profiles such as socio-demographic characteristics, lifestyle, and personality.



In general, however, the present study has demonstrated the importance of risk and has cast useful light on the mechanism of how consumers deal with risk in leisure and medical tourism.

## Appendix 5.1a

## Factor Analysis for Predictors of Destination Decisions – Leisure Tourism

Factor	Load Factor 1	Load Factor 2	Load Factor 3	Load Factor 4	Load Factor 5	Cronbach's $\alpha$
<b>LEISURE TOURISM</b>						
<b>Factor 1 - Consumer Knowledge</b> <ul style="list-style-type: none"> <li>I am familiar with leisure tourism.</li> <li>I have had experience with leisure tourism.</li> </ul>					0.809 0.842	0.696
<b>Factor 2 - Trust</b> <ul style="list-style-type: none"> <li>In general, leisure tourism is reliable.</li> <li>I generally trust leisure tourism.</li> <li>I believe the information regarding leisure tourism.</li> </ul>				0.844 0.882 0.868		0.926
<b>Factor 3 - Risk Perception</b> <ul style="list-style-type: none"> <li>I worry that I would not receive good value for my money.</li> <li>I worry that accommodations would be unsatisfactory.</li> <li>I worry that the facilities would not be acceptable.</li> <li>I worry that employees in leisure tourism would not be courteous.</li> <li>I worry that employees in leisure tourism would not be professional.</li> <li>I worry that I might not be personally satisfied with a trip to Singapore/Indonesia.</li> <li>I worry that preparation for visiting Singapore/Indonesia for leisure would take too much time.</li> </ul>	0.768 0.846 0.858 0.823 0.838 0.765 0.788					0.928
<b>Factor 4 – Risk Reduction Tactic</b> <p><b>RRT</b></p> <ul style="list-style-type: none"> <li>I would seek advice from travel agents when I travel to Singapore/Indonesia for leisure.</li> <li>When I travel to Singapore/Indonesia for leisure, I would search for the latest information about the destination through brochures, advertisements in newspaper or travel magazines, TV shows, radio broadcasts, or information on the Internet.</li> <li>When I travel to Singapore/Indonesia for leisure, I would read about Singapore/Indonesia and its culture.</li> </ul> <p><b>RMT</b></p> <ul style="list-style-type: none"> <li>I would purchase travel insurance when I travel to Singapore/Indonesia for leisure.</li> <li>When I travel to Singapore/Indonesia for leisure, I would allocate a larger budget for unexpected expenses.</li> <li>When I travel to Singapore/Indonesia for leisure, I would take note of the Singapore/Indonesia government emergency hotline for tourists.</li> </ul>		0.728 0.767 0.725 0.754 0.645 0.803				0.762  0.732
<b>Factor 5 - Willingness to Take Risk</b> <ul style="list-style-type: none"> <li>I am willing to take risks visiting Singapore/Indonesia for leisure purposes.</li> </ul>					0.840	

## Appendix 5.1b

### Factor Analysis for Predictors of Destination Decisions – Medical Tourism

Factor	Load Factor 1	Load Factor 2	Load Factor 3	Load Factor 4	Load Factor 5	Cronbach's $\alpha$
<b>MEDICAL TOURISM</b>						
<b>Factor 1: Consumer Knowledge</b> <ul style="list-style-type: none"> <li>I am familiar with medical tourism.</li> <li>I have had experience with medical tourism.</li> </ul>					0.895 0.759	0.635
<b>Factor 2: Trust</b> <ul style="list-style-type: none"> <li>In general, medical tourism is reliable.</li> <li>I generally trust medical tourism.</li> <li>I believe the information regarding medical tourism.</li> </ul>				0.891 0.915 0.893		0.930
<b>Factor 3 - Risk Perception</b> <ul style="list-style-type: none"> <li>I worry that I would not receive good value for my money.</li> <li>I worry that accommodations would be unsatisfactory.</li> <li>I worry that the facilities would not be acceptable.</li> <li>I worry that employees in medical tourism would not be courteous.</li> <li>I worry that employees in medical tourism would not be professional.</li> <li>I worry that I might not be personally satisfied with a trip to Singapore/Indonesia.</li> <li>I worry that preparation for visiting Singapore/Indonesia for medical treatment would take too much time.</li> </ul>	0.708 0.812 0.763  0.787  0.780  0.653  0.693					0.882
<b>Factor 4 – Risk Reduction Tactic</b> <b>RRT</b> <ul style="list-style-type: none"> <li>I would seek advice from travel agents when I travel to Singapore/Indonesia for medical treatment.</li> <li>When I travel to Singapore/Indonesia for medical treatment, I would search for the latest information about the destination through brochures, advertisements in newspaper or travel magazines, TV shows, radio broadcasts, or information on the Internet.</li> <li>When I travel to Singapore/Indonesia for medical treatment, I would read about Singapore/Indonesia and its culture.</li> </ul> <b>RMT</b> <ul style="list-style-type: none"> <li>I would purchase travel insurance when I travel to Singapore/Indonesia for medical treatment.</li> <li>When I travel to Singapore/Indonesia for medical treatment, I would allocate a larger budget for unexpected expenses.</li> <li>When I travel to Singapore/Indonesia for medical treatment, I would take note of the Singapore/Indonesia government emergency hotline for tourists.</li> </ul>		0.686  0.858  0.798				0.795  0.875
<b>Factor 5 - Willingness to Take Risk</b> I am willing to take risks visiting Singapore/Indonesia for medical purposes.					0.521	

## Appendix 5.2

*The Average Variance Explained (AVE), the Maximum Shared Variance (MSV), the Average Shared Squared Variance (ASV), and Factor Correlation Matrix*

FACTOR	AVE	MSV	ASV	RM	CK	TR	PR	RR
<b>LEISURE TOURISM</b>								
RM	0.489	0.778	0.215	0.699				
CK	0.566	0.303	0.107	0.100	0.752			
TR	0.809	0.303	0.160	0.121	0.550	0.900		
PR	0.650	0.260	0.128	-0.238	-0.293	-0.510	0.806	
RR	0.526	0.778	0.244	0.882	0.177	0.247	-0.328	0.725
<b>MEDICAL TOURISM</b>								
RM	0.707	0.810	0.211	0.841				
CK	0.623	0.067	0.030	-0.186	0.789			
TR	0.595	0.228	0.074	-0.032	0.258	0.771		
PR	0.519	0.228	0.057	0.012	0.027	-0.478	0.720	
RR	0.572	0.810	0.207	0.900	-0.128	0.022	-0.014	0.756

Note: RM=Risk Mitigation; CK=Consumer Knowledge; TR:Trust; PR=Perceived Risk; RR: Risk Relief

## Appendix 5.3

*Confirmatory Factor Analysis for All Constructs – Leisure and Medical*

FACTOR	Cut-off value	Reference	LEISURE	MEDICAL
CMIN/DF	$\leq 5.00$	Wheaton, 1977	2.967	3.552
CFI	$\geq 0.90$	Hooper et al., 2008	0.930	0.906
TLI	$\geq 0.80$	Hooper et al., 2008	0.914	0.885
RMSEA	$\leq 0.08$	Hooper et al., 2008	0.056	0.063

## 5.7 References

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## **CHAPTER 6**

### **GENERAL DISCUSSION**

## **6.1 Summary of Results**

This study had been conducted to address three important issues regarding the status and meaning of the construct of willingness to take risk. Firstly, should it be better regarded as an attitudes or as a behaviour; Secondly, it has examined the combined effect of visit experience and other risk-related predictors (i.e., cultural distance and risk aversion); and, thirdly, it has examined the impact of risk relief and risk mitigation strategies as a tool for risk reduction on the willingness to take a travel risk. The hypotheses were proposed and tested using a quantitative approach and the results are presented in Table 1. This study is based on the continuum of experience-credence services and positions leisure and medical tourism based on the differences in the differences in inherent risk between leisure and medical tourism services. In general, all the hypotheses were supported in both settings of leisure and medical tourism.

Chapter Two indicate that risk-related predictors of destination decisions generally have an important impact on destination decisions in the contexts of both leisure and medical tourism. Consumer knowledge, trust, perceived risk, and willingness to take risk (WTR) significantly influence destination decisions. Following the framework of the theory of reasoned action (Fishbein & Ajzen, 1975), the present study presents two competing models, namely, the hierarchical model and the mediating model. By applying a mediating variable test (Baron & Kenny, 1986), the results of the present study suggest that WTR partially mediates the relationship between attitude variables (i.e., consumer knowledge, trust, and perceived risk) and destination decisions. These results provide an empirical basis to view WTR as a behavioural, rather than an attitudinal measure in both leisure and medical tourism contexts. The results indicate that the mediating model better explains destination decisions that are made in both leisure and medical tourism than the hierarchical model. The WTR findings indicate that the risk factors that are embedded in a tourism service (Sirakaya & Woodside, 2005) are important variables that are considered

before respondents make travel decisions. In addition, WTR partially mediates other risk-related predictors of destination decisions.

Table 6.1  
*Summary of Hypotheses and Results*

Chapter	Hypothesis	Results
2	<i>Hypothesis 1:</i> WTR is better measured as a behaviour than as an attitude in destination decision models in leisure and medical tourism settings.	Supported
3	<i>Hypothesis 1:</i> “Low cultural distance” groups are more likely than “high cultural distance” groups to visit a country of destination for leisure and medical purposes.	Generally supported
	<i>Hypothesis 2:</i> “Experienced” groups are more likely than “non-experienced” groups to visit a country of destination for leisure and medical tourism.	Generally supported
	<i>Hypothesis 3a:</i> Respondents with “low cultural distance and visit experience” have the highest likelihood of traveling for leisure and medical tourism. <i>Hypothesis 3b:</i> Respondents with “high cultural distance and no visit experience” have the lowest likelihood of traveling for leisure and medical tourism.	Generally supported
4	<i>Hypothesis 1:</i> Risk-takers are more likely to visit a country of destination than risk-averse.	Generally supported
	<i>Hypothesis 2:</i> The likelihood that both “risk-taker” and “risk-averse” groups visit a destination country is higher for leisure than for medical tourism.	Generally supported
	<i>Hypothesis 3:</i> Destination decisions of “risk-taker” and “risk-averse” consumers differ with respect to prior visit experiences.	Generally supported
5	<i>Hypothesis 1:</i> Risk reduction strategy may be decomposed into two interrelated constructs namely risk relief and risk mitigation strategy.	Supported

In addition to satisfaction and destination image (see Table 1.1 in Chapter One), prior experience (i.e., visit experience) is among the most frequently discussed predictors of destination decisions, particularly in the context of leisure tourism. The present study extends the discussion of visit experiences in the previous tourism literature by investigating the interactive effects of prior experience with other predictors of destination



decisions. In Chapter Three, this study discussed the differentiating effects of visit experience and cultural distance on destination decisions. Because both cultural distance and visit experience are treated as stand-alone variables, these variables significantly distinguish destination decisions. Notably, the type of tourism service (i.e., leisure tourism and medical tourism, in this study) and country of origin cues also contribute to distinguish destination decisions. Respondents with “low cultural distance” are more confident than those with “high cultural distance” in visiting a destination country; however, they are more likely to make travel decisions to visit (particularly for a leisure purpose) a country of destination with a more positive image (e.g., Singapore). The lowest likelihood of destination decision applies when those perceiving “high cultural distance” are considering visiting a country with a less positive image (e.g., Indonesia). Subsequently, although respondents with prior visit experience express the highest likelihood of deciding to visit a country, they are even more likely to make a travel decision for leisure purposes to a country of destination with a positive image (e.g., Singapore). However, respondents with no prior visit experience are more reluctant to choose a destination than those who have prior visit experience and are even more reluctant to visit a country of destination with a less positive image (i.e., Indonesia), particularly for medical purposes.

Chapter Three extends the discussion on the role of cultural distance and prior visit experience in destination decisions. In that chapter, 2x2 matrices were applied that consisted of two categories of prior visit experience (i.e., with experience and no experience) and cultural distance (i.e., low and high cultural distance). The findings indicate that respondents with “low cultural distance and visit experience” express the highest likelihood to visit a country of destination in the contexts of both leisure and medical tourism. By contrast, respondents with “high cultural distance and no visit experience” express the lowest likelihood to visit a country of destination for leisure and medical tourism. In general, the findings suggest that visit experience coupled with cultural

distance more consistently produces differential effects on destination decisions than cultural distance alone, particularly with respect to the context of leisure tourism. Furthermore, respondents are more reluctant to initiate travel decisions for medical than for leisure purposes. Visit experience and cultural distance indicate that there may be “synergy” effects in distinguishing destination decisions in the contexts of leisure and medical tourism in Indonesia and Singapore.

The role of visit experience and risk aversion in destination decisions was examined in Chapter Four. The findings indicate that visit experience and risk aversion produce differential effects on destination decisions in both leisure and medical tourism. “Risk taker with visit experience” respondents express the highest level of positive destination decisions, whereas “risk averse with no experience” respondents are the least likely to travel to a country of destination. Moreover, the type of tourism service (i.e., leisure or medical tourism) amplifies the differential effects produced by risk aversion and prior visit experience on destination decisions. Respondents have a greater likelihood of traveling for leisure than for medical purposes. In addition, the results suggest that prior visit experience coupled with risk aversion is a stable predictor in distinguishing destination decisions compared with risk aversion alone. The findings of Chapters Three and Four suggest that prior visit experience is the strongest predictor in distinguishing destination decisions for leisure and medical tourism settings than the cultural distance and risk aversion constructs.

The final set of findings in Chapter Five relates to the relevance of risk reduction strategies in mediating the relationship between attitude variables (i.e., consumer knowledge, trust, and perceived risk) and behavioural measures (i.e., WTR). The principles of *genus proximum* and *differentia specifica* provide the theoretical foundation for positioning risk relief (RRT) and risk mitigation tactics (RMT) as subclasses of more general concept (i.e., risk reduction tactics), but they differ in their unique properties. In

other words, RRT focuses on an increase in positive outcome certainty, and RMT focuses on reducing the consequences of potential loss regarding (travel) behaviour. The results provide empirical evidence that RRT and RMT differ in their unique purposes and influential direction, although they are positioned in the common domain of risk reduction strategies. The tendency to choose RRT increases WTR, and a preference for RMT tends to decrease WTR. In this sense, the results support the notion that tourists value information as a tool for reducing uncertainty during vacation travel planning (McCleary & Whitney, 1994). In addition, the use of RMT implies that respondents are reluctant to take risks and, therefore, attempt to compensate for such reluctance through efforts to reduce the potential consequences of their decisions. The results of the current study indicate, however, that, RRT and RMT do not have direct significant effects on destination decisions.

## **6.2 Theoretical Implications**

This thesis suggests that the WTR construct is more appropriately seen as a behavioural, rather than attitudinal, measure across both leisure and medical tourism. As a consequence, future tourism studies might further usefully study the role of WTR in tourists' decision-making. To date, there is no consensus concerning the role of the WTR construct. To date, consumer behaviour studies do not seem to consider WTR as strictly one domain, either in terms of definition (see Nicholson et al., 2005) or construct measurement (see Grable & Roszkowski, 2008). Therefore, the present study provides empirical justification for positioning WTR in the behaviour domain, in addition to its widely accepted attitude domain. The manner in which the construct is defined and measured implies that WTR can be considered a complex construct. To date, WTR has not been frequently discussed as a predictor of destination decisions, and thus the choice of WTR as an alternative predictor of destination decisions merits further investigation. At

the same time, its domain must be specified and confirmed to justify the position of WTR, particularly if future studies apply the theory of reasoned action (Fishbein & Ajzen, 1975) as a framework for proposed models. In the present study, the mediating variable testing procedure supports the conclusion that WTR acts as a mediating variable between attitude variables (i.e., consumer knowledge, trust, and perceived risk) and destination decisions.

Chapters Three and Four confirm the importance of prior visit experience in distinguishing destination decisions. The results suggest that visit experience is a more consistent predictor of differential effects than attitudinal predictors such as cultural distance and risk aversion. Perhaps unsurprisingly, respondents are particularly consistent when providing their responses regarding their destination decisions in the same context or purpose as their prior visit experience (i.e., visiting a destination mainly for leisure or medical tourism). These results are consistent with the logical principle that knowledge from prior experience is a strong predictor of behavioural intentions (Taylor & Todd, 1995). Therefore, given the importance of prior visit experience in destination decisions, it is important to measure visit experience.

The findings of Chapter Five suggest that risk reduction strategies significantly influence WTR, rather than directly influencing destination decisions. The choice of risk reduction strategies determines the level of respondents' WTR. Those who prefer to utilize RRT implicitly may have at least minimal prior confidence in the process of service evaluation and might believe that a risk associated with the evaluated tourism service can be managed. RRT can be regarded as a tool for increasing the certainty of a service outcome. However, individuals' preferences for RRT do not necessarily lead to an increased likelihood of making destination decisions which is caused by situational factors (see Belk, 1975; Gehrt & Pinto, 1991). For instance, respondents may be asked to evaluate a tourism service within a specific and constrained time frame and might, as a consequence, consider that conducting an extensive information search through various

channels (i.e., family, reference groups, the media, etc.) is not necessary or feasible. By contrast, risk mitigation involves anticipating a tourism risk attached to a particular service. Those who evaluate the service with this approach assume that they cannot manage the risk associated with the service and assume that they might incur a loss as a result of their travel decisions. Therefore, tourists who prefer risk mitigation believe that they must reduce any potential negative consequences of the decision, by, for example, purchasing travel insurance. Risk mitigation is thus likely to be preferred by those with low WTR, but the preference for risk mitigation does not necessarily lead to an increased likelihood of making particular destination decisions.

The findings of Chapter Five also provide empirical support for distinguishing two types of risk reduction tactics (i.e., RRT and RMT) in the research model. This study provides empirical evidence that different types of discriminant validity tests may differ in their sensitivity to distinguishing relevant constructs in the proposed model. This issues is particularly beneficial in identifying and distinguishing between constructs that are in the same *genus proximum* but have their own *differentia specifica* (see(Brante, 2011; Heink & Kowarik, 2010). Factor analyses was used to find that both RRT and RMT are positioned in the same class category (i.e., risk reduction tactics), and a nested model test (Bagozzi et al., 1991) demonstrates that RRT and RMT differ, although they belong to the same domain of risk reduction tactics. Because they belong to the same domain, there is the possibility of poor model fit which must be resolved by measuring error covariance between RRT and RMT (e.g., Gudmundsdottir et al., 2004). The present study provides a method to apply both factor analysis and a nested model test to justify the relation between broader constructs that are related to more specific constructs. Nevertheless, this procedure should be tested across other constructs to confirm its reliability.

### 6.3 Managerial Implications

The results of this study lead to several managerial implications that might be implemented in designing marketing communication strategies. As the results of this study demonstrate, risk is an important factor in the tourist decision-making process. Responses concerning risk factors (i.e., the decision to visit Indonesia or Singapore) may vary depending on several moderators, such as the type of tourism service (e.g., leisure or medical tourism), country image, prior visit experience, cultural distance, and risk aversion. The following managerial implications arise from the findings of this study:

1. Country branding (e.g., Gilmore, 2002) at the macro (national) and micro (e.g., tourism attractiveness and/or the quality of hospitals, doctors, or beauty clinics) levels is needed to boost the positive image of destination countries. In turn, a better country image may improve attitudinal responses and WTR in destination decisions for both leisure and medical tourism. In the present study, the respondents perceived a less positive image of Indonesia compared with Singapore in several areas (i.e., safety, cleanliness, crime, and natural disasters). Therefore, it is important to encourage more positive evaluations of a destination country, such as through celebrity endorsements (Glover, 2009). A destination country's image relates to the risk associated with any product or service that is offered by the country (Laroche et al., 2005). As a country's image becomes increasingly positive, tourists become more likely to perceive a lower risk level, improve their attitudinal responses, and increase their WTR, which is followed, in turn, by a higher likelihood of tourists making positive destination decisions about the country. Given that the nature of the service differs between leisure and medical tourism, tourism marketers, should increase their understanding of the differing consumer attitudes towards the different types of tourism (i.e., leisure and medical tourism).

2. Prior visit experience consistently distinguishes destination decisions and the magnitude of its effects increases when individuals evaluate the same tourism services (i.e., visiting a destination mainly for leisure or medical purposes). Prior visit experience logically increases the level of confidence among respondents when they evaluate a service prior to purchase. The findings of the current study have highlighted the importance of prior visit experience and suggest that “experienced” and “first time” visitors comprise significantly distinct market segments. In the short term, therefore, tourism marketers may, for example, focus their marketing communication strategies on experienced visitors by, for example, offering a “visitor loyalty program” in the form of price discount rewards that are applied based on trip frequency. Such a program would be particularly useful to introduce to experienced visitors new destinations in Indonesia, which has features that have substantial potential for boosting tourism, such as natural and cultural richness and Bali. In the long term, tourism marketers may encourage first-time visitors by providing relevant and timely information about risk issues (e.g., safety and health) that might concern potential tourists. In addition, tourism marketers may provide incentives for “first-time visitors”. The focus of such a program would be to provide an opportunity for first-time visitors to overcome their perceptions of risk and of the less positive image of the services offered by a destination country.
3. Language is an element that contributes to cultural distance (Ye et al., 2012). Therefore, one strategy that tourism markers can use to address cultural distance is to ensure that all parties that are responsible for delivering services – for both direct and indirect interactions – have sufficient competency in an international language (at least English proficiency). Tourism marketers should also encourage the use of non-English languages to communicate with other potential markets, such as tourists from China. The requirement for language proficiency is crucial, particularly in the

context of medical tourism, in which healthcare providers must communicate and deliver medical treatment to medical tourists with a high level of clarity and accuracy. Understanding a foreign tourist's language will help improve the quality of interaction, which in turn will reduce perceptions of risk experienced by medical tourists (Ye et al., 2012) and assist them in understanding the local medical and legal systems in relation to potential malpractice (Turner, 2007). The level of language proficiency among employees should be assessed through an English test designed for a specific purpose (e.g., medical service) beyond standard TOEFL and IELTS tests.

4. This study suggests that both types of risk reduction tactics (i.e., RRT and RMT) significantly influence WTR as a predictor of destination decisions. However, neither RRT nor RMT provides a significant direct impact on destination decisions. This study suggests that tourism marketers should encourage the use of RRT rather than RMT because RRT leads to increased WTR. For instance, tourism marketers could cooperate with travel agents to provide necessary and additional information regarding a destination country. In particular, tourism marketers can use travel agents to communicate appropriate information and responses concerning matters that are related to risk factors – such as issues concerning natural disasters, safety, and terrorism. In addition, tourism marketers may utilize various types of media such as brochures, the Internet, radio broadcasts, travel magazines, and TV shows to provide a more comprehensive understanding of a country of destination.

## **6.4 Limitations**

Naturally, the current study is not without its limitations. Some limitations of this study relate to the sampling procedure, construct measurements, and justification of the construct domain. This study only involved Australian respondents who evaluated leisure



and medical tourism across two Southeast Asian countries, Indonesia and Singapore. A question might arise regarding the choice of evaluating medical tourism in Indonesia and Singapore rather than other Southeast Asian countries such as Malaysia (Turner, 2007), the Philippines (Crooks et al., 2010), or Thailand (Herrick, 2007), which are also actively pursuing the emerging medical tourism market. In the current study, leisure and medical tourism in Indonesia and Singapore were selected as the subject countries due to their locations in the same region and the contrast between the countries regarding tourism competitiveness. Singapore is a benchmark for tourism competitiveness not only in Southeast Asia but also in the Asia Pacific region (World Economic Forum, 2015). In contrast, the Indonesian tourism sector has substantial natural and cultural richness (Sunario, 2007) but must address several risk-related issues such as natural disasters, terrorism, safety, cleanliness, health (Sunario, 2007), and a lack of infrastructure and connectivity (Nangoy, 2012).

A further issue concerns the test of a construct with a single-item measurement such as WTR, which might be criticized due to a lack of internal consistency reliability (Wanous et al., 1997). However, some scholars support the use of single-item measurements given their ability to generate acceptable psychometric properties (Fuchs & Diamantopoulos, 2009) and ‘non-psychometric’ benefits such as being short (Nagy, 2002) and efficient (Gardner et al., 1998), which lead to an increased level of questionnaire completion (Wanous et al., 1997). Previous studies that have applied a single-item measurement of WTR have also demonstrated behavioural validity (e.g., Dohmen et al., 2011). In addition, there is an issue in terms of reliability of the consumer knowledge measure (i.e., low values of Cronbach alpha) despite the view that reliability is still acceptable in the setting of preliminary research (Nunnally et al., 1967). The assessment of construct reliability in previous published marketing research also indicates that the current study provided acceptable values of reliability estimates (see Peter, 1979). Another

important issue is that this study focused only on the use of quantitative approach and, consequently, lacked a qualitative insight into the question of the country of destinations (i.e., Indonesia and Singapore). Nevertheless, the findings still validate the conclusion that risk factors are clearly relevant when evaluating tourism destination decisions.

## **6.5 Future Study Suggestions**

With respect to whether this study provides generalizable conclusions, it would be useful to testing the current model across more destination countries and across sample populations beyond Australia. Such a test would potentially demonstrate the robustness of the general conclusions. Furthermore, this test can be implemented by involving more countries from the same region (e.g., Malaysia, the Philippines, and Thailand for the Southeast Asia region) or countries with similar tourism sector competitiveness (e.g., Thailand, India, Singapore, and South Korea for medical tourism). In addition, leisure and medical tourism in a particular country can be evaluated by respondents from various countries of origin. An additional suggestion for future research is to apply a “search service” setting such as an online ticketing system for airline, resort, or hotel services to complete the discussion of tourist decision making in the context of the search-experience-credence service framework (Mitra et al., 1999).

Future studies may apply a product/service involvement construct to provide additional confirmation that there is a distinction between leisure and medical tourism and that the result fits in the framework of an experience-credence service. Future studies of product/service involvement might, therefore, examine the differences between leisure and medical tourism based on some measures of product/service involvement, such as product/service importance, interest, risk, emotion, and badge value (see Assael, 2005). The proposed hypothesis is that tourists are more likely to be involved with a medical rather than leisure tourism service. In addition, future studies may examine whether the

extent of product/service involvement in leisure and medical tourism services differs consistently across cultures (e.g., Zaichkowsky & Sood, 1989). If a consistent difference exists, then tourism marketers might have to customize their strategies to communicate and deliver tourism services to different markets rather than communicating and delivering standardized tourism services and messages to a fragmented market as a result of cultural differences.

## **6.6 Concluding Remarks**

In summary, the current study provides valuable insights that risk is a relevant factor in the evaluation of destination decisions for leisure and medical purposes. There are differences in attitudes and behavioural responses, although the same mediating model framework applies for both tourism services. WTR is supported as a behavioural, rather than an attitudinal, measure in the mediating model framework. This position is consistent with the theory of reasoned action and the procedure of mediating variable testing. Leisure and medical tourism can be positioned in the framework of an experience-credence service that considers variations in the level of risk associated with leisure and medical tourism. To date, tourism studies have not discussed the main travel purpose in the framework of experience-credence services. The present study explains the relation between main travel purposes (i.e., leisure or medical purposes) and risk properties associated with each travel purpose. This study extends the discussion on prior visit experience by incorporating attitudinal measures such as cultural distance and risk aversion to generate interactive effects on destination decisions. Overall, this study finds that the preference for different types of risk reduction strategies might be distinguished as an expression of WTR. The preference for RRT indicates the tendency for risk taking; by contrast, RMT tends to express a hesitancy to take risks. While the topic of risk and its implications for tourists' destination decisions is neither novel, nor surprising, the present study has explored its

complexity and demonstrated its central importance in understanding and marketing to potential tourists.

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## APPENDIX

### ETHICS APPROVAL



ALBERT NUGRAHA <albert.nugraha@students.mq.edu.au>

#### Final Approval - 5201200636(D)

Mrs Yanru Ouyang <yanru.ouyang@mq.edu.au>

Mon, Sep 17, 2012 at 3:32 PM

To: Prof Greg Elliott <greg.elliott@mq.edu.au>

Cc: Mr Hamin Hamin <hamin.hamin@mq.edu.au>, Mr Albert Kriestian Novi Adhi Nugraha <albert.nugraha@students.mq.edu.au>

Dear Prof Elliott,

Re: 'Consumers' decisions to visit a risky country destination: An analysis of tourists' risk taking.'

Reference No.: 5201200636

Thank you for your recent correspondence. Your response has addressed the issues raised by the Faculty of Business & Economics Human Research Ethics Sub Committee. Approval of the above application is granted, effective 17 September 2012 and you may now commence your research.

This research meets the requirements of the National Statement on Ethical Conduct in Human Research (2007). The National Statement is available at the following web site:

[http://www.nhmrc.gov.au/\\_files\\_nhmrc/publications/attachments/e72.pdf](http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72.pdf).

The following personnel are authorised to conduct this research:

Prof Greg Elliott  
Mr Hamin Hamin  
Mr Albert Kriestian Novi Adhi Nugraha

NB. STUDENTS: IT IS YOUR RESPONSIBILITY TO KEEP A COPY OF THIS APPROVAL EMAIL TO SUBMIT WITH YOUR THESIS.

Please note the following standard requirements of approval:

1. The approval of this project is conditional upon your continuing compliance with the National Statement on Ethical Conduct in Human Research (2007).
2. Approval will be for a period of five (5) years subject to the provision of annual reports.

Progress Report 1 Due: 17th Sept 2013  
Progress Report 2 Due: 17th Sept 2014  
Progress Report 3 Due: 17th Sept 2015  
Progress Report 4 Due: 17th Sept 2016  
Final Report Due: 17th Sept 2017

NB. If you complete the work earlier than you had planned you must submit a Final Report as soon as the work is completed. If the project has been discontinued or not commenced for any reason, you are also required to submit a Final Report for the project.

Progress reports and Final Reports are available at the following website:

[http://www.research.mq.edu.au/for/researchers/how\\_to\\_obtain\\_ethics\\_approval/human\\_research\\_ethics/forms](http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms)

3. If the project has run for more than five (5) years you cannot renew approval for the project. You will need to complete and submit a Final Report and submit a new application for the project. (The five year limit on renewal of approvals allows the Committee to fully re-review research in an environment where legislation, guidelines and requirements are continually changing, for example, new child protection and privacy laws).

4. All amendments to the project must be reviewed and approved by the Committee before implementation. Please complete and submit a Request for Amendment Form available at the following website:

[http://www.research.mq.edu.au/for/researchers/how\\_to\\_obtain\\_ethics\\_approval/human\\_research\\_ethics/forms](http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/forms)

5. Please notify the Committee immediately in the event of any adverse effects on participants or of any unforeseen events that affect the continued ethical acceptability of the project.

6. At all times you are responsible for the ethical conduct of your research in accordance with the guidelines established by the University. This information is available at the following websites:

<http://www.mq.edu.au/policy/>  
[http://www.research.mq.edu.au/for/researchers/how\\_to\\_obtain\\_ethics\\_approval/human\\_research\\_ethics/policy](http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human_research_ethics/policy)

If you will be applying for or have applied for internal or external funding for the above project it is your responsibility to provide the Macquarie University's Research Grants Management Assistant with a copy of this email as soon as possible. Internal and External funding agencies will not be informed that you have final approval for your project and funds will not be released until the Research Grants Management Assistant has received a copy of this email.

If you need to provide a hard copy letter of Final Approval to an external organisation as evidence that you have Final Approval, please do not hesitate to contact the FBE Ethics Committee Secretariat, via [fbe-ethics@mq.edu.au](mailto:fbe-ethics@mq.edu.au) or 9850 4826.

Please retain a copy of this email as this is your official notification of final ethics approval.

Yours sincerely  
Alan Kilgore  
Chair, Faculty of Business and Economics Ethics Sub-Committee