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Patient-Centeredness Communication Strategy for the Medical Tourism Industry

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Abstract

The concept of patient-centeredness in the Malaysian medical tourism certified hospitals is the commonly preached topic amongst providers. However, there is hardly any nationwide research on medical tourism let alone health communication in Malaysia. Studies have shown that provider-patient communication significantly influences the satisfaction level and health outcomes and ultimately the behavioural intentions of the patients. As such, this research was designed to look at the sub-populations of medical tourists in Malaysia and to understand the differences that exist in these sub-populations. The results indicated that there were slight differences amongst the Indonesians and Singaporeans. The Indonesians were more loyal yet vocal as compared to the Singaporeans. On top of that there were more Indonesians that sought treatments in haematology, oncology, endocrinology, cardiology, and neurology. The results also revealed that Indonesians were more likely to rely on friends, agents, and media to gather information about medical tourism industry in Malaysia. More research needs to be done to understand the medical tourists in Malaysia in order for the providers to stay competitive.

Keywords

Medical tourism; Patient-centeredness; Communication strategy; Communication mix; Malaysia

Introduction

World Trade Organisation (WTO) defined service as "a wide range of intangible and heterogeneous products and activities" whereas Zeithaml et al. [1] characterised service with additional attributes – inseparability and perishability. However, the final definition remains uncertain amidst the various arguments. Moeller [2] argued that the intangible, heterogeneous, inseparability and perishability (IHIP) model only focuses on one single service entity. She proposed the Facilities, Transformation, and Usage (FTU) framework which allow IHIP model to work in dynamic service environment. There were at least 16 different categories of services in the WTO classification; ranging from basic service (such as hotel and catering, and domestic services) to knowledge-based services (such as healthcare and professional).

The contribution of services to the world economy was astronomical and estimated to represent over two thirds of the world Gross Domestic Product (GDP); with the United States as the largest service exporter in the world (about 77% of the nation's GDP). On the other hand, the global commercial services export in 2009 was about US$3.4 trillion, which was around 21% of the total world trade. Due to the intangibility nature of services, most of the exporting companies have no other choice but to be closer to customers. As such, the degree of face-to-face interaction has to increase. But with the advent of technology, communication has transcended across boundaries and barriers. As such, multilateral regulation WTO General Agreement on Trade in Services (GATS) was established in 1985. Based on GATS, international trade in services were classified into four modes of supply; Mode 1 (cross-border supply), Mode 2 (consumption abroad), Mode 3 (commercial presence in another country), and Mode 4 (presence of natural persons) [3].

Distinct from the rest of the other services is the knowledge-based services, which has been growing between 10% and 12% in the past few years [4]. Zack [5] argued that knowledge-based does not mean that the core of the service is knowledge centred. Jackson and Cooper [6] proposed that knowledge-based services should have additional characteristics on top of the normal definition of services which are credence properties, high customisation, complexity, risk and uncertainty, and high value added. In order to achieve this, Zack [5] proposed that organisations must refocus on 10 key actions that revolve around four main characteristics – process, place, purpose, and perspective.

In Malaysia, the service industry is expected to continue to be more prominent. As such, the service industry will play a bigger role and create more jobs. We have seen how the landscape transformed drastically since the 1960's where 60% of the labour force was in agriculture, 23% in industry, and 26% in services. In 1997, only 27% of the labour force was into agriculture, 23% in industry, and 50% in services [7]. But more important was the impact of knowledge-based service – such as professional and business services, education, and healthcare – as the nation moves towards high income economy. Thus, it is not surprising to know that Malaysia is fast becoming an education and medical tourism hubs.

Due to the intangible characteristics of health services, patients have to rely on word-of-mouth (WOM) and/or prior experiences. As such, interactions between foreign patients in Malaysia and hospital personnel (medical and non-medical) play an important role in formulating the perceptions that will ultimately influence the word-of-mouth communication outcome amongst medical tourists [4]. Grant et al. [8] and Hirsch et al. [9] argued that holistic patient care is important to ensure that patients feel comfortable. When patients are comfortable with the hospital personnel then, patients will be more open to communicate effectively. This will indirectly lead to patient compliance and will speed up the recovery process. As a result patient satisfaction is achieved

Another characteristic of knowledge-based medical services is the importance of face-to-face interaction between patient and doctor [10,11]. Paterson and Cicic [12] argued that in such cases high customisation and interpersonal skills are crucial. As such, the authors proposed a two dimensional classification model – degree of

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face-to-face and degree of tangibility. Based on this model, medical tourism falls into Location-Free Professional Services segment (where there is low degree of face-to-face interaction and tangibility) and Value-Added Customised Services segment (where there is high degree of face-to-face interaction and tangibility). In Location-Free Professional Services segment, foreign patients are usually out-patients who are in Malaysia for simple procedures, check-ups or follow-ups such as executive or health screening. On the other hand, Value-Added Customised Services segment, foreign patients may be in-patients who have just undergone some massive surgery such as cholecystectomy. Thus, patients need more counselling and education to adapt to post-operation lifestyle modification.

Literature Review

Why do these foreign patients travel abroad to seek medical treatments? In order to answer this question let's take a look at the healthcare industry briefly. According to WHO [13] the term healthcare encompasses a wide scope which includes all goods and services available within the healthcare system to "(prevent, cure and provide) palliative interventions, whether directed to individuals or to populations". In today's society healthcare is usually used to mean scientific medicine, which is the modern practice of evidence-based medicine or "Western" perspective.

In the past, access to healthcare was accompanied by legal regulation whereby the law enforcement officers had to ensure that the public receive the necessary or intended medical treatment. One example of this was smallpox vaccination which was brought under control in 1977 with enforcement. Today all of us take healthcare for granted as healthcare is considered basic human rights as chartered by United Nations in 1948.

The organised provision of healthcare services to the public can be institutionalised into a healthcare system which is defined as all activities related to promoting, restoring or maintaining health [14]. Most of the healthcare systems can be appraised based on two dimensions – financer and the management of the system [15].

Essentially, the medical tourism phenomenon is driven by the lacks of one of the above healthcare services in home country which causes patients to look elsewhere to fulfil the basic need as proposed by Maslow [16]. Some of the possible problems with the home country health systems are 1) high cost, 2) long waiting period, 3) uninsured procedures, 4) uninsured patients, 5) better quality of care, 6) unavailability of healthcare services (due to ethical or economic reasons), and 7) specialised skills (due to home demand) [17-31]. In Malaysia, the medical tourism industry is driven by the Free Market healthcare system. Hospitals in this system are proactive in finding ways to match the needs of customers with various product and/or service offerings.

Thus, it is not surprising that the global medical tourism is being viewed as a retailing business. Healthcare retailing is serious business as providers are able to sell the goods and/or services directly to consumers. Ultimately, these retail hospitals are there to capitalise on the profits by increasing repatronage [32]. As such, proper marketing communication strategy could be employed to reach out to these consumers who may come from diverse backgrounds.

Keller [33] defined marketing communication as "means by which firms attempt to inform, persuade and remind consumers – directly or indirectly – about the products and brands they sell." These activities can be summarised into three main categories; the voice for the brand or company, establishing dialogues with consumers, and building relationships with consumers. To accomplish these activities, organisation utilise various forms of communication mix – advertising, sales promotion, events and experiences, public relations and publicity, direct marketing, interactive marketing, word-of-mouth marketing, and personal selling – to achieve the goals of reaching out to the consumers.

The objectives of this study are to identify the nationalities of medical tourists that are patronising the Malaysian private hospitals and to understand the differences that exist amongst the sub-population such as the communication mix that these nationality used to influence their decision when seeking medical treatments in Malaysia.

Health Communication and Patient Satisfaction

Kreps [34] argued that health communication focuses on three most fundamental issues – explicate, examine, and address – related to promoting healthcare. He further argued that identifying the appropriate communication mix to reach and influence the consumer is very important. Also, considering the uniqueness and numerous parties involved in the healthcare industry it is utmost important that comprehensive team of multi-disciplinary people be involved in the process. The need for evidence-based healthcare communication has become more important because this is a new discipline and of the increasing demand to ensure that every effort leads to success.

Part of health communication involves provider-patient communication and is also known as patient centeredness. This form of communication may be classified into a few categories depending on the purposes 1) exchanging information, 2) interpersonal relationship, 3) shared decision-making, 4) patient satisfaction, 5) adherence to treatment, and 6) health outcomes. Amongst all these purposes, the most studied and researched is patient satisfaction [35]. Verlinde et al. [36] stressed that patient centeredness was complex and may be influenced by physicians' communication style, patients' characteristics, demographic, patients' communication, empowering patients, and trust [37].

One of the earliest definitions of patient satisfaction was coined by Linder-Pelz [38], who defined it as "individual's positive evaluation of distinct dimensions of healthcare." Linder-Pelz [38] showed the relationship between perception and value. However, he failed to show the relationship between value and expectancy [39]. Thus, another alternative definition was coined by Pascoe [40] who stated that patient satisfaction is the cognitive assessment of service received by patients in comparison with the patients' subjective standard, from past experiences or ideas that have been communicated to the patients.

Macintosh [37] in his study amongst dental professionals found that rapport is "a customer's perception of having an enjoyable interaction with the service provider employee, characterised by a personal connection between the two interactions" [41] and positive rapport directly influences positive word-of-mouth. Cooper et al. [42] stressed that knowledge based service industry like medical tourism must meet the fundamentals of patient centeredness which are rapport and patient satisfaction. Good rapport over longer period of time is related to better treatment outcome amongst patients [43-50].

Douglas and Mort [51] on the other hand stressed the importance of communication amongst the service providers or organisation

with their customers. They argued that there are three possible types of communicators: huggers, movers, and shakers. On the far two extremes are the huggers who are mission minded and the shakers who are money minded whereas the movers are well-balanced between the two extremes. Considering that the priority of each of the communicator is different therefore, the communication strategy, objectives, processes, and outcome for each communication type also varies.

Method

Sampling

In this study the samples were obtain only from the medial tourism certified hospitals; there were 35 in total and existed in groups centring around the main cities. Thus, the cluster sampling was employed and each of the hospital was considered as a cluster. Invitation letters were sent to all the 35 clusters but, only seven clusters responded to participate in this research. Over 2,000 questionnaires were circulated amongst these clusters. The questionnaires were left with the Marketing or Customer Service Department. These heads of department were then responsible to circulate the questionnaire to the respective clinics. Each cluster was enrolled at different time due to the late response to the invitation and was given a period of two months to complete the survey. The whole duration of the survey was about four months in total.

Out of 2,000 questionnaires only 524 questionnaires were returned. There were five inclusion criteria; they were 18 years of age or older, fluent in English and/or Bahasa Indonesia, non-Malaysian who were receiving out-patient medical attentions from one of the medical tourism certified hospitals, visited Malaysia for medical purposes with or without tourism activities, and participated in this survey for the first time. On the other hand, the exclusion criteria included residence in any parts of Malaysia for more than 12 months (unless for certain unforeseen medical circumstances), foreign students who were pursing their studies in Malaysia, expatriates or diplomats based in Malaysia for some form of work related duties, not directly associated with the medical personnel, and not part of any charity missions or sponsored patients by the hospitals.

Development of questionnaire

There were five sections to the questionnaire – Section 1: SERVQUAL questionnaire, Section 2: Behavioural intention, Section3: Patient satisfaction, Section 4: Patient and hospital criteria, and Section 5: Demographic. Sections 1, 2, and 3 of the questionnaire were modified from existing literature. Sections 4 and 5 were based on the interviews and focus groups conducted amongst four groups – Malaysian Ministry of Health, hospital administrators, medical personnel from the hospital, and medical tourism agents. The questionnaire was initially sent to the various people involved in the interviews and focus groups to get their respective feedback. Subsequently, various changes were made and a pilot study was conducted amongst 30 medical tourists. After the pilot study the questionnaire was fine-tuned and the focus was shifted from general patients to only out-patients.

Results

From the 524 responses that were returned, 54 were rejected based on various reasons such as currently residing in Malaysia for more than 1 year, respondents who are Malaysian citizens or Malaysian Permanent Resident holders, working, studying, or residing in Malaysia under the Malaysian My Second Home (MM2H) programme, and below 18 years of age. Table 1 represents the breakdown of the rejected responses.

The respondents consisted of medical tourists from 19 countries; the largest was from Indonesia with 72.2%, followed by Singapore with 23.0%, and others (which comprised of Japan, China, Vietnam, Cambodia, Korea, US, Africa, Sweden, Canada, Thailand, Australia, France and Germany) with 4.8%. There were 43.9% male respondents and 56.1% female respondents who responded to the survey. The largest age group was between 31 and 45 with 41.7%, followed by age group between 46 and 60 with 34.7%, and followed by age group between 18 and 30 with 17.0%. The average age was around 43 years old. Table 2 represented the frequency distribution of the responses by nationality, age, and gender.

In an attempt to identify univariate outliers for the variables histograms and box-plots were visually inspected and standard scores were calculated for each respondent. There were eight respondents with potential outliers, which displayed standard scores with an absolute value in excess of 3.29 ($p<.001$). These respondents were removed. Subsequently, Independent t-test and Pearson Chi-Square were employed to further distinguish the difference between the two largest groups of medical tourist groups – Indonesians and Singaporeans – and to see how these two groups differ in terms of medical procedures, and sources used to obtain more information about hospitals in Malaysia.

Table 1: Summary responses to the questionnaire survey

Responses	Frequency	Percentage
Valid	470	89.69
Invalid		
Residing in Malaysia for more than 1 year, for work, MM2H programme, or for education purposes	39	7.44
Below 18 years old	7	1.34
Malaysian citizens	7	1.34
Incomplete responses	1	.19
Total	**524**	**100.00**

Table 2: Demographic by nationality, gender, and age.

Demographic variable	Frequency	Percentage
Nationality (n = 439)		
Indonesia	317	72.21
Singapore	101	23.01
Others	21	4.78
Gender (n = 424)		
Male	186	43.87
Female	238	56.13
Age (n = 441)		
18 – 30	75	17.00
31 – 45	184	41.72
46 – 60	153	34.69
>60	29	6.58

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Medical service quality

Based on the SERVQUAL model, the five variables – tangibility, reliability, responsiveness, assurance, and empathy - were used and the patients were required to evaluate the performance of the healthcare providers. Except for assurance all the other four variables did not show any significance. Thus, indicating that there is no difference between patients from Indonesia and Singapore. The assurance value was t (df=217) = 2.59, p< .05. The mean values indicates that Indonesians require more assurance (M=3.93) than Singaporeans (M = 3.80). Table 3 is the descriptive statistics of the medical service quality differences between the two nationalities.

Patient satisfaction

There were six sets of feeling that patients were given to evaluate and a composite variable was created from these six sets of feelings. The result indicated that there was no significant difference in patient satisfaction between patients from Indonesia (M=3.81) and patients from Singapore (M= 3.72). Table 4 is the descriptive statistics of the patient satisfaction differences between the two nationalities.

Behavioural intention

There were three variables that were identified – recommendation, loyalty, and complaint. There was no difference between Indonesian and Singaporean patients when it comes to recommendation; both groups were slightly above the average, M=3.74 and M=3.72 respectively. The result from the analysis indicates that there was a significant difference between Indonesian and Singaporean samples in loyalty [t (df =394) = 4.87, p< .01] and complaint [t (df =215) =2.54, p< .05]. The mean values indicate that Indonesians were more loyal and also tend to be more vocal when they were not receiving adequate services or unsatisfied as compared to Singaporeans; Indonesian loyalty mean was 3.42 compared to Singaporean loyalty mean was 3.10, and Indonesian complaint mean was 3.38 compared to Singaporean complaint mean was 3.22. Table 5 is the descriptive statistics of the behavioural intention differences between the two nationalities.

Patient criteria

There were two variables that were identified – culture and stability - and there were no significant differences between the two groups [t (df=230 =1.36, p>.01]. Table 6 is the descriptive statistics of the patient criteria between the two nationalities.

Hospital criteria

There were two variables that were identified – reputation and convenience - and there were no significant differences between the two groups. Table 7 is the descriptive statistics of the patient criteria between the two nationalities.

Medical treatments

The Pearson Chi-Square statistical analyses revealed that there were no procedural differences in terms of preferred medical treatments among medical tourists for 16 of the medical disciplines. There were, however, differences in five medical treatments between Singaporean and Indonesian tourists using healthcare facilities in Malaysia; Indonesian medical tourists were more likely to seek treatments in the following disciplines – haematology [χ^2(df=1)=21.64, p<0.001], oncology [χ^2(df=1)=7.58, p<0.05], endocrinology [χ^2(df=1)=6.46, p<0.05], cardiology [χ^2(df=1)=6.63, p<0.05], and neurology [χ^2 (df=1)=11.70, p< 0.05]. Table 8 is the crosstab of the five medical procedures amongst the two nationalities.

Table 3: Mean scores of the medical service quality by citizen.

	Citizen	N	Percentage	Mean	Std. Deviation	Std. Error Mean
Tangibility	Indonesia	296	74.75	3.83	.569	.033
	Singapore	100	25.25	3.72	.478	.048
Reliability	Indonesia	286	74.09	3.79	.582	.034
	Singapore	100	25.91	3.77	.434	.043
Responsiveness	Indonesia	294	74.43	3.82	.544	.032
	Singapore	101	25.57	3.77	.450	.045
Assurance	Indonesia	300	75.00	3.93	.518	.030
	Singapore	100	25.00	3.80	.402	.040
Empathy	Indonesia	303	75.00	3.86	.565	.032
	Singapore	101	25.00	3.84	.363	.036

Table 4: Mean scores of the patient satisfaction by citizen.

	Citizen	N	Percentage	Mean	Std. Deviation	Std. Error Mean
Satisfaction	Indonesia	284	73.77	3.81	.703	.042
	Singapore	101	26.23	3.72	.534	.053

Table 5: Mean scores of the behavioural intention by citizen.

	Citizen	N	Percentage	Mean	Std. Deviation	Std. Error Mean
Recommendation	Indonesia	290	74.17	3.74	.548	.032
	Singapore	101	25.83	3.72	.473	.047
Loyalty	Indonesia	295	74.49	3.42	.560	.033
	Singapore	101	25.51	3.10	.622	.062
Complaint	Indonesia	293	74.55	3.38	.650	.038
	Singapore	100	25.45	3.22	.514	.051

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Sources used for evaluation

The Pearson Chi-Square statistical analyses revealed that there were differences in terms of the preferred source of information between Singaporeans and Indonesians medical tourists. For example, Indonesians out-patients were more likely to use friends (χ^2(df=1)=4.47, p<0.05); agents (χ^2(df=1)=5.97, p<0.05); and media (χ^2(df=1)=14.06, p<0.001) as their sources of information when researching for medical tourism services in Malaysia. Table 9 is the crosstab of the three sources used for evaluation amongst the two nationalities.

Discussion

The result of this study indicates that the medical tourism industry in Malaysia is heavily reliant on the Indonesian and Singaporean markets. As such, analysis was conducted to find out if there were any differences between the Indonesian and Singaporean clientele. The results from the analysis on these two sub-populations indicated that there were very little differences between both. If Malaysia plans to continue serving these two nationalities then further communication initiatives may be required to ensure that specific patient needs are met. For example, the Indonesians appear to be more expressive and willing to provide feedback as reflected in Table 5. Feedback per se may not necessary be viewed as negative complaints because communication involves two way exchanges [52,53]. Failure in the communication process may lead to the collapse of the industry. The importance can be seen more clearly as the analysis also indicated that Indonesians are more reliant on friends to get recommendations, as shown in Table 9.

As such, the medical tourism certified hospitals in Malaysia may look at utilising the concept of Expatriate Management, a branch of Human Resource Management (HRM), when handling these foreign tourists. In such cases, the subject matter experts should know everything about the culture, politics, socio-economic, and national policies of importing countries. Besides that the experts should also be familiar with the various transportation modes (such as airports or seaports or local or emergency arrangements and transfers), government policies (such as medical insurance reimbursement), government-to-government initiatives, cross border enforcement (such as immigration, customs, and visas), monetary issues (such as currency exchange, bank transfers, and tax rebates), and diplomatic services (such as communication with embassies or consulates or high commissioners). HRM per se differs from Customer Service Management (CSM) because HRM takes into account of the complete welfare of the person rather than just answering questions to satisfying the customers; only then will patient-centeredness be realised.

Considering that the provider in the healthcare industry comprises more than the doctors then, proper communication strategy may have to be set in place to ensure that other personnel (medical and non-medical) are also well-versed with the patient communication process. But communication alone will not be effective if proper knowledge translation processes are not put in place. Khamarko et al. [54] recommended five steps in the knowledge translation process; which are 1) identifying needs of trainees, 2) engaging the stakeholders in the training process, 3) tailoring training to audience needs, 4) incorporating engaging activities into training, and 5) providing post-training support.

Whilst provider-patient communication is important it is also important that other ecological factors could also be taken into account as outlined in the Person-Environment-Occupational

Table 6: Mean scores of the patient criteria by citizen.

	Citizen	N	Percentage	Mean	Std. Deviation	Std. Error Mean
Culture	Indonesia	299	74.75	3.79	.657	.038
	Singapore	101	25.25	3.74	.487	.048
Stability	Indonesia	297	74.62	3.76	.565	.033
	Singapore	101	25.38	3.73	.404	.040

Table 7: Mean scores of the hospital criteria by citizen.

	Citizen	N	Percentage	Mean	Std. Deviation	Std. Error Mean
Reputation	Indonesia	300	74.81	4.02	.657	.038
	Singapore	101	25.19	4.08	.639	.064
Convenience	Indonesia	301	74.88	3.64	.649	.037
	Singapore	101	25.12	3.75	.578	.058

Table 8: Number of respondents by medical treatments and by nationality (n=410).

Procedure	Citizen	No		Yes	
		N	Percentage	N	Percentage
Haematology	Indonesia	252	81.55	57	18.45
	Singapore	101	100.0	0	0
Oncology	Indonesia	261	84.47	48	15.53
	Singapore	96	95.05	5	4.95
Endocrinology	Indonesia	284	91.91	25	8.09
	Singapore	100	99.09	1	0.01
Cardiology	Indonesia	251	81.33	58	18.77
	Singapore	93	92.08	8	7.92
Neurology	Indonesia	270	87.38	39	12.62
	Singapore	100	99.09	1	.01

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Table 9: Number of respondents by sources of information and by nationality (n=410).

Source	Citizen	No		Yes	
		N	Percentage	N	Percentage
Friends	Indonesia	175	56.63	134	43.37
	Singapore	45	44.55	56	55.45
Agent	Indonesia	280	90.61	29	9.39
	Singapore	99	98.02	2	1.98
Media	Indonesia	284	91.91	25	8.09
	Singapore	79	78.21	22	21.78

Performance (PEOP) model. Smith and Hudson [55] argued that interactions between individuals, environment, and occupations are vital in order to improve the communication between provider-patient. Thus, it is utmost important that the patient should be able to comprehend the language that is used in the communication processes [56]. Providing standby translators and/or working closely with the embassies or consulate offices of various nationalities may be a good opportunity for medical tourism hospitals to be effective in reaching out to new target markets [57].

Hou and Shim [35] argued that patients who are not satisfied with their providers will often time turn to alternative communication sources such as internet. While this is true in the Western studies but the situation may not necessary be the same in the Asian setups especially amongst the medical tourists who are coming to Malaysia. The largest population of tourists coming to Malaysia are between the ages of 31 and 60. These population groups many not necessarily be IT savvy especially when telecommunication infrastructure may not be that developed in certain parts of their countries.

Further to that, it was also noted that the Indonesians were more likely to seek treatments in the following disciplines as compared to the Singaporeans; haematology, oncology, endocrinology, cardiology, and neurology, as shown in Table 8. However, the top five most commonly sought after disciplines in Malaysia by medical tourists, in general, are orthopaedic, ophthalmology, cardiology, surgery, and haematology. Either ways, it is important for the providers to realise their own core competencies and to change the mind-set from being good to great. Piper [58] argued that "the thinking is that if more and more people are undergoing a certain procedure at a certain hospital, the outcomes must be favourable." This transformation from good to great may take a number of initiatives but one of the keys may be to communicate the success rates of these treatments or disciplines in order to increase the confidence level amongst the medical tourists.

Based on Douglas and Mort's [51] communication model, the medical tourism industry in Malaysia appears to mimic the "movers" where the strategy is often times unplanned processes with short term gains. Thus, it is not surprising that the objective is mainly to pursue financial gains in the short term. The communication processes are mainly to 1) influence patrons, 2) create beneficial alliances with agents and doctors, 3) rely on word of mouth spread, 4) maximise on advertising and sponsorships, and 5) exchange or transfer of technology to increase patient pool. This communication strategy is not necessary bad but the players may not achieve the esteemed position that the government has planned at the outset when venturing into this industry. This may be due to the fact that there is limited understanding about the clientele. As such, adopting broader communication strategy and communication mix could probably attract more medical tourists.

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