

Health Tourism in Malaysia: Prospects and Challenges

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Abstract

It is estimated that the health tourism industry in Asia will be worth US\$4bil (RM14.2 bil) by 2012, and Malaysia is positioning itself as one of the major players in this region, expecting to earn up to US\$590 mil (RM2.1 bil) within five years (The Star, Nov 8, 2008). In 2007 alone, Malaysia received 341,288 medical tourists with revenue of RM253.84 million (www.tourism.gov.my). Thus, the potential of the industry is enormous, and the Malaysian government is making the right strategic move in this direction. Health tourism as is practised and promoted today is a relatively new concept, although patients travelling far and wide in search for medical treatment is not anything new. The paper explores the development and growth of medical tourism in the global context, as well as among the Asian key players in the industry, before moving into the Malaysian experience. The role of key players in advancing the agenda of the industry, namely the Ministry of Health, Ministry of Tourism, Ministry of International Trade and Industry, the Association of Private Hospitals etc, will also be discussed. Finally, challenges faced by an industry still in its infancy will also be discussed.

Keywords: *Health tourism, healthcare, private hospitals.*

Introduction

Malaysia's tourism industry is a vibrant sector of the country's economy. During the Eighth Malaysia Plan (2001-2005) period, foreign exchange earnings from tourists increased at an average annual growth rate of 12.4 percent, from 17.3 billion in 2000 to almost 50 billion in 2008 (Ministry of Tourism, 2008). Although adversely affected by the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003, the tourism industry has otherwise remained robust. During the Ninth Malaysia Plan (2006-2010), tourism was expected to continue as a major source of new growth and a driver in the services sector (Economic Planning Unit, 2005). The Visit Malaysia 2007 campaign and a series of high profile events celebrating Malaysia's 50th independence also proved successful, which saw 20.97 million tourists into the country, representing an increase of 19.5 percent increase year on year (Malaysia Tourism Report, 2008). A record high of 22.05 million tourist arrival, however, was recorded for 2008 surpassing the 21.5 million target set under the Ninth Malaysia Plan (Ministry of Tourism, 2008). Among the tourism products that is being heavily promoted, health tourism has the potential of offering a pot of gold at the end of the rainbow, with earnings valued at RM 925 million in 2005, exceeding education tourism which stood at RM 450 million for the same year (Economic Planning Unit, 2005). Research has also shown that health tourists spend twice as much as normal tourists-US\$362 compared with US\$144 per day (Ang, 2009). The multiplier effect from health tourism reverberates into other industries. A medical tourist who comes for surgery such as a coronary bypass will stay longer, and is also normally accompanied by family members who will need accommodation and other necessities. The transportation industry will also gain from the requirements for flight tickets and the need for patient (and relatives) mobility during the treatment and recuperation period. A new model to the travel agency business has also developed out of the industry; that of the medical brokerages which arrange for services between the patient and the caregiver, and other needs of the patient and family members. Given the huge potential of the

industry, the Malaysian government is very keen to establish Malaysia as a health tourist destination in the region. Public-private partnership has been set-up by the government in order to facilitate the growth of the industry. Health tourism is also seen as a driver for the country to move up the services value chain in line with Vision 2020. The government's commitment is exemplified in the promotion of health tourism as an area of focus for the health sector under the Ninth Malaysia Plan (Aseambankers, 2006).

Origin, Growth and Trend of Health Tourism

A review of the literature indicates that health tourism is not a new concept born out of the need to adapt to our changing lifestyle and habits. Travelling abroad for health has a long history for the upper social classes who sought spas, mineral baths, and innovative therapies as destinations for health improvement and wellness (Gray and Poland, 2008). In the seventeenth century, the wealthy of Europe travelled to spas and specialty hospitals on the Nile (Burkett, 2007). In recent times however, literature on the subject published around 1980s and 1990s was focused on countries in Europe and the United States as health tourist destinations. European countries known for its health tourism industries are Switzerland, Germany, Austria, Hungary, United Kingdom and France (Goodrich and Goodrich, 1987). Health tourism then was discussed in the context of services offered by health resorts and spas which centres on thermal springs and related health facilities. This took the form of hotels and tourist facilities offering health services such as medical check-ups, special diets, vitamin-complex treatments, herbal remedies etc, on top of the conventional tourist attractions as a market positioning advantage (Goodrich and Goodrich, 1987; Becheri, 1989; Gilbert and Weerdt, 1991; Witt and Witt, 1989). Many cities or resorts have grown up around thermal springs such as Baden, Lausanne, St Moritz and the Interlaken in Switzerland; Baden-Baden and Wiesbaden in Germany; Vienna in Austria, and Hot Springs in Arkansas, US (Goodrich and Goodrich, 1987). Scientific advancement in water therapy also led to the creation of specialised spas concentrating on the curative powers of the thermal springs. Consequently, such treatments were also incorporated into the national health services of countries such as Germany, France, Austria, Switzerland and Belgium. This development was however not incorporated into Britain's National Health Service (NHS), which led to the decline and neglect of health spas in the United Kingdom (Gilbert and Weerdt, 1991).

Apart from the spas and health resorts, health tourism also took the form of patients from less developed countries going for medical treatment to Europe or the United States where the health facilities are better-equipped and technologically more advanced. Examples of renowned institutions in the US favoured by health tourists are the Cleveland and Mayo Clinics and John Hopkins (Volz, 2008). In the 1980s and 1990s also, many US medical facilities took the position of attracting international clientele when competition for US patients became stiff, and the involvement of managed care and consolidation of health insurance reduced their profitability. Some of the well-regarded hospitals within the same locality banded together to create a niche among their clientele. Thus, hospitals in Boston were favoured by the Kuwaitis, Saudis and those from United Arab Emirates. In Miami, such hospitals catered for wealthy patients from Argentina, Brazil, Peru and Venezuela; while in Texas, the medical centres draw affluent patients from Mexico (Turner, 2007). In Europe, Austria is acknowledged for its medical competence where a major source of expertise is the Medical University of Vienna. Its excellent medical facilities coupled with scenic beauty have made Austria the country of choice for medical services among royalties and foreign leaders (Bruggraber, 2009). In London, Harley Street is well-known for its clinics and hospitals which are frequented by the rich and famous from the world over.

However, of late, there has been a reversal in the trend whereby patients from developed countries such as the US and Britain is travelling to other parts of the world for their medical needs. In the US where medical cost for a major surgery may wipe out an uninsured patient's whole life savings, the more cost-effective option is to have the operation done in another country where it is cheaper. In the case of Britain, the long queue on the wait list of the National Health Service (NHS) for elective surgery prompts patients to avoid the line by seeking treatment in another country. Connell (2006) quoted an estimate of 50,000 people leaving Britain in 2003 as medical tourists. More and more Americans are also seeking medical treatment abroad with estimates ranging from 50,000 to 500,000 (York, 2008). For American health tourists, the essence is cost. Healthcare spending in America is astronomical, where in 2007 it stood at US\$2.2 trillion, and represented 16 percent of the country's GDP. A study carried out in 2007 also revealed that half of the country's bankruptcies in 2001 were caused by medical bills (York, 2008). On top of that, for the 46 million Americans who are uninsured, or those with restrictive policies or pre-existing conditions, health tourism provides the solution to a critical situation. Thus, health tourism that is being promoted today takes a different form and angle from the health spas of Europe or the cutting-edge US hospitals. Rather, the movement of patients is from developed to less developed countries. Over twenty years ago, the industry catered primarily for dental treatment and cosmetic surgery, but it now provides for the whole spectrum of health and medical services. The industry has also developed into a very lucrative market valued at US\$ 60 billion worldwide in 2006 (Leahy, 2008).

The terms 'health tourism', 'medical tourism' or 'health services outsourcing' are often interchangeably used to describe health services provision in another country (Salmon, 2008). The concept of health tourism in a broader sense may include all health-seeking behaviours by consumers into another country. This may include getting health services, tourism for indigenous and alternative medical treatments, and any other form of tourism undertaken with the purpose of addressing a health concern, usually motivated by seeking cheaper care (Salmon, 2008). However, health tourism that is on offer today takes more than just the preventive and wellness approach of health resorts and spas, but broadens into invasive medical treatment such as hip replacement surgery or coronary bypass, in another country particularly due to cost considerations. This prompted authors like Connell (2006) to delineate medical treatment done in another country as medical tourism; while tourism which precludes invasive medical treatment such as those offered at spas and health resorts, as health tourism. (For the purpose of this paper, the term will be used interchangeably). The emphasis is also shifting from American and European health facilities towards Asia and Latin America. There is currently intense excitement on this new direction of the industry, due to its emergent position and huge potential for growth.

The rise and rise of health tourism

According to Deloitte Centre for Health Solutions Research, global health tourism industry generated revenues of up to US\$ 460 billion with a 20 percent annual growth (Cruetz, 2009). Patient mobility across borders has been significant, and the numbers are increasing. In 2003, more than 350,000 patients from developed countries travelled to less-developed countries for their healthcare needs. In 2004, 1.18 million patients from all over the world travelled to India as health tourists, and another 1.1 million went to Thailand. The number of Americans who sought healthcare offshore was estimated at 750,000 in 2007, and was projected to increase to six million in 2010 (Horowitz and Rosensweig, 2007). The rapid growth of health tourism has been attributed to factors such as excessive medical costs in rich countries, long waiting lists, relative affordability of international air travel, favourable economic exchange rates, and the ageing of the affluent baby-boomer generation (Connell, 2006). Rapid growth of the industry has also been facilitated by the internet revolution that has allowed for the proliferation of medical brokerages around the

world which premise their business on the virtual platform. A survey carried out by the Medical Tourism Association showed that 49 percent of health tourists found out about medical care in a foreign country from the internet (MTA, 2009). Prior to their travel, prospective patients would require purchasing airline tickets, finding an appropriate medical facility and qualified physicians, making hotel reservations which may include for accompanying family members, making arrangements for payments and also for the transfer of medical records. These requisite services are being met by health brokerage companies which fill the gap between the clients and the caregivers (Turner, 2007).

Medical brokerage companies advertise extensively on the internet, promoting the lure of exotic vacation with world-class medical facilities. In essence, the medical brokers service their clients in similar ways to the travel agents. Apart from the medical brokers, hospitals engaged in health tourism also widely advertise their services on the internet. The physicians and their academic credentials and experience are also published on the hospitals' websites. A large number of physicians in the major health tourism hospitals are also western-trained, a fact that would be liberally communicated to prospective patients in an attempt to allay any fears regarding the quality and standard of medical care. In fact, destination hospitals like the Apollo Hospitals Group in India have many of their surgeons trained at renowned centres in US such as the Memorial Sloan-Kettering Cancer Institute. Bumrungrad Hospital in Bangkok has also been quoted as having more than 200 US board-certified physicians (Burkett, 2007). Apart from their human resource capital, major destination hospitals also leverage on accreditation for market positioning. Accreditation, especially by Joint Commission International (JCI), which is part of the governing body of the US-based Joint Commission on Accreditation of Healthcare Organisations (JCAHO), gives the assurance of an internationally accepted level of technical standard of care. The JCI has been described as the 'gold standard' in global healthcare standards (Chambers and McIntosh, 2008), and it is more specific to hospital services than the generic ISO quality management standard. More than 102 hospitals in over 20 countries have been certified by JCI since its inception in 1994. This is also indicative of the fact that hospitals in the global front are moving towards a common standard of care rather than diverging measures and quality of care (Schroth and Khawaja, 2007). To that extent, Rick Wade, the senior vice president of the American Hospital Association has been quoted as saying that *"he has no doubt that some international hospitals are just as high-quality as their US counterparts"* (Fried and Harris, 2007). Accordingly, major hospitals especially those in Asia are able to promote themselves as first-class resorts and world-class medical facilities (Burkett, 2007).

The flight of American patients away from the American healthcare system cannot be underestimated. The United States has the highest per capita healthcare cost in the world, yet its healthcare system is ranked 37th in the world for quality according to the World Health Organisation (Douglas, 2007). Anecdotal evidence of individuals going offshore for medical treatment graces the literature on the subject (Turner, 2007; York, 2007; Cuddehe, 2009; Gray and Poland, 2008; Milstein and Smith, 2006; Connell, 2006). While Americans enjoy the highest standard of care, the country's healthcare delivery system is flawed by excessive costs as well as issues of inequity and access. In fact, the number one cause for personal bankruptcies in the US today is medical expenses. Forty-six millions American do not have health insurance coverage in a system that does not provide universal coverage, and a further 25 millions are underinsured (Rizco and Rizco, 2009). High premiums for health insurance led to a situation where millions have to make do with purchasing low-budget plans that cover only a limited number of medical conditions. Cream-skimming in the form of excluding those with pre-existing conditions from a health plan also exacerbates access and equity to healthcare. Reduction in retiree benefits, and widespread reduction or elimination of health benefits for employees are also leaving more and more Americans without health insurance coverage (Turner, 2007). These situations coupled with the astronomical costs of healthcare provide a fertile ground for health tourism. The recent

financial meltdown and depressed American economy will only add to the attractiveness of health tourism to thousands of Americans who lost their jobs. A glance at the comparison of costs of medical procedures between US and Asian health tourist destinations as follows reflects the situation succinctly:

Table1: Comparative costs of medical procedures by country

Procedure	US(US\$)	India(US\$)	Thailand(US\$)	Singapore(US\$)
Heart bypass	130,000	10,000	11,000	18,500
Heart valve replacement	160,000	9,000	10,000	12,500
Angioplasty	57,000	11,000	13,000	13,000
Hip replacement	43,000	9,000	12,000	12,000
Hysterectomy	20,000	3,000	4,5000	6,000
Knee replacement	40,000	8,500	10,000	13,000
Spinal fusion	62,000	5,500	7,000	9,000

Source: York, Diane (2008), Medical tourism: The trend toward outsourcing medical procedures to foreign countries, *Journal of Continuing Education in the Health Professions*, vol. 28, no. 2, pp. 99-102

While the move has initially been an individual choice, the development is gaining institutional support from organisations overburdened with excessive medical costs. Blue Ridge Paper Products became the first company in the US to introduce health tourism incentive to its employee benefit plan. Employees who opt to have non-emergency surgeries at approved hospitals in India would be paid flight tickets by the company, with extra sick-leave time and an additional bonus of US\$10,000 as further inducement. Although the plan was resisted by the union and subsequently withdrawn, it sent a strong signal to the healthcare industry (Burkett, 2007). Health insurance companies such as Aetna, Blue Cross/Blue Shield of South Carolina, Blue Shield of California and United Group Programs are beginning to reimburse for some offshore medical treatment. Blue Cross/Blue Shield of South Carolina was the first insurance company in the US to create a subsidiary to cater specifically for overseas medical procedures. State legislatures in Colorado and West Virginia have also introduced bills which allow their employees to travel overseas for surgery (York, 2008). Blue Shield of California and Health Net are encouraging their patients to get medical care in Mexico, while United Group Programs is promoting elective surgery in Thailand (Horowitz and Rosensweig, 2007). While it is still too early to see the impact of outsourcing on the American healthcare system, the gloom has already been predicted, with some cautioning that this may have the same potential as did the Japanese automakers to the American carmakers (Kher, 2006; Dunn, 2007)

In a clear case of somebody's loss is somebody else's gain, two regions which have markedly benefitted from health tourism is Latin America and Asia. Both regions are developing economies with some of the countries having relatively low-priced high quality healthcare services. Countries in Latin America that are focused on medical tourism are Mexico, Costa Rica, Brazil, Argentina, Guatemala, Colombia, Chile and El Salvador (Vequist, Valdez and Morrison, 2009). In Mexico, Americans form the largest number of international patients, and the form of treatment has

changed from dental procedures or cosmetic surgery in the past, to invasive procedures such as hip replacements and heart surgeries (Cuddehe, 2009). Argentina has established itself as a favoured destination for cosmetic surgery (Connell, 2006). Many of the Latin American countries have also established the core competence in dental care. Like their Asian counterparts, these countries are endowed with scenic locations, beautiful beaches, world class hotels, as well as a friendly and caring culture. Although some are not as advanced as the Asian players in health tourism, they have however, the advantage of being geographically closer to the United States. The Medical Tourism Association (MTA) estimated that by 2017, up to 23 million Americans could be travelling overseas and spending up to US\$79.5 billion per year; and with more than 50 percent of that business going to Latin American countries (Vequist, Valdez and Morrison, 2009).

Countries in Asia which have positioned themselves as health tourist destinations are India, Thailand, Singapore, Malaysia, the Philippines and South Korea. The industry in this region is expected to be worth at least US\$4 billion by 2012 (Ang, 2009). Asia has some of the best hospitals with state-of-the art technology and finest medical specialists offering a broad array of medical services from general health screening and check-up to complex medical procedures. They are also world leaders in low-cost pricing in healthcare. The region also has a huge population to provide for the health tourism revenue. Indonesia, for example, with a population of over 200 million provides most of the medical tourists for Malaysia and Singapore. Some of these countries also have a more mature health tourism markets, facilities and practices; as well as public/private partnerships geared towards enhancing the growth of the industry. Asian countries are also well-known for their scenic locations and unspoilt beaches, as well as a friendly and caring culture. They are also known to place emphasis on education and healthcare. For example, in countries such as Singapore, Malaysia, and the Philippines, English are widely spoken, and it is also the national language of India. As for healthcare, countries like Malaysia has always had a strong public healthcare delivery system which is regarded as one of the best in the Asia-Pacific region (Omar, 2000). Currently an estimated 1.32 million health tourists come to Asia from all over the world, including the US and Europe, although the bulk of the travel is still within the Asian region (Vequist, Valdez and Morrison, 2009). The ease of air travel and the advent of low cost carriers into the transportation industry had also augment tourism in this region. AirAsia for example, transported 15 million passengers by 2005 within four years in operation; and surpassed the twenty-million mark by 2006 (Ze and Ng, 2008). Apart from Malaysia, countries in this region like Singapore and Thailand have also established their own low-cost carriers which further facilitate travel in the area.

Among the Asian countries, Thailand, India and Singapore have had a good head start in this burgeoning industry. More than one million tourists have received some form of medical care in Thailand, ranging from executive health tests to cardiac packages, cancer therapy, eye surgery, liposuction and cosmetic options. The country has been quoted as having reaped US\$1.6 billion from health tourism in 2003 (Connell, 2006). Health facilities such as Bumrungrad Hospital have established an outstanding reputation for itself in health tourism. It is the first hospital in Asia to receive JCAHO (Joint Commission on Accreditation of Healthcare Organisations) accreditation (Arellano and Annette, 2007). The hospital has more than 700 internationally-trained and board-certified doctors and provides the whole range of medical services and treatment. It has 200 surgeons certified in the United States and also has all English-speaking staff. To facilitate any barriers in communication, it also employs 70 interpreters (Connell, 2006). In 2004 alone, Bumrungrad treated more than 355,000 foreign patients accounting for a third of its total patients and almost 50 percent of the hospital's revenue (IJHCQA, 2010). In 2005, 55,000 Americans underwent treatment there (Fried and Harris, 2007), and it now provides care to over 430,000 international patients a year (Turner, 2007). Apart from Bumrungrad, Thailand's Phuket Hospital

has also been a favoured health tourist destination. It receives about 20,000 foreign patients a year and provides the services of interpreters in 15 languages (Connell, 2006).

Health tourism in Thailand took off in response to the Asian financial crisis in late 1990s which saw its middle class population squeezed out and left its private hospitals with no choice but to move into the international market for patients. It was taken as a strategic business move in response to an economic crisis which resulted in the drop in the value of the baht. The situation was used as an opportunity by hospitals like Bumrungrad and the Bangkok Hospital Group to capitalise on its competitive pricing, with the resultant effect in significant increase in the number of international patients (Turner, 2007). Low cost medical procedures for international patients transformed Thailand into a major destination for health travellers. Success breeds success and Thailand's model was followed suit by its neighbouring countries. Among its neighbours, Singapore was quick to realise the huge gain from health tourism.

Unlike Thailand whose health tourism effort was initiated by individual private hospitals, Singapore's approach was well-supported by the government. The country has positioned itself as a provider of high quality medical care and made world headlines for performing complex neurosurgical procedures and delivering cutting-edge medical treatment by some of the world's finest medical specialists in the region (IJHCQA, 2010). The Singapore government has also given a grant of US\$350 million for Duke University to create a postgraduate medical school in collaboration with National University of Singapore (Turner, 2007). Among Asian health tourist destinations, Singapore chooses to compete on the basis of quality, and superior technology; rather than price (Connell, 2006). Thus, relative to other Asian countries, healthcare costs in Singapore is more expensive, but is still very competitive by world standard, and particularly the US. For example, a liver transplant which would cost US\$300,000 in US would cost only US\$150,000 in Singapore (Burkett, 2007). Its hospitals leverage on outcome measures as a mean of assuring prospective patients on the standard of quality of care. Singapore's National Healthcare Group, which is a conglomerate of acute care and specialist hospitals, regularly publishes results on outcome measures which are of international standards. Among others, it reports a 100 percent rate for dispensing aspirin at discharge for acute myocardial infarction and 0.6 to 2.2 percent 30-day mortality rate for heart failure (Dunn, 2007). The strategy paid well and Singapore managed to increase its international patient base from 150,000 in 2000 to 374,000 in 2005 (Turner, 2007). Singapore aims to bring in one million patients by 2012 (Ganesan, 2008).

India, another regional player which positions itself as a provider of cost-effective high quality treatment, saw its number of health tourists increased from less than 10,000 five years ago to more than 100,000 annually (Jyothis and Janardhanan, 2009). The country's venture into health tourism also has the blessings of its government with India's national health policy recognising services to international patients as an 'export'. Consequently government incentives aimed at encouraging the growth of the industry such as special zoning laws, reduction in tariffs for imported medical devices, lowered corporate taxes and improvements in transportation infrastructure were undertaken by the government (Turner, 2007). The Indian government has also created a special visa which allows health tourists to stay in the country for up to a year to receive medical treatment (Burkett, 2007). India's private hospitals responded well to the government initiatives. The Apollo Group of hospitals, which is a well-established provider of medical tourism, has even gone to the extent of relocating its services closer to American shores. It has signed a memorandum of understanding with the American International Medical University in Bahamas and St Lucia to build specialised teaching, treatment and research hospitals in Barbados and the Bahamas, which will be staffed by students and physicians from India. In other words, if patients cannot travel to India, the service is literally transported to them (Turner, 2007). Apart from government support, India also has the advantage of having a large number of physicians trained in the West to meet the needs of its health tourism industry. It also has the benefit of having

numerous physicians among the Indian diaspora. It is estimated that 40,000 non-resident Indians are currently practicing medicine in the US, and the country is trying to lure them back. The Wockhardt Hospitals Group in India has successfully managed to attract 28 physicians from the US to join them, and they are setting a goal of attracting 130 physicians back to India by 2010. Most of these physicians have at least 15 years experience and are board certified in high-end clinical specialties and sub-specialties (Dunn, 2007). Reaping the benefits of its investments, India's health tourism is now worth US\$333 million (Jyothis and Janardhanan, 2009), and is projected to grow to US\$2.2 billion by 2012 (Horowitz and Rosenweig, 2007).

Health tourism in Malaysia

As in the case of Thailand, Malaysian private hospitals also began sourcing for international patients in response to the financial crisis the country went through in 1997, when local patients could not afford private medical care. However, Thailand had an earlier head start in health tourism when it began specialising in sex change operations as early as in the 70s, and then into cosmetic surgery (Connell, 2006). In this respect, Malaysia is a relative newcomer, although public-private partnership is already in place to spearhead the industry to the next level of growth. The intensification of the industry can be seen from the increasing number of international patients into the country. In 2001, the number of health tourists was 75,210 and by 2006, the number had increased to 296,687 which generated a total revenue of RM203.66 million (US\$ 59 million). In 2007, Malaysia received 341,288 health tourists with revenue of RM253.84 million (Ministry of Tourism, 2008). The target set for health tourism under the Ninth Malaysia Plan is for the country to gain a total of RM2.0 billion in foreign exchange from this sector (Economic Planning Unit, 2005). The industry has been growing at an impressive rate of 30 percent annually prior to the current global economic slowdown (Bernama, 2009). The following table reflects the growth of the industry:

Table 2: Number of patients and income under the Health Tourism Programme 2002-2006.

Year	2002	2003	2004	2005	2006	2007
No. of patients	84,585	102,946	174,189	232,161	296,687	341,288
Income (RM million)	35.9	58.9	105.0	150.9	203.7	253.84

Source: Association of Private Hospitals Malaysia (APHM)

Malaysia is thus poised to be a favourite contender in the industry. The country already has the right infrastructure due to its strong healthcare delivery system, and tight control over quality assurance of its medical services. It also has a high number of western-trained physicians and Malaysian nurses are highly regarded and well-sought after particularly in the middle-east. Medical education and practise is well-regulated, and the Ministry of Health closely supervises both public and private healthcare services in the country. Malaysia is also not short of medical achievements in its own right. The National Heart Institute recently scored a first in Asia with a new procedure called trans catheter aortic valve implantation which does not require patients to undergo cardio pulmonary bypass; and public doctors in Selayang Hospital performed the world's first arm and hand transplant in 2000 (Najib, 2009). Accreditation of hospitals is carried out by the Malaysian Society for Quality in Health (MSQH), which is based on the Australian healthcare standard. Most hospitals in the country are also ISO 9000 registered. Hospitals which are accredited by JCI are the National Heart Institute, Sime Darby Medical Centre, Prince Court Medical Centre, Penang Adventist Hospital and International Specialist Eye Centre (JCI, 2010). Since the outbreak of the *nipah* virus, Malaysia has had the experience of handling major epidemic and had successfully managed to contain the SARS incidence in the country. Malaysia's health

indicators such as infant mortality rate and life expectancy are also at par with most developed countries. This has built up the reputation of the country as a credible healthcare provider.

The Malaysian government has been very supportive of private sector involvement in the industry. As in Singapore and Thailand, health tourism in Malaysia is also mainly dominated by private hospitals. The Ministry of Health (MOH) has identified 35 private hospitals which are being promoted for health tourism. A Corporate Policy and Health Industry Division has also been established under the Ministry, in order to ensure regulatory and promotional efforts are focused on the development and growth of the industry. Earlier efforts towards the promotion of health tourism were undertaken by the National Committee for the Promotion of Health Tourism which was set up in 1998. The Committee comprises members from the Ministry of Health, Ministry of Tourism, Association of Private Hospitals of Malaysia, and other stakeholders such as the Malaysian Association of Tours and Travel Agencies, Malaysian Airlines and several private hospitals. The Committee has been collaborating with agencies such as Malaysian External Trade Development Corporation (MATRADE), Tourism Malaysia, the state governments and the Association of Private Hospitals in carrying promotional activities (Tourism Malaysia, 2007). The government has also set up a gateway, 'Malaysia Healthcare' for prospective patients to seek information on Malaysian healthcare services through the internet at (www.myhealthcare.gov.my) (Khoo, 2009).

The profile of medical tourists coming to Malaysia is slightly different from Thailand or Singapore. This is because the majority of the patients are from Indonesia, which make up 72 percent of foreign patients in 2007. This was followed by Singaporeans (10 percent), Japan (5 percent), India (5 percent), Europe (3 percent) and others (6 percent) (Sivanandam, 2009). Malaysia is also fast catching up as a medical tourism destination due to the higher foreign exchange rate in Singapore and the political situation in Thailand (Frost and Sullivan, 2009). The majority of the medical tourists seek treatment in Penang, Johor and Malacca. These states register a high number of medical tourists because of their proximity and ease of travel to and from Indonesia. The Malacca state government is also building the Malacca airport which will further facilitate the travel of Indonesians to Malacca. The state has created a niche in health tourism among patients from Sumatra who can easily take a ferry ride to Malacca. In 2008, Malacca attracted 70,000 tourists from Sumatra (NST, 2009). Patients from Singapore are also coming for treatment in Malacca due to the higher cost of care in the Republic. Apart from health tourists from within the region, Malaysia has also seen an upward trend of patients from the middle-east. According to Connell (2006), an onshore oil operation company in Abu Dhabi sends 36,000 of its employees to Malaysia for medical check-ups. The government has been promoting health tourism to the middle-east by stressing on Islamic facet such as *halal* food and Islamic practices in hospitals. The country's cost advantage has also prompted Malaysian hospitals to explore new markets such as Bangladesh, Vietnam, Cambodia, United States, Europe and Canada. A health brokerage company, Malaysia Healthcare (MHC) has already set up office in Dhaka. Apart from lower cost, Malaysia's political stability is also a competitive advantage.

To facilitate the arrival of health tourists into the country, the Immigration Department has also implemented the Green Lane system at main entry points which expedites custom clearance for medical travellers. In order to stimulate the industry further, visa for health tourists has also been extended from 30 days to six months (Bernama, 2008). The government has also established the Malaysian Healthcare Travel Council (MHTC), which is a one-stop centre to promote the country's medical services abroad (Razak, 2009). The MHTC is another public-private partnership which is tasked with the responsibility to formulate strategic plan for the promotion of Malaysian health tourism. The government has also initiated other strategies to boost the industry. Among others, 100 percent tax exemption of qualifying capital expenditure will be given for the construction of new hospitals or renovation of existing facilities, applicable from 2010 until 2014.

Hospitals which set up the International Patients Unit will also be eligible for the incentive, provided they are registered with the Ministry of Health for the promotion of health tourism. Expenses incurred by private hospitals to obtain accreditation either locally from MSQH, or from internationally recognised accreditation bodies such as JCI, will be given double tax exemption. Apart from tax incentive, the Ministry of Health, Malaysian Medical Council and the Association of Private Hospitals has also been instructed by the government to review existing guidelines on advertising of medical services in order to meet the changing role of private hospitals with respect to health tourism. To strengthen human resource capability and to encourage more Malaysian medical specialists abroad to return home, the non-Malaysian spouse who qualify as a professional as per the Malaysian Classification of Occupation (MASCO) will automatically be offered employment pass (Razak, 2009).

Other measures aimed at facilitating the stay of medical tourists have also been approved by the government. The Commercial Vehicle Licensing Board (CVLB) will issue relevant permits to allow health tourist hospitals to ferry patients and accompanying persons to and from the airport or seaport to the respective hospitals and hotels. Medical tourists entering Malaysia on emergency via 'Visa-on-arrival (VOA)' will be allowed to convert their VOA status to social visit pass upon the recommendation of the attending private hospital provided the hospital is registered as a health tourist hospital with the Ministry of Health (Razak, 2009).

Challenges and Conclusion

The changing global landscape of the healthcare industry is indicative of the fact that the future lies in health tourism. Healthcare of the future will be borderless and it is within this industry that the ground is most fertile for the transformation. Advances in medical technology helps to develop procedures that are less and less invasive yet with higher degree of precision and efficacy, and this augurs well for the travelling patient who will need less time to recuperate, not to mention his or her peace of mind in times of sickness. The business dimension of healthcare also means that new technology and advances can also be purchased and practised in health facilities around the globe. The internet allows for medical data to be transported with ease, and advances in information technology also allow mobility of patient data. A patient can bring his or her whole life medical record in a tiny chip without the hassle of hard data. The internet revolution also brought countries far away into homes of prospective patients, allaying the fear of alien culture. It has also brought much efficiency to the airline industry, which in turn helps low-cost carriers to flourish, and this in turn facilitates the growth of medical tourism.

While there has been much excitement over the dawn of a new industry, the journey is also strewn with challenges. Shortage of human resource is an incessant affair in the health sector. Unlike other fields of studies, it takes a longer duration to produce a medical graduate, and much longer to produce a medical specialist or sub-specialist. The rigour to being a medical consultant is not for the fainthearted. It is also in the interest of the medical fraternity not to flood the market with medical graduates, hence the barrier to entry in the form of academic excellence or quota for university entrance. The situation may worsen in countries where there is marked difference in the healthcare delivery system, i.e. between private and public healthcare, as in the case of Malaysia. In this respect, the country has seen for a number of years the migration of health professionals from the public to the private sector. The large salary gap between private and public hospitals is a known source of dissatisfaction among doctors in public hospitals, and is a contributory factor to the migration of doctors from public to private hospitals (Samah, 2000). On average, some 300 doctors and specialists resign and another 30 opt for optional retirement annually among the doctors in public hospitals (Lim, 2002). Low pay, unattractive working hours and conditions, preference of doctors to serve in urban rather than rural areas, and the long period of time required

to produce a medical specialist are some of the factors affecting the supply and retention of physicians in Malaysian public hospitals. While remuneration package of health professionals have much increased over the years, it is still not feasible for public sector pay to match the private sector. Under the circumstances, the government has to tread carefully not to aggravate the situation further by losing more health professionals, particularly physicians to the private sector, at the expense of the health of the nation's masses. In essence, growth and development of health tourism should not lead to 'brain drain', but rather 'brain gain' where Malaysian medical specialists who are working abroad are enticed to return home and serve the health tourist sector. Accordingly, public sector remuneration also has to be reconsidered in light of recent developments.

The foremost concern of any healthcare delivery system is equity and access to health services. While it is without doubt that the country benefits from health tourist revenue, caution must also be exercised to ensure that equity and access to quality healthcare for Malaysians in general are not affected in our enthusiasm to join the health tourism bandwagon. Malaysia has, over so many years, carefully crafted an equitable healthcare delivery system, and for all intent and purposes, it should remain so.

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