



An Examination of Expatriates' Awareness of Health Tourism in Turkey ^a

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Abstract

Aim: To determine the awareness levels of Turkish citizens (expatriates) living in Europe regarding health tourism in Turkey, and whether this awareness varies according to demographic variables.

Methods: In this study, the survey model, one of the quantitative research methods, was employed. While the population of the research consists of Turkish citizens living in Europe (expatriates), the sample comprises 498 participants who fully completed the online survey form. The 17-item "Health Tourism Awareness Scale" developed by Yaba (2022) was used as the data collection tool. The analysis of the data obtained was performed using the SPSS 22.0 statistical software package.

Results: In the context of educational status, it was determined that the awareness and positive perceptions of expatriates with basic and secondary education levels were higher than those of higher education graduates. Taking the region of residence into consideration, it was found that expatriates residing in

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Northern Europe have a higher general awareness and image perception regarding health tourism compared to those living in Western and Southern Europe. Additionally, it was understood that the awareness and perceptions of the participants whose hometowns in Turkey are in the Eastern and Southeastern Anatolia regions are higher, especially compared to those from the Marmara and Black Sea regions

Conclusion: When the sub-dimensions of the scale were examined, it was determined that the perception of "institutional competence" had the lowest average, while the "effects of health tourism" dimension had the highest average. As a result, it is emphasized that Turkey's potential in the field of health tourism is largely known by expatriates; however, in order to fully utilize this potential, there is a need for target-audience-oriented special promotion and communication strategies that will address institutional trust deficiencies and take demographic differences such as region and gender into account.

Keywords: Health Tourism: Awareness: Expatriates

INTRODUCTION

There appears to be a general consensus in the literature regarding the definition of the concept of medical tourism (Acar, Turan 2016; Aktepe 2013; Altın et al. 2012; Bülbül 2015). Within this consensus, health tourism is defined as a form of tourism encompassing journeys made by individuals outside their own country to receive medical treatment, rehabilitation or other health-related services. In this context, health tourism covers not only medical interventions but also a wide range of services such as rehabilitation, dental care, advanced diagnostic tests and diagnostic services. Globally, and particularly in Turkey, a large number of patients are seeking various options to maintain a healthy lifestyle. Patients first explore suitable treatment options in their local area; however, when local facilities are insufficient, they may be forced to travel to other cities or countries. Although high-quality and rapid treatment options are available in developed countries, the cost of these services is quite high. Consequently, patients unable to afford these high costs opt for alternative treatment methods (Göçer, Aydın 2016).

When planning their trips, patients consider both the accommodation and transport arrangements related to their treatment process and the support mechanisms available during this process, such as insurance, translation and guidance services (Göçer, Aydın 2016). Viewed on a global scale, the medical tourism market is growing at double-digit rates each year and, as of 2020, has reached a volume exceeding approximately 150 billion US dollars. Within this market share, developing countries are securing a share of this pie thanks to their low-cost advantage and rapid

service delivery, whilst developed countries are gaining a competitive edge through high technology and accreditation standards (Kuşat, Esen 2022).

When examined from a historical perspective, health tourism has emerged in various forms throughout different periods of human history and has evolved over time to attain its current multifaceted structure. It has been a common phenomenon throughout history for people to travel beyond their own region to other areas in search of recovery, healing and improved well-being. According to Aydın (2012), during the Ancient Greek period, individuals visited thermal water sources located in the Mediterranean basin for therapeutic purposes. In this period, health tourism was generally practised in close association with religious beliefs and natural resources. It is known that the so-called ‘Asklepions’—temples of healing—served as the health centres of this era. Research by the Turkish Health Foundation and the Health Association (2012) reveals that health tourism underwent significant development in subsequent centuries, particularly during the Renaissance. Between the 14th and 17th centuries, a period marked by the rise of art and science, notable advancements were also made in the field of health. For example, with the discovery of iron-rich thermal springs in the region known as Ville d’Eaux (Town of Waters) in Europe in 1326, the foundations were laid for the concept of ‘SPA’ that is widely used today. In this context, SPA centres not only provide healing but also fulfil the functions of socialising and spiritual relaxation. With the discovery of the New World, health tourism became increasingly diverse and spread across vast geographical areas during the 17th century. It is known that English and Dutch settlers established primitive health facilities on the American continent by constructing wooden structures around mineral springs. During this period, the indigenous peoples’ mastery of herbal treatment methods was also closely observed by European travellers, and over time this knowledge was transmitted through intercontinental interaction (Gülen, Demirci 2012). Herbal cures, natural healing waters and massage techniques were particularly in vogue during this period. By the 18th century, members of Europe’s wealthy classes had begun travelling to different regions in pursuit of a healthy lifestyle. It is evident that the thermal springs around the Nile River became attractive destinations for health-seeking Europeans during this period. Such journeys were undertaken not only for physical recovery but also with the aim of spiritual purification (Smith, Puczkó 2009). By the 21st century, the direction of health tourism had shifted, with a significant increase in demand for countries offering access to lower-cost, high-quality healthcare services. In particular, high

healthcare costs and long waiting times in developed countries have led individuals to seek alternative solutions (Connell 2013).

Following its historical development, health tourism has now become a major global industry. Among the leading countries in the field of medical tourism worldwide are Panama, Brazil, Malaysia, Costa Rica and India. These countries stand out for their affordable healthcare services and technological infrastructure (Özer, Songur 2012). In terms of thermal tourism, India, Turkey and Malaysia stand out, whilst destinations such as Hungary, the Czech Republic, Austria, Bali and the Maldives are favoured for spa and wellness. In Europe, Germany is one of the leading countries in the utilisation of thermal resources, whilst the Czech Republic and Slovakia attract health tourists with their modernised spa infrastructure. Similarly, Mediterranean countries such as France, Spain and Italy also host a large number of thermal facilities. Russia possesses significant tourism potential with its spa centres, whilst Japan boasts over 1,500 spa facilities, combining its historical heritage in this field with modern technology. In the United States, too, an increase in investment in thermal facilities has been observed, particularly in recent years. Hungary, meanwhile, is regarded as one of Europe's key health centres thanks to its geothermal resources and strategic location (Aktepe 2013). Across the Asian continent, India stands out as one of the leading countries in terms of health tourism.

It has become a preferred destination for citizens of many countries, particularly due to the quality of its medical services and the advantage of affordable prices. Countries such as Singapore, Indonesia, Malaysia and China are attractive destinations for medical tourists from South Asia and the Middle East. Thailand, meanwhile, is a regional leader in the fields of cosmetic surgery, organ transplantation, dentistry, orthopaedics, cardiology and general surgery. With its advanced healthcare infrastructure, team of specialist doctors and patient-friendly practices, the country attracts a significant flow of patients. Countries such as Jordan, Saudi Arabia and South Korea are also prominent destinations in the medical tourism sector, thanks to the quality of their healthcare services and regional advantages (Connell 2006; Western Mediterranean Development Agency 2013).

In addition to these dynamics in the global market, Turkey has made significant strides in the field of medical tourism since the 1990s, establishing itself as a major global player in this sector. Various challenges faced in the 1980s—such as infrastructure deficiencies, the fragmented nature of the social security system, and issues regarding the qualifications of healthcare

personnel—were transformed into opportunities in the post-1990 period. In particular, the growing interest in medical tourism from both the public and private sectors from 2005 onwards, alongside initiatives such as the 2010–2014 strategic plans and the establishment of the Medical Tourism Unit in 2010, have brought management processes in the sector under a more centralised structure. Turkey has established a firm foothold in the field of health tourism, alongside its historical and natural heritage. Significant achievements have been recorded, particularly in areas such as organ transplantation, genetic diagnosis, eye health, cardiology and dentistry.

According to the World Tourism Organisation's (UNWTO) 2013 report, although the number of international patients visiting Turkey has increased, it remains below the global average. Whilst this indicates that the healthcare infrastructure and staff qualifications are beginning to improve, it also demonstrates that the sector has strong growth potential, despite remaining below the average for OECD countries. For Turkey to make further progress in this area, the infrastructure must be continuously strengthened, service quality must be raised to international standards, and promotional activities must be intensified. It is believed that Turkey could thus achieve a more competitive position in the global health tourism market and catch up with the global average (www.satark.gov.tr, accessed 30 April 2024). Turkey is attracting the interest of an increasing number of tourists by improving the quality and efficiency of its health tourism sector. In this process, both public and private sector investments, alongside the improvement in the qualifications of healthcare personnel, have played a critical role. These developments have enabled Turkey to approach European standards and have provided momentum for the continuation of health tourism activities (Barca et al. 2013). As stated by Bülbül (2015), the reasons for choosing Turkey can be listed as follows:

- Its strategic geographical location,
- High-quality healthcare staff,
- Cost-effectiveness,
- Accredited and reliable healthcare institutions,
- The number and quality of thermal springs,
- Natural beauty,
- Favourable climatic conditions,
- A rich historical heritage.

Increasing competition in the field of medical tourism has given a strong impetus to Turkey's development efforts in this sector. Investments in the private sector, which gained momentum after the 2000s, have also influenced the public sector due to their high returns. Turkey has focused on enhancing the professional qualifications of healthcare personnel to attract more tourists; within this framework, education programmes in foreign languages have been expanded in medical faculties, thereby strengthening the capacity to provide services in line with international standards (Acar, Turan 2016). These strategic steps have reinforced Turkey's competitiveness in the medical tourism market, establishing the country as a leading destination.

When examining the impact of these developments in health tourism on the patient profile, the concept of 'mindfulness' comes to the fore. Mindfulness is defined as an individual's ability to consciously perceive what is happening in their surroundings, their internal processes, or a specific subject. This concept is particularly prominent within the discipline of psychology and meditation practices, and involves focusing one's attention on one's current experiences, thoughts, emotions and sensory perceptions, and accepting them without judgement. Furthermore, awareness can also refer to possessing a certain level of knowledge regarding a specific subject. For example, health awareness refers to individuals having knowledge about healthy living practices and using this knowledge effectively in their decision-making processes. An increase in this level of awareness is generally achieved through awareness-raising and educational activities (Akşit, Özsoy 2018).

On the other hand, mindfulness has a long history dating back some 2,500 years. It is known that this concept was first incorporated into daily practice by the Buddha. Over time, it has formed the basis of practice and philosophical systems in Buddhist monasteries (Almond 1988).

This concept, which can be translated into Turkish as 'a state of deep awareness', has been defined by Brown and Ryan (2003) as 'living in the present moment without judgement'. Mindfulness is regarded not merely as a mental state, but also as a practice and mental skill that is cultivated on a regular basis. This approach enables individuals to better analyse the reasons behind their reactions to environmental stimuli, to facilitate problem-solving processes, and to enhance their creativity (Steele 2008). Mindfulness is a state of consciousness that develops on the basis of "detachment", enabling the individual to confront distressing thoughts and emotions. The opposite of this is when an individual becomes overly identified with their emotions, leading to a loss of psychological balance (Ögel 2012). This state of consciousness is viewed as a universal skill that

can be developed regardless of an individual's mental capacity or demographic background, and it holds the potential to enhance life satisfaction and general well-being (Dutt, Ninov 2016). This level of awareness involves the individual observing and making sense of negative emotions without judgement, rather than suppressing or avoiding them (Kirkpatrick 2005).

Furthermore, in the literature, Grossman (2010) defines mindfulness as a path that transcends everyday life and transforms an individual's life. This approach supports inner peace and alleviates psychological distress by developing the individual's emotional, behavioural, cognitive, moral and social aspects. According to Çeliker (2017), however, this is defined as the ability to accept and observe the present moment as it is, without judgement. This definition is based on the individual directing their attention with an open and curious attitude.

When examining the implications of the concept of mindfulness in the context of tourism, it becomes apparent that the relationship between these two variables is noteworthy. The first study to examine the relationship between mindful awareness and tourism was conducted in 1986 by Moscardo and Pearce at a cultural heritage site in the United Kingdom. This research aimed to analyse how tourists perceive cultural heritage sites and how they evaluate the services provided. The findings revealed that tourists with a high level of awareness gained more information from these sites and experienced higher overall satisfaction (Moscardo & Pearce 2009). This clearly demonstrates the positive effects of conscious awareness on tourism experiences. Increasing awareness supports tourists in understanding historical and cultural sites more deeply and deriving a higher level of satisfaction from these experiences. A clear understanding of the concept of conscious awareness plays a significant role in identifying tourists with this characteristic; for such tourists are individuals who are open to learning, engage in in-depth evaluation, and take pleasure in deriving meaning from the sites they visit.

According to Moscardo (1996), conscious tourists experience cultural heritage sites more thoughtfully by engaging actively in the process of acquiring information. Furthermore, this state of awareness not only contributes to an enhanced quality of experience but also facilitates the establishment of a sustainable connection between the tourist and the heritage site. Tourists with a high level of awareness actively analyse information from their surroundings, approach activities at destinations with a critical perspective, and thereby gain a deeper understanding of the meaning of cultural heritage (Prentice, Guerin, McGugan 1998). As Moscardo (2009) notes, this profile holds a significant place in the tourism sector. This is because these individuals evaluate the areas

they visit more consciously than other tourists and avoid attitudes and behaviours that could harm the environment or other people. At the same time, these tourists experience a higher level of satisfaction with the places they visit and are inclined to recommend their experiences to others.

1. RESEARCH METHODOLOGY

In this study, which was conducted to determine the awareness levels of Turkish citizens living abroad regarding health tourism services in Turkey, a quantitative research method (Creswell, 2013, p. 4), where relationships between variables are analyzed using numerical data, was adopted. In this context, it was aimed to obtain realistic and reliable results by utilizing the survey model (Karasar, 2014, p. 77), which aims to describe the current situation in its natural state without any intervention.

Research data was collected using the "Health Tourism Awareness Scale" developed by Yaba (2022). The scale, which accounts for 52.31% of the total variance, consists of a total of 17 items in four sub-dimensions: awareness (6 items), institutional competence (5 items), effects of health tourism (3 items), and image (3 items).

Prior to the data collection process, ethical approval was obtained from the Sivas Cumhuriyet University Social Sciences Scientific Research Proposals Ethical Review Board with the decision dated November 20, 2024, and numbered E-99711239-050.04-492855. Following the ethical approval, the questionnaire was transferred to an online platform via Google Forms. Between December 20, 2024, and June 20, 2025, the questionnaire link was sent to 500 expatriates, and 498 individuals were reached within the scope of the research. Statistical analyses of the obtained data were performed using the SPSS software.

2. ANALYSIS

Table 1. Reliability Coefficients for the Health Tourism Awareness Scale

Sub-dimensions	Number of Items	Cronbach's Alpha
Awareness	6	0.92
Institutional Competence	5	0.94
Impacts of Health Tourism	3	0.91
Image	3	0.95
General Health Tourism Awareness	17	0.96

The overall Cronbach's alpha internal consistency coefficient for the 17-item Health Tourism Awareness Scale was calculated as 0.96. The reliability coefficients for its sub-dimensions were 0.92 for awareness (6 items), 0.94 for institutional competence (5 items), 0.91 for the effects of health tourism (3 items), and 0.95 for image (3 items). All values exceeding the 0.90 threshold indicates that the measurement tool and its sub-dimensions are highly reliable.

Table 2. Skewness and Kurtosis Values for the Health Tourism Awareness Scale

Sub-dimensions	N	Skewness Value	Skewness Error	Std. Kurtosis Value	Kurtosis Error	Std.
Awareness	498	-0.61	0.11	-0.64	0.22	
Institutional Competence	498	-0.29	0.11	-1.21	0.22	
Impacts of Health Tourism	498	-1.41	0.11	1.08	0.22	
Image	498	-0.68	0.11	-0.98	0.22	
General Health Tourism Awareness	498	-0.69	0.11	-0.54	0.22	

Skewness and kurtosis values (within the ± 2 range) confirmed that the data exhibited a normal distribution (George, Mallery 2010). Consequently, parametric tests (t-test and ANOVA) were utilized for the analysis, with the Tukey post-hoc test applied afterward to determine specific group differences.

Table 3. Demographic Characteristics of Migrants Participating in the Study

Variable	Category	N	%
Gender	Female	162	32.5
	Male	336	67.5
Age	18-25 Years	16	3.2
	26-35 Years	75	15.1
	36-45 Years	141	28.3
	46-55 Years	101	20.3
	56-65 Years	134	26.9
	66 Years and Over	31	6.2
Marital Status	Married	269	54.0
	Single	229	46.0

Education Level	Primary School	85	17.1
	Middle School	99	19.9
	High School	110	22.1
	Associate Degree	41	8.2
	Bachelor's Degree	124	24.9
	Postgraduate	39	7.8
Country of Residence	Western Europe (Germany)	126	25.3
	Western Europe (Belgium)	54	10.8
	Northern Europe (Denmark)	28	5.6
	Western Europe (France)	96	19.3
	Western Europe (Netherlands)	65	13.1
	Northern Europe (England)	44	8.8
	Southern Europe (Hungary)	15	3.0
	Southern Europe (Macedonia)	14	2.8
	Northern Europe (Norway)	50	10.0
	Southern Europe (Italy)	6	1.2
Hometown in Turkey	Eastern Anatolia (Ağrı)	14	2.8
	Marmara (Bilecik)	10	2.0
	Eastern Anatolia (Bingöl)	60	12.0
	Black Sea (Bolu)	74	14.9
	Mediterranean (Burdur)	11	2.2
	Marmara (Bursa)	14	2.8
	Aegean (Denizli)	15	3.0
	Central Anatolia (Konya)	26	5.2
	Aegean (Manisa)	16	3.2
	Central Anatolia (Sivas)	49	9.8
	Black Sea (Tokat)	82	16.5
	Mediterranean (Adana)	1	0.2
	Aegean (Afyonkarahisar)	5	1.0
	Central Anatolia (Ankara)	2	0.4

Mediterranean (Antalya)	1	0.2
Eastern Anatolia (Ardahan)	3	0.6
Aegean (Aydın)	1	0.2
Marmara (Balıkesir)	1	0.2
Black Sea (Bartın)	4	0.8
Eastern Anatolia (Bitlis)	6	1.2
Black Sea (Çorum)	5	1.0
Black Sea (Düzce)	3	0.6
Marmara (Edirne)	3	0.6
Eastern Anatolia (Elazığ)	5	1.0
Eastern Anatolia (Erzurum)	1	0.2
Central Anatolia (Eskişehir)	1	0.2
Southeastern Anatolia (Gaziantep)	1	0.2
Eastern Anatolia (Iğdır)	5	1.0
Mediterranean (Isparta)	5	1.0
Marmara (İstanbul)	3	0.6
Aegean (İzmir)	9	1.8
Eastern Anatolia (Kars)	6	1.2
Central Anatolia (Kayseri)	2	0.4
Aegean (Kütahya)	1	0.2
Aegean (Muğla)	7	1.4
Eastern Anatolia (Muş)	1	0.2
Black Sea (Ordu)	2	0.4
Mediterranean (Osmaniye)	1	0.2
Marmara (Sakarya)	6	1.2
Black Sea (Samsun)	4	0.8
Southeastern Anatolia (Siirt)	4	0.8
Marmara (Tekirdağ)	1	0.2
Black Sea (Trabzon)	3	0.6
Eastern Anatolia (Tunceli)	4	0.8

Southeastern Anatolia (Şanlıurfa)	1	0.2
Aegean (Uşak)	8	1.6
Eastern Anatolia (Van)	4	0.8
Central Anatolia (Yozgat)	7	1.4

An analysis of the demographic data in the table reveals that the profile of the 498-person group participating in the study consists predominantly of men (67.5%) and married individuals (54%). Looking at the age distribution, it is notable that the vast majority of participants are concentrated in the middle-aged and older age group (36–65 years), whilst the younger population is relatively small. Although educational backgrounds show a fairly diverse distribution, the largest shares are held by university graduates (24.9%), high school graduates (22.1%) and secondary school graduates (19.9%). Data on the countries where participants reside indicates that this group consists of the Turkish diaspora living in Europe; it is understood that participants reside predominantly in Western European countries, particularly Germany (25.3%) and France (19.3%). When examining their home regions in Turkey, although origins are spread across various regions, it is noted that the provinces of Bolu (14.9%) and Bingöl (12%) stand out significantly compared to others.

Table 4. t-Test for the Gender Variable in the Health Tourism Awareness Scale

Sub-dimensions	Gender	N	$\bar{X}$	SD	t	p
Awareness	Female	162	03.06	1.46	-4.36	0.000**
	Male	336	3.62	1.08		
Institutional Competence	Female	162	2.69	1.42	-6.37	0.000**
	Male	336	3.52	1.25		
Impacts of Health Tourism	Female	162	04.03	1.22	-1.95	0,052
	Male	336	4.25	1.06		
Image	Female	162	3.29	1.58	-3.33	0.001**
	Male	336	3.77	1.37		
General Health Tourism Awareness	Female	162	3.16	1.30	-4.91	0.000**
	Male	336	3.73	0.97		

According to the analysis, with the exception of the “effects of health tourism” sub-dimension ($p=0.052$), a statistically significant difference exists between men and women across all other dimensions (“Awareness”, “Institutional Competence”, “Image”, and “General Awareness”) ($p<0.05$). In all these dimensions, male participants scored significantly higher than female participants. In summary, the findings indicate that men possess higher levels of general health tourism awareness, positive image perceptions, and assessments of institutional competence compared to women.

Table 5. ANOVA Test for the Age Variable in the Health Tourism Awareness Scale

Sub-dimensions	Age	N	$\bar{X}$	SD	F	p	Post-Hoc
Awareness	18-25 Years	16	3.27	1.32	7.19	0.000**	56-65 Years > 26-35 Years 56-65 Years > 36-45 Years 56-65 Years > 46-55 Years 66 Years and Over > 26-35 Years 66 Years and Over > 36-45 Years 66 Years and Over > 46-55 Years
	26-35 Years	75	3.12	1.45			
	36-45 Years	141	3.24	1.23			
	46-55 Years	101	3.25	1.30			
	56-65 Years	134	3.82	0.98			
	66 Years and Over	31	4.15	0.94			
Institutional Competence	18-25 Years	16	2.70	1.52	7.73	0.000**	36-45 Years > 26-35 Years 46-55 Years > 26-35 Years 56-65 Years > 26-35 Years 66 Years and Over > 18-25 Years 66 Years and Over > 26-35 Years
	26-35 Years	75	2.57	1.43			
	36-45 Years	141	3.25	1.36			
	46-55 Years	101	3.22	1.37			
	56-65 Years	134	3.58	1.18			
	66 Years and Over	31	3.87	01.05			

Impacts of Health Tourism	18-25 Years	16	4.10	1.10	1.29 267
	26-35 Years	75	4.15	1.13	
	36-45 Years	141	04.08	1.15	
	46-55 Years	101	4.15	1.18	
	56-65 Years	134	4.21	1.11	
	66 Years and Over	31	4.62	0.65	
Image	18-25 Years	16	3.15	1.51	4.68 0.000**
	26-35 Years	75	3.35	1.62	
	36-45 Years	141	3.38	1.46	
	46-55 Years	101	3.60	1.46	
	56-65 Years	134	3.89	1.34	
	66 Years and Over	31	4.44	0.85	
General Health Tourism Awareness	18-25 Years	16	3.23	1.26	6.57 0.000**
	26-35 Years	75	3.18	1.24	
	36-45 Years	141	3.42	1.13	
	46-55 Years	101	3.46	1.22	
	56-65 Years	134	3.83	0.89	
	66 Years and Over	31	4.20	0.75	

An analysis of expatriates' health tourism awareness based on age reveals no significant differences in the “effects of health tourism” sub-dimension ($p>0.05$). However, significant differences were identified in the “awareness,” “institutional competence,” and “image” sub-dimensions ($p<0.05$). Upon closer examination, older participants—particularly those aged 56 and over (and 36 and over for institutional competence)—scored significantly higher than younger groups. In summary, the findings clearly indicate that as age increases, participants' health tourism awareness, positive image, and perceptions of institutional competence consistently improve.

Table 6. t-Test for the Marital Status Variable on the Health Tourism Awareness Scale

Sub-dimensions	Marital Status	N	$\bar{X}$	SD	t	p
Awareness	Married	269	3.86	1.04	8.66	0.000**
	Single	229	2.94	1.28		
Institutional Competence	Married	269	3.70	1.19	8.49	0.000**
	Single	229	2.72	1.36		
Impacts of Health Tourism	Married	269	4.41	0.96	5.15	0.000**
	Single	229	3.90	1.22		
Image	Married	269	3.97	1.28	06.05	0.000**
	Single	229	3.20	1.53		
General Health Tourism Awareness	Married	269	3.93	0.91	8.77	0.000**
	Single	229	03.09	1.18		

* $p<0.01$; * $p<0.05$

According to the analysis results in Table 6, which examines the levels of awareness of health tourism among expatriates according to the marital status variable; statistically significant differences were found between the groups both in the overall total of the scale and in all its sub-dimensions (“awareness”, “institutional competence”, “effects of health tourism” and “image”) ($p<0.05$). Upon examining the mean scores, it was found that married expatriates had significantly higher levels of both general health tourism awareness and perceptions regarding all sub-dimensions of the scale compared to single expatriates.

Table 7. ANOVA Test for the Educational Status Variable in the Health Tourism Awareness Scale

Sub-dimensions	Education Level	N	$\bar{X}$	SD	F	p	Post-Hoc
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Awareness	Primary School	85	3.97	1.16	14.49	0.000**	Primary School > Associate Degree Primary School > Bachelor's Degree Primary School > Postgraduate Middle School > Associate Degree Middle School > Bachelor's Degree Middle School > Postgraduate High School > Associate Degree High School > Bachelor's Degree High School > Postgraduate
	Middle School	99	3.72	01.09			
	High School	110	3.75	01.09			
	Associate Degree	41	2.93	1.20			
	Bachelor's Degree	124	2.91	1.22			
	Postgraduate	39	2.92	1.38			
Institutional Competence	Primary School	85	3.74	1.21	11.74	0.000**	Primary School > Associate Degree Primary School > Bachelor's Degree Primary School > Postgraduate Middle School > Associate Degree Middle School > Bachelor's Degree Middle School > Postgraduate High School > Associate Degree High School > Bachelor's Degree High School > Postgraduate
	Middle School	99	3.55	1.28			
	High School	110	3.58	1.30			
	Associate Degree	41	2.54	1.33			
	Bachelor's Degree	124	2.76	1.30			
	Postgraduate	39	2.83	1.40			
Impacts of Health Tourism	Primary School	85	4.43	0.95	3.51	0.004**	Primary School > Bachelor's Degree High School > Bachelor's Degree
	Middle School	99	04.09	1.25			
	High School	110	4.39	0.93			
	Associate Degree	41	4.24	01.08			
	Bachelor's Degree	124	3.95	1.16			
	Postgraduate	39	3.86	1.31			
Image	Primary School	85	4.13	1.17	5.98	0.000**	Primary School > Associate Degree Primary School > Bachelor's Degree Primary School > Postgraduate

General Health Tourism Awareness	Middle School	99	3.77	1.38	12.43	0.000**	PostgraduateMiddle School > Bachelor's DegreeHigh School > Bachelor's Degree
	High School	110	3.80	1.41			
	Associate Degree	41	3.27	1.62			
	Bachelor's Degree	124	3.19	1.47			
	Postgraduate	39	3.29	1.63			
	Primary School	85	04.01	0.95			
	Middle School	99	3.75	01.05			
	High School	110	3.82	1.00			
	Associate Degree	41	3.10	01.09			
	Bachelor's Degree	124	3.10	1.11			
	Postgraduate	39	3.12	1.29			

**p<0,01; *p<0,05

An analysis examining expatriates' health tourism awareness based on their educational status reveals statistically significant differences across all sub-dimensions of the scale (“awareness,” “institutional competence,” “effects,” and “image”) ($p<0.05$). Specifically, participants with primary, secondary, and high school education consistently scored significantly higher in these dimensions compared to those with higher education qualifications (associate, bachelor's, and postgraduate degrees). Broadly speaking, the findings indicate that expatriates with lower educational backgrounds (primary and secondary levels) possess higher awareness and more positive perceptions regarding health tourism than higher education graduates.

Table 8. ANOVA Test for the ‘Region of Residence’ Variable on the Health Tourism Awareness Scale

Sub-dimensions	Region of Residence	N	$\bar{X}$	SD	F	p	Post-Hoc
Awareness	Western Europe	341	3.36	1.31	5.42	0.005**	

	Southern Europe	35	3.15	1.00				Northern Europe > Western Europe
	Northern Europe	122	3.74	01.06				Northern Europe > Southern Europe
	Western Europe	341	3.22	1.39				
Institutional Competence	Southern Europe	35	2.85	1.19	2.96	53		
	Northern Europe	122	3.45	1.28				
	Western Europe	341	4.13	1.15				
Impacts of Health Tourism	Southern Europe	35	3.97	01.08	2.52	82		
	Northern Europe	122	4.36	01.02				
	Western Europe	341	3.46	1.51				
Image	Southern Europe	35	3.46	1.34	8.82	0.000**	Northern Europe > Western Europe	
	Northern Europe	122	04.09	1.22				
	Western Europe	341	3.47	1.17				
General Health Tourism Awareness	Southern Europe	35	3.26	0.87	5.80	3		
	Northern Europe	122	3.83	0.99				
	Western Europe	341	3.47	1.17				

**p<0,01; *p<0,05

An analysis of expatriates' health tourism awareness based on their region of residence reveals no significant differences in the “institutional competence” and “effects of health tourism” sub-dimensions ($p>0.05$). However, significant differences were found in “general awareness,” “awareness,” and “image” ($p<0.05$). Ultimately, the findings show that expatriates residing in

Northern Europe possess significantly higher levels of general health tourism awareness and more positive image perceptions compared to those living in other regions, particularly Western and Southern Europe.

Table 9. Health Tourism Awareness Scale Hometown Variable ANOVA Test

Sub-dimensions	Hometown	N	$\bar{X}$	SD	F	p	Post-Hoc
Awareness	Mediterranean	19	3.32	1.18	9.99	0.000**	E. and S.E. Anatolia > Black Sea E. and S.E. Anatolia > Marmara Aegean > Black Sea Aegean > Marmara Central Anatolia > Marmara
	E. and S.E. Anatolia	115	3.95	0.89			
	Aegean	62	3.72	1.16			
	Central Anatolia	87	3.48	1.17			
	Black Sea	177	3.17	1.40			
	Marmara	38	2.66	01.01			
Institutional Competence	Mediterranean	19	3.60	1.50	12.00	0.000**	Mediterranean > Marmara E. and S.E. Anatolia > Black Sea E. and S.E. Anatolia > Marmara Aegean > Marmara Central Anatolia > Marmara Black Sea > Marmara
	E. and S.E. Anatolia	115	3.72	1.10			
	Aegean	62	3.51	1.37			
	Central Anatolia	87	3.45	1.31			
	Black Sea	177	2.97	1.40			
	Marmara	38	02.09	0.97			
Impacts of Health Tourism	Mediterranean	19	4.11	1.18	7.62	0.000**	E. and S.E. Anatolia > Black Sea E. and S.E. Anatolia > Marmara Central Anatolia > Black Sea
	E. and S.E. Anatolia	115	4.60	0.76			
	Aegean	62	4.22	01.09			
	Central Anatolia	87	4.34	0.87			
	Black Sea	177	3.84	1.29			
	Marmara	38	04.01	1.19			
Image	Mediterranean	19	3.56	1.60	10.02	0.000**	

General Health Tourism Awareness	E. and S.E. Anatolia	115	4.31	01.05	
	Aegean	62	3.70	1.38	
	Central Anatolia	87	3.69	1.34	
	Black Sea	177	3.25	1.57	
	Marmara	38	2.93	1.41	
	Mediterranean	19	3.59	1.25	E. and S.E. Anatolia > Central Anatolia E. and S.E. Anatolia > Black Sea E. and S.E. Anatolia > Marmara
	E. and S.E. Anatolia	115	04.06	0.78	
	Aegean	62	3.74	01.05	
	Central Anatolia	87	3.66	01.01	
	Black Sea	177	3.24	1.24	
	Marmara	38	2.78	0.92	

**p<0,01; *p<0,05

The analysis reveals statistically significant regional differences ($p<0.05$) in expatriates' health tourism awareness based on their hometowns in Turkey. Overall, expatriates originating from the Eastern and Southeastern Anatolia regions demonstrate the highest levels of awareness, institutional competence, and perceived impacts compared to other regions, particularly the Black Sea. Conversely, the Marmara Region consistently scored the lowest across all examined sub-dimensions, falling behind all other regions in terms of perception and awareness.

3. DISCUSSION/CONCLUSIONS AND RECOMMENDATIONS

This study was conducted to determine the level of awareness among Turkish citizens living abroad (expatriates) regarding health tourism in Turkey and to establish whether this awareness varies according to demographic variables. The findings indicate that health tourism must be considered not only in terms of service supply but also in terms of perception and awareness.

According to the research findings, participants' overall level of awareness of health tourism is medium-high ($\bar{x}=3.54$). This indicates that Turkey's healthcare infrastructure, service diversity

and cost advantages are largely known to expatriates. However, it was found that awareness is not evenly distributed across all sub-dimensions, with significant differences observed in certain areas.

3.1. Assessment of Awareness Levels by Gender

The empirical evidence indicating that male participants demonstrate a higher general awareness, more positive image perceptions, and stronger evaluations of institutional competence compared to female participants points toward distinct health-seeking behaviors and information processing channels. In diaspora communities, structural and logistical decision-making processes—such as managing cross-border finances, arranging travel logistics, and assessing legal or corporate competence—are frequently driven predominantly by male family members. This traditional division of responsibility exposes male expatriates to greater informational flow regarding healthcare alternatives, market costs, and administrative qualities. Consequently, while female participants approach healthcare choices through localized, experiential, and trust-centered micro-dynamics, male participants engage more extensively with the institutional and macroeconomic dimensions of Turkey's medical tourism market.

According to the research findings, there is a statistically significant difference in levels of awareness of health tourism in terms of the gender variable ($p < 0.01$). This finding indicates that male participants' levels of awareness of health tourism are higher than those of female participants. The results obtained reveal that male individuals seek more information during decision-making processes regarding healthcare services and evaluate factors such as treatment options, cost comparisons and service access more intensively.

Similarly, the literature indicates that men adopt a more rational, benefit- and outcome-oriented approach in their decision-making processes regarding healthcare services (Aydın, 2012). This supports the findings of the present study.

On the other hand, it appears that female participants' awareness of health tourism is shaped primarily by emotional, social and experiential factors. According to the research findings, it can be said that women take greater account of factors such as perceived trust, empathy, quality of communication and the influence of their social environment in their healthcare decision-making processes. This aligns with the findings highlighted in Yaba's (2022) study, which suggest that women are more sensitive to emotional and relational factors in healthcare services. In this context, it is important to develop gender-sensitive strategies for promotional and marketing activities in the field of health tourism. It is recommended that studies targeting men prioritise

rational factors such as cost, quality, accessibility and treatment success; whilst studies targeting women should emphasise emotional and social dimensions such as trust, empathy, quality of care and service experience. It is believed that this approach will contribute to raising awareness of health tourism and to the development of more effective communication strategies for the target audience (Tengilimoğlu, 2017).

3.2. A Comparison of Northern and Southern Europe

The higher general awareness and positive image perceptions among expatriates residing in Northern Europe compared to those in Western and Southern regions can be attributed to the specific operational models of Northern European welfare states. While healthcare in Northern Europe is highly institutionalized, it is frequently characterized by rigid bureaucratic protocols, strict gatekeeping systems via general practitioners, and protracted waiting lists for non-emergency or elective procedures. These systemic delays prompt Northern European expatriates to seek alternative, high-speed solutions abroad. Additionally, the high costs of dental care, cosmetic procedures, and specialized rehabilitation services not fully covered by public insurance in Northern Europe enhance the relative utility and financial attractiveness of Turkey's health tourism capacity, thereby fostering an enhanced awareness and positive institutional image.

One of the most striking findings of the study is that levels of awareness of health tourism vary significantly depending on the region of residence. In particular, it was found that expatriates living in Northern Europe have significantly higher levels of awareness of health tourism compared to those living in Western and Southern Europe ($p < 0.01$). The average level of general awareness of health tourism among individuals living in Northern Europe was $\bar{x} = 3.74$, whilst this value was $\bar{x} = 3.36$ for those living in Western Europe and $\bar{x} = 3.15$ for those living in Southern Europe. Similarly, there are significant differences in favour of Northern Europe in the 'image' and 'general awareness' sub-dimensions. In particular, it is noteworthy that the average for the Northern Europe group in the 'image' dimension ($\bar{x} = 4.09$) is quite high.

This difference stems from the fact that Turkish citizens living in Northern European countries have greater interaction with their healthcare systems, a high level of digital health literacy, and well-developed skills in comparing and evaluating healthcare services. Furthermore, the bureaucratic constraints and long waiting times associated with accessing healthcare services in these countries are driving individuals to seek alternatives; Turkey is perceived as a strong alternative in this regard. The lower level of awareness among expatriates living in Southern

European countries can be explained by the relatively easier access to healthcare services in these countries and the fact that cultural proximity reduces the perceived need for healthcare services. In this context, communication and promotional strategies for medical tourism must be restructured to take regional differences into account.

3.2.1. Assessment of Awareness Levels by Hometown Origins

The findings show that expatriates originating from Eastern and Southeastern Anatolia have higher awareness and more positive perceptions compared to those originating from the Marmara region. This difference stems from the rapid sharing of positive healthcare experiences thanks to this group's collectivist structure in Europe and their direct experience of Turkey's modern medical infrastructure through frequent homeland visits.

3.3. Perceived Institutional Competence and Image

The study found that the ‘institutional competence’ dimension had a lower average score compared to the other sub-dimensions ($\bar{x}=3.25$). This indicates that, although Turkey’s healthcare infrastructure is robust, this strength is not sufficiently reflected at the perceptual level. In particular, there are perceptual gaps regarding issues such as accreditation processes, patient safety, transparency and compliance with international standards. Conversely, the fact that the “effects of health tourism” dimension has the highest mean score ($\bar{x}=4.17$) indicates that individuals strongly believe in the economic, social and individual benefits of health tourism. This situation reveals that whilst Turkey’s potential for health tourism is recognised, this potential has not been sufficiently integrated with the institutional image.

3.4. Comparison of the Findings with the Literature

When the findings regarding educational status are evaluated, it is observed that expatriates with basic and secondary education levels exhibit higher health tourism awareness and more positive perceptions compared to those with higher education degrees. This situation can be conceptualized through the lens of institutional trust and risk perception profiles associated with educational backgrounds. Higher education graduates tend to possess a more critical and questioning approach toward health systems, rendering them more cautious regarding cross-border healthcare risks, legal protections, and international accreditation complexities. Conversely, individuals with lower educational attainment may rely more heavily on information from immediate social networks and community-based references rather than formal structural dimensions. Furthermore, lower education groups may face greater financial and bureaucratic

barriers within Western European healthcare systems leading them to perceive Turkey's fast, affordable, and culturally familiar healthcare environment as a more substantial relative advantage, thereby shaping a more favorable image perception.

The research findings largely align with those of studies in the literature. The findings indicating that awareness of health tourism is linked to individuals' level of education, country of residence and cultural capital demonstrate that health tourism is a phenomenon closely connected to the socio-cultural structure. This aligns with previous research indicating that awareness of health tourism is influenced by individual characteristics and social factors (Yaba, 2022). Furthermore, findings indicating that trust, perceived service quality and organisational image are decisive factors in decision-making processes align with studies in the literature (Zengingönül et al., 2012).

This study has revealed that Turkish citizens living abroad generally have a high level of awareness regarding health tourism in Turkey; however, this awareness varies significantly according to demographic variables. In particular, it was found that Turkish expatriates living in Northern Europe have a higher level of awareness of health tourism compared to those in Western and Southern Europe. This situation is directly related to regional living conditions, the structure of healthcare systems and the level of access to information. The research findings indicate that health tourism policies should not be uniform but should be implemented through strategies tailored to the target audience. In particular, informative campaigns, digital health communication and trust-based promotional activities aimed at Turkish citizens living in Southern Europe should be increased. Furthermore, in health tourism communication targeting women, emotional trust, patient experience and quality of care should be prioritised.

3.5. Academic and Industry Recommendations

To maximize health tourism potential, strategic steps must be taken across various stakeholders. Policymakers should focus promotional campaigns on regions with low awareness, while healthcare institutions need to highlight quality accreditations to build trust and adopt multilingual digital systems for online booking and patient tracking. In academic research, utilizing qualitative methods is recommended to better understand the socio-psychological factors influencing awareness. The business and tourism sectors should implement country-specific marketing strategies—aimed at maintaining the Northern European market and expanding into Southern Europe—and utilize platforms like Turkish Airlines' in-flight screens for broader

promotion. Ultimately, Turkey's significant medical tourism potential can only be fully realized through comprehensive, target-audience-focused strategies that carefully account for regional differences.

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