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### RESEARCH ARTICLE

## DENTAL TOURISM: KEY FACTORS THAT INFLUENCE THE SELECTION OF A DENTAL CLINIC IN A BORDER REGION.

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### Abstract

This quantitative study investigates the factors that took into account the 380 visitors surveyed to choose a dental clinic for their treatments in the city of Tijuana. The problem consists in the lack of knowledge of the factors by which the tourists of a border region choose the clinics of a foreign city for their dental treatments. Therefore, the information was obtained by applying an exit pool survey to a selected sample of patients from clinics in the city. Fourteen items were included in the factor analysis. The results show five key factors influencing the decision: Quality-Price, Facilities and Technology, Length of Time and Price of Treatments, Credit and Urban Image. The first four of them correspond to situations or aspects that must be addressed and solved by clinics managers and owners; meanwhile the fifth factor requires the partnership work between local authorities and dental entrepreneurs.

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### Introduction:-

According to the World Tourism Organization (WTO, 1995), tourism encompasses activities carried out by individuals during their travels and stays in places other than their usual environment, for a consecutive period of less than one year, for the purpose of leisure, business and others. In addition, it points out that the expenses for international tourism are those incurred abroad by visitors to other countries, including the payment of their transfers to foreign transport companies. All other advance or post-travel payments for goods and services received in the country of destination must also be included. According to these criteria, all foreigners visiting a country for health reasons, are considered tourists and contribute to the accounting of spending generated by international tourism.

### Context of the Binational Region Tijuana, Mexico - San Diego, California:-

The city of Tijuana is bordered to the north by the county of San Diego, California, United States. According to data from the Population Census 2010 of the National Institute of Statistics and Geography (INEGI, 2011), the population of the city of Tijuana amounts to 1'559, 683 inhabitants, 58.9% of its population is economically active, with an average age of 26 years. In addition, according to INEGI (2011), 45.1% of the total population of Tijuana was born in another state of Mexico or in another country, which gives the city an economic richness and a cultural diversity that is increased by the influx of foreigners through the two inland border crossings that connect Tijuana with the neighboring city of San Diego in California, United States. According to the US Census Bureau (2010), 32.7% of San Diego County residents are of Hispanic descent, which is explained mainly by their proximity to the Mexican border and the international migration.

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Gilberto Bosques International Studies Center (2014) points out that the border crossings between Tijuana and San Diego (San Ysidro and Otay border crossings), making them the most traveled worldwide because they register more than 30 Million of annual crosses (75,000 daily) if only private vehicle and pedestrian crossings are accounted for. The fact that these border crossings respond more to tourism and the strong socio-economic integration of the two cities than to volumes of commercial cargo also stands out.

### **Literature Review:-**

#### **Reasons for Tourists' Travel:-**

It is necessary to specify the different categories in which travelers can be classified for medical or health reasons. According to WTO (1995), The "tourist" is the person who temporarily moves out of their place of residence (habitual environment) and stays in the place visited more than one day performing at least one overnight at the destination, and uses some of the services classified as tourist. From time duration and geographical coverage of displacement, they are classified as follows: if the travel is made within the same country and accounted for at least one overnight, then it is considered "national tourist". But if the travel is made to another country and stay at least one overnight, then it is called "international tourist". On the other hand, if the traveler remains only a few hours a destination in the same country and returns to his place of residence without an overnight stay, acquires the status of "national excursionist". But if the tour is done on the fringes or border areas of another country and return to their place of habitual residence without having spent the night, then it is considered "frontier excursionist" or "international excursionist".

Identifying the main reason for the visitors' travel is essential not only to recognize their preferences, needs and expectations but also to characterize their behavior in terms of consumption and expenditure. The WTO (2000) recommends differentiate between the main motive and the secondary motive (s) that originated the trip, and points out that the main motive is that without which the displacement would not have taken place. Secondary motivations should not be excluded as they are equally important, and generally complement the factors to make the decision to make the trip. At the present time the tourist realizes a trip driven by more of a motivation or with purpose of covering more of a personal objective, either to make a trip for the purpose of vacations and at the same time to visit family or friends; move for professional reasons and take the opportunity to combine it with holidays; take part in a peregrination and thermal water therapy, etc.

For Beck (1998) to live in a globalized world society means at least two things: on the one hand, to experience a set of social relations and power politically organized in a non-national way; and on the other, the experience of living and acting above and beyond borders.

#### **Dental Tourism:-**

The International Medical Travel Journal (IMTJ, 2008) indicates that this modality of tourism registered an accelerated growth in the last decade, with important variations in the direction of the flow of this type of travelers. In the traditional tourism scheme, patients from countries with less economic development were moving to the more developed countries in search of more advanced medical treatments. Travelers in this new niche move to a greater number of countries with different levels of development, including the so-called emerging countries which have transformed this business network from unilateral to multilateral. In this sense, the American Dental Association (ADA, 2008) defines dental tourism as the action of traveling to another country in order to obtain dental treatment.

Bolis (2008) points out the reasons for which the patterns of travel of this type of tourists are being modified, which can be divided into four main categories: 1) the lack of services in the country of origin. 2) The cost of treatment in relation to the quality perceived by the user. 3) Cultural aspects such as communicating in the same language or the doctor-patient relationship. 4) Regional integration that facilitates the movement of people from one country to another.

Hudson and Xiang (2011) state that medical tourism studies have concentrated on international travelers but that there is a lack of knowledge about the volume, attitudes and behavior of medical tourism at the national level in the United States. Similar results are presented for the Canadian case, Johnston, Crooks, Adams, Snyder, and Kingsbury (2011), indicate that there are very few reports that present systematic and reliable information regarding the volume of medical tourism patients, which from the perspective of public health, hinders efforts to establish actions to reduce the risks of such travelers as well as to monitor what happens in countries of origin and destination. Similarly, when referring to the United Kingdom, Álvarez, Chanda and Smith (2011), consider that when

policymakers should make decisions about whether or not to participate in medical tourism, they generally find a lack of information, since it does not know the total volume of this segment of travelers, neither the economic impacts in the countries of origin nor the destination countries, nor the effects on the health systems are known, reason why these issues cannot be solved until having precise and of better quality information.

With regard to specific knowledge about this segment of travelers, Johnston, Crooks, Adams, Snyder, and Kingsbury (2010) argue that there is a very limited body of empirical research on the subject. They add that the "initial estimates and ideas" about medical tourism were repeated and referenced so much that they came to be considered as facts. This happened both in academia and in the public and private sector.

Like any emerging market niche, medical tourism should be further studied and especially at the local level, ensuring that the methods and techniques used allow to generate comparable information at national and international level. Information on the supply side: the type of services offered, new forms of integration that are carried out, innovations made, the type of participation and the activities carried out by public, private or social sector actors, among others. As well as in the characterization of the demand, based on factors such as age, gender, place of origin, medical treatment used, medical coverage plan available, type and trip configuration, among others (Johnston et al., 2010).

The reasons given by Pocock and Phua (2011) to explain this growth are associated with the increase in the income of the inhabitants of the developed countries, the demographic change increased by the aging of the population which causes the need for treatments of diseases, long waiting lists for treatment in their countries of residence, as well as the increase in the costs of medical services, in addition, due to the option of receiving cheaper services in underdeveloped countries. This activity has grown rapidly in Southeast Asian countries (and in Latin America) thanks to private sector investment in the medical sector that is capitalizing on a lucrative business opportunity.

When thinking about medical tourism, it generally refers to those who travel long distances from their usual place of residence to another country, and who mostly travel by air. However, there is another type of medical tourism that although they visit another country, they travel by land and usually in their own automobile, visiting areas bordering abroad.

Karydis, Komboli-Kodovazeniti, Hatzigeorgiou and Panis (2001) argue that the variables that gave patients the highest priority were the expectations, the demands for greater empathy and the guarantee of the procedure performed. Two very significant quality gaps were observed between the desires of the patients and their perceptions. The first is related to the information received about oral disease and, secondly, to the ability of the medical staff to respond.

Österle, Balázs and Delgado (2009) conclude that Hungary has become a major provider of medical services for patients in Central Europe, since lower prices continue to play a decisive role in choosing it as the country that provides these services, followed by Factors such as service, friendly attention, quality controls and because Hungarian dentists have incorporated these key elements into their sales strategy.

Gill and Singh (2011) state that the three main factors that are taken into account before deciding whether or not to take a trip abroad are "competent physicians", "high quality medical care" and "immediate medical treatment when necessary." The results will be useful for companies that are directly or indirectly involved with this industry, such as insurance companies, travel agencies, hotels, food and beverage business and medical companies.

With respect to the factors that determine consumer satisfaction in medical tourism, Coțiu (2014) points out six determinant categories: aspects of care and safety; interactions between staff and patient; the outcome of medical treatment; the facilities; the patient's background and the care given to family and friends. However, it also recognizes the lack of a common theoretical-conceptual framework that allows the evaluation of these factors in a standardized way.

On the other hand, Marković, Lončarić and Lončarić (2014), when analyzing the relationship between quality of service and patient satisfaction, conclude that patients attach great importance to cleanliness and neatness of facilities and equipment, to the attitude towards patients and the reliability of the provision of services. However, in order to gain a competitive edge in the health tourism market, they recommend improving the quality of services that come out of the medical services field, such as hospitality services, recreational activities, and entertainment,

and should meet the expectations of patients, according to market trends and apply a survey to measure customer satisfaction and quality of service.

When referring to the determinants that stimulate the demand for medical services in Baja California by visitors, the State Secretary of Tourism (Secture, 2013) found that price, quality and service are the main reasons for which visitors decide to attend in the state. Also, that the mouth-to-ear recommendation continues to be the most important promotion and advertising medium.

**Research Methodology:-**

From the problem of lack of knowledge of the factors by which tourists from a border region choose the clinics of a foreign city for their dental treatments, it was decided to carry out a descriptive study using the quantitative method, applying the survey technique to achieve the following objectives.

**Research Objectives:-**

1. To identify the socioeconomic and sociodemographic profile of dental tourism that visits the city.
2. Hierarchize the factors that visitors to the city of Tijuana take into account to choose a clinic for some procedure or dental treatment.

**Sampling Unit:-**

It was determined to survey patients at the exit of dental clinics. Only were included tourists or excursionist residing in Mexico and abroad who accepted to respond to the survey, excluding patients residing in the city of Tijuana.

**Definition of Sample Size and Procedure for Data Collection:-**

To define the sample size, a confidence level of 95% and a margin of error of  $\pm 5\%$  were established, resulting in 380 patients being surveyed at the exit of dental clinics. The survey was carried out in five different areas of the city characterized as being the ones with the highest concentration of dental clinics, in addition to being the areas where the largest affluence of visitors to the city is recorded. In order to validate the final instrument, two pilot samplings of the instrument were carried out in the months of April and March of 2015, each pilot test was conducted with a sample of 30 visitors.

This allowed the design of the final survey, which in addition to the socioeconomic and sociodemographic data, includes fourteen factors to choose a dental clinic; a five-point Likert scale was used with the following response options: 5= Extremely Important, 4 =Very Important, 3 = Important, 2 = Less important and 1 = Not important.

**Statistical Tools:-**

1. Descriptive measures
2. Exploratory factor analysis

**Analysis and Discussion:-**

The sociodemographic profile of the respondents (Table 1) shows that, overall, 51.59% are between 31 and 50 years old. 50% of the respondents were male and the other half were female.

That only 20.3% correspond to tourists (people who spend at least one night in the city) and 79.9% are day visitors or excursionist. The ethnic profile of the visitors is represented mainly by Hispanics with 84.7%, either Hispanics who immigrated to the United States, or children of Hispanics who emigrated but who were born in the United States. Cash was the principal method of payment. The majority was employees, residents of Southern California and the 27.9% reported a monthly income between \$ 2,000 and \$ 4,000.

**Table 1:-** Sociodemographic characteristics of participants.

Variable	Characteristics	Frequency	%
Age	20 to 30	138	36.31
	31 to 40	97	25.53
	41 to 50	99	26.06
	51 to 60	30	7.89
	61 and above	16	4.21
Gender	Male	191	50.30
	Female	189	49.70
Type of visitor	Tourist	77	20.30
	Excursionist	303	79.70
Length of stay	Less than a day (hours)	303	79.70
	Two days	67	17.60
	Three days	9	02.40
	Four days and above	1	0.30
Ethnic profile	Hispanic emigrated to the US	203	53.40
	Hispanic born in the US	119	31.30
	Asian	10	2.60
	American	3	0.80
	Mexican	45	11.80
Method of payment	Cash	362	95.3
	Credit or debit card	15	3.9
	Medical insurance	3	0.8
Occupation	Self-employed	18	4.70
	Employee	234	61.60
	Student	50	13.20
	Home	68	17.90
	Retired	10	2.60
Place of residence	California, US	334	87.90
	Baja California, Mexico	45	11.80
	Arizona, US	1	0.30
Monthly income (US dollars)	\$2,000 dollars and below	24	6.30
	\$2,000 to \$ 4,000	106	27.90
	\$4,001 to \$6,000	47	12.40
	\$6,001 and above	23	6.10
	Did not declare income	180	47.40

**Reliability of instrument:-**

Table 2 shows the results of the reliability analysis – Cronbach's Alpha Value. The test demonstrates the consistency between the measurements scales used in the fourteen variables used in the research. A score of 1.0 on the Cronbach Alpha indicates 100 percent reliability. The score obtained from .734 is above the generally accepted score of Nunnally (1978) of 0.7; this result shows the reliability of the questionnaire.

**Table 2:-** Reliability Statistics

Cronbach's Alpha	Number of elements
.734	14

**Exploratory Factor Analysis:-**

In order to identify the aspects that visitors take into account when choosing a dental clinic, as well as to examine the appropriateness of the data to carry out the factorial analysis, the KMO test was also performed, as well as Bartlett's sphericity test. If the total result exceeds 0.50 means that factor analysis is useful with the given data (Hair, Black, Babin & Tatham, 2006). In this case results suggest that the data are adequate for factor analysis due to the value of 0.712 and confirms that a factor analysis is appropriate. Additionally, the level of significance has a very small value (Sig. = 0.000) indicating that the variables are highly correlated (Table 3).

**Table 3:-** KMO and Bartlett's test

Kaiser-Meyer-Olkin Measure of Sample Adequacy		.712
Bartlett's Test of sphericity	Approx. Chi-Squared	1373.621
	df	91
	Sig.	.000

With the purpose of determining the minimum number of factors that account for the maximum variance of the data, the principal component analysis was applied.

As shown in Table 4, after reducing the 14 variables indicating the characteristics that visitors take into account when choosing a dental clinic, and considering only Initial eigenvalues greater than one (1) it was found that five (5) representative uncorrelated components together explain 63.58% of the total variance over the decision. The rest of the components with initial eigenvalues smaller than one (1) were discarded because together they explain only 36.42% of the cumulative variance.

**Table 4:-** Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of variance	Cumulative %	Total	% of variance	Cumulative %	Total	% of variance	Cumulative %
1	3.842	27.445	27.445	3.842	27.445	27.445	2.886	20.612	20.612
2	1.735	12.395	39.840	1.735	12.395	39.840	2.086	14.898	35.510
3	1.183	8.447	48.288	1.183	8.447	48.288	1.649	11.777	47.287
4	1.136	8.113	56.401	1.136	8.113	56.401	1.205	8.610	55.898
5	1.006	7.188	63.589	1.006	7.188	63.589	1.077	7.691	63.589
6	.891	6.367	69.957						
7	.773	5.524	75.481						
8	.736	5.257	80.738						
9	.668	4.770	85.508						
10	.603	4.305	89.813						
11	.493	3.519	93.332						
12	.382	2.729	96.062						
13	.331	2.364	98.426						
14	.220	1.574	100.000						

Extraction Method: Principal Component Analysis.

The idea of rotation is to reduce the number factors on which the variables under investigation have high loadings. The result of the Factor Analysis shows five (5) components that highlight the variables to choose a dental clinic (table 5). The rotated component matrix allows identifying the variables that present significant loads in the same factor, enabling the definition of common factors.

**Table 5:-**Rotated Component Matrix

Number	Variables	Component				
		1	2	3	4	5
1	Cleanliness of the clinic	<b>.789</b>	.019	.011	.026	-.088
2	Service provided by staff	<b>.740</b>	.180	.113	.039	.013
3	Care provided by staff	<b>.610</b>	.199	.144	.082	.090
4	Quality perceived by the patient	<b>.631</b>	.152	.024	.105	.163
5	Location of the clinic in the city	.071	<b>.852</b>	.017	.014	.149
6	Exterior Appearance of facilities (Facade)	.273	<b>.793</b>	.093	.109	.115
7	Technology used for dental procedures	.399	<b>.513</b>	.050	.170	.367
8	Treatment follow-up	<b>.508</b>	.389	.045	.030	.101
9	Swiftness of service	<b>.429</b>	.402	.208	.132	.185
10	Price of separate treatments	<b>.533</b>	.177	.083	.141	.298
11	Urban signs, traffic volume and street conditions	.032	.039	.008	.093	<b>.853</b>
12	Number of visits per treatment	.039	.027	<b>.918</b>	.159	.007

13	Total cost of treatment	.021	.056	<b>.838</b>	.424	.009
14	Partial Payment on each visit	.026	.024	.066	<b>.945</b>	-.067
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. a. Rotation converged in 6 iterations.						

The first component of relevance, which was called "Quality-Price Factor", includes, in order of importance, six variables: cleanliness of the clinic (.789), service provided by staff (.740), quality perceived by the patient (.631), the price of separate treatments (.533), the treatment follow-up (.508) and the swiftness of service (.429). By itself this factor account for a variance of 20.61%.

The second component determined as "Facilities and Technology Factor" includes aspects such as: the location of the clinic in the city (.852), physical appearance of facilities (Facade) (.793), technology used for dental procedures (.513) and swiftness of service (.429), and it represents 14.89 % of the variance.

Thirdly, appears the component called "Length of Time and Price of Treatments Factor", which includes aspects directly related to the number of visits required for each treatment (.918), as well as the total cost of treatment (.838), explaining the 11.77 % of the variance.

The fourth component called "Credit Factor" refers to the possibility of making partial payments during each visit (.945), until the total price of the treatment is completed, explicating the 8.61% of the variance.

The fifth and final component, called "Urban Image Factor", it refers to urban signs, traffic volume and street conditions (.853), specifically associated with driving conditions in the city, and account for a variance of 7.69%.

### **Discussion and Conclusion:-**

Dental clinics in the city have the ability to control the key factors that respondents considered important to choose them as their service provider, and turn them into a positioning strategies to increase revenues in the border region market. This strategy should include aspects such as quality in the care and service provided by the staff, the swiftness of care during the visit, as well as the follow-up they give their patients throughout their treatment.

On the other hand, the total price of dental treatments paid by foreign visitors deserves greater attention. From the outset, it is assumed that prices in Tijuana are cheaper than prices in California because of the economic asymmetries between a developed country like the United States and a developing one in the case of Mexico. It should also be remembered that only 5.8% of the respondents have health insurance, and that 95.3% make their payments in cash.

What explains then that they go to the city of Tijuana? The facts indicate that the total price of a dental treatment is divided by the number of visits that are required to complete it. It should also be remembered that only 5.8% of the respondents have health insurance, and that 95.3% make their payments in cash. What explains then that they go to the city of Tijuana? The facts indicate that the total price of a dental service is divided by the number of visits that are required to complete it. Especially if we take into account that 84.7% of the demand analyzed is made up of Hispanics and employees with moderate incomes.

Other aspects that are beyond the control of those responsible for dental clinics in the city, but which may negatively affect their commercial activity, are based on the factor called urban image and is related to the fact that approximately 87% of visitors arrives to Tijuana by car, so it is suggested that to improve their experience, city authorities must maintain street cleaning, improve road signs, as well as maintaining in good condition the public lighting of the city, among other actions.

The factorial analysis and the matrix of rotated components show five factors that must be taken into account by the owners and administrators of dental clinics. The first four of them correspond to situations or aspects that must be addressed and solved within the clinics, since they include elements that are properly related to the provision of the service.

However, in the fifth factor there is an element that escapes the possibilities of attention and solution of the owners and administrators of the clinics, and refers to the urban image of the city and that includes aspects such as the urban signs, traffic volume and street conditions, among others. Therefore, entrepreneurs in this sector should work together with local authorities to turn this weakness into strength to attract more dental tourism – tourist or excursionist.

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