

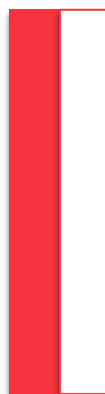
MASTER
SERVICES MANAGEMENT

WHAT MOVES THE MEDICAL TOURISTS? THE MAIN MOTIVATIONS AND FEARS - THE IMPACT OF THE NATIONALITY

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Abstract

Due to the growth of medical tourism, studying the different aspects of this topic is becoming more and more important. Therefore, learning the profile of the medical tourists is becoming fundamental. This study intends to contribute to a better understanding of the profile of the medical tourists/potential medical tourists, namely in terms of their main motivations and fears. For this purpose, phone interviews were done. The findings revealed some different fears and motivations to be explored by the literature. In terms of fears, the unknowing/untrusting in the healthcare system of the country of destiny, the eventual consequences for the individual's health, and not being able to communicate with the medical staff. Also, the culture and geographic proximity and the positive information, among others, were identified as motivations. Additionally, it was possible to conclude that the motivations related to the quality/the perceived quality of the medical procedure influence the decision to perform or not an aesthetic intervention abroad. The motivations not directly related to it probably impact the decision but should not be determinative. Finally, it was possible to identify some aspects that may significantly impact the choices of the medical tourists/potential medical tourists, such as the expected time of recovering in the other country. Additionally, this study intended to compare the influence of the nationality in the impact of the main motivations and fears in the decision to perform (or not) medical tourism. For this purpose, an online survey was conducted. The findings revealed that, as a rule, people from nationalities with a high level of uncertainty avoidance are less willing to perform medical tourism and will be more influenced by the main motivations and fears, however, some exceptions exist.

Keywords: Medical tourism; Medical travel; Medical tourist; Potential medical tourist; Motivations and fears; Aesthetic intervention; International patient.

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1. Introduction

The recent developments in the health and social care systems led to medical tourism growth. Several governments worldwide have been recognising the benefits of medical tourism to the economy and investing in it (World Travel & Tourism Council, 2019). Therefore, studying different aspects of medical tourism is becoming more and more critical.

Medical tourism and the satisfaction of the medical tourists have been widely approached in the Academy in the last few years, namely by articles in journals of the first quartile following the scale SJR 2020, such as the Journal of Hospitality and Tourism Management, the Journal of Destination Marketing and Management and the Journal of Hospitality and Research.

Some authors have studied satisfaction in medical tourism contexts because this variable is more important in these contexts than in traditional forms of tourism (Mikulić et al., 2021). In this regard, the authors have already studied topics like the evaluation of the medical travellers' satisfaction through online review analysis (Ahani et al., 2021), the effect of cultural distance on medical tourism (Esiyok et al., 2017), a framework for medical tourists' satisfaction and loyalty by customer segmentation and quality improvement (Nakhaeinejad et al., 2021) and the factor structure of medical tourist satisfaction: exploring key drivers of choice, delight, and frustration (Mikulić et al., 2021).

In fact, it is possible to conclude, from the research performed and from the different articles analysed, that, in line with Tapia et al. (2020), there is a lot of literature about medical tourism and that this literature is aligned with the growing importance of the sector and the visible benefits of it to the economy of the countries. Notwithstanding, most of the studies considered only individuals who were already medical tourists and not also people that could potentially become one. This is a significant gap in the literature, as it seems relevant to understand what inhibits the individuals to perform this activity. Thus, it is important to also perform studies among people who never practised medical tourism.

As referred, medical tourism is a service that implies high-involvement and high-risk (Kang et al., 2014). According to Hofstede Insights' website (2021), the uncertainty avoidance is an important cultural dimension, which depends on the nationality, and which is expected to have influence on the decisions and main motivations and fears of the medical tourists and potential medical tourists, considering the risk related to this activity. Notwithstanding, until this point, and even though it may be relevant for the Academy, no

one has studied the impact of the nationality in the main motivations and fears of the medical tourists and in the predisposition for the individuals to become medical tourists.

Additionally, most of the studies were made considering only the medical tourists that travelled to or from a specific location (for example, Esiyok et al., 2017, and Mikulić et al., 2021), which might also be understood as an important gap.

In 2019, according to the World Travel & Tourism Council (2021), Travel & Tourism was one of the largest sectors of the economy in the world, corresponding to 10.4% of the global GDP (the correspondent of USD 9.2 trillion) and 10.6% of the worldwide jobs (the correspondent to 334 million jobs). In 2020, because of the COVID-19 pandemic, the sector of Travel & Tourism's contribution to the GDP declined to 5.5% of the global GDP (the correspondent to USD 4.7 trillion). The jobs associated with the sector fell to 272 million jobs, i.e., 62 million jobs were lost (World Travel & Tourism Council, 2021).

Notwithstanding the above, there are predictions of massive growth of global medical tourism from USD 19.79 billion in 2020 to USD 40.03 billion in 2025. According to the Medical Tourism Global Market Report 2021: COVID 19 Growth and change to 2030, as well as the expectation of the Market Data Forecast, which estimates that the medical tourism market in Europe will grow from USD 7.26 billion in 2021 to USD 17.26 billion in 2026 (CAGR of 18.9%), make it urgent to have more studies about medical tourism and medical tourists, namely as the medical tourism appears now as a way to boost the Travel & Tourism sector.

Considering all the above, we propose to study the main motivations and fears of the potential medical tourists, by responding to the question “What moves the medical tourists?” and “What stops the medical tourists?”, i.e., discovering which factors besides the ones already explored in the literature influence the medical tourists and the potential medical tourists to perform medical tourism, both for the positive by motivating the performance of this type of tourism and for the negative by contributing to the decision of not performing this activity, and, afterwards, discovering the impact of the nationality of the individuals in these factors.

For purposes of this study, a qualitative methodology was used to identify which motivations and fears were still to be discovered by the literature as this was identified in the Academy as the most suitable methodology to discover new variables not identified by the literature (Augusto, 2014). In this regard, the research was performed through phone interviews.

Additionally, and in order to study the impact of the nationality in the factors that move (or stop) the medical tourists a quantitative methodology was used as this was identified by the Academy as the most suitable methodology to study causal relations (Augusto, 2014). For this purpose, the research was performed through an online survey.

For an easiest understanding, the present report starts by presenting the literature review, namely of the concepts of tourism, medical tourism, the medical tourists and their motivations and fears, and of Hofstede's cultural dimensions. Then, the empirical study is presented, beginning by the qualitative analysis, and finishing in the quantitative one, as explained above. Finally, the conclusion notes are presented, including the reflection about the contributions of this study both to the Academy and to the Management, and the limitations of the study, together with notes for future research.

2. Literature Review

This chapter presents the literature review regarding the relevant concepts of this study, and the relation among them. The main objective of this chapter is to understand on what exactly consists the medical tourism, one type of tourism that has been raising (Nakhaeinejad et al., 2021) and that, for its characteristics has been considered a vital industry for many countries and economies (Ahani et al., 2021; Suess et al., 2018).

This study will be about the impact of the nationality in the main motivations and fears of the medical tourists/potential medical tourists, which seems more important in this type of tourism than in its traditional forms (Kang et al., 2014; Mikulić et al., 2021; Woo & Schwartz, 2014).

Finally, this chapter will review previous studies about the nationality and its implications in high-risk situations as medical tourism; this review is made considering Hofstede's Cultural Dimensions and its implications (Hofstede, 1984, 2001; Hofstede & Bond, 1988).

2.1. Tourism

Even though the literature has a lot of empirical studies related to tourism and to the different aspects in this regard, there is a clear gap in what respects to the theoretical framework of this area, which may be caused by the unique nature of this activity in which the consumers travel to another to consume non-traded goods and services (Calero & Turner, 2020).

Some authors have understood tourism as a collection of activities in which tourists (who are external visitors) participate. Therefore, tourism corresponds to a bundle of goods and services, which, for academic purposes, may be viewed as different and complex since it includes a lot of different goods and services and since each destination has unique features (Calero & Turner, 2020; Luzzi & Flückiger, 2003).

In fact, tourism is a major industry for many countries. Its benefits can be very significant, notwithstanding some challenges that arise from it, such as the environmental impact, the high traffic and accidents and the high prices, for example (Ahmad et al., 2020). In this regard it has been considered that the impact of the main negative aspects of the tourism may be mitigated with the reduction of the seasonality of this activity (Ahmad et al., 2020).

At the beginning of the century, a study referred already that tourism was clearly “one of the most remarkable economic and social phenomena” (Luzzi & Flückiger, 2003, p. 239)

of the XX century, and that it would maintain this position for the centuries that would follow. Between the beginning of the year 2009 and until September 2019, the international tourist arrivals of overnight visitors in the world grew at an average of 4,2% per year, and, if the year of 2009 is not considered, this growth corresponded to an average of 5,6% per year (World Tourism Organization, November 2019). The industry of tourism was widely affected by the pandemic. Notwithstanding, the international tourism already saw a small improvement in June and July 2021 (World Tourism Organization, September 2021). Even though there is still a lot of uncertainty about the future of travel and tourism after the pandemic (Ernst & Young Global Limited, 2021) and are still no definitive results of the balance of payments of tourism after the beginning of the pandemic, it is important to note that, in 2019, the total of tourism exports of goods and services in the world corresponded to 25,159 billion of USD, which represents a significative growth since 2010, when this result corresponded to 19,270 billion of USD (World Tourism Organization, May 2021).

The literature identifies a lot of different types of tourism. Some have existed for a long time, and others are more recent and have been developing in the past few years - business tourism, culinary tourism, cultural tourism, ecotourism, educational tourism, health tourism, medical tourism, seaside tourism, sports tourism, religious tourism, rural tourism, urban tourism, wine tourism, among others (Camilleri, 2018).

This investigation focus will be the medical tourism, namely because of its particular characteristics, such as the high-involvement and high-risk associated (Kang et al., 2014), as well as the high growth verified in the past few years and the huge importance that this type of tourism has been having in different countries for economic, social and other reasons (Ahani et al., 2021; Mikulić et al., 2021; Suess et al., 2018; Tapia et al., 2020).

2.2. Medical Tourism

Due to the increasing attention to personal health and its globalisation, a new branch of tourism has been raising, medical tourism (Nakhaeinejad et al., 2021). This new branch of tourism, “is increasing quickly since it contributes both to the health and tourism sectors” (Ahani et al., 2021, p. 519). Initially, it was viewed as an exclusive luxury reserved for the rich people, however, today its consumption is already generalised, becoming an international trend (Kang et al., 2014).

The generality of the authors has defined medical tourism as an industry in which people travel to another country to seek different types of medical services (Ahani et al., 2021; Bies & Zacharia, 2007; Cesario, 2018; Mathijssen, 2019; Tapia et al., 2020; Yu & Ko, 2012). In this regard, and as a complement to the previous definition, it is important to note that some authors identified medical tourism as the outsourcing of healthcare (Ahani et al., 2021; Bies & Zacharia, 2007; Yu & Ko, 2012). Also, some authors identified the existence of “domestic medical tourism”, which is the activity in which people travel to another city/area in the country of their residence to seek different types of medical services (Cesario, 2018). Due to the objectives of this study, only international medical tourism was considered.

In this regard, it is also important to note that, in the context of the tourism related to health, besides the medical tourism, another category of tourism has been raising in the past few years, the wellness tourism, which involves traveling to seek preventive and rehabilitative healthcare, which may include, among others, relaxing/resting activities (Cesario, 2018; Tapia et al., 2020). In fact, the health tourism has been considered as the set of medical tourism and wellness tourism (Cesario, 2018; Tapia et al., 2020). Notwithstanding, the focus of this research will be the medical tourism, and not the wellness one.

Medical tourism is an industry that is growing, and that fact represents an important opportunity for the economies of all the countries that are able to invest in it properly (Tapia et al., 2020). The rapid growth of this industry is explained mainly by the fast and exponential growth of the number of medical tourists/travellers around the entire world (Ahani et al., 2021; Ghosh & Mandal, 2019). Different countries consider medical tourism a way to diversify the economy because it has been a “rapidly developing market” (Ahani et al., 2021, p. 520). In this regard, many authorities have been recognising medical tourism as a vital industry, namely because it diversifies the current types of tourism, improves the local healthcare systems, creates more jobs, and contributes to the economic development of the countries (Ahani et al., 2021; Suess et al., 2018). Also, medical tourism is particularly relevant in a lot of countries to reduce the high seasonality of the tourism sector (Mikulić et al., 2021; Tapia et al., 2020), as well as the uneven tourism development across the different areas of the countries (Mikulić et al., 2021).

Taking into consideration everything that was referred above, it is important to note that, in contexts of medical tourism “treatment can be considered obligatory, meaning that treatment is required to manage a life-threatening condition, or it may be elective, meaning that it is dependent on personal preferences or desires” (Cesario, 2018, p. 269). Considering

the purpose of this research, which is to study the impact of nationality in the main motivations and fears of the medical/potential medical tourists, it will only be considered the elective treatment, as it corresponds to the part of medical tourism in which there is effectively a choice by the tourist.

Even if the treatment involved corresponds to an elective one, medical tourism is a service that implies high involvement and high-risk situations. Therefore, the consumers choose to increase the benefit or reduce the risk (Kang et al., 2014). Thus, and as referred, the tourists' satisfaction and motivations and fears are more important in this context of tourism than in the traditional forms (Kang et al., 2014; Mikulić et al., 2021; Woo & Schwartz, 2014).

2.3. Medical tourists and their motivations and fears

The term “tourist” has been defined differently by different authors and, therefore, there is no consensual definition in the Academy. Notwithstanding, the definition considered here is that tourists correspond to people visiting a different area from one of their residences for purposes differing from work-related obligations, or another type of personal obligation (Masberg, 1998).

“A medical tourist is an international traveller whose motivation is the search for healthcare services in a different country from his own country of residence” (Tapia et al., 2020, p. 4). These tourists/potential tourists are influenced by several factors, which affect not only if the individuals perform or not medical tourism but also the choice of the destination, such as cultural aspects (Mathijssen, 2019; Nakhaeinejad et al., 2021; Tapia et al., 2020), the availability of the medical treatment desired; the financing possibilities and the perceived quality (Mathijssen, 2019; Tapia et al., 2020). Even though it is possible to identify the main factors that influence, in general, the medical tourists, as well as the potential medical tourists, the relevance of the factors and the eventual identification of other relevant ones will depend on each individual and on the treatment required, for example, the search for low prices widely influences the international search for plastic surgery (Woo & Schwartz, 2014), but it may not influence the international search for other types of medical care (Tapia et al., 2020).

It is important to note that, since medical tourism is a high-risk and high-involvement activity, as the medical treatments associated with it have a direct influence on the individuals'

health, it generally causes in the tourist/potential tourist the fear of receiving medical treatment in foreign countries (Kang et al., 2014). In this regard, the works of Sheng-Hsiung et al. (1997) and Kang et al. (2014) already identified that the fears of the medical tourists are mainly related to the sociopsychological fear of the unknown conditions of the country of destiny, which may include criminal attacks, unfair laws against international travellers and the possible disappointment and dissatisfaction regarding the accommodation facilities, both in terms of hygiene and security, travel contents, means of transportation, namely in terms of convenience and safety, local food, among others (Kang et al., 2014; Sheng-Hsiung et al., 1997).

A recent study showed the central importance of the hospital reputation and the physician's expertise, followed by the shorter waiting lists for treatment/service, the accessibility, and the uniqueness of treatments/services as key factors for choosing a particular medical institution in contexts of medical tourism (Mikulić et al., 2021). Another recent study concluded that the key factors of medical tourism, with a significant positive influence on the tourism attraction and the revisit intention, are the doctor's expertise and reputation, the health evaluation, the presence of international certified doctors and staff, the safety of medication quality, the quality of the medical treatment, the high healthcare quality, the service orientation of the medical staff, the advanced medical treatment, the availability of medications, the on-site pharmacy and the prescription assistance, the waiting time for medical treatment from the time of the first contact to the time of the real treatment, the quality of the required treatment, and the hospital contact information (Wang et al., 2020). The same study also concluded that the tourism attraction does not influence the revisit intention (Wang et al., 2020).

The literature has, in fact, already identified some factors that influence the decision to perform or not medical tourism. As for the motivations, there are already different studies (Mathijssen, 2019; Mikulić et al., 2021; Tapia et al., 2020; Wang et al., 2020) that identify some motivations, which are summarised in Table 1. As for the fears, there are fewer studies published in this regard, notwithstanding, Kang et al. (2014) and Sheng-Hsiung et al. (1997) already identified some fears of the medical tourists (Table 1).

Table 1*Main motivations and fears of the medical tourists identified in the literature so far.*

Motivations	Fears
Hospital's good reputation (Mikulić et al., 2021)	Criminal attacks (Kang et al., 2014; Sheng-Hshiang et al., 1997)
Physician's and staff's reputation and certification (Mikulić et al., 2021; Wang et al., 2020)	Unfair laws against international travellers (Kang et al., 2014; Sheng-Hshiang et al., 1997)
Service orientation of the medical staff (Wang et al., 2020)	Lack of hygiene and security of the accommodation facilities (Collins et al., 2019; Kang et al., 2014; Sheng-Hshiang et al., 1997)
Shorter waiting lists (Mikulić et al., 2021; Wang et al., 2020)	Dissatisfaction regarding the travel contents (Kang et al., 2014; Sheng-Hshiang et al., 1997)
Large financing possibilities (Collins et al., 2019; Mathijssen, 2019; Tapia et al., 2020)	Dissatisfaction regarding the means of transportation (Kang et al., 2014; Sheng-Hshiang et al., 1997)
Uniqueness of treatments (Mikulić et al., 2021)	Local food (Kang et al., 2014; Sheng-Hshiang et al., 1997)
Availability and perceived safety of medication quality (Wang et al., 2020)	The weather (Fetscherin & Stephano, 2016)
Availability and perceived quality of the treatment (Wang et al., 2020)	
Advanced medical treatment (Wang et al., 2020)	
Accessibility (Mikulić et al., 2021)	
The low cost of the healthcare services (Fetscherin & Stephano, 2016)	
The stability of the exchange rate (Fetscherin & Stephano, 2016; Yu & Ko, 2012)	
The convenience of the travel (Fetscherin & Stephano, 2016; Yu & Ko, 2012)	
The low corruption (Fetscherin & Stephano, 2016; Smith et al., 2011)	
The stability of the economy (Fetscherin & Stephano, 2016; Yu & Ko, 2012)	

The language proximity (Fetscherin & Stephano, 2016)	
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Notwithstanding the above, “understanding what drives choice-making for health patients is a complex venture” (Mathijssen, 2019, p. 374), which is one of the reasons why this study is being performed.

2.4. Hofstede’s dimensions

As referred above, medical tourism is an activity that implies high-risk (Kang et al., 2014). Risks may be objective or subjective. “An objective risk is defined as the probability of negative outcomes weighted by their severity” (Le, 2021, p. 297). On the other hand, the subjective (or perceived) risk corresponds to the believe of the individuals regarding the severity and probability of possible negative outcomes (Le, 2021; Wolff et al., 2019). In this regard, it has been concluded that high risk perceptions are normally associated to strong feelings of anxiety, nervousness, and worry (Wolff et al., 2019).

The perception of the risk, as well as the uncertainty avoidance, are influenced by several factors, such as the culture and the nationality (Hofstede, 1984, 2001; Hofstede & Bond, 1988; Le, 2021; Seabra et al., 2013), the gender (Le, 2021; Lepp & Gibson, 2003; Seabra et al., 2013), the age (Lepp & Gibson, 2003; Seabra et al., 2013), personality traits (Seabra et al., 2013) and income and education (Floyd & Pennington-Gray, 2004; Seabra et al., 2013), among others.

Hofstede (2001) has defined culture as the collective programming of the mind that differentiates members of a particular group from the other groups. As already done in the past in the context of tourism, the present study will consider nationality as a good enough approximation of “cultural background”/”culture” (Seabra et al., 2013). Also, the present study will focus on the impact of the nationality and the culture in the uncertainty avoidance and the perception of risk.

Hofstede’s cultural dimensions (Hofstede, 1984, 2001; Hofstede & Bond, 1988) have been widely accepted in the Academy and considered by different authors when performing investigations influenced by the nationality/cultural reality of the individuals and its correspondent dimensions until nowadays (Le, 2021; Seabra et al., 2013). Therefore, in this study, when focusing on the impact of the culture and nationality in the perception of the

risk and on the uncertainty avoidance, the cultural dimensions of Hofstede will be considered.

In his studies, Hofstede proposed six cultural dimensions which are today recognised as “Hofstede’s Cultural Dimensions” and which correspond to the power distance, the individualism/collectivism, the masculinity/femininity, the uncertainty avoidance, the long-term/short-term orientation, and the indulgence/restraint (Hofstede, 1984, 2001; Hofstede & Bond, 1988; Insights, 2021). These six cultural dimensions explain the influence of nationality on the attitudes and behaviours of individuals and provide key aspects to understand the way of thinking of individuals.

“Power distance at the individual level can be defined as the extent to which an individual expects and accepts a powerful supervisor” (Adamovic, 2022, p. 3). This characteristic was early identified by Hofstede and is today one of “Hofstede’s Cultural Dimensions”, since in his first studies he concluded that the answers related to hierarchical relationships were systematically different among individuals from different countries (Hofstede, 1984).

The individualism, as collectivism opposite, which is also one of “Hofstede’s Cultural Dimensions” corresponds to the higher tendency of the individuals to look after themselves or to integrate and remain integrated in groups, namely family and friends, it also may be observed in the tendency to prefer working individually instead of working in groups (Adamovic, 2022; Hofstede, 2001).

In “Hofstede’s Cultural Dimensions” arises also the masculinity, as femininity opposite. This dimension was defined as corresponding to “the distribution of emotional roles between genders (...), it opposes “tough” masculine to “tender” feminine societies” (Hofstede, 2001, p. xx).

The long-term/short-term orientation, which is also one of “Hofstede’s Cultural Dimensions” corresponds to the planning horizon of the individuals (Hofstede, 1984, 2001; Strauß et al., 2021). “In short-term oriented countries, society is focused on quick results” (Strauß et al., 2021, p. 989).

The indulgence/restraint cultural dimension corresponds to the tendency for the individuals to fulfil their desires, i.e., the extent to which the individuals from a particular nationality are able to control (or not) their desires and impulses (Hofstede Insights, 2021). In this regard, indulgence countries allow free gratification of basic human drives, namely related to having fun and enjoying life (Hofstede Insights, 2021).

As for the sixth and last “Hofstede’s Cultural Dimension”, the uncertainty avoidance “is the extent to which a culture programs makes its members to feel either uncomfortable or comfortable in unstructured situations” (Hofstede, 2001, p. xix). In this regard, Hofstede (2001) defined an unstructured situation as corresponding to a “novel, unknown, surprising, different from usual” (Hofstede, 2001, p. xx) and identified clearly that this dimension is mainly related to “the degree to which a society tries to control the uncontrollable” (Hofstede, 2001, p. xx) and is related with feelings of anxiety. This “Hofstede’s Cultural Dimension” describes the individuals’ tolerance to the ambiguity (Bernard et al., 2022; Hofstede, 1984, 2001; Hofstede & Bond, 1988).

In this regard, it is important to note that past studies already identified that societies with a high level of uncertainty avoidance are most likely not to assume risks and to take actions to minimise them, namely in international travel contexts (Bernard et al., 2022; Manrai & Manrai, 2011; Money & Crofts, 2003).

As referred, the uncertainty avoidance should influence the way of thinking, acting and behaving of individuals from different nationalities/cultural backgrounds and, therefore, should conduct to different decisions/actions when facing situations in which there is a high-risk involved (Hofstede, 1984, 2001; Hofstede & Bond, 1988; Manrai & Manrai, 2011; Money & Crofts, 2003).

In this regard, and considering that nationality has an impact on the uncertainty avoidance (Hofstede, 1984; Hofstede & Bond, 1988) and, consequently, on the risk perception, and knowing that medical tourism is a high-risk activity (Kang et al., 2014), probably, the nationality will have an impact on the main motivations and fears of the medical tourists and potential medical tourists.

2.5. Conclusion

As referred, medical tourism is a high-risk activity (Kang et al., 2014). The perception of risk, as well as the uncertainty avoidance, are influenced by several factors, among which are the national culture (Hofstede, 1984, 2001; Hofstede & Bond, 1988; Le, 2021; Seabra et al., 2013), the gender (Le, 2021; Lepp & Gibson, 2003; Seabra et al., 2013), personality traits (Seabra et al., 2013) and the income and education (Floyd & Pennington-Gray, 2004; Seabra et al., 2013).

One of “Hofstede’s Cultural Dimensions” is the uncertainty avoidance, which corresponds to “the extent to which a culture program makes its members to feel either uncomfortable or comfortable in unstructured situations” (Hofstede, 2001, p. xix). Past studies already identified that societies with a high level of uncertainty avoidance are more likely to not assume risks (Bernard et al., 2022; Manrai & Manrai, 2011; Money & Crotts, 2003).

Considering all the above, and namely the fact that the nationality as an impact on the uncertainty avoidance (Hofstede, 1984, 2001; Hofstede & Bond, 1988) and, consequently on the risk perception and on the willing to assume risks, and that medical tourism is a high-risk activity (Kang et al., 2014), probably, the nationality will have an impact on the main factors that influence the medical tourists and the potential medical tourists to perform medical tourism, both for the positive, by motivating the performance of this type of tourism, and for the negative by contributing for the decision of not performing this activity.

This study focuses the impact of the national culture in the perception of risk in contexts of medical tourism and on the uncertainty avoidance in this regard. For this purpose, the cultural dimensions of Hofstede will be considered.

3. Empirical Study

In this chapter, the main aspects of the empirical study performed will be presented, namely the research goals and questions, the methodology, the information about the samples and the results and its discussion.

3.1. Research goals and questions

The main goal of this study is to analyse the impact of nationality on the main motivations and fears of the medical tourists and of the potential medical tourists. In this regard, it is possible to identify two research questions:

Q1: Which are the main motivations and fears of the medical tourists/potential medical tourists?

Q2: What is the impact of nationality on the main motivations and fears of the medical tourists/potential medical tourists?

It is important to note that, in contexts of medical tourism, “treatment can be considered obligatory, meaning that treatment is required to manage a life-threatening condition, or it may be elective, meaning that it is dependent on personal preferences or desires” (Cesario, 2018, p. 269). Considering the purpose of this research, which is to study the main motivations and fears of the medical/potential medical tourists, only the elective treatments are considered, as on it there is effectively a choice by the tourist, focusing on the aesthetic services, such as plastic surgeries.

3.2. Research question 1 – Which are the main motivations and fears of the medical tourists/potential medical tourists?

To answer research question 1, a qualitative methodology was used, as this is the most suitable methodology to discover new variables not identified by the literature (Augusto, 2014).

3.2.1. Survey development

A survey was conducted, and the correspondent questionnaire was developed based on previous work in the related literature, as presented above.

In the first section of the questionnaire – “personal data” – the following three questions were presented: “How old are you?”, “What is your gender?”, and “What are your academic qualifications?”, with the purpose of being able to define the sample. Next, the respondents were asked to answer, in generic terms, whether they would be willing to travel to another country to perform an aesthetic intervention and to what extent they would be willing to do it, by using a scale of levels of intervention (1 = intervention without anaesthesia, 2 = intervention with local anaesthesia, 3 = intervention with general anaesthesia, 4 = intervention combining local and general anaesthesia).

In the third and central section of the questionnaire, the respondents were asked to answer the following questions, first regarding India, second Costa Rica, and third Canada.

1. Imagine that someone offered you an aesthetic intervention; would you go to the referred country?

In the cases in which the answer was “not”, the respondents were asked: 2. Why not?
3. What would make you go?

In the cases in which the answer was “yes”, the respondents were asked: 2. Why would you go?

India, Costa Rica and Canada are part of the top 10 countries with more medical tourism in 2020 (Medical Tourism Magazine, 2020) and were selected based on their Human Development Index (HDI), which was obtained through the website of the United Nations Development Programme (2022). India corresponds to the country with a lower HDI in the top 10, Canada with a higher HDI in the top 10 (together with Singapore), and Costa Rica corresponds to an intermediate HDI in the top 10.

Finally, the respondents were asked if there was anything else that was not referred to in the interview and that they understood that could be relevant in the moment of the choice for performing an aesthetic intervention abroad.

3.2.2. Sample and data collection

To perform the present study, the sample corresponded to twenty Portuguese adults, stratified in terms of age, gender and academic qualifications.

The data was collected through telephone interviews conducted by the researcher. An aleatory method was used to select the telephone numbers, which corresponded to drawing a

number (0-9) for each character of the nine telephone numbers, except for the first character, which always corresponds to nine in Portugal, and of the second character, which always corresponds to 1, 2, 3 or 6 in Portugal.

3.2.3. Data analysis

Initially, the analysis of the data obtained in the phone interviews, was analysed by using the conceptions of previous studies and authors and, then, new conceptions were added, throughout the development of the study, in order to bring new knowledge to it.

The information obtained in the phone interviews, was synthesised afterwards and categorised, in order to be able to extract the relevant knowledge presented in the next section.

3.2.4. Results

In this section, the results of the qualitative study are presented. For better understanding, this section starts by presenting the profile of the respondents and, then, the presentation and discussion of the results obtained.

Profile of the respondents

At the beginning of the research, the twenty respondents were stratified according to the Portuguese population. Therefore, the final sample included a large age dispersion; half people were male, and the other half were female, and people with and without higher education were interviewed, as follows:

Table 2

Respondents' characteristics

Respondents' characteristics			
Respondent	Gender	Age	University attendance
1	Male	27	Yes
2	Female	69	No
3	Female	53	Yes
4	Female	23	Yes
5	Female	49	Yes

6	Female	26	Yes
7	Male	31	Yes
8	Male	21	No
9	Male	73	Yes
10	Female	61	No
11	Female	31	Yes
12	Male	52	Yes
13	Male	58	Yes
14	Female	40	Yes
15	Male	64	No
16	Female	37	No
17	Male	41	Yes
18	Male	49	Yes
19	Female	58	Yes
20	Male	38	Yes

The data used to identify the current structure of the Portuguese population in terms of gender and age was taken from *Pordata*, as is specified in Annex I.

Presentation and discussion of the results obtained

Next, the main results of this part of the study are presented.

From the research made and the interviews performed, and as already referred above, it was possible to understand that people with lower education qualifications may not feel comfortable with the idea of medical tourism, namely in the aesthetic area of intervention, both for unfamiliarity with the themes and preconceptions about the same. This conclusion results from the fact that in almost all the contacts made with individuals with lower formal education degrees, the individuals felt uncomfortable with the first questions of the interview and it was not possible to obtain any relevant information from them, except for the reasons for their discomfort, as referred, and even to conclude the interview.

It was possible to understand that the majority of the people probably, a priori, would not be willing to travel to another country to perform an aesthetic intervention; the level of intervention, namely in terms of the need to use (or not) local and general anaesthesia may be a factor that influences this decision. Most of the respondents, even those who said upfront that they would be willing to travel to another country for the referred purpose, admitted that

they would probably not go abroad to perform an aesthetic intervention if it required more than local anaesthesia. Notwithstanding, and even though in the minority, there should be a part of the population, namely among the female individuals, willing to perform an aesthetic intervention abroad with local and general anaesthesia combined. It was also understood from the research conducted that the female individuals may also be the part of the population more willing to perform an aesthetic intervention outside of their country of residence.

Additionally, from the research performed, it appears that most of the population probably would not be willing to travel to a country with an HDI lower than the one in which they live. Notwithstanding, it was also possible to see that some individuals, if they have not to pay anything, would be willing to go to these countries, which may also be indicative that, as already presented by Woo and Schwartz (2014), the price is a relevant factor in the choice to perform (or not) medical tourism, and in the country selection. Probably most of the population would easily travel to a country with higher HDI than the one they live in to perform an aesthetic intervention.

Regarding the fears, this study supports the impact of the unknown conditions of the country of destiny, namely the possible disappointment and dissatisfaction regarding the accommodation facilities and hygiene and security/safety (Collins et al., 2019; Kang et al., 2014; Sheng-Hshung et al., 1997). In this regard, and based on the present study, not knowing the country's healthcare system of destiny probably constitutes a major fear.

Additionally, it is understood that the trust (or untrust) in the health system of the country of destiny, as well as the eventual consequences for the health (both in the short and long term), namely for inadequate treatment, and the possibility of having some problem during the treatment, constitute fears of the medical tourists/potential medical tourists when deciding whether to perform or not medical tourism, namely in the aesthetic area.

Still in the field of fears, it was identified in the present investigation that the medical tourists/potential medical tourists may be afraid of getting trapped in the country of destiny, namely because of postoperative complications, of the trip by itself and of not having the adequate response capacity in the destination country, namely in terms of the physicians' expertise and quality and the technology available.

Finally, the fear of not being able to communicate with the medical staff of the country of destiny should constitute an important fear in this field.

In fact, it is possible to divide the fears of the medical tourist/potential medical tourists into two major groups: the ones directly related to the medical procedure and the consequences that may arise from it and the ones related to the lack of knowledge and comfort arising from travelling to a different country for purposes of medical tourism. The first group includes the eventual consequences for the health in the short and long term, namely inadequate treatment, the possibility of having some problem during the treatment, and postoperative complications. As for the second group, it includes the following fears identified: the fear of the unknown conditions of the country of destiny, namely in terms of the possible disappointment and dissatisfaction regarding the accommodation facilities and hygiene and security/safety, not knowing the healthcare system of the country of destiny, the fear of getting trapped in that country, of the trip by itself and of not having the adequate response capacity in the destination country, namely in terms of the physicians' expertise and quality and the technology available.

The motivations may be divided into two: the ones directly related to the quality/the perceived quality of the medical procedure, such as the reputation of the hospital and the physician and the international certification of the staff, and the ones that are not directly related to the quality/the perceived quality of the medical procedure, such as the accessibility and the shorter waiting lists. Regarding the first motivations presented, probably they have a direct impact on the decision to perform or not the aesthetical intervention abroad and the choice of the correspondent country, reason why they may be considered as core motivations; as for the second ones, probably they have an impact on the decision but are not determinative, reason why they may be seen as accessory motivations. It is important to note that the uniqueness of the treatment, i.e., its exclusivity in the correspondent destination country, appears not to have such an important role in the decision concerned.

Besides the above, this study also added as being relevant in contexts of medical tourism the following motivations: the trust in the country's health system; the safety of the country; having a lot of positive information about the country and the procedure, namely having real success stories, the curriculum of the doctor, etc.; the culture and geographic proximity; the desire to visit the country; being advised by doctors of the individuals' trust to perform such treatment in such country; and having positive feedback from someone close.

Table 3 presents the new motivations and fears that the individuals may feel when considering performing medical tourism [the ones identified with a (*)], together with the ones

already identified by the literature before this study. The groups of motivations presented have some inspiration in the work of Sag and Zengul (2018). However, some changes were made, since the authors were studying the choice of one medical tourism destination instead of others and, in this study, the object of study corresponds to the motivation to perform medical tourism by itself. As for the fears, the groups below were made only in order to provide an easier understanding of the realities in analysis, by synthetising it.

Table 3

Main motivations and fears of the medical tourists

Motivations	Fears
<p><u>Core motivations:</u></p> <ul style="list-style-type: none"> - Hospital's good reputation (Mikulić et al., 2021) - Physician's and staff's reputation and certification (Mikulić et al., 2021; Wang et al., 2020) - Uniqueness of treatments (Wang et al., 2020) - Availability and perceived safety of medication quality (Wang et al., 2020) - Availability and perceived quality of the treatment (Wang et al., 2020) - Advanced medical treatment (Wang et al., 2020) - Trust in the destiny country's health system (*) - Having a lot of positive information, namely in terms of real success stories (*) - Being advised by doctors of the individuals' trust to perform such treatment in such country (*) - Positive feedback from someone close (*) 	<p><u>Fears related to the lack of knowledge and comfort arising from travelling to a different country for this purpose:</u></p> <ul style="list-style-type: none"> - Criminal attacks (Kang et al., 2014; Sheng-Hshiang et al., 1997) - Unfair laws against international travellers (Kang et al., 2014; Sheng-Hshiang et al., 1997) - Lack of hygiene and security of the accommodation facilities (Collins et al., 2019; Kang et al., 2014; Sheng-Hshiang et al., 1997) - Dissatisfaction regarding the travel contents (Kang et al., 2014; Sheng-Hshiang et al., 1997) - Dissatisfaction regarding the means of transportation (Kang et al., 2014; Sheng-Hshiang et al., 1997) - The weather (Fetscherin & Stephano, 2016) - Local food (Kang et al., 2014; Sheng-Hshiang et al., 1997) - Not knowing the country's healthcare system of destiny (*) - Untrust in the health system of the country of destiny (*) - Getting trapped in the country of destiny (*) - The trip by itself (*) - The cost of the trip (*) - The negative image of the country in terms of medical tourism (*) - Not being able to communicate with the medical staff of the country of destiny (*)
<p><u>Accessory motivations:</u></p>	<p><u>Fears directly related to the medical procedure and the consequences that may arise from it:</u></p>

<ul style="list-style-type: none"> - Service orientation of the medical staff (Wang et al., 2020) - Shorter waiting lists (Mikulić et al., 2021; Wang et al., 2020) - Accessibility (Mikulić et al., 2021) - Large financing possibilities (Collins et al., 2019; Mathijssen, 2019; Tapia et al., 2020) - The low cost of the healthcare services (Fetscherin & Stephano, 2016) - The convenience of the travel (Fetscherin & Stephano, 2016; Yu & Ko, 2012) - The stability of the exchange rate (Fetscherin & Stephano, 2016; Yu & Ko, 2012) - The low corruption (Fetscherin & Stephano, 2016; Smith et al., 2011) - The stability of the economy (Fetscherin & Stephano, 2016; Yu & Ko, 2012) - Safety of the country (*) - Culture and geographic proximity (*) - The language proximity (Fetscherin & Stephano, 2016) - Desire to visit the country of destiny (*) 	<ul style="list-style-type: none"> - Not having the adequate response capacity in the destination country, namely in terms of the physicians' expertise and quality and the technology available (*) - Eventual consequences for the health both in the short and long term (*)
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Finally, in the study performed, it was possible to understand that the following aspects may have a severe impact on the choices of the medical tourists/potential medical tourists when considering the possibility of performing medical tourism: some countries/areas are known for being a reference in some areas of the medicine, therefore, the people may not want to go to those countries to do any medical procedure, but want to go (or have more motivations to go) to perform that specific intervention; the expected time of recovering in the other country; and the constant contact that the people have with failure cases of interventions in countries less developed, namely on television, may also have an essential role on this type of decisions. It was also possible to understand that older people are usually less willing to perform medical tourism, which is in line with the conclusions previously obtained by Lepp and Gibson (2003); Seabra et al. (2013) regarding the impact of the age on the risk perception.

3.3. Research question 2 - What is the impact of nationality on the main motivations and fears of the medical tourists/potential medical tourists?

A quantitative methodology was used to proceed with the present study and to answer the questions above identified, as this is the most suitable methodology to study causal relations (Augusto, 2014).

3.3.1. Survey development

A survey was conducted, and the correspondent questionnaire was developed based on previous work in the related literature and on the results of the investigation work performed regarding the first research question, as presented above. The questionnaire was made available in English, Portuguese, Spanish and French.

After the consent of the respondents, in the first section of the questionnaire – “personal information” – the following questions were presented:

- Age
- Gender (“male”; “female”; “other”; “prefer not to say”)
- Which is your nationality? If you have more than one nationality, please indicate the one with which you feel a stronger connection to.
- Have you finished or at least enrolled in a college degree? (“Yes”; “No”)
- Please indicate your current situation considering your net income, by using the following statements for each sentence below: “Strongly disagree”; “Disagree”; “Neither disagree or agree”; “Agree”; “Strongly agree”
 - “I have enough money to buy the things I want.”
 - “I do not have to worry much about paying my bills.”
 - “Currently, I feel relatively wealthy.”

This scale was initially presented by Mittal and Griskevicius (2016). However, no information regarding the scale’s validity was provided by the authors. Therefore, a scale validation was made.

According to Pinto (2016), to evaluate a reflective measurement model, the rules presented in Table 4 should be followed.

Table 4

Rules to evaluate a reflective measurement model

Aspect to analyse	Value(s) to be observed	Reference value(s)
Individual internal consistency of the indicator	<i>Loading</i> of the indicator (Hulland, 1999)	≥ 0.7 (desirable minimum) ≥ 0.4 (minimum acceptable in exploratory studies)
Composite internal consistency	Composite internal consistency index (Werts <i>et al.</i> , 1974)	≥ 0.7 (desirable minimum) ≥ 0.6 (minimum acceptable in exploratory studies)
Convergent validity	<ul style="list-style-type: none"> - Statistical significance of the indicators (Gefen & Straub, 2005) - Average variance extracted (AVE) (Fornell & Larcker, 1981) 	<ul style="list-style-type: none"> - $t(\textit{bootstrap}) > 1.96$ (if $\alpha \approx 0.05$) - $AVE \geq 0.5$
Discriminant validity	<ul style="list-style-type: none"> - Comparison between the correlations between constructs and the square root of the AVE (Fornell & Larcker, 1981) - <i>Crossloadings</i> (Chin, 1998) 	<ul style="list-style-type: none"> - $\sqrt{AVE} \geq$ correlation between the construct and the remaining ones - <i>loading</i> of the indicator in the construct $>$ <i>loading</i> that it registers in the remaining constructs

Note. Source: Pinto (2016). Translation from Portuguese to English by the author.

The validation of the factors presented in Table 4 was made using SmartPLS 3, and the validity of the scale was confirmed, in accordance with the information presented in Table 5 and Table 6. Even though the value of the loading for the second variable is not higher than 0.7, due to the proximity of the value and in order to avoid compromising the theoretical framework, it was considered that the validity of the entire scale is achieved.

Table 5

Validation of the scale of perception of the income received presented by Mittal and Griskevicius (2016), in the context of this study, using SmartPLS 3

Variables	Loading	T - value	Cronbach's Alpha	CR > 0.7	AVE > 0.5
Perception of the income received			0.815	0.849	0.658

Income_1: I have enough money to buy the things I want.	0.756	10.061
Income_2: I do not have to worry much about paying my bills.	0.662	6.330
Income_3: Currently, I feel relatively wealthy.	0.982	59.141

Table 6

Test of the discriminant validity, using Fornell-Lacker Criterion for Discriminant Validity, in SmartPLS 3

	Familiarity with “medical tourism”	Perceived value of “medical tourism”	Perception of the income received	Willingness to perform medical tourism
Familiarity with “medical tourism”	0.857			
Perceived value of “medical tourism”	0.723	0.851		
Perception of the income received	0.542	0.486	0.811	
Willingness to perform medical tourism	0.668	0.839	0.504	0.852

Note. Exported from SmartPLS 3.

Next, the following question was presented to the respondents, which was made since it was identified by the existent literature that some people may see the aesthetic procedures as been “frivolous and unnecessary” (Marchac, 2007, p. 211), which may influence the perception of the individuals regarding the remaining questions about performing this type of health treatment outside of their country.

- Do you consider the aesthetical interventions something useful?
 - Yes, as much as any other medical procedure.
 - Yes, but less than other medical procedures.
 - No.

In the second section of the questionnaire – “General questions about medical tourism”, the respondents were asked to answer the question “Please indicate, regarding each

of the statements below, how strongly you agree or disagree with it.”, regarding the statements presented in Table 7, using “Strongly disagree”, “Disagree”, “Neither disagree or agree”, “Agree”, “Strongly agree”.

The scale presented in the sentences 1 to 10 corresponds to an adaptation of the patient willingness to undergo surgery scale, developed by Anania et al. (2021) and it is intended to measure the willingness of the individuals to perform medical tourism. As for the scale presented in the sentences 11 to 15, it corresponds to an adaptation of the familiarity scale, developed by Anania et al. (2021), and it intends to understand how much the respondents are (or not) familiarised with the concept of “medical tourism” and the correspondent implications. Finally, the scale presented in the sentences 16 to 19 corresponds to an adaptation of the scale of perceived value of the same authors and it is supposed to measure the perceived value given to “medical tourism” by the individuals.

Table 7

Sentences presented in the questionnaire and its respective sources and measurable variables

Scale	Statement in the questionnaire	Adapted from
Willingness to perform an aesthetic surgery abroad	<ol style="list-style-type: none"> 1. “I would be willing to undergo an aesthetic surgery in another country.” 2. “I would be comfortable undergoing an aesthetic surgery in another country.” 3. “I would have no problem undergoing an aesthetic surgery in another country.” 4. “I would be happy to undergo an aesthetic surgery in another country.” 5. “I would feel safe undergoing an aesthetic surgery that does not require general anaesthesia in another country.” 6. “I would feel safe undergoing an aesthetic surgery in another country that requires general anaesthesia.” 7. “I have no fear of undergoing an aesthetic surgery in another country.” 8. “I feel confident undergoing an aesthetic surgery in another country.” 9. “I would feel safe undergoing an aesthetic surgery in another country with a higher economic development than the one I live in.” 10. “I would feel safe undergoing an aesthetic surgery in another country with a lower economic development than the one I live in.” 	Anania et al. (2021)

Familiarity with the concept of “medical tourism”	11. “I am familiar with the concept of “medical tourism”.” 12. “I have a lot of knowledge about “medical tourism”.” 13. “I have read a lot about “medical tourism”.” 14. “Medical tourism” has been of interest to me for a while now.” 15. “I think I know more about “medical tourism” than the average person.”	Anania et al. (2021)
Perceived value of “medical tourism”	16. “Performing an aesthetical surgery abroad is something that would be beneficial to me.” 17. “Having an aesthetical surgery abroad would be something valuable for me.” 18. “I think “medical tourism” is useful.” 19. “There would be value in performing “medical tourism”.”	Anania et al. (2021)

Since the above presented scales were never used in contexts of medical tourism, and since its models also correspond to reflective measurement models, the validation of the factors presented in Table 4 was made for each scale using SmartPLS 3, and the validity of the scales was confirmed, in accordance with the information presented in Table 5 and Table 6, already presented.

Even though the value of the loading for the ninth variable of the willingness to perform medical tourism scale and the first variable of the familiarity scale are not higher than 0.7, due to the proximity of the values and in order to avoid compromising the theoretical framework, it was considered that the validity of the entire scales is achieved.

Table 8

Validation of the scales presented by Anania et al. (2021), in the context of this study, using SmartPLS 3

Variables	Loading	T - value	Cronbach's Alpha	CR > 0.7	AVE > 0.5
Willingness to perform medical tourism			0.960	0.964	0.726
MT_Willingness_1: I would be willing to undergo an aesthetical surgery in another country.	0.845	40.384			
MT_Willingness_2: I would be comfortable undergoing an aesthetical surgery in another country.	0.874	49.591			
MT_Willingness_3: I would have no problem undergoing an aesthetical surgery in another country.	0.847	36.103			

MT_Willingness_4: I would be happy to undergo an aesthetical surgery in another country.	0.906	110.076		
MT_Willingness_5: I would feel safe undergoing an aesthetical surgery that does not require general anaesthesia in another country.	0.859	74.951		
MT_Willingness_6: I would feel safe undergoing an aesthetical surgery in another country that requires general anaesthesia.	0.876	54.350		
MT_Willingness_7: I have no fear of undergoing an aesthetical surgery in another country.	0.846	40.779		
MT_Willingness_8: I feel confident undergoing an aesthetical surgery in another country.	0.898	67.982		
MT_Willingness_9: I would feel safe undergoing an aesthetical surgery in another country with a higher economic development than the one I live in.	0.692	20.409		
MT_Willingness_10: I would feel safe undergoing an aesthetical surgery in another country with a lower economic development than the one I live in.	0.861	57.769		
Familiarity with the concept of “medical tourism”			0.907	0.932 0.735
Familiarity_1: I am familiar with the concept of “medical tourism”.	0.693	28.082		
Familiarity_2: I have a lot of knowledge about “medical tourism”.	0.899	117.614		
Familiarity_3: I have read a lot about “medical tourism”.	0.910	119.403		
Familiarity_4: Medical tourism” has been of interest to me for a while now.	0.891	97.600		
Familiarity_5: I think I know more about “medical tourism” than the average person.	0.874	74.836		
Perceived value of performing aesthetical interventions in the context of medical tourism			0.882	0.978 0.724
PV_1: Performing an aesthetical surgery abroad is something that would be beneficial to me.	0.916	63.135		
PV_2: Having an aesthetical surgery abroad would be something valuable for me.	0.931	71.551		
PV_3: I think “medical tourism” is useful.	0.770	22.867		
PV_4: There would be value in performing “medical tourism”.	0.773	24.071		

In the third and final section of the questionnaire – “Motivations and fears related to the performance of medical tourism”, the respondents were asked to answer the question “Imagine that you were considering performing an aesthetic treatment abroad, which would be the influence of the following factors on your decision?”, using “Nothing important”, “Unimportant”, “Slightly important”, “Important”, “Very important”. The motivations and fears presented in the questionnaire were the ones presented in Table 9.

Table 9

Motivations and fears presented in the questionnaire and its respective sources

Motivation/fear	Source
1. The hospital’s good reputation.	Mikulić et al. (2021)
2. The physician’s and staff’s reputation and certification.	Mikulić et al. (2021); Wang et al. (2020)
3. The uniqueness of treatments.	Mikulić et al. (2021)
4. The availability and perceived safety of medication quality.	Wang et al. (2020)
5. The availability and perceived quality of the treatment.	
6. The advanced medical treatment.	
7. The trust in the destiny country’s health system.	Qualitative research conducted
8. Having a lot of positive information, namely in terms of real success stories.	
9. Being advised by doctors of my trust to perform such treatment in such country.	
10. A positive feedback from someone close.	
11. The service orientation of the medical staff.	Wang et al. (2020)
12. The shorter waiting lists.	Mikulić et al. (2021); Wang et al. (2020)
13. The accessibility.	Mikulić et al. (2021)
14. The large financing possibilities.	Collins et al. (2019); Mathijssen (2019); Tapia et al. (2020)
15. The cost of the healthcare services.	Fetscherin and Stephano (2016)
16. The stability of the exchange rate.	Fetscherin and Stephano (2016); Yu and Ko (2012)
17. The low corruption.	
18. The stability of the economy.	

19. The safety of the country of destiny.	Qualitative research conducted
20. The culture and geographic proximity.	
21. The language proximity.	Fetscherin and Stephano (2016)
22. The desire to visit the country of destiny.	Qualitative research conducted
23. The existence of frequent criminal attacks in the country of destiny.	Kang et al. (2014); Sheng-Hshiang et al. (1997)
24. The existence of unfair laws against international travellers in the country of destiny.	
25. The lack of hygiene and security of the accommodation facilities.	Collins et al. (2019); Kang et al. (2014); Sheng-Hshiang et al. (1997)
26. The travel contents.	Kang et al. (2014); Sheng-Hshiang et al. (1997)
27. The means of transportation.	
28. The weather.	Fetscherin and Stephano (2016)
29. The local food.	Kang et al. (2014); Sheng-Hshiang et al. (1997)
30. Not knowing the country's healthcare system of destiny.	Qualitative research conducted
31. Not trusting in the health system of the country of destiny.	
32. The possibility of getting trapped in the country of destiny.	
33. The trip by itself.	
34. The inconvenience of the travel.	Fetscherin and Stephano (2016); Yu and Ko (2012)
35. The cost of the trip.	Qualitative research conducted
36. The possibility of not being able to communicate with the medical staff of the country of destiny.	
37. Not knowing if there will be an adequate response capacity in the destination country, namely in terms of the physicians' expertise and quality and the technology available.	
38. Eventual consequences for the health both in the short and long term.	
39. The negative image of the country in terms of medical tourism.	

According to Pinto (2016), to evaluate a formative measurement model, the rules of Table 10 should be ensured.

Table 10*Rules to evaluate a formative measurement model*

Aspect to analyse	Value(s) to be observed	Reference value(s)
Contribution of the indicator to the latent variable	- <i>Weight</i> and <i>loading</i> of the indicator - <i>t (bootstrap)</i> (Hair <i>et al.</i> , 2011)	- <i>t (bootstrap)</i> (<i>weight</i>) > 1.96 (if $\alpha \approx 0.05$) there is empirical evidence to maintain the indicator - <i>t (bootstrap)</i> (<i>weight</i>) < 1.96 e <i>t (bootstrap)</i> (<i>loading</i>) < 1.96 (if $\alpha \approx 0.05$) there is no empirical evidence to maintain the indicator
Content validity	Theory to support the model	The theory supports the maintenance of the indicator
Possible multicollinearity	Variance inflation factor (VIF) for each indicator (Hair <i>et al.</i> , 2011)	VIF ≥ 5 (problem of multicollinearity)

Note. Source: Pinto (2016). Translation from Portuguese to English by the author.

For purposes of the scale validation and further analysis the groups of motivations presented in Table 3 were used (“Core motivations”; “Accessory motivations”). As referred in the previous sections, the core motivations are the ones directly related to the quality/the perceived quality of the medical procedure, and the accessory motivations correspond to the ones that are not directly related to the quality/the perceived quality of the medical procedure.

As for the fears, as there are no groups defined by the literature, in order to have consistent groups, a factor analysis of the principal components was made in SPSS (see Annex IV for further details). Since the KMO and Bartlett’s Test confirmed the possibility of considering the results of the test made, based on the information obtained in the rotated component matrix (Figure 8), the following groups of fears were determined, considering the group in which they were more significative.

The names of the groups were attributed based on the characteristics of the fears that they represent, following the same principle used for the motivations.

Table 11*Groups of fears used to perform the empirical study*

Core fears	Accessory fears
23. The existence of frequent criminal attacks in the country of destiny.	26. The travel contents.

24. The existence of unfair laws against international travellers in the country of destiny.	27. The means of transportation.
25. The lack of hygiene and security of the accommodation facilities.	28. The weather.
30. Not knowing the country's healthcare system of destiny.	29. The local food.
31. Not trusting in the health system of the country of destiny.	33. The trip by itself.
32. The possibility of getting trapped in the country of destiny.	34. The inconvenience of the travel.
36. The possibility of not being able to communicate with the medical staff of the country of destiny.	35. The cost of the trip.
37. Not knowing if there will be an adequate response capacity in the destination country, namely in terms of the physicians' expertise and quality and the technology available.	39. The negative image of the country in terms of medical tourism.
38. Eventual consequences for the health both in the short and long term.	

The validation of the scales presented was made for each group of motivations and fears using SmartPLS 3, and the validity of the formative measurement model was confirmed for each of them, in accordance with the information presented in Table 12.

Table 12

Validation of the formative measurement model for each group of motivations and fears, using SmartPLS 3

Variables	VIF < 5	T - value	P-value
Core motivations			
MF_1: The hospital's good reputation.	2.469	24.323	0.000
MF_2: The physician's and staff's reputation and certification.	2.318	21.454	0.000
MF_3: The uniqueness of treatments.	1.187	4.583	0.000
MF_4: The availability and perceived safety of medication quality.	2.248	21.627	0.000
MF_5: The availability and perceived quality of the treatment.	2.357	22.821	0.000
MF_6: The advanced medical treatment.	2.048	20.316	0.000
MF_7: The trust in the destiny country's health system.	1.940	24.060	0.000

MF_8: Having a lot of positive information, namely in terms of real success stories.	2-016	17.748	0.000
MF_9: Being advised by doctors of my trust to perform such treatment in such country.	1.825	14.021	0.000
MF_10: A positive feedback from someone close.	1.561	10.618	0.000
<hr/>			
Accessory motivations			
<hr/>			
MF_11: The service orientation of the medical staff.	1.441	12.098	0.000
MF_12: The shorter waiting lists.	1.829	4.145	0.000
MF_13: The accessibility.	2.094	9.207	0.000
MF_14: The large financing possibilities.	2.002	8.444	0.000
MF_15: The cost of the healthcare services.	2.097	14.742	0.000
MF_16: The stability of the exchange rate.	1.989	5.953	0.000
MF_17: The low corruption.	1.811	10.452	0.000
MF_18: The stability of the economy.	2.108	9.744	0.000
MF_19: The safety of the country of destiny.	1.787	33.943	0.000
MF_20: The culture and geographic proximity.	1.902	7.670	0.000
MF_21: The language proximity.	1.962	9.555	0.000
MF_22: The desire to visit the country of destiny.	1.686	3.043	0.002
<hr/>			
Core fears			
<hr/>			
MF_23: The existence of frequent criminal attacks in the country of destiny.	2.132	14.364	0.000
MF_24: The existence of unfair laws against international travellers in the country of destiny.	2.41	13.248	0.000
MF_25: The lack of hygiene and security of the accommodation facilities.	2.235	17.045	0.000
MF_30: Not knowing the country's healthcare system of destiny.	2.331	12.441	0.000
MF_31: Not trusting in the health system of the country of destiny.	2.930	15.869	0.000
MF_32: The possibility of getting trapped in the country of destiny.	2.492	19.215	0.000

MF_36: The possibility of not being able to communicate with the medical staff of the country of destiny.	2.370	19.570	0.000
MF_37: Not knowing if there will be an adequate response capacity in the destination country, namely in terms of the physicians' expertise and quality and the technology available.	2.752	20.218	0.000
MF_38: Eventual consequences for the health both in the short and long term.	1.957	30.924	0.000
<hr/>			
Accessory fears			
<hr/>			
MF_26: The travel contents.	2.041	10.743	0.000
MF_27: The means of transportation.	2.175	10.452	0.000
MF_28: The weather.	2.725	3.817	0.000
MF_29: The local food.	2.683	4.642	0.000
MF_33: The trip by itself.	2.434	9.195	0.000
MF_34: The inconvenience of the travel.	2.624	10.185	0.000
MF_35: The cost of the trip.	1.771	19.491	0.000
MF_39: The negative image of the country in terms of medical tourism.	1.406	22.917	0.000

3.3.2. Hypotheses

Below, the theoretical hypothesis of this part of the study are presented.

Since individuals from nationalities with high level of uncertainty avoidance are less willing to assume risks and, as referred, medical tourism is a high-risk activity, the hypothesis 1 corresponds to the following:

H1: Individuals from nationalities with high level of uncertainty avoidance are less willing to perform medical tourism.

- Dependent variable: willingness to perform medical tourism.
- Independent variable: level of uncertainty avoidance of the individuals.
- Moderator variables: age, perception regarding the income received, the frequency (or not) of a college degree.

Additionally, as individuals from nationalities with high level of uncertainty avoidance are less willing to assume risks and to try different experiences, and, travelling to a country

with a lower HDI may increase the risk perception of performing medical tourism, the hypothesis 2 corresponds to the following:

H2: Individuals from nationalities with high level of uncertainty avoidance are less willing to travel to countries with a lower HDI than the one in which they live to perform medical tourism.

- Dependent variable: willingness to travel to countries with a lower HDI to perform medical tourism.
- Independent variable: level of uncertainty avoidance of the individuals.
- Moderator variables: age, perception regarding the income received, the frequency (or not) of a college degree.

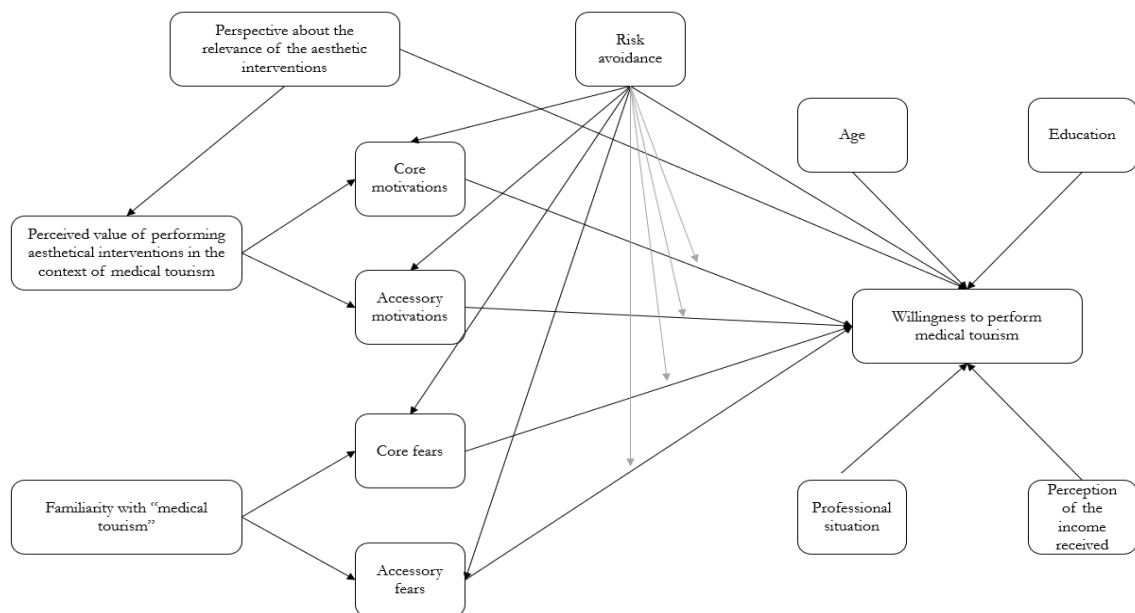
Finally, as the individuals from nationalities with low levels of uncertainty avoidance are more willing to take risks and usually take decisions quickly, the hypothesis 3 may be described as following:

H3: The level of uncertainty avoidance of the individuals influences the impact of the motivations and fears in the willingness to perform medical tourism.

To a more complete answer some antecedents of fears and motivations were included in this study. The correspondent model is synthetised in Figure 1, which illustration contains the dependent and independent variables, as well as the moderator variables duly identified and the correspondent sub hypotheses.

Figure 1

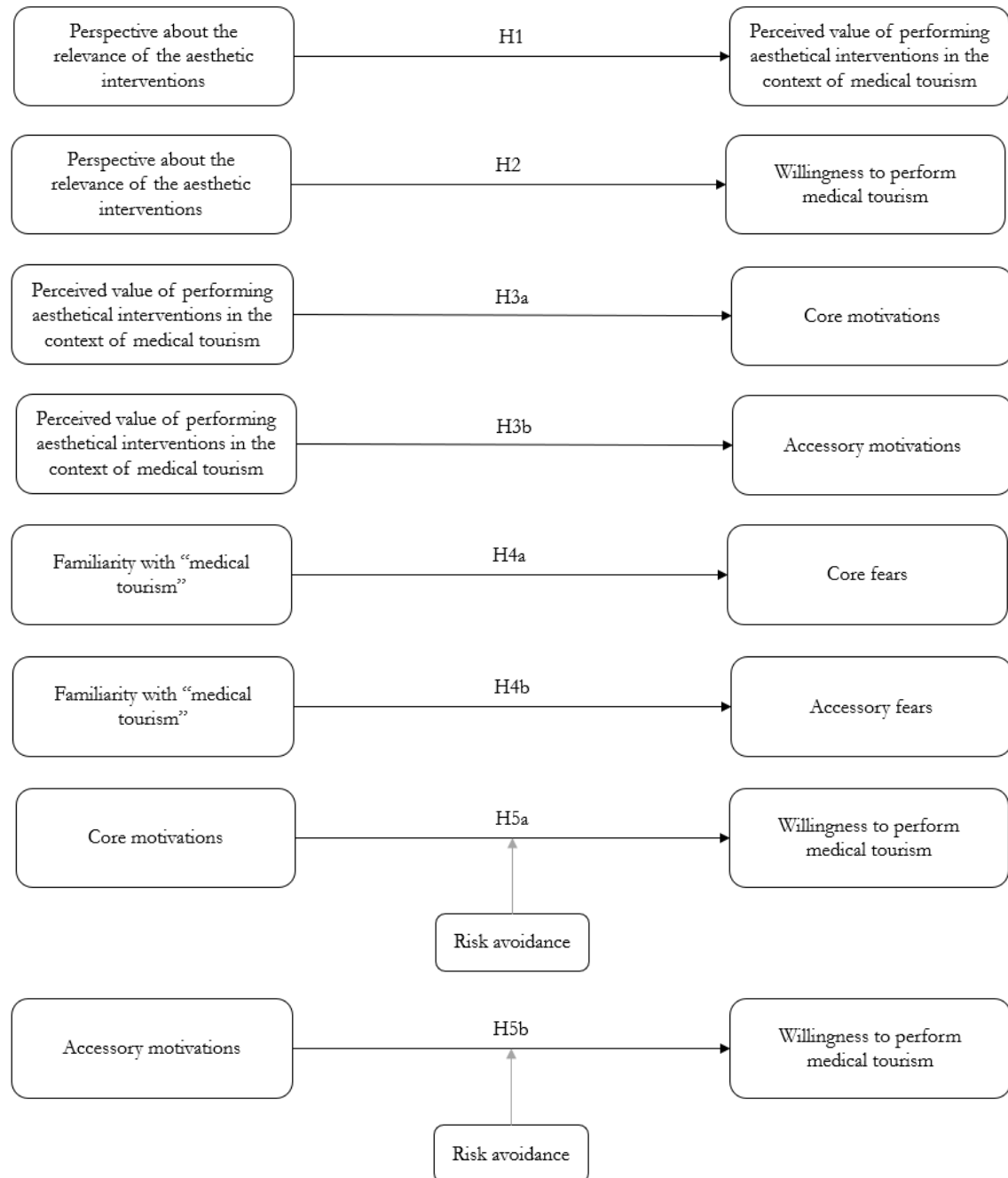
Representation of H3

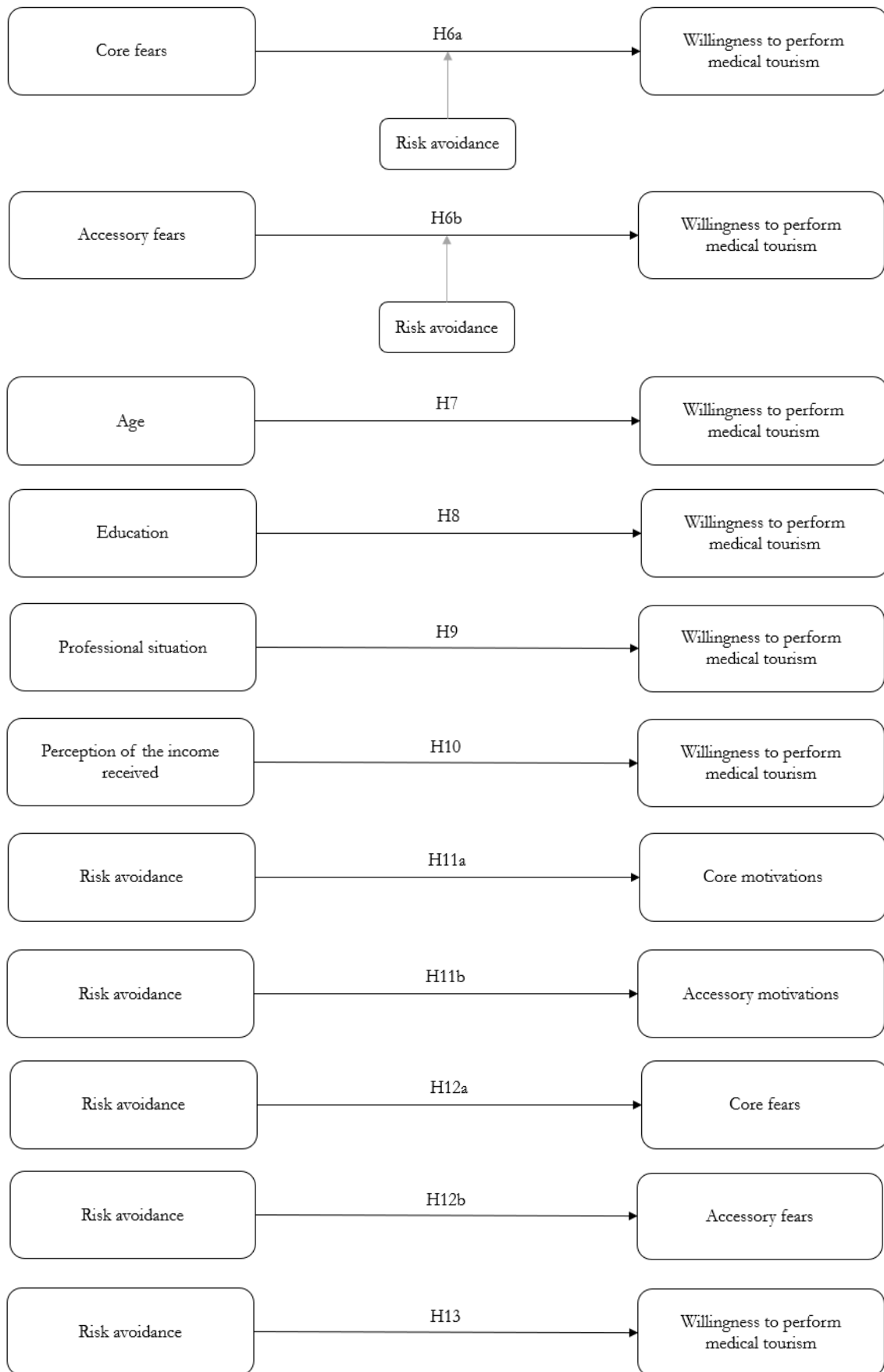


For better understanding, in Figure 2, there is a representation of each sub hypothesis individually.

Figure 2

Representation of the sub hypotheses of H3 individually





The H1 states that the perspective of the individuals about the relevance of the aesthetic interventions should have an impact on the perceived value of performing aesthetical interventions in the context of medical tourism. Individuals that consider that the aesthetic interventions are not relevant should perceive less value in performing this kind of treatments in a context of medical tourism. This understanding is based on the work made by Marchac (2007) for a different context.

As for H2, it implies that the perspective of the individuals about the relevance of the aesthetic interventions should have an impact on their willingness to perform medical tourism, since individuals that consider the aesthetic interventions as something not relevant should be less willing to perform medical tourism in this context. Similar to the hypothesis above, this understanding is based on the work made by Marchac (2007) for a different context.

The H3a and the H3b state that the perceived value of performing aesthetical interventions in the context of medical tourism should influence the impact of the motivations in the moment of deciding to perform (or not) this type of tourism.

As for H4a and H4b, these hypotheses state that the familiarity with the concept of “medical tourism” should influence the impact of the fears in the moment of deciding to perform (or not) this type of tourism. Individuals more familiarised with the concept, as are more informed, should be less influenced by the fears related to it.

The H5a and the H5b refer that the impact of the motivations in the individuals should influence their willingness to perform medical tourism (Mathijssen, 2019; Tapia et al., 2020; Wang et al., 2020) and that this relation should be influenced by the level of risk avoidance of the individuals’ nationality.

Regarding H6a and the H6b, these hypotheses refer that the impact of the fears in the individuals should influence their willingness to perform medical tourism (Kang et al., 2014; Sheng-Hshiang et al., 1997) and that this relation should be influenced by the level of risk avoidance of the individuals’ nationality.

H7 refers that the age should also influence the willingness of the individuals to perform medical tourism. According to the qualitative research conducted, older individuals should be less willing to perform medical tourism.

The H8 refers that the formal education (have enrolled or not in a college degree) should influence the willingness of the individuals to perform medical tourism. According to

the qualitative research conducted, individuals with higher levels of formal instruction should be more willing to perform medical tourism.

H9 states that the current professional situation of the individuals should influence their willingness to perform medical tourism. Individuals in a more stable situation should be more willing to perform medical tourism.

As for H10, it refers that the perception of the income received by the individuals should influence their willingness to perform medical tourism. Individuals that consider themselves as more wealthy should be more willing to perform medical tourism.

H11a, H11b, H12a and H12b state that the risk avoidance related to the nationality of the individuals should influence the impact of the motivations and fears in the decision to perform (or not) medical tourism. Individuals from nationalities with higher levels of risk avoidance are less willing to take risks (Hofstede, 1984, 2001; Hofstede & Bond, 1998). Since medical tourism is a high-risk activity (Kang et al., 2014), the individuals from nationalities with higher levels of risk avoidance should be more influenced both by the motivations and fears related to this matter.

Finally, H13 refers that the risk avoidance should have an impact on the willingness to perform medical tourism. Individuals from nationalities with higher levels of risk avoidance should be less willing to perform medical tourism, as medical tourism is a high-risk activity (Kang et al., 2014) and these individuals are less willing to take risks.

3.3.3. Sample and data collection

The data was collected through an online survey, which was published on several social networks. Every individual answered to the survey voluntarily and no limitations to the participation of anyone were made, based on any biographic characteristic, except for the requirement for the individuals to be over 18 years old, and for them to be Portuguese, Indian or Americans.

For purposes of the present study, the sample corresponded to 64 Indian individuals, 158 Portuguese individuals and 461 American individuals.

The Portuguese nationality was chosen to represent individuals for a nationality with a high level of uncertainty avoidance, as Portugal was identified by Hofstede's website has

having 99/100 uncertainty avoidance. On the other hand, India and the USA were the countries chosen to represent a group of individuals with a low level of uncertainty avoidance. According to Hofstede's website, the Indian population has an uncertainty avoidance of 40/100 and the USA population of 46/100.

Therefore, the sample had a total of 158 individuals with a high level of uncertainty avoidance and a total of 525 individuals with a low level of uncertainty avoidance. The individuals of both groups have a high age range (from 18 to 74 years old), a good distribution in terms of gender (approximately 59% of individuals identified themselves as female and approximately 41% as male) and include individuals that have been to college at some point and individuals that have never been to college.

3.3.4. Statistical analysis

Hypotheses 1 and 2

For purposes of analysing the validity of the formulated hypotheses 1 and 2, an analysis of covariance (ANCOVA) was made for each of them, as this is the most suitable statistical analysis to confirm the impact of an independent variable in a dependent variable, excluding the effect of the moderator variable(s).

An ANCOVA can only be performed if the following assumptions are filled:

1. The distribution of the continuous data must be normal.
2. The independent variable should not influence the moderator variables.
3. There should be a homogeneity of the regression parameters.

Regarding the assumption number 1, following the Central Limit Theorem, since the sample is higher than 30, it was assumed that the distribution of the continuous data is normal and, therefore, the assumption is fulfilled.

It was tested, through SPSS, if the independent variable of each hypothesis had an influence in any on the moderator variables, by using an ANOVA test. It was concluded that neither of the independent variables influence either of the moderator variables, as the P-value obtained for each case was higher than 5%.

Finally, as for the assumption number 3, the homogeneity was also tested, through SPSS. Since the P-value of the interaction of each independent variable with each moderator variable was higher than 5%, it was concluded that the homogeneity was met for each of the hypotheses.

Therefore, and since all the assumptions required to perform a ANCOVA were fulfilled, the analysis was made for each hypothesis. The details obtained through SPSS are enclosed in the next section for each of the hypotheses. Regarding hypothesis 1, and since this variable was represented for more than one affirmation (affirmations 1 to 10 of Table 7), a reduction of factors throughout the method of the principal components was made prior to the realisation of the ANCOVA.

Hypothesis 3

For purposes of analysing the validation of hypothesis 3 and of its sub hypotheses, a structural equation model with latent variables was used. Therefore, and as identified by the existent literature, namely by Pinto (2016), after concluding the design of the model, a parameter estimation and model evaluation was made through SmartPLS 3.

3.3.5. Results

Hypothesis 1

H1: Individuals from nationalities with high level of uncertainty avoidance are less willing to perform medical tourism.

This hypothesis was supported by the empirical study. The results obtained using SPSS are presented next, in figure 3.

Figure 3

SPSS results for the ANCOVA made for H1

Descriptive Statistics			
Dependent Variable: REGR factor score 1 for analysis 1			
Risk_avoidance	Mean	Std. Deviation	N
IN/US	,0911903	1,02897125	525
PT	-,3030056	,83064794	158
Total	,0000000	1,00000000	683

Tests of Between-Subjects Effects

Dependent Variable: REGR factor score 1 for analysis 1

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	126,786 ^a	4	31,696	38,706	<,001
Intercept	8,411	1	8,411	10,271	,001
Age	21,398	1	21,398	26,130	<,001
College_Degree	6,378	1	6,378	7,789	,005
Income_1	75,540	1	75,540	92,246	<,001
Risk_avoidance	13,439	1	13,439	16,411	<,001
Error	555,214	678	,819		
Total	682,000	683			
Corrected Total	682,000	682			

a. R Squared = ,186 (Adjusted R Squared = ,181)

Note. Exported from SPSS.

As it may be observed, by the results above, there is, indeed a direct relation between the risk avoidance and the willingness of the individuals to perform medical tourism.

Hypothesis 2

H2: Individuals from nationalities with high level of uncertainty avoidance are less willing to travel to countries with a lower HDI than the one in which they live to perform medical tourism.

This hypothesis was supported by the empirical study. The results obtained using SPSS are presented next, in figure 4.

Figure 4

SPSS results for the ANCOVA made for H2

Descriptive Statistics			
Dependent Variable: MT_Predisposition_10			
Risk_avoidance	Mean	Std. Deviation	N
IN/US	1,86	1,344	525
PT	1,05	,916	158
Total	1,67	1,303	683

Tests of Between-Subjects Effects

Dependent Variable: MT_Predisposition_10

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	248,158 ^a	4	62,040	46,239	<,001
Intercept	18,129	1	18,129	13,512	<,001
Age	25,499	1	25,499	19,005	<,001
College_Degree	10,118	1	10,118	7,541	,006
Income_1	124,366	1	124,366	92,692	<,001
Risk_avoidance	65,954	1	65,954	49,157	<,001
Error	909,684	678	1,342		
Total	3074,000	683			
Corrected Total	1157,842	682			

a. R Squared = ,214 (Adjusted R Squared = ,210)

Note. Exported from SPSS.

As it may be observed, by the results above, there is, indeed a direct relation between the risk avoidance and the willingness of the individuals to travel to a country with a lower HDI than the one in which they live in to perform medical tourism.

Hypothesis 3

H3: The level of uncertainty avoidance of the individuals influences the impact of the motivations and fears in the willingness to perform medical tourism.

This hypothesis was not supported by the empirical study.

The results obtained are presented next, in Table 13. The sub hypotheses accepted are the ones for which the P-value is lower than 5%, i.e., sub hypotheses H1, H2, H3a, H3b, H4b, H5b, excluding the impact of the risk avoidance (moderator variable), H7, H8, H10 and H11b.

Afterwards, the model was modified, in accordance with the results obtained. This modification and the final model may observe in the next section, in Figure 5.

Table 13

Parameter estimation made for H3, using SmartPLS 3

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T statistics (O/STDEV)	P values
Accessory motivations > Willingness to perform medical tourism	0.170	0.177	0.044	3.854	0.000
Age > Willingness to perform medical tourism	-0.123	-0.124	0.032	3.791	0.000

Perspective about the relevance of aesthetic interventions > Perceived value of performing aesthetic interventions in the context of medical tourism	0.473	0.474	0.032	14.805	0.000
Perspective about the relevance of aesthetic interventions > Willingness to perform medical tourism	0.252	0.248	0.036	7.068	0.000
Core motivations > Willingness to perform medical tourism	0.076	0.085	0.041	1.849	0.065
Education > Willingness to perform medical tourism	0.054	0.053	0.032	1.657	0.098
Familiarity with “medical tourism” > Core fears	-0.179	-0.076	0.186	0.965	0.335
Familiarity with “medical tourism” > Accessory fears	0.457	0.464	0.042	10.967	0.000
Core fears > Willingness to perform medical tourism	0.027	0.02	0.041	0.663	0.508
Accessory fears > Willingness to perform medical tourism	0.081	0.083	0.044	1.843	0.066
Moderating Effect 1 > Willingness to perform medical tourism	-0.022	-0.020	0.048	0.453	0.650
Moderating Effect 2 > Willingness to perform medical tourism	-0.028	-0.031	0.041	0.671	0.503
Moderating Effect 3 > Willingness to perform medical tourism	0.058	0.027	0.065	0.892	0.373
Moderating Effect 4 > Willingness to perform medical tourism	-0.011	-0.01	0.041	0.275	0.783
Perceived value of performing aesthetic interventions in the context of medical tourism > Accessory motivations	0.329	0.346	0.059	5.535	0.000
Perceived value of performing aesthetic interventions in the context of medical tourism > Core motivations	0.374	0.39	0.037	10.082	0.000
Perception of the income received > Willingness to perform medical tourism	0.252	0.247	0.039	6.486	0.000
Professional situation > Willingness to perform medical tourism	0.034	0.036	0.033	1.047	0.296

Risk avoidance > Accessory motivations	-0.226	-0.211	0.089	2.555	0.011
Risk avoidance > Core motivations	0.312	0.307	0.044	7.083	0.000
Risk avoidance > Core fears	0.209	0.126	0.172	1.216	0.224
Risk avoidance > Accessory fears	0.073	0.079	0.056	1.307	0.192
Risk avoidance > Willingness to perform medical tourism	-0.079	-0.081	0.044	1.779	0.076

As it may be observed, by the results above, it was not possible to prove that the level of uncertainty avoidance of the individuals influences the impact of the motivations and fears in the willingness to perform medical tourism.

However, some other interesting relations were discovered. There is a statistically significant relationship between the accessory motivations and the willingness to perform medical tourism, the age and the willingness to perform medical tourism, the perspective about the relevance of aesthetical interventions and the perceived value of performing aesthetical interventions in the context of medical tourism, the perspective about the relevance of aesthetical interventions and the willingness to perform medical tourism, the familiarity with “medical tourism” and the accessory fears, the perceived value of performing aesthetical interventions in the context of medical tourism and the two groups of motivations, the perception of the income received and the willingness to perform medical tourism, the risk avoidance and the both groups of motivations. All of these relations will be further analysed in the next section.

3.3.6. Discussion

Table 14 presents a summary of the results obtained for each hypothesis, as described above.

Table 14

Result of the analysis of the hypotheses

Hypotheses	Result
H1: Individuals from nationalities with high level of uncertainty avoidance are less willing to perform medical tourism.	Supported

H2: Individuals from nationalities with high level of uncertainty avoidance are less willing to travel to countries with a lower HDI than the one in which they live to perform medical tourism.	Supported
H3: The level of uncertainty avoidance of the individuals influences the impact of the motivations and fears in the willingness to perform medical tourism.	Not supported

The **hypothesis 1**, which identifies that “Individuals from nationalities with high level of uncertainty avoidance are less willing to perform medical tourism.”, was supported. This result is in line with what was possible to predict from the previous literature, which stated that individuals from nationalities with high level of uncertainty avoidance are less willing to assume risks (Bernard et al., 2022; Hofstede, 1984, 2001; Hofstede & Bond, 1988; Manrai & Manrai, 2011; Money & Crofts, 2003) and that medical tourism is a high-risk activity (Kang et al., 2014).

As for the **hypothesis 2**, “Individuals from nationalities with high level of uncertainty avoidance are less willing to travel to countries with a lower HDI than the one in which they live to perform medical tourism.”, it was also supported. This result is also in line with what was possible to predict from the previous literature, which stated that individuals from nationalities with high level of uncertainty avoidance are less willing to assume risks and to try different experiences (Bernard et al., 2022; Hofstede, 1984, 2001; Hofstede & Bond, 1988; Manrai & Manrai, 2011; Money & Crofts, 2003), and that travelling to a country with a lower HDI may increase the risk perception of performing medical tourism (Kang et al., 2014).

In fact, based on the results of the empirical tests made for hypotheses 1 and 2, it is possible to conclude that the risk avoidance has a big influence on the willingness of the individuals to perform (or not) medical tourism and on the country they will choose for that purpose.

This information may be interesting for the countries and institutions that are in position and want to invest in medical tourism, in order for them to be able to have a more effective and directed communication and to be able to target better the potential medical tourists.

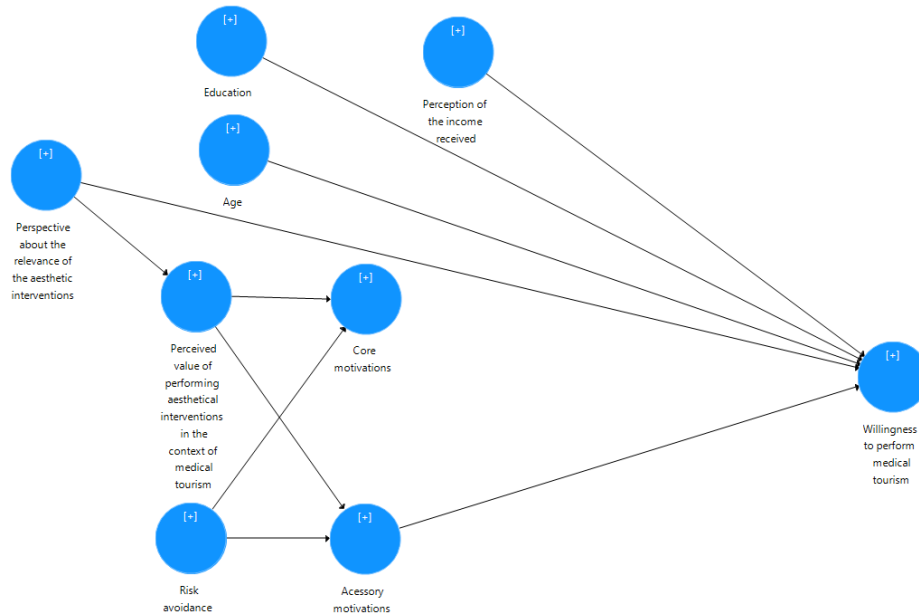
Concerning the **hypothesis 3**, “The level of uncertainty avoidance of the individuals influences the impact of the motivations and fears in the willingness to perform medical tourism.” was not supported. However, the model revealed important insights about the antecedents and consequents.

In this regard, considering the results obtained, and following the methodology proposed by Pinto (2016), the model was modified to the one presented in Figure 5.

Figure 5

New model obtained for H3

Note.



Author's own elaboration, using SmartPLS 3.

From the analysis performed and the final model presented, it was possible to conclude that the age has a direct impact on the willingness to perform medical tourism, older people are less willing to perform medical tourism. This conclusion is in line with the literature, since, according to Lepp and Gibson (2003); Seabra et al. (2013), the age has an impact on the risk perception. This is also in line with the qualitative research performed and should be a good indicator that younger people will be more willing to perform medical tourism, reason why probably the focus of the strategies of the entities of the sector should be younger people.

As for the education, it was confirmed that the frequency (or not) of a college degree has an impact on the willingness to perform medical tourism, namely, to perform an aesthetical intervention, this confirmation is also in line with the information obtained in the qualitative research performed. According to the results obtain, it is possible to conclude that people that have enrolled in a college degree are more willing to perform medical tourism than people than have not.

Additionally, the perception of the income received also impacts the willingness to perform medical tourism, people that have a perception that their income is able to pay for more things are more willing to engage in medical tourism. This relation can be easily

explained by the fact that medical tourism is a relatively expensive and, therefore, people that feel wealthier should be in better position to be willing to perform medical tourism and should be able to perform medical tourism in better conditions, they may, for example, stay in more comfortable and hygienic hotels. Additionally, the income received also influences the risk perception, more wealthy people usually have a lower perception of the risk (Floyd & Pennington-Gray, 2004; Seabra et al., 2013, which may also influence the willingness to perform medical tourism, as a high-risk activity (Kang et al., 2014). On the other hand, the current employment situation of the individuals seems to not have an impact on their willingness to perform medical tourism, which should be due to the fact that the employment situation may not correspond directly to a situation of more or less wealthiness, being possible to conclude that the perception of the money availability is much more important for this decision than the employment situation by itself.

As for the perspective about the relevance of the aesthetic interventions, it seems to have a direct impact on the willingness to perform medical tourism and on the perceived value of performing aesthetical interventions in the context of medical tourism. It was possible to conclude based on the work performed by Marchac (2007) that some people consider aesthetical interventions as something superfluous and not relevant. Therefore, it seems natural for this perspective to have a direct impact on the willingness of the individuals to travel to other countries to perform these interventions and on the perceived value that may arise from it.

Also, it was possible to conclude that, for individuals that perceive more value in performing aesthetical interventions in the context of medical tourism, both the core and accessory motivations have a greater impact in the decision of performing medical tourism and that, therefore, this perceived value has an indirect impact on the willingness to perform medical tourism, through its direct impact on the accessory motivations. It is possible to conclude that an individual that perceives a greater value in performing aesthetical interventions in the context of medical tourism will valorise more the accessory motivations that influence the medical tourists/potential medical tourists and that, by influence more the accessory motivations, will be more willing to perform medical tourism.

In fact, it was possible to conclude that there is a direct impact of the accessory motivations on the individuals' willingness to perform medical tourism: the bigger the impact of the accessory motivations on the individuals, the more willing they should be to perform medical tourism. However, it was also possible to conclude that the influence of the core

motivations on the individuals do not have an impact on their willingness to perform medical tourism. Even though it may not be directly explained by the existent literature, the influence of the core motivations may not have an impact on the willingness to perform medical tourism due to the fact that, since these motivations are a central point of the performance of the procedure and may actually bring problems to the wellbeing of the individuals, they should be widely relevant for both the individuals with higher and lower willingness to perform medical tourism.

As for the fears, it was concluded that neither the impact of the core fears or of the accessory fears influences the willingness of the individuals to perform medical tourism. As for the core fears, which are mainly related to the lack of security of the country and/or the procedure, probably the reason why there is no direct influence between the variables is due to the same reason referred for the core motivations. As for the accessory fears, which are mainly related to the content of the trip/travel, probably these fears do not influence directly the willingness of the individuals to perform medical tourism, as they may look to the respondents as indicators rather related to the tourism in general and not as much related with the situation of performing specifically medical tourism.

Still in the field of the fears, it is important to note that, even though this is not part of the final model obtained, the familiarity with “medical tourism” impacts the influence of the accessory fears. In line with what was referred above, the accessory fears may not be easily identified as fears related with medical tourism, therefore, maybe only the individuals with better knowledge of this reality will be in position to actually understand the impact that they may have in a situation of medical tourism. Also, it was possible to conclude that the familiarity with “medical tourism” does not impact the core fears, which should be once again related to the fact that these fears are directly related to the wellbeing of the individuals and, therefore, probably the individuals will be similarly affected by them, despite of their familiarity with this type of tourism.

Finally, and as for the variable of the risk avoidance, represented by the nationality, according to Hofstede’s work, it was concluded that, even though the literature indicated that the risk avoidance should directly influence the willingness of the individuals to perform medical tourism, as medical tourism is a high-risk activity (Kang et al., 2014), the empirical study shows that there is not a direct influence between this two variables. The risk avoidance influences, indeed, the willingness of the individuals to perform medical tourism (as concluded as well in the analysis of H1), however only indirectly, by having a direct

implication in the accessory motivation than, for its turn, influence the willingness of the individuals to perform medical tourism directly.

Additionally, it would be expected for the risk avoidance to directly influence the impact of both the fears and the motivations in the decision to perform (or not) medical tourism. However, the empirical study proved that it only affects the impact of the motivations.

The same way, according to the previous research made, and based on the literature about it, it would be expected for the risk avoidance to be a moderator of the impact of the influence of the motivations and fears when deciding to perform medical tourism in the willingness to perform this type of tourism. However, it was also not verified.

In brief, and regarding the model studied, it was possible to show that the perceived value of perspective of the individuals about the relevance of the aesthetic interventions as an impact on the willingness to perform medical tourism and on the perceived value of performing aesthetical interventions in the context of medical tourism. It was also possible to prove that the perceived value of performing aesthetical interventions in the context of medical tourism influences the impact of the core and accessory motivations in the decision and that the risk avoidance has a direct impact on the two groups of motivations as well. Finally, it was possible to show that the willingness to perform medical tourism is directly influenced by the age, education, perception of the income received, the perspective about the relevance of the aesthetic interventions and the accessory motivations and indirectly influenced by the perceived value of performing aesthetical interventions in the context of medical tourism and by the risk avoidance, through the influence of these variables in the accessory motivations (for further details, please see Figure 5).

4. Conclusions

4.1. Final considerations

The recent developments in the health and social care systems led to a significant growth of the medical tourism. Therefore, studying different aspects of medical tourism is becoming more and more critical, namely the motivations and fears related to the performance (or not) of medical tourism.

The main goals of this investigation were to discover motivations and fears when considering performing medical tourism that had not yet been explored by previous literature and, afterwards, analysing the impact of the nationality on the main motivations and fears that affect the individuals when considering performing medical tourism.

This investigation started with the literature review regarding tourism, medical tourism, the motivations and fears of the medical tourists and the nationality, using the Hofstede's cultural dimensions, since the review of these concepts was indispensable for the empirical analysis that was made, in order to answer the two research questions: Q1 – “Which are the main motivations and fears of the medical tourists/potential medical tourists?”; Q2 – “What is the impact of nationality on the main motivations and fears of the medical tourists/potential medical tourists?”.

To answer the first research question, a qualitative methodology was used. For this purpose, twenty phone interviews were made. It was possible to conclude that, besides the motivations already identified by the previous literature, maybe the trust in the destiny country's health system, having a lot of positive information, namely in terms of real success stories, being advised by doctors of the individuals' trust to perform such treatment in such country, the positive feedback from someone close, the safety of the country, the culture and geographic proximity and the desire to visit the country of destiny are also relevant motivations in this regard. Additionally, it was possible to conclude that, besides the fears already identified by the previous literature, maybe not knowing the destiny country's healthcare system, untrusting in the health system of the country of destiny, the fear of getting trapped in the country of destiny, the trip by itself, not being able to communicate with the medical staff of the country of destiny, the fear of not having the adequate response capacity in the destination country, namely in terms of the physicians' expertise and quality, and the technology available and the eventual consequences for the health both in the short and long term are also relevant fears in this regard.

In order to address the second research question, a quantitative methodology was used to test the hypothesis identified. The data was collected through online surveys, the sample included a total of 683 valid answers and the data was treated using SPSS. It was possible to conclude that the nationality has an impact on the willingness of the individuals to perform (or not) medical tourism, namely in countries with a lower HDI than the one the individuals live in, and that, as rule, the nationality influences the impact of the motivations of the individuals when considering to perform medical tourism, but not of the fears, as it was not possible to establish a statistically significant relation between these variables.

In the quantitative part of the research, it was possible to verify that, as expected, the age, the education level and the perception of the income received have a direct impact on the willingness of the individuals to perform medical tourism, as well as the perspective of the individuals regarding the relevance of the aesthetic interventions/of its frivolous and the impact of the accessory motivations. It was also possible to conclude that the risk avoidance and the perceived value of performing aesthetical interventions in the context of medical tourism have an impact on the influence of the motivations (core and accessory) and, therefore, have an indirect impact on the willingness of the individuals to perform medical tourism.

4.2. Management and Academic contributions

As referred already, the recent developments in the health and social care systems led to medical tourism growth. Therefore, studying different aspects of medical tourism is becoming more and more critical both to the Academy and to the market.

From an Academic point of view, this investigation should contribute to the enrichment of the knowledge about the medical tourists and their motivations and fears. Also, it should be helpful to assist in responding to some of the gaps in the literature, such as, to understand better what inhibits the individuals to perform medical tourism, as most of the studies performed up to this one, only considered individuals that already had performed medical tourism, as well as the fact that no one had studied the impact of the nationality in the main motivations and fears of the medical tourists and in the predisposition of the individuals to become medical tourists before this investigation.

Also, this investigation brings to the Academy attention to the fact that, despite what could be expected from previous research made, fears should not have a central part on the

willingness of the individuals to perform medical tourism, which should influence the future research to be made. As well as the attention given to the major importance of the accessory motivations, which increases the knowledge available about the profile of the medical tourists.

As for the market, since there are predictions of massive growth of global medical tourism from USD 19.79 billion in 2020 to USD 40.03 billion in 2025, it is urgent for the private entities and for the Government of the different countries to have more information about this activity and about the medical tourists/potential medical tourists, in order to be able to make more effective decisions in this regard.

In this context, it was possible to understand that the impact of the fears does not influence the willingness of the individuals to perform medical tourism, only the motivations do, namely the accessory ones, i.e., the ones that are not directly related to the procedure to be performed. Therefore, in order for the entities and the governments to be able to increase the willingness of the individuals to perform medical tourism, they should mainly work essentially on the motivations.

Additionally, it was possible to conclude that the perspective of the individuals about the relevance of the aesthetic interventions have a significant influence on the willingness of the individuals to perform medical tourism, both directly and indirectly, by affecting the motivations. Therefore, and since some individuals may see these interventions as “frivolous and unnecessary” (Marchac, 2007, p. 211) and this perspective will influence their lack of willingness to perform medical tourism, it may be important and effective for the market to carry out campaigns that may add value to aesthetic interventions and help deconstructing preconceptions of frivolous.

4.3. Limitations of the Study and Future Research

The main limitations of the qualitative part of the study, i.e., the identification of additional motivations and fears that impact the individuals when choosing to perform (or not) medical tourism are the size of the sample and the fact that all the interviewed individuals were Portuguese nationals, and people from other countries should also be interviewed. The two main limitations presented, even though do not compromise the results obtained, are probably a good indicative that there may be still a lot of new information to be discovered in the field of the motivations and fears of the medical tourists /potential medical tourists,

as new inputs should be discovered interviewing more people and people with other nationalities and, thus, another background. Therefore, future studies may consider extending the research to a larger group of individuals and people from different nationalities, not only Portuguese individuals.

Regarding the quantitative part of the study, i.e., the study of the implications of the nationality in the main motivations and fears that influence the medical tourists/potential medical tourists when deciding to perform (or not) medical tourism, the main limitations correspond to the fact that only three countries were considered in the study (India, Portugal and USA) and the fact that, nowadays, due to globalisation the nationalities may not be as representative as they used to be and, therefore, individuals from the same nationality may have a significantly different level of uncertainty avoidance. In this regard, future studies may consider extending the research to more countries, namely to countries with a medium level of uncertainty avoidance, to consider more/different Hofstede's cultural dimensions, or to choose a different factor to differentiate the individuals.

Additionally, it may also be interesting to extend the research to other type of medical interventions/procedures. In this regard, and as already referred, it should be relevant to continue studying procedures that are elective, and not obligatory (required to manage a life-threatening condition). Future studies may also consider investigating if there are (or not) significant differences between the motivations related to the performance of medical tourism and to the performance of wellness tourism.

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6. Annexes

6.1. Annex I

Figure 6

Portuguese resident population according to the censuses: total and by major age groups

Anos	Grandes grupos etários			
	Total	0-14	15-64	65 ou mais
1960	8.889.392	2.591.955	5.588.868	708.569
1970	8.611.125	2.451.850	5.326.515	832.760
1981	9.833.014	2.508.673	6.198.883	1.125.458
1991	9.867.147	1.972.403	6.552.000	1.342.744
2001	10.356.117	1.656.602	7.006.022	1.693.493
2011	± 10.562.178	± 1.572.329	± 6.979.785	± 2.010.064
2021	Pro 10.344.802	Pro 1.331.396	Pro 6.589.284	Pro 2.424.122

Note. Source: Pordata (2021).

Figure 7

Portuguese resident population according to the censuses: total and by gender

Anos	Sexo		
	Total	Masculino	Feminino
1960	8.889.392	4.254.416	4.634.976
1970	8.663.252	4.109.360	4.553.892
1981	9.833.014	4.737.715	5.095.299
1991	9.867.147	4.756.775	5.110.372
2001	10.356.117	5.000.141	5.355.976
2011	± 10.562.178	± 5.046.600	± 5.515.578
2021	Pro 10.344.802	Pro 4.921.170	Pro 5.423.632

Note. Source: Pordata (2021).

6.2. Annex II

Figure 8

SPSS factor analysis of the principal components results

➔ Factor Analysis

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		,911
Bartlett's Test of Sphericity	Approx. Chi-Square	7069,924
	df	136
	Sig.	,000

Rotated Component Matrix^a

	Component	
	1	2
MF_23	,660	,279
MF_28		,825
MF_24	,707	,244
MF_25	,770	,128
MF_26	,206	,735
MF_27	,207	,757
MF_29		,814
MF_30	,754	,143
MF_31	,827	
MF_32	,796	,184
MF_33	,200	,779
MF_34	,186	,774
MF_35	,374	,585
MF_36	,763	,216
MF_37	,826	
MF_38	,716	,130
MF_39	,425	,502

Extraction Method: Principal

Component Analysis.

Rotation Method: Varimax with
Kaiser Normalization.^a

a. Rotation converged in 3
iterations.

Note. Author's own elaboration, using SPSS.