Pertanika J. Soc. Sci. & Hum. 25 (S): 203 - 214 (2017)

PERTANIKA JOURNALS

SOCIAL SCIENCES & HUMANITIES

Journal homepage: http://www.pertanika.upm.edu.my/

Assessing Sharia Compliance Medical Destination Behaviour: A Medical Tourism Perspective

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ABSTRACT

This study, using Sharia Compliance Medical Destination Behaviour (SCoM-DB) model, aims to assess the psychological factors that influence the tourist's selection of sharia compliant medical destination. It further attempts to identify linkages between religiosity towards attitude and destination image towards the subjective norm. A survey questionnaire method using judgmental sampling technique was adopted. Data A total of 105 respondents were recruited for this purpose and data obtained was used to test the relationship using partial least square structural equation modelling (PLS-SEM). Findings revealed that attitude and perceived behavioural control have a significant influence on destination choice whereby the latter (perceived behavioural control) proved to be the strongest contributing factor. Meanwhile, subjective norm is found to have an insignificant effect on destination intention behaviour. The significant relationship between religiosity towards attitude and destination image was also noted.

Keywords: Destination intention behaviour, intention, medical tourism, sharia compliance, Theory of Planned Behaviour (TPB)

INTRODUCTION

Medical tourism has grown into a lucrative industry with significant economic potential (Bookman & Bookman, 2007). Voigt et al. (2010) define medical tourism as "the process of patients travelling abroad for medical care and procedures as a result of unavailability or unaffordability of certain medical procedures in their respective countries" (p. 8). Crooks, Kingsbury, Snyder, & Johnston (2010) found that international demand for medical services in developed countries has increased due to lower cost of health care services there.

ARTICLE INFO

Article history:
Received: 15 September 2016
Accepted: 30 December 2016

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ISSN: 0128-7702

Thus, developing nations such as Malaysia must offer a new product in order to compete with their rivals such as Thailand, Singapore and India. Malaysia's reputation as a medical travel destination grew when the International Medical Travel Journal (IMTJ) named Malaysia as "Medical Travel Destination of the Year". The award recognised Malaysia as the preferred choice of destination for tourists from the Middle East by positioning its *halal* (or permissible) brand. Furthermore, there is an increasing demand from Muslim consumers for quality healthcare products that adhere to sharia principles (Al-Harran & Low, 2008). Thus, sharia compliance medical services would give a better choice for Muslims seeking medical services abroad. In an attempt to promote medical tourism among Muslim countries such as Brunei, UAE, Indonesia and the Middle East, Malaysia needs to consider offering Sharia compliant medical services.

Hence, this study examines factors influencing choice of medical travel destination that provides sharia compliance health care (Prem, 2009) that takes into account halal medical products, availability of Muslim medical doctors and nurses, and sharia compliant related medical services. Putit, Suki, Yusof, and Khan (2014) further postulated that attitude and perceived behavioural control influence tourist destination choice for halal medical care services. In this study, Sharia Compliance Medical Destination Behaviour (or SCoM-DB) refers to tourists' destination choice in seeking sharia compliance medical treatment abroad. Previous researches have suggested that sharia compliance medical care refers to only halal practices and products (Mahjom, Alias & Zulkifli, 2011). However, the consumption of non-halal elements is permissible by Islam if it involves life and death situation.

Hence, this paper uses the SCoM-DB model to assess tourists' intention to select Malaysia as their preferred destination as a sharia-compliant medical tourism. Additionally, it aims to examine the relationship between religiosity, destination image and the destination intention behaviour in the context of sharia compliance medical care. Specifically, the proposed SCoM-DB model aims to: (1) assess the robustness of Theory of Planned Behaviour (TPB) with attitude, subjective norms and perceived behavioural control towards adopting a destination intention behaviour; and (2) determine linkages between religiosity towards attitude and destination image towards the subjective norm.

LITERATURE REVIEW

Destination choice is influenced by individual and environmental factors (Sirakaya, Sonmez, & Choi, 2001). In the tourism sector, behavioural intention implies a traveller's expectation of his/her future trip to the destination (Chen & Tsai, 2007). The TPB is often used as a robust framework to predict the intention of selecting a destination (Jalilvand, Samiei, Dini, & Manzari, 2012). Suki et al. (2014) and Putit et al. (2014) have also stressed

on the elements of TPB, that is, attitude, subjective norm and perceived behavioural control in affecting the tourist's intention towards the adoption of destination choice behaviour.

Theory of Planned Behaviour (TPB)

The TPB as proposed by (Ajzen, 1991) is widely applied to behavioural studies that can be used to predict the likelihood of intention. In medical tourism, attitude is developed based on the motivational acceptance to travel to obtain medical treatment (Martin, Ramamonjiarivelo, & Martin, 2011). In this study, attitude towards behaviour reflects a consumer's overall evaluation of the aftermaths of selecting a destination for medical treatment.

Several authors have stressed relationships with family, friends, and relatives as a most dominant source of information for choice of destination (Nolan, 1976; Walter & Tong, 1977). Potential tourists who are making a riskier destination selection lean on information from travel professionals (Bieger & Laesser, 2004). However, in the case of medical tourists, word-of-mouth from doctors and insurance companies are more reliable rather than information from other external sources. (Jotikasthira, 2010). Furthermore, while seeking medical treatment, the tourists typically tend to travel along with family, relatives or friends.

Perceived behavioural control (Ajzen, 1985, 1991) indicates the belief of the individual with regards to his or her own ability to undertake the predicted behaviour. In the medical tourism sector, several factors may present as obstacles which include currency differences, language barriers and cultural barriers among others. Thus, the possibility of failure due to factors that are perceived to be beyond an individual's the control to perform a particular behaviour will impact the likelihood to accomplish the targeted behaviour (Martin et al., 2011).

Destination Image

The importance of destination image is emphasised by both academic researchers and practitioners as a key predictor of successful tourism marketing (Dolnicar & Grun, 2012). Social influences play a significance role in shaping the significant others regarding the image of a travel destination. Furthermore, it will influence a patient's intention to travel abroad to seek medical services. If the said destination has a good image, it will thus influence others to visit the destination. Murphy, Moscardo and Benckendorff (2007a) mentioned that recommendations play a significant role in Word-of-mouth (WOM) for choice destinations where they will seek references from family, friends and other travellers when they are not familiar with the destination.

Religiosity

The significance of religiosity has been discussed in consumer behaviour research (Mokhlis, 2009). Johan and Putit (2016) also acknowledged the role of religion in affecting Islamic sharia financial services'

adoption amongst consumers. Alam, Mohd and Hisham (2011) examined the effect of religiosity on Muslim consumers' purchasing decision behaviour, and found that religious Muslims consider Islam as their source of reference as commanded by God. Religiosity has proven to mediate the relationship between relative and contextual variables, and purchase behaviour of Muslim consumers. Thus, highly religious people tend to follow strict philosophies set forth by God, and these influences their attitude and behaviour (Anuar, Adam, & Omar, 2012). Therefore, it can be assumed that religious people tend to focus on sharia compliance services.

Following the above discussion, the following hypotheses are proposed:

- Hypothesis 1: Religiosity significantly influences attitude
- Hypothesis 2: Attitude has significant influence on destination intention behaviour
- Hypothesis 3: Destination image significantly influences subjective norms
- Hypothesis 4: Subjective norms have a significant influence on destination intention behaviour
- Hypothesis 5: Perceived behavioural control influences destination intention behaviour

Thus, this study developed a model of sharia compliance medical destination intention behaviour. Specifically, the proposed SCoM-DB model aimed to: (1) assess the robustness of TPB with attitude, subjective norms and perceived behavioural control in affecting tourist selection of destination; and (2) identify linkages between religiosity towards attitude and destination image towards subjective norm. Following this, the SCoM-DB model was generated as shown in Figure 1 below:

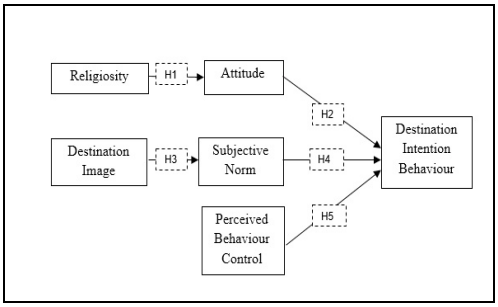

Figure 1. Sharia Compliance Medical Destination Behaviour (SCoM-DB) model

METHODS

This is a quantitative research using structured survey questionnaires. A total of 200 questionnaires was distributed to targeted respondents though only 105 was usable; judgmental sampling has been used to assure representatives. In measuring the item of each construct, 7-point Likert scale was used. In this study, the unit of analysis involved foreign tourists visiting Malaysia to obtain medical services in private hospitals/ medical centres registered under Malaysia Health Travel Council (MHTC). Data analysis was carried out using partial least square structural equation modelling (PLS-SEM) technique that provided statistical methods.

RESULTS AND DISCUSSION

The analysis is based on data gathered from 105 respondents who were tourists seeking medical services at selected hospital/ medical centres in Malaysia (See Table 1) below:

Table 1
Demographic information

Item	Frequencies (n=105)	Percentages (%)
Gender		
Male	62	59
Female	43	41
Continents		
Asia	82	78.09
Africa	20	19.05
Europe	3	2.86
Age		
< 21 years old	8	7.6
21-30 years old	51	48.6
31-40 years old	26	24.8
41 - 50 years old	14	13.3
51 - 60 years old	4	3.8
61 and above	2	1.9

The male respondents at 59% outnumbered the females.The target respondent's age group was mainly distributed in six intervals: less than 21 years old (7.6%), 21-30 years old (48.6%), 31-40 years old (24.8%), 41-50 years old (13.3%), 51-60 years old (3.8%) and more than 61 years old (1.9%). Most of the tourists were Asians, Africans and Europeans. The largest number of tourists wasfrom Yemen (13.3%), followed by Libya (11.4%) and Indonesia (9.5%). The medical travel information is shown in Table 2 below:

Table 2
Medical travel information

Information	Frequency (n=105)	Percentages (%)
Funding		
Insurance	59	56.2
Self-funded	44	41.9
Sponsored	2	1.9
Reason for medical tourism		
Destination familiarity	31	29.5
Well known procedure specialist	10	9.5
Cost effective	21	20.0
Saves time	6	5.7
Recommendation	16	15.2
Excellent medical facilities	3	2.9
Destination reputation	6	5.7
Tourism purposes	12	11.4
Activities		
Shopping	25	23.8
Touring	46	43.8
Visiting friends or relatives	12	11.4
Nothing	4	3.8
Others	18	17.1

The SmartPLS 3.0 statistical software was used in analysing data using Partial Least Squares Structural Equation Modelling (PLS-SEM) technique (Hair et al., 2016). Validity and reliability of the measures were tested using two-stage analytical procedures followed by an examination

of the structural model in testing the hypothesised relationship (Hair et al., 2016); the latter recommended a bootstrapping method (5000 resamples) to verify the significance of path coefficients and the loadings.

Measurement Model

The result showed loadings above 0.7; Composite Reliability (CR) was higher than 0.7, and the Average Variance Extracted (AVE) was also greater than 0.5 as shown in Table 3 below.

Table 3
Convergent validity

Construct	Item	Loadings	AVE	CR
Attitude	ATT1	0.616	0.542	0.777
	ATT2	0.712		
	ATT5	0.86		
Subjective Norm	SN1	0.899	0.798	0.959
	SN2	0.863		
	SN3	0.924		
	SN4	0.827		
	SN5	0.917		
	SN6	0.925		
Perceived Behaviour Control	PBC2	0.654	0.581	0.846
	PBC3	0.829		
	PBC4	0.833		
	PBC5	0.716		
Religiosity	R1	0.833	0.571	0.902
	R2	0.842		
	R4	0.72		
	R5	0.766		
	R6	0.54		
	R7	0.77		
	R8	0.778		
Destination Image	PDI1	0.897	0.639	0.84
	PDI4	0.689		
	PDI6	0.798		
Intention	INT1	0.877	0.745	0.946
	INT2	0.918		
	INT3	0.845		
	INT4	0.842		
	INT5	0.871		
	INT6	0.822		

Item R3, PDI2, PDI3, PDI5, ATT3, ATT4, ATT6, ATT7, PBC1 and PBC6 deleted due to low loading

Discriminant validity of the measures was used in comparing the correlations between constructs and the average variance extracted from that construct (Fornell & Larcker, 1981). Table 4 below shows that all values of the square root of average were greater indicating that the measures were discriminant.

Table 4
Discriminant validity

Construct	Attitude	Destination Image	Intention	PBC	Religiosity	Subjective Norm
Attitude	0.736					
Destination Image	0.492	0.799				
Intention	0.44	0.453	0.863			
PBC	0.328	0.481	0.486	0.762		
Religiosity	0.505	0.368	0.299	0.287	0.756	
Subjective Norm	0.261	0.554	0.253	0.535	0.079	0.893

Note: Values on the diagonal (bolded) are the square root of the AVE while the off-diagonals are correlations

Bootstrapping procedures were applied to show the relationship between said variables. First, religiosity ($\beta = 0.505$, $p<0.05$) which is the predictor of attitude, was accepted, thus it was positively related to attitude by explaining 41.11% of the variance in attitude. Therefore, H1 were accepted with R^2 values of 0.255. Second, destination image ($\beta = 0.554$, $p<0.05$) was positively influenced on subjective norm explaining 30.7% of the variance in subjective norm. These results supported H3. The R^2values of 0.307 were above the 0.26 value as suggested by Cohen (1988) indicating a robust model.

Lastly, the overall result of predictors for intention involving attitude, subjective norm and perceived behavioural control was discussed. Attitude ($\beta = 0.319$, $p< 0.05$) and perceived behavioural control ($\beta = 0.407$, $p<0.05$) were both positively related to intention, while subjective norm ($\beta = -0.048$, $p<0.05$) were negatively related to intention, explaining 32.6% of the variance in intention. The R^2 values of 0.326 were above the 0.26 value as suggested by Cohen (1988) indicating a solid model. Thus, H2 and H5 were accepted, and H4 rejected (see Table 5 below).

In this study, the initial testing of TPB revealed that only attitude and perceived behavioural control had an influence on destination intention behaviour. Perceived behaviour control proved to be the strongest indicator of intention, followed by attitude, while subjective norm revealed an adverse

Table 5
Hypothesis testing

Hypothesis	Relationship	Std Beta	t-value*	Decision	R^2	f^2
H1	Religiosity → Attitude	0.505	11.094	Accepted	0.255	0.342
H2	Attitude → Intention	0.319	3.674	Accepted		0.133
H3	Destination image → Subjective Norm	0.554	6.488	Accepted	0.307	0.443
H4	Subjective Norm → intention	-0.048	0.52	Rejected		0.002
H5	PBC → intention	0.407	4.218	Accepted	0.326	0.166

*p<0.05

effect with intention. Lam and Hsu (2006) confirmed that perceived behavioural control and past behaviour significantly correlated with behavioural intention in the chosen destination. Meanwhile, attitude plays an important role as it leads to performing a behaviour as suggested by Ajzen (1991). Several studies showed a positive relationship between attitude and behavioural intention (Lam & Hsu, 2006).

Subjective norm was found to have no effect on destination choice. In subjective norm, the role of social influence such as family and friends has had a lesser impact on destination intention behaviour. Snyder et al. (2013) confirmed this by stating that family physicians need to discuss and advise patients on their decision to seek medical treatment abroad. It stressed on the significant role of physicians towards encouraging patients in choosing service providers abroad.

Second, this study has proven two significant linkages, that is, between religiosity and attitude, and destination image and subjective norm. Religiosity is a significant predictor as religion does influence a person's attitude in behavioural adoption. It affects consumers' attitude given the individual ethics, beliefs, and consumers' behaviour, which are similar to intuition (Light, Keller, & Calhoun,1989).

Analysis of the influence of destination image and subjective norm showed a positive relationship. These proved that family and friends would recommend the destination that has a good image and reputation. Beerli and Martin (2004) found that word of mouth from friends or family can be influential in the formation of elements in image perceptions of a destination.

CONCLUSION

This study has developed and tested SCoM-DB model and extended the application of TPB by exploring its relationship with religiosity and destination image in the selection of destination. The study has also assessed the robustness for TPB, namely attitude, subjective norm and perceived behaviour control and investigated the

linkages between religiosity attitude and destination image towards the subjective norm.

Several constructs such as attitude, subjective norm, perceived behavioural control, religiosity, destination image and intention have been applied in this study. The results revealed that only attitude and perceived behavioural control significantly influenced destination intention behaviour. Perceived behavioural control proved to be the strongest contributing factor towards intention followed by attitude. Meanwhile, subjective norm shows a negative relationship with destination intention behaviour. This study also showed linkages between religiosity and attitude and destination image towards subjective norm which shows a significant relationship.

The findings of this study however, cannot be generalised as its focus was the central region of Peninsular Malaysia only. Therefore, a large scale study can be generalised by widening the study area, especially in the northern region which attracts more medical tourists. From a practical perspective, this study could lead to an increased awareness of the existence of Islamic sharia compliance procedures among medical tourists and thus, would be given a choice in choosing their destination. Furthermore, relevant government agency could also focus on promoting Malaysia as a sharia compliant destination in medical tourism. Also, collaborative efforts within government agencies can be undertaken and subsequently set a clear benchmark in sharia compliance. Finally, industry service providers such as travel agencies, medical centres and hospitals could greatly benefit from this research by further exploring Malaysia's potential for sharia compliant medical services.

ACKNOWLEDGMENT

This research was supported by Ministry of Education and Universiti Teknologi MARA (UiTM) via the Fundamental Research Grant Scheme (FRGS) [File No: 600-RMI FRGS 5/3 (127/2013).

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