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From the Lens of Healthcare Facilitators: A Multi-Stakeholder Involvement Model for the Medical Tourism Industry in Malaysia

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Abstract

Purpose: Pressure from the low utilisation rate of private hospitals brought them to seek for foreign patients abroad. Over two decades, this industry has bloomed into a key source of income for Malaysia. Despite the increasing trend of revenue earned and inbound patients, a problem on industry development is detected when 'Medical' expenditure only takes up 3.7%, on average, from the Total Foreign Tourist Expenditure. Therefore, this article focuses on the interactions within the stakeholders by exploring their collectiveness in running this industry. In view of developing the medical tourism industry, this article aims to delineate the relations between the service providers in this industry by adapting the Multi-stakeholder Involvement Model (MSIM) framework.

Design/methodology/approach: The researchers conducted 11 in-depth semi-structured interviews with three major stakeholders, namely private hospitals, healthcare facilitators and medical doctors. With the assistance of Atlas.ti version 8, 'codes' and 'group codes' have been established.

Findings: Thus, this research unravelled the inconsistent definition of healthcare facilitators between stakeholders. Moreover, the roles of facilitators in assisting patients are deemed in diminishing in several ways.

Research limitations/implications: Samples are only tight to the actual case study research. Once the researchers have reached information saturation for the original study, it marked the end of the data collection. Further, the absence of other stakeholders such as the state tourism board may have impinged the richness of this data. Moreover, this cross-sectional study barricaded the researcher from attaining a trend of behaviour and perceptions between the stakeholders over a period of time.

Practical implications: Through the MSIM framework, this study suggested frequent dialogues between the stakeholders to establish a transparent ecosystem for the industry with the appropriate roles and relations between them.

Originality/value: This article is novel in offering new insights from the healthcare facilitators in the medical tourism industry. As this area has not been explored much, the present article adds more knowledge about the role of this stakeholder group in developing the industry.

Keywords: Healthcare Facilitators, Industry Development, Medical Tourism, Multi-stakeholder Involvement Model (MSIM)

Introduction

Medical tourism in Malaysia is a relatively new industry due to its conception in the late 1990s. Nevertheless, healthcare internationalisation is also seen as one of the world's fastest-growing industry (Yeoh, Othman, & Ahmad, 2013). Meanwhile, the Chief Executive Officer (CEO) of the Malaysia Healthcare Travel Council (MHTC) stated that global medical travel was worth USD 19.7 billion in 2016 and is expected to reach USD 46.6 billion in 2021 (Nisha, 2017). This industry is peculiar to the behaviour of foreign patients from developed nations such as Australia, the United Kingdom (UK) and the United States (US) travelling to developing economies such as Costa Rica, Mexico, Thailand and Malaysia (Yeoh et al., 2013).

Nevertheless, patients also travel to other developed countries such as South Korea due to the strength of Word-of-Mouth (WOM) that brings confidence to them (Choi, Kim, & Lee, 2018). As Malaysia has been nurturing this industry for over two decades, statistics have shown an increasing number of inbound medical tourists (Malaysia Healthcare Travel Council, 2019b). Apart from that, Malaysia also receives numerous global recognitions such as 'Best Country in the World for Healthcare'.

Furthermore, Malaysia also won various awards on the International Medical Travel Journal (IMTJ) Medical Travel Awards such as 'Health and Medical Tourism: Destination of the Year' between 2015 and 2018 consecutively (Malaysia Healthcare Travel Council, 2019c). Despite the awards and achievements, Malaysia still faces the issue of low industry development as 'Medication' only takes up 3.7% from the total foreign tourists' expenditure in Malaysia in 2017 without much changes from the previous years of 3.6% (2016) and 3.1% (2015) (Tourism Malaysia, 2016, 2017, 2018).

This issue occurs due to the low utilisation of high-value treatments among medical tourists who mainly visit Malaysia for health screenings and dental procedures (National Transformation Program, 2017). Although cardiology, orthopaedic and fertility are among the top chosen treatments, their amount is not translated in the Total Foreign Tourists' Expenditure, thus resulting in the mentioned figures.

Moreover, scholars have also acknowledged the less emphasis given on healthcare facilitators towards developing the medical tourism industry (Skountridaki, 2017). Therefore, the present research aims to delineate the relations between the service providers in this industry by adapting the Multi-stakeholder Involvement Model (MSIM) framework.

It is crucial to note that this article was produced as part of a more significant project on medical tourism. Hence, the participants are limited to what the initial project has derived. The researchers analysed from three perspectives, namely healthcare facilitators, medical doctors and private hospitals as a means to explore in the area of industry developments. As a means to achieve this aim, the present article seeks to explore the challenges that the healthcare facilitators face. Next is to explore their multiple roles in meeting the needs of the stakeholders. Finally, is to propose possible avenues for the way forward.

Literature Review

An Overview of the medical tourism industry in Malaysia

Malaysia began marrying the medical and tourism sectors during the 1997 Asian economic crisis. It was when private hospitals had to resort for foreign patients to utilise the existing capacities (Yeoh et al., 2013; Yusof, Rosnan, & Zamzuri, 2019). Due to the decreased purchasing power of the local patients, they have shifted their treatment preferences to public healthcare, leaving private hospitals with low occupancy rates. In light of meeting their ends meet, a number of the private hospitals began reaching for patients in Indonesia to have their treatments underwent in Malaysia (Yusof et al., 2019).

Accordingly, the Thai Baht devaluated in July 1997, causing the escalation of political and social crisis in Malaysia and Indonesia (Sakura Institute of Research, 1999). During those critical times, Malaysia's annual Gross Domestic Product (GDP) growth dropped to -7.4% in 1998 from 7.3% in the year before and rose up to 6.13% in 1999 (The World Bank, 2019) indicating severely deteriorating business activities. Accordingly, Sakura Institute of Research (1999) explained that Malaysians became more conservative in their spending behaviour, which caused them to cut down their expenses, including medical expenditure.

Meanwhile, the private consumptions rose consistently by over 5% annually since 1994 dropped to -6% in 1998, thus affecting various industries. Specifically, Yeoh et al. (2013) described that the undesirable situation changed the healthcare sector. Many of the local patients reverted to public hospitals leading the private hospitals to issue "code blue" signals from the reduced utilisation rates in the clinics, wards and other facilities. Consequently, Malaysia's public healthcare saw an increase between 10% and 18% in the number of patients. Meanwhile, the private healthcare providers, including hospitals and clinics, showed a prominent decrease of between 10% and 30% (UNFPA, 1998; cited in Yeoh et al., 2013).

Nevertheless, it is now seen as one of the significant income drivers to spur the growth of the Malaysian economy (The Star Online, 2018). This is recognised by the steady growth of the medical tourists' inflow and the revenue that they brought in, as shown in Table 1 below.

Table 1: Records of the number of health travellers and revenue earned between 2011 and 2018. Source (Malaysia Healthcare Travel Council, 2019b)

Year	Number of patients	Revenue received (RM)
2011	643,000	527 million
2012	728,000	603 million
2013	881,000	727 million
2014	882,000	777 million
2015	859,000	915 million
2016	921,000	1.123 billion
2017	1,050,000	1.3 billion
2018	1,200,000	1.5 billion

An overview of the frameworks in medical tourism

As medical tourism has gained the attention of scholars for nearly two decades, numerous studies have been conducted to conceptualise it. Hence, medical tourism has been approached through the demand- and supply-side. From the demand perspective, Ngamvichaikit and Beise-Zee (2014) contributed to the information and communication needs of Western medical tourists in Asian healthcare services. Apart from the push-and-pull factors that drive medical tourists to travel abroad (Balogun & Ogunnaike, 2017; Cheng, Abdul Manaf, & Lim, 2013; de la Hoz-Correa, Muñoz-Leiva, & Bakucz, 2018), Shahrokh, Brojeni, Nasehifar, and Kamalabadi (2017) delineated the multi-level decision making process that patients go through prior to deciding their destination country.

On the other hand, the supply perspectives have been studied upon the barriers to market development (Heung, Kucukusta, & Song, 2011; Rokni, Turgay, & Park, 2017) and attributes of market competitiveness (Junio, Kim, & Lee, 2017). Moreover, other scholars (Heung, Kucukusta, & Song, 2010; Hudson & Li, 2012) have opened the doors of opportunities for more studies on the roles of intermediaries that bridge the service providers and medical tourists.

As for the Malaysian context, past studies unravelled the satisfaction level of inbound medical tourists (Musa, Doshi, Wong, & Thirumoorthy, 2012; Um & Kim, 2018), their travelling

behaviour which includes motivations and intention (Musa, Thirumoorthi, & Doshi, 2012; Seow, Choong, Moorthy, & Chan, 2017), the healthcare treatments that they sought for and their average spending amount (Musa, Thirumoorthi, et al., 2012).

Nevertheless, there seems to be a lack of findings that untangle the roles of healthcare facilitators in view of developing the medical tourism industry. As emphasised by Tham (2018) on the needs for more empirical findings to conceptualise on the importance of healthcare facilitators, the present article is deemed necessary. Findings from this research are pivotal to provide a better understanding of the healthcare facilitators as the qualitative approach allowed them to express their experiences and the meanings that made up through it.

An overview of the Multi-stakeholder Involvement (MSIM)

The MSIM framework was first brought into discussion by Waligo, Clarke, and Hawkins (2013) as a means to explain sustainable tourism (ST). The motivation behind the MSIM framework was due to the lack of clarity on how to solve the stakeholder participation within the tourism industry to achieve ST. Thus, this framework was developed to have three strategic levels: attraction, integration and management of stakeholder involvement. In which, six stages are embedded within the three levels namely i) scene-setting, ii) recognition of stakeholder involvement capacity, iii) stakeholder relationship management, iv) pursuit of achievable objectives, v) influencing implementation capacity and finally vi) monitoring stakeholder involvement.

Numerous studies on tourism have been conducted using stakeholder management that contributes to the literature on tourism (Caffyn & Jobbins, 2003; Mistilis, Buhalis, & Gretzel, 2014; Sautter & Leisen, 1999). However, to best of the researchers' knowledge, there seems to be lack of studies done on the MSIM framework other than Australia's domestic medical tourism development (Tham, 2018) and Hawaii's ST development (Catherine, 2018).

Hence, the gap in this body of knowledge offers the opportunity for the present article to explore the relations between the stakeholders of Malaysia's medical tourism in light of developing the industry. This study is built from past research specifically by Tham (2018) who posited for the needs to gain an in-depth understanding of the meanings of stakeholder relations from healthcare facilitator's perspectives.

Method

This article seeks to bridge the gap by Skountridaki (2017) who proposed for HF's perspectives with regard to the interaction between the supply-side stakeholders in medical tourism. Hence, a qualitative case study was conducted in view of exploring this less focused area. Although Stake (1978) put forward on the inability of case studies to achieve generalisation, Flyvbjerg (2006) emphasised that the close-proximity to real-life situations in case studies allows for the establishment of context-dependent knowledge. This type of knowledge is claimed to be a concrete avenue for novice researchers to being an expert in a specific field within the study of human affairs.

Furthermore, scholars claimed that case studies permit the researcher to capture the individual experiences of a subject being studied (Flyvbjerg, 2006; Stake, 1978). Consequently, it constructs a detailed knowledge about a particular context by capturing various meanings and experiences from the subject being studied. Such methodological perspective is aligned with the researchers' frame of interpretivism.

This paradigm believes in the absence of a single truth about reality. This is because the truth is thought to be different between an individual's own experiences (Guba & Lincoln, 1994). Hence, a case study approach is deemed suitable in meeting the interpretivism paradigm as

participants are offered with an ample room to develop their subjective and humanistic meanings about a particular knowledge based on their own experiences.

Stake (1978) mentioned that a case does not need to be on just a human or enterprise but any "bounded system" of interest. Therefore, the present article embarks on a single case study design with an embedded unit of analysis by Yin (2014). This design constructs the current research in such a way that Malaysia's medical tourism is classified as a single case study.

Meanwhile, the embedded multiple units of analysis consist of facilitators, medical doctors, and hospitals. This study adds several essential contributions to present literature on medical tourism. First is the narratives of the facilitators' own experiences which reviews are found to be lack of other than Skountridaki (2017), Medhekar (2019) and Perkumienė, Vienažindienė, and Švagždienė (2019). Second, this study has successfully delineated the essential elements that make up healthcare facilitators. This includes the definition of healthcare facilitators from the industry players' perspectives, the role of the facilitators from various points of view as well as the challenges and expectations that the facilitators have on other stakeholders.

The researchers conducted data collection in two phases. Phase 1 was direct observations and followed by Phase 2, which were in-depth semi-structured interviews. Phase 1 began with the researchers' participation in a conference and workshop organised by government agencies. Direct observation is classified as one of the broader qualitative research paradigms (Mackellar, 2013) since the researcher stands as the principal instrument in observing participants' behaviour during their engagement in activities (Creswell, 2014).

Furthermore, Merriam and Tisdell (2015) delineated that observation is considered a research tool when it is systematic and bringing forward specific research questions. Although Yin (2014) argued that this method is prone to being bias due to the researcher's manipulation of events, direct observation allows for the researcher to be objective and detached with the participants (Merriam & Tisdell, 2015). However, 'participants' observation' requires the observer to merge with participants. As for this study, the researchers perceived that the former is the best option because information on the desired findings can be attained through presentations, forum sessions and discussions during the events. Therefore, this condition rules out the needs of the researchers to immerse with the participants.

With qualitative studies being inductive, the researchers conducted direct observations in the two events with some underlying knowledge about the industry. In an attempt to keep the findings free from preconceived notions, the researchers only set the objective of earning rich data on the current challenges in Malaysia's medical tourism industry. Accordingly, the researcher attended the InsigHT2018 Conference by MHTC in September 2018 and the Private Healthcare Productivity Nexus (PHPN) Implementation Strategy Workshop organised by the Malaysia Productivity Corporation (MPC).

While the findings from these events are not meant to be discussed here explicitly, it was during this phase that the researchers began building rapport with the industry players. The researchers exchanged name cards with the representatives from private hospitals across Peninsular Malaysia, healthcare facilitators and government bodies. It wasn't until November 2018 that the researchers began emailing and making phone calls with them in favour of conducting an interview.

As observation should be entitled to check-and-balance to produce reliable results (Merriam & Tisdell, 2015), this study then moved towards Phase 2 of the data collection. This phase serves two functions. First, is to triangulate the findings attained in Phase 1. Second, is to provide a more in-depth understanding of the individual stakeholders, thus assist the study in answering the research questions.

Hence, sampling was derived from MHTC official website, which lists the private hospitals under the Elite and Ordinary membership. From a total of 76 members, the researchers initially

get in touch with the existing contact numbers that were attained from the previous events. While only a few responded with an agreement, the series of the interview occurred between December 2018 and April 2019.

The earlier participants snowballed some of the later ones. This brought the researchers to meet them in person in Klang Valley, Johor, Melaka and Penang. One participant was interviewed through Skype due to the distance issue. For this article, only the relevant stakeholders are included consisting of private hospitals (n=7), healthcare facilitators (n=2) and medical doctors (n=2). For anonymity, the private hospitals are coded as Private Hospital 1 (PH1), PH2…PH7. Meanwhile, healthcare facilitators are coded as HF1 and MCL, which will be further elaborated in the next section. On the other hand, the medical doctors are termed as Doctor 1 (D1) and D2 The interviews were conducted at their workplace, which took one hour on average. Before the meeting, the researchers emailed the participants an interview protocol which listed the interview questions for their perusal. The interview sessions began with the participants giving their signature on the interview protocol as an agreement to participate in the interview voluntarily and to be audiotaped. For information validity, an email with a summary of the interview was sent to each of the participants so they could validate if the information is delivered correctly to the researchers. This step is adopted from Merriam and Tisdell (2015), who described the qualitative research way of ensuring the quality of the information.

Thus, the recordings were transcribed in verbatim and analysed with the help of Atlas.ti version 8. The software is used to assist the researchers in building the ‘codes', ‘group codes', frequency and networks between them. While the software is useful, it is essential to note that a computer program is merely to facilitate the categorising thus should not be deemed as an analysis tool. This is because the researchers are the one who should be doing the analysis (Merriam & Tisdell, 2015) as they are the researcher instruments. Hence, findings and discussions are provided in the next section.

Findings

The 11 in-depth interviews consist of private hospitals, medical doctors and healthcare facilitators. Hence, findings recorded that from the total seven hospitals, only PH2 began venturing into medical tourism during the 1997 Asian economic crisis. This was due to the low utilisation rate by local patients as they shifted toward public healthcare. Their purchasing power deteriorated. Hence, PH2 had no choice but to call for foreign patients to have their treatments in Malaysia.

Meanwhile, the majority of other hospitals entered this industry in around 2008, and several others only started going active in medical tourism for the last two years. The latter's choice of entering medical tourism only in recent years was due to the expansion of their hospitals' facilities. Not wanting to jeopardise or crowd-out the local patients, these hospitals waited for the completion of their new buildings before going more aggressive in this industry.

Apart from that, the healthcare facilitators consist of an independent healthcare facilitator (HF1) and a representative from the MHTC Concierge and Lounge (MCL). HF1 is an Indonesian-based company established in 2016. The company offers facilitation through free information on their website and pre-appointment booking with the desired hospitals. Besides, they also provide advice on the hospitals, doctors and necessary treatments that suit the patients' budget and requirements. Although HF1 does not offer ground assistance from leaving to coming home, they provide advice and guidelines on the destination's whereabouts.

For instance, the *halal* places to eat, accommodations, tourism spots and the means of transportation. As a company that operate mostly online for the last three years, the company has received one million visitors on its website. Apart from that, they have received over 3,000

enquiries about health travel thus far and made 600 confirmed appointments in January 2019 alone.

Meanwhile, MCL stands for MHTC Concierge and Lounge. They are situated in Penang International Airport and Kuala Lumpur International Airport (KLIA). For this study, the researchers only managed to reach for MCL in an airport in Malaysia and conducted a face-to-face interview with a front desk staff from the Lounge. Thus, the participant explained that MCL in Penang and KLIA airports are under the Facilitation Department under MHTC.

Hence, MCL's role is to facilitate patients' experience before their travelling, during their arrival and as they leave the airport for home. Specifically, MCL's primary role is to page for patients, making sure a seamless healthy travel experience for them. Specifically, MCL is to provide patients with comfortable seats and some refreshments while waiting for their flights or shuttle to fetch them to the desired hospital.

Furthermore, MCL also assists patients in arranging for appointment bookings with the respective hospital's International Patient Centre (IPC) should they require some help. Moreover, MCL also caters to the tourists' enquiries since they tend to enquire as they passed by the Lounge. In those situations, MCL would advise on the means of planning their travels ranging from the documentation, accommodation, treatments and the like.

On the other hand, the medical doctors involved in this study are a physician doing sub-speciality in cardiology (D1) and a consultant cardiologist (D2). They serve in two different private hospitals in Malaysia who are listed as MHTC members. Hence, these doctors were reached through snowballing from other interviewees and acquaintance. Both of them treat medical tourists who came from several countries, including Somalia, Indonesia and Japan. While D1 has been a medical doctor for over 13 years, D2 has been serving patients for more than twenty years with 13 years of experience in cardiology.

Discussion and Conclusion

Definitions of Healthcare Facilitators

From the interviews conducted, the study revealed a various understanding of the description of healthcare facilitators. While the researchers' initial through of facilitators as established businesses, the participants explained that they could come through various means. For instance, PH1, a Marketing Director of the hospital revealed that,

"Basically, Healthcare Facilitators are travel agents. But they want to come out with a different term, so they call themselves healthcare facilitator. However, if doctors from other countries are referring our hospital to their patients, these doctors are also called healthcare facilitators."

Similarly, PH5, a Chairman of a private hospital Group, also denoted that he/she often provides suggestions to patients about which hospital they could refer to that suits their requirements and needs. Otherwise, actual patients would come to any of the hospital's booth in a health exhibition asking for advice from the doctors available during the event. Hence, patients would book a flight together with the hospital's team to Malaysia for the intended treatments because they have trusted the words of the doctors.

In situations like this, it is seen that healthcare facilitators are not just businesses but also individuals that help to channel patients into Malaysia. This situation is slightly different from Medhekar (2019) who defined healthcare facilitators as individuals or companies that offer medical tourism packages that include wellness, treatments and tourism. This group of service providers also aid in patients' travelling matters such as connecting patients to the hospitals at

the destination country, managing their booking arrangements, accommodation and travel matters.

Nevertheless, Medhekar (2019) also described healthcare facilitators as intermediaries to connect patients with the hospitals, specialist surgeons, making all medical travel arrangements. As for our findings, the doctors and prominent figures are also termed as healthcare facilitators when they act as intermediaries that bring in medical tourists into Malaysia, despite not providing the necessary arrangement. Hence a summary of the discussions is provided in Table 2 below.

Table 2: Summary on the motivation, roles and relations of healthcare facilitators with other stakeholders

Codes	Elaboration	Freq
Motivation and goals	Non-availability of structured information, hence they need to organise and translate them to assist patients in making decision	4
Challenges- fast pace and patients complaints	Making a booking, paging for patients and entertain patients' complaints	7
Services offered	Provide free information on the internet. E.g., on the list of hotels, *halal* food etc	4
	Conduct Appointment & registration with hospital	2
	Communicate with Pts about more info in case they need it	1
	Liaise with hospitals to get the required info and update Pts later	2
Healthcare Facilitators' role- to develop trust	Provide enough information on a website, appearance is essential, so patients are comfortable to provide their personal data and accept facilitator's advice	11
Healthcare Facilitators' role- online marketing no need rep office	This method allows for a larger reach	3
Healthcare Facilitators' role - diminishing hotels are listed online easy to book	Because of the online listing, they have their online promo. Patients can book themselves	11
Healthcare Facilitators' role- marketing	Conduct marketing on travel aspect. But for the medical part, need to be more conservative	1
Healthcare Facilitators' role- Communicate with hospitals	Helper for the hospital. Liaise for booked and walk-in appointments. Important to cater for fussy patients	5

The Role and Challenges of Healthcare Facilitators

From the interviews conducted, this research unfolded the motivation for healthcare facilitators to venture into the medical tourism industry. For this, HF1 stated that the non-availability of structured information about a country's medical tourism motivated them to conceive the business. This then delineated the objectives of their business, which are to organise the data so as to assist patients in making decisions. Apart from that, HF1 also aims to translate the

medical information such as the disease terms, the costs, risks and consequences in language appropriate to the public.

Findings from the interviews also revealed an inconsistent understanding of the role of healthcare facilitators. Both MCL and HF1 agreed that their primary function is to offer advice, suggestions and assistance to patients on the medical and logistics aspects of their health travel. Nonetheless, some of the private hospitals, such as PH6 said that the healthcare facilitators' roles in bridging the gap between hospitals and patients are diminishing. This is because patients are able to make their own research on the internet, thus making the necessary arrangements that suit their travelling forte.

Apart from that, for the patients that have already established a strong loyalty to individual hospitals, they tend to make the arrangements themselves. As the hospital staffs have known their patients very well from the past treatments, they tend to come to Malaysia on their own without putting reliance on healthcare facilitators anymore. Thus, PH6 said that,

"In fact now, they (other hospitals in the same state as PH6) have stopped signing with agencies. Because most of the patients have already known them very well. And they come by themselves without going through agents anymore."

Moreover, HF1 also agreed that accommodation and transportation bookings are not in their niche service as hotels are readily available online through online agencies and e-hailing services such as Agoda.com, Airbnb, Grab and the like. Specifically, PH2 denoted that transportation services such as airport pickup and drop-off are already provided by the hospitals at free of charge as one of the perks for patients. Meanwhile, the online agencies listing hotels, homestays and other types of accommodations are presently in a competitive environment. Consequently, the hotels are offering promotions and discounts to attract their customers.

"Most of the hospitals, not every hospital, but most of the hospitals provide, like airport pickup, while for like accommodation booking, I think it's now.. we outsource this trend. In the past, hospitals collaborate with hotels to provide discounts to patients. But right now almost all hotels are already listed online, like on Agoda, or Traveloka, so it's very convenient for the patients to just looking through those websites and book there directly. There is also a lot of promo on those online portals, and this is also another trends.."

Along with the discussion on the changing role of healthcare facilitators, the interviews also captured on the subtle role of developing trust to the patients before anything else. The importance of trust is second to none as patients would not be able to cooperate in providing their personal information to those that they are not confident with. Therefore, MCL described the importance of appearance by wearing the corporate shirt as the first touch point for patients to develop their trust. With medical treatments being highly confidential, growing their confidence should be the foremost priority of MCL apart from ensuring patients' comfort and smooth travelling.

Additionally, trust was also emphasised in the way information is delivered to patients. This was exemplified by the availability of treatments costs as accentuated by HF1 on PH2. HF1 mentioned that PH2 is the only service provider that is transparent enough to display the average costs of the procedures. Apart from that, the availability of language translation on the website is also crucial since not all patients understand English. Hence, HF1 have the expectations for hospitals to provide such facility on their website.

Besides, information like these would also be useful for patients who typically plan for their travels seven months to 1 year prior to their travelling time. MCL Penang described language like the number one barrier to their daily operations. In addition, information on doctors' availability and performance should also be cascaded to the healthcare facilitators. From this,

MCL explained that hospitals are expected to regularly update the facilitators on their doctor's availability, name lists, work performance and even complaints that they received. This information would assist the facilitators in providing authentic pieces of advice to patients should they require assistance before making choices.

Apart from trust, the hospitals are also expecting the facilitators to widen their marketing activities. This would come through online platforms, and it is the preferred one compared to the traditional representative offices. HF1 mentioned that online marketing permits them to reach for more potential patients through Indonesia in a timely manner and lower cost. Having that said, HF1 was also aware that they could go all out to market the 'travel' part of medical tourism, leaving the 'medical' part remained conservative. Nevertheless, D1 and D2 did not mention any needs for healthcare facilitators to run the marketing apart from the Marketing Department of their respective hospital.

Apart from narrating the role and expectations of healthcare facilitators, the interview questions were channelled towards exploring the challenges that they face. Language, as described earlier, is a significant hurdle for them because it distorts the communication between the facilitators and patients. Apart from that, dealing with medical tourists has a distinctive set of challenges versus healthy and leisure tourists. While the former is, at times, bound to certain food restrictions and limited physical capacities, they tend to be moody as opposed to the latter. The differing time orientation and travelling period also cause jetlag, which adds on to the patients' gruesome behaviour. Specifically, MCL mentioned about patients being grumpy due to their poor health condition, thus affecting the way they talk to the staff in charge.

Another prominent challenge that healthcare facilitators face is the pace of the work done. Particularly at MCL, the staffs need to regularly page for patients, attend to their enquiries with confirmed information from the hospitals, passing information from patients to the hospitals and updating their own records. Moreover, patients keep coming from arrival and for departure, which adds to their daily challenges at the workplace. While there are two staffs working at the same time, it is also recorded that they also have to deal with patients complaints on top of the presently fast-pace environment. They usually received complaints on the pickup service, especially when the shuttle was behind schedule or when patients being cramped in one shuttle. This caused uneasiness for them, considering that they have had long flights before that. The lounge's condition has also been receiving complaints that it is rather small and easily packed by patients.

Apart from that, the surrounding is also noisy as the lounge is located next to the central aisle with many passersby. As the researchers went there for the interview, it is evident that its location could be strategically improved into a more secluded room such as the business class lounge. Moreover, the participants also hoped to open a new lounge at KLIA2 Airport to cater to medical tourists that arrive there.

"We have to be very fast, and we have to be very orientated. Usually, our paging sometimes, when we page for the patients, we have to coordinate that, at the same time there will be problems like, 'I'm not comfortable with this place, noisy'. The complaints we have to attend and at the same time this booking we have to do. So, we have to be a runner. We have to run and manage everything. It's not tough, but it's like challenging. We have to be quick. Being quick has to be trained because we cannot do things like in an improper way."

Moreover, the facilitators are also challenged by some of the hospital infrastructures. By this, HF1 pointed out that some hospitals do not provide appointment or reservations. Instead, patients are left with a walk-in option to see the doctors. Consequently, it resulted in situations whereby patients queuing up as early as 3 a.m. at the hospital. While the hospitals have been

advised to improve on this system because it jeopardises the patients' experience, HF1 claimed that they still prefer to stay the same way. This is undoubtedly inconvenient to the patients who, everyone would have understood, are physically limited due to their poor health condition.

Relations between Healthcare Facilitators and Other Stakeholders

From the interviews conducted, it can be seen that healthcare facilitators have generally been receiving positive network with private hospitals. Sound communication between these stakeholders is essential for the fast pace of information transfer. Further, this would assist the facilitators and hospitals in catering for fussy patients as they have been given a heads up about the incoming patient to their hospital premise. Fortunately, MCL gave a positive remark on how the hospitals have been treating them as he/she described a good bonding between them,

"Yes, very good bonding. They always have a very good conversation (with us). They will update us what are the new things they have, new doctors, and these are information very important to us because when patients come they will ask, 'can you suggest me one doctor for hair loss?' Just like that. So we have to know a few places, few doctors, so if you want the latest one will be better. So this information, and then some updates like doctors are not good, very rude, these updates are also important because the negative part is to improve ourselves."

Within the Malaysian context, it is seen that facilitators typically deal with the Customer Service and/or the IPC of the respective hospitals with regards to patient handling. The numerous means of keeping in touch through email and phone calls reflect the ease of communication between these two players. Thus, MCL described that,

"Yes, very good. Sometimes patients have enquiries regarding the hospital, we will email to the customer service in the hospital, we will get a reply from them, and we will forward to the patients, or sometimes we will call and inform to them."

The private hospitals described their ease of collaboration with the local tourism board in their state. For instance, PH5 explained that this industry is riding on the brand name of Malaysia's tourism. Thus PH5 mentioned that they would easily participate in the state tourism's marketing activities. Moreover, PH6 and PH2 were also in agreement about their respective state government's support by them going on the ground together with the hospitals in an exhibition and other marketing activities. However, the facilitators reported the opposite. While HF1 is a foreign company that does not put much reliance on Malaysia's Tourism Board, MCL recorded a little disappointment about how cold their bond is with the local tourism board. At their level, the only communication that occurs is being the referral to each other. When tourists come to the tourism desk to enquire about medical, they would hand them over to MCL and vice versa. Hence, MCL denoted on the absence of bonding between these two actors whose collaboration at this operational level would have been helpful to escalate medical tourism activities in Malaysia. Even if the collaboration has been established at Ministerial level, it has not been entirely cascaded down to all levels inclusive of the front desk personnel.

"Yeah. If we know more about tourism, we can help them. When people ask anything about medical, they (tourism front desk) will just refer the patients to our counter. So if it is just a referral, it's different. If we are bonded, we have really had to be a bonded thing there. We have to have a meeting together. We have to have a gathering together."

Furthermore, the interviews also unveiled that hospitals prefer to run marketing activities on their own instead of placing much reliance on healthcare facilitators. PH2 explained that travel agents in their region are not keen to do health facilitation because of the relatively low commission than catering for leisure tourists per se. Moreover, PH3 only deals with facilitators to assist in taking the patients and their families on tourism activities such as shopping. Although PH5 was optimistic about their relations with this actor group, other hospitals did not express their attention to healthcare facilitators. In fact, PH1 described that healthcare facilitators do stand as one of their sales channels. Nevertheless, it is unravelled that the hospitals' marketing department is separated between the local and international markets which suggest their capacity in running the marketing activities themselves.

Skountridaki (2017) delineated on the barriers in the relations between facilitators and healthcare facilitators. The study was conducted with MDs that are practising privately and participate in medical tourism. Hence, their sample differs from the present article whose MDs are an employee and consultant to a prominent private hospital, respectively. Therefore, it is seen that the MDs in this study do not directly involve the marketing activities that include healthcare facilitators. Instead, these MDs are only invited for health talks, basic screenings and consultations in exhibitions. Meanwhile, the healthcare facilitators in this context mostly deal with the marketing, customer service or IPC departments. As a whole, this study contributes to the narratives of healthcare facilitators' definition, roles and expectations. Through an exploratory case study on two healthcare facilitators, seven private hospitals and two doctors, this research has provided a more extensive nuanced understanding of the interactions between the stakeholders with regards to developing the industry.

The strength of this research is first, the involvement of multiple stakeholders with their own importance. This approach offers a broader view of the industry with a more realistic reflection of the industry. Second, the face-to-face in-depth interviews allowed the researchers to attain rich data from the industry players instead of being constrained by a set of preconceived notions in questionnaire surveys. Third, as healthcare facilitators from two distinctive business structures were involved, it contributed to the knowledge on the roles of intermediaries by (Heung et al., 2010; Hudson & Li, 2012) while bridging the gap in the findings from Tham (2018).

The findings from this research revealed that while hospitals are keen to expand their outreach programmes to attract more medical tourists, the roles of independent healthcare facilitators are deemed vague. This is due to the redundant work of promotion and marketing activities which are presently conducted by private hospitals themselves. The lack of communication between hospitals and doctors with independent healthcare facilitators paved the way for the needs of more dialogues between the actors. This calls for the needs for MHTC to conduct frequent discussions between the actors so as to illustrate a more explicit framework between them.

Hence, the present research aims to conceptualise the MSIM framework for Malaysia's medical tourism. This is done by intensifying on the roles of the healthcare facilitators in developing the industry. This article adds to the present scale of knowledge on medical tourism by comprehending the means to manage the relevant stakeholders, thus ensuring that their individual capacities and needs are appropriately allocated. The MSIM framework adapted is hoped to assist in managing the stakeholders involved. Past studies have delineated that consistent dialogues and meetings between stakeholders would help in the timely dissemination of information between stakeholders (Connell, 2013). Furthermore, to encourage the development of medical tourism, a collaboration between healthcare and tourism actors should be explored (Ormond & Sulianti, 2014).

As MCL and HF1 addressed their concerns on the need for Malaysia to promote the medical and tourism aspects, the present article illustrates the suggested means and ways that the actors could undertake. This is anticipated to pave roads for the development of Malaysia's medical tourism industry. Hence, the adapted MSIM framework by Tham (2018) is depicted in Figure 1 below.

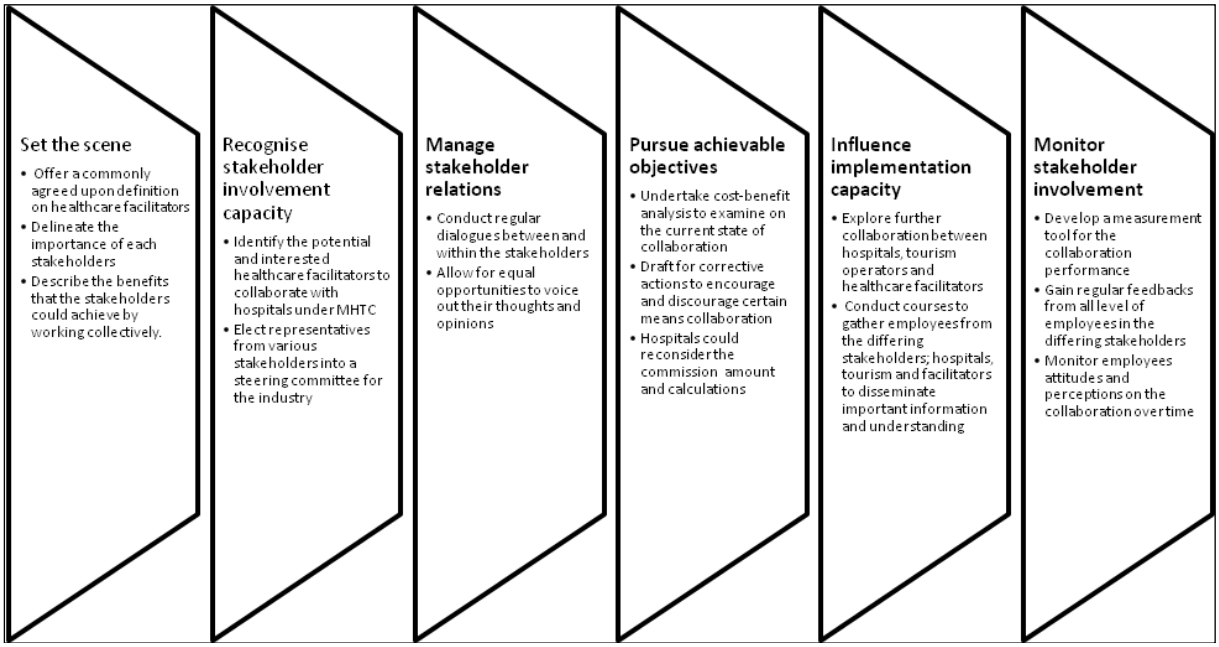

Figure 1: MSIM for the relations between stakeholders in Malaysia's medical tourism industry

Conclusively, this study has uncovered the narratives of the roles, expectations and relations of healthcare facilitators from various perspectives. Thus, it is seen that only the MCL and hospitals are deemed to acknowledge the presence of healthcare facilitators. On the other hand, medical doctors seem to have less understanding of their existence and roles. This happens because medical doctors are only aware of usual travel agencies that manage the tourism aspect of the patients' travel. Given the incongruence in establishing a clear relationship between the stakeholders, the present research proposes the MSIM framework. The framework is hoped to provide a means for the stakeholders to reconsider establishing the roles and relations between them, thus escalating the efforts of developing the medical tourism industry.

As with any research, the present article is not free from limitations. Due to the nature of this article being a small part of an extensive study, the samples are only tight to the actual sampling method. Once the researchers have reached information saturation for the original research, it marked the end of the data collection. Apart from that, the participation of only three embedded stakeholders raises the issue of robustness in the findings. The absence of other stakeholders such as the state tourism board and MHTC may had impinged the richness of this data. Moreover, this cross-sectional study barricaded the researcher from attaining a trend of behaviour and perceptions between the stakeholders over a period of time.

Despite the limitations, the present article is believed to have opened more doors of opportunities for future research. The researchers suggest for an exploratory study on the business structure of healthcare facilitators considering that the hospitals deem their roles to be diminishing. Thus, it would be important to understand their models and sustainability in the medical tourism industry. Moreover, a questionnaire survey could be considered involving a larger sample size to attain generalisable findings to the entire Malaysian market. Otherwise, a qualitative case study is also suggested at the state level to analyse the contextual knowledge

between the states of Malaysia that actively involved in medical tourism. This is essential to provide a ground understanding between the states as Klijs, Ormond, Mainil, Peerlings, and Heijman (2016) denoted that each state in Malaysia runs and earns from medical tourism differently.

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