Tourism Management 61 (2017) 538–552

Contents lists available at ScienceDirect

Tourism Management

journal homepage: www.elsevier.com/locate/tourman

Dental tourism: Examining tourist profiles, motivation and satisfaction

Mustaffa Jaapar [a, d], Ghazali Musa [b], Sedigheh Moghavvemi [c], Roslan Saub [d, *]

[a] Oral Health Division, Terengganu State Health Department, Tingkat 1, Wisma Persekutuan, Jalan Sultan Ismail, 20920 Kuala Terengganu, Terengganu, Malaysia
[b] Department of Business Strategy and Policy, Faculty of Business and Accountancy, University of Malaya, 50603 Kuala Lumpur, Malaysia
[c] Department of Operation and Management Information System Faculty of Business and Accountancy, University of Malaya, 50603 Kuala Lumpur, Malaysia
[d] Department of Community Oral Health and Clinical Prevention, Faculty of Dentistry, University of Malaya, 50603 Kuala Lumpur, Malaysia

HIGHLIGHTS

- We purposely sampled 196 inbound dental tourists in Malaysia.
- Important motivations are dental care quality, information access, and cost-savings.
- Information access and dental care quality positively influenced satisfaction.
- Cost-savings and cultural similarity negatively influenced satisfaction.
- We propose some marketing and managerial recommendations.

ARTICLE INFO

Article history:
Received 13 June 2016
Received in revised form
22 February 2017
Accepted 27 February 2017

Keywords:
Medical tourism
Dental tourism
Motivation
Satisfaction
Malaysia

ABSTRACT

Despite the overwhelming interest in medical tourism research, knowledge in dental tourism, which is its subspecialty, remains limited. This study is the first to measure tourist profiles, travel motivation and satisfaction among inbound dental tourists in Malaysia. We purposely sampled twelve selected private dental clinics in Kuala Lumpur, Selangor, Melaka and Penang; and distributed the questionnaires to their inbound dental tourists. A total of 196 inbound tourists responded to the questionnaire, mainly from Southeast Asia, Australia, New Zealand and Europe. In order of importance, the main motivation factors were dental care quality, dental care information access, and cost-savings. Tourists were extremely satisfied with dental care services received in the country. While dental care quality, dental care information access and supporting services positively influenced tourist satisfaction; cost-savings and cultural similarities had negative influences. Based on the research findings, we propose some managerial and marketing recommendations.

1. Introduction

Traditionally, wealthy people from less developed countries travel for medical care to developed nations (Alleman et al., 2010; Chanda, 2002; Wachter, 2006). The trend however has lately reversed with more people from developed nations travelling to developing countries for high quality medical care at a lower cost (Alleman et al., 2010; Chanda, 2002; Gill & Singh, 2011; Hall, 2011; Ormond, 2011; Vijaya, 2010; Wong & Musa, 2013). Tourists seek various medical services that could be classified as preventive medical services (e.g. medical checkups and health screening), surgery (e.g. hip replacement, knee replacement, gastric bypass, heart bypass, and eye surgery), dental care (e.g. crown, tooth whitening and dental implants), cosmetic surgery (e.g. rhinoplasty, tummy tuck, liposuction), organ, cell and tissue transplants (e.g. stem cell, organ transplantation) and cardiology (e.g. bypass, valve replacement surgery) (Gill & Singh, 2011; Heung, Kucukusta, & Song, 2011; Lunt et al., 2011).

Medical tourism involves "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

* Corresponding author.
E-mail address: roslans@um.edu.my (R. Saub).

http://dx.doi.org/10.1016/j.tourman.2017.02.023
0261-5177/

medical intervention" (Musa, Thirumoorthi, & Doshi, 2011, p. 3). Cuba, Colombia, Costa Rica, Mexico, Hungary, Israel, Jordan, Lithuania, Malaysia, Brunei, Philippines, Singapore, Thailand, Hong Kong, India, and United Arab Emirates are countries that have been actively promoting medical tourism (Alleman et al., 2010; Singh, 2008). In Asia, the four main competing medical tourism destinations are Thailand, Singapore, Malaysia and India (Alleman et al., 2010; Connell, 2006; Crooks, Kingsbury, Snyder, & Johnston, 2010; Ernst, 2006; Healy, 2009; Heung et al., 2011; Lunt & Carrera, 2010; Ormond, 2011; Wong & Musa, 2013).

The Malaysia Healthcare Travel Council (MHTC, 2017) was formed and approved by the Malaysian Cabinet in 2009 to improve the performance of the medical tourism industry by promoting and positioning Malaysia as a unique destination for world-class healthcare services, facilitating the development of healthcare travel services by the industry players, both private and government sectors. According to Frost and Sullivan (2010), medical tourism in Malaysia has been recognized as an attractive destination for medical tourists and better than average compared to other countries in the ASEAN region due to the availability of well-trained medical personnel and high quality facilities, which include different ranges of treatments and cost spectrums (Borneo Post Online, 27 January 2015). Malaysia has received an influx of foreign patients especially from Indonesia, Singapore and Japan (Frost & Sullivan, 2010). The number of healthcare travelers has increased from 643,000 in 2011 to 882,000 in 2014, with estimated earnings of more than MYR730 million in 2014 (MHTC, 2017; The Star Online, 2015, March 29).

Medical tourism in Malaysia mainly involves private medical establishments. All private medical facilities and services are regulated for safety and quality standards under the Private Healthcare Facilities and Services Act 1998 and Regulations 2006 (MHTC, 2014a). Under the act, Malaysia has 37 private hospitals accredited by the Malaysian Society for Quality in Health (MSQH) and 10 private hospitals accredited by the Joint Commission International (JCI) (MHTC, 2014b). At present, there are no healthcare accreditation standards existing for dental care services (MHTC, 2014b). However, the dental care service sector is one of the products and services which is gaining momentum and attracting many inbound medical tourists.

Malaysia is not only a fast growing medical tourism hub, offering well trained doctors at affordable prices, but also has diverse cultural experiences and languages, a wide range of leisure activities and a myriad of food choices (MHTC, 2014c; Salleh, Omar, Yaakop, & Mahmmod, 2013). The following paragraph explains dental tourism in more detail.

1.1. Dental tourism

Dental tourism is defined by the American Dental Association (2009) as the act of travelling to another county for the purpose of obtaining dental treatment. Dental care is a subset of medical care where tourism has increasingly become prominent (Turner, 2008; Elliot-Smith, 2010). It has been one of the popular services sought by tourists, well known in professional circles and well covered in the media (Österle, Balazs, & Delgado, 2009). Countries reportedly known for offering dental tourism services are Hungary, Mexico, Poland, Romania, Bulgaria, Croatia, Argentina, Costa Rica, Peru, Thailand, Malaysia, Singapore, India, Philippines, Korea (Deasy, Kim, & Hong, 2013; Kamath et al., 2015; Kovacs & Szocska, 2013; Lunt et al., 2011; Turner, 2009; Österle et al., 2009).

Chandu (2015: page 405) classified dental care tourists into two. Firstly, the classic dental tourists are among those who travel to a foreign country to access dental treatment, either for the sole purpose of dental treatment, or dental treatment as part of holiday package. Secondly, migrant tourists are among those who return to their native country for a holiday or to visit relatives and who then access dental treatment during their visit. Also there are two types of dental care; general and specialized dental care. General dental care includes scaling and polishing, simple fillings and tooth whitening. While specialized dental care is carried out by dental specialists such as complex restorative treatment and surgery e.g. implant surgery (Chandu, 2015). Dental care differs from other healthcare services by its nature and organization (Sintonen & Linoosmaa, 2000). According to Österle et al. (2009), the demand for dental care is considered to be non-emergency dominated, whereby non-immediately treated dental illnesses are often less likely to lead to catastrophic/dramatic health consequences compared to demands for other health care. Similar dental care is required by most people throughout their lives (Österle et al., 2009) such as professional cleaning i.e. scaling and polishing, and preventive services on regular visits.

In Malaysia, inbound dental tourism is largely provided by private dental establishments. The sector is relatively new in the country, and therefore, its baseline information, which could guide its current and future development, is required to enhance the industry further (Oral Health Division, 2012). In line with the classical dental tourists classified by Chandu (2015) and adapting medical tourism definition by Musa et al. (2011: page 3), we define dental tourism as activities related to travel and hosting a tourist who stays at least one night at the destination region, for purposes which include maintaining, improving or restoring health through dental care intervention. This study aims to examine inbound dental tourists in Malaysia, in terms of their profiles, motivation and satisfaction. This is achieved through the following four objectives: firstly, to examine the profile of inbound dental tourists in Malaysia; secondly, to identify dental tourists' travel motivation factors; thirdly, to measure dental tourists" satisfaction; and fourthly, to identify the influence of travel motivations on satisfaction among dental tourists. We also compare inbound dental tourists' motivations and satisfactions with their selected demographic profiles.

2. Literature review

2.1. Theory of travel motivation

Motivation is 'a psychological condition in which an individual is oriented towards and tries to achieve a kind of fulfillment' (Jang & Wu, 2006, p. 307). Maslow (1970) hierarchy of needs is the most popular theory in both academic and public domains (Hsu & Huang, 2008) which highlights five tiers of human needs beginning from the basic psychological needs, ascending stepwise to safety, belonging and love, esteem, and self-actualization (Maslow, 1970). Dye, Mills, and Weatherbee (2005) critiqued it for the lack in empirical evidence. Tourists' behavior is driven by needs (Mansfeld & Pizam, 1999) from the internal state of an individual (Schiffman & Kanuk, 1978) and highly affected by motivation (Wong & Musa, 2014). Some researchers applied the Maslow's model in tourism studies from the perspectives of individual aesthetic needs and the need to know and understand (Hsu & Huang, 2008). However, Witt and Wright (1992) argued, the theory lacks explanation on the tourist behavior of dominance, abasement, play and aggression.

A modified version of Maslow's model is the Travel Career Ladder (TCL) theory, in which the hierarchy of needs/motivation begins with relaxation, followed by safety/security, relationship, self-esteem and development, and fulfillment needs at the top level (Ryan, 1998). People's motivation to travel accumulates and changes throughout his/her life based on their travel experience