Serving the Medical Tourists in Malaysia: Are local patients being put the second?

Norzayana Yusof [1], Herwina Rosnan [2]

[1]Faculty of Business and Management,
[2]Arshad Ayub Graduate Business School,
Universiti Teknologi MARA, Malaysia

norzayana.yusof@gmail.com; herwinaros@gmail.com

Abstract

Despite the concern that local patients are being put the second, this article attempts to prove the otherwise. Ten in-depth interviews were conducted with a government division, medical doctors, and private hospitals serving medical tourists. Through Atlas.ti version 8, it is found that locals are still the primary focus as medical tourists only take about 10%, on average, of the total patients in these hospitals. Further, hospitals only went aggressive in medical tourism after their capacity expansion. This research suggests for the policy-makers to take the necessary actions in developing medical tourism industry while simultaneously catering for the locals' needs.

Keywords: Medical Tourism; Local Patients; Public Healthcare; Patients' needs

DOI: https://doi.org/10.21834/aje-bs.v5i15.360

1.0 Introduction

The Malaysian medical tourism industry has been showing constructive growth over the past decade. This is reflected in the number of medical tourists and revenue received in 2018 that rose to 1.2 million travellers. These health travellers brought in RM1.5 billion to the country in the same year. Hence, the figure illustrates a steady increase of 85% from 2011 as Malaysia only received 643,000 health travellers with total revenue of RM527 million for the year (Malaysia Healthcare Travel Council, 2019a). 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 budgets.

In the recent 2020 Budget, the Ministry of Finance Malaysia allocated RM25 million to the Malaysia Healthcare Travel Council (MHTC). This is aimed at strengthening the position of Malaysia as the medical hub for oncology, cardiology and fertility treatment (Ministry of Finance Malaysia, 2019). On the other hand, the 2019 Budget speech recorded that MHTC was funded with RM20 million as a means to spur growth in the industry through collaboration with reputable private hospitals as well as escalating the brand name of Malaysia as the chosen destination for medical tourism (Ministry of Finance Malaysia, 2018). Thus, the increase in financial allocation resembled the importance of the medical tourism industry in supporting Malaysia's economic growth.

Moreover, the government has also facilitated in the records of medical tourists through the establishment of e-visa applications for 10 countries including China and India (Ministry of Finance Malaysia, 2019). To further support the application process, licensed travel agents under the Ministry of Tourism and Culture (MOTAC) are permitted to submit group applications for up to 100 people per transaction through the Electronic Travel Registration & Information (eNTRI) and eVISA systems. Additionally, this industry is also deemed valuable as it is one of the key drivers of growth for the country and key sources of income for the national economy (Ministry of Finance Malaysia, 2017)

Despite the bright outlook of the medical tourism industry as it is expected to grow 25% and earn RM1.8 billion hospital revenue in 2019 (Malaysia Healthcare Travel Council, 2019b), there have been concerns on the externalities that this economic activity could bring to Malaysia especially the local patients. For instance, it is feared that the establishment of more private hospitals and recruitment of specialists into this group of healthcare provider would impinge the accessibility of healthcare especially to the bottom 40 (B40) of Malaysian income group (Malaysiakini, 2019). Furthermore, global scholars have been running studies on this issue apprehending for the overlapping regulations between medical tourism and public health (Labonté, Crooks, Valdés, Runnels, & Snyder, 2018). Similarly, this matter also includes masking the concerns on health equity to local patients (Adams, Snyder, Crooks, & Berry, 2018).

While these concerns have long been established, the present article finds the lack of research that delineates the narrative of health equities. Specifically, research within the context of the service providers' behaviour of serving the medical tourists is scarce, let alone in attaining first-hand insights into their perspectives. Hence, this article aims to

describe the state of focus given to the local patient vis-à-vis medical tourists. Supported by primary data, this article offers an overview of the behaviours of private hospitals, medical doctors and government agencies that reflect their efforts in balancing the two patient groups.

2.0 Literature Review

Having derived the problem and objectives of the article, the present section articulates on the review of existing literature. Hence, assessments are presented into two major groups which are i) medical tourism in Malaysia; and ii) Health equity between medical tourists and local patients.

2.1 Medical Tourism in Malaysia

According to Adams et al. (2018), medical tourism is a term 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 gave birth to an industry described as 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 the 'Best Country in the World for Healthcare' which was measured by the state-of-the-art medical facilities, 13 Joint Commission International (JCI) accredited hospitals, a global gold standard in the world, affordable treatment costs than the counterparts and ease of access to specialists (International Living, 2019).

Apart from that, Malaysia also won the Medical Travel Awards between 2015 and 2018 consecutively which carriers various titles such as Health and Medical Tourism: Cluster of the Year and Destination of the Year (Malaysia Healthcare Travel Council, 2019a). At hospital level, the country's prominent players such as the National Heart Institute (NHI) was awarded the 2018 International Specialist Patient Centre of the Year, while Gleneagles Kuala Lumpur received the 2018 International Hospital of the Year along with several other healthcare providers with their awards.

2.2 Health equity between medical tourists and local patients

It is 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 nationality and other 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, interviews were conducted 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 Guatemala, Labonté et al. (2018) conducted 50 in-person semi-structured interviews with participants ranging from public, private and community representatives who have interest and concerns over the medical tourism industry in 2013. Thus Labonté et al. (2018) delineated the absence of adequate public regulation to ensure that the medical tourists are treated well and improvements on healthcare services for the locals are allocated by reaping the benefits of medical tourism.

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 affecting human health and social work, manufacturing, followed by trade, real estate, transport and storage, and other (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 2018 (Malaysia Healthcare Travel Council, 2018). Moving forward, a target of 20-30% growth with RM2.8 billion is set in hospital revenue with an estimated economic impact of RM10 billion (Malaysia Healthcare Travel Council, 2018). Given the positive records of medical tourism in Malaysia, it is seen that there exist a substantial potential for the local patients to benefits from the medical tourism industry due to the strong history of economic impacts that this industry generates.

3.0 Methodology

This article centralises on the behaviour of service providers in the medical tourism industry in light of developing the industry to explore whether or not 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, ten in-depth interviews were conducted with the service providers between December 2018 and April 2019. Specifically, the discussions involved private hospitals (n=7), a division under the Ministry of Health (MOH) that manages private healthcare providers (n=1), and medical doctors that serve medical tourists (Doctors) (n=2).

The participants for private hospitals range from the Chief Executive Officer (CEO), Marketing Director and Executive to Marketing Clerk that handles the medical tourists firsthand. On average, each interview session took approximately one hour and held at the participants' office. Their consent was made on two matters; i) agreement to interview and ii) agreement to be audio recorded. To assure anonymity, the participants' organisation name, including GB, will be enclosed. The private hospitals will be termed as Private Hospital 1 (PH1), PH2, PH3 and up to PH7. On the other hand, the Doctors will be classified as D1 and D2 and the government division as GB.

The sample was taken from MHTC website that lists their Elite and Ordinary members. The initial contact of the private hospitals was during the insigHT2018 Conference which was held on 3rd to 4th September 2018 as well as the Private Healthcare Productivity Nexus (PHPN) Implementation Strategy Workshop organised by a government agency on 8th to 11th October 2018 where the researcher began building networks with the potential participants. Throughout these two events, the researcher exchanged name cards with the hospital representatives and contacted them later to request for an interview session. From there, the participants were snowballed which brought the researcher to Penang, Melaka, and Johor, on top of Selangor and Kuala Lumpur.

To ensure the validity of the information attained, the participants were emailed with the summary of their interview answers, and it is found that they mainly do not make many amendments from what they mentioned during the interview. Hence, data was transcribed 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. Reference was made to Yin (2014) as a guide for this exploratory qualitative case study. For this article, the data was analysed 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. Thus, the next section discusses further the primary data.

4.0 Results

Having derived the methodology, this research has then successfully arrived at numerous profound findings. Hence, this section delineates the demographic information of the participants and the inductive theme that the findings have arrived at.

4.1 Participants' demographic information

The private hospitals are derived from the elite and ordinary members of MHTC. Among which, only P2 began their medical tourism activities during the 1997 Asian economic crisis as 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 from two different private hospitals in Kuala Lumpur. Doctor 1 (D1) is a fellow specialist in Cardiology while

Doctor 2 (D2) is a consultant cardiologist with 13 years of experience in this field alone. These doctors were chosen from the researcher's acquaintance, as their hospitals fall within the sample criteria and that they both serve for the medical tourists. On the other hand, the GB is a branch under the MOH that are further divided into three main sectors that cover technical and operations, service evaluation and sources and standards respectively.

4.2 Categorisation of the inductive findings emerged from data collection.

As the demographic information has been delineated, the present section offers a summary of the findings in the present study. Therefore, Table 1 below provides an illustration of the inductive theme 'Attention to local patients' from the in-depth interviews conducted. It is seen that this theme emerges from fourteen quotations that appeared across the interview transcripts. This signifies its importance of bringing forward the concern on health equities thus rationalising the needs for the present article.

Table 1: Quotations under the theme 'Attention to local patients' emerged from the in-depth interviews

Freq.	Quotation Name	Quotation Content
2	No favouritism between local and foreign patients Priorities based on patients' conditions	"The doctor-patient relationship is actually the same, not much different to that for the local patient (or overseas)… Who to treat first ya? It depends on their medical condition. Which one is on emergency, we will treat first. Regardless of whether they are overseas or local."
3	Local patients as bread and butter, taking the majority of the capacity	"Private local. That is our bread and butter… Currently, we have 60% government, 37% private, and the rest are actually medical tourism. It's very small (3%)."
		"I think the majority we can say is local. So only about 3% of our interest in tourism. So that means we are not really depending on health tourism actually."
3	Delayed health tourism, avoid crowd-out of local patients	"So, if we go aggressively, that means later our local patients will be displaced, sort of, you know.. We have to send them to the other hospital.."
3	Healthcare accessibility to local in rural-'Zoning'.	We will look at Section 9 of the Act. Basically, Zoning is made in such a way that we control the establishment of private hospitals as for now… Otherwise, everyone has to travel to KL to get access to quality healthcare, this shouldn't be happening.
2	Doctors at private healthcare- relatively easy build rapport with patients	"In government, you don't really have that rapport with your doctor. Usually, there's no specific doctor you see in the government.. It's very difficult to see the specialist because in government setting the top people usually are dealing with the administration or some other non-clinical things."

On the other hand, Figure 1 below depicts the primary findings that the study has attained. Thus, the behaviour of the service providers is derived from the perspectives of private hospitals, doctors and a GB. Hence, the discussions on this theme are assorted

into two main groups which are i) local patients as the priority of private hospitals; and ii) healthcare provisions for the locals: quality, accessibility and the way forward.

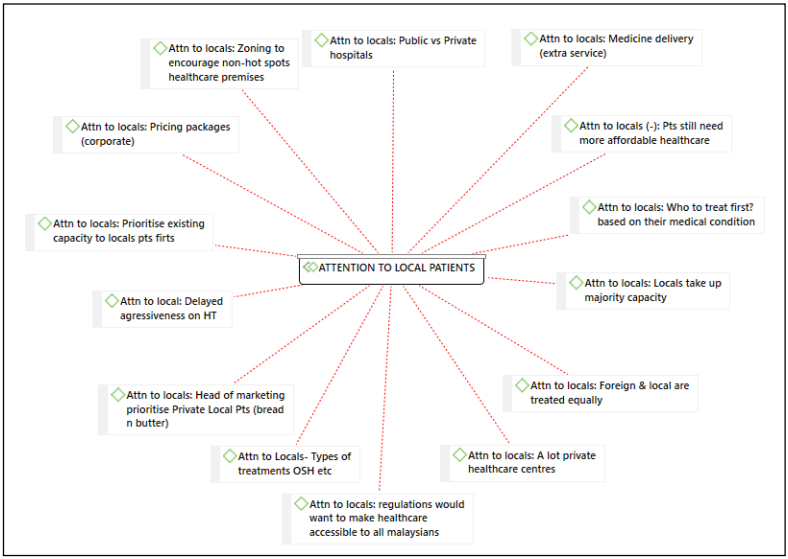

Figure 1: Summary of the justifications for the attention given to local patients.
Extracted from Atlas.ti version 8

5.0 Discussion

This section describes the behaviours of the stakeholder groups. Hence, they indicated that the locals are not at the expense of developing the medical tourism industry. As a means to rebuke and accept the argument, a detailed explanation of the findings is provided below.

5.1 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'. (PH6, Line 8:37, Atlas.ti)

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 existing 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 the 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 the 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 role of GB is to ensure that the service providers abide by 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, Malaysia 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."
(GB, Line 14:65, Atlas.ti)

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'.
(GB, Line 14:54, Atlas.ti)

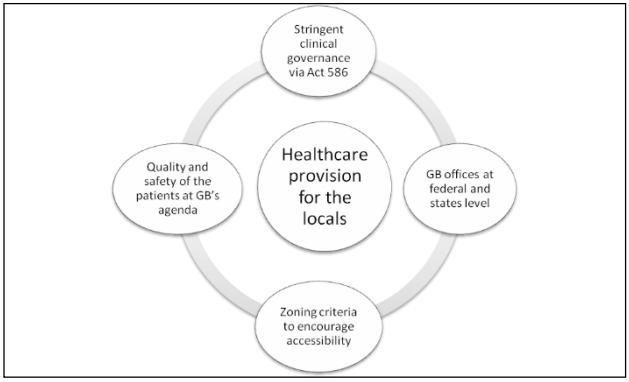

Fig. 2: Private healthcare sector with its distinctive Branch under the MOH signifying the provisions of healthcare for the locals

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.

Although government regulations are found to be scarce in other host countries (Adams et al., 2018; Labonté et al., 2018), the Malaysian government commits to the escalation to public healthcare deliveries through 'Zoning' and other means. As local patients are the focus of Malaysian public healthcare, its governance are separated from private services. Nevertheless, private healthcare operators are also expected to be in line with the national agenda. For instance, GB, as a Division in MOH catering for private healthcare, requires private service providers to meet the provisions under Act 586. The Act, among mony other, helps to ensure that private healthcare is accessible to local patients in city, suburban and 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

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 for 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 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 medical tourists whose opinions are skewed 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, Ormond, Mainil, Peerlings, and Heijman (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.

Acknowledgement

The authors would like to thank the Research Management Centre, Institute of Research Management & Innovation (IRMI), Universiti Teknologi MARA, for the financial support through Geran Inisiatif Penyeliaan (GIP), file no: 600-RMI 5/3/GIP (018/2018) and for managing the fund.

References

Adams, K., Snyder, J., Crooks, V. A., & Berry, N. S. (2018). A critical examination of empowerment discourse in medical tourism: the case of the dental tourism industry in Los Algodones, Mexico. *Globalization and Health, 14*(1), 70.

Almhafdy, A., Ibrahim, N., Ahmad, S. S., & Yahya, J. (2013). Analysis of the Courtyard Functions and its Design Variants in the Malaysian Hospitals. *Procedia - Social and Behavioral Sciences, 105*, 171-182. doi:https://doi.org/10.1016/j.sbspro.2013.11.018

Ghazali, R., & Abbas, M. Y. (2012). Newly Built Public Paediatric Wards Increase Length of Stay (LOS)? In M. Y. Abbas, A. F. I. Bajunid, & N. F. N. Azhari (Eds.), *Ace-Bs 2012 Bangkok* (Vol. 50, pp. 623-632). Amsterdam: Elsevier Science Bv.

International Living. (2019). 6 Countries with the Best Healthcare in the World. Retrieved from https://internationalliving.com/countries-best-healthcare-world

Kamali, N. J., & Abbas, M. Y. (2012). Healing Environment: Enhancing Nurses' Performance through Proper Lighting Design. *Procedia - Social and Behavioral Sciences, 35*, 205-212. doi:https://doi.org/10.1016/j.sbspro.2012.02.080

Klijs, J., Ormond, M., Mainil, T., Peerlings, J., & Heijman, W. (2016). A state-level analysis of the economic impacts of medical tourism in Malaysia. *Asian-Pacific Economic Literature, 30*(1), 3-29.

Labonté, R., Crooks, V. A., Valdés, A. C., Runnels, V., & Snyder, J. (2018). Government roles in regulating medical tourism: evidence from Guatemala. *International journal for equity in health, 17*(1), 150.

Lawson, B. (2013). Design and the Evidence. *Procedia - Social and Behavioral Sciences, 105*, 30-37. doi:https://doi.org/10.1016/j.sbspro.2013.11.004

Malaysia Healthcare Travel Council. (2018). Reference Material for IMTJ Awards 2018. Accessed on June 15th, 2019. Retrieced from https://www.mhtc.org.my/imtj2018cotymhtc/#_Text

Malaysia Healthcare Travel Council. (2019a). Number of Healthcare Travellers and Revenue between 2011-2018. Retrieved on June 10th, 2019 from https://www.mhtc.org.my/

Malaysia Healthcare Travel Council. (2019b). Medical tourism receipts to see 25% rise. Retrieved on June 10th, 2019, from https://www.mhtc.org.my/blog/2019/03/18/medical-tourism-receipts-to-see-25-rise/

Malaysiakini. (2019). PSM: Putrajaya's position on healthcare for B40 contradictory. Retrieved on June 5th, 2019 from https://www.malaysiakini.com/news/465825

Medical Practice Division. (2014). Guidelines on Zoning Approval Application for the Establishment of Private Hospitals.

Ministry of Finance Malaysia. (2017). *Budget 2018*. Kuala Lumpur: Percetakan Nasional Malaysia Berhad.

Ministry of Finance Malaysia. (2018). *Budget 2019*. Kuala Lumpur: Percetakan Nasional Malaysia Bhd,.

Ministry of Finance Malaysia. (2019). *Budget 2020*. Kuala Lumpur: Percetakan Nasional Malaysia Bhd.

Ngowtanasuwan, G., & Ruengtam, P. (2013). Applied Simulation Model for Design of Improving Medical Record Area in Out-patient Department (OPD) of a Governmental Hospital. *Procedia - Social and Behavioral Sciences, 101*, 147-158. doi:https://doi.org/10.1016/j.sbspro.2013.07.188

Rani, N. A. A., Baharum, M. R., Akbar, A. R. N., & Nawawi, A. H. (2015). Perception of Maintenance Management Strategy on Healthcare Facilities. *Procedia - Social and Behavioral Sciences, 170*, 272-281. doi:https://doi.org/10.1016/j.sbspro.2015.01.037

Samah, Z. A., Ibrahim, N., & Amir, J. S. (2013). Translating Quality Care Factors to Quality Space: Design Criteria for Outpatient Facility. *Procedia - Social and Behavioral Sciences, 105*, 265-272. doi:https://doi.org/10.1016/j.sbspro.2013.11.028

Selim, A., Noor Hazilah, A. M., & Rafikul, I. (2017). Measuring quality performance between public and private hospitals in Malaysia. *International Journal of Quality and Service Sciences, 9*(2), 218-228. doi:10.1108/IJQSS-02-2017-0015

Yin, R. K. (2014). *Case Study Research Design and Methods*. United Kingdom: SAGE Publications, Inc. Kindle Edition.