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Medical Tourism in Malaysia: International Movement of Healthcare Consumers and the Commodification of Healthcare

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**Medical Tourism In Malaysia:
International Movement of Healthcare Consumers and
the Commodification of Healthcare**

Chee Heng Leng

Travelling overseas for healthcare is not a new phenomenon for the elites of developing countries. For this social group, the consumption of healthcare overseas is part of a general pattern of consumption of foreign goods and services, which either cannot be found, or are deemed of lower quality, in their home countries. Hospitals in the United States, such as the Mayo Clinic for example, are among the choice options of the developing world elite when they are in need of medical care; but neighbouring countries with superior (whether perceived or real) healthcare are also part of their range of options.

In recent times, the privilege of travelling to another country for healthcare has come within the reach of the middle classes. Destination countries are not necessarily only developed countries, but also developing countries that have positioned themselves to take advantage of this new market.

In addition, a fairly new phenomenon may be observed, which is that of people from developed countries travelling to developing countries to seek medical care. Many reasons have been suggested for this, including the long waiting lists in the healthcare services of some developed countries, and the high costs of care in these countries coupled with a lack of medical insurance, or under-insurance (Garcia-Altes 2005).

In many instances, these new international flows of patients have risen in response to the emergence of 'health tourism' or 'medical tourism' as a deliberate marketing strategy, not only of hospitals, but also of the governments of these countries.¹ In Southeast Asia, the countries that have developed this strategy are Singapore, Malaysia, and Thailand. In

¹ In this paper, the term 'medical tourism' will be used to denote travelling to another country to seek medical treatment, including medical screening, from the health care services in that country; while 'health tourism' will be used to encompass a broader range of travel activities such as spa, massage, or just to avail oneself of another type of climate for the purposes of health. This follows a similar use of these terms in MOH (2002b: 104).

Malaysia and Thailand, these developments took off in a particularly big way after the 1997 Asian Financial Crisis.

In this paper, I will examine the development of medical tourism in Malaysia, drawing some comparisons with Thailand and Singapore where relevant. This development will be framed in the context of globalisation of the healthcare industry, and an increasing trend in the commodification of healthcare. I will propose that the advent of medical tourism in Malaysia marked a significant moment for the domestic healthcare provider industry, allowing it to survive a critical juncture.

Subsequent growth of the industry has been characterised by the synergies obtained from a regional integration of capital (in hospital ownership), and an expansion of the medical tourism market. With increasing globalisation of the healthcare industry, that is, the spread of healthcare corporations across countries, and the integration of the medical tourism market, the commodification of healthcare is intensified.

In all this, I will illustrate the pivotal role of the Malaysian state which has not only provided the policy environment conducive for corporate healthcare growth, but is also playing a major role in marketing Malaysian healthcare to the global medical tourism market. The process of transforming Malaysian healthcare into a global commodity is well underway, as the state institutionalises measures for standardization, quality control, as well as sales promotion, advertising and marketing.

COMMODIFICATION OF HEALTHCARE

In his classic work, *The Social Transformation of American Medicine*, Starr (1982: 22) locates the commodification of healthcare as occurring when the market became the dominant institution for the care of the sick, characterising this process as involving increased specialization of labour, greater emotional distance between the sick and their carers, and men increasingly taking on the dominant positions in the management of health and illness. Starr argues that the medical profession, in its rise to sovereignty, was able to establish its authority and control over the market by standardizing its product, and this was accomplished by standardizing the training and licencing of the producers, that is, the doctors.

More specifically, Caplan (1989) points out that healthcare became transformed into a commodity in the United States in the 1890-1920 period, before which, healthcare was largely family and home-based, even when the use of remedies prepared in the home eventually gave way to patent medicines purchased on the market. According to this work, the commodification process was characterised by three aspects: first, the eventual demise of domestic healthcare and the increase in public purchasing of medical services, second, a marked decline in the demand for patent medicines and a rise in the sale of prescription drugs; and third, an ideological shift in public discourse favouring professionalised medical care rather than self-care, which helped to legitimize the commodification process.

Schaniel and Neale (1999), in attempting to clarify the concept of *commodification*, take as the point of departure their interpretation of Marx's idea of commodities as things that are "produced, ... in factory-like circumstances, ... for sale, ... on a commercial market." According to these criteria, medical care service does not qualify as a commodity, and even though it may be treated as a commodity, it does not portray the characteristic behaviour of other commodities in a free market. Nevertheless, in examining a few case studies, the authors concede that when things are treated as though they are commodities, processes of commodification may occur even though these processes may not lead to full commodification, but instead result in different degrees of commodification. The authors propose that using the terms 'quasi-commodities' and 'quasi-commodification' in these instances will achieve greater clarity and less confusion.

Other writings have employed the term 'commodification' generally to refer to the increasing use of the market to organise the provisioning of healthcare services in society, while emphasizing various aspects of the definition of 'commodity'. For example, in an introduction to a series of articles examining healthcare from an ethical viewpoint, the idea of a commodity as a "... good inserted into the stream of commerce" is elucidated in terms of its price, its fungibility, and its instrumental (not intrinsic) value (Kaveny, 1999). While arguing that healthcare does not fit the features of a commodity although healthcare is being commodified, this writer addresses the disjuncture by resorting to Margaret Radin's concept of 'incomplete commodification' to refer to the way in which we understand and describe the value of healthcare in both market and non-market terms (Radin, 1996, as cited in Kaveny, 1999).

The commodification of healthcare is inextricably linked to the expansion of markets in healthcare, and to the rise of neo-liberal economics, which emphasizes the desirability of consumer choice as one reason for the promotion of markets. As healthcare is commodified, patients are recast as consumers (Pellegrino, 1999: 252; Keaney, 1999). This follows from the logic that commodities are produced for consumption. Meanwhile, the changeover from patient to consumer is supported by the increasing availability of information on clinical conditions on the one hand, and by more standards being imposed on professionals (for example, clinical practice guidelines, best practice guidelines) on the other. Among the consequences of healthcare commodification therefore is the change in the nature of the relationship between patient and doctor. As consumers and providers respectively, the relationship will be primarily regulated by the rules of the market, in which profit-making is legitimately foregrounded.

While recognizing that the process of commodification of healthcare may have begun much earlier in history, I will use the term ‘commodification’ in this paper to refer to the contemporary phenomenon in which the market is increasingly encroaching into the healthcare system. This is juxtaposed against a previous historical period when healthcare was thought of as a human right and an entitlement of citizenship. In many countries in the 1960s and 1970s, despite the fact that healthcare as a general human right was not recognised in national legislation, the basic right to healthcare was widely acknowledged, even in the United States (Starr, 1982: 388-9), and for all intents and purposes, incorporated into national policies.

‘Commodification of healthcare’ in this paper therefore refers to the way in which healthcare is treated as a commodity, and the process by which it is rendered more and more similar to a commodity that is amenable to being traded on the market. Following from the works cited earlier, this usage does not rest on any assumption that healthcare is a commodity or can be a commodity in the pure sense of the word. Nonetheless, the process of commodification of healthcare involves moving toward ‘product standardization’, market expansion, and marketing healthcare to consumers.

CORPORATIZATION IN THE MALAYSIAN HEALTHCARE SYSTEM

The healthcare system in Malaysia is a mixed public-private one. In terms of the number of doctors, the ratio is fairly balanced. In 2002, for example, 54 per cent of the doctors were in the public sector, and 46 per cent private (MOH 2002a). Most of the private sector doctors, however, are general practitioners, who provide much of the primary care in the urban areas. A market in healthcare has long existed inasmuch as private practitioners have been operating since colonial times up till now.

Nevertheless, the healthcare system as a whole was dominated by a public service ethos at the time the country gained Independence from the British (in 1957) and thereafter. The rural health system was rapidly built up in the 1960s and 1970s, and is now constituted by an extensive network of clinics, which form the first point of contact in a referral system that goes through the district hospitals, and end at the various state and tertiary hospitals. Up until the 1970s, and even until the early 1980s, the healthcare system was practically a national health service, insofar as the vast majority of the population was rural and had to depend on the public health services, which were financed primarily from taxation with only nominal charges at the point of use.²

Growing urbanization, particularly in the 1990s, meant that increasing proportions could avail themselves of the private healthcare established in the cities and towns. Although the urban population generally goes to private practitioners for primary care,³ they still depend on the public sector to a large extent for hospital care. The most recent country-wide representative data (Public Health Institute 1999) shows that 78.4 per cent of those hospitalised used Ministry of Health (MOH) hospitals compared to 17.9 per cent who used private hospitals.

² In 1970, the urban population was 27 per cent, creeping up to 34 per cent in 1980, and to 41 per cent in 1990. There was rapid urbanisation in the 1990s, with 62 per cent of the population living in urban areas by 2000 (Department of Statistics 1977: 275; Malaysia 1986: Table 5-4; Department of Statistics 2002).

³ In 1996, 54.2 per cent of recent illness or injury was seen to in private clinics, 38.7 per cent in government facilities, 4.8 per cent by alternative practitioners, and only 2.3 per cent in private hospitals (Public Health Institute, 1999). As urbanisation increased through the years, the proportion using private clinics has increased, because it is the rural population that depends heavily on government clinics for primary care.

Nevertheless, the seemingly low utilization rate of private hospitals belies their rapid growth within the last two decades. In 1980, private hospital beds made up only five per cent of total acute beds, but this figure steadily rose to 15 per cent by 1985 (Table 1). There was a slight dip between 1985 and 1988, an effect of the severe economic recession of the mid-1980s. Another spate of growth occurred in the 1990s, when private beds grew from 15 per cent in 1990 to 25 per cent in 1998. The private share again dropped in 1999 (to 21 per cent), an effect of the 1997 Asian financial crisis, but has since recovered to 25 per cent (2002).⁴

A large part of this growth has been in the setting up of large corporate investor-owned hospitals, which has attracted a large outflow of medical specialists, physicians, nurses, and other allied health expertise from the public sector. The growth in private specialist services has been particularly rapid. A registration system has yet to be set up for the private sector, but already, indications are that private specialist services outstrip the public sector. For example, the number of oncologists in the private sector is about twice that in the public sector, while over 70 percent of the specialist services in radiotherapy, magnetic resonance imaging, CT scanning, mammography, and cardio-thoracic treatment over 1999-2001 were in the private sector.⁵

Beginning in the early 1980s, therefore, there has been a definite trend toward the private sector playing a bigger role at the higher end of the healthcare spectrum. Traditionally, the private sector has been made up of non-profit hospitals and general practitioners operating as small businesses. A few small private hospitals were set up in the 1970s by groups of physicians, but this quickly changed, when the large corporations came into the sector, buying up the small hospitals, enlarging them, and setting up more of their own.⁶

Furthermore, the government embarked on a privatisation and corporatization policy, which involved corporatizing the National Heart Institute in 1993, and the University of Malaya Medical Centre in 1998.⁷ There are plans to extend this to all other government hospitals. Malaysian healthcare is therefore becoming more corporate in nature, on the whole; and it is

⁴ Calculated from the Ministry of Health Annual Report for various years.

⁵ Personal communication from an officer in the Ministry of Health in 2003.

⁶ A more detailed account is given in Chee and Barraclough (forthcoming).

⁷ Corporatization in these instances meant that the public hospitals were restructured into corporate entities with ownership still held by governmental bodies.

the corporatisation of healthcare that provides the context and the conditions for the increasing commodification of healthcare.

THE DEVELOPMENT OF MEDICAL TOURISM IN MALAYSIA

The 1997 Asian financial crisis: Turning to a foreign clientele

On an uptrend since the 1980s, private healthcare in Malaysia nonetheless encountered a downturn in the late 1990s due to the Asian financial crisis. The 1997 crisis caused many local patients of private hospitals to revert to public healthcare. Many of the businesses affected by the crisis either closed, downsized, or cut back on the range of benefits for employees, resulting in healthcare benefits being reduced or removed. Managed care companies also cut benefits, or placed restrictions on healthcare spending per person and choice of providers. In general, purchasing power decreased, and there were households which allowed private medical insurance to lapse. A study that was conducted in the immediate aftermath of the crisis highlighted the way in which the public healthcare system functioned as a social safety net during that time (UNFPA, 1998).⁸

Following from the rapid devaluation of the Thai baht in July 1997, the Malaysian ringgit also dropped rapidly.⁹ This not only affected purchasing power for healthcare and employer health benefits, thereby causing utilization rates in private hospitals to drop, but also caused the prices of imported pharmaceuticals, medical supplies, and medical equipment to soar.¹⁰ In the prevailing economic climate then, private hospitals could not increase prices, and therefore, their operating margins and profits were badly affected.

⁸ This study reported a 10 to 18 percent *increase* in patient load in public hospitals, and a 10 to 30 percent *decrease* in private hospitals and general practitioner clinics (UNFPA, 1998: 85-86). It also reported that some private companies imposed limits on medical claims for their employees, while others removed benefits for out-patient medical care, and there was a decrease in the movement of doctors and specialists from the public to the private sector. Similar accounts are found in MOH (2002b:104-113), Rabobank International (1999), and Wong (2003).

⁹ Capital controls were eventually imposed in Malaysia, but this happened quite late, in 1998.

¹⁰ The UNFPA (1998: 85-86) study reported an increase of 10 to 30 percent (sometimes 50 percent) in the cost of imported drugs, which made up more than 60 percent of the drugs used in the whole country. It also obtained direct feedback from private hospitals that increases in operating costs were the main problem, although this was made worse by a decrease in patient load and no increase in professional consulting fees. The study pointed out that the newer, more sophisticated and expensive hospitals were affected to a greater degree than the smaller and more modest hospitals.

It was in response to this crisis that private hospitals in Malaysia turned to foreign countries to attract patients, a move that had the full support, if not the active leadership, of the government. The National Committee for the Promotion of Medical and Health Tourism was formed by the MOH in January 1998.¹¹ Five subcommittees covered various types of action considered necessary to attract foreign patients – one each for identifying suitable source countries for promoting health tourism; drawing up tax incentives; fee packaging; accreditation guidelines; and advertising guidelines. The functions of the committee include formulating a strategic plan, promoting a ‘smart partnership’ between government, healthcare facilities, travel organizations and medical insurance groups, and forging strategic alliances and linkages with renowned overseas centres of excellence for mutual benefit.¹²

In the several years since then, much has been achieved by these subcommittees. The target countries mentioned in the MOH report (MOH 2002b:104-113) are essentially of three categories, first, countries with inadequate medical facilities such as Indonesia, Myanmar, Vietnam, and Laos; second, countries with high costs of medical treatment, including Singapore, Japan and Taiwan; and third, countries with long waiting lists, essentially the United Kingdom, where private healthcare is expensive. In addition, the middle classes from the Middle East (United Arab Emirates, Bahrain, Saudi Arabia) and China are also being targeted.

Road shows and marketing promotions have been organized and carried out by the Malaysia External Trade Development Association (MATRADE) and Tourism Malaysia, both of which are government bodies. Between 2001-2002, MATRADE organized at least three specialised healthcare missions to promote health tourism in the Middle East, Myanmar, Vietnam, Jakarta, and Surabaya (MOH 2002b:108-109). In 2005, the schedule of promotional activities included various places in Indonesia, the Middle East (Dubai, Bahrain), China (Shenyang, Beijing, Nanjing), Vietnam, and Cambodia.¹³

¹¹ In 2001, the name was changed to National Committee for the Promotion of Health Tourism in Malaysia.

¹² The information on the steps taken by the government on medical tourism has been drawn largely from an official report (MOH 2002b:104-113).

¹³ From the website of the Association of Private Hospitals of Malaysia (APHM) <http://www.hospitals-malaysia.org/index.cfm?menuid=68&parentid=28> accessed 15 December 2005.

Corporate Strategies

Currently, hotels and tourist agencies are linking up with medical centres to offer holiday packages that combine hotel accommodation together with health screening and medical check-ups (Wong 2003). For example, Country Heights Health Tourism (CHHT), a private limited company, was intending to bring in 10,000 tourists (equivalent to an estimated RM 48 million¹⁴ worth of business) from Indonesia and Europe for preventive health screening, offering a battery of diagnostic tests including fluoroscopy and abdominal ultrasounds, within a five-star resort (*The New Straits Times*, 8 August 2004). Resorts World, a public-listed company, launched a health holiday package, tying up with HSC Medical Centre (*The Edge Daily*, 2 March 2004), while the Palace of the Golden Horses Hotel in Kuala Lumpur built a RM 6 million medical centre within its premises, offering a battery of tests with results delivered within five hours (*The Straits Times*, 19 March 2005). In the state of Penang, Beautiful Holidays,¹⁵ offers plastic surgery packages in conjunction with the Loh Guan Lye Centre, a 25-year old hospital (*Time Asia*, 27 Oct 2003).

A strong element in the Malaysian strategy is to capitalise on its image as a ‘Muslim country’, with easily available halal food and conveniences for practising Muslims. The Muslim countries targeted include Middle East countries, Brunei, and Bangladesh. Gleneagles Intan Medical Centre, for example, formed a partnership with a Bangladeshi company (that did not initially have any interests in healthcare, but were engaged in furniture, automotive, home appliance and urban taxi services), whereby patients will meet up with appointed medical representatives in Bangladesh who will assess the type of treatment needed and give an estimate of costs before travelling to Malaysia. (*The Business Times*, 10 March 2004)

¹⁴ The Malaysian ringgit was pegged to the US dollar at RM 3.80 in September 1998 in the aftermath of the Asian financial crisis. The peg was lifted in July 2005 but the exchange rate was maintained by a ‘managed float’ (*The Edge Daily*, 22 July 2005). Since then, the exchange rate has been kept close to RM 3.80, although the ringgit strengthened somewhat in 2006.

¹⁵ *Beautiful Holidays* was started in 2003 by Marloes Giezenaar, a 26 year old Dutchwoman, who has been co-opted to be co-chairman of the Health Tourism Promotion Taskforce of the Penang Tourism Council. In an interview, she says that Europe is her main market, but also has clients from Singapore and Hong Kong (*Malaysiakini.com*, 27 Jan 2004). In another interview in 2005, she said that they handled 108 medical tourists that year, with 70 percent coming from the United Kingdom, 6 percent from other European countries, and 10 percent from Australia, New Zealand and the United States (*The New Straits Times*, 24 November 2005).

Appointing 'local' agents is a common marketing strategy of hospitals. Sunway Medical Centre in Petaling Jaya, for example, has an agent in Medan, Indonesia, who conducts talks for the public, and meets with doctors there, and arranges tourism packages that include airport transfers, accommodation for accompanying family members, shopping, sightseeing tours, etc. (*The Star*, 21 August 2004). Another example is Mahkota Medical Centre in Melaka, which has a local representative in Indonesia to handle enquiries on a daily basis, while its marketing director and other officials travel fortnightly to Indonesian towns to carry out promotions among the public and doctors, as well as to maintain links with the authorities (*The Malay Mail*, 12 February 2006).

One recently-established company is aggressively employing both strategies – of targeting Muslim countries as well as tying up with agents in these countries. Medical Service Coordination International, officially launched on 30 December 2003, and led by executive chairman Datuk Syed Hussein Al Habshee, former Malaysian ambassador to the United Arab Emirates, aims to act as a one-stop medical tourism agency among various parties locally and abroad. In Malaysia, it collaborates with a panel of hospitals – the government-owned National Heart Institute, as well as Sunway Medical Centre, Gleneagles Intan Medical Centre, six hospitals in the Pantai group, and six hospitals in the *Kumpulan Perubatan Johor* (KPJ) Group, while in Indonesia, it has teamed up with 20 travel agents. (*The Sun Weekend*, 31 July – 1 August 2004) Together with the Association of Private Hospitals Malaysia (APHM), the MOH, the Ministry of Culture, Arts and Tourism, and the Ministry of International Trade and Industry, it created a commercial on medical tourism for airing on satellite television stations beamed to West Asia, one of its targeted Muslim markets. (*The New Straits Times*, 19 April 2004)

State Strategies

Quality is one of the aspects that is continually emphasised both by the state and the industry in their marketing efforts. In order to ensure that only high-quality services enjoy state sanction, 35 private hospitals have been selected out of a total of over 220 for official health tourism promotion in Malaysia. These hospitals are listed at the Association of Private Hospitals Malaysia (APHM) website (<http://www.hospitals-malaysia.org/>), from which each of their own websites may be accessed.

Other efforts to institutionalise quality assurance programmes, and to make this visible, include encouraging private hospitals to seek and acquire governmental accreditation and quality (MS ISO 9000) certification. Accreditation of hospitals, introduced in 1997, is implemented by the MOH in collaboration with the Malaysian Society for Quality in Health. So far, 25 hospitals have received accreditation for one or three years, but only one private hospital has received accreditation for three years (MOH 2002b:109). Affiliation with world-renowned healthcare centres – the MAYO Clinics, Johns Hopkins University Medical Centre, and Great Ormond Street Children’s Hospital – is also considered a quality assurance step. ‘Bringing in foreign patients’ was even used, or at least expressed, as the reason for efforts to benchmark the corporatised teaching hospital, University Malaya Medical Centre, to medical institutions in Australia, New Zealand, and the United States.¹⁶ (*The Star*, 6 April 2004).

The Malaysian government encourages the development of the healthcare industry through tax incentives. Tax incentives are available for building hospitals (industry building allowance), using medical equipment (exemption from service tax for expenses incurred on medical advice and use of medical equipment), pre-employment training (deduction for expenses incurred), promoting services (double deduction for expenses incurred on promotion of exports), and use of information technology. Furthermore, the national committee on health tourism has proposed further incentives, including exempting from taxes the revenue from foreign patients in excess of five per cent (threshold) of the total revenue for the hospital, double deduction for money spent on accreditation, and reinvestment allowance in relation to accreditation requirements. (MOH 2002b:110)

In another move, the conventionally stringent prohibitions on medical advertising have been gradually relaxed. (*The Star*, 29 November 2002) The Medicine Advertising Board re-evaluated the guidelines so as to provide more flexibility in the content of advertisements, and also agreed to accord special attention in expediting the applications for publications of advertisements from the APHM. In June 2005, it was announced that medical practitioners and institutions were allowed to advertise their services with immediate effect, and allowed to publish their names, disciplines, places of practice, credentials and photos, in newspapers,

¹⁶ The teaching hospital and Faculty of Medicine of the University of Malaya, originally recognised by the British General Medical Council, had its recognition revoked in 1988.

websites and telephone directories, although the information still has to be submitted to Medicine Advertisements Board for vetting. (*The Star*, 28 June 2005)

CURRENT STATUS OF MEDICAL TOURISM IN MALAYSIA

The availability of statistics on medical tourism is poor. Many hospitals do not provide the data requested by the MOH, which has no legal means to compel them to do so.¹⁷ Nevertheless, available statistics indicate that revenue from foreign patients in Malaysian private hospitals has seen an increasing trend. (MOH 2002b: 108) Eight private hospitals reported an increase of 197 percent in revenue from foreign patients between 1989 and 2001. From 2000 to 2001, ten private hospitals reported an increase in number of foreign patients from 56,133 to 75,210 (an increment of 34 percent), and a corresponding increase in income generated from RM 32.6 million to RM 44.3 million (an increment of 36 percent).

The uptrend in medical tourism revenue has continued: RM 56 million in the first nine months of 2004, which was a major leap from the estimated RM 48 million for the whole of 2003 (*The Edge Malaysia*, 20 June 2005). Again, these figures are not all-inclusive because some hospitals declined to disclose their revenues. There were two estimates for the total revenue generated from foreign patients in 2002 -- RM 90 million and RM 150 million.¹⁸ Revenues were projected by the MOH to rise to RM 400 million in 2005 and RM 2.2 billion by 2010 (Wong 2003).

The medical tourists who come to Malaysia thus far may be divided into two groups: the middle and upper classes from countries where 'quality' healthcare services are not available – Indonesia, Vietnam, China, Myanmar, Cambodia; and those from developed countries where waiting lists are long and private services less affordable. The majority of the medical tourists in Malaysia are from the first category, coming from Indonesia, Brunei, and Thailand,

¹⁷ It is envisaged that regulations will eventually be formulated under the 1998 Private Hospitals and Facilities Act to compel private facilities to provide data to the MOH, but this has yet to be done. As recently as early 2006, the Minister of Health was reported to have chided several private hospitals for not divulging information on the number of their foreign patients, saying that the health care legislation requiring hospitals to disclose these details will be enforced within the year. (*The Sun*, 28 February 2006)

¹⁸ Total revenue cannot be computed because not all private hospitals have complied in providing statistics (MOH 2002b: 108). The first estimate given here is provided by the Socio-economic and Environmental Research Institute (SERI), the research think-tank of the Penang state government (SERI 2004), while the second estimate is from the Malaysian Institute of Economic Research (MIER), a research think-tank of the Federal Government. (Wong 2003)

with the Indonesians constituting the largest group, accounting for 72 percent of total foreign patients in 2003, although medical tourists of the second category, primarily from Singapore, are also a substantial group. (SERI 2004)

In the state of Penang, the largest group are also Indonesians, followed by Japanese.¹⁹ In 2003 alone, Indonesians accounted for 20-30 percent of total outpatients in one of the leading hospitals in Penang, contributing 10-20 percent of monthly revenue. Teng Chang Yeow, the Penang state executive councillor on tourism development and environment announced that from 2001-2003, 80 percent of the foreign patients in the seven Penang hospitals earmarked for health tourism were from Indonesia. (*The Sun Weekend*, 31 July – 1 August 2004) In the state of Melaka, the Melaka Mahkota Medical Centre, majority-owned by Singapore-listed company Health Management International, and one of the three Melaka hospitals in the health tourism list, reported that some 15 percent of its 160,000 patients in 2003 were from Indonesia. (*The Edge Singapore*, 19 April 2004)

According to Datuk Dr. K Kulaveerasingam, who heads the health tourism committee in the APHM, the procedures in demand by medical tourists are procedures for coronary heart disease, plastic surgery, hip and knee implants, dental implants, and high-end diagnostic services. (*The Sun Weekend*, 31 July – 1 August 2004) In Penang, it is reported that the services most in demand by foreign patients are cardiology, cardiothoracic surgery, general surgery, orthopaedic, eye, and ob-gyn services, as well as general medical screening. (SERI, 2004) However, media reports label Penang as a prime destination for cosmetic surgery, which accounted for about 23 percent of the treatment sought by foreign patients in the years 2001-2003 (*The Sun Weekend*, 31 July – 1 August 2004). Procedures for heart ailments, followed by joint replacement surgery and eye surgery, was also identified as the highest in demand by Datuk Dr. Ridzwan Bakar, then-Chairman of Pantai Holdings, which operates a chain of seven private hospitals.

It should be noted that Malaysian statistics on foreign patients are not limited to foreigners who come for the specific purpose of medical treatment, but also include non-citizens who are already resident in the country. Although non-citizen residents will also include foreign

¹⁹ Out of the 35 hospitals earmarked for medical tourism promotion, the largest number (15) are located in the Klang Valley (which includes the metropolitan area of Kuala Lumpur), followed by seven in the state of Penang, and three each in the state of Melaka and the city of Ipoh in Perak state.

migrant workers, this group is probably not able to afford the private hospitals. The statistics therefore may be taken as being inclusive of two main groups of residents, that is, expatriate employees (international migrant workers of a higher social class), and participants of the *Malaysia My Second Home* programme.

‘Malaysia, My Second Home’ Programme

The ‘Silver Hair Programme’, first introduced in 1988, was originally conceived as a scheme to lure wealthy elderly Europeans and Japanese aged 50 years and above to the country. It was not a success, however, even when it was expanded in 1999 to all countries except Israel and Yugoslavia, and by February 2001, only 482 tourists had participated in the programme (MOH 2002b).

The programme was then restructured into ‘Malaysia, My Second Home’ (MMSH), and the age limit removed. Participants younger than 50 years old, however, need to show a fixed monthly income of at least RM 7,000 (single) or RM 10,000 (couple), as well as make a deposit of at least RM 100,000 (single), or RM 150,000 (couple), while participants aged 50 and above need only fulfil one of these criteria.²⁰ Under this programme, foreigners are given a five-year multiple entry visa, and allowed to buy property above RM 150,000 (whereas other foreigners may only buy property above RM 250,000).

In contrast to the ‘Silver Hair Programme’, the MMSH succeeded in drawing 2,834 applications from 2002 to early 2004 (*New Straits Times*, 26 April 2004), and of the 3,000 or so participants (including those under the SHP), most come from Britain, which has a historical link to Malaysia, and from other neighbouring countries -- China, Indonesia, Singapore, and Taiwan.²¹ The Chinese are a very recent group to figure prominently in this programme. For example, out of a total of 1,332 MMSH applicants in 2003, 513 were from the People’s Republic of China, constituting the largest group, which was followed by Singaporeans (121), and then the British (105).²²

²⁰ Information from ‘Malaysia: My Second Home’ seven-page brochure produced by the Ministry of Tourism, Malaysia.

²¹ Yamashita and Ono (2006) report that the figure given by the Malaysian Immigration Office was 3,732 being granted the visa under this programme from 1996 until April 2004, and the nationalities of these visa holders are Chinese, British, Singaporeans, Indonesians, Taiwanese, and Japanese, in descending order of numbers.

²² Unpublished statistics provided by Penang Tourism Action Council during field visit, 9 January 2006.

The MMSH is under the jurisdiction of the Ministry of Tourism and the Ministry of Housing and Local Government, reflecting the two major motivations behind this programme. The interests of the real estate industry behind this programme is clearly enunciated, for example, in their many and detailed recommendations to the government on ways to 'improve' the MMSH programme. (*The Star, Business Section*, 10 May 2004) Property developers also promote the programme, particularly at the point when they are marketing a new housing project.²³

Procuring medical tourists, therefore, is not a major objective of the MMSH programme. MMSH participants, however, are required to have medical insurance, and are considered potential medical tourists. (MOH 2002b) Thus for example, in a 'marketing' programme structured for Japanese considering retiring in Penang, the potential MMSH participants, besides being taken to condominiums and other places of specific interest to long-stayers, are given a tour of one of the leading private hospitals, where they are shown, among other things, the laboratories and state-of-the-art equipment.²⁴

The MMSH aside, it is possible that the stream of elderly seeking healthcare abroad will grow in the future.²⁵ The MOH, for example, includes, as one of the ways in which the country can leverage itself, the provision of healthcare specifically aimed at the elderly and retirees from overseas (MOH 2003:44-57). Although the current linkage between the medical tourism industry and the overseas retirement programme does not appear strong, it is obvious that each could potentially gain from the other.

Whether or not elderly healthcare could become a lucrative medical tourism branch industry in the future will of course depend on many institutional factors in source countries, such as the adequacy of social security and health insurance, the portability of health insurance, as

²³ See for example, *The New Straits Times*, 15 June 2005.

²⁴ This is a programme carried out by the PJI (M) Sdn Bhd in collaboration with the Penang Tourism Action Council. The author participated as a member of a conference team in one of these tours on 9 January 2006. See also *The Star Metro*, 31 January 2006.

²⁵ Furthermore, the MMSH statistics do not include those who come on a social visit pass for a 'short-term long-stay' of less than 90 days, the numbers of which could be substantial. For example, it has been reported that an average of 200-300 tourists come from Japan to Penang annually for short-term long-stay (*The Star Metro*, 31 January 2006), in contrast to 46 MMSH participants from Japan for the whole of 2003 (unpublished statistics provided by Penang Tourism Action Council during field visit, 9 January 2006).

well as state support and national policy. Even if the medical tourism industry does not specifically target the elderly as a group in its marketing, it would still gain from overseas retirement programmes and other long-stay programmes, considering that this group of people would have a likelihood of needing healthcare, and when they do, would most likely avail themselves of private healthcare.

COMPETITORS: THAILAND AND SINGAPORE

The development of medical tourism in Malaysia is a fairly recent phenomena, compared to that in countries such as Costa Rica, Cuba, and Singapore, which have long had people from surrounding regions come in for medical treatment. Currently, Singapore and Thailand are Malaysia's closest regional competitors in medical tourism, while India, with the Apollo chain of hotels, is also becoming an important player. Like the Malaysian government, the Singaporean and Thai governments have played a dominant role in developing, regulating and promoting medical tourism.

The private hospitals in Thailand, like those in Malaysia, were badly affected by the 1997 Asian financial crisis. Similar to Malaysia, private hospitals in Thailand expanded rapidly in the 1990s, up to July 1997. One private analyst estimates that the growth was 90 percent, resulting in an over-capacity of 300 percent, which was a more serious problem than that faced by Malaysia (Rabobank International 1999).²⁶ When the financial sector crashed, the contractions were therefore more painful. Many of the private hospitals were servicing loans that were denominated in foreign currency, and therefore incurred large losses, requiring debt-restructuring in order to survive.

Bumrumgrad Hospital, the largest private hospital in Thailand, for example, was one hospital that was badly affected by the crisis. The devaluation of the baht, on the other hand, provided the opportunity for the hospital to attract overseas patients on the basis of the relatively lower charges. As a result, phenomenal growth in patient load occurred after 1997, with a large influx of patients from North America, Japan, Europe, and South Asia. By 2003, foreign patients made up more than a third of its total patients, and accounted for 41 percent of its

²⁶ Like Malaysia, the majority of hospital beds in Thailand are in the public sector. Despite the growth, private hospital beds accounted for less than 30 per cent of total beds. (Rabobank International 1999)

revenue (*The Straits Times*, 19 March 2005; UOB Kay Hian Securities 2004). With an expansion in the number of beds from 554 in 2004 to 700 in 2006, it is slated to become the largest medical facility in Southeast Asia (UOB Kay Hian Securities 2004).

Bumrumgrad's growth is reflective of the medical tourism industry in Thailand. In 2002, the country had a total of 632,300 foreign patients in the 33 private 'medical tourist' hospitals, which was a growth of 13 percent from the previous year (*Tourist Agency of Thailand News*, 23 April 2004). In 2003, the numbers surpassed previous projections, with foreign patient numbers reaching 800,000, spending over 19 billion baht,²⁷ (*The Straits Times*, 19 March 2005) well over the RM 150 million²⁸ estimate for Malaysia. The source countries for Thailand's hospitals are also slightly different that for Malaysia. Most of the foreign patients who go to Thailand are from Japan, America, Europe, China, and Indo-China.

The medical tourism industry in Singapore is distinctly different from that in Malaysia and Thailand. The upper-middle classes from neighbouring countries Indonesia and Malaysia have been utilising Singapore's medical centres since the 1980s. Through the 1997 Asian financial crisis, Singapore's financial sector and currency were not badly affected, and domestic financing for healthcare remained largely intact. However, the financial crisis affected its major medical tourist source countries, Indonesia and Malaysia, as a result of which, foreign patients fell by more than a third between 1997 and 1998. (Khoo 2003) The sharp drop in overseas patients together with a shift to public hospitals by local patients resulted in a contraction in occupancy rates from over 70 percent to 55 percent. (Rabobank International 1999: 26)

²⁷ Equivalent to about USD 465.5 million (exchange rate as at 3 January 2006).

²⁸ Equivalent to about USD 39.6 million (exchange rate as at 3 January 2006).

The 2003 figures show a recovery to pre-1997 levels, with SGD 75 million²⁹ spent on medical services by visitors.³⁰ (*The Straits Times*, 14 October 2004) Although Indonesians and Malaysians still constituted the largest groups of foreign patients, they were fewer than before 1997, while patients from United States, Canada, United Kingdom, Brunei, and South Asia (India, Pakistan, Sri Lanka) had increased. (Khoo 2003)

Singapore Medicine, a multi-agency government initiative, launched by the Acting Minister of Health on 20 Oct 2003, now spearheads and coordinates such efforts. It includes the Economic Development Board, which promotes new investments in the healthcare industry, the Singapore Tourism Board, which is in charge of marketing, strengthening service delivery, and developing overseas referral channels, and International Enterprise Singapore, which promotes the growth and expansion of Singapore's healthcare players. The target is to attract 1 million international patients by 2012, from the current 200,000-plus, and to bring in revenue of SGD3 billion (about USD1.8 billion). (*The Straits Times*, 26 November 2003)

Challenged by the new competition from Thailand and Malaysia, Singapore has now increased its efforts, with MOUs signed at governmental level with some Middle Eastern countries, including the United Arab Emirates (UAE) and Bahrain.³¹ Three growth areas have been targeted by Singapore Medicine – heart, eye and cancer treatment. (*The Straits Times*, 26 November 2003)

²⁹ Equivalent to about USD 45.3 million (exchange rate as at 3 January 2006).

³⁰ Other figures have been reported in the media. For example, Khaw Boon Wan, the Health Minister was reported as saying that each year, some 200,000 foreign patients spend about SGD 450 million (approximately USD 272 million) in Singapore. (*The Straits Times*, 26 November 2003) The number of foreign patients has been more consistently reported at 320,000 foreign patients in 2004 (*The Edge Malaysia*, 21 November 2005, *The Straits Times*, 29 March 2006) and 374,000 in 2005 (*The Straits Times*, 29 March 2006). It should be noted that the official statistics on foreign patients in Singapore do not include expatriate residents, which is a substantial group in the country. (Khoo 2003)

³¹ Free medical care is provided for UAE citizens by the government, which started sending cancer referrals to Singapore in 2002. As many as 70 percent of the UAE's overseas referrals travel to Singapore. (*The Straits Times*, 15 January 2005) Singapore also has a memorandum of understanding with the Bahrain government. (*The Straits Times*, 27 November 2004). Qatar and Kuwait, whose citizens do not require visas to enter Singapore, are also targeted for medical tourism.

REGIONAL INTEGRATION AND EXPANSION

For many healthcare corporations in Malaysia, the 1997 financial crisis was a critical juncture, which they may not have survived had they not been able to get medical tourist-patients from outside their own countries. As the crisis hit, the domestic markets contracted sharply, profit margins plunged, balance sheets went into the red, and the corporations desperately sought out new markets in foreign countries.

In fact, the case may even be made that if not for the successful development of medical tourism at that critical juncture, the healthcare corporations would have been in jeopardy, and definitely would not have expanded to the extent that they subsequently did. This is reflected in the way that their expansion since then has been linked to a regional integration, as well as an intense focus on medical tourism, which makes up an increasing proportion of their businesses.

The regional integration has primarily been conducted across Malaysia, Thailand and Singapore, although India, Philippines, the Middle East, and several other countries are also involved. For example, Parkway Holdings, a Singapore-based company which owns three high-end hospitals in Singapore,³² recently acquired Malaysia's Pantai chain of hospitals, and is expanding into Vietnam and India. In a 2003 interview, the managing director said that their emphasis will be on foreign patients, who make up 25-30 percent of their patient volume, a figure which is still increasing. (*The Edge Singapore*, 17 March 2003) In a more recent report, the group is said to have marketing offices in 15 countries, with 40 percent of their revenue coming from foreign patients. (*The Straits Times*, 29 March 2006)

Following their acquisition by Parkway Holdings, Malaysian hospital operator Pantai Holdings announced that they would spend RM 50 million to build new facilities in an effort to target the medical tourism segment – RM 40 million to set up a new hospital in Johor and to transform four wards into an international wing for foreign patients, and the rest on a multi-disciplinary cancer centre. The managing director was quoted as saying that the aim is

³² Twenty percent of hospital care in Singapore is provided by the private sector, and 70 percent of this is cornered by Parkway hospitals.

to triple Pantai's foreign patients to reach the level of 15 per cent of total patients in the next three years. (*The Business Times*, Malaysia, 1 Dec 2005)

Both Parkways Holdings and the Raffles Medical Group, also Singapore-based, reported double-digit profit growth in the first half of 2005, most of the growth in patient numbers coming from foreign patients. (*The Straits Times*, 11 August 2005) Like the Parkway hospitals, the growth in foreign patients in Singapore's Raffles Hospital has been rapid, from 20 percent in 2000 to over 30 percent in 2005. (*The Straits Times*, 29 March 2006) Bumrungrad Hospital in Bangkok, one of the largest hospitals in the Southeast Asia region, partly owned by Singapore's investment company Temasek Holding, and also by the Dubai's government private equity fund,³³ has about one third of its one million annual patients coming from overseas. (*The Straits Times*, 21 January 2006)

In Malaysia, foreign patient admissions were reported to have grown by about 30 percent over the three-year period 2001-2003. (SERI 2004) Medical tourists to seven private hospitals in the state of Penang climbed from 72,000 in 2001, to 84,000 in 2002, 92,000 in 2003, and 152,000 in 2004.³⁴ TMC Life Sciences, a Malaysian healthcare provider specialising in fertility treatments, reported that foreign patients made up 10 percent of its revenue in 2005, up from 5 percent in 2004, and is expected to reach 30 percent in 2008 when its new facilities are built (*The Sun*, 28 February 2006). Reports such as these point to the importance that healthcare companies place on medical tourism as a source of business growth.

It should be pointed out that the transnational corporatisation of healthcare companies in Southeast Asia is not limited to regional players. Parkway Holdings, is majority-owned (26 percent) by Newbridge Capital, an American private equity company; while Columbia Asia which owns the Columbia Asia Medical Centre, Seremban, and two other hospitals in Malaysia, two hospitals in Vietnam, and three medical centres in Bangalore, is owned by the Columbia Group from Seattle, Washington, USA.

³³ They each own about six per cent.

³⁴ To recapitulate, the estimated foreign patient numbers are 800,000 (2003) for Thailand, and 374,000 (2005) for Singapore. It has been difficult to determine the numbers for Malaysia, as explained earlier. However, a crude estimate from the 2004 Penang total would give an average of 21,714 foreign patients per hospital, and multiplying this average by 35 hospitals will give about 760,000. This could be an over-estimate, considering that Penang hospitals would probably have above-average foreign patient numbers.

As healthcare companies integrate across national borders, they create an international market for healthcare services. Even if medical tourism was a lifeline for these healthcare corporations in the first place, the synergy created by corporations expanding and integrating across national borders in turn encourages the further expansion of the medical tourism market. One of the important reasons for healthcare corporations to acquire facilities in different countries is so that they can use these facilities to refer and cross-refer patients: a hospital in Indonesia or Vietnam may refer patients to another hospital in Singapore, where both hospitals are owned by the same corporate entity.

At the basic level, however, the expansion of medical tourism hinges on the cultivation of healthcare customers; turning patients or potential patients into consumers of healthcare, who willingly travel abroad for their consumption. For this to happen, healthcare services has to be commodified so as to facilitate the process of consumption; so that it becomes easy and feasible to consume healthcare services even if one has to cross national borders in order to do so.

FEATURES OF COMMODIFICATION

The process of commodification of healthcare is reflected in three features that are increasingly seen in the healthcare sector in Malaysia. First, is the use of and emphasis on ‘marketing’ as an important activity by which to procure patients-customers. Before this, advertising was not only strictly regulated but also frowned upon among the medical profession, because medicine was considered first and foremost a profession rather than a service commodity, and it was considered more important to maintain fraternal relations and solidarity within the profession rather than foster competition. But now, the regulations have been liberalised, and advertising can be freely carried out. The medical establishments have launched aggressive marketing strategies to sell their products abroad, with the active support of the government agencies. In legitimising the ‘marketing’ of medical services, there is an implicit acceptance that healthcare is a commodity that has to be sold in a competitive environment.

The second feature is the increasing emphasis on quality, and in order to achieve it, the use of benchmarking and standardization in accordance with internationally recognised markers. To become a global commodity that is able to withstand competition, not only does Malaysian healthcare need to reach a certain level of quality, but it has to be seen to have achieved this standard. The easiest way in which this can be done is to be benchmarked to established and well-known healthcare providers in developed countries. Nevertheless, the government also provides an accreditation process through which healthcare providers can be assessed and labelled. The quest for quality through internationally-recognised standards, clinical guidelines, and best practices, is closely linked to the process of standardization which makes the product for sale more uniform and more universally ‘understood’. The process of accreditation and standardization is meant to inspire trust and confidence among consumers all over the world, no matter from which country or region.

The third feature in the process of commodification is the creation of customers and consumers. One essential feature of a healthcare market is the emphasis on consumer choice, which is often used in neoliberal arguments on the desirability of expanding private-sector medicine. In the medical tourism marketplace, healthcare users are presented with a plethora of options – listings of clinics and hospitals, with information on the technology and treatment offered, and the specialists who are in attendance. These are provided through websites, printed materials, and marketing agents.³⁵

Where before and now, in the Malaysian healthcare system, the general practice is for a patient at the first point of contact to consult a medical officer or general practitioner, who then makes a referral to a specialist if necessary, this step is either dispensed with, or it is assumed that the medical tourist already has a diagnosis. Thus, for example, in a marketing guide, the customer is given a list of ‘common medical conditions or diseases’ each with corresponding suggestions on which type of specialists to see.³⁶ In the doctor-patient relationship, the doctor often makes the decisions for the patient, but in the customer-provider relationship, the customer has greater freedom of choice. The specialities may be marketed separately, and it is technically easy for customers to change doctors if dissatisfied. Further resembling a sales strategy of commodities, medical services are ‘packaged’, for example,

³⁵ See for example Penang, Malaysia (undated), Melaka, Malaysia (2003).

³⁶ Penang, Malaysia, undated.

with a specific price for six visits for lower back pain, or health screening packages such as the executive health screening package.³⁷

STATE INVOLVEMENT AND IMPLICATIONS

From the very beginning, the Malaysian state has been intimately and directly involved in promoting medical tourism. It does this in three major ways. First, tax incentives are given to support the growth of healthcare corporations. Second, it creates the institutional infrastructure for upholding standards and quality – the accreditation system, standardization guidelines, fee packaging guidelines, etc. And third, the Malaysian state directly leads in the marketing of medical tourism overseas through trade missions and other promotional activities.

The state's involvement in medical tourism is problematic when considered in relation to its historical role in ensuring the welfare and security of its citizens. Medical tourism is intertwined with the increasing commodification of healthcare, which has detrimental implications for the notion that access to healthcare is a human right, or that citizens have an entitlement to healthcare. Treating patients as customers of course undermines the principle of free access at the point of utilisation. The market is not concerned with inequalities in the distribution of services and treatment, nor even with the denial of care to those who cannot pay or do not have access to health insurance. To put it crudely, consumer choice only exists for the consumers, those who are included within the system (Pellegrino, 1999; Keaney, 1999).

Nevertheless, the Malaysian state has historically been welfare-oriented in its healthcare policies. Insofar as healthcare provision has been entrenched as one of the functions that legitimizes the state, and healthcare access is seen as one of the entitlements of citizenship, there is a tension between the historical role of the state and its involvement in private healthcare, and in particular, its aggressive promotion and support of medical tourism.

³⁷ Stoeckle (2000) suggests that the way in which healthcare is sold – as *packaged* medical services, surgical services, over-the-counter drugs, diagnostic and treatment technologies – illustrates its characteristic as a service commodity.

This tension is reflected in the need for an official rationalization that argues the positive effects of medical tourism for the local population. Thus for example a Ministry of Health report states:

Trade in health services offers countries the opportunities to improve their health systems through the generation of additional income from foreign clients and patients. This can be utilised to improve the infrastructure and to upgrade medical knowledge and technological capacities. There is therefore great potential to improve the national health services for the benefit of the local population. (MOH 2003:51)

Nevertheless, the same document acknowledges ‘potential negative impacts’:

[G]ains may largely benefit those who are already better off. The poor may only be able to benefit through better access to healthcare if resources were re-allocated within the public sector. This may happen if there is greater use of the private sector by those able to pay. Skilled health professionals leaving the public for the private sector would result in loss of expertise ... (MOH 2003:51)

Indeed, the loss of doctors from the public sector has been significant, as medical officers and specialists leave for the private hospitals that are increasingly more lucrative due to a growing international market. So far, this has been offset by the recruitment of foreign doctors, as well as by the doctors who have to undergo their first three years of compulsory government service.

Whether or not intended or desired, medical tourism and the commodification of Malaysian healthcare is leading to a growing gap between a corporate sector catering to a paying (including foreign) clientele, and a public sector for the others. Official sources implicitly acknowledge an awareness of this problem.³⁸ It has been suggested, for instance, that the public sector health services need to be restructured into a government-owned non-profit

³⁸ There is thinking within the MOH, for example, to have ‘... differently priced packages offered to locals and foreign patients, in order to make it affordable to the local citizens’ (MOH 2002b: 104-113).

entity operating within the private sector in order to avoid the creation of a two-tier system (MOH 2003:44-57). Malaysian healthcare is poised for structural change – a national health security fund and corporatization of government hospitals are on the agenda – but the process of commodification is not likely to be curbed in the foreseeable future.

Table 1: Private Medical Facilities and National Income

Year	Facilities	Hospital Beds		Per capita GNP
	(No.)	(No.)	(% of total) ¹	(at purchasers' value, in 1978 prices, RM)
1980	50	1171	4.7	3221
1985	133	3666	14.5	3758
1990	174	4675	15.1	4426
1995	197	7192	19.4	5815
1997/8	216	9060	25.1	--
2000	224	9547	21.9	7593
2002	211	9849	25.0	-- ²

¹Total of acute beds in MOH hospitals and private hospitals

²GNP per capita at purchasers' value in 1987 prices was RM8,418
(calculated from Malaysia 2003).

Source: Ministry of Health *Annual Report*, various years; GNP figures from Fifth and Seventh Malaysia Plans (Malaysia 1986, Malaysia 1996).

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