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Service Providers' Behaviour in Light of Developing the Medical Tourism Industry in Malaysia: at the Expense of Local Patients?

Herwina Rosnan¹, Norzayana Yusof²

¹ Arshad Ayub Graduate Business School, ² Department of Postgraduate and Professional Studies,
Faculty of Business and Management,
Universiti Teknologi MARA. 40450. Shah Alam. Selangor. Malaysia

herwinaros@gmail.com; norzayana.yusof@gmail.com
Tel: +6019-2345680

Abstract

Despite the concern that medical tourism causes local patients to be neglected, this article attempts to prove the otherwise. Ten in-depth interviews were conducted with doctors and private hospitals that serve medical tourists. Through Atlas.ti version 8, our interviews found that the locals are still the primary focus as medical tourists only take about 10% on average of the total patients in these hospitals. Further, hospitals are bound to Act 586 by the central government. This research suggests for the policy-makers to take the necessary proactive actions in developing the medical tourism industry while simultaneously catering for the locals' needs.

Keywords: Medical Tourism; Local Patients; Public Healthcare; Healthcare Equity

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1.0 Introduction

The medical tourism industry has been showing positive growth over the past decade as Malaysia received 1.2 million travellers who brought in RM1.5 billion. Realising on the potential that this industry has and its benefits in contributing to the national economy, medical tourism has been getting attention from the government through fund allocations in the annual budget. Recently, the Ministry of Finance Malaysia has allocated RM20 million to the Malaysia Healthcare Travel Council (MHTC) in the National Budget 2019. It stands as a means to spur growth through collaboration with reputable private hospitals as well as escalating the brand name of Malaysia as the destination for medical tourism (Ministry of Finance Malaysia, 2018). However, there are concerns with the establishment of more private hospitals and the recruitment of specialists. This activity is feared to barricade the accessibility of public healthcare, especially to the bottom 40% (B40) of Malaysian income group (Malaysiakini, 2019). Furthermore, global scholars have been doing studies on this issue fearing for overlapping regulations between medical tourism and public health (Labonté, Crooks, Valdés, Runnels, & Snyder, 2018).

Nonetheless, we find the lack of research that delineates the narrative of health equities within the context of the service providers' behaviour. Hence, this article aims to describe the state of focus given to the local patients vis-à-vis medical tourists. Supported by primary data, this article offers an overview of the behaviour of private hospitals, specialists and government agencies that reflect their efforts in balancing the two patient groups. It is essential to note that this study is a part of more extensive research. 'Attention to local patients' is a subtopic that emerged during the data collection process. Due to its prominent appearance, we decided to explore more on this issue throughout the data collection. Hence, this article is subject to several limitations, including the absence of players in public healthcare whose opinions would validate the actual situation in the public hospital setting.

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2.0 Literature Review

2.1 Medical Tourism in Malaysia

According to Adams, Snyder, Crooks, and Berry (2018), medical tourism is a term taken to describe health travellers who traverse beyond their national borders in search of private healthcare services and treatments. This activity can come through invasive medical procedures or healing environments such as spa and mineral bath. A combination that marries travelling, tourism and health give birth to an industry called medical tourism. This industry began its conception in Malaysia during the 1997 Asian economic crisis where the local patients switched their preferences to public hospitals due to their decreased purchasing power. As a means to keep the business running, it resulted in several private hospitals seeking for foreign patients to get their treatments in Malaysia. Consequently, the medical tourism industry was born. Over the next two decades, this industry has been showing positive growth in the number of medical tourists arrived and the revenues that they brought in. What used to be a solution to a problem is now a growing venture for private healthcare providers, commonly termed as private hospitals. Internationally, numerous reports have ranked Malaysia top in various categories. For instance, the 2019 Global Retirement Index by International Living awarded Malaysia as 'Best Country in the World for Healthcare'. This was measured through state-of-the-art medical devices, 13 Joint Commission International (JCI) accredited hospitals, affordable treatment costs and ease of access to specialists (International Living, 2019).

2.2 Health equity between medical tourists and local patients

Scholars agreed that hospitals should ensure conducive environment within the premise as it affects patients satisfaction level (Ghazali & Abbas, 2012). Such situation constitutes clean facilities, aesthetic elements in the building and courtyard (Almhafdy, Ibrahim, Ahmad, & Yahya, 2013) and appropriate management strategy (Rani, Baharum, Akbar, & Nawawi, 2015). These are the rights of all patients, regardless of their status. Specifically, in the dental tourism industry, Adams et al. (2018) conducted a case study in Los Algodones, Mexico, in search of whether the locals have been at the expense of this activity. Specifically, they conducted interviews on differing professional roles, including dentists, dental assistant, patient facilitator, and marketing professionals. Hence, Adams et al. (2018) suggested that medical tourism possesses potential negative impingement to the locals in terms of accessibility to well-equipped dental clinics in rural areas. Similarly, in 2013, Labonté et al. (2018) conducted 50 semi-structured interviews with the public, private and community representatives who have interest and concerns over the medical tourism industry in Guatemala. Thus, Labonté et al. (2018) delineated that the public regulation is inadequate to ensure that the medical tourism industry could benefit local patients.

Despite the claimed disparity in other countries, Malaysia is seen to be having positive economic impacts from medical tourism activities. Through input-output (I-O) analysis, Klijs, Ormond, Mainil, Peerlings, and Heijman (2016) found that nine states in Malaysia generated an output of RM1,313.4 million with RM468.6 million in value-added with over 19,000 jobs created in 2007. Furthermore, impacts on non-medical expenditure are found to be more prominent. This situation affects human health and social work, manufacturing, followed by trade, real estate, transport and storage, among many others (Klijs et al., 2016). Through the multiplier effect of 2.23, Malaysia was able to achieve a 16% revenue growth with a total gross economic impact of RM5 billion in 2017. Hence a target of 20-30% growth with RM2.8 billion is set in hospital revenue with an estimated economic impact of RM10 billion by 2020 (Malaysia Healthcare Travel Council, 2018).

3.0 Methodology

This article centralises on the behaviour of service providers in light of developing the medical tourism industry. Specifically, this research aims to explore whether medical tourism is growing at the expense of local patients. Due to the lack of research that narrates the meanings of negating the local patients, we conducted ten in-depth interviews with the service providers between December 2018 and April 2019. Specifically, the discussions involved private hospitals (n=7), a government division that manages private healthcare providers (n=1), and doctors that serve medical tourists (n=2). The participants for private hospitals range from the Chief Executive Officer (CEO), Marketing Director to Marketing Clerk that handles the medical tourists firsthand. On average, each interview session took approximately one hour at the participants' office. Their consent was made on two matters; i) agreement to be interviewed and ii) agreement to be audio recorded. To assure anonymity, the participants' organisation name, including GB, will not be disclosed. We classified the private hospitals as Private Hospital 1 (PH1), PH2, PH3 ... PH7. Meanwhile, we coded the Doctors as D1 and D2 and the government division as GB.

We determined the sample from MHTC website that lists their Elite and Ordinary members. We began building networks with the potential participants during the insigHT2018 Conference, which was held on 3rd to 4th September 2018. Also, during the Private Healthcare Productivity Nexus (PHPN) Implementation Strategy Workshop organised by a government agency on 8th to 11th October 2018. Throughout the interview sessions, participants were snowballed, which brought us to Penang, Melaka, and Johor, on top of Selangor and Kuala Lumpur. To ensure the validity of the information attained, we emailed a summary of their interview. Hence, we transcribed the interview by verbatim and analysed with the assistance of Atlas.ti version 8 to run the 'coding', 'group coding', and finally to build the networks between them. We referred to Yin (2014) as a guidance for this exploratory qualitative case study. For this article, we analysed the data as a group with three embedded units of analysis consisting of PH, GB, and Doctors. One profound limitation in the sampling is the absence of a representative from the public healthcare such as the doctors or management teams in the public hospitals. Consequently, this limits the thoroughness of our discussion.

4.0 Findings

Participant's demographic information

From the seven private hospitals, only PH2 began their medical tourism activities during the 1997 Asian economic crisis. They had 'no choice' but to seek for foreign patients to utilise their services. Meanwhile, the majority of others started medical tourism around 2008 while some others only began in 2016. Meanwhile, the doctors are from the cardiology department in two different private hospitals in Kuala Lumpur. Doctor 1 (D1) is a Fellow Specialist, and Doctor 2 (D2) is a Consultant Cardiologist with 13 years of experience in this field alone. These doctors are chosen, from our acquaintance, as the hospital that they work at fall within the sample criteria, and they both serve medical tourists. On the other hand, the GB is a branch under the MOH that is further divided into three main sectors that cover technical and operations, service evaluation and sources and standards respectively. Therefore, we provide an illustration of the findings in Figure 1 below. □

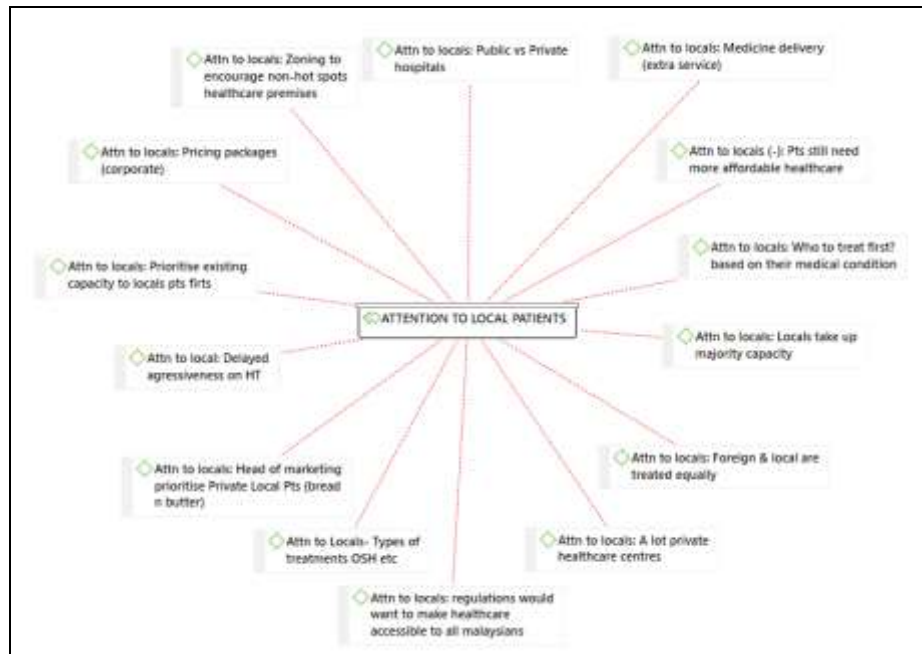


Fig. 1: Summary on the justifications on the attention given to local patients from private hospitals and doctors' perspectives. Extracted from Atlas.ti version 8.

5.0 Discussion

The present section discusses the findings attained with support from the literature. This section delineates the behaviour of the service providers from the private hospitals, doctors and a GB's perspectives. Hence, we categorise the discussion into three main components.

5.1 Attention to local patients as the priority for private hospitals

This study reveals that local patients are still in the priority of private hospitals. This is seen from their intention to venture into medical tourism only after the expansion of their hospital capacities, including new buildings and beds. A number of the participants are relatively young in the medical tourism industry as they have only been in it for about three years. When asked about the reason for not doing it earlier, we received the same response, and it was due to the limited beds and other physical constraints that hindered them. Not wanting to jeopardise the comfort and rights of the local patients to get treatments, these hospitals decided to endeavour into medical tourism comparatively late than their counterparts. The behaviour of private hospitals prioritising local patients counteracts the claim of local patients being crowd-out due to the shortage of facilities that they depend on (Beladi, Chao, Ee, & Hollas, 2019). In our interview, PH6 explained that,

'... I mean, we don't have enough beds. So if we go aggressively (to market medical tourism), that means our local patients will be displaced, sort of, and we don't want that'.

Moreover, private hospitals run medical tourism as 'along-the-way' kind of business. It means that the private hospitals, which initially run their premises according to the needs of the locals, are extending their services with the available capacity to serve the medical tourists. This situation illustrates the existingly strong focus toward local patients as some of the hospitals described the local patients as their 'bread and butter'. On another note, this study also unveiled that the percentage of medical tourists from the total patients in the respective hospitals is as low as 2%. Although medical tourists take 30% to 70% of the total patients in specific

hospitals, this only happens in selective premises such as in Penang Island, where flights and connectivity are easy from Indonesia. Meanwhile, the opposite situation occurs in majority of hospitals in other regions. □

As for the doctors, who are a clinical fellow in cardiology and a consultant cardiologist respectively, they were asked about whom they would prefer to treat between the local and foreign patients. Hence, D1 and D2 conjectured that patients' medical condition is the indicator to serve for and not their nationality. This answer conforms to the norm of medical practices throughout the entire medical line. In fact, due to language and documentation barriers, several doctors are even reluctant to serve medical tourists. In situations like this, the management would firstly ask the doctors if they can commit to serving medical tourists. In cases where they are not, the administration would then cross their names from the doctor's list. It helps to ensure that the doctors could work comfortably to cater for the locals while certifying that the medical tourists are treated by only those who are keen. □

Moreover, the different situations of Malaysian doctors' interest to participate in medical tourism activities reflect the actual meanings of their behaviour in treating the two groups of patients. While Adams et al. (2018) put forward that many doctors are interested in serving the medical tourists due to the opportunities of career, income and work condition growth, this article has proven the opposite. Several participants explained that the doctor charges are indifferent between the local and medical tourists, as this boils down the respective hospital's pricing structure instead of the doctors' will. □

5.2 Healthcare provisions for the locals: quality, accessibility and the way forward

Our participation in one of the events in late 2018 has led to the discovery of the GB that overviews private healthcare sector in Malaysia. This division is placed under the Ministry of Health (MOH), and it runs the duty of licensing, law enforcement and surveillance to all kinds of private healthcare providers. This includes private hospitals, clinics, dental clinics, maternity clinics and mobile clinic throughout Malaysia. With federal and state representative offices available, this reflects the entirety that the MOH is providing to the locals. Hence, an interview was conducted with a representative of this GB, and it is found that GB places a strong emphasis to ensure the quality, safety, and accessibility of healthcare to the local patients. Specifically, the GB's role is to ensure that the service providers abide the Private Healthcare Facilities and Services Act (PHFSA), also known as Act 586.

When asked whether the medical tourism activities are classified as one of the agendas in GB, the participant responded that it is not listed under their agenda as they are focused to

'...enforce all of this (the Act). Whether the private hospital is related to MHTC, Malaysian Healthcare Travel Council or not, that's not our concern. We do what we need to do... What concerns us is the quality of the healthcare given to the patients and the safety of the patients.'

This signifies the level of quality that the locals are getting from the private healthcare providers as the GB runs surveillance activities throughout Malaysia. Although some of the private hospitals describe the GB as hindering their business activities, PH6, for instance, agreed that the stringent documentation and surveillance by GB is good for the private healthcare providers because it speaks volume of the strong clinical governance that Malaysia is known for among the medical tourists. As a result, the local patients are enjoying high-quality services by the same healthcare providers. Furthermore, it is also found that the GB is very concerned about the accessibility of private healthcare to the locals, especially in suburban and rural areas. This is described by the 'zoning criteria' that the Act imposes to ensure that, □

'... everyone gets access to healthcare. Otherwise, everyone needs to go to Kuala Lumpur to get access to good hospitals, and this shouldn't be happening'.



Fig. 2: Private healthcare sector with its distinctive Branch under the MOH signifying the provisions of healthcare for the locals

. Accordingly, the Guidelines on Zoning Approval Application for the Establishment of Private Hospitals (Medical Practice Division, 2014) has outlined the criteria for application on the establishment of new private hospitals. This includes the types of healthcare facilities and services (HFS) as specialised or multi-disciplinary; availability of existing HFS; the needs to have 25 beds:1000 citizen with distance of 30km radius in Peninsular Malaysia and 50km for Sabah and Sarawak; the future needs for HFS; as well as other matters including the application for establishing new private hospitals to cater for health tourism if relevant. The Guideline poses indirect protection of the local patients' rights for access to healthcare. Nevertheless, this situation illustrates the attention that the government takes on ensuring the availability of private healthcare providers throughout Malaysia by controlling the establishment of new private hospitals. Hence, the findings are contradicting the claim that the healthcare providers' behaviour is prone to serve the

demand of medical tourists as mentioned by Hoffman, Crooks, Snyder, and Adams (2015) because Malaysia's healthcare system is highly regulated by the central government. The distinctive Division in MOH that caters for private healthcare requires service providers to meet the provisions under Act 586. The Act helps to ensure that private healthcare is accessible to local patients in city, sub-urban and in rural areas.

Provisions of equitable healthcare facilities to the locals are essential. Hence, improvements in the public healthcare provisions are crucial as this sector is to meet the purpose of public welfare. This may come in the form of building more public hospitals in rural areas to improve its accessibility, which will create more job offerings for the medical workforce. Moreover, Selim, Noor Hazilah, and Rafikul (2017) posited that the public healthcare lags behind the private sector in terms of service quality which suggests for a large room for improvements within this sector. This situation also echoes to the needs for the public healthcare services to enhance its space quality including technicality, functionality, and aesthetics (Samah, Ibrahim, & Amir, 2013) providing a healing ambience to the patients and medical professionals (Kamali & Abbas, 2012).

6.0 Conclusion & Recommendations

While the demand for ample, efficient and productive improvements for healthcare facilities is high (Ngowtanasuwan & Ruengtam, 2013), it is vital to note that local patients are still the primary focus of the private healthcare providers. This is seen by the private hospitals' aggressiveness in promoting medical tourism only after the expansion of their building, which suggests their intention of not wanting to jeopardise the local patients' right to get treatments. Apart from that, with the medical tourists occupying about 2% to 10% in most of the private hospitals serving for this industry, it indicates that our existing capacities in private hospitals are still taken up mainly by local patients. Moreover, GB implements and enforces the provisions under Act 586, indicating that the law has long been set to cater for the welfare of local patients. Furthermore, there are also enforcement bodies to ensure that the Act is being adhered. However, this article strongly suggests for detailed guidelines by the government that demonstrates the rules and limitations for private hospitals in serving the medical tourists so that local patients do not get crowd-out.

The present article is deemed non-exhaustive. Findings are only attained from the private hospitals that serve the medical tourists whose opinions are bias towards their benefits in this industry. This brings forward the issue of robustness of the study. Nevertheless, we strongly believe that this exploratory research on Malaysian healthcare has opened new doors opportunities. As hospitals offer an immense avenue for research (Lawson, 2013), future studies are suggested to be directed towards the perspectives of public hospitals and whether they have been affected by the growth of medical tourism. Qualitative approaches are suggested at state-level analysis as Klijs et al. (2016) conjectured that each state in Malaysia runs and makes returns from medical tourism differently. Moreover, quantitative studies are also essential to gain representativeness for the entire Malaysian market. Hence, questionnaire surveys could be distributed throughout Malaysia's public hospitals to attain a larger volume about their perspective.

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