Group 25

PREDICTING FOREIGN TOURISTS' INTENTION ON HEALTH TOURISM IN MALAYSIA: AN EMPIRICAL STUDY

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DECLARATION

We hereby declare that:

(1) This undergraduate research project is the end result of our own work and that due acknowledgement has been given in the references to ALL sources of information be they printed, electronic, or personal.

(2) No portion of this research project has been submitted in support of any application for any other degree or qualification of this or any other university, or other institutes of learning.

(3) Equal contribution has been made by each group member in completing the research project.

(4) The word count of this research report is 23,642.

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AIDS	Acquired Immune Deficiency Syndromes
ASEAN	Association of Southeast Asian Nations
BCE	Breast Cancer Examination
ETP	Economic Transformation Program
GCC	Gulf Cooperation Countries
GDP	Gross Domestic Product
GNI	Gross National Income
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
INT	Intention
JCI	Joint Commission International
KL	Kuala Lumpur
KLCC	Kuala Lumpur City Center
KLIA	Kuala Lumpur International Airport
MATRADE	Malaysian External Trade Development Corporation
MHTC	Malaysia Healthcare Travel Council
MOH	Ministry of Health
MRA	Multiple Regression Analysis

NCPMHT	National Committee for the Promotion of Medical and Health Tourism
NKEAs	National Key Economic Areas
OIC	Organization of Islamic Conference
PEN	Penang International Airport
PMT	Protection Motivation Theory
PS	Perceived Severity
PTPTN	Perbadanan Tabung Pendidikan Tinggi Nasional
PV	Perceived Vulnerability
RE	Response Efficacy
SARS	Severe Acute Respiratory Syndrome
SAS	Statistical Analysis System
SCT	Social Cognitive Theory
SE	Self Efficacy
SMEs	Small and Medium Enterprises
SWOT	Strengths, Weaknesses, Opportunities, Threats
TDAP	Tetanus, Diphtheria and Acellular Pertussis
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UAE	United Arab Emirate

UNESCAP	United Nations Economic and Social Commission For Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNWTO	World Tourism Organization
US	United State
UTAR	Universiti Tunku Abdul Rahman

PREFACE

It is compulsory to carry out a research project in order to achieve our study – Bachelor Degree of Business Administration (Hons). The topic of the research project is "Predicting Foreign Tourists' Intention on Health Tourism in Malaysia: An Empirical Study". This study is conducted because health tourism is identified as one of the attractive industries that many countries are eyeing on its potential to generate lucrative profit and to drive up the growth of their economy.

Nowadays, most of the countries are now competing with each other by promoting various healthcare services and investing in large amount of infrastructure to position themselves as leaders in this niche market. Besides that, Malaysia is lagging behind other neighbouring countries in this industry. This research will provide a more comprehensive and general information that are essential for policy makers and travel agents to come out with various strategies to attract foreign tourist to undertake health tourism in Malaysia.

In this research study, we outline the four important variables that affect the foreign tourists' intention for undertaking health tourism in Malaysia. The variables are perceived severity, perceived vulnerability, self-efficacy, and response efficacy. These four variables play an important role in determining the intention of foreign tourist to undertake health tourism in Malaysia.

ABSTRACT

Decisions on having health tourism in Malaysia tend to be crucial in providing information for market practitioners. The purpose of this study is to find out the tourists' intention on health tourism in Malaysia, whether their intention is affected by perceived severity, perceived vulnerability, self-efficacy and response efficacy. Pearson Correlation Coefficient has been adopted to examine the relationship between theses four independent variables and intention. Multiple regression analysis was used to identify the most influential factors affecting tourists' intention. Questionnaires have been distributed to 500 foreign tourists in Malaysia with only 265 responses was deem acceptable. From the result, all of the variables are significantly and positively correlated with intention. It is found that response efficacy is the most influential variable to intention.

Perceived severity and perceived vulnerability were found not strong significant indicators of intention. This may due to most of the respondents are between 18 to 30 of age where they were not too worry and conscious about their health matters. Future researchers are recommended to integrate more health behaviour theories to enhance the prediction of intention. This study also suggested Malaysia Healthcare Travel Council (MHTC) and relevant healthcare providers could utilize the result to form new marketing strategies.

Keywords: Perceived Severity, Perceived Vulnerability, Self-efficacy, Response Efficacy, Intention, Health Tourism

CHAPTER 1: INTRODUCTION

1.0 Introduction

This chapter starts with an overview about health tourism industry and its trend in global environment. Health tourism is the industry that would benefit the local economy by increasing national income and enhancing the nation's development particularly in building up more infrastructures to support this trend. By conducting a study, we could predict on foreign tourists' intention on health tourism in Malaysia. With the result generated, we could form strategies to retain existing tourists and to attract more new foreign tourists from around globe for health tourism.

In this chapter, we will discuss systematically from background study, problem statement, research objectives, research questions, hypotheses, significance of the study and a brief summary of the chapter.

1.1 Research Background

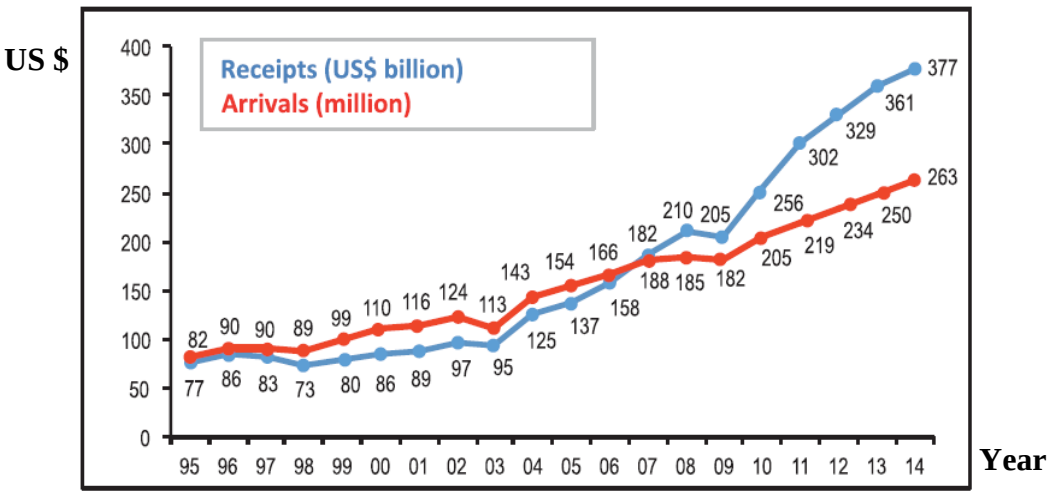
1.1.1 World Health Tourism Trend

Health tourism serves as an alternative for people to escape from pressure and head towards relaxation (Vajirakachorn, 2004). As a niche sector within the tourism industry, health tourism is generally defined as people travelling abroad to get healthcare services in desirable country, including tourists and patients (UNESCAP, 2007). Since ancient Greece time, there has been a trend to combine both healthcare services and travelling activities across the national borders (Bookman & Bookman, 2007). During the 20th Century, people travelled from less developed countries to developed nations to enjoy professional healthcare services and advanced

facilities. However, the current ways of healthcare service acquisition have been different from the past. Nowadays, people travelling from developed to less developed countries as they involve more regional movements due to the existence of a global market (Lunt, Smith, Exworthy, Green, Horsfall & Mannion, 2011).

Trumping by great demand of health tourism, it is identified as one of the attractive industries that many countries are eyeing on its potential to generate lucrative profit and to drive up the growth of their economy (Chaynee, 2003). Many countries are promoting through multiple marketing channels to attract tourists around the world (Tang, 2015). Health tourism is seen as the new business opportunity to stimulate the local economy and to generate source of income through foreign currency inflow (Heung, Kucukusta & Song, 2010).

Figure 1.1: Asia and the Pacific: Inbound Tourism



Source: World Tourism Organization (UNWTO)

In Figure 1.1, it shows that foreign tourist arrivals have achieved 263 million in 2014 and generated total revenue of US$377 billion. Based on the result, tourism in Asia region will continue to become one of the fastest growing tourism regions in the world (UNWTO, 2015).

Health tourism is getting more popular basically due to low-cost jet travel ('Medical tourism: Need surgery, will travel', 2004) that makes travelling around the world easier to acquire healthcare services. In Asia region, countries that are actively participating in health tourism include India, Malaysia, Singapore, and Thailand (Lunt et al, 2011).

People who acquire healthcare services in developing countries are able to save up to 40 to 60 percent comparing to developed countries such as United States (Herrick, 2007). Due to the cost effectiveness and unique geographical environment of Asia region, it can be considered as an attractive destination for health tourism. According to Medical Tourism Association (n.d.), the number of medical tourists travelling to Asia is expected to exceed 10 million by 2015 with more than 80% of market share, which is expected to be controlled by Singapore, Thailand, and India.

1.1.3 Current Health Tourism Trend in Malaysia

Back to 1990s, Malaysia encountered an economic downturn due to Asian financial crisis in 1997. In response to this financial crisis, Malaysia government had pinpointed health tourism as one of the important industries in 8th Malaysia Plan in order to revitalize the local economy growth by emphasizing more on foreign currency exchange. The actions taken include the formation of National Committee of Health Tourism in 1997 to promote health tourism in Malaysia by giving incentives to encourage private sector to be involved in the development process (Eighth Malaysia Plan, 2001-2005).

Later in the year, 9th Malaysia Plan, covering year 2006 to 2010, was introduced to continue its effort on health tourism with next phrase development. In the plan, Malaysia My Second Home Program was launched to attract and encourage foreign tourists to choose Malaysia as

their second home among other countries (Ninth Malaysia Plan, 2006-2010). The program successfully attracted foreign tourists majoring from China and Bangladesh due to Malaysia's unique multi-ethnic society and diversity of culture (Dahlui & Aziz, 2012).

In Economic Transformation Program 2010 (ETP), which was in part of the 10th Malaysia Plan, tourism industry was chosen as one of the country's 12 National Key Economic Areas (NKEAs). NKEA is defined as the important driver of economic activities that contributes to the growth which is measured by Gross National Income (GNI) ('Economic transformation programme: A roadmap for Malaysia', 2010). According to 10th Malaysia Plan (2011-2015), government has taken initiatives to readjust its strategies in improving and promoting Tourism Malaysia offices in foreign countries, particularly in key markets such as China, India, Middle East and Russia.

Furthermore, Malaysia Healthcare Travel Council (MHTC) was formed in 2009 with the aim to restructure healthcare sector and to attract more foreign tourists (Jin, 2010). MHTC is the special council registered under Ministry of Health (MOH) which has a combination of dedicated health tourism website and the availability of call centre service in order to serve foreign tourists better. Health tourism representative offices at international airports and in foreign countries have been launched to act as an intermediary to provide relevant information and value-added services such as hospital appointment arrangement, healthcare service enquiries and tourism-related information.

Promotional strategies implemented to successfully attract foreign tourists from developed countries include acquiring international accreditation schemes such as Joint Commission International (JCI) and providing ease of entry for foreign tourists by extending their visa from one month to six months (Bernama, 2008).

Table 1.1: Tourist Arrivals and Receipts in Malaysia

Year	Arrivals (Millions)	Receipts (RM Billion)	Threats
1998	5.56	8.6	
1999	7.93	12.3	
2000	10.22	17.3	
2001	12.78	24.2	
2002	13.29	25.8	911 Bombing
2003	10.58	21.3	Bali Bombing
2004	15.70	29.7	SARS & Iraq War
2005	16.43	32.0	Tsunami
2006	17.55	36.3	
2007	20.97	46.1	
2008	22.05	49.6	
2009	23.65	53.4	H1N1 & World Economic Crisis
2010	24.58	56.5	
2011	24.71	58.3	
2012	25.03	60.6	
2013	25.72	65.44	
2014	27.44	72.0	

Source: Tourism Malaysia Website

Malaysia has a long history as a tourist destination. Tourists visit Malaysia to experience different culture, food, lifestyle, and beautiful nature. Based on Table 1.1, Malaysia tourism industry is experiencing an impressive increasing trend since 1998 with the exception in 2003 that a bombing incident happened in Bali, Indonesia that had caused a reduction of tourist arrivals in Malaysia. Although the industry has been hit by continuous incidents such as the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2004, the increased in oil prices and the global economic slowdown in 2008, Malaysia is able to recover and maintain the flow of tourist arrivals. The inconsistent increase in tourists' arrivals from 2004 to

2010 supports the claim that the tourism industry is very competitive (Tourism Malaysia, 2011). Overall, tourism industry in Malaysia is doing well with more than 27 million of tourist arrivals that contributed travel receipts of RM72 billion in 2014. Tourism industry is the 6th largest contributor to the country's economy, contributing a total of RM161 million (14.9%) of Gross Domestic Product (GDP) in 2014 (Mohsen, 2015). According to the Budget 2016 announced by the Prime Minister, RM1.2 billion has been allocated to the Tourism and Culture Ministry, and the E-Visa will be implemented with China, India, Myanmar, Nepal, Sri Lanka, United States and Canada to boost tourist arrival. Government is targeting 30.5 million tourists for 2016 to generate a whopping RM103 billion for the national economy ('Budget 2016 will spur tourism development', 2015)

Table 1.2: Health Tourism Receipts / Revenue in Malaysia, Year 2000-2011

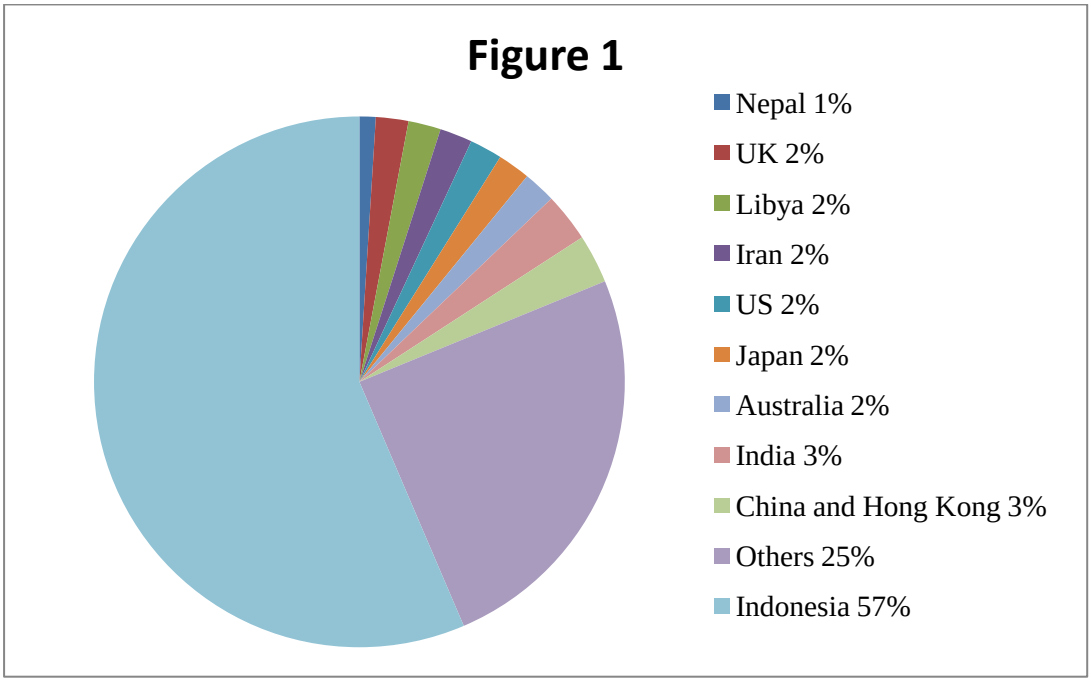
YEAR	VALUE (RM MILLION)	GROWTH (%)
2000	33	48.4
2001	44	35.7
2002	36	-18.7
2003	59	63.6
2004	105	78.2
2005	151	43.8
2006	204	35.0
2007	254	24.6
2008	299	17.8
2009	288	-3.7
2010	378	31.5
2011	511	34.9

Source: Malaysia Healthcare Travel Council

According to Bank Negara Malaysia (2002), Tourism Malaysia had shifted its focus towards countries in Asia region such as China, India and West Asia after the 911 incident happened in United State in 2001. From the table, we can see that there is a negative growth rate in 2002 due to a reduction of foreign tourist receipts from the Western countries.

In addition, Malaysia was affected by global financial crisis in mid-2008. There has been a slightly decrease of tourism receipts in 2009. However, Malaysia's impressive recovery has revived the industry to total revenue of RM511 million in 2011, indicating a growth rate of 34.9% (Penang Institute, 2013).

Figure 1.2: Health Tourist Arrivals to Malaysia, 2011



Source: Malaysia Healthcare Tourism Council

As shown in Figure 1.2, the majority of Malaysia's medical tourists come from Indonesia which accounts for 57% of health tourist arrival among the others. As a member of Organisation of Islamic Conference (OIC),

Malaysia has gained interest from Gulf Cooperation Countries (GCC) as healthcare travel destination, given its understanding of Muslim culture (Malaysia Health Travel Council, 2014). The poor quality and unavailability of medical facilities had spur the interest of Indonesians to receive healthcare services in Malaysia for which short travel time, cost effectiveness, cultural similarity, religion, language and food play important role in their healthcare destination choice (International Trade Centre, 2014). According to MHTC, international travellers choose Malaysia for medical treatment because of six critical factors: highly qualified professionals, state-of-the-art facilities, affordable rates, the Malaysian hospitality, confidentiality assured, and Malaysia fascination.

1.2 Problem Statement

With the background discussed in the previous section, the growth of health tourism in these years had increased the interest of many governments to join in the bandwagon, especially in Asia. With the availability of medical and technical expertise, high quality infrastructure, political and economical stability and scenic beauty of the land, Malaysia is making a breakthrough in health tourism industry within the ASEAN region (Aniza, Aidalina, Nirmalini, Inggit & Ajeng, 2009). In spite of that, Malaysia is lagging behind other neighbouring countries. For example, India is having an impressive growth rate of 27 per cent in revenue annually with their low cost treatment strategies (Vishnuprasad, 2014).

Recently, several adverse factors have negatively affected Malaysian tourism industry – including unfavourable media coverage of aviation tragedies in 2014, natural disasters, dengue, and security issues in Sabah ('Malaysia's tourism industry taxis towards recovery', 2015). In response to these incidents, the Malaysian government has sought to reduce its dependence on leisure tourism and broaden its tourist market to include other sector such as health tourism. Therefore, there is an urgent and serious need to carry out research to analyse the current position and future potential of Malaysian health tourism industry in order to

realise its vision of promoting Malaysia to become a unique destination for international healthcare services.

In view of the rapid growth of inbound tourists discussed in Section 1.1, it is vital to obtain a better understanding of how these existing tourists evaluate and perceive health threat as well as how they deal with such threat when there is an opportunity of having health tourism in Malaysia. With the enormous potential for further expansion given by health tourism, a growing number of countries are now competing by promote various healthcare services and invest large amount of infrastructures to capture foreign tourists (Horowitz & Rosensweig, 2007). For instance, countries such as Singapore and Thailand have positioned themselves as leaders in this niche market, providing quality healthcare and high value health experiences (Nadaraj, 2014). It is worthwhile to undertake a study to identify strategies for policy makers to attract the existing tourists to involve not only for leisure purpose, but at the same time, receiving healthcare services while they are travelling to Malaysia.

Previous studies on health tourism have concluded the components of consumer decisions to undertake healthcare services abroad and identified a number of driving forces of health tourism, such as cost, healthcare quality, waiting list, treatment availability, access to information, privacy, and confidentiality (Altin et al., 2011; Crooks et al., 2011; Ricafort, 2011; Jadhav et al., 2014). Academic researchers have also investigated on the medical providers' perspective by indicating and analysing the strengths, weaknesses, opportunities and threats (SWOT) of specific locations as health tourist destinations (Cohen, 2008; Aniza et al., 2009; Dawn and Pal, 2011; Wong et al., 2014). Given the importance and potential of health tourism, however, prospective health tourists' behavioural intention and their whole decision-making process to perform or not to perform health-related behaviour (in this study, health tourism) have rarely been investigated.

To date, there has been little published research on the specific question of consumer behaviour, such as what motivate them to make decisions about having healthcare services abroad in the context of health tourism. As a result, decisions

on health tourism in host countries tend to be made on the basis of intuition as information for managerial decision-making is not enough. Because health tourism involves personal health and well-being, prospective health tourists are expected to exert significant effort and tend to perceive that the level of risk involved in making such decision is high as compared to leisure tourism (Zaichkowsky, 1985, Bieger and Laesser, 2004, Hanlan et al., 2006). The cognitive process in making a risky decision is therefore important in the prediction and understanding of the prevailing factors in decision making to undertake health tourism.

This study, by covering the whole decision-making process, should therefore prove to be very useful for organisations and healthcare providers in implementing their management and marketing functions in Malaysia. Besides that, the understanding of tourists' intention and decision-making process is also important for its influences on economic reasons that rely heavily on understanding tourists' decision-making in order to promote tourism (Crompton, 1979).

In summary, the study provides more comprehensive and general information that are affecting the intention to make health tourism decisions. It is essential for the policy makers and travel agents in Malaysia, which being a late comer to the health tourism industry (Yau, 2013), to come out with various strategies so as to attract the existing tourists by understanding the evaluations they place on making health decisions. It is anticipated that the findings of this study will assist both the management of Malaysia healthcare providers and government entities (such as the Malaysia Healthcare Travel Council and the Ministry of Health) in promoting health tourism to foreign tourists.

1.3 Research Objectives

In corresponding with the issues discussed above, the objectives of this research can be stated as below:

1. To obtain a better understanding about foreign tourists' perceptions of health tourism in Malaysia.

2. To assess the behavioural intention of foreign tourists in performing health-related behaviours.

3. To investigate how perceived severity, perceived vulnerability, self-efficacy and response efficacy are used to predict the likelihood of having healthcare services in Malaysia.

1.4 Research Questions

The following research questions are to be answer in our study:

1. How do foreign tourists perceive health tourism in Malaysia?

2. What is the behavioural intention of foreign tourists in performing health-related behaviours?

3. How perceived severity, perceived vulnerability, self-efficacy and response efficacy are used to predict the likelihood of having healthcare services in Malaysia?

1.5 Hypotheses of the Study

The research hypotheses for this study are:

H_1: There is a significant relationship between perceived severity and foreign tourists' intention.

H_2: There is a significant relationship between perceived vulnerability and foreign tourists' intention.

H_3: There is a significant relationship between self-efficacy and foreign tourists' intention.

H_4: There is a significant relationship between response efficacy and foreign tourists' intention.

$H_{5:}$ The four variables (perceived severity, perceived vulnerability, self-efficacy and response efficacy) are significant in explaining the intention of foreign tourists to undertake healthcare services in Malaysia.

1.6 Significance of Study

In this research, we aim to achieve both economic and social outcomes. At first, the research can contribute to Malaysia's economy growth by strengthening Malaysia position in health tourism industry. Much of the initiatives have been done in the past and we have had achieved substantial performance in terms of service quality and competitive ability, the main outcome that we would like to achieve is the ability to increase foreign tourists to existing market and to attract more potential tourists from around the world particularly those from Europe and Western countries.

We believe that only through attracting foreign tourists from developed countries we can boost our economy growth by having series of foreign currency exchange in healthcare service expenditures. This is one of the significant ingredients that are crucial for economic development. Generally, health tourism is the

combination of healthcare cum travelling purposes and it would bring monetary benefits to tourism sector such as accommodation and entertainment. This sequential effect would give raise to multiple small and medium enterprises (SMEs) and encourage more entrepreneurial activities.

In addition, we can improve healthcare and tourism infrastructure by promoting health tourism globally. This is true because only with top-tier healthcare facilities we can attract foreign tourists and to show confidence in providing quality healthcare services. If healthcare infrastructures are improved, Malaysian would enjoy the benefits together and this marks a higher stage of social development.

Last but not least, health tourism is the lucrative industry which contributes to part of national income. Being part of the National Key Economy Areas (NKEA), health tourism industry is forecasted to generate MYR 9.6 billion in revenue and MYR 4.3 billion in gross national income by year 2020 ('Creating wealth through excellence in healthcare', 2010). This emerging industry would require more healthcare professionals and business partners which typically mean that it would create job opportunities and stimulate economic growth.

1.7 Chapter Layout

In this research paper, it consists of five chapters. The initial chapter provided an introduction to the study, research background, purpose, significance of the study and problem arises that induced the research to be conducted. The research question, objective and hypothesis have been identified and formed to answer all the queries of the researchers. Chapter 2 consists of the review of literature and relevant theoretical models of past study. Researchers also included the proposed conceptual framework of their study and formulate hypotheses to ease the research findings. Chapter 3 is the research methodology that describes how the researchers carry out their study, sampling framework, data collection methods, research instruments, construct measurement, data processing and data analysis. In Chapter 4, researchers present the examination and evaluation of the result pattern

and analysis which relevant to the hypotheses of the research. Chapter 5 is the whole research conclusion which includes discussion, implications, limitations and recommendation of the study.

1.8 Conclusion

In summary, we have examined the trend of health tourism in the world and the performance of health tourism in Asia region. Major players such as Thailand, Singapore, and India are actively participating in this profit-generating industry. Malaysia might not be comparable to Thailand in terms of traditional healthcare treatment (massage) and Singapore and India in terms of advance medical facilities. Therefore, given such intense competition in health tourism industry, Malaysia might not be advantageous in positioning themselves against neighbouring countries.

By studying foreign tourists' intention, we could find out the factors that influence their decisions in undertaking healthcare services abroad. A more detailed literature review will appear in the following Chapter 2 whereby we would form a research framework by reviewing the issue critically from relevant journals and articles.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

In this chapter, the literature review on the subject matter would be discussed based on information gathered from journal articles and relevant research papers. Other secondary data is also used to support the review of literature.

There are five sections under Chapter 2. Section 2.1 is the review of literature from studies done by previous researchers. Section 2.2 is the review of relevant health behaviour theories while Section 2.3 is the proposed theoretical framework. Next, we develop research hypotheses in Section 2.4 and provide a brief conclusion of Chapter 2 in Section 2.5.

2.1 Review of the Literature

2.1.1 Definition and Nature of Health Tourism

There is no general consensus on the definition of health tourism. The following table summarized the definition and nature of health tourism adopted from various studies in the field.

Table 2.1: Summary of the Definition and Nature of Health Tourism

Author(s)	Definition
An (2014)	Medical tourism refers to the vacation that is done for medical services by travelling outside countries to access medical service abroad.

Table 2.1: Summary of the Definition and Nature of Health Tourism (Continued)

Author(s)	Definition
Krishnan, Chelliah, Mohamed & Bahauddin (2013)	Health tourism includes medical tourism and wellness tourism. Medical tourism involve of medical treatment such as surgery while wellness tourism mainly for relaxation activities such as spa and facials.
Musa et al. (2012)	Hosting a tourist who stays at the destination region for at least one night, as well as any activities relating to travel with the purpose of restoring and maintaining health conditions.
Helmy and Travers (2009)	Medical tourism is also called "medical travel", "medical outsourcing" or global healthcare.
Bookman and Bookman (2007)	Travelling with the purpose of improving health condition, also an economic recreation that involves services trading and constitute two areas: tourism and medical
Youngman (2007)	Medical services including cosmetic or heart surgery, replacement for knee or hip, and dental procedures obtained while travelling to other countries with acquiring medical and surgical care as main purpose.
Carrera and Bridges (2006)	Enhancing and restoring an individual's condition of health by engaging in medical intervention while travelling beyond his/her natural jurisdiction for healthcare.
Connell (2006)	View as a culture in which healthcare services including surgical and dental care are obtained by travelling abroad and at the same time having the chances to visit touristic areas in that country.
Vajirakachorn (2004)	Health tourism delivers healthy people with illness prevention tourism by giving individual healthcare services; whereas ill people receive medical services such as spa or convalescence tourism by engaging in health tourism

Table 2.1: Summary of the Definition and Nature of Health Tourism (Continued)

Author(s)	Definition
Hall (2003)	A commercial phenomena where people travelling from their normal environment for the welfare of improving and sustaining health status. It also involves the destination country's promotion of its facilities in providing such benefits.
Laws (1996)	A form of leisure where one's health condition is improved by travelling to other destination countries and getting various medical services with the aims of addressing one's concern for health.
Goodrich & Goodrich (1987)	Medical tourism involves intentionally promoting for healthcare services and facilities, as well as regular tourist spots with its attempt to attract tourists.
Medical Tourism Association (MTA, n.d.)	People staying in one country travel to another country to receive the same or better medical or dental care as compared to such services in their home country, and are travelling due to affordable and better access to high quality of medical care.

Source: Developed for the research

For the purposes of this study in which the process of decision making is emphasised, we define health tourism as people, whether health or ill, go through international travel or travelling from place of residence for health reason with the purpose of maintaining, enhancing and restoring one's well-being in mind and body through health intervention. The health intervention may cover a wide range of healthcare services ranging from illness, wellness, health enhancement, to reproduction.

2.1.2 Review of Past Health Tourism Studies

Despite the extensive research on health tourism mentioned in Appendix 2.1, however, there is a lack of evidence from empirical studies on how foreign tourists' evaluation and perception on a health threat and how they confront with such threat are combined to predict the likelihood of having healthcare services in Malaysia. Besides that, the literature still suffers from a lack of preliminary studies on foreign tourists' intention to undertake healthcare services abroad which is also influenced by many psychological factors. Therefore the main objective of this research is to explore what constitute among intention of foreign tourists for health tourism in Malaysia.

2.2 Review of Relevant Health Behaviour Theories

The concept of health behaviour has been explained and predicted by a number of psychosocial theories. According to expectancy-value theory (Fishbein, 1962), behaviour is a function of one's expectation and the importance of the goal in which one is working. The expectancy and value relevant with each element are worked together to assess an individual's attitude toward health condition. Expectancy-value models provide a useful framework for understanding self-protective health behaviour. A number of theories proposed for the understanding of health behaviour are categorized as expectancy-value theories, including the Health Belief Model (HBM) (Hochbaum, 1958; Maiman and Becker, 1974), the Theory of Reasoned Action (Fishbein and Ajzen, 1975), the Theory of Planned Behaviour (Ajzen, 1985), and the Protection Motivation Theory (PMT) (Rogers, 1975; Rogers, 1983). These models are outlined below and their common criticisms are discussed.

2.2.1 Health Belief Model (HBM)

The HBM was developed by Irwin Rosenstock in 1966. It is one of the earliest and widely applied models in health promotion and include four core elements: (1) perceived susceptibility (an individual's evaluation of their possibility of having the disease, (2) perceived severity (the seriousness of the disease and its outcomes), (3) perceived barriers (factors that related to adopting a recommended behaviour such as inconvenience, time, and side effects), and (4) perceived costs of attaching to the proposed action. Factors related to motivation were embraced under vulnerability and fear of the disease (Rosenstock, 1966).

There have been several critics made on HBM, one of which is the fact that not all health behaviour is based on conscious and rational decision. Leventhal and Nerenz (1985) claimed that health-related behaviour is relating more toward how people clarify their symptoms. For instance, you would probably do something if you are not feeling well and that you feel it is not going to cure it. The HBM also lacks concepts about change strategies. It focuses on negative factors instead of positive motivations that encourage healthy behaviours and concerns only individual factors but not environmental and socioeconomic factors that encourage victim blaming (Roden, 2004).

2.2.2 Theory of Reasoned Action (1975) & Theory of Planned Behaviour (1985)

The Theory of Reasoned Action (TRA) was developed by Fishbein and Ajzen in 1975. The theory proposed that intention is a function of two basic contributing factors: behavioural attitude (an individual's assessment of exercising the behaviour) and subjective norm (the perceived expectations others that are important to the individual in carrying out the behaviour) (Ajzen and Fishbein, 1975). The critique of the TRA is that not

all behaviours are under an one's control including habitual behaviours, spontaneous actions, and cravings.

Ajzen (1985) extended the TRA and developed the Theory of Planned Behaviour (TPB) by including a perceived behavioural control predictor. Ajzen highlighted the role of intention and suggested that the possibility of behaviour change is relevant to the amount of control an individual has over a given behaviour and the hardiness of their intent to change.

The TPB is being criticized for ignoring emotional determinants of behaviour (Kanbe, 2012). Compared to the models of affective processing, Ajzen's (2006) theory excludes emotional variables such as threat, fear, anxiety, and mood by assuming all behaviour is rational. However, it is not necessary that human act according to their rational thinking. This limits the measurement of intention using TPB.

2.2.3 Social Cognitive Theory

Social Cognitive Theory (SCT) is one of the health promotion theories used in past studies. SCT is also known as Social Learning Theory. SCT explained people's behaviour is learned by observation, imitation, and positive reinforcement. In other word, people will intend to do certain behaviour through observing how others performing (Bandura, 1977; Bandura, 1989).

Expectancies and incentives are element used to determine behaviours in SCT. Expectancies can be divided into three types which are expectancies about environment cues, expectancies of outcomes and expectancies about individual's competences. Incentive is also known as reinforcement which is defined as the value of a particular outcome or object (Rosenstock, Strecher, & Becker, 1988).

In addition, reproduction, motivation, retention, and attention are four basic processes of social learning. Reproduction is meant to imitate behaviour of others. Self-efficacy is an important particular of social learn. If an individual believe that they are able to perform like what other perform to achieve desired result, then the action will have higher chance to be imitated. For instance, if a tourist that seek for medical treatment in Malaysia and it solves their health issue, the particular tourist's friend or family are more likely to travel for a health tourism in Malaysia because there are a success track of record (Bandura, 1977; Bandura, 1989).

Although SCT is able to explain why people act on behaviour, but it is insufficient to explain people intention of behaviour. Thus, it is explain people intention by expectation and incentive, it will not insufficient to explain intention of people because people would act on behaviour other than the two concept mentioned in SCT. For example, people will intend to imitate other behaviour when the response cost or intrinsic rewards. In addition, SCT only show a little correlated between self-efficacy and intention. However, past studies in other theories such as PMT and HBM determined that self-efficacy is the strongest predictor of intention.

2.2.4 Protection Motivation Theory (PMT)

Protection Motivation Theory (Rogers, 1983) was at first developed to describe the way individual react to a given fear-fostering health threat or `fear appeals.' Protection motivation can be referred to as an individual's motivation to avoid from a health threat which is usually defined as the intention an individual has to engage in the recommended action.

Threat appraisal and coping appraisal works together to affect intention. Threat appraisal focuses on the evaluation about a fear appeal related to an individual's perception of how endangered he or she feels by a threat disease(s). It concerns the source of the elements and threat that increase

or decrease the probability (severity and vulnerability) of maladaptive responses (e.g. denial, avoidance, wishful thinking). Fear is an intervening variable between the degree of threat appraisal and the perceptions of severity and vulnerability. Thus, higher level of fear will be stimulated when an individual believes he or she is vulnerable to a health threat and that his or her motivation to involve in protective behaviour will be increased. In addition to severity and vulnerability that impede maladaptive responses, a number of rewards, both intrinsic (e.g. pleasure) and extrinsic (e.g. social support) may increase the probability of maladaptive behaviour.

Coping appraisal assesses the variables of a fear appeal that are linked to an individual's judgement of the recommended coping response to the appraised threat. It concerns the coping responses that an individual has to deal with threat and factors which influence the probability of an adaptive response. When an individual believes the recommended action will successfully reduce the threat (i.e. response efficacy) and that him or herself is capable of carrying the recommended action (i.e. self-efficacy), this increases the probability of an adaptive response. In addition to response efficacy and self-efficacy that inhibit adaptive response, a number of response costs (e.g. availability of facilities and resources) may exist to influence the performance of the adaptive behaviour.

The intention to undertake a recommended action (protection motivation) arises from threat and coping appraisal and is positively linked with perceived severity, perceived vulnerability, response efficacy and self-efficacy, and negatively related to perceived rewards corresponding with maladaptive responses and the response costs of the adaptive behaviour.

For protection motivation to be elicited, perceptions of severity and vulnerability should goes beyond the rewards connected with maladaptive responses. Moreover, response costs of the adaptive behaviour should less than the perceptions of self-efficacy and response efficacy. Thus,

protection motivation works as a mediating variable between the threat and coping appraisal processes and also protective behaviour.

The alternative of a having health tourism is connected with a greater level of perceived risk to personal well-being and health, and hence a higher degree of participation, than that linked with other types of destination choice (Beatty and Smith, 1987, Moutinho, 1987). In evaluating such risks, the PMT is an useful approach (Sonmez and Graefe, 1998), which involves the cognitive processes of a decision-maker in making a risky decision.

As discussed above, there are many theories strived to describe the way people respond to health threat. Among which, the PMT (Rogers 1975, 1983, 1985), by combining features from the HBM, the TRA and the TPB, is the most representative and the most influential theory of health behaviour.

Table 2.2: Past Studies on Protection Motivation Theory

Topic	**Sources**
Tobacco use	(Maddux & Rogers, 1983; Pechmann, Zhao, Goldberg & Reibling, 2003)
Alcohol consumption	(Wallerstein & Sanchez, 1994;Runge, Prentice & Scogin, 1993)
Sunscreen	(Reich, Harupa, Bury , Chrzaszcz & Starczewska, 2009; McClendon et. al., 2001)
Getting vaccinated	(Reich et. al., 2009)
Screening behaviours	(Helmes, A. W., 2002)
Motivation to follow exercise	(Rippetoe, 1987)

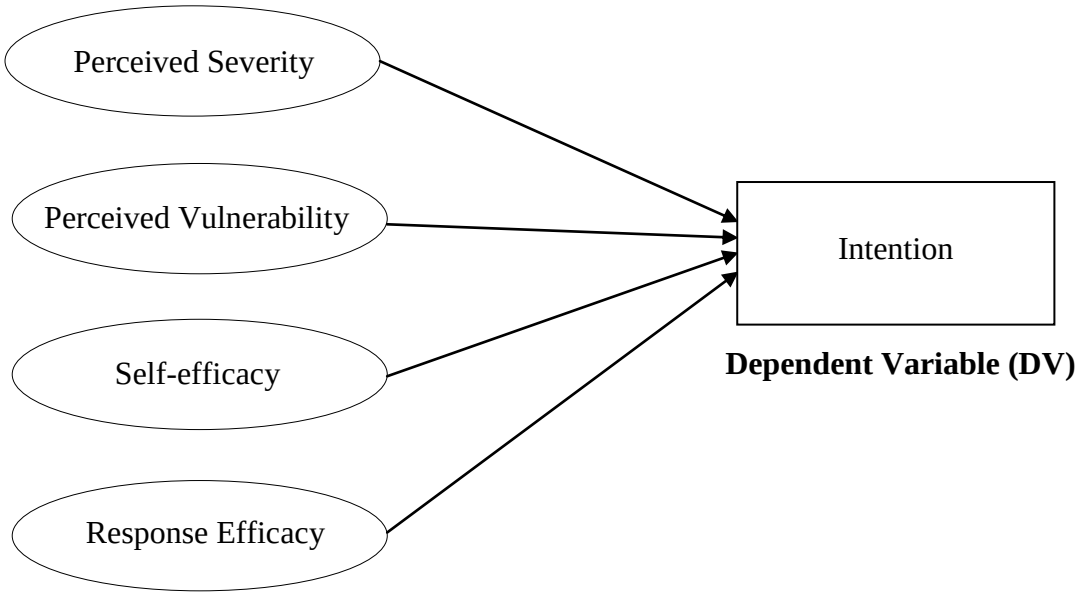
Table 2.2 : Past Studies on Protection Motivation Theory (Continued)

Topic	**Sources**
Physical activity	(Wurtele & Maddux, 1987; Plotnikoff et al., 2010)
Self-care	(Fry & Prentice-Dunn, 2006)
Safe and protective behaviours at the worksite	(Rogers, 1983)
Parental protective behaviour	(Strobino, Keane, Holt, Hughart & Guyer, 1996)
Safe computing practices	(Anderson & Agarwal, 2010)
Environmental hazard reduction	(Vaughan, 1993)
PMT has been utilized in intervention research to develop and evaluate programs for purposeful behaviour change, including interventions to promote adherence to medical treatment regimens	(Flynn, Lyman & Prentice, 1995; Palardy, Greening, Ott, Holderby & Atchison, 1998)
To prevent substance use	(Wallerstein , Sanchez 1994; Runge , Prentice & Scogin, 1993)
To discourage HIV risk behaviours and encourage HIV protective behaviours	(Eppright, Tanner & Hunt, 1994; Chen X et al., 2009; Gong et al., 2009; Chen X et al., 2010)

Source: Developed for the research

2.3 Proposed Theoretical Framework

Figure 2.1 Proposed Theoretical Framework



Source: Developed for the research

This research study's model and their hypothesis association is draw upon four variables – perceived vulnerability, perceived severity, self-efficacy, and response efficacy in measuring foreign tourists' intention to deal with health tourism in Malaysia. As show in Figure 2.1, the framework is developed based on review of all health related theories in the previous section. Among the numerous health related theories, PMT appeared to be a more influential theory of health behaviour because it shares a number of similarities with other health related theories. Thus, the defined relationships between PV, PS, SE, and RE with intention drive us to choose these four strongest variables in our studies.

Perceived severity is one of the factors that related to motivation. From HBM framework, we know that individual perception (Perceived Severity) will increase a likelihood of behaviour indirectly through perceived threat. Perceived severity is known as cues of an action (Rosenstock, 1966). The result had proved that perceived severity will definitely lead to a likelihood of behaviour. According to

PMT, perceived vulnerability is positively related to health-protective intentions and behaviour. Thus, we can explain that medical tourists seek for medical treatment in Malaysia because Malaysia is currently develop well in health tourism. Low risk vulnerability is critical to motivate patient in selecting treatment as it will directly impact to their health.

Besides, response efficacy has been manipulated in essays that argue that there is an effective method to prevent or treat a disease (Fruin, 1992). Self-efficacy was proved as the most powerful predictor of behavioural intentions in TPB and PMT studies (Rudman, 1999; Maddux & Roger, 1983; Bandura 1994). In a meta-analysis carried out by Floyd et al. (2000), self-efficacy is the only variable which has the largest effect size in predicting intention and behaviour on health related issues. Thus, we choose it as our variable in measuring intention in our studies. With this four constructs, the research framework should be comprehensive to explain foreign tourists' intention to undertake healthcare services in Malaysia in relating to their health perceptions.

2.3.1 Dependent Variable: Intention

Intention is defined as something that an individual wants and plans to do in Cambridge dictionary. Intention also means trying to perform a given behaviour rather than in relation to actual performance (Ajzen, 1985). Besides, it can be defined as how willing is an individual work toward its goals (Ajzen, 1991). According to Fishbein and Ajzen (1975), intention indicates the probability of a person behaving in a certain way. Before one's behaviour there must be an intention for the person to perform the action. Given the close relationship between intention and behaviour, it is possible to define intention by using similar elements.

In the past, there were many studies about intentions of individuals to act on specific behaviours. Among of these past studies, health-related researches about intention also play a part. For instance, Wolf, Gregory

and Stephan (1986) completed a research on the prediction of intentions to engage in anti-nuclear war behaviours. According to Greening and Stoppelbein's study (2000), they evaluated young drivers' intentions to drink and drive. They decided to do the research because they found that although young drivers understand about the dangers of drinking and driving, they still want to put themselves and others at risk by driving after drinking alcohol. Moreover, there was also study that examined intentions and self-reported behaviour of a low-fat diet to prevent coronary heart disease (Plotnikoff & Higginbotham, 1995). In 1999, a research from Llovet, Fuster and Bruix had been published, which was regarding intention-to-treat analysis of surgical treatment for early hepatocellular carcinoma.

In our research, tourists' intention refers to the intention of tourists to go for medical treatment or healthcare services in a specific country. We use four variables to examine the tourists' intention to head for healthcare services in Malaysia during their visitation, which will be discussed in next section.

2.3.2 Independent Variables

2.3.2.1 Perceived Severity

Risk severity is defined as the amount of hardship that would happen if one experienced the risk (Martin, Bender & Raish, 2007). Perceived severity reflects the fear of a person towards the significance of threat (Yoon, Hwan & Kim, 2012).

Perceived severity (also known as perceived seriousness) mentioned to how the people perceive the deleterious consequences or outcome of serious health event, such as the diagnosis of cancer. Pre-existing health problem is the one of the consequences relate to

a predicted event which may happen to current state or in future ("Perceived severity-National Cancer Institute," 2014). McClendon (2011) stated that perceived severity is the subjective view of the seriousness and consequences in a condition. Besides, the level of a condition's seriousness or the illness is differing from person-to-person. An individual's emotion influences his or her perception of seriousness aroused by the thought of sickness and also by the perception of difficulty that the health condition will inflict.

Smoking is the main reason of lung cancer that causes to death among the American population ("Lung cancer fact sheet," n.d.). Smokers may not aware of the difficulty level to detect and treat the lung cancer. Smoker may also not aware how the painful and long lasting an illness it occurs in their life. Perceived severity attempts to increase the consciousness of an individual on how serious the consequences of behaviours can be for the purpose of enhancing the quality of their life.

In essence, perceived severity is the seriousness perception of people if one were to contract a severe disease or health issue. Perceived severity also has been evaluated in assessment for the non-health consequences of health threat, including the effect of disease on psychological, social, financial outcomes ("Perceived severity," n.d.). Janz and Becker (1984) stated the dimension of perceived severity involves the assessment of both medical consequences (pain, disability and death) and the possible social outcome, such as effect on family life, conditions on work and social relations.

According to Milne, Sheeran and Orbell (2000), perceived severity has been actualized in terms of physical severity and psychosocial severity by applying the Protection Motivation Theory (PMT) to health-related behaviour. For instance, Abraham, Sheeran, Abrams,

and Spears (1994) actualized perceived severity in terms of assessing the lethality of HIV: How many HIV patients actually die of it? Hodgkins and Orbell (1998) also measured psychosocial severity by using question such as "I would be forced to change the goals in my life by the developing breast cancer".

2.3.2.2 Perceived Vulnerability

Vulnerability outlines the tendency of exposed elements like human beings, their livelihoods and assets to endure negative effect when affected by disaster. It can also be considered as situation-specific which interacts with a hazard event to engender the risk (Cardona, Aalst, Birkmann, Fordham, McGregor, Perez, Pulwarty, Schipper, Sinh, Decamps, Keim, Davis, Ebi, Lavell, Mechler, Murray, Pelling, Pohl, Smith & Thomalla, 2012).

Perceived vulnerability reflects the belief of an individual about the likelihood of developing a health issue or the possibility of a health threat's occurrence (Gerrard & Houlihan, n.d.). Perceived vulnerability refers to the assessment of an individual for his or her own probability of being exposed to a threat (Woon, Tan & Low, 2005). According to Zarlengo (2012), perceived vulnerability can be explained as the perception of uncontrollable events and anxiety leading to negative outcomes. It assesses how susceptible a particular person senses the communicated threat (Milne, Sheeran & Orbell, 2000). In order to prevent risk, perceived vulnerability is also a significant component in the formation of motivation (Gerrard, Gibbons & Bushman, 1996).

Perceived vulnerability can also be explained as a belief that person is vulnerable to those future negative and undefended from the danger or misfortune. Affective component is accompanying perceived vulnerability which composed feeling of fear,

nervousness and fretfulness. A greater precision to define vulnerability is focusing only three dimensions of threat, including the public perceptions of likelihood, control and consequences (Jackson, 2009). In Perloff (1983) theoretical paper, she examined that non-victims often have an "illusion of invulnerability", specifically in relation to seeing themselves as less susceptible to victimization than others.

Fear is a mediating variable between the vulnerability perception and threat appraisal level. If a particular person perceives himself or herself to be susceptible to a serious health issue, the greater level of fear will be aroused and thus increase the motivation of an individual to engage in protective behaviour (Norman, Boer & Seydel, 2005).

According to the research of Mermelstein and Riesenberg (1992), they investigated the perceptions of skin cancer factors among adolescents, thus predicted the relationship between perceived susceptibility to skin cancer and the intention to take preventative actions. Individual that prefers to use the sunscreen like females, older students and that particular person with high-risk skin type should take preventative actions. Hence, a one-session school based intervention is improving knowledge and the susceptibility perception to the skin cancer but not the behavioural intention to engage in protective behaviour.

In the measurement of perceived vulnerability, a number of assessment methods and the difference between these methods have emerged. Absolute Perceived Vulnerability measure refers to the perceived possibility a hazard event will happen, such as, "How likely is it that the person will get lung cancer?" or "What is the risk that you think will get AIDS?"

Conditional Perceived Vulnerability measure is created to evoke the consideration of anticipated or intended future behaviour in order to avoid the confounding of intentions, assumptions, and current risk behaviours with the susceptibility perceptions. Conditional measures allow researchers to differentiate between perceived vulnerability when it is suitable to take the preventive action and when it is not. For example, "how likely do you think that will develop gum disease if brush your teeth daily?" followed by "how likely do you think that will develop gum disease if not brush your teeth daily?" Comparative Perceived Vulnerability indicates that respondents usually make comparison between health behaviour and characteristic of their own with others. For instance, "Compare your age to others, how likely is it that will have a smoking-related illness at some time in future?" (Gerrard & Houlihan, n.d.).

2.3.2.3 Self-efficacy

Self-efficacy is referred to as individuals' judgments on their capabilities to organize and carry out actions to achieve identified goals (Bandura, 1977, 1986, 1997). It can also be considered as the individuals' belief about their ability to perform the suggested coping actions (Milne, Sheeran & Orbell, 2000). Self-efficacy reflects the level of confidence in one's ability to exercise control over his or her own behaviour, motivation, and social environment (Bandura, 1990). In psychological perspective, scholars often apply the concept of self-efficacy to behaviours related to self-management of chronic disease, smoking cessation, alcohol use, eating, pain control and exercise (Forsyth, Carey & Fuqua, 1997).

Self-efficacy can also be defined as "beliefs in one's capabilities to mobilize the motivation, cognitive resources, and courses of action

needed to meet given situational demands" (Wood & Bandura, 1989). Some researchers found out a trait-like generality dimension of self-efficacy (Eden, 1988, 1996, 2001; Gardner & Pierce, 1998; Judge, Erez & Bono, 1998; Judge, Locke, & Durham, 1997), which is called as general self-efficacy (GSE). GSE is "individuals' perception of their ability to perform across a variety of different situations" (Judge et al, 1998), whereas specific self-efficacy (SSE) is constrained to a particular task at hand (Luszczynska, Scholz & Schwarzer, 2005). According to Eden, both GSE and SSE indicate individual's beliefs about the ability to achieve desired results. However, the constructs differ in the scope (i.e., generality or specificity) of the performance.

If people believe that some recommended actions can be taken to solve their problems effectively, they will tend do so and feel more committed to this decision. When an individual believes that he or she is able to perform an event, it can actually conduct a more self-determined and active life course. (Schwarzer, Bassler, Kwiatek, Schroder & Zhang, 1997). In the aspect of medical area, perceived self-efficacy represents the individuals' belief to execute personal action in order to change risky health behaviours. An efficacy belief affects the intention to change risky behaviours, how many efforts expended to reach the target, and the persistence to continuously putting effort in spite of the barriers that may undermine one's motivation. When coping with high-risk situations, the success depends on one's belief that he or she operates as active agents of his own actions and possesses the skills that are necessary to bring around should a slip occur (Schwarzer & Fuchs, 1996).

2.3.2.4 Response Efficacy

Response efficacy is referred to the extent to which people believe whether a message provides effective and useful strategies (Lewis, Watson and White, 2010). It also indicates the belief of an individual about a recommended response will effectively reduce a health threat (Witte, 1992, 1994). In short, it refers to the perceived effectiveness of possible responses to a threat (Roger, 1975; Witte, 1994). Response efficacy features focus on the effectiveness of actions (Keller, 2006). Response efficacy is somehow being conceptualized as a characteristic of a message, such as when an information has response efficacy characteristic, as well as whether an individual believe in the ability of a suggested behaviour to reduce a health threat, such as a belief of condoms can help prevent AIDS (Witte, 1992).

In health-related research, response efficacy is commonly used to refer to perceived response-outcome expectancies (Roger, 1983). Response efficacy overlies with several notions in the health communication literature, including perceived benefits which is referred to the beliefs about the positive results related to behaviour in response to a perceived threat ('Response Efficacy', n.d.). For instance, the perceived benefits of limiting a person's number of sexual partners may include an individual's belief that he or she is able to reduce their probability to be infected by AIDS such as "Do you think you can reduce your risk of AIDS by limiting the number of male sex partners you have?" (Aspinwall, Kemeny, Taylor & Schneider, 1991).

Response efficacy has also been used to define an individual's belief in the effectiveness of a prescribed treatment or strategy for a particular health benefit. For example, participants may be vary in the beliefs about how effective karate is in deterring attack, or they may vary in the beliefs about the situations in which karate

techniques are effective or ineffective (Feltz & Chase, 1998). According to Lewis et al. (2010), the message of an advertisement which included information to reduce the risk of speeding will probably be effective to the individual. However, if the individual thought that the advertisement does not provide a strategy to reduce the risk of speeding, the message will become ineffective to the individual. It is confirmed that the importance of both emotional and cognitive elements of persuasive messages and identified response efficacy as a key cognitive construct will influence the effectiveness of fear-based and also an important mediator for positive emotion-based messages (Lewis et al., 2010).

2.4 Hypotheses Development

2.4.1 Relationship between Perceived Severity and Intention

The relationship between perceived severity and intention is not consistent as the results from several researches were different. According to Janz and Becker (1984), perceived severity has been shown to correlate with measure of health-related behaviour; however, such correlations tend to be small. Sheeran & Abraham (1996) and Weinstein (1988) explained that severity only influence motivation when severity exceeds a certain threshold, and, once the threshold is reached, the more important component that influences the motivation or intention may not be perceived severity. Furthermore, Ronis and Harel (1989) found that the effects of perceived severity on intention were mediated by another variable (perceived benefits), but not directly affected.

In contrast to the above findings, the authors found out that the perception of pertussis severity for the pregnant women and their infant was strongly associated with an intention to receive a tetanus, diphtheria and acellular

pertussis (Tdap) vaccine before delivery (Chamberlain et al., 2015). According to the research measured the acceptance of a newly developed vaccine against pandemic (H1N1) 2009 influenza A among healthcare workers (HCW) in Mexico, 80% of the HCW intended to accept the H1N1 pandemic vaccine, and the intention to be vaccinated was associated with high perceived severity of H1N1 (Esteves-Jaramillo et al., 2009). Meanwhile, in a study about risk perception of food safety and behavioural intentions to read food safety labels conducted by Miao (2014), Chinese college students were more likely to read food-safety labels and buy food accordingly when severity of food safety was stressed.

Given evidence from prior studies on the relationship between perceived severity and behavioural intentions, the severity of the disease is believed to have affected the foreign tourists' intentions to receive healthcare services across the globe if they encountered health issue. For example, when a specific disease is severe to a tourist, he or she will go for healthcare services to prevent such disease. However, as mentioned above, the result of past studies were different from each other. Therefore, further research is needed to examine the relationship between perceived severity of a health threat and the intention to receive healthcare services in Malaysia. The following hypothesis was made:

H_1: There is a significant relationship between perceived severity and foreign tourists' intention.

2.4.2 Relationship between Perceived Vulnerability and Intention

Perceived vulnerability is related to the intention of making changes in one's lifestyle or looking for medical advice (Glanz, Rimer, and Viswanath, 2008). For instance, an individual is unlikely to optimize their fertility if they do not feel vulnerable to the reduced chance of pregnancy.

According to a study about how to elicit higher intention to get an annual pap test conducted by Balbo (2010), participants that felt themselves vulnerable (e.g. participants that thought that they could have a cervical cancer in their life) had higher intention to get an annual Pap. Mermelstein and Riesenberg (1992) studied and examined perceptions of skin cancer factors among adolescents. It predicted the relationship between perceived susceptibility to skin cancer and the intention to take precautions. Females and those people with high-risk skin type were most likely to use the sunscreen to take precautions.

According to Norman, Conner, and Bell (1999), lower intentions to stop smoking is expected when smokers think that they are not vulnerable to the negative outcomes of smoking. The fact is that smokers tend to underestimate their vulnerability to the bad outcomes, although they understand that smoking increase the chance of confronting illness (Arnett, 2000). This is similar to the intention to undertake cancer screening where women are less likely to have cancer screening carried out when they do not think they are vulnerable to cancer (Kim et al., 2008). If an individual has a strong sense of perceived vulnerability toward cervical cancer, it is more likely that they will take preventive actions (Russell, 2002). When women became cautious of their potential vulnerability to cervical cancer, they would request for more screening services after they learn more about cervical cancer and the screening information (Bingham et al., 2003).

In light of the previous discussion featuring the role of perceived vulnerability in facilitating behavioural intentions, it is proposed that foreign tourists who feel vulnerable to a health threat should be more likely to take preventive actions and to increase their intentions to obtain healthcare services in Malaysia. We expect foreign tourists with higher level of perceived vulnerability exhibit a greater likelihood of engaging in healthcare services in Malaysia. Hence, the following hypothesis is made:

H_2: There is a significant relationship between perceived vulnerability and foreign tourists' intention

2.4.3 Relationship between Self-efficacy and Intention

Self-efficacy not only significantly influences intention to adopt recommended coping behaviour but is also the most powerful predictor of behavioural intentions. In other word, when a person has the belief to be capable of performing a requisite behaviour, he or she will be more likely to perform it (Maddux & Rogers, 1983). For instance, those who belief in little difficulty in reducing or eliminating cigarette smoking (high self-efficacy), they will had a greater intention to eliminate cigarette smoking (Maddux & Rogers, 1983). According to Jensen (2012), individuals who are low in self-efficacy are not likely to approach unfamiliar situation with anxiety or to avoid them entirely.

Strecher, Devellis, Becker, and Rosenstock (1986) claimed that individual with high self-efficacy exhibited the highest overall smoking reduction within three months, while individual with low self-efficacy exhibited the lowest overall level of smoking reduction. Meanwhile, Boer and Seydel (1996) proposed that self-efficacy was one of the major predictor of the intention to participate in certain medical check-up. For instance, woman with high self-efficacy had stronger confidence in their ability to perform breast self-examination correctly than did women in the low self-efficacy condition. According to Bandura (1997), the greater the perception of self-efficacy, the more likely the people would reduce habits that are health-damaging and start to adopt health-promoting habits into their daily lifestyle.

Based on the prior discussion on the role of self-efficacy in shaping behavioural intention, self-efficacy had been proved to be the best predictor of behaviour (Bandura, 2001; Garcia & Mann, 2003; Maddux & Rogers, 1983). Thus, we presume this relationship to be presented in the context of foreign tourists' intention toward health tourism in Malaysia. When foreign tourists know how to seek for advice about health tourism in Malaysia, they will be more likely to pursue it. Hence, it is important to

assure foreign tourists that healthcare services in Malaysia is efficient than their home country, so that their intention to adopt such cross-border action is strengthened. Thus, we make the following hypothesis:

H_3: There is a significant relationship between self-efficacy and foreign tourists' intention

2.4.4 Relationship between Response Efficacy and Intention

When expectations of danger were high, high response efficacy was enough to lead to intentions to adopt a preventive behaviour (Maddux & Rogers, 1983). According to Aboulnasr (2013), individuals who believe that the use of nutrition labels is effective in sustaining a healthy diet and preventing illness (high response efficacy) exhibited a higher intention to make use of the nutrition label.

Response efficacy has been introduced in various models including the AID Risk Reduction Model, the Health Belief Model, and Bandura's Model (Casey et al., 2009). The underlying assumption is that when people believe a recommended behaviour is effective in overcoming a problem or attaining a desired objective they are more likely to engage in such behaviour. According to Floyd, Prentice-Dunn, and Rogers (2000), response efficacy was linked to intentions and behavioural outcomes in various courses of studies like the reduction of alcohol consumption and the prevention of AIDs and cancer. Yun, Silk, Bowman, Neuberger and Atkin (2009) claimed that mother's intention to have their daughters in embracing healthy diets and avoiding chemical exposure to prevent cancer is well predicted by their efficacy of these behaviours.

Using the previous study on the role of response efficacy in shaping behavioural intentions as foundation, we anticipate this relationship to be existed in the context of foreign tourists' intention toward health tourism

in Malaysia. If foreign tourists do not perceive that health tourism are useful, they will be less likely to use them. Hence, it is expected that foreign tourists' belief that engaging in health or medical treatment in Malaysia is effective in maintaining a healthy lifestyle will strengthen their intentions to adopt such cross-border action. We thus make the below hypothesis:

H_4: There is a significant relationship between response efficacy and foreign tourists' intention

2.5 Conclusion

In a nutshell, this chapter discusses all relevant literature on health-related theories and models. It provides an insight to our research topic particularly in predicting foreign tourists' intention towards health tourism in Malaysia. Thus, proposed framework is developed and research hypotheses are formed to proceed with our research methodology in the following Chapter 3.

CHAPTER 3: RESEARCH METHODOLOGY

3.0 Introduction

In this chapter, the research methodology will be unveiled. First, we determine the research design as whether it is a qualitative or quantitative research. Next, we will cover the data collection methods whereby primary data will be collected from target respondents (foreign tourists) through questionnaire and secondary data from published journals and articles. Furthermore, the procedure of sampling design is discussed together with the research instrument which includes questionnaire design, pilot test, construct measurement, data processing and data analysis.

3.1 Research Design

In this section, the research is developed in quantitative manners. We tend to find the intention of foreign tourists and the effect on Malaysia economy. Quantitative research is defined as a systematic measurement based on evidences or facts that can be counted in numerical form and is the result of statistical analysis (Garbarino & Holland, 2009).

Descriptive study is one of the research design methods that is undertaken to ascertain and to describe the characteristics of the variables of interest (Polit & Hungler, 2004) which is the intention of foreign tourists to visit Malaysia for health tourism. The research is intended to find out what are the causes behind their intention to travel across borders and to receive healthcare services outside their home country.

According to Mouton & Marais (1998) the descriptive method provides the benefits of getting more accurate data and presenting clearer understanding of the subject under the research. Generally, descriptive method is used to explain the

overview of foreign tourists by collecting data with the aid of questionnaire regarding the behavioural intention towards health tourism in Malaysia.

This research is aimed to identify the cause and effect relationship between the independent variables (namely; perceived severity, perceived vulnerability, response efficacy, and self-efficacy) and dependent variable (the tourists' intention). Therefore, causal research is also being chosen as the research design because the major emphasis is on determining cause-effect relationships (Churchill & Brown, 2004).

3.2 Data Collection Methods

There are two types of data which are primary and secondary data. Data collection from both primary and secondary data sources are important to gather all relevant data and information that would be used to test the hypotheses and to find out research outcome.

3.2.1 Primary Data

Primary data is all the original information collected from first-hand sources (Hox & Boeije, 2005). There are two available data-collection methods namely observation and survey. Observation is the method used to provide a brief description of the situations that are being examined. According to Sekaran and Bougie (2010), observation provides rich information and clues about the phenomena observed and offer understanding of interpersonal and group dynamics. On the other hand, survey is used to establish generalizable findings that can be tested with hypothesised relationship between constructs.

In this study, we aim to obtain the findings regarding tourists' intention so that the data can be utilized by Malaysia policy-makers to improve health

tourism industry. The findings are designed to examine the intention and behaviour of foreign tourists in undertaking health tourism in Malaysia. Therefore, survey method is appropriate to collect primary data.

We will be conducting a survey by distributing questionnaires regarding the research questions as stated in Chapter 1.4. The questionnaires will be distributed to target respondents in selected sampling area. According to Sekaran and Bougie (2010), questionnaires enable the researchers to obtain the data from respondents within a short period of time. Other than that, questionnaire is useful in developing research hypotheses whereby respondents would provide their feedbacks to enhance the research questions.

3.2.2 Secondary Data

Secondary data is the existing data that can be obtained through various published information and be reused for another research purpose (Hox et al., 2005). For example, related journal articles that are retrieved from online database such as ProQuest, ScienceDirect and other relevant databases. Therefore, secondary data can be defined as information gathered by someone other than the researcher conducting the current study (Sekaran et al., 2010).

It is true that obtaining secondary data is less time consuming and less costly as compared to primary data. According to Sekaran et al. (2010), secondary data is useful to assist researchers effectively and provide a better understanding of the research problem. All these secondary data are important to develop Chapter 2 in this research as supportive evidence to prove certain facts especially in Literature Review. In addition, we have also utilized the online resources such as UTAR online database, government department official websites and online journal articles to retrieve official statistics and figures to improve the overall presentation.

3.3 Sampling Design

3.3.1 Target Population

Target population refers to a specified group of population in which the researchers is intended to collect information from them (Hair, Bush & Ortinau, 2006). The central objective of our study is to determine the factors that contribute to the intention of foreign tourists in receiving healthcare services abroad. Therefore, the criteria to be included in the target population are (1) foreign tourists who visited Malaysia and (2) for leisure or business purposes (Mill & Morrison, 1985). The term 'tourist' is defined as people "travelling to and staying in places outside their usual environment for leisure, business and other purposes" (World Tourism Organization, 2015). To ensure the validity of the information, tourists will be asked about their country of origin and the purpose of visit upon filling the questionnaire.

3.3.2 Sampling Frame and Sampling Location

Sampling frame is defined as a source of material where the sample for the intended research is chosen (Zikmund, Babin, Carr & Griffin, 2010). On the other hand, sampling location is the place or destination that the research had been carried out or the location that the information had been collected. The objectives of this study are to capture the perceived awareness of Malaysia as a health tourism provider among foreign tourists and to examine the predicting role of tourists' intention on the formation of their future behavioural intention.

The survey will be conducted in major tourist attractions in Malaysia, namely Kuala Lumpur, Penang, and Malacca. These three locations are selected for several reasons:

Figure 3.1: Major Tourist Attractions in Malaysia

In 2011, health tourists travelled to Penang (61%) the most, followed by Malacca (19%) and Kuala Lumpur (11%) with a relatively smaller portion of health tourists received (Ormond, 2011). In term of revenue generated from health tourism, medical facilities in Penang attracted around 49% of total foreign medical revenues, while KL and the greater Klang Valley received 21% of total expenditure and those in Malacca generated about 10% (Yap, 2013).

Based on the table that illustrates Malaysia hotel guests by state 2013/2014 below, Kuala Lumpur and Penang are among the top two locations that attracted the most foreigners.

Table 3.1: Malaysia Hotel Guests by State, 2013/2014

MALAYSIA HOTEL GUESTS BY STATE
***2013/2014**

STATE	DOMESTIC		% CHANGE	FOREIGNER		% CHANGE	TOTAL		% CHANGE
	*2013	2014	13/14	*2013	2014	13/14	*2013	2014	13/14
KUALA LUMPUR	5,149,295	6,584,325	27.87	8,520,340	9,867,899	15.82	13,669,635	16,452,224	20.36
PUTRAJAYA	168,136	353,632	110.32	152,531	154,369	1.21	320,667	508,001	58.42
SELANGOR	1,610,726	2,466,995	53.16	1,220,613	1,664,686	36.38	2,831,339	4,131,681	45.93
PENANG	2,639,182	3,617,170	37.06	2,062,917	3,230,399	56.59	4,702,100	6,847,569	45.63
PERAK	2,081,122	2,274,077	9.27	302,059	252,693	(16.34)	2,383,180	2,526,770	6.03
KEDAH	1,750,611	2,077,765	18.69	1,049,886	1,221,362	16.33	2,800,497	3,299,127	17.81
PERLIS	163,430	170,232	4.16	6,359	4,912	(22.76)	169,790	175,144	3.15
KELANTAN	936,908	1,144,316	22.14	72,942	63,193	(13.37)	1,009,850	1,207,509	19.57
TERENGGANU	1,425,421	1,461,756	2.55	109,942	165,649	50.67	1,535,363	1,627,405	5.99
PAHANG	5,515,873	8,053,176	46.00	2,481,302	2,317,011	(6.62)	7,997,176	10,370,186	29.67
JOHOR	3,138,895	4,023,691	28.19	2,631,675	2,402,884	(8.69)	5,770,570	6,426,575	11.37
MELAKA	2,201,143	2,675,011	21.53	1,930,622	1,757,952	(8.94)	4,131,765	4,432,963	7.29
N.SEMBILAN	1,348,403	1,701,432	26.18	302,300	544,508	80.12	1,650,703	2,245,939	36.06
PENINSULAR MALAYSIA	28,129,147	36,603,578	30.13	20,843,488	23,642,603	13.43	48,972,635	60,246,181	23.02
SABAH	2,698,361	4,089,879	51.57	1,295,755	1,936,093	49.42	3,994,116	6,025,972	50.87
LABUAN F.T	239,843	577,120	140.62	60,128	115,325	91.80	299,971	692,445	130.84
SARAWAK	3,202,408	4,106,798	28.24	660,542	589,985	(10.68)	3,862,950	4,696,783	21.59
GRAND TOTAL	34,269,759	45,377,375	32.41	22,859,913	26,284,006	14.98	57,129,672	71,661,381	25.44

Source : Tourism Malaysia (based on Hotel Survey)
**2013 : Revision*

Besides that, Kuala Lumpur and Penang are also among the top three locations with the most approved and registered hospitals, with 31 and 12 medical providers respectively, under MHTC (2015) to be the participating medical tourism providers in Malaysia. The following are the number of MHTC Approved and Registered Medical Providers based on their state or location:

Malacca, which listed into UNESCO's World Heritage List in 2008, has been revived as a top-pick tourism location due to its many historical attractions. Not only that, with the support from the Malaysian government to participate in health tourism, Mahkota Medical Centre had attracted more than 80,000 foreign patients for medical and surgical treatment annually (Mahkota Medical Centre, n.d.). Mahkota hospital also has travel agency to arrange accommodations, travel documents from health tourists (Ormond, 2011).

3.3.3 Sampling Elements

Sampling element is the population which made up of elementary units that are clustered into sampling units (Hitzig, 2004).We choose tourists who are travelling to Malaysia as the sampling element for our research. In this study, the best method to collect data is through questionnaire survey and it will be conducted in a manageable proximity within the locations, such as Penang International Airport, Swettenham Pier Cruise Terminal, Kuala Lumpur International Airport (KLIA), Subang Airport, Petronas Twin Towers, Menara KL Tower, Old Fort A Famosa, Jonker Street and Baba Nyonya Heritage Museum.

In Malaysia, Kuala Lumpur International Airport (KLIA) is known as the main international airport and is also one of the major airports of Southeast Asia's major aviation hubs. In year of 2013, there is around 47 million visitors handled by KLIA and is also considered as the fastest growing airport in Asia which achieving a 19.1% growth year-on-year. In Asia, KLIA airport was ranked as the 10^{th} busiest international airport and was the 11^{th} busiest airport in the world by that international passenger traffic ("Travel to Malaysia, n.d.).

Subang Airport is the airport located in Subang Jaya which is one of the busiest cities in Malaysia. Due to its close proximity to Kuala Lumpur, Subang Airport is commonly used by locals and some tourists as an alternative to the international airport KLIA. For instance, travellers only spend around 25 minutes from Kuala Lumpur City Center (KLCC) to Subang Airport instead of spending almost an hour to KLIA ("Subang Airport (Sultan Abdul Aziz Shah Airport)," n.d.).

Swettenham Pier Cruise is the latest terminal opened in Penang Port in 2010. In 2010, Swettenham Pier Cruise Terminal handled around 1.1 million travellers and it had increased significantly by 17.6% or 1.29 million travellers in 2013. Langsa, Acheh in Indonesia, Langkawi islands

and Pulau Payar in northern state of Kedah are the places that Swettenham Pier Cruise Terminal caters for some ferry services that ply between Penang ("Swettenham Pier Cruise Terminal," n.d.).

Old Fort A' Famosa is in the state of Malacca that consists a high population of tourists. Old Fort A' Famosa is one of the distribution spot that we choose to distribute our questionnaire due to its wide range of tourists and it is also the most important and famous cultural site in Malacca. At Old Fort A' Famosa, tourists are given the chance to join in various cultural activities and interesting monuments (Lee, 2009).

Jonker Street is located in the heart of the Malacca city. Jonker Street is one of the famous and attractive places for tourists to visit in Malacca due to the fact that this place is very historical and cultural in its roots. At here, tourists can find and visit various antique buildings which are all being well-preserved and can still have a glimpse of the historical stories that possess by the state. Jonker Street is also well-known for its nightlife and night activities. Therefore, Jonker Street would definitely be the best places for tourists to visit and have a taste on the local culture ("Jonker Street," n.d.).

3.3.4 Sampling Technique

Sampling technique helps to minimize cost and act as a method that used to investigate whole population. In this research, all probability sampling techniques are inappropriate because a limited number could not be obtained in the sampling frame. A structure quantitative approach seems more appropriate in order to acquire the relevant data on a public location. A convenience sampling approach will be adopted since it was a save time and relatively low cost method.

Sampling refers to the "deliberate choice of a number of person, the sample, who are to provide you with the data from which you will draw the conclusions about the population and whom these people represent" (Jankowicz, 1995). A convenience sampling method will be used to access the health tourists through an entry or exit point (Penang International Airport, Swettenham Pier Cruise Terminal, Kuala Lumpur International Airport (KLIA) and Subang Airport) and attraction places (Petronas Twin Towers, Menara KL Tower and Old Fort A' Famosa) in Malaysia using a self-administered questionnaire. Those respondents who are waiting for their ferries or flights will be approached. The target respondents will be requested to participate in survey after verifying their nationality.

Upon the agreement from tourists on voluntary survey participation, an explanation of the survey's objective and questionnaire will be giving out to target respondents. Simultaneously, we will also convince the target respondents for their anonymity and confidentiality to encourage a higher tendency of respondents to answer the questionnaire in good faith and to decrease the probability of responding in a socially desirable manner (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). Even though the questionnaire is self-administered, the target respondents will be permitted to ask any questions. For the month of January 2016, the self-administered questionnaire was distributed and collected from the target respondents on the spot.

In this research, judgmental sampling is also one of the non-probability sampling techniques that are appropriate for the present research. Judgmental sampling method refers to the researcher's judgment to filter and choose the elements that seem more informative for the inclusion in the sample, which will save time and money ("Judgement Sampling," n.d.). This method is appropriate in which the population is hard to achieve.

The responses from foreign tourists who visited Malaysia to seek for healthcare treatment or services will only be considered in order to reduce any bias between actual behaviour and the intentions. Therefore, foreign

expatriates and workers will not be involved in our research study. This approach enables us to assess the motivation and behaviour of health tourists more precisely as well as to avoid misperceptions.

3.3.5 Sampling Size

In determining the sample size, there are three key considerations which include the degree of accuracy, degree of population's diversity, and the number of variables to be examined.

Table 3.2: Tourist Arrivals and Receipts to Malaysia

TOURIST ARRIVALS & RECEIPTS TO MALAYSIA		
YEAR	ARRIVALS	RECEIPTS (RM)
2014	27.44 Million	72.0 Billion
2013	25.72 Million	65.44 Billion
2012	25.03 Million	60.6 Billion
2011	24.71 Million	58.3 Billion
2010	24.58 Million	56.5 Billion
2009	23.65 Million	53.4 Billion
2008	22.05 Million	49.6 Billion
2007	20.97 Million	46.1 Billion
2006	17.55 Million	36.3 Billion
2005	16.43 Million	32.0 Billion
2004	15.70 Million	29.7 Billion
2003	10.58 Million	21.3 Billion
2002	13.29 Million	25.8 Billion
2001	12.78 Million	24.2 Billion
2000	10.22 Million	17.3 Billion
1999	7.93 Million	12.3 Billion
1998	5.56 Million	8.6 Billion

Source: ("Tourist Arrivals & Receipt to Malaysia," n.d.)

The table shows the figures recently released by Malaysia's Immigration Department in country have received 27.44 million tourists in 2014 compared to 25.72 million tourists in 2013.

Taro Yamane technique will be applied to calculate the size of sample group from the tourist statistical population. Confidence level of 95% and 5% sampling error are considered ("Chapter 3 Research Methodology," n.d.).

Formula $n = N / (1+Ne^2)$

Where, n = the sample size or respondents for this research

N = Size of target population which is the number of tourists in Malaysia

e = the level of precision (a 95% confidence level or 5% precision level)

$n = 27440000 / [(1) + 27440000 (0.05)^2]$

n = 400 (sample size)

Table 3.3: Minimum and Typical Sample Size for Market Research

Research purpose	Minimum sample size	Typical sample size
Problem identification	500	1000–2500
Problem-solving research	200	300–500
Product test	200	300–500
Test-marketing studies	200	300–500
TV/radio/print advertisement (per commercial)	150	200–300
Test market audits	10 stores	10–20 stores
Focus group	6 groups	10–15 groups

Source: (Jotikasthira, 2010)

The Table 3.11 shows that the most appropriate for present study is represented by the problem-solving research category. It would seem that a sample size of 300-500 respondents would be appropriate. There is a "rule of thumb" regarding the sample size, whereby 100 is considered as "poor", 200 is considered as "fair", and 300 is considered as "good" (Jotikasthira, 2010). As a rule, the larger sample size, the higher the reliability, the lower the error and thus the greater the confidence that one can place on the

findings reflecting the population's characteristics as a whole (Doshi, 2008).

3.4 Research Instrument

3.4.1 Questionnaire Design

In this study, we use personally administered questionnaire as our mode of data collection. Personally administered questionnaire is being selected based on several reasons such as the ability to establish rapport with respondents, respondents' doubts can be clarified, and the anonymity of respondent is high. Besides that, questionnaire also enables a large amount of information to be collected from a large number of people and provides the benefit in terms of time efficiency and cost effectiveness (Introduction to Research, n.d.). The questionnaire is designed in fixed-alternative questions which require less interviewer skill, ease the problem of time consuming, as well as easier for respondents to answer (Zikmund, Babin, Carr, & Griffin, 2010). Respondents are required to select the answer belong to their viewpoint from a given limited alternative. For the types of fixed-alternative questions, we use simple-dichotomy question and determinant-choice question to create our questionnaire. We also use open-ended question in demographic section when asking about the nationality of respondents as we are not able to list out all the respondents' countries of origin in our questionnaire.

The questionnaire consists of two sections. In Section A, the four independent variables are perceived severity, perceived vulnerability, self-efficacy, and response efficacy. Combining with dependent variable (intention), there are a total of 30 questions in this section. This will help to measure the dependent variable, which is the foreign tourists' intention, and the relationship between the independent variables and the intention of

foreign tourists on health tourism in Malaysia. As for Section B, there are 12 questions on demographic profiles which are designed to obtain some basic information from the respondents. The questions which include country of origin, gender, age group, religions, travelling period, primary purpose of the particular visit to Malaysia, travel companions, marital status, annual personal income, educational level, employment status and in what way the respondent learns about Malaysia. The main reason for placing demographic questions at the end of the questionnaire is to convince respondents the genuineness and legitimacy of the questions designed; hence, they are more inclined and amenable to share personal information, especially for highly sensitive information such as details of income.

Likert scale questions are designed in Section A. Likert scale is used to measure attitudes by asking respondents to answer in terms of the extent to which they agree with the series of statements about a topic, tapping into the cognitive and affective components of attitudes (Likert, 1932). The benefit of using likert scale questions is that it allows for degrees of opinion or even no opinion at all (e.g. neutral), but not just simple yes or no answer from respondents (McLeod, 2008). In our research, odd-numbered scales have been used to design our questionnaire. It consists of a middle value and the mid-point may be appropriate to keep when the topic is highly sensitive (Losby & Wetmore, 2012). We use 5 likert scale questions in Section A. Respondents are required to select from the range of 1-5 to represent their intention. For example, 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree and 5 = strongly agree. According to Revilla, Saris and Krosnick (2013), researchers who use agree-disagree scales should provide 5 answer categories rather than 7 or 11. This is because 7 or 11 answer categories yield data of lower quality as more variations in an individual interpretation of the scale are possible with more categories, providing the scale with more categories will be more effective. Thus, the validity and quality will be lower when we use larger scale. Questionnaire using 5 likert scales have been used widely by

researchers measuring tourists' behavioural intention (Ng, Lee & Soutar, 2007; Joynathsing & Ramkissoon, 2010; Hsieh, 2012).

3.4.2 Pilot Test

A pilot test has been conducted on a small group of respondents to examine the reliability and internal consistency as well as potential problem of the research method before the actual result is tested. There are a lot of studies suggested different sample size that is suitable for pilot testing. For example, Sandvik, Erikssen, Mowinckel, and Roedland (1996) suggested minimum of 20 in total. Sim and Lewis (2012) suggested that 55 is the suitable sample size for pilot testing. According to Issac and Michael (1995), 10 to 30 respondents are highly recommended for sample size of pilot study. Moreover, Hill (1998) also recommended that 10 to 30 respondents are fair enough for conducting pilot study. Referred back to our research, our respondents are the foreign tourists located in Malaysia, the maximum of 30 respondents may be necessary for us to get accurate pilot testing result. Therefore, 30 sets of questionnaire were distributed to pilot-test our research. After the information has been collected, the result is being tested for reliability and validity using the Statistical Analysis System (SAS). This process is essential because it allows for adjustment in the questionnaire in order to improve the reliability of this test. After completed all the amendments, the main questionnaire surveys were distributed. We took about one month time to carry out the survey and pilot test, which is in August 2015.

3.4.2.1 Result of Pilot Test

According to Zikmund, Babin, Carr, and Griffin (2010), coefficient alpha ranges in value from 0 (no consistency) to 1 (complete consistency). Scales with a coefficient alpha between 0.80 and 0.95

are considered to have very good reliability. Scales with a coefficient alpha between 0.70 and 0.80 are considered to have good reliability, and an alpha value between 0.60 and 0.70 signifies fair reliability. The scale has poor reliability when the coefficient alpha is below 0.60. Based on this standard, the result of Cronbach's alpha coefficient in pilot test was shown in Table 3.3.

Table 3.4: Cronbach's Alpha Coefficient for Pilot Test

Variables	**Cronbach's Alpha**	**Range**	**Strength of Association**
Perceived Severity	0.751502	> 0.7	Good
Perceived Vulnerability	0.486838	< 0.6	Poor
Self-efficacy	0.871650	> 0.8	Very Good
Response Efficacy	0.842681	> 0.8	Very Good
Intention	0.948650	> 0.8	Very Good

Source: Developed for the research

In reliability analysis for pilot test, it was revealed that the Cronbach's α coefficients of perceived vulnerability is 0.486838 which is fall under the range <0.6, indicating that the seven items measuring perceived vulnerability have poor reliability. The overall reliability can be improved by removing Question 2 (It is possible that I could develop health problems.) and Question 6 (People who receive healthcare services are less possibly to get sick.). Hence, Question 2 and 7 were deleted in this paper. Based on the pilot test result mentioned above, the questionnaire items were revised for the formal questionnaires used in this study.

3.5 Constructs Measurement

3.5.1 Origin of Construct

In this study, the questionnaire is designed by adopting the questionnaire from other researchers. The below Table 3.1 is the origin of the questionnaire from the researchers and the number of items which adopted in this study.

Table 3.5: The Origin of Construct in the Research

Construct	Adopted From	No. of items
Perceived	Wall, J. M. (2009).	1
Severity	Grindley, E. J., Zizzi, S. J., & Nasypany, A. M.	1
	(2008).	1
	Milne, S., Sheeran, P., & Orbell, S. (2000).	2
	Frankenfield, K. M. (2009).	
Perceived	Frankenfield, K. M. (2009).	3
Vulnerability	Ritland, R., & Rodriguez, L. (2014).	2
Self-efficacy	Taylor, A. H., & May, S. (1996).	2
	Frankenfield, K. M. (2009).	3
	Lee Younghwa	2
Response	Frankenfield, K. M. (2009).	1
Efficacy	Ritland, R., & Rodriguez, L. (2014).	2
	Lwin, M. O. (2014).	2

Source: Developed for the research

3.5.2 Scale of Measurement

The process of gathering the data in the form of numbers can be known as a measurement. The numbers will convey some of the information which is being measured. Scale is a tool which uses to measure the grade of any variables and object. The scale is divided into four categories which are nominal scale, ordinal scale, interval scale and ratio scale (Sekaran & Bougie, 2012).

3.5.2.1 Nominal Scale

According to Sekaran and Bougie (2012), nominal scale represents the most basic level of scale measurement. It is a very simple and convenient way to assign a certain value to groups or categories purposes. There is no quantities are being represented, thus, the value can be or does not have to be. For example, asking respondent to indicate their gender does not involve any quantities and there is no value to be given.

Example of Nominal Scale

Please indicate your gender:

☐ Male ☐ Female

3.5.2.2 Ordinal Scale

Moreover, ordinal scale also has some properties of nominal scale. It also can be known as ranking scale. The property of ordinal scale allows the variable categories and is arranged based on rank-orders. But, it does not tell the value of the interval between rankings

(Sekaran & Bougie, 2012). For example, "Educational Level" is under ordinal scale because it arranged from rank-orders.

Example of Ordinal Scale

Educational Level

- ☐ Up to and including High School
- ☐ College Diploma
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate Degree
- ☐ Other (please specify) _____

3.5.2.3 Interval Scale

The properties of nominal scale and ordinal scale also can be found in interval scale. Interval scale is a type of scale which uses the distances between observations to captures quantities which have arbitrary origin. It also does not represent any phenomenon; therefore it is not iconic (Sekaran & Bougie, 2012).

Example of Interval Scale

No.		SD	D	N	A	SA
1	It is not convenient for me to go for health tourism in Malaysia.	1	2	3	4	5

3.6 Data Processing

Data processing refers to a description of data preparation. After data are obtained through questionnaires, they need to be edited, coded, and keyed in before analyzing the data to test hypotheses.

3.6.1 Data Editing

Data editing is the process of checking the completeness, consistency, and legibility of data and getting the data for coding and transfer to storage. Item nonresponse refers to an unanswered question on an otherwise complete questionnaire. Plug value is used to replace blanks or missing values when the relationship between two questions is important, such as that between a question about perceived severity and health problem. The decision rule is that to plug in an average or neutral value in each missing data, which allow a response to this item to be salvaged. This could be a good option because the response is important and effective sample size would be too small if all missing responses are deleted (Zikmund et al., 2010).

3.6.2 Data Coding

Allocating a number to the respondents' responses is referred to as data coding. All responses have to be coded prior entering into database.

In Section A of the questionnaire, the responses for each questions asked is coded as below:

- "Strongly Disagree" is coded as 1
- "Disagree" is coded as 2
- "Neutral" is coded as 3
- "Agree" is coded as 4
- "Strongly Agree" is coded as 5

While in Section B of the questionnaire, the responses for each demographic questions asked is coded as below:

Table 3.6: Data Coding for Demographic Profile

Q1	Country of Origin	-
Q2	Gender	• "Male" - 1 • "Female" - 2
Q3	Age group	• "18-30 years old" - 1 • "31-40 years old" - 2 • "41-50 years old" - 3 • "51-60 years old" - 4 • "61-70 years old" - 5 • "71 years old and above" - 6
Q4	Religions	• "Muslims" - 1 • "Christians" - 2 • "Buddhists" - 3 • "Hindus" - 4 • "Jews" - 5 • "Folk Religions" - 6 • "Unaffiliated" - 7 • "Other" - 8

Table 3.6: Data Coding for Demographic Profile (Continued)

Q5	Visiting period	• "Less than 24 hours" - 1 • "Within 1 to 7 days" - 2 • "Within 1 to 4 weeks" - 3 • "Within 1 to 12 months" - 4 • "More than one year" -5
Q6	Visiting purpose	• "Pleasure/Vacation" - 1 • "Business/Work" - 2 • "Medical Treatment" - 3 • "Visit friend and relatives" - 4 • "Convention/Exhibition" - 5 • "Other" - 6
Q7	Travelling with	• "Alone" - 1 • "Spouse/Family" - 2 • "Friend(s)/Relatives" - 3 • "Tour group" - 4 • "Business associates" - 5 • "Other" - 6
Q8	Marital status	• "Single" - 1 • "Married" - 2 • "Divorced" - 3 • "Cohabiting" - 4 • "Separated" - 5 • "Widowed" - 6
Q9	Annual income (USD)	• "$10,000 and below" - 1 • "$10,001-30,000" -2 • "$30,001-60,000" - 3 • "$60,001-100,000" - 4 • "$100,001-200,000" - 5 • "More than $200,000" - 6

Table 3.6: Data Coding for Demographic Profile (Continued)

Q10	Educational level	• "Up to and including High School" - 1 • "College Diploma" - 2 • "Bachelor's Degree" - 3 • "Master's Degree" - 4 • "Doctorate Degree" - 5 • "Other" - 6
Q11	Employment Status	• "Unemployed" - 1 • "Employed with temporary contract" - 2 • "Freelance professionals" - 3 • "Corporate firms employees" - 4 • "Business owners" -5 • "Other" - 6
Q12	Ways to Learn about Malaysia	• "Previous trip(s)" - 1 • "Travel agent" -2 • "Advertisement" - 3 • "Internet" - 4 • "Word-of-mouth" - 5 • "Brochures/Travel guidebooks" - 6 • "Other" - 7

Source: Developed for the research

3.6.3 Data Transformation

Data transformation refers to the procedure of replacing another value to the originally represented quantitative value. This step is necessary when several questions have been used to measure a single variable (Sekaran & Bougie, 2010). For instance, "perceived severity is measured using 5 items, thus a new "perceived severity" score needs to be generated from the scores that reflected in the 5 individual items. For example, our respondent

has circled 4, 3, 5, 4, and 3 respectively on the five questions measuring perceived severity. The combined score on perceived severity would be (4+3+5+4+3=19/5=3.8).

3.7 Data Analysis

After the data had been gathered, the data will be interpreted and analysed with Statistical Analysis System Enterprise Guide (SAS) software.

3.7.1 Descriptive Analysis

Descriptive analysis is the process of converting raw data into a form that is easily understood and interpreted by the readers. (Zikmund, 2003). There are three methods in organizing and summarizing the data in an informative way which are frequency, percentage, and average. According to Sekaran (2003), descriptive analysis describes the data in terms of mean, standard deviation and frequency.

We apply descriptive analysis for section B of the questionnaire which is related to demographic profile. The data collected will be presented in pie chart, histogram and bar chart according to the scale of measurement which are nominal and ordinal scales. The reason of using pie chart is to indicate the nominal scale items in a clear and easy way. Ordinal scale items will be displayed in bar chart to show the ranking of the data.

3.7.2 Scale Measurement

3.7.2.1 Reliability Test

According to Sekaran and Bougie (2012), reliability indicates how stable and consistent the instruments measure the concept of the research. It is an indication to what extent the questionnaire is error-free or free from bias.

The most familiar method that is applied to measure the reliability test is Cronbach's Alpha (Sekaran, 2003). Therefore, a reliability test based on a Cronbach's Alpha statistic will be used to test whether these factors were consistent and reliable.

The range of the Cronbach's Alpha has been shown in the table below:

Table 3.7: Cronbach's Alpha Range

Level of Reliability	Coefficient Alpha ranges, α
Poor Reliability	Less than 0.60
Fair Reliability	0.60 to 0.70
Good Reliability	0.70 to 0.80
Very Good Reliability	0.80 to 0.95

Source: (Sekaran & Bougie, 2010)

3.7.3 Inferential Analysis:

3.7.3.1 Pearson Correlation Coefficient

The Pearson Correlation Coefficient is appropriate for likert scale variables and is used to examine the relationship and direction between independent variables and dependent variable. It shows the strength of the variables towards the dependent variable which, in this study, the tourists' intention. According to Sekaran & Bougie (2010), the result can be either positively correlated (plus 1) or negatively correlated (minus 1). A stronger level of variables association can be represented by a positive correlation while a weaker level of variables association has negative correlation.

In this research, the questions in Section A are using this analysis to test the relationship between the variables whereby Likert Scale has been used to show the level of agreement on each question regarding tourists' intention towards health tourism in Malaysia. The strength of relationship between variables is interpreted based on the coefficient range as shown below.

Table 3.8: Rules of Pearson Correlation Coefficient Analysis

Coefficient Range	Strength
± 0.91 to ± 1.00	Very strong
± 0.71 to ± 0.90	High
± 0.41 to ± 0.70	Moderate
± 0.21 to ± 0.40	Small but definite relationship
0.00 to ± 0.20	Slight, almost negligible

Source**:** Hair, J. F. Jr., Money, A. H., Samouel, P., & Page, M. (2007). Research methods for business. England: John Wiley & Sons, Inc.

3.7.3.2 Multiple Regression Analysis

Multiple Regression Analysis (MRA) is best known for its ability to tell the significant relationship when there are more independent variables used to describe one dependent variable (Sekaran & Bougie, 2010). In this analysis, the square of multiple-r (R-square) is generated to explain the level of effect each variable has on dependent variable.

In this research, we are able to identify which independent variables (perceived severity, perceived vulnerability, response efficacy, and self-efficacy) are the most influential factors in affecting the dependent variable, the tourists' intention.

3.8 Conclusion

This chapter explains about our research methodology which includes research design, data collection methods, sampling design and research instrument. To improve our research reliability, we apply the most familiar research measurement which is the Cronbach's Alpha statistic. Next, all the hypotheses will be tested under Pearson Correlation Coefficient and Multiple Regression Analysis in which the relationships between independent and dependent variables will be determined. In the following Chapter 4, a series of data interpreting works will be carried out to explain in further details about the data collected and information generated from both pilot study and actual survey.

CHAPTER 4: RESEARCH RESULTS

4.0 Introduction

In this chapter, all the data were analysed and computed by using SAS Enterprise Guide 5.1 software, and the results will be shown in tables and figures. We measured respondents' demographic profile using descriptive analysis. The result of Pearson Correlation Coefficient Analysis and Multiple Regression Analysis, which is to measure the variables' reliability and model's predicting power, will also be measured by using scale measurement.

4.1 Descriptive Analysis

4.1.1 Respondent Demographic Profile

In our questionnaire, we collected personal information of respondents, such as country of origin, gender, age group, religion, visiting period, visiting purpose, travel companions, marital status, annual income, educational level, employment status and ways to learn about Malaysia.

4.1.1.1 Country of Origin

Table 4.1 Country of Origin

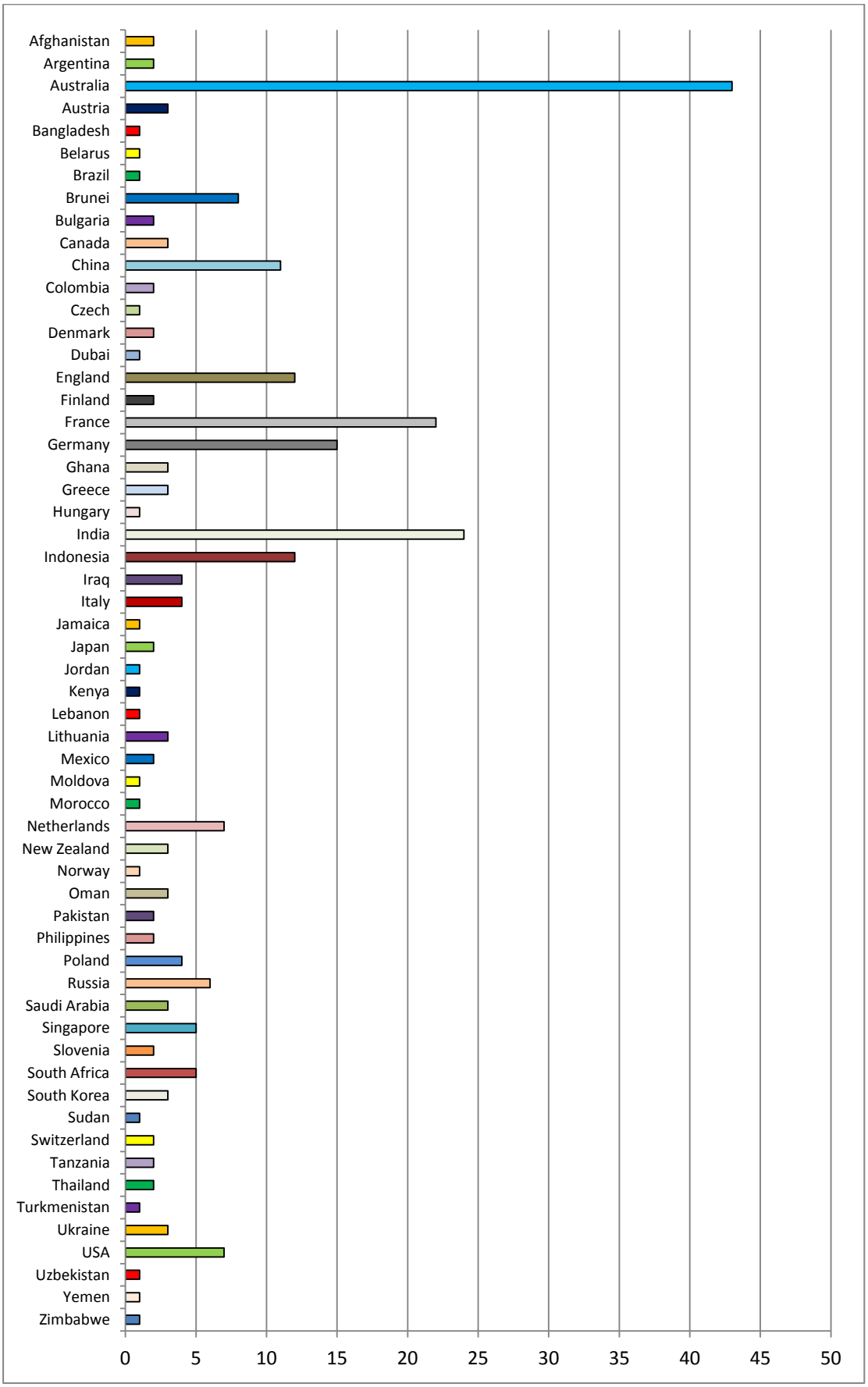
Country of Origin	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Afghanistan	2	0.8	2	0.8
Argentina	2	0.8	4	1.5
Australia	43	16.2	47	17.7
Austria	3	1.1	50	18.9
Bangladesh	1	0.4	51	19.2
Belarus	1	0.4	52	19.6
Brazil	1	0.4	53	20.0
Brunei	8	3.0	61	23.0
Bulgaria	2	0.8	63	23.8
Canada	3	1.1	66	24.9
China	11	4.2	77	29.1
Colombia	2	0.8	79	29.8
Czech	1	0.4	80	30.2
Denmark	2	0.8	82	30.9
Dubai	1	0.4	83	31.3
England	12	4.5	95	35.8
Finland	2	0.8	97	36.6
France	22	8.3	119	44.9
Germany	15	5.7	134	50.6
Ghana	3	1.1	137	51.7
Greece	3	1.1	140	52.8
Hungary	1	0.4	141	53.2
India	24	9.1	165	62.3
Indonesia	12	4.5	177	66.8
Iraq	4	1.5	181	68.3
Italy	4	1.5	185	69.8
Jamaica	1	0.4	186	70.2
Japan	2	0.8	188	70.9

Table 4.1 Country of Origin (Continued)

Country of Origin	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Jordan	1	0.4	189	71.3
Kenya	1	0.4	190	71.7
Lebanon	1	0.4	191	72.1
Lithuania	3	1.1	194	73.2
Mexico	2	0.8	196	74.0
Moldova	1	0.4	197	74.3
Morocco	1	0.4	198	74.7
Netherlands	7	2.6	205	77.4
New Zealand	3	1.1	208	78.5
Norway	1	0.4	209	78.9
Oman	3	1.1	212	80.0
Philippines	2	0.8	214	80.8
Pakistan	2	0.8	216	81.5
Poland	4	1.5	220	83.0
Russia	6	2.3	226	85.3
Saudi Arabia	3	1.1	229	86.4
Singapore	5	1.9	234	88.3
Slovenia	2	0.8	236	89.1
South Africa	5	1.9	241	90.9
South Korea	3	1.1	244	92.1
Sudan	1	0.4	245	92.5
Switzerland	2	0.8	247	93.2
Tanzania	2	0.8	249	94.0
Thailand	2	0.8	251	94.7
Turkmenistan	1	0.4	252	95.1
Ukraine	3	1.1	255	96.2
USA	7	2.6	262	98.9
Uzbekistan	1	0.4	263	99.2
Yemen	1	0.4	264	99.6
Zimbabwe	1	0.4	265	100.0
Total	**265**	**100**	**265**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.1 Country of Origin



Source: Developed for the research

According to collected data, the largest portion of respondents is from Australia, followed by India and France. A lot of Australians like to travel to Malaysia might be due to the reason that they do not need a visa to visit Malaysia, as long as the visit is up to three months, the passport is still valid for at least six months on arrival, and they have a confirmed return or onward international ticket (High Commission of Malaysia, n.d.). It is also found that there was a strong growth of arrivals to Malaysia from Western nations, including Australia. Arrivals from India also became the 6th biggest source of visitors, which has a 21 percent increased (Ng, 2015).

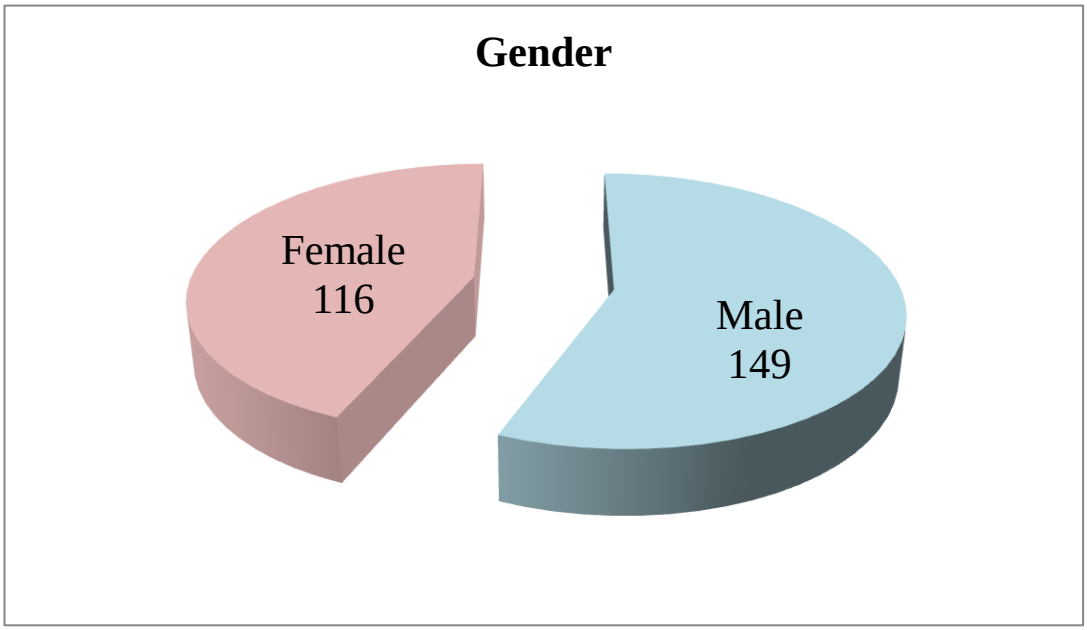
4.1.1.2 Gender

Table 4.2 Gender

Gender	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Male	149	56.2	149	56.2
Female	116	43.8	265	100.0
Total	**265**	**100**	**265**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.2 Gender



Source: Developed for the research

In certain circumstances, we found that men actually travel more than women. According to a statistic that shows the air travel frequency of citizens in the United States by gender, 8% of male respondents claimed themselves as frequent air travellers, comparing with 6% of female respondents. Besides, 74% of male respondents and 68% of female respondents labelled themselves as an occasional air traveller. From this result, we can see that male respondents have higher air travel frequency than female respondents (Statista, 2015).

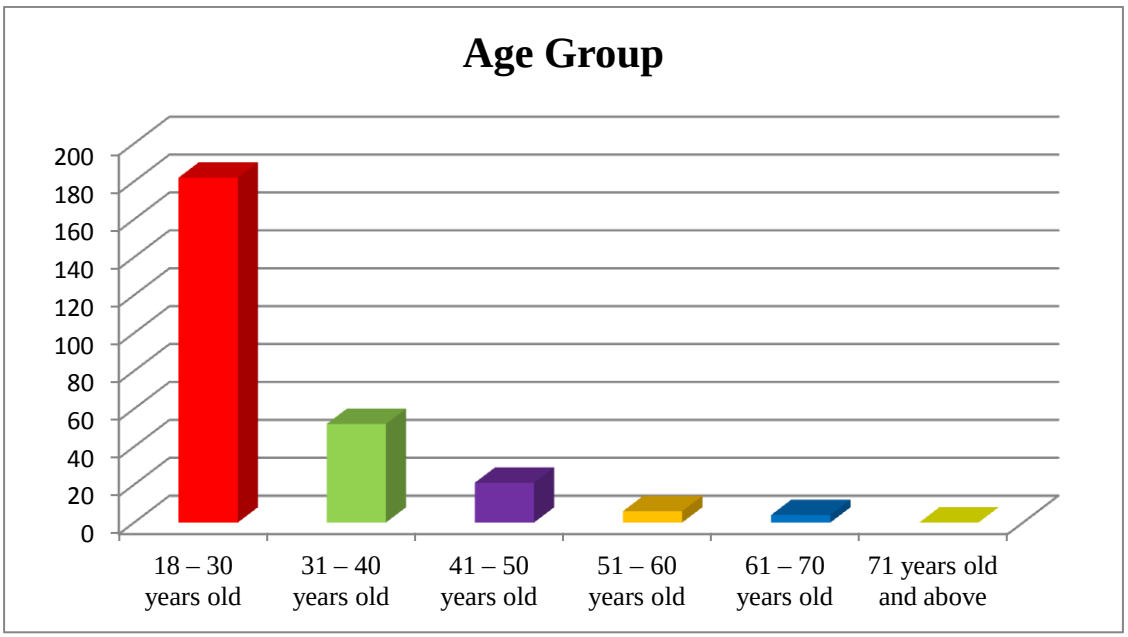
4.1.1.3 Age Group

Table 4.3 Age Group

Age Group	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
18 – 30 years old	182	68.7	182	68.7
31 – 40 years old	52	19.6	234	88.3
41 – 50 years old	21	7.9	255	96.2
51 – 60 years old	6	2.3	261	98.5
61 – 70 years old	4	1.5	265	100.0
71 years old and above	0	0	265	100.0
Total	**265**	**100**	**265**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.3 Age Group



Source: Developed for the research

It is obviously showed that there is a total of 68.7% respondents are from the age 18 to 30 years old. The result is align with the report from World Youth Student and Educational Travel Confederation, in which young people are travelling more, staying away for longer periods of time and spending more money, comparing with older people (HotelManagement, 2013). Older travellers who are 61 years old and above occupied the smallest portion in this question. This is probably related to certain health safety concern. For example, old travellers tend to feel the effects of jet lag more than younger travellers (Government of Canada, 2015).

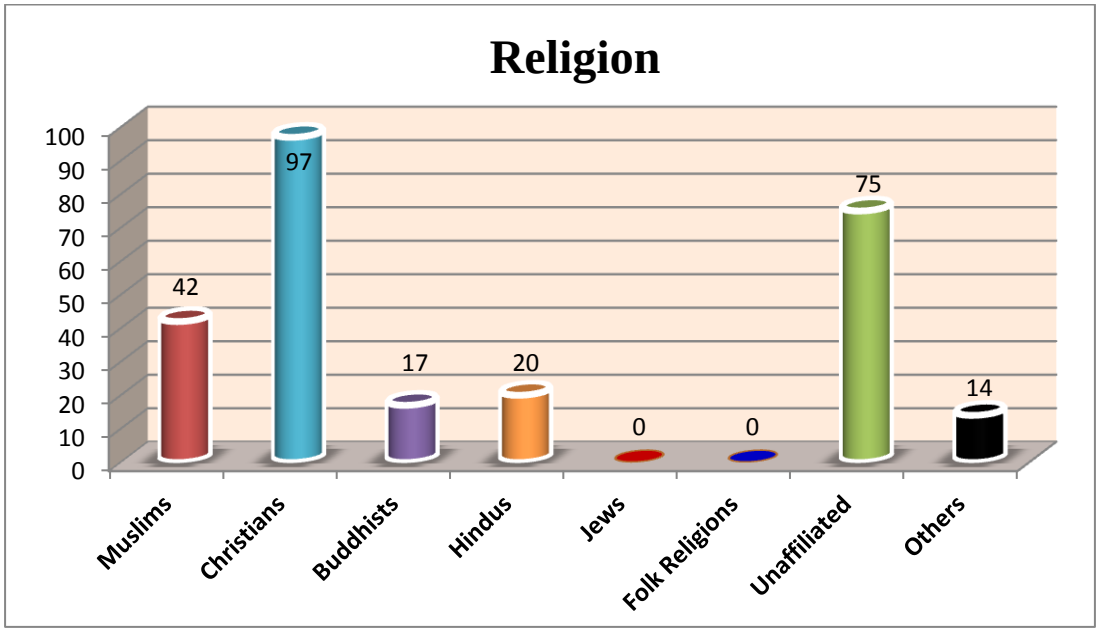
4.1.1.4 Religion

Table 4.4 Religion

Religion	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Muslims	42	15.9	42	15.9
Christians	97	36.6	139	52.5
Buddhists	17	6.4	156	58.9
Hindus	20	7.5	176	66.4
Jews	0	0	176	66.4
Folk Religions	0	0	176	66.4
Unaffiliated	75	28.3	251	94.7
Other	14	5.3	265	100.0
Total	**265**	**100**	**265**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.4 Religion



Source: Developed for the research

Table 4.4 and Figure 4.4 show the frequency and percentage of the religion of the respondents. From the results shown, majority of the respondents, which total 97 respondents are Christians, followed by Muslims, Hindus and Buddhists. There are total 75 of respondents is unaffiliated, while the remaining 14 respondents chose the option of "other" which indicating to other religions.

Malaysia is the home to most of the world's major religions, involving Islam, Buddhism, Christianity, Hinduism and Sikhism. In Malaysia, there are many major places of worship serve not only for their religious purposes, but it also become popular favourites for most tourists fascinated with Malaysia's cultural and religious diversity (Ang, 2013). According to our survey collected, majority of the respondents travel to Malaysia was Australians, followed by Indians and French. In Australia, nearly two thirds (64%) of the population claim that at least nominal adherence to a Christian-based religion, while nearly one third (30%) of the population is

unaffiliated. Thus, the remaining population is a diverse group that includes fast-growing Buddhist and Islamic communities ("Australian Religion and Culture," n.d.).

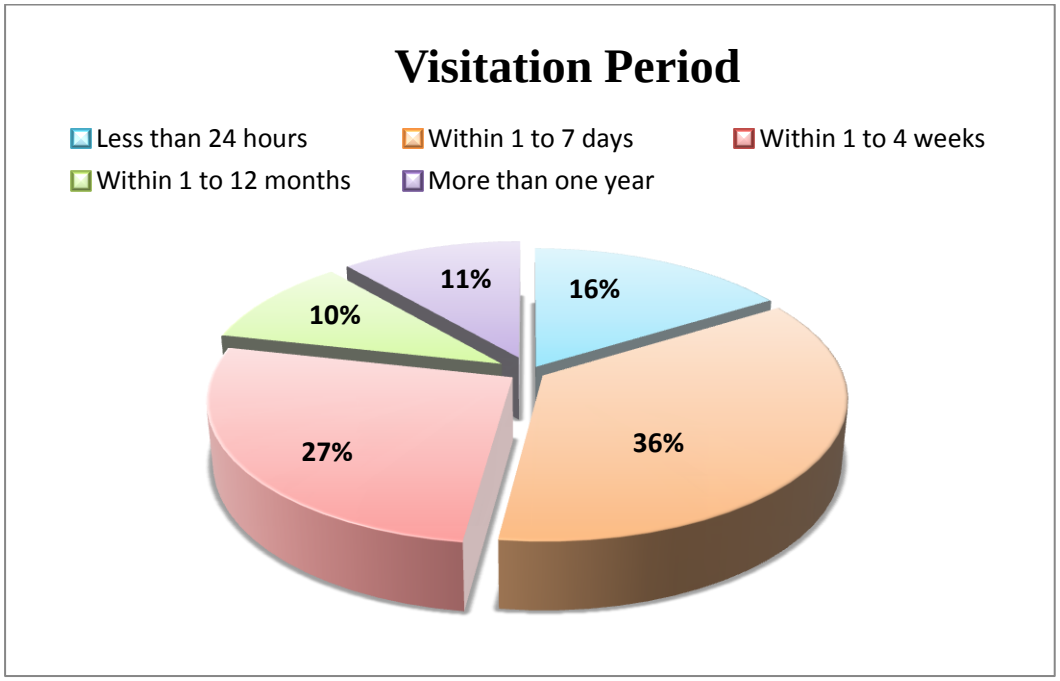
4.1.1.5 Visitation Period

Table 4.5 Visitation Period

Visitation Period	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Less than 24 hours	43	16.2	43	16.2
Within 1 to 7 days	95	35.9	138	52.1
Within 1 to 4 weeks	70	26.4	208	78.5
Within 1 to 12 months	27	10.2	235	88.7
More than one year	30	11.3	265	100
Total	**265**	**100**	**265**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.5 Visitation Period



Source: Developed for the research

Table 4.5 and figure 4.5 present the frequency and percentage of the visitation period of the respondents. According to the data collected, majority of the respondents which are 95 respondents (36%) stay in Malaysia for within 1 to 7 days, followed by within 1 to 4 weeks (27%), less than 24 hours (16%), more than one year (11%) and within 1 to 12 months (10%).

A holiday trip to Malaysia is generally affordable and not expensive, but considering the fact that the eventual costs may turn out fairly high when the foreign tourists stay in Malaysia for 2 to 3 weeks. For instance, there are costs related to travel like hotel costs, living costs, transportation costs, entertainment costs, travel insurance, vaccinations costs, and numerous other costs. However, there are no costs of a visa since it is not compulsory when tourists stay in Malaysia for less than 90 days ("Travel costs for Malaysia,"

n.d.). From the results, there is a minority of respondents visiting Malaysia for more than one month and more than one year.

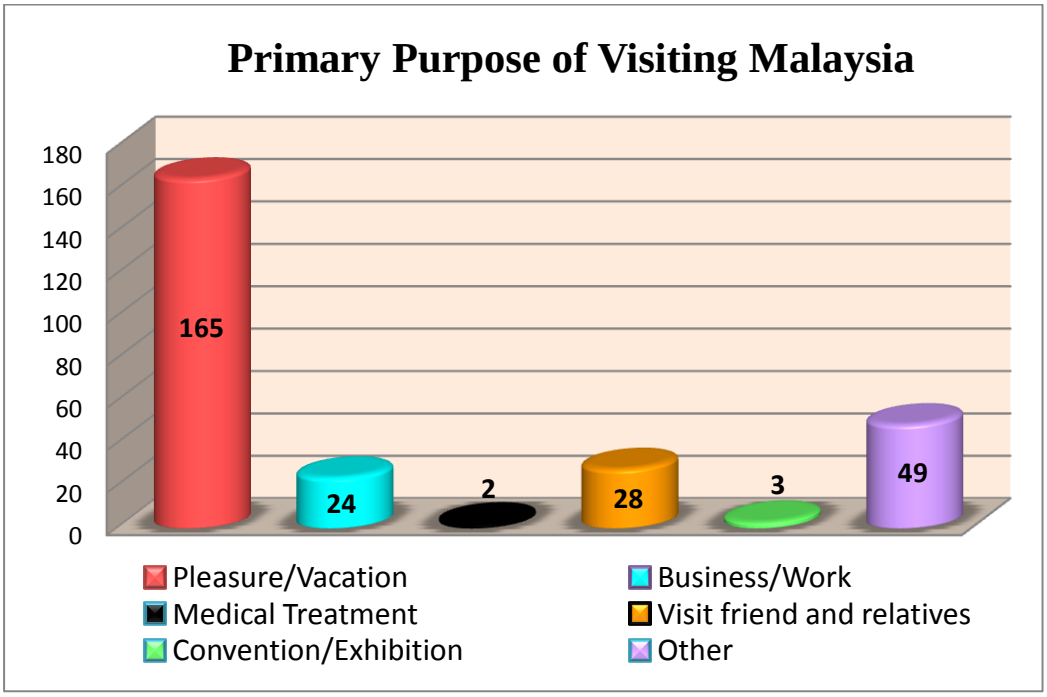
4.1.1.6 Primary Purpose of Visiting Malaysia

Table 4.6 Primary Purpose of Visiting Malaysia

Primary Purpose	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Pleasure/Vacation	165	60.9	165	60.9
Business/Work	24	8.9	189	69.8
Medical Treatment	2	0.7	191	70.5
Visit Friend and Relatives	28	10.3	219	80.8
Convention/Exhibition	3	1.1	222	81.9
Other	49	18.1	271	100
Total	**271**	**100**	**271**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.6 Primary Purpose of Visiting Malaysia



Source: Developed for the research

Table 4.6 and Figure 4.6 summarize the respondents' primary purpose in travelling Malaysia. Some of the respondents would choose more alternatives that applied to their situation. Therefore, the total number of answers is thus greater than the number of respondents. From the results shown, it is apparent that the majority of respondents were interested in pleasure or vacation, followed by visit friend and relatives, business work, and convention or exhibition. The least-reported alternative was medical treatment.

Throughout the country, the main areas of activities that Malaysia offers extensively in leisure and recreation tourism which involves entertainment, beach and island tourism, adventure and sports. Genting Highlands and the integrated resorts that around Kuala Lumpur like Mid-valley Megamall, Sunway Lagoon Resort, and Mines Wonderland and Resort have offered a variety of chances

for urban tourism activities like shopping and entertainment. The beach and island destination like Pangkor Islands, Langkawi, Pulau Tioman are the example of coastal tourism in Malaysia and the adventure activities include rafting, snorkeling, scuba diving and caving (Sudipta, Sarat & Babu, 2010).

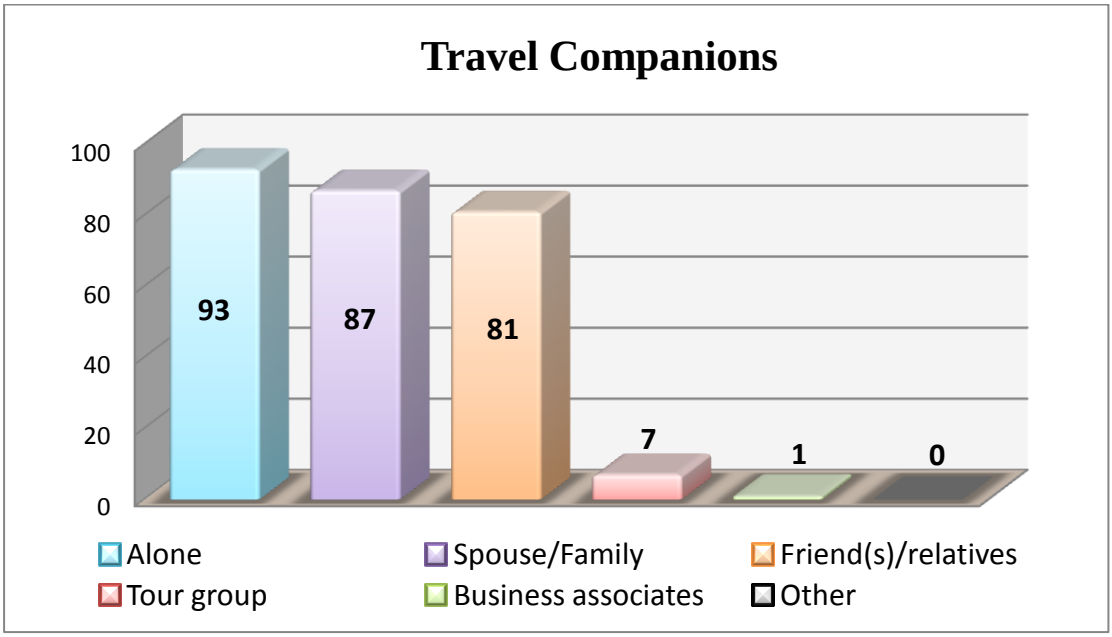
4.1.1.7 Travel Companions

Table 4.7 Travel Companions

Travel Companions	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Alone	93	34.6	93	34.6
Spouse/Family	87	32.3	180	66.9
Friend(s)/relatives	81	30.1	261	97
Tour group	7	2.6	268	99.6
Business associates	1	0.4	269	100
Other	0	0	269	100
Total	**269**	**100**	**269**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.7 Travel Companions



Source: Developed for the research

Table 4.7 and Figure 4.7 illustrate the travel companions by the respondents travel in Malaysia. From the results, the total number of answers is greater than the number of respondents since there are some respondents chose one or more options as their choices. Researchers found that most respondents travel to Malaysia alone, which consists of 93 respondents (34.6%). There are total 87 respondents (32.3%) who travel to Malaysia with companions comprising Spouse or family, thus followed by friends or relatives, which has 81 respondents (30.1%). Subsequently, there are fewer respondents who travel to Malaysia with companions Tour group and business associates.

Sometimes, travelling alone has its own benefits like they can get to set their own pace, meet new friends more easily and also have more direct contact with foreign cultures ("Her Own Way A Woman's safe-travel guide," n.d.). Haltiwanger (2015) stated that travelling alone helps to reduce stress and increase self-awareness.

Furthermore, individual excursion helps in broadening our perspectives while also making us more keenly aware of our idiosyncrasies and vulnerabilities.

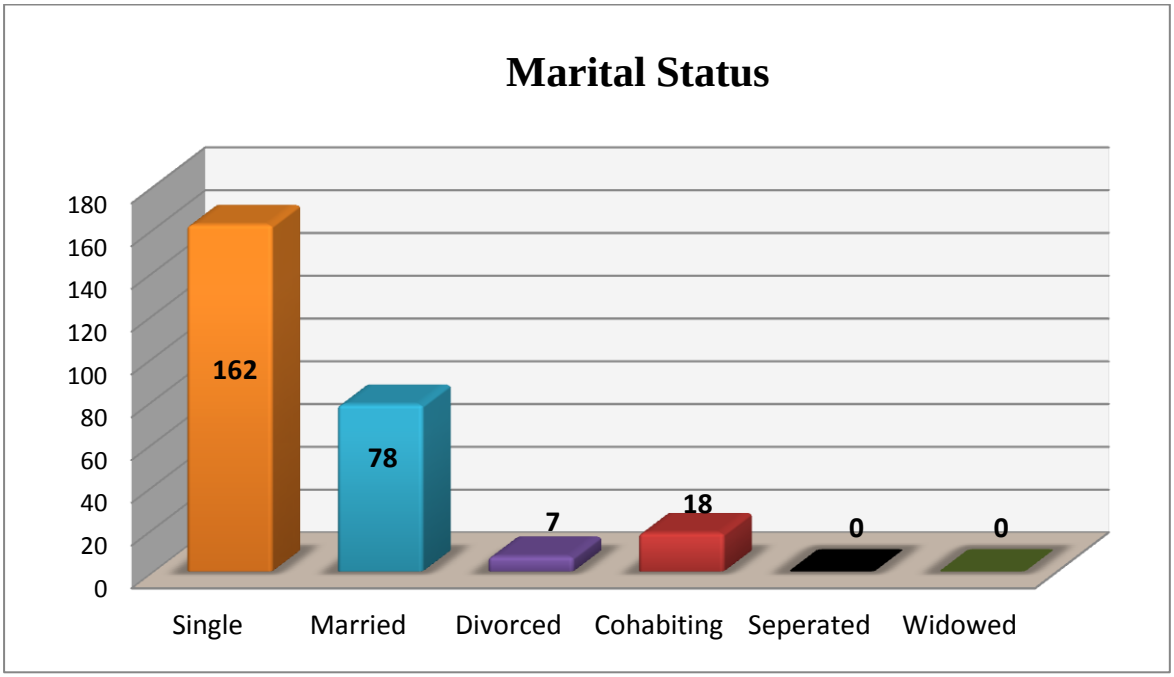
4.1.1.8 Marital Status

Table 4.8 Marital Status

Marital Status	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Single	162	61.1	162	61.1
Married	78	29.4	240	90.5
Divorced	7	2.7	247	93.2
Cohabiting	18	6.8	265	100
Seperated	0	0	265	100
Widowed	0	0	265	100
Total	**265**	**100**	**265**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.8 Marital Status



Source: Developed for the research

Table 4.8 and Figure 4.8 demonstrate the marital status of the respondents. According to collected data, single respondents represented the largest group (162), followed by married respondents (78), cohabiting (18) and divorced respondents (7).

From the results, single respondents prefer travelling since there are certain awesome chances that present themselves to solo travel, including opportunity for growth, self-discovery and awesome freedom (Lee, 2011). For instance, they like setting their own schedule, wandering aimlessly and listening to their own needs without worrying about anyone else (Steph, 2015).

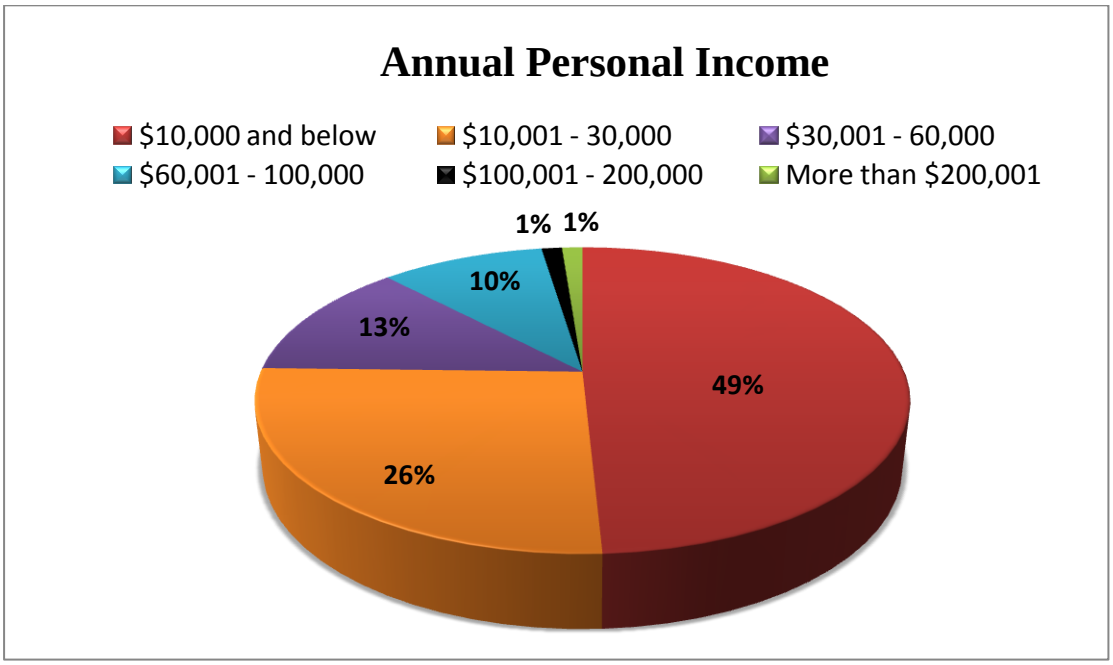
4.1.1.9 Annual Personal Income

Table 4.9 Annual Personal Income

Annual Personal Income	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
$10,000 and below	122	49.2	122	49.2
$10,001 – 30,000	65	26.2	187	75.4
$30,001 – 60,000	31	12.5	218	87.9
$60,001 – 100,000	24	9.7	242	97.6
$100,001 – 200,000	3	1.2	245	98.8
More than $200,001	3	1.2	248	100
Total	**248**	**100**	**248**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.9 Annual Personal Income



Source: Developed for the research

Table 4.9 and Figure 4.9 show the frequency and percentage of the annual personal income of 248 respondents since the remaining of 17 respondents not willing to disclose their annual income details.

In determining the annual personal income of the tourists group, it is revealing that most respondents (approximately 75% in all) were in either the lower socio-economic stratum (with 49% of respondents earning <USD$10,000) or the lower-middle socio-economic stratum (with 26% earning USD$10,001-30,000 annually). Next, it is followed by the band range of "USD$30,001-60,000" and "USD$60,001-100,000) which account for 13% and 10% respectively. Subsequently, it is followed by the band range "USD$100,001-200,000" and >$200,001" which have the same percentage 1%.

Chiu, Ramli, Yusof and Ting (2015) studied and examined that students have high interest in travelling even though they have relatively low income, where those students relied mainly on student loans (PTPTN) and scholarship to fund their travelling activities. Young travellers are actively involved in the Malaysia tourism activities and they are willing to spend a big fraction of their money on entertainment and recreation.

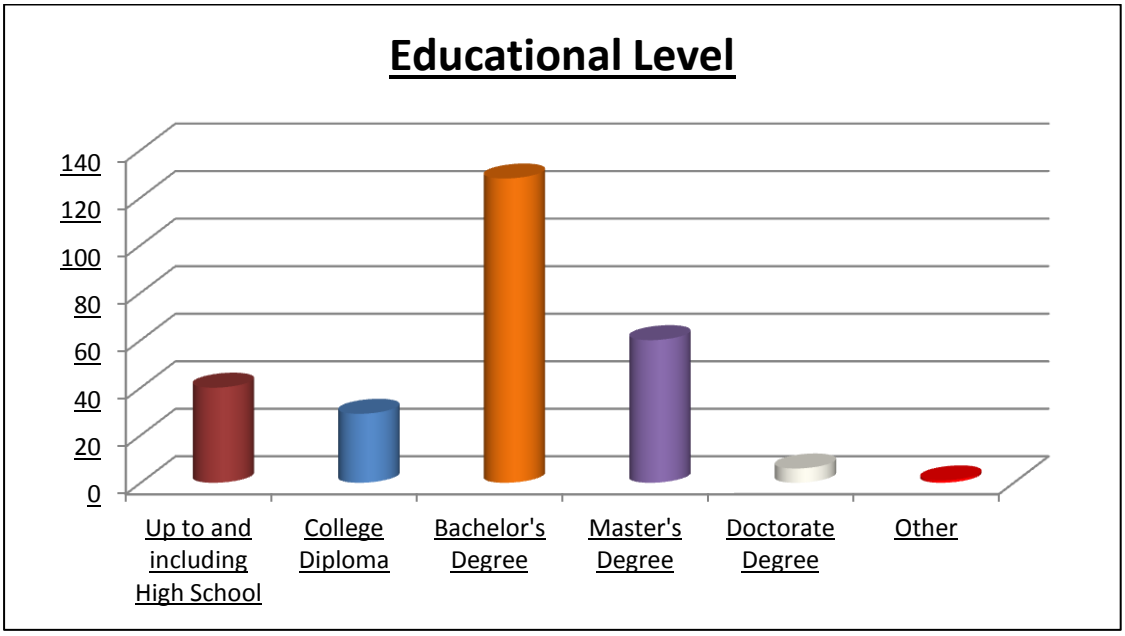
4.1.1.10 Educational Level

Table 4.10 Educational Level

Educational Level	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Up to and including High School	40	15.2	40	15.2
College Diploma	29	11.0	69	26.1
Bachelor's Degree	128	48.5	197	74.6
Master's Degree	60	22.7	257	97.3
Doctorate Degree	6	2.3	263	99.6
Other	1	0.4	264	100.0
Total	**264**	**100**	**264**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.10 Educational Level



Source: Developed for the research

Among the options of educational qualifications, most of our respondents are bachelor's degree holders, followed by master's degree holders. According to the report, bachelor's degree holders earn more than college diploma holders, who has $1.55 million in lifetime earnings, or a high school diploma holder who has about $1.30 million lifetime, indicating that no matter the field of study. Bachelor's degree holders earn about $2.27 million over the lifetime, while master's degree holders earn $2.67 million lifetime (Burnsed, 2011). This shows that higher educated people have more capacity while going for vacation overseas.

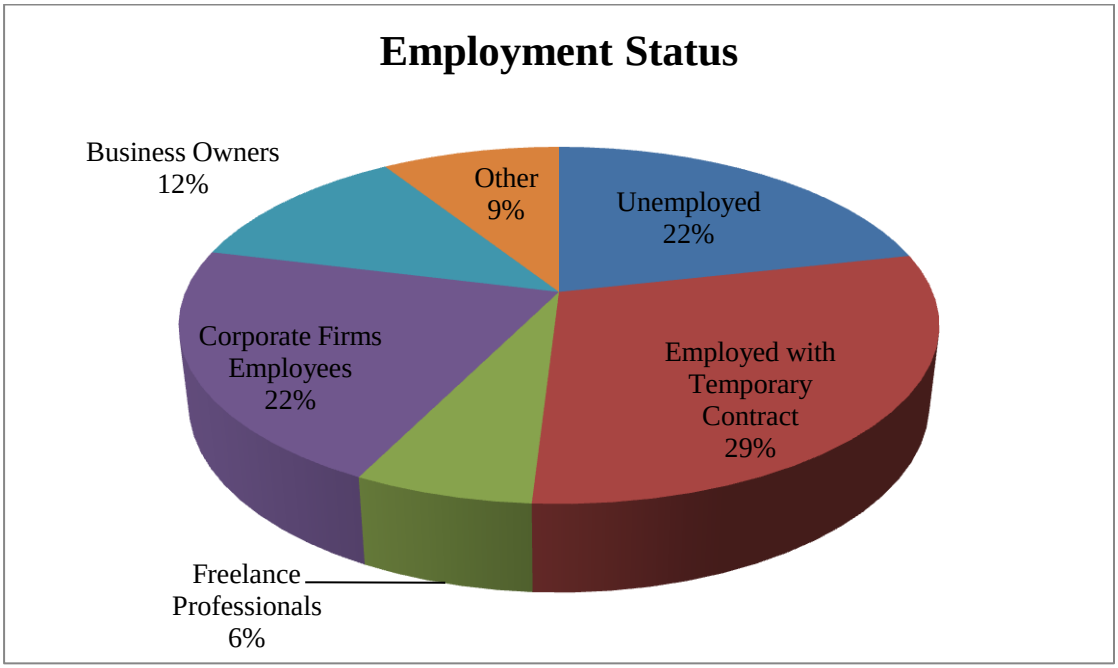
4.1.1.11 Employment Status

Table 4.11 Employment Status

Employment Status	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Unemployed	57	21.5	57	21.5
Employed with Temporary Contract	78	29.4	135	50.9
Freelance Professionals	17	6.4	152	57.4
Corporate Firms Employees	57	21.5	209	78.9
Business Owners	32	12.1	241	90.9
Other	24	9.1	265	100.0
Total	**265**	**100**	**265**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.11 Employment Status



Source: Developed for the research

From the result, respondents who are employed with temporary contract occupied largest portion. There are 15 students who stated that they are still studying without employment, 1 works on volunteering job, 2 retirees, 1 works as civil servant, and 5 of the respondents did not disclose their occupations. Comparing part-timer and full-timer, part time workers might have more time to go for vacation than full time workers, and they can travel for longer period in other countries.

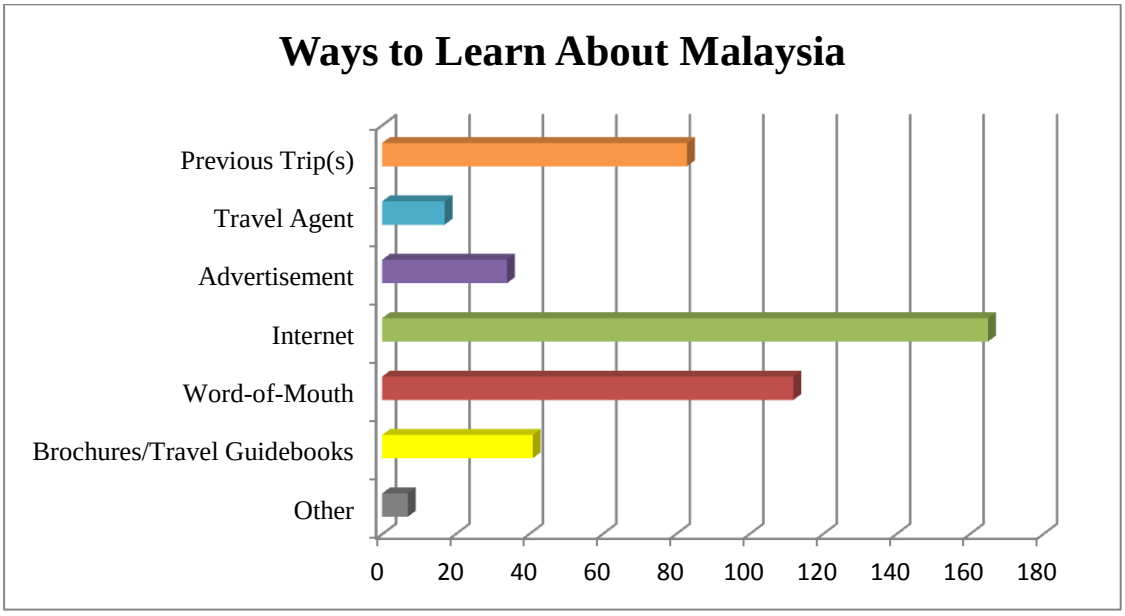
4.1.1.12 Ways to Learn About Malaysia

Table 4.12 Ways to Learn About Malaysia

Ways to Learn About Malaysia	Frequency	Percentage	Cumulative Frequency	Cumulative Percentage
Previous Trip(s)	83	18.1	83	18.1
Travel Agent	17	3.7	100	21.8
Advertisement	34	7.4	134	29.2
Internet	165	35.9	299	65.1
Word-of-Mouth	112	24.4	411	89.5
Brochures/Travel Guidebooks	41	8.9	452	98.5
Other	7	1.5	459	100.0
Total	**459**	**100**	**459**	**100**

Source: Developed from SAS Enterprise Guide 5.1

Figure 4.12 Ways to Learn About Malaysia



Source: Developed for the research

Respondents are entitled to choose more than one option in this question. From the data we collected, we found that most of the respondents learn about Malaysia through internet, as the advanced technology allows them to view the information about Malaysia anytime. There are 2 respondents stated that they learn about Malaysia through business connections, and 5 of the respondents did not disclose any information about this question.

4.1.2 Central Tendencies Measurement of Constructs

Table 4.13 Central Tendencies Measurement

Variable	N	Min	Max	Mean	Standard Deviation
Perceived Severity	265	1.40	5.00	3.40679	0.71145
Perceived Vulnerability	265	1.40	5.00	3.24906	0.68058
Self-efficacy	265	1.00	5.00	3.30189	0.66558
Response Efficacy	265	1.00	5.00	3.60604	0.62979
Intention	265	1.00	5.00	3.00896	0.86649

Source: Developed for the research

Based on the Table 4.13, the variable that has the highest average score (mean) is the independent variable, response efficacy which is 3.60604 with the standard deviation of 0.62979. Perceived severity is the second highest of mean (3.40679) with the standard deviation of 0.71145. Self-efficacy is the third highest value of mean (3.30189) with the standard deviation of 0.62979. The fourth highest mean score is perceived vulnerability variable (3.24906) with the standard deviation of 0.68058. The dependent variable (intention) consists of 3.00896 for the lowest mean score and 0.86649 for standard deviation.

4.2 Scale Measurement

In this part, researchers conduct again the reliability analysis with the total sample size of 265 respondents. Reliability analysis is important as it used to measure the consistency of a set of items correlated with each other. By using SAS software, reliability of the independent variable (perceived severity, perceived vulnerability, self-efficacy and response efficacy) and dependent variable (intention) are evaluated in order to ensure that all the data collected are adequate for hypothesis testing. Below is the summary table of the reliability statistic of all the variables.

4.2.1 Reliability Analysis

Table 4.14 Reliability Statistic

No.	Dimensions	Number of Items	Cronbach's Alpha
1	Perceived Severity	5	0.699922
2	Perceived Vulnerability	5	0.713937
3	Self-efficacy	7	0.822846
4	Response Efficacy	5	0.758646
5	Intention	8	0.930365

Source: Developed for the research

Based on table 4.14, it illustrates that all variables used are reliable. Self-efficacy (0.822846) and dependent variable of intention (0.930365) are fall under Cronbach's Alpha range as very good reliability. On the other hand, the reliability of perceived severity (0.699922) is considered as fair while perceived vulnerability (0.713937) and response efficacy (0.758646) are considered good reliability.

4.3 Inferential Analyses

4.3.1 Pearson Correlation Coefficient Analysis

As mentioned in Chapter 3, Pearson Correlation Coefficient indicates the direction, strength and significance among two variables by using the "Rules of Pearson Correlation Coefficient Alpha" (shown in).

Table 4.15 Pearson Correlation Coefficient Analysis

Pearson Correlation Coefficient, N=265 **Prob > |r| under H0: Rho=0**				
	PS	**PV**	**SE**	**RE**
INT	0.22955 0.0002	0.22695 0.0002	0.33272 <.0001	0.45959 <.0001

Note: INT = Intention; PS = Perceived Severity; PV = Perceived Vulnerability; SE = Self-efficacy; RE = Response Efficacy

Source: Developed for the research

4.3.1.1 Perceived Severity and Intention

H_1: There is a significant relationship between perceived severity and foreign tourists' intention.

According to Table 4.15, there is a positive relationship between perceived severity and intention, due to the positive value of correlation coefficient (0.22955). Therefore, when respondents perceived that the health threat is serious for them, their intention of undertaking healthcare services in Malaysia is high. Besides, the

value of the correlation coefficient is 0.22955, which falls under the coefficient range from ±0.21 to ±0.40. This indicates that the relationship between perceived severity and intention is small but definite relationship. The relationship between these two variables is significant, as the p-value 0.0002 is less than alpha value 0.05.

4.3.1.2 Perceived Vulnerability and Intention

H_2: There is a significant relationship between perceived vulnerability and foreign tourists' intention.

From the result, there is a positive relationship between perceived vulnerability and intention because of the positive value of correlation coefficient. The perceived vulnerability variable has a 0.22695 correlation with the intention variable. Thus, when respondents feel vulnerable to a health threat, their intention to obtain healthcare services in Malaysia will be increased. The value of this correlation coefficient 0.22695 is fall under coefficient range from ±0.21 to ±0.40. Therefore, the relationship between perceived vulnerability and intention is small but definite relationship. Next, the relationship between perceived vulnerability and intention is significant. It is because the p-value 0.0002 is less than the alpha value 0.05.

4.3.1.3 Self-efficacy and Intention

H_3: There is a significant relationship between self-efficacy and foreign tourists' intention.

Since the value of correlation coefficient is positive (0.33272), there is a positive relationship between self-efficacy and intention. Hence, when respondents know how to seek for advice about

health tourism in Malaysia, they will have high intention to pursue it. The value of 0.33272 falls under coefficient range from ±0.21 to ±0.40. This indicates that the relationship between self-efficacy and intention is small but definite relationship. The p-value is less than 0.0001, which also less than alpha value 0.05. Therefore, the relationship between self-efficacy and intention is significant.

4.3.1.4 Response Efficacy and Intention

H_4: There is a significant relationship between response efficacy and foreign tourists' intention.

The positive value of correlation coefficient shows that the relationship between response efficacy and intention is positive. The response efficacy variable has a 0.45959 correlation with the intention variable. Thus, when respondents perceive that health tourism is useful to them, they will have high intention to undertake healthcare services in Malaysia. The value of this correlation coefficient (0.45959) falls under the coefficient range from ±0.41 to ±0.70. This shows that the relationship between response efficacy and intention is moderate. In addition, the relationship between response efficacy and intention is significant, as the p-value (<.0001) is less than the alpha value 0.05.

4.3.2 Multiple Regression Analysis

Table 4.16 Analysis of Variance

Source	DF	Sum of Squares	Mean Square	F Value	Pr > F
Model	4	54.72107	13.68027	24.79	<.0001
Error	260	143.49202	0.55189		
Corrected Total	264	198.21309			
Root MSE	0.74289		**R-Square**	0.2761	
Dependent Mean	3.00896		**Adj R-Sq**	0.2649	
Coeff Var	24.68940				

Source: Developed for the research

Based on Table 4.16, the p-value (Pr > F) is less than 0.0001, which is less than the alpha value of 0.05. This explains that the F-statistic is significant, the model for this study is a good descriptor of the relation between the independent variables and dependent variable. Therefore, all the independent variables are significant to explain the variance in dependent variable. The alternate hypothesis is supported by the data. R-square represents the percentage the independent variables can explain the variations in dependent variable. From the result, the independent variables can explain 27.61% of the variations in dependent variable.

Table 4.17 Parameter Estimates

Variable	DF	Parameter Estimate	Standard Error	t Value	Pr > |t|
Intercept	1	-0.46189	0.36586	-1.26	0.2079
PS	1	0.12367	0.07727	1.60	0.1107
PV	1	0.13254	0.08009	1.65	0.0992
SE	1	0.26765	0.07350	3.64	0.0003
RE	1	0.48118	0.07943	6.06	<.0001

Source: Developed for the research

In this study, perceived severity is not significant to predict intention of foreign tourists to undertake healthcare services in Malaysia. This is because p-value for perceived severity is 0.1107, which is more than the alpha value (0.05). Perceived vulnerability has a p-value of 0.0992, this indicates that this variable is not significant to predict intention, as it is more than the alpha value of 0.05. Next, self-efficacy is significant to predict intention, due to the p-value (0.0003) which is less than alpha value of 0.05. Response efficacy is also significant to predict tourists' intention, since the p-value is less than 0.0001, which is also less than alpha value of 0.05.

Regression Equation:

$Y = a + b1 (x1) + b2 (x2) + b3 (x3) + b4 (x4) + e$

By substituting the result collected:

Y = Intention
a = constant
x1 = PS
x2 = PV
x3 = SE
x4 = RE
b = regression of coefficient of x_i
$_i$=1, 2, 3, ...
e = an error term, normally distributed of mean 0 (assumes e = 0)

Intention = -0.46189 + 0.12367 (PS) + 0.13254 (PV) + 0.26765 (SE) + 0.48118 (RE)

From the equation above, response efficacy is the predictor variable that contribute the highest to the variation of the dependent variable because the value of parameter estimate for this predictor variable is the largest (0.48118) if compare to other predictor variables. This indicates that

response efficacy makes the strongest unique contribution to explain the variation in dependent variable, when the variance explained by all other predictor variables in the model is controlled for. The variable that contributes the second highest to the variation of dependent variable is self-efficacy. The parameter estimate value of self-efficacy is 0.26765, which is the second largest among the variables. This means that self-efficacy makes the second strongest unique contribution to explain the variation in dependent variable when the variance explained by all the other variables in the model is controlled for. Next, perceived severity is the variable with least contribution to the variation of dependent variable as the value of parameter estimate is the smallest among the variables, which is only 0.12367.

4.4 Conclusion

In this chapter, there are three analysis have been done which including descriptive analysis, reliability analysis and inferential analysis. In descriptive analysis, the demographic profiles of 265 respondents have been analyzed and presented in the table forms, such as origin country, age, gender, religion, visitation period, purpose, travel companions, marital status, annual personal income, education level, employment status and ways that learnt about Malaysia. Reliability analysis is also conducted on all studied variables with the sample size of 265. Furthermore, inferential analysis also carried out to test the assumptions that previously formed. From the result shown, most of the hypothesis alternates are being accepted. However, when testing the Multiple Regression effect of the variables, perceived severity and perceived vulnerability independent variables is found not significant to predict the dependent variable (intention). Only the response efficacy and self-efficacy is found to be the predictor variables that contribute the highest to the variation of dependent variable. In the following Chapter 5, it will provide the justification and discussion of the finding on the results gained in this chapter.

CHAPTER 5: DISCUSSION AND CONCLUSION

5.0 Introduction

In this chapter, a summary of statistical analysis will be discussed which include the data interpretation on both descriptive and inferential analysis from the data collected through our field survey. The chapter is continued with the discussion on the implications of the study and some limitations and recommendations for future research.

5.1 Summary of Statistical Analyses

5.1.1 Descriptive Analysis

Table 5.1 Summary of Descriptive Analysis

Variables	Frequency	Percentage
Country of origin		
Asia	90	34.3
Africa	15	5.8
North America	12	4.5
South America	5	2
Europe	97	36.9
Australia / New Zealand	46	17.3
Gender		
Male	149	56.2
Female	116	43.8

Table 5.1 Summary of Descriptive Analysis (Continued)

Variables	Frequency	Percentage
Age groups		
18-30 years old	182	68.7
31-40 years old	52	19.6
41-50 years old	21	7.9
51-60 years old	6	2.3
61-70 years old	4	1.5
71 years old and above	0	0
Religions		
Muslims	42	15.9
Christians	97	36.6
Buddhists	17	6.4
Hindus	20	7.5
Jews	0	0
Folk Religions	0	0
Unaffiliated	75	28.3
Other	14	5.3
Travelling period		
Less than 24 hours	43	16.2
More than one day	95	35.9
More than one week	70	26.4
More than one month	27	10.2
More than one year	30	11.3
Visiting Purpose		
Pleasure/Vacation	165	60.9
Business/Work	24	8.9
Medical Treatment	2	0.7
Visit friend and relatives	28	10.3
Convention/Exhibition	3	1.1
Other	49	18.1
Travel companions		
Alone	93	34.6
Spouse/Family	87	32.3
Friend(s)/relatives	81	30.1
Tour group	7	2.6
Business associates	1	0.4
Other	0	0

Table 5.1 Summary of Descriptive Analysis (Continued)

Variables	Frequency	Percentage
Marital status		
Single	162	61.1
Married	78	29.4
Divorced	7	2.7
Cohabiting	18	6.8
Separated	0	0
Widowed	0	0
Personal Income		
$10,000 and below	122	49.2
$10,001 – 30,000	65	26.2
$30,001 – 60,000	31	12.5
$60,001 – 100,000	24	9.7
$100,001 – 200,000	3	1.2
More than $ 200,000	3	1.2
Educational level		
Up to and including High School	40	15.2
College Diploma	29	11.0
Bachelor's Degree	128	48.5
Master's Degree	60	22.7
Doctorate Degree	6	2.3
Other	1	0.4
Employment status		
Unemployed	57	21.5
Employed with temporary contract	78	29.4
Freelance professionals	17	6.4
Corporate firms employees	57	21.5
Business owners	32	12.1
Other	24	9.1

Table 5.1 Summary of Descriptive Analysis (Continued)

Variables	Frequency	Percentage
Ways to learn about Malaysia		
Previous trip(s)	83	18.1
Travel agent	17	3.7
Advertisement	34	7.4
Internet	165	35.9
Word-of-mouth	112	24.4
Brochures/travel guidebooks	41	8.9
Other	7	1.5

Source: Developed for the research

Table 5.1 displayed the demographic information of the respondents in present research. Based on the data collected, male respondents are more than female respondents with reported percentage of 56.2% and 43.8% respectively. The majority of respondents were between 18 and 30 years old which accounted for 68.7% of our data and over 61% of the respondents are single. Over 49% of our respondents receive $10,000 or below annual personal income, whereas respondents' employment status varied among unemployed, employed with temporary contract and corporate firm employees with reported figures of more than 20% respectively. The sample is considered well educated with 73.5% having at least a university degree. In terms of respondents' travelling information, majority of them (60.9%) visit Malaysia for pleasure or vacation purpose, while their travelling companions distributed sequentially: alone (34.6%), spouse/family (32.3%), and friends (30.1%). Finally, Internet and word-of-mouth together accounted for more than 50%, which is 35.9% and 24.4% respectively, in terms of their ways to learn about Malaysia.

5.1.2 Scale Measurement

Table 5.2: Summary of Reliability Test Result

No.	Dimensions	Cronbach's Alpha	Reliability
1	Perceived Severity	0.699922	Fair
2	Perceived Vulnerability	0.713937	Good
3	Self-efficacy	0.822846	Very Good
4	Response Efficacy	0.758646	Good
5	Intention	0.930365	Very Good

Source: Developed for the research

The independent variables and dependent variable in the present study reported strength of reliability ranges from fair reliability to very good reliability. The 5 items that supposed to measure perceived vulnerability and response efficacy generated good reliability with Cronbach's Alpha of 0.71 and 0.76 respectively. Meanwhile, perceived severity received fair reliability with 5 items under the variable being measured. Self-efficacy and intention loaded a very good reliability which indicates that they produce identical results when conditions are consistent.

5.1.3 Inferential Analysis

5.1.3.1 Pearson Correlation Coefficient

Table 5.3: Summary of Pearson Correlation Coefficient Result

		Perceived Severity	Perceived Vulnerability	Self-efficacy	Response Efficacy
Intention	Pearson Correlation	0.22955	0.22695	0.33272	0.45959
	Sig. (2-tailed)	0.0002	0.0002	<.0001	<.0001
	N	265	265	265	265

Source: Developed for the research

The table has indicated that the intention (INT) is significantly related with perceived severity (PS), perceived vulnerability (PV), self-efficacy (SE) and response efficacy (RE). The significant values for PS, PV, SE and RE were indicated 0.0002, 0.0002, <.0001 and <.0001 respectively. The result indicated that the PS, PV, SE and RE were significant and positively related with INT, which the significant values are less than alpha value 0.05.

5.1.3.2 Multiple Regression Analysis

Table 5.4: Summary of Multiple Regression Analysis Result

Variable	Parameter Estimate	Pr > |t|	R-Square
Intercept	-0.46189	0.2079	
PS	0.12367	0.1107	
PV	0.13254	0.0992	0.2761
SE	0.26765	0.0003	
RE	0.48118	<.0001	

Source: Developed for the research

Multiple regressions were performed to determine the power of prediction of the proposed framework. Parameter estimates were deployed to assess the contribution of predictors relative to the dependent variable. R-Square is used to assess the total percentage of variance explained in the dependent variable which shows the research model's prediction power. The independent variables can explain 27.61% of the variations in dependent variable. All predictors, except perceived severity and perceived vulnerability, have a positive effect toward health tourism intention. Response efficacy was found to be the most influential predictor of health tourism intention (parameter estimate=0.48118) followed by self-efficacy (parameter estimate=0.26765). Perceived severity and perceived vulnerability did not significantly predict health tourism intention (p=0.1107 and p=0.0992, respectively). Hypotheses 3 and 4 are supported in the Multiple Regression Analysis, but hypotheses 1 and 2 are not supported.

5.2 Discussion of Major Findings

This study investigated the impact of four independent variables in relation to foreign tourists' intention on health tourism in Malaysia. A sample of 265 foreign tourists completed questionnaire relevant to their perception of severity and vulnerability to a health threat, response efficacy and self-efficacy, as well as their intention to undertake health tourism in Malaysia. The results showed a positive correlation between each of the independent variable (PS, PV, SE and RE) and dependent variable, the foreign tourists' intention. Multiple Linear Regression models were employed to further evaluate the connection between independent and dependent variable. The results demonstrated that both SE and RE are significant predictors of foreign tourists' intention to undertake healthcare services in Malaysia.

Table 5.5: Summary of Findings

Hypotheses	Result	Supported
H_1: There is a significant relationship between perceived severity and foreign tourists' intention.	r=0.22955 p=0.0002 ($p < 0.05$)	Yes
H_2: There is a significant relationship between perceived vulnerability and foreign tourists' intention.	r=0.22695 p=0.0002 ($p < 0.05$)	Yes
H_3: There is a significant relationship between self-efficacy and foreign tourists' intention.	r=0.33272 p=<.0001 ($p < 0.05$)	Yes
H_4: There is a significant relationship between response efficacy and foreign tourists' intention.	r=0.45959 p=<.0001 ($p < 0.05$)	Yes

Source: Developed for the research

Major Finding 1: All of the predicting variables (Perceived Severity, Perceived Vulnerability, Self-efficacy, and Response Efficacy) were found to be significantly and positively correlated with intention at different strengths.

Based on our research finding, foreign tourists' perceived health threat's severity has small but definite positive effects on their intention to undertake health tourism in Malaysia. The more severe an individual experienced as a result of his or her health condition, the more possible that they are to express greater intentions to receive healthcare services in Malaysia. This finding matches the research carried out by Miao (2014) where food safety is communicated among college students, they are more likely to purchase product that comes with safety label. The studies in other field using the Protection Motivation Theory also revealed a positively correlated relationship between perceived severity and intention (Chamberlain et al., 2015; Esteves-Jaramillo et al., 2009; Bockarjova & Steg, 2014). When the perception of threat exists, people adjust how they behave according to the level of severity they recognize (Grothmann & Reusswig, 2006). When perceived severity is diminished, people tend to act in a less cautious way, just as people would reduce the use of seatbelts when they drive to a close location or at lower speeds (Dorn & Brown, 2003).

Perceived vulnerability was also found to have small but definite positive relationship towards foreign tourists' intention to have healthcare services carried out in Malaysia. The more vulnerable an individual perceived himself to be in relation to a health threat, the more likely he is to engage in health tourism in Malaysia. Past research of Protection Motivation Theory in cervical cancer and skin cancer also elicited similar results in which perceived vulnerability is positively correlated with the intention to engage in protective behaviour (Mermelstein & Riesenberg, 1992; Balbo, 2010; Russell, 2002; Bingham et al., 2003). Similar findings have been reported by Norman et al. (1999) whereby the intention to quit smoking is low when perceived vulnerable to the negative impacts of smoking is low. The significant positive relationship between the perception of vulnerability and intention was also found in the Milne et al. (2000) meta-analysis which proposed that vulnerability perception determines protective

behaviour. People tend to behave in a healthy manner when there is increase in perceptions of vulnerability (Gochman, 1997).

Self-efficacy was found to be positively correlated with foreign tourists' intention toward health tourism in Malaysia. When they believe that they are capable of receiving healthcare services in Malaysia, they are more likely to carry out such activities. Past research on sexual behaviour, cancer-related preventive behaviour, medical adherence behaviour and health behaviour also generated similar positively correlated result between individuals' perceived self-efficacy and their intention to adopt preventive behaviours (Aspinwall et al., 1991; Orbell & Sheeran, 1998; Rudman et al., 1999; Plotnikoff & Higginbottom, 1998). The more an individual's self-efficacy or own capability is perceived, the more health-promoting habits are to be expected as a result of reducing health-damaging habits (Bandura, 1994). Individuals with low self-efficacy are less likely to approach unfamiliar situation with anxiety or to avoid them entirely (Jensen, 2012).

From our findings, response efficacy has the greatest positively correlated strength (r=0.45959) with intention amongst the four independent variables. With this positive correlation, people who believe having healthcare services being undertaken in Malaysia is effective in overcome their health issues are more likely to have such activity pursued. The role of response efficacy has been proved to be of great support in the studies relating to health behaviours (Moriarty, 2009). Past research in other fields such as smoking cessation and prevention of cancer yield similar result in which response efficacy was related to behavioural intentions (Floyd et al., 2000). A number of studies have proved the positive relationship between response efficacy and intention. For example, response efficacy was found to positively influence the intention to embrace anti-malware software among executives (Lee & Larsen, 2009).

Major finding 2: In the proposed framework, self-efficacy and response efficacy were found to be significant predictor of intention, while perceived severity and perceived vulnerability were insignificant.

In Multiple Linear Regression, amongst the sample collected from foreign tourists, response efficacy (parameter estimate=0.48) appeared to be the best single predictor of their intention to received healthcare services in Malaysia, followed by self-efficacy (parameter estimate=0.27) which reported to be the predictor variable that provides second highest contribution to the intention of foreign tourists. However, perceived severity and vulnerability were not significant predictors of intention in this study. These results differ from previous researches which found them to be significant predictors and work together to affect action intention (Courneya & Hellsten, 2001; McGowan & Prapavessis, 2010; Plotnikoff et al., 2009; Beck 1984). The research outcomes of Tulloch et al. (2009) also reported that threat and coping appraisal in Protection Motivation Theory collaborate to influence behavioural intention. The present study matches the research of Ritland and Rodriquez (2014) about the intention to eat healthily and exercise among American, where self-efficacy and response efficacy appeared to be better in predicting behavioural intention than the perception of severity and vulnerability.

The contradict results of the perceptions of severity and vulnerability toward intention might be accredited to the samples used. In this study, distinct subgroups of respondents might exist. For some, the greater the perception of severity might lead to decline in motivation to undertake the recommended behaviour, possibly because they feel stressed or uncertain when encounter life-threatening disease. For others, they believe having their behaviour changed can refine their illness or perhaps assist them to keep away from diseases, thus elicit greater motivation as a result of greater severity. When this happens, the outcome of the research could have been 'washed out' (Weinstein, 2000).

Severity construct measured how seriously the participant takes the health threats. In this study, over 68% of the participants were between 18 to 30 years old. People in this age group have fewer health problems (Ross & Wu, 1996), which may lead to lower tendency to protect ones health through diet than those in older age groups. Moreover, young people always lack the knowledge and awareness of the threat related to risky behaviours, as well as the necessary skills to protect

themselves against any harm or to search help about their health concerns (Chown et al., 2008).

Based on the findings, instead of focusing the adverse consequences (severity) and risk aspects (vulnerability), healthcare practitioners should emphasise the well-being of carrying out healthy behaviours (response efficacy), undertaking healthcare services in Malaysia in the present context, as well as foreign tourists' capabilities of performing such actions (self-efficacy).

5.3 Implication of the Study

5.3.1 Academician Implications

Many academic studies on health tourism have been discussed in past research. However, empirical research on intention thus far and given limited academic literature available in this area. This research attempts to measure intention by adopting four variables from a number of health related theories. The variables are perceived severity, perceived vulnerability, self-efficacy and response efficacy and this study tends to apply behavioural studies into a new context. The selected variables have been adopted from Protection Motivation Theory (PMT), Theory of Planned Behaviour (TPB) and Health Belief Model (HBM) framework and have been proved to be significance to intention studies.

According to PMT and HBM, perceived severity and perceived vulnerability are having significance relationship with intention (Norman, Boer, & Seydel, 2005). Thus, it is worth investigating the causal relationship between these two variables and intention. On the other hand, efficacy is proven as the predictor and makes greater contribution to the prediction of intention in TPB (Armitage & Conner, 1999; Ajzen, 1991; Giles, Mcclenahan, Caims, & Mallet, 2004).

From this study, we know that two of our variables (self-efficacy and response efficacy) are significant to predict intention while the other two (perceived severity and perceived vulnerability) are insignificant. As a result, in order to have a better measurement of intention, future researchers are recommended to go beyond this research studies. Future researchers are encouraged to extend the independent variables by integrating more health-related theories such as learning theories and social support theories to enhance the prediction of intention. This approach is likely to ensure a stable theoretical development. Lastly, this study provides an initial blueprint to develop further understanding of these causal relationships.

5.3.2 Managerial Implications

The result of this empirical study provides sufficient evidence that the four independent variables are closely related with foreign tourists' intention on health tourism in Malaysia. It is notable that the strongest result generated for response efficacy should be useful for decision makers in implementing relevant strategies. For instances, the MHTC should take advantage of the offices set up in Dhaka, Jakarta, and Hong Kong to show its ability in providing quality healthcare services to foreigners. Instead of focusing on promoting and advertising, the public-private partnership body could extend their marketing strategies by partner-up with the local tourism or government body to refer their patients to Malaysia for healthcare services. Such practices could enable medical practitioners in Malaysia to extend the healthcare services for those countries where medical infrastructure are limited and at the same time building good affiliations with the foreign country. Example of two countries that performing such approach are: (1) Fiji has long been referring the patients to India for treatment due to inexperienced medical professionals to handle breast cancer patients; (2) Nepal has spent about US$27 million to fund treatment abroad for its citizen because of underdeveloped health services.

This study also pointed out some important issues regarding awareness among foreign tourists towards the severity of health threat and importance of health tourism which have not been addressed by previous studies. We found out that the awareness of severity on health threats among foreign tourists is very low and that probably means they are not taking precaution to improve their health. It is suggested that Malaysia government to develop more advertising activities in foreign countries to increase health awareness and provide more information regarding to health tourism in Malaysia.

Previous studies have shown that the majority foreign tourists who undertake health tourism in Malaysia come from Singapore, India and Thailand. However, the present study found out that Australians contribute to the highest population in travelling to Malaysia. Therefore, new strategies that could attract and inspire high intention of Australian to undertake health tourism in Malaysia are suggested. For instance, relevant health agencies could offer family body check-up package with a distinct price to encourage foreign tourists to participate health tourism together with family members.

Furthermore, MHTC could set up a service counter providing simple and free check-up in airport to increase the chances of foreign tourists to receive healthcare services in Malaysia. Such services could be simple stress test as most of the people travel to Malaysia is for leisure and relaxation purpose. Upon completion of test, tourists could be recommended to visit tourist attractions that are helpful to their physical and mental well-being. Moreover, through word-of-mouth, people tend to share good experience with others. If they think that health tourism in Malaysia is good and reliable, it will attract more people to try out such healthcare services.

In summary, the result improves the managerial decision making on health tourism since it involves personal health and is relatively riskier compared to leisure tourism. Healthcare providers and relevant organisations could

utilize the result to form new marketing strategies. This study also indicates that word-of-mouth is more favourable than relying on improving the current promotional activities such as advertisement. Relevant healthcare providers also need to understand the intention and decision making process of foreign tourists to ensure they would choose Malaysia as their health tourism destination.

5.4 Limitations of the Study

5.4.1 Limited Sample Size and Insufficient Usable Data

The research focuses on the tourists' intention towards health tourism in Malaysia. As mentioned in Chapter 3, we distributed 500 questionnaires to foreign tourists in three locations in Malaysia which are Penang, Kuala Lumpur and Malacca. However, there are still foreign tourists in other states of Malaysia that we are not able to reach due to time constraint.

Moreover, only 265 out of 500 questionnaires that we have distributed are usable. The remaining 235 are not usable because the respondents did not fill up the questionnaires completely. As the research was only conducted in three locations, the sample size of this study may be insufficient to represent the total population of foreign tourists in Malaysia. Hence, it may influence the accuracy of the data in representing the entire population of foreign tourists in Malaysia.

5.4.2 Single Language Version Questionnaire

Another limitation in our study is that we only provided English version questionnaire for respondents. Our response rate was limited because there were some foreign tourists who do not understand English very well. For

instance, some of the Spaniards and Chinese respondents rejected to fill in the questionnaires due to language barrier. Hence, it limited the feedback from those respondents who are willing to cooperate with us but they are not able to express their intended responses.

5.4.3 Lengthy Time to Get Survey Permission

Although we had obtained approval letter from university that allowed us to conduct survey in public location, however, there were some restrictions for us to conduct survey in certain location. For example, we had limited time to proceed our survey as the process of getting approval from KLIA as well as Westlake International School was time consuming.

5.4.4 Financial Constraint

We also faced financial constraint in conducting our research. There were no token of appreciation given to respondents who take time to participate in answering the questionnaire as we do not have such budget to provide incentives for the respondents in order to achieve higher response rate.

5.4.5 Young Respondents' Perception towards Health Issues

One of the problems that affected our data accuracy was that most of the respondents are in the age range from 18 to 30. Since they are still young, they might not aware of their health conditions, so that their responses are not so justifiable in the health context. Most of them indicated that they never take any potential health issues into consideration. Therefore, they do not intend to go for health tourism in Malaysia.

As a conclusion, although there were some limitations, but it will not affect the result upon the completion of our study. The limitations can be improved in the future studies and served as a fundamental for future researchers to overcome the limitations.

5.5 Recommendations for Future Research

There are numerous of limitations being found out that would affect the reliability of this research. Therefore, we suggested some resolutions for future research.

First and foremost, the limitation that might affect the reliability of this research is the limited sample size and the sampling location. Sample size of 500 respondents and only three sampling locations (Kuala Lumpur, Melaka and Penang) are insufficient to represent the population of foreign tourists in Malaysia, since not all of the data collected are usable. Researchers should expand the survey by including more sampling locations across Malaysia and increase the sample size so that there is higher probability to get more usable data and to improve the reliability of the research.

Secondly, since our questionnaire is designed only in English language, future researchers are recommended to prepare questionnaire in different languages such as Malay, Mandarin, French as well as Spanish. By providing multi language version, it will definitely eliminate the communication barrier and increase the level of understanding on the survey questions to achieve higher response rate.

Apart from this, the time of getting permission to conduct our survey is lengthy and the procedure of application is complicated. Therefore, future researchers are recommended to have a proper planning to keep track on the survey activities and to ensure the data collection process can be done within scheduled time frame.

A problem with face-to-face distribution of questionnaires is that some of the tourists faced difficulties in understanding the survey questions. Future

researchers may consider using other data collecting method such as face-to-face interview so that they can provide clearer explanation about the survey questions to their respondents. By conducting interview, researchers may also gain in-depth information and feedback on the spot rather than using mere distribution method.

Moreover, the result generated from Multiple Regression Analysis showed that perceived severity and perceived vulnerability are not significant to measure intention. The reason might be 68.7% of our respondents fall under the age range from 18 to 30. Young adults' risk of encountering health issues is relatively low. Future researchers are recommended to target respondents who are 30 years old and above because they might have higher risk of encountering health issues as compared to young adults. Thus, their perception towards severity and vulnerability may improve the results.

Last but not least, future researchers are recommended to further investigate the insignificant relationship between perceived severity and perceived vulnerability with intention by decomposing the variables into more detailed framework in order to provide more comprehensive results. Besides, it is recommended to consider "word-of-mouth" and "past experience" as additional variables in the research framework.

5.6 Conclusion

In a nutshell, the finding in this research is to show the variables which are perceived severity, perceived vulnerability, self-efficacy and response efficacy that can predict the foreign tourists' intention towards health tourism in Malaysia.

There is significant relationship between self-efficacy and response efficacy with intention while perceived severity and perceived vulnerability having insignificant but definite relationship with intention. The significant relationship indicates that self-efficacy and response efficacy can be used to predict the intention of foreign tourists.

Prediction is important to understand the cognitive process on decision making of foreign tourists. Predicting foreign tourists' intention is essential because it will provide more comprehensive information for the policy makers to come out with impressive strategies to promote health tourism of Malaysia. Moreover, predicting the foreign tourists' intention would be able to anticipate the needs and wants of them and to ensure that policy makers provide the right service to the right people at the right time.

As a result, we could decide the course of action to be taken to influence their behavioural intention towards health tourism in Malaysia. Prediction made in this study provides an initial blueprint to develop further understanding of these causal relationships.

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Appendix 2.1: Summary of Existing Studies on Health Tourism and Related Fields

Table below summarizes the existing literature on health tourism and its related fields together with their main findings and conclusions conducted by past researchers and academicians.

Author(s)	Published Title	Finding(s)/Conclusions	Limitation (s)
Han & Hyun(2015)	Customer retention in the medical tourism industry: Impact of quality, satisfaction, trust, and price reasonableness	• Perceived quality, satisfaction, and trust in the staff and clinic have significant associations affecting intentions to revisit clinics and the destination country. • Price reasonableness had a significant moderating role.	• 66.7% of the survey respondents were female. • Sampling range is limited as data were collected in medical clinics located in two metropolitan cities in Korea. • Not all the possible attributes of quality is evaluated, the measures were nonspecific and somewhat alike. • Not all possible influences on international patient's behavioural intentions were included in the proposed conceptual model.

Author(s)	Published Title	Finding(s)/Conclusions	Limitation (s)
Wongkit & McKercher (2015)	Desired Attributes of Medical Treatment and Medical Service Providers: A Case Study of Medical Tourism in Thailand	• Quality considerations are pre-eminent regardless of the type of treatment sought. • Medical procedures also influence the decision-making processes of medical tourists when they are looking for medical service providers.	• Data collection was conducted during the severe floods of 2011 in Bangkok. Therefore, both tourist numbers and access to hospitals by tourists were reduced. • Data were collected by convenience sampling; findings may not be able to be generalized to the entire population of medical tourists in Thailand.
An (2014)	Understanding Medical Tourists in Korea: Cross-Cultural Perceptions of Medical Tourism among Patients from the USA, Russia, Japan, and China	• Respondents' overall attitudes significantly differ across the four nations. • While travel related risks are the most influential factor among Russian, Japanese, and Chinese patients, Americans are influenced mostly by health-related risks. • Postoperative risks, access to information, and availability of procedures have different effects across the four nations.	• Sample was taken at the hospital sites of the Seoul metropolitan areas only; it may not be completely representative of the population of interest. • This study measured attitudes toward medical tourism without reference to specific types of medical tourism products.

Author(s)	Published Title	Finding(s)/Conclusions	Limitation (s)
Huang & Xu (2014)	A cultural perspective of health and wellness tourism in China.	• The behaviours of Chinese wellness tourists are greatly influenced by the traditional Chinese wellness culture. • Being in nature, doing moderate exercise in nature, and appropriate diet are the key activities for the wellness tourists in Bama.	• The wellness tourists interviewed were those who seemed to be more accessible. • The views wellness tourists in other seasons may be underrepresented as data were collected in the summer time.
Lee, Han & Lockyer (2012)	Medical tourism—attracting Japanese tourists for medical tourism experience	• Industry practitioners should put effort into attracting Japanese medical tourists. • Authorities should influence word-of-mouth information exchange and should seek feedback to develop marketing strategies. • Regulatory and safety regulations must be in place with easy access to information.	• Consumers may not behave as they planned as intervening factors may exist. • Emotional factors that may influence the process of decision making are ignored by using TPB model. • Korea was used as a single specific destination.

Author(s)	Published Title	Finding(s)/Conclusions	Limitation (s)
Musa, Thirumoorthi& Doshi(2012)	Travel behaviour among inbound medical tourists in Kuala Lumpur	• Health tourism in Kuala Lumpur is indeed a high-yield industry. • 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.	• Limited number of respondents (138 samples) • Deliberate examination of only pull factors in travel motivation • No in-depth interviews and focus group discussions were carried out due to difficulty in accessing health tourists
Musa, Doshi, Wong &Thirumoorthy (2012)	How satisfied are inbound medical tourists in Malaysia? A study on private hospitals in Kuala Lumpur	• Medical tourists are most satisfied with doctors, nurses, hospital services, hospital atmosphere, and hospital facilities. • Hospital facilities and doctors are the two most important dimensions in influencing the overall satisfaction.	• Only private hospitals within the Kuala Lumpur area are chosen for data collection purposes • The sample size of 137 is rather small (the result of the extreme difficulty in gaining cooperation of both hospitals' administration and patients themselves).

Author(s)	Published Title	Finding(s)/Conclusions	Limitation (s)
Ye, Qiu & Yuen (2011)	Motivations and experiences of Mainland Chinese medical tourists in Hong Kong.	• One of the most important reasons for obstetric patients travelling to give birth in Hong Kong was to avoid China's 'One Child' policy. • Variations in staff attitudes were found among different hospitals and even in the same hospital. • Perceived discrimination by the medical tourists emerges in the form of less favourable service and less information sharing.	• Limited number of participants through snowball sampling which may not represent the whole population. • The current study is qualitative and exploratory in nature. • Future research should adopt a quantitative method to target a larger sample for validation of these findings.
Jotikasthira (2010)	Salient factors influencing medical tourism destination choice	• Medical tourists with lower levels of familiarity tend to engage in greater external search behaviour. • Medical tourists avoid visiting destinations whose quality of care is lower than their threshold level. • Saving potential and images regarding hygiene and safety/security are also found to influence the desirability of a medical tourism destination.	• Mo quantitative research undertaken in the decision-making processes of medical tourists. • Data collected before significant political turmoil occurred in Thailand (April 2009). • Result might be biased as respondents were familiar with Thailand as a medical tourism destination.

Author(s)	Published Title	Finding(s)/Conclusions	Limitation (s)
Chen, Prebensen & Huan (2008)	Determining the motivation of wellness travellers	• The study finds that relaxation, pursing multiple activities, recreation, and enjoying nature are the top four motivations. • In terms of the ranks of Importance, relaxation is the leading indicator.	• The samples are drawn from the residents of Taiwanese resorts; possible culture differences in the concept of wellness may exist among different nationalities.
Caballero-Danell & Mugomba (2006)	Medical tourism and its entrepreneurial opportunities: A conceptual framework for entry into the industry.	• On a macro perspective the medical tourism favours market entry. • the gap between the supply of medical care and demand for non-cosmetic medical care widens in developed countries and within the medical tourism • Market rules are developed as a market grows therefore there are unknown penalties	• Only exploratory and descriptive research was conducted • In-depth empirical study may reveal the disadvantages of the no-rules market environment and what effect this may have on market entry

Vajirakachorn (2004)	Implementation of an effective health tourism development plan for Thailand	• Nature, technology, culture, and funding from government and private organizations influence the development of health tourism. • Health tourism can be pictured as a big system including several stakeholders that play an important role in its operation.	The compilation is only a literature review: • No experimental investigation was attempted or completed. • Some research may have been overlooked.

Source: Developed for the Research

Appendix 3.1: Questionnaire

UNIVERSITY TUNKU ABDUL RAHMAN
FACULTY OF BUSINESS AND FINANCE
BACHELOR OF BUSINESS ADMINISTRATION (HONS)
FINAL YEAR PROJECT

SURVEY QUESTIONNAIRE

Predicting Foreign Tourists' Intention on Health Tourism in Malaysia:

An Empirical Study

Dear Respondent,

We are researchers of Bachelor of Business Administration (Hons) from University Tunku Abdul Rahman (UTAR). We are conducting a survey on health tourism in Malaysia**.** This research can be a reference for medical service providers to have a better understanding in decision making process on foreign tourists' intention.

Your co-operation to answer those questions is very important in helping our research. We appreciate if you could complete the following questionnaire. Any information obtained regarding with this study will remain confidential. In any written reports or publications, no one will be identified and only group data will be presented.

Thank you very much for your time and participation.

Best Regard,

AN YU QING
ANG RUO XUAN
TAN BOON KAR
TAN LI WEI
WOO JIN XIONG

Instruction for Completing the Questionnaire

1. There are **TWO (2)** sections in this questionnaire. Kindly answer **ALL** the questions in Section A and Section B.
2. Completion of this questionnaire will take you approximately 10-15 minutes.
3. This questionnaire will be kept strictly **CONFIDENTIAL**.

Please be informed that accordance with Personal Data Protection Act 2010 ("PDPA") which came into force on 15 November 2013, Universiity Tunku Abdul Rahman ("UTAR") is hereby bound to make notice and require consent in relation to collection, recording, storage, usage and retention of personal information.

Acknowledgement of Notice

[ ] I have been notified by you and I hereby understood, consented and agreed per UTAR notice.

[ ] I disagree, my personal data will not be processed.

Last but not least, please read the instruction carefully before answering the question. Thank you for your cooperation and willingness to answer the questionnaire. Your response will be kept confidential and used solely for academic purposes.

Section A:

Please circle only ONE appropriate number that BEST represents your agreement with the statement on the scale 1 to 5.

Strongly Disagree (SD)	Disagree (D)	Neutral (N)	Agree (A)	Strongly Agree (SA)
1	**2**	**3**	**4**	**5**

Part 1: Perceived Severity

No.		SD	D	N	A	SA
1.	The thought of health issues scare me.	1	2	3	4	5
2.	I fear that my life will be at risk if I do not care about my health.	1	2	3	4	5
3.	Being unhealthy would endanger my personal relationships.	1	2	3	4	5
4.	I am afraid to even think about health problems.	1	2	3	4	5
5.	If I were to develop health problem, I would suffer a lot of discomfort.	1	2	3	4	5

Part 2: Perceived Vulnerability

No.		SD	D	N	A	SA
1.	I may be at risk of getting sickness.	1	2	3	4	5
2.	There is a high possibility that I will be exposed to health issues.	1	2	3	4	5
3.	I will be at risk of having health problems if I fail to concern about my health.	1	2	3	4	5
4.	I feel that my chances of getting sick are high if I never pay attention to my health.	1	2	3	4	5
5.	My current physical health condition increases the likelihood of health threat.	1	2	3	4	5

Part 3: Self-efficacy

No.		SD	D	N	A	SA
1.	I am capable of going for health tourism in Malaysia.	1	2	3	4	5
2.	Having healthcare services in Malaysia is completely up to my control.	1	2	3	4	5
3.	I have sufficient resources to go for health tourism in Malaysia.	1	2	3	4	5
4.	I have good opportunity to go for health tourism in Malaysia.	1	2	3	4	5
5.	I know how to seek for advice about health tourism in Malaysia.	1	2	3	4	5
6.	It would be easy for me to seek healthcare services in Malaysia.	1	2	3	4	5
7.	I will have no serious difficulty in searching for information about health tourism in Malaysia.	1	2	3	4	5

Part 4: Response Efficacy

No.		SD	D	N	A	SA
1.	Having regular health check-ups will keep me healthy.	1	2	3	4	5
2.	Receiving healthcare services in Malaysia may provide assurance about my health conditions.	1	2	3	4	5
3.	Undertaking health tourism in Malaysia could improve my well-being.	1	2	3	4	5
4.	Having health tourism is effective to avoid health problems.	1	2	3	4	5
5.	Health tourism work against prevention in some health issues.	1	2	3	4	5

Part 5: Intention

No.		SD	D	N	A	SA
1.	I am willing to travel to Malaysia for healthcare services.	1	2	3	4	5
2.	I would make an effort to travel to Malaysia for affordable healthcare services.	1	2	3	4	5
3.	I plan to receive healthcare services while travelling in Malaysia.	1	2	3	4	5
4.	I will make a visit to Malaysia for health tourism.	1	2	3	4	5
5.	I will recommend health tourism in Malaysia to others.	1	2	3	4	5
6.	I would possibly take up health tourism in Malaysia.	1	2	3	4	5
7.	I am certain that health tourism in Malaysia will add value to my experience.	1	2	3	4	5
8.	I believe that I could communicate to others regarding healthcare services in Malaysia.	1	2	3	4	5

Section B:

Please tick (√) for the most appropriate responses / answer in the following items.

1. What is your country of origin?

_____

2. Please indicate your gender:

☐ Male ☐ Female

3. Which of the following age groups you belong to?

☐ 18 – 30 years old ☐ 51 – 60 years old

☐ 31 – 40 years old ☐ 61 – 70 years old

☐ 41 – 50 years old ☐ 71 years old and above

4. Which of the following you belong to?

- ☐ Muslims
- ☐ Christians
- ☐ Buddhists
- ☐ Hindus
- ☐ Jews
- ☐ Folk Religions
- ☐ Unaffiliated
- ☐ Other (please specify) _____

5. How long is your visit to Malaysia?

- ☐ Less than 24 hours
- ☐ Within 1 to 7 days
- ☐ Within 1 to 4 weeks
- ☐ Within 1 to 12 months
- ☐ More than one year

6. The primary purpose of your visit to Malaysia (select only one)

- ☐ Pleasure/Vacation
- ☐ Business/Work
- ☐ Medical Treatment
- ☐ Visit friend and relatives
- ☐ Convention/Exhibition
- ☐ Other (please specify)_____

7. Who are you travelling with?

- ☐ Alone
- ☐ Spouse/Family
- ☐ Friend(s)/relatives
- ☐ Tour group
- ☐ Business associates
- ☐ Other (please specify) _____

8. What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Cohabiting
- ☐ Separated
- ☐ Widowed

9. Please state your annual personal income in US Dollar.

- ☐ $10,000 and below
- ☐ $10,001 – 30,000
- ☐ $ 30,001 – 60,000
- ☐ $60,000 – 100,000
- ☐ $100,001 – 200,000
- ☐ More than $200,001

10. Educational Level

- ☐ Up to and including High School
- ☐ College Diploma
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate Degree
- ☐ Other (please specify) _____

11. Employment Status

- ☐ Unemployed
- ☐ Employed with temporary contract
- ☐ Freelance Professionals
- ☐ Corporate Firms Employees
- ☐ Business Owners
- ☐ Other (please specify) _____

12. Where did you learn about Malaysia? (Check all that apply)

- ☐ Previous trip(s)
- ☐ Travel agent
- ☐ Advertisement
- ☐ Internet
- ☐ Word-of-mouth
- ☐ Brochures/travel guidebooks
- ☐ Other (please specify) _____

Thank you for participating in this study.

Personal Data Protection Statement

Please be informed that in accordance with **Personal Data Protection Act 2010 (PDPA)** which came into force on 15 November 2013, **Universiti Tunku Abdul Rahman (UTAR)** is hereby bound to make notice and require consent in relation to collection, recording, storage, usage and retention of personal information.

Notice:

1. The purposes for which your personal data may be used are inclusive but not limited to:-

- **For assessment of any application to UTAR**
- **For processing any benefits and services**
- **For communication purposes**
- **For advertorial and news**
- **For general administration and record purposes**
- **For enhancing the value of education**
- **For educational and related purposes consequential to UTAR**
- **For the purpose of our corporate governance**
- **For consideration as a guarantor for UTAR staff/ student applying for his/her scholarship/ study loan**

2. Your personal data may be transferred and/or disclosed to third party and/or UTAR collaborative partners including but not limited to the respective and appointed outsourcing agents for purpose of fulfilling our obligations to you in respect of the purposes and all such other purposes that are related to the purposes and also in providing integrated services, maintaining and storing records. Your data may be shared when required by laws and when disclosure is necessary to comply with applicable laws.

3. Any personal information retained by UTAR shall be destroyed and/or deleted in accordance with our retention policy applicable for us in the event such information is no longer required.

4. UTAR is committed in ensuring the confidentiality, protection, security and accuracy of your personal information made available to us and it has been our ongoing strict policy to ensure that your personal information is accurate, complete, not misleading and updated. UTAR would also ensure that your personal data shall not be used for political and commercial purposes.

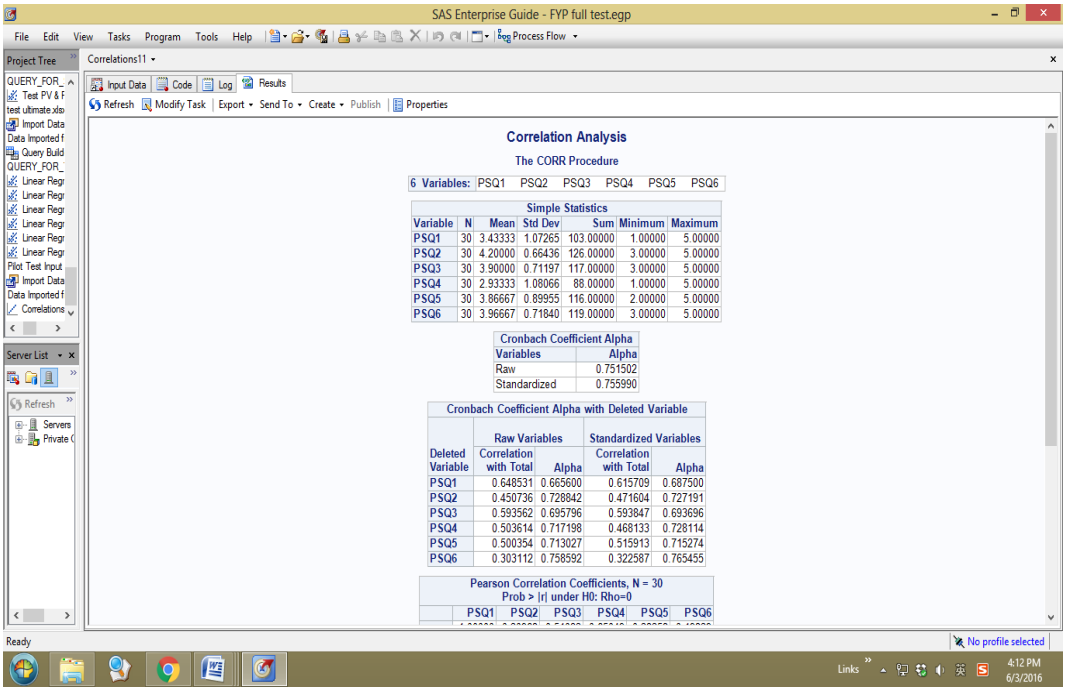
Consent:

1. By submitting this form you hereby authorise and consent to us processing (including disclosing) your personal data and any updates of your information, for the purposes and/or for any other purposes related to the purpose.

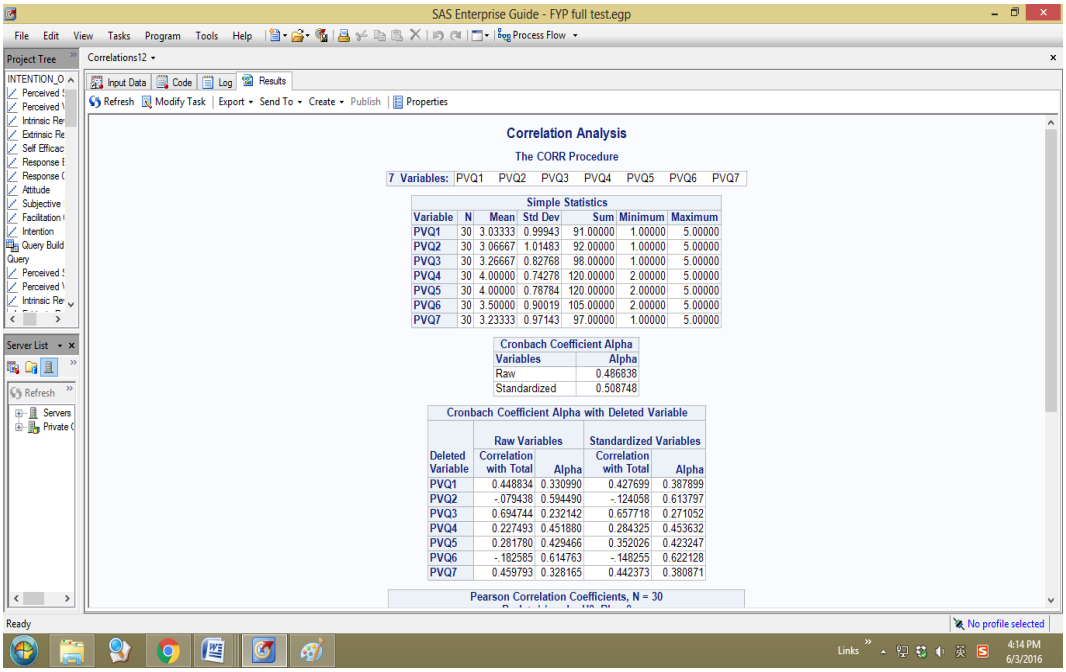
2. If you do not consent or subsequently withdraw your consent to the processing and disclosure of your personal data, UTAR will not be able to fulfil our obligations or to contact you or to assist you in respect of the purposes and/or for any other purposes related to the purpose.

3. You may access and update your personal data by writing to us at dhr@utar.edu.my.

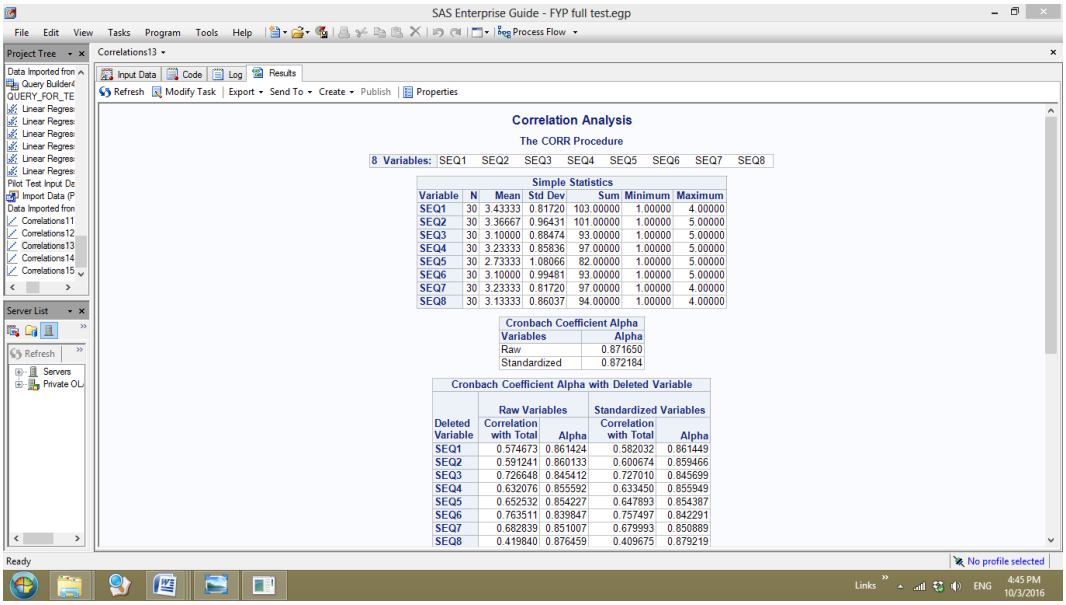
Appendix 3.2: Reliability Test Result – Perceived Severity (Pilot Test)



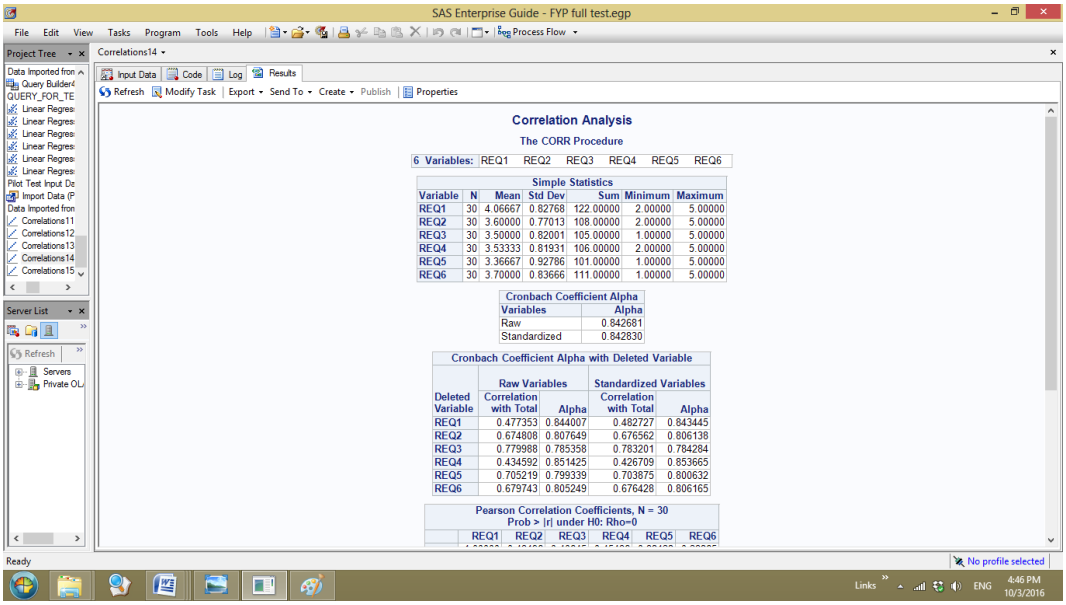
Appendix 3.3: Reliability Test Result – Perceived Vulnerability (Pilot Test)



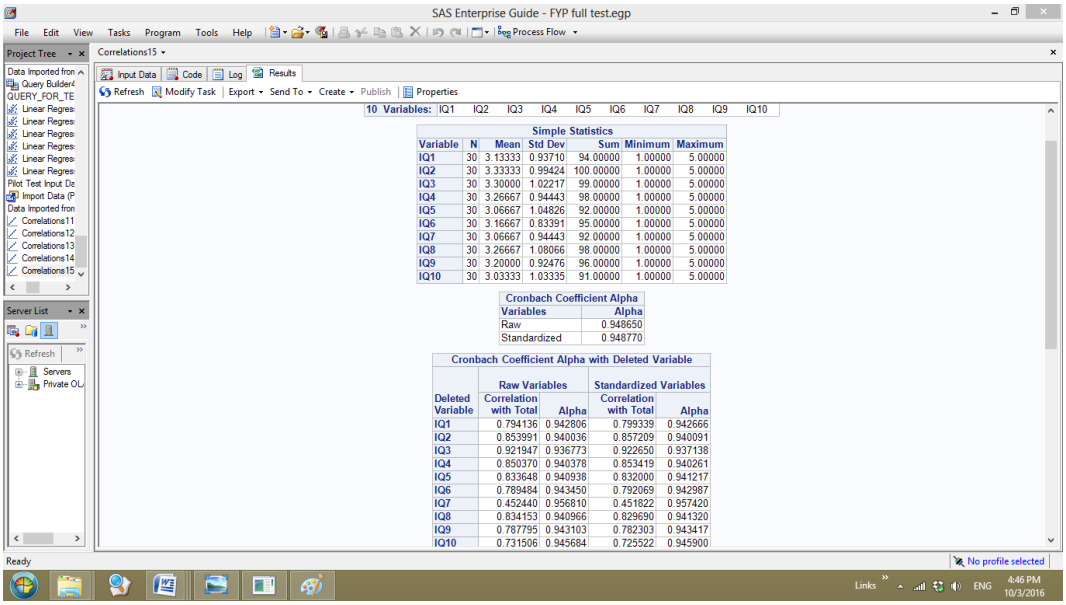
Appendix 3.4: Reliability Test Result – Self Efficacy (Pilot Test)



Appendix 3.5: Reliability Test Result – Response Efficacy (Pilot Test)



Appendix 3.6: Reliability Test Result – Intention (Pilot Test)



Simple Statistics

Variable	N	Mean	Std Dev	Sum	Minimum	Maximum
IQ1	30	3.13333	0.93710	94.00000	1.00000	5.00000
IQ2	30	3.33333	0.99424	100.00000	1.00000	5.00000
IQ3	30	3.30000	1.02217	99.00000	1.00000	5.00000
IQ4	30	3.26667	0.94443	98.00000	1.00000	5.00000
IQ5	30	3.06667	1.04826	92.00000	1.00000	5.00000
IQ6	30	3.16667	0.83391	95.00000	1.00000	5.00000
IQ7	30	3.06667	0.94443	92.00000	1.00000	5.00000
IQ8	30	3.26667	1.08066	98.00000	1.00000	5.00000
IQ9	30	3.20000	0.92476	96.00000	1.00000	5.00000
IQ10	30	3.03333	1.03335	91.00000	1.00000	5.00000

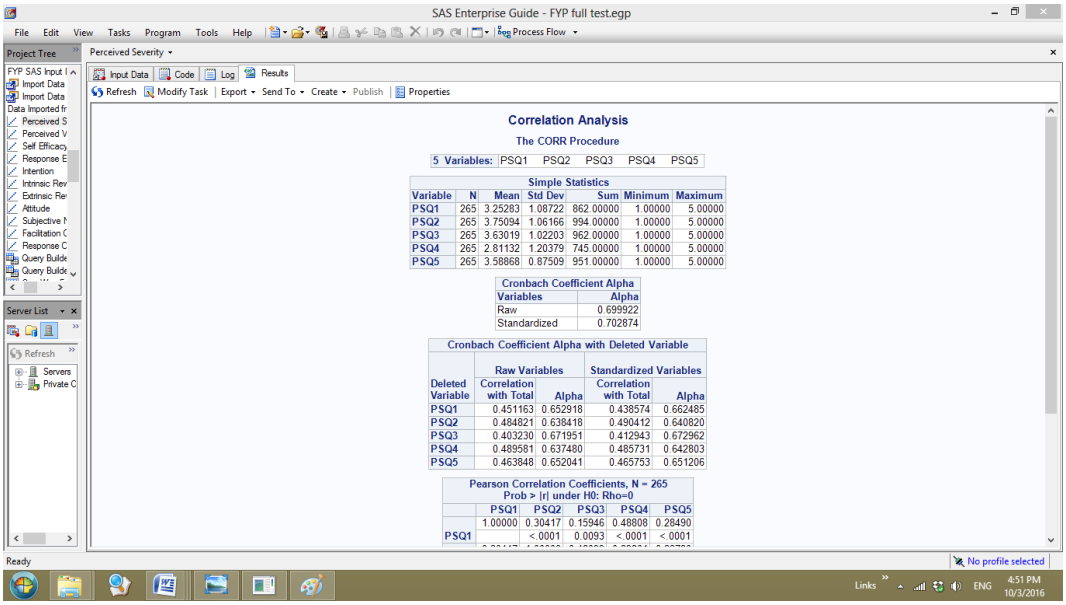
Cronbach Coefficient Alpha

Variables	Alpha
Raw	0.948650
Standardized	0.948770

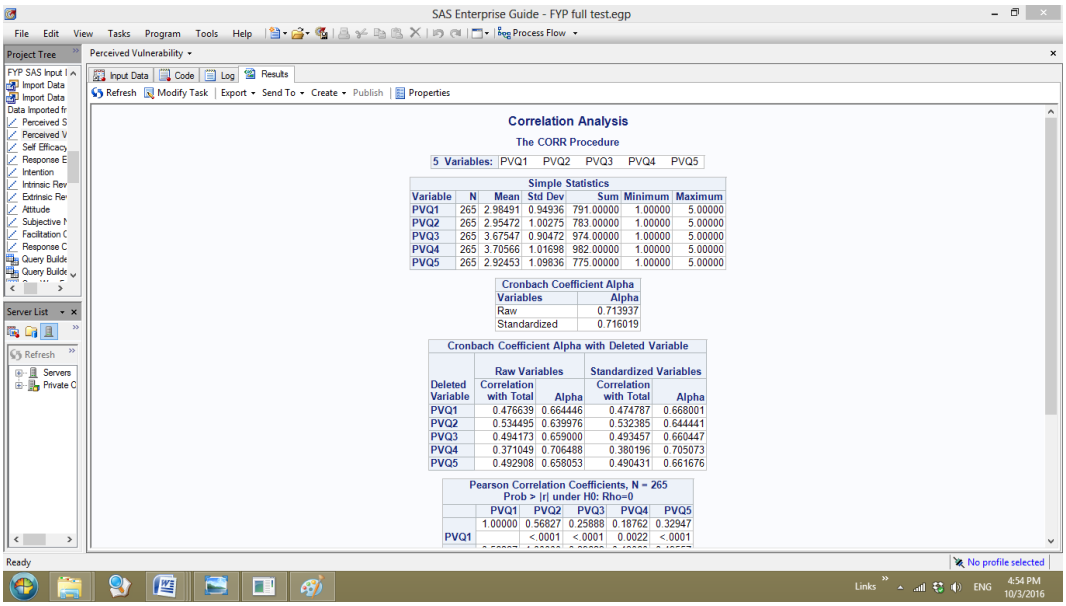
Cronbach Coefficient Alpha with Deleted Variable

	Raw Variables		Standardized Variables	
Deleted Variable	Correlation with Total	Alpha	Correlation with Total	Alpha
IQ1	0.794136	0.942806	0.799339	0.942666
IQ2	0.853991	0.940036	0.857209	0.940091
IQ3	0.921947	0.936773	0.922650	0.937138
IQ4	0.850370	0.940378	0.853419	0.940261
IQ5	0.833648	0.940938	0.832000	0.941217
IQ6	0.789484	0.943450	0.792069	0.942987
IQ7	0.452440	0.956810	0.451822	0.957420
IQ8	0.834153	0.940966	0.829690	0.941320
IQ9	0.787795	0.943103	0.782303	0.943417
IQ10	0.731506	0.945684	0.725522	0.945900

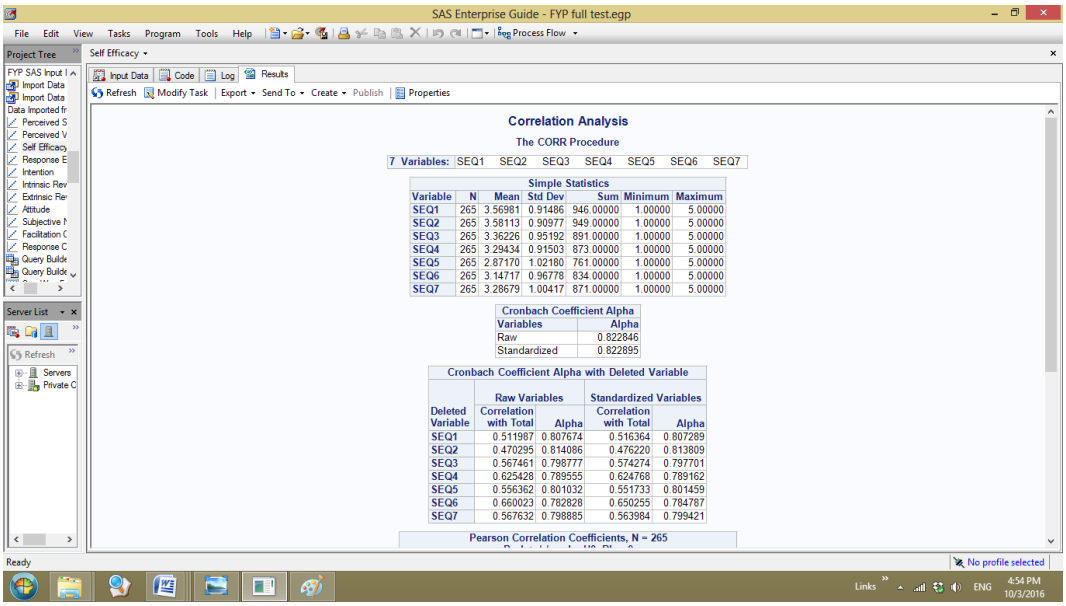
Appendix 4.1: Reliability Test Result – Perceived Severity (265 Respondents)



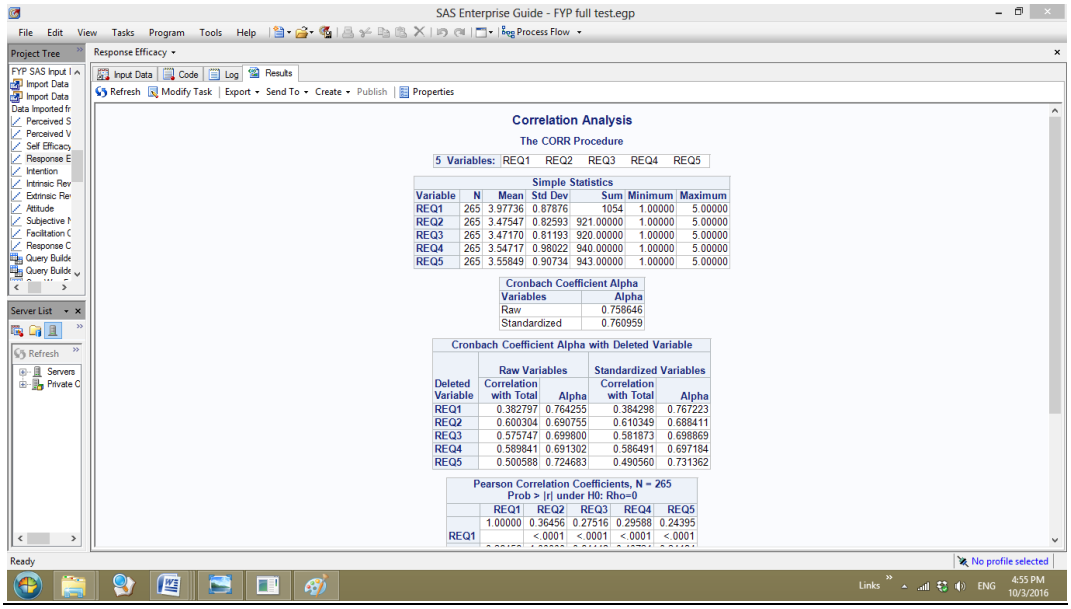
Appendix 4.2: Reliability Test Result – Perceived Vulnerability (265 Respondents)



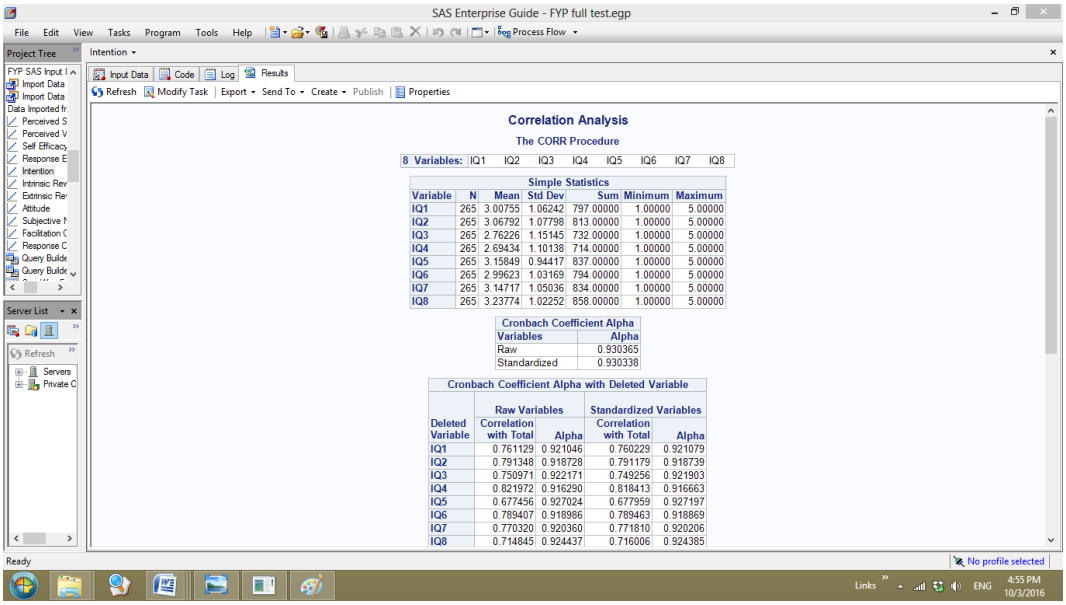
Appendix 4.3: Reliability Test Result – Self Efficacy (265 Respondents)



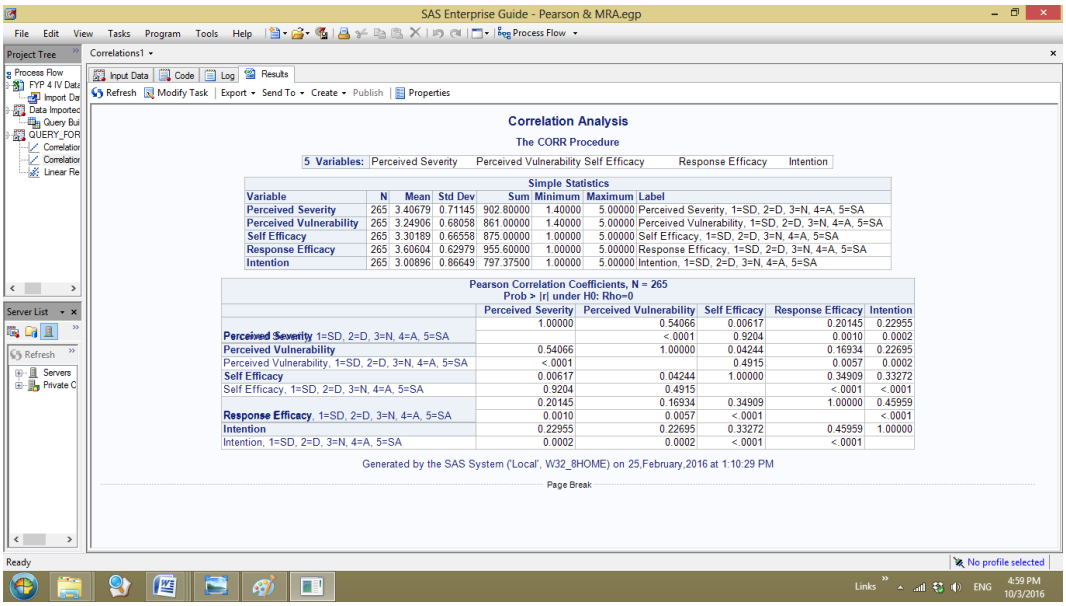
Appendix 4.4: Reliability Test Result – Response Efficacy (265 Respondents)



Appendix 4.5: Reliability Test Result – Intention (265 Respondents)



Appendix 4.6: Pearson Correlation Coefficient Analysis



Appendix 4.7: Multiple Linear Regression Analysis