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Travel behaviour among inbound medical tourists in Kuala Lumpur

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Despite recording the highest growth among tourism sub-sectors [Dhesi, D. (2009, March 25). Medical tourism rises in Malaysia despite economic downturn. The Star Online. Retrieved from http://www.malaysiahealthcare.com/; Leonard, T. (2009, July 24). Medical tourists to bring in RM 540 million by 2010. Retrieved from http://www.malaysiahealthcare.com/; Tourism Malaysia. (2008). Profile of tourist by selected markets 2008. Kuala Lumpur: Tourism Malaysia], little is known empirically with regard to travel behaviour among inbound medical tourists in Malaysia. This study examined the demographic profile, travel motivation, healthcare consumption, and expenditure behaviour among them in Kuala Lumpur. Using the combination of purposeful and convenience sampling, a total of 138 questionnaires were completed, returned, and analysed. The majority of the respondents were female, middle aged, travelling with two others and Indonesians. Their main travel motivation factors were ‘value for money’, ‘excellent medical services’, ‘supporting services’, ‘cultural similarity’, and ‘religious factor’ in descending order of importance. Medical treatment, cosmetic procedure, surgical procedure, and medical check-up were important healthcare services sought after by the respondents. On average, medical tourists spent MYR 26,844.19 per visit, with females and tourists of European descent contributing significantly more. Tourists from ASEAN had stronger motivation of ‘cultural similarity’ compared with other tourists. This paper is unique in providing the empirical evidence of the city’s unique selling points (pull factors) in attracting inbound medical tourists. It also highlights the potential economic contribution and some managerial implications in terms of marketing and product development.

Keywords: medical tourism; motivation; healthcare consumption; spending behaviour; Kuala Lumpur

1. Introduction

Following the economic downturn in the late 1990s, the Malaysian government has identified tourism as one of the economic sectors to be developed in order to bring the nation to economic recovery (Chong, Boey, & Vathsala, 2005). The sector has also been identified as one of the 12 initiatives proposed under the National Key Economic Areas that could help the nation to achieve the status of a developed economy by 2020. Within tourism, the health sub-sector is singled out as the most promising and lucrative area for the development of the industry in the country (Dewi, 2003; Ormond, 2011).

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While tourist arrivals increased by 300% from 5.5 million in 1998 to 22.1 million in 2008, over the same period, medical tourist arrivals increased by 856% from 39,114 to 374,063 (Dhesi, 2009; Leonard, 2009; Tourism Malaysia, 2008; Wellnessvisit.com, 2008). The Association of Private Hospitals of Malaysia (APHM) predicted revenue from medical tourism to grow at least 30% annually and that by 2010 the sector would contribute MYR 540 million to the nation’s economy (Leonard, 2009).

Ormond (2011) pointed out that health tourist destinations develop for two main reasons. From the pull-factor perspective, it is developed as a result of the provision of world-class medical facilities and services in the destination region. On the other hand, from the push-factor perspective, tourists’ movement is motivated by the failure of their health system to fulfill the needs of prospective patients in the tourist-generating region. Malaysia has successfully responded to these unfulfilled needs and attracts not only tourists from the less-developed Indonesia but also the ‘value-for-money’ seekers of middle-class American society and the Middle Easterners who have been ethnically and religiously discriminated from the West after the 9/11 tragedy.

Ormond (2011) listed out four main reasons for tourists preferring to travel overseas to seek health treatment. The reasons are that in the tourist-generating region, medical services are higher in cost, longer in waiting list, and stricter in prohibitive regulatory control of certain medical procedures and perhaps lack of cultural sensitivity, especially for immigrant patients. Additional reasons noted by Hall (2011) are the opportunity to combine medical services with a holiday in exotic locations and the availability of organ transplants.

Presently, the Malaysian government and related stakeholders have been making efforts to develop the country’s infrastructure, facilities, and services to be positioned as a preferred health tourism destination in the region. The joint efforts between the Ministry of Tourism, the APHM, and other health tourism stakeholders have actively promoted health services in the traditional markets of Indonesia, Singapore, the Philippines, and Japan (Novasans, 2010). The attention has also now shifted to new markets such as Vietnam, Cambodia, the Middle East, Europe, the USA, and Canada (Novasans, 2010).

Malaysia is not the only player in the region, as many other regional countries are competing to attract medical tourists globally. Among them are the ‘uniquely’ superior-quality Singapore, the ‘amazing’ Thailand and the emerging ‘incredible’ India, all of which are promoting under the umbrellas of their own tourism industries. To offer unique competitive advantages in the current globalisation in healthcare services, Malaysia is in an urgent need of identifying its unique selling points. Thus, it is the aim of this study to explore the travel behaviour among health tourists for the purpose of marketing management and product development. This is achieved through the following objectives:

1. To identify the demographic profile of inbound health tourists in Kuala Lumpur.
2. To explore travel motivation (pull factors) among inbound health tourists in Kuala Lumpur.
3. To determine healthcare consumption and spending behaviour among inbound health tourists in Kuala Lumpur.
4. To examine the influences of demographic profile on travel motivation and spending behaviour among inbound health tourists in Kuala Lumpur.

This paper begins with the review of literature, which includes health and medical tourism in general as well as specific to Malaysia, travel motivation of medical tourists, issues of quality in health services and spending behaviour. This is followed by sections
2. Related literature

2.1 Health and medical tourism: definitions and critical issues

There is some resemblance between the phenomena of social tourism in some parts of Europe (e.g. France, Spain, and Poland) and health tourism in developing countries. The primary aim of social tourism was to provide access to tourism activities for all citizens, but at the same time contribute to the sustainability of the European tourism industry, especially during the low season (Diekmann & McCabe, 2011; Minnaert, Maitland, & Miller, 2011; Puczko & Rtaz, 2011). Today, health tourism in developing countries (e.g. Malaysia, Thailand, and India) not only provides an alternative option for better access to health services to inbound tourists, in terms of cheaper costs and superior services, or both, but also helps these countries to sustain their growth domestic products, especially with the recent deterioration and fluctuation of economy in many Asian countries (e.g. Asian Economic Crisis in late 1990s).

The definitions of health tourism and medical tourism are still hotly contested. Collectively, health tourism could be defined as travelling to destinations which provide facilities and services for the purpose of maintaining or improving health through wellness tourism and medical tourism (Goodrich & Goodrich, 1987; Hall, 1992; Mueller & Kaufmann, 2001). Whittaker (2008) recognised the difference between medical tourism and wellness tourism. The former involves the application of biomedical procedures to the patients, while the later refers to travelling to spa resorts or for traditional/alternatives therapies. Carrera and Bridges (2006) defined health tourism as travel for the enhancement of body, mind, and wellbeing. According to them, medical tourism is a subset of health tourism which aims at restoring health through medical intervention.

Hall (2003) recognised the two crucial elements in defining health tourism, which are tourists and service providers. According to him, health tourism is defined as ‘a commercial phenomenon of industrial society which involves a person travelling overnight away from the normal home environment for the express benefit of maintaining or improving health, and the supply and promotion of facilities and destinations which seek to provide such benefits’ (Hall, 2003, p. 274). The term has lately widely been used internationally along with the notion of medical tourism. Such changes have been accompanied by an understanding of health that focuses not only on wellness and prevention but also on curing illnesses (Nahrstedt, 2004). Hall (2011) acknowledged the overlapping concepts of wellness tourism, health tourism, and medical tourism along with the continuum of preventive, promoting, and curative purposes in the motivation of travel. For the purpose of this study, medical tourism is defined as all the activities related to travel and hosting a tourist who stays at least one night at the destination region for the purpose of maintaining, improving, or restoring health through medical intervention.

Horowitz and Rosensweig (2007, 2008) suggested the existence of two medical tourism models: the traditional international medical care model and the medical tourism model. The first model is characterised by patients with sufficient financial resources from less-developed countries who travel to developed countries to seek treatment. On the other hand, the second model involves patients from developed countries visiting the less-developed nations for the same purpose. Often their financial constraints drive them to opt for alternative medical services (Gray & Poland, 2008; Herrick, 2007; Horowitz &
Nations that once primarily exported medical services to less developed countries are now purchasing healthcare from these same countries’ (Horowitz & Rosensweig, 2007, p. 26).

Health tourism is high-yield industry and often stimulates the development and the provision of the state-of-the-art facilities that eventually benefit the local healthcare. However, the development could also be at the expense of the public in tourist destination regions. There are reports of neglect of the locals in developing countries (Arellano, 2007; Burkett, 2007; Gray & Poland, 2008; Whittaker, 2008). With the influx of health tourists filling up the limited capacity of health services, local patients at times are left undertreated or not treated at all (Burkett, 2007). In India and Thailand, the residents’ access to healthcare is compromised as private hospitals are focusing more on attracting health tourists (Arellano, 2007).

Hall (2011) highlighted the concerns of bio-security in the form of higher rates of cross-infection and transplant failures among medical tourists. There are also a bioethical issue of reproductive tourism which enables tourists to have sex-change operations (Whittaker, 2008) and a social issue where tourists travel for assisted suicide (Hall, 2011). Besides, the activities of ‘kidney hunters’ and ‘body trade Mafia’ are rising parallel to the tremendous growth of organ transplants (Whittaker, 2008). The source of these organs is normally the poor population. Whittaker (2008) warned that moral issues which revolve around medical tourism cannot be ignored as they will result in the deterioration of the society in the long run. The next section examines medical tourism in Malaysia.

2.2 Medical tourism in Malaysia

The National Committee for the Promotion of Medical and Health Tourism was formed by the Ministry of Health in January 1998 to establish Malaysia as a regional hub for healthcare services (Chee, 2007). This has recently been re-named as Malaysia Healthcare Travel Council. It has a role, among others, in the packaging and standardisation of the prices for healthcare services and to market them internationally. Market analysis indicated that the majority of the medical tourists in Malaysia are from Indonesia (72.0%), Singapore (10.0%), Japan (5.0%), and West Asia (2.0%) (UNESCAP, 2007). More recent statistics produced by Frost and Sullivan (2010) also showed that the majority of the medical tourists are from the neighbouring countries of Indonesia (69%), Singapore (12%), and Japan (4%). The significant flow of Indonesian medical tourists is the result of large socio-economic differences, political instability, and poor access to healthcare (Ormond, 2011).

Malaysia is heavily relying on intraregional tourists who stay for a short period and are low in spending compared with tourists who visit other ASEAN neighbours. This behaviour is arguably also the feature of medical tourists in the country. The majority of the medical tourists travel to Penang (61%), while Malacca and Kuala Lumpur only receive 19% and 11% of health tourists, respectively (Ormond, 2011). Penang is known to attract primarily lower middle income patients from the nearby Indonesian island of Sumatra (Ormond, 2011). The state is currently under pressure to improve its health infrastructure, facilities, and services in order to attract the higher spending tourists from developed countries. The island promotes itself as a health resort destination through its seven private hospitals which have been accredited and endorsed by the Ministry of Health to host medical tourists.

The government has made various efforts to improve healthcare services in Malaysia for the benefit of the health tourism industry. It has extended the visa period for health patients and provided tax incentives to refurbish wards and rooms in private hospitals (Foong,
Most of the private medical centres have achieved certification for internationally recognised quality standards, for example, ISO 9002 or the Malaysian Society for Quality of Health (APHM, 2008). The health tourism web site (http://www.myhealthcare.gov.my/en/index.asp) produced by the Ministry of Health Malaysia (2010) provides comprehensive information about products, prices, and places of healthcare services. Among other positive initiatives taken by various hospitals are the establishment of international customer departments and links with several travel agencies and hotels. Mahkota hospital in Malacca even has its own in-house travel agency which arranges all travel documents, accommodation, and logistics of health tourists (Ormond, 2011). All these efforts together with the provision of excellent healthcare services and facilities are strong pull factors for international tourists to seek medical healthcare services in the country.

Based on the quality and affordability (value for money) of healthcare and receptiveness to foreign investment, Malaysia ranked third in the world behind Panama and Brazil and the first in Asia (Yanos, 2008). According to Nuwire – an online source for news related to real estate investment and other investment opportunities – Malaysia has an advantage in attracting medical tourists and investors due to its favourable exchange rate, political and economic stability, and high literacy rate (Yanos, 2008). Tourism Malaysia (2007) claimed that the country is gaining the reputation as one of the preferred locations for medical tourists because of its highly efficient medical staff as well as modern healthcare and wellness facilities. The waiting list is short (Ministry of Health Malaysia, 2010), and the country has a harmonious, plural, multi-cultural, and multi-racial society practising a variety of religions. Thus, Malaysia could offer multi-ethnic and multi-lingual hospital staff from various religious denominations (Tourism Malaysia, 2007). The Islamic credential and image are strong (Henderson, 2003), and this is an added advantage to attract health tourists from the Middle East (Chaynee, 2003). The following section discusses travel motivations among medical tourists.

2.3 Travel motivation of medical tourists

Travel motivations play a fundamental role in destination choice. Dann (1977) introduced the concept of push and pull factors for explaining travel motivation. Push factors are intrinsic desires of human beings, which include the desire to escape, novelty seeking, adventure seeking, dream fulfilment, rest and relaxation, health and fitness, prestige, and socialisation (Uysal & Jurowski, 1993). On the other hand, pull factors are those specific elements that drive people to realise their needs of particular travel experiences, such as natural and historical attractions, food, people, recreational facilities, and the image of the destination (Uysal & Hagan, 1993). Krippendorf (1987) argued that even though people are generally more motivated by push factors, it is generally accepted that the actual behaviour itself is determined more by other factors such as social pressures, financial considerations, and time availability.

In reference to medical tourism, among the main push factors are a long waiting list (Connell, 2006; Gray & Poland, 2008; Hall, 2011; Horowitz & Rosensweig, 2007; Muddle, 2007; Ormond, 2011), services that are not funded by national health programmes, for example, cosmetic surgery and gender-reassignment operations (Hall, 2011; Horowitz & Rosensweig, 2007; Ormond, 2011; UNESCAP, 2007), and privacy and confidentiality (Hall, 2011; Horowitz & Rosensweig, 2007; Ormond, 2011). There is a growing popularity in cosmetic surgery which could be carried out more cheaply in developing countries (UNESCAP, 2007). In Malaysia, cosmetic surgery is popular among long-haul health tourists such as
Americans, Europeans, and Australasians (Discovermedicaltourism.com, 2008; Oon, 2006). Health tourism is further facilitated by the availability of comprehensive information on the Internet (UNESCAP, 2007). Additionally, Kim, Putjuk, Basuki, and Kols (2003) and Connell (2006) claimed that the rising number of senior citizens who have time, money, and motivation to maintain good health is one of the main drivers of the health tourism market. However, the market requires the provision of destinations that offer active, healthy, and social amenities (Pollock & Williams, 2000).

The main pull factor that drives health tourists to seek treatment in less-developed countries is the low cost (Connell, 2006; Gray & Poland, 2008; Hall, 2011; Herrick, 2007; Horowitz & Rosensweig, 2007; Ormond, 2011; UNESCAP, 2007). Connell (2006) added that tourists are also taking advantage of affordable air travel and favourable exchange rates. Other important pull factors include the emergence of the state-of-the-art medical facilities in developing countries and the aftercare which is equal in terms of quality (UNESCAP, 2007). According to Yap (2007), people travel for four types of healthcare: essential, affordable, quality, and premium healthcare. Essential healthcare relates to the care which is not available in the home country. Affordable healthcare is the seeking of cheaper healthcare, while quality healthcare is the need for higher standard healthcare. Finally, premium healthcare is the luxury healthcare that adds prestige. Americans travel overseas for the affordable healthcare (Devon, 2007). The following section discusses the quality of health services.

2.4 Quality and insurance of health services

Health tourism has various concerns that are to be considered. Among them are the lack of governmental safeguards ensuring the quality of healthcare, the safety and effectiveness of certain procedures, and the quality of physicians and other healthcare professionals (Burkett, 2007). Herrick (2007) pointed out that upon returning from health treatment overseas, health tourists often have difficulty in obtaining a follow-up from local physicians for their post-treatments, as the physicians do not want to be held liable for any complication(s). There is also concern about legal issues with regard to the negligence of medical service providers in developing nations (Herrick, 2007; Whittaker, 2008).

Medical tourists are those who seek healthcare services at a reasonable price in other countries (Gray & Poland, 2008; Hall, 2011; Horowitz & Rosensweig, 2007; Ormond, 2011). These countries, according to Herrick (2007), are able to offer such a price because of cheap labour and lower malpractice litigation cost. Despite cheaper cost, the quality of medical services is often not compromised. Many of the hospitals are accredited by Joint Commission International and International Standards Organization. Some hospitals are affiliated with prestigious universities and healthcare providers such as Cleveland Clinic, Harvard Medical School, and John Hopkins International. Besides, the physicians and other healthcare professionals have internationally respected credentials (Herrick, 2007).

In America, Burkett (2007) proposed three solutions in order to make sure its citizens enjoy quality healthcare in other countries. These are regulations on insurance to cover health tourism, emphasis on international hospital accreditation, and restriction to the approved health tourism destinations. The government can protect the interest of health tourists by allowing Americans to access hospitals in other countries that have accreditation under the same standards as American hospitals. With this, the quality of healthcare is maintained and simultaneously the government can limit the number of health tourists seeking treatment in developing countries.
The insurance companies have now offered new healthcare plans with the changing trend of healthcare (Gray & Poland, 2008; Herrick, 2007). The healthcare financer may opt to offer premium coverage of treatments in other countries by foreign providers (Burkett, 2007; Herrick, 2007). This inevitably will affect the domestic healthcare, but the patients are more likely to enjoy the economic benefits of this trend (Burkett, 2007). The following section examines medical tourist behaviour.

2.5 Medical tourist behaviour

Medical tourists are beneficial not only for the health sector but also for other services such as hotels, restaurants, attractions, and transportation. Often, they possess a sizeable income and travel with some others (‘Health Tourism’, 2004). Tourism expenditure is defined as the total consumption expenditure made by a tourist or on behalf of a tourist for and during his/her trip and stay at a destination (Odunga, 2005; Tourism Malaysia, 2006). According to Tourism Malaysia (2008), components of tourists’ expenditure comprise accommodation, shopping, food and beverages, local transportation, entertainment, domestic airfares, organised tours, and miscellaneous.

The majority of the tourists’ spending in Malaysia is on accommodation, shopping, and food and beverages. In 2008 (the year this study was carried out), the average length of stay among tourists was 6.4 nights and the average per capita expenditure was MYR 2247.4 (Tourism Malaysia, 2008). As for health tourists, the APHM (2006) recorded the average spending of MYR 686, which was five times lower than the average medical expenditure (MYR 3521.25) discovered by Oon (2006) in Penang. The overall average expenditure of health tourists recorded by Oon (2006) was MYR 20,818, and this was 10 times higher than the average leisure tourist spending in Malaysia in the same year.

Horowitz, Rosensweig, and Jones (2008) noted the role of female patients in medical tourism. Similar to men, they seek treatment in less-developed countries due to cheaper cost. Among the treatments sought after by them are gynaecological surgery, assisted reproductive technology and obstetrical services. Sometimes, they also choose to deliver in off-shore facilities (Horowitz et al., 2008). The following section discusses the methodology employed in this study.

3. Methodology

The selection of the hospitals to be included in the study was done by purposeful sampling. The hospitals involved were KPJ Ampang Puteri Specialist Hospital, Sime Darby Medical Centre Subang Jaya, Sunway Medical Centre, Pantai Medical Centre (Bangsar), and Pantai Hospital Klang. These are among the main private hospitals which host health tourists in Kuala Lumpur (Ministry of Health Malaysia, 2010). Within each hospital, the questionnaire survey was administered. Considering the difficulty in obtaining information from health tourists and the protective policy among hospital administrators so that their patients would receive minimum disturbances, convenience sampling was employed in selecting respondents. The sampling was done among international health tourists who stayed for at least one night in the hospitals listed above.

As direct contact between the research team and the health tourists was less favoured by the private hospitals, enumerators among hospital nurses and customer service staff were employed for data collection. The nominated enumerators distributed and collected the questionnaires within their respective hospitals. Data collection started in March 2008 and ended in November 2008. Based on the estimated health tourist population of
350,000 in Malaysia for 2008, the target sample was set at 384 (Saunders, Lewis, & Thornhill, 2003). Over the period of eight months, a total of 400 questionnaires were distributed to health tourists. Respondents were given options either to return the questionnaires immediately to the enumerators or to post them in pre-paid envelopes provided to the researchers. Due to temporal and financial constraints, data collection could only be carried out for the period of eight months. During the period, only 138 questionnaires were completed and returned, giving the response rate of 34.5%. The numbers of questionnaires returned from private hospitals were 43 (Sunway Medical Centre), 21 (Pantai Hospital Klang), 25 (Pantai Medical Centre (Bangsar)), 22 (Sime Darby Medical Centre Subang Jaya), and 27 (KPJ Ampang Puteri Specialist Hospital).

The questionnaires were made available in two different languages: English and Bahasa Indonesia. The original questionnaire, which was prepared in English, was professionally back-to-back translated to Bahasa Indonesia (Shigenobu, 2007). The translation was done with care and attention being paid to lexical, idiomatic, and experiential meanings as well as grammar and syntax (Usunier, 1998). To limit the scope of this study, only pull-factor motivation was studied. The reason for the deliberate inclusion of only pull factors was to discover the city’s unique selling propositions that could be used in marketing management and future health product and service development.

Due to the difficult nature of access to inbound medical tourists as stated previously, no in-depth interviews or focus group discussions were carried out to assist in the selection of travel motivation items. Therefore, all the 30 motivation items included to measure the pull factors among the respondents were adapted and derived from various literature (Connell, 2006; Gray & Poland, 2008; Herrick, 2007; Horowitz & Rosensweig, 2007; Oon, 2006; Tourism Malaysia, 2008; Uysal & Hagan, 1993). The items were measured by the six-point Likert scale (Blaikie, 2003; Mitchell, 1994). To allow a more sensitive analysis, the scale was rescaled to the 11-point Likert scale (Dawes, 2002). Other questions included were the types of healthcare services obtained (Ministry of Health Malaysia, 2010) and the expenditure components (Odunga, 2005; Tourism Malaysia, 2006). The following section presents the results of the study.

4. Results

4.1 Demographic profile of inbound health tourists in Kuala Lumpur

The demographic profile of the respondents is presented in Table 1. Females made up most of the respondents (56.5%), while males constituted 42.8%. A high percentage (41.3%) of the respondents were aged between 21 and 40 years and 38.4% were within the age group 41–60 years. With regard to educational background, the majority of the respondents were with degree (29.0%), high school (26.1%), and college (20.3%) qualifications. Health tourists from South East Asia constituted 52.2% of the respondents. European tourists amounted to 18.1%, while 10.1% were from Australia and New Zealand. Among the respondents, by nationalities, the top five health tourists were from Indonesia (47.8%), Australia (5.1%), New Zealand (5.1%), the Philippines (4.3%), India (4.3%), and Sudan (2.9%).

4.2 Travel motivation (pull factors) among inbound health tourists in Kuala Lumpur

Table 2 presents the means of the individual motivation items. The top five motivation items among the respondents were related to the hospitals which have clean and hygienic physical environment, modern and up-to-date medical treatment, reputable and excellent track
Table 1. Demographic profile.

<table>
<thead>
<tr>
<th>Demographic profile</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nationality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASEAN (South East Asia)</td>
<td>72</td>
<td>52.2</td>
</tr>
<tr>
<td>Asia</td>
<td>13</td>
<td>9.4</td>
</tr>
<tr>
<td>Europe</td>
<td>25</td>
<td>18.1</td>
</tr>
<tr>
<td>Australia and New Zealand</td>
<td>14</td>
<td>10.1</td>
</tr>
<tr>
<td>Others</td>
<td>13</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–20 years</td>
<td>13</td>
<td>9.4</td>
</tr>
<tr>
<td>21–40 years</td>
<td>57</td>
<td>41.3</td>
</tr>
<tr>
<td>41–60 years</td>
<td>53</td>
<td>38.4</td>
</tr>
<tr>
<td>61–80 years</td>
<td>13</td>
<td>9.4</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>59</td>
<td>42.8</td>
</tr>
<tr>
<td>Female</td>
<td>78</td>
<td>56.5</td>
</tr>
<tr>
<td><strong>Sources of information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends/relatives visited Malaysia</td>
<td>59</td>
<td>42.8</td>
</tr>
<tr>
<td>Friends/relatives living in Malaysia travel</td>
<td>24</td>
<td>17.4</td>
</tr>
<tr>
<td>Internet</td>
<td>20</td>
<td>14.5</td>
</tr>
<tr>
<td>Travel agent</td>
<td>17</td>
<td>12.3</td>
</tr>
<tr>
<td>Newspaper</td>
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<td>2.9</td>
</tr>
<tr>
<td>Tourism Malaysia collaterals</td>
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<td>2.2</td>
</tr>
<tr>
<td>Travel guide books</td>
<td>2</td>
<td>1.4</td>
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<tr>
<td>Business</td>
<td>2</td>
<td>1.4</td>
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<tr>
<td>Airlines</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Travel magazine</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>Travel companions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/relatives</td>
<td>65</td>
<td>47.1</td>
</tr>
<tr>
<td>Spouse</td>
<td>21</td>
<td>15.2</td>
</tr>
<tr>
<td>Friends</td>
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<td>13.0</td>
</tr>
<tr>
<td>Alone</td>
<td>14</td>
<td>10.1</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Business associates</td>
<td>5</td>
<td>3.6</td>
</tr>
<tr>
<td>Children</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Special interest group</td>
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<td>0.7</td>
</tr>
<tr>
<td><strong>Education background</strong></td>
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<td></td>
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<tr>
<td>Primary school</td>
<td>8</td>
<td>5.8</td>
</tr>
<tr>
<td>High school</td>
<td>36</td>
<td>26.1</td>
</tr>
<tr>
<td>College</td>
<td>28</td>
<td>20.3</td>
</tr>
<tr>
<td>Graduate</td>
<td>40</td>
<td>29.0</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>16</td>
<td>11.6</td>
</tr>
<tr>
<td><strong>Type of treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical treatment</td>
<td>57</td>
<td>41.3</td>
</tr>
<tr>
<td>Cosmetic procedures</td>
<td>28</td>
<td>20.3</td>
</tr>
<tr>
<td>Medical check-up</td>
<td>20</td>
<td>14.5</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>10</td>
<td>7.2</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Days for treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–5 days</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>6–10 days</td>
<td>89</td>
<td>64.5</td>
</tr>
<tr>
<td>11–15 days</td>
<td>12</td>
<td>8.7</td>
</tr>
<tr>
<td>16–20 days</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>More than 21 days</td>
<td>5</td>
<td>3.6</td>
</tr>
</tbody>
</table>

(Continued)
record, and wide range of medical services. The least important motivation items were of non-medical nature such as amenities for religious practices, halal food, the presence of relatives and friends in Malaysia, interesting travel packages, and tourist attractions.

An exploratory factor analysis was performed in order to identify the underlying constructs of travel motivation (Table 3). Principal axis factoring was carried out, followed by varimax rotation with Kaiser normalization. The Kaiser–Meyer–Olkin measure of sampling adequacy value was 0.842, and five factors were derived with the variance...
explained at 68.52%. The factors were termed as ‘excellent medical services’, ‘value for money’, ‘religious factor’, ‘cultural similarity’, and ‘supporting services’. A cut-off value of 0.50 and higher was assigned such that only items with loadings of at least 0.50 were retained in order to obtain a power level at 80% at 0.05 significant levels (Hair, Anderson, Tatham, & Black, 1998). A total of eight items were deleted for the improvement of either Cronbach’s alpha values or the loadings which were below 0.5. Cronbach’s alpha values of the factors ranged from 0.800 to 0.908, which signify strong contributions of each item within the factors.

However, it was also noted that some of the items were loaded in the factors which did not reflect the names of the factors. For instance, items of ‘affordable health care’ and ‘similarity in language spoken’ were loaded in the ‘supporting services’ factor. Ideally, the first item was more appropriate to be loaded in the ‘value-for-money’ factor, while the second item was appropriate to be loaded in the ‘cultural similarity’ factor. Similarly, the item of the

Table 3. Factor analysis of travel motivations.

<table>
<thead>
<tr>
<th>Motivation items</th>
<th>Excellent medical services</th>
<th>Value for money</th>
<th>Religious factor</th>
<th>Cultural similarity</th>
<th>Supporting services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent track record of medical services</td>
<td>0.831</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal touch by doctors</td>
<td>0.795</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Convenient clinical/hospital hours</td>
<td>0.784</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dedicated customer service</td>
<td>0.748</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reputable medical services</td>
<td>0.739</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wide range of medical services</td>
<td>0.571</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent safety and security</td>
<td>0.537</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Popular destination for medical treatment</td>
<td>0.519</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit card payment facility</td>
<td>0.511</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State-of-the-art medical facilities</td>
<td>0.750</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value-for-money medical services</td>
<td>0.674</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modern and up-to-date medical treatment</td>
<td>0.571</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Halal’ food is easily available</td>
<td>0.864</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amenities offered for religious practices</td>
<td>0.790</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not far from my country</td>
<td></td>
<td>0.809</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Similarity in food</td>
<td></td>
<td></td>
<td>0.637</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent transportation services</td>
<td></td>
<td></td>
<td></td>
<td>0.557</td>
<td></td>
</tr>
<tr>
<td>Ease of immigration clearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.550</td>
</tr>
<tr>
<td>Cronbach’s alpha</td>
<td>0.908</td>
<td>0.795</td>
<td>0.810</td>
<td>0.725</td>
<td>0.715</td>
</tr>
</tbody>
</table>
‘availability of the language interpreter’ was loaded under the ‘cultural similarity’ factor, which should have been loaded under the ‘supporting services’ factor. Furthermore, the ‘clean and hygienic physical environment’ factor was loaded in the ‘value-for-money’ factor, which did not seem to be an accurate representation. Thus, these four items were omitted and the reliability tests were conducted on all the factors with the exception of the ‘excellent medical services’ factor. Cronbach’s alpha values of the factors ranged from 0.715 to 0.908. These values were accepted as suggested by Nunnally (1978).

By calculating the mean of each factor, its importance can be identified. ‘Value for money’ (mean = 9.55) was the main motivation factor that drove medical tourists to seek medical treatment in Malaysia. This was followed by ‘excellent medical services’ (mean = 9.50) and ‘supporting services’ (mean = 8.85). The factors ‘cultural similarity’ (mean = 7.82) and ‘religion’ (mean = 6.20) were rated as less important.

4.3 Healthcare consumption and spending behaviour among inbound health tourists in Kuala Lumpur

The main sources of information about healthcare services in Malaysia were friends and relatives (60.2%) who either have visited or are living in Malaysia. This was followed by the Internet (14.5%) and travel agents (12.3%). Respondents largely travelled to Malaysia in the company of their family and relatives (47.1%). A total of 15.2% and 13.0% of the respondents travelled with their spouses and friends, respectively. Those who travelled alone constituted only 10.1% of the respondents. The actual number of travel companions varied from none to 13 in a group with an average of two others.

The main healthcare services sought after were medical treatment (41.3%), cosmetic procedures (20.3%), and medical check-ups (14.5%). Respondents who came for surgical procedures were represented by 7.2%. Among the examples of the medical treatments were the treatments for hypertension, kidney illness, diabetes, rheumatology, and heart diseases.

The majority of the respondents received healthcare services in the hospital for a period of 6–10 days (64.5%). However, 3.6% of the respondents stayed for more than 21 days, and of these, three resided for longer than a year for chronic illnesses such as cancer. Other than receiving treatment in the private hospitals, respondents’ other activities included touring (21.0%), shopping (17.4%), and visiting friends and relatives (VFR) (8.0%).

Table 4 shows the estimated amount of money spent by health tourists during their stay in Malaysia. The total average spending among health tourists per capita was MYR

<table>
<thead>
<tr>
<th>Spending components</th>
<th>Minimum (MYR)</th>
<th>Maximum (MYR)</th>
<th>Sum (MYR)</th>
<th>Mean (MYR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare services</td>
<td>150</td>
<td>107,000</td>
<td>1,127,840</td>
<td>12,259.13</td>
</tr>
<tr>
<td>International airfares</td>
<td>35</td>
<td>36,800</td>
<td>355,618</td>
<td>3743.35</td>
</tr>
<tr>
<td>Accommodation</td>
<td>100</td>
<td>59,000</td>
<td>267,050</td>
<td>3256.71</td>
</tr>
<tr>
<td>Organized tours</td>
<td>200</td>
<td>15,000</td>
<td>63,200</td>
<td>2747.83</td>
</tr>
<tr>
<td>Shopping</td>
<td>60</td>
<td>35,000</td>
<td>215,420</td>
<td>2504.88</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>50</td>
<td>50,000</td>
<td>87,300</td>
<td>2494.29</td>
</tr>
<tr>
<td>Food and beverages</td>
<td>25</td>
<td>50,000</td>
<td>146,885</td>
<td>1650.39</td>
</tr>
<tr>
<td>Entertainment</td>
<td>50</td>
<td>10,000</td>
<td>47,870</td>
<td>1087.95</td>
</tr>
<tr>
<td>Domestic transportation</td>
<td>15</td>
<td>10,000</td>
<td>53,146</td>
<td>617.98</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>250</td>
<td>4,27,500</td>
<td>2,818,640</td>
<td>26,844.19</td>
</tr>
</tbody>
</table>

Among all the spending components, healthcare services recorded the highest at the average of MYR 12,259.13 per person. The second highest spending component was international airfares (mean = MYR 3743.35), followed by the spending on accommodation (mean = MYR 3256.71), organised tours (mean = MYR 2747.83) and shopping (mean = MYR 2504.88).

4.4 The influences of demographic profile on travel motivation and spending behaviour among inbound health tourists in Kuala Lumpur

A one-way ANOVA is used to examine the differences in the mean values of the dependent variables for several categories of single independent variables (more than two groups). The test was conducted to explore the relationship between nationality groups and travel motivation dimensions. The findings revealed that two motivation dimensions were significantly different with regard to nationality groups: religion \(F(4, 106) = 4.971, p = 0.001\) and cultural similarity \(F(4, 113) = 19.719, p = 0.001\). Post hoc comparisons using the Scheffe test indicated that health tourists from other regions (\(M = 9.18, SD = 1.94\)) placed more importance on the religious factor when compared with those who were from Europe (\(M = 4.62, SD = 3.71\)) and Australia (\(M = 3.81, SD = 3.46\)). In terms of cultural similarity, health tourists from Southeast Asia scored a higher mean (\(M = 9.23, SD = 2.26\)) and they were followed by those from other Asia (\(M = 8.09, SD = 2.68\)), other regions (\(M = 5.08, SD = 2.68\)), and Europe (\(M = 4.94, SD = 3.10\)).

An independent sample t-test was conducted to compare motivation dimension scores for males and females. Females (\(M = 9.90, SD = 1.32\)) were significantly more motivated by value for money \(t(80.354) = 2.681, p = 0.009\) compared with the males (\(M = 9.04, SD = 2.01\)).

Based on total expenditure, the biggest spenders were tourists from Australia and New Zealand, followed by those from Europe, other regions, Asia, and ASEAN \(F(4, 99) = 8.67, p = 0.000\). With regard to healthcare services, tourists from Europe were the biggest spenders, followed by those from Australia and New Zealand, other regions, Asia, and ASEAN \(F(4, 86) = 26.19, p = 0.000\). Europeans also spent more on airfares \(F(4, 89) = 11.47, p = 0.000\), while Australians and New Zealanders spent more on accommodation \(F(4, 76) = 6.49, p = 0.000\) and entertainment \(F(4, 39) = 3.44, p = 0.017\).

The total amount of spending of females was three times higher (mean = 35,279.78, SD = 58,865.8) than that of males (mean = 11,501.81, SD = 15,813.13) \(t(83.54) = -3.13, p = 0.002\). Females also spent significantly more than males on international airfares, accommodation, healthcare services, and domestic transportation.

5. Discussion and conclusion

In this survey, females constituted the majority of the respondents (56.5%). Females not only have slightly different health-related behaviour (Macias, Lewis, & Shankar, 2004), but are also more likely to comply with the request to answer a questionnaire (Ng, Frances, & Les, 2006; Upchurch & Teivane, 2000). The predominance of female respondents sampled in this study may also be explained by the fact that 20.3% of the respondents in this survey had cosmetic procedures, and of these, 89.3% were females.

The majority of the respondents (79.7%) were aged between 21 and 60 years, which is reflective of leisure tourist arrivals in Malaysia (Tourism Malaysia, 2008). Respondents aged 20 years and below and above 60 years were represented only by 9.4% each. Thus,
there is a potential for further development of healthcare services for these market segments.
As stated by Kim et al. (2003), senior tourists are higher spenders. To attract them to visit the
country, there is a need to develop Kuala Lumpur as an active, healthy, and social destination
(Pollock & Williams, 2000). The other lucrative market is that which focuses on younger
tourists as they are even more likely than other medical tourists to travel with companions
(parents). The market segment inevitably contributes to greater spending.

The majority of the tourists were Indonesians (47.8%). However, this percentage was
much lower than other records of 72.0% (UNESCAP, 2007), 69% (Frost and Sullivan,
2010), and 99.0% (Oon, 2006). The lower percentage of Indonesian tourists could be the
result of the sampling method — purposeful and convenience — and the sampling site of
Kuala Lumpur. There is a greater mix of medical tourists in the capital city in terms of
nationalities, as it is the main gateway to Malaysia. Furthermore, Indonesians prefer to
receive health services in Penang and Malacca (Ormond, 2011) as well as in Johor
Baru (Oon, 2006). The popularity of Malaysian destinations among Indonesian health
tourists could be the result of short distance, cultural similarities, and value for
money. Kuala Lumpur is easily accessible by flights from several major cities in
Indonesia such as Jakarta, Medan, and Bali. Indonesians may also have chosen Malaysia
for what Yap (2007) has stated as the combination of essential, affordable, and quality of
healthcare.

Among the five motivation factors extracted from the factor analysis, ‘value for money’
was the most important. The importance of ‘value for money’ in motivating health tourists
to seek treatment overseas supports similar claims made by other authors (e.g. Connell,
2006; Devon, 2007; Hall, 2011; Lew & McKercher, 2006; Ormond, 2011; UNESCAP,
2007; Yanos, 2008; Yap, 2007). The next important pull factors were ‘excellent medical
services’ and ‘supporting services’, which confirmed the claim made by Tourism Malaysia
(2007) and the Ministry of Health Malaysia (2010). Motivation factors of ‘cultural simi-
larity’ and ‘religion’ were of less importance, which is in congruence with the finding of
Oon (2006). However, for ASEAN tourists, ‘cultural similarity’ appeared to be an impor-
tant motivation element in choosing Kuala Lumpur as a tourist destination. Malaysia and
Indonesia share cultural similarities, especially in terms of language and food, and this
could be emphasised in the marketing messages for the Indonesian market.

In line with the claims made by Oon (2006) and Discovermedicaltourism.com (2008),
respondents of European descent are more likely to undergo cosmetic procedures in Malay-
sia. Further exploration of the latest cosmetic procedure products and services which are not
yet available in some countries (e.g. stem cell therapy) could create greater pull factors for
Malaysia. These medical procedures are normally not supported by health insurance (Hall,
2011; Horowitz & Rosensweig, 2007; Ormond, 2011; UNESCAP, 2007), and tourists often
choose the destination which offers value for money (Connell, 2006; Devon, 2007; Gray &
Poland, 2008; Herrick, 2007; Horowitz & Rosensweig, 2007; Ministry of Health Malaysia,
2010; UNESCAP, 2007).

With regard to the consumption pattern, the average total spending of health tourists was
MYR 26,844 compared with MYR 2247.4 spent by leisure tourists in 2008 (Tourism Malay-
sia, 2008). Thus, the total expenditure of health tourists was 12 times higher than that of
leisure tourists in 2008. In this study, the average spending on healthcare services among
health tourists was MYR 12,259. This was 18 and 3.5 times higher than what had been,
respectively, recorded by the APHM (MYR 86) and Oon (2006) (MYR 3521).

Health tourists often travel with companions (‘Health Tourism’, 2004). This claim was
confirmed in this study as each respondent was, on average, accompanied by two other
people. This figure might point towards the possibility that in 2008 medical tourism-
related tourists could have been as high as one million in Malaysia. The average length of stay among respondents was 15 days, while the average spending as stated earlier was MYR 26,844.19. If this figure was representative, health tourism might have contributed MYR 9 billion to the Malaysian economy in 2008. However, the combination of purposeful and convenience sampling employed in this study might have included the relatively higher spending tourists in Kuala Lumpur. Kuala Lumpur may also have attracted the middle-upper income health tourists as compared with the lower middle income health tourists in Penang (Ormond, 2011). All these impressive figures, however, clearly demonstrate that health tourism is indeed a high-yield industry.

Generally, tourists of European descent spend a considerably higher amount while in Malaysia compared with shorter distance travellers from other Asian countries. The striking discovery in this study sample was the fact that female respondents spent three times more than males on total expenditure. Females spent more on the expenditure components of healthcare services, international airfares, accommodation, and domestic transportation. Efforts must be intensified to attract tourists into this market further, especially female tourist of European descent. As stated, earlier 89.3% of the tourists had cosmetic medical procedures performed in Kuala Lumpur.

Even though Singapore and Thailand share land borders, Kuala Lumpur received a low percentage of tourists from Singapore and none from Thailand. These two countries possess their own comparable healthcare services and are the main competitors of Malaysia. Singaporean health tourists sampled in this study could be the example of the Malaysian immigrants in Singapore who preferred to have treatment in Malaysia for cultural reasons (Hall, 2011; Ormond, 2011). Malaysia should aim at reaching other potential markets among ASEAN countries which are still lacking in healthcare services such as Laos, Cambodia, and Myanmar. With the emergence of Islamic tourism and the excellent credential of Malaysia as an Islamic country (Chaynee, 2003; Henderson, 2003), medical tourists from the Middle East could also be targeted.

A total of 60.2% of the respondents gained information about healthcare in Malaysia from their friends and family members who either have visited or are living in the country. This is hardly surprising as medical services could be categorised as high-risk purchases with high credence values (Lovelock & Wirtz, 2011). Many will resort to their friends and relatives before making their final consumption decision. Word of mouth (especially from friends and family) is an effective risk-reducing strategy. Focus should then be on providing healthcare services which exceed the expectation of health tourists, as this will generate positive word of mouth. Comparatively, only 14.5% of the respondents relied on the Internet as the information source.

The main limitation of this study was the limited number of respondents. The results are perhaps best regarded as exploratory in nature. Despite its small sample, this study has succeeded in identifying the key elements of travel behaviour among health tourists in Kuala Lumpur, which is a great platform for future research. There were considerable hardship and obstacles in carrying out health tourism research in private hospitals in the city. Hospital managers were rather reluctant to allow their patients to be interviewed to minimise the disturbances to their recuperation. Patients themselves were also reluctant to answer the questionnaires as they had just completed the medical treatment. Even enumerators often felt dejected as their research effort was frowned upon by both hospital management and patients themselves. The future success of consumer studies on medical tourism requires greater commitment and cooperation, at least from the managers of private hospitals. Perhaps, attractive incentives could be offered to encourage patients to answer questionnaires.
As stated in Section 3, due to the difficulty in accessing health tourists, no in-depth interviews and focus group discussions were carried out in order to guide in the identification of travel motivation items. Future research with more financial and temporal capability as well as support from relevant stakeholders may need to improve on this aspect. Another limitation of this study was the deliberate examination of only pull factors in travel motivation. This was done as the research focus was mainly on the discovery of the city’s unique selling propositions that could be used in marketing management and future medical tourism product and service development. However, future research may also need to examine the push factors among health tourists. Since word of mouth was the most important marketing tool, a study on the degree of satisfaction provided by healthcare services in Kuala Lumpur is mandatory for gauging the current performance and improving the healthcare services further. Another aspect that could be considered is the future intention to choose Malaysia as a healthcare provider to tourists.

In conclusion, health tourism in Kuala Lumpur is indeed a high-yield industry. Developing it further merits closer attention and further and deeper research. The unique selling points or pull factors are strong, and Kuala Lumpur already has a desirable reputation as a health tourism destination which provides value for money and excellent health services. This is a solid foundation on which to build future research.

References


