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Understanding medical tourists: Word-of-mouth and viral marketing as potent marketing tools

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HIGHLIGHTS

- We conducted nationwide study on medical tourists in Malaysia.
- We determine the demographics of outpatient medical tourists.
- Main medical tourists are from Indonesia and Singapore.
- Medical tourists spend about seven days with at least one companion.
- Medical tourists are highly influenced by friends, family, relatives and doctor's referral.

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ABSTRACT

The medical tourism industry in Malaysia has grown drastically over the past ten years. This research seeks to determine the demographics of the medical tourists that are visiting Malaysia for various medical treatments. A nationwide questionnaire survey was carried out amongst outpatient medical tourists from medical tourism certified hospitals. The results indicated that majority of the tourists were repeat tourists from Indonesia and most of these outpatient patients spend about seven days in Malaysia with at least one companion. The results also revealed that most of the tourists were influenced by friends, family, relatives and doctor's referral.

1. Introduction

The medical tourism industry is a new industry and one of the fastest growing industries globally. The global industry is expected to generate over US$40 billion with over 780 million tourists spreading across 96 countries (Nicolaides, 2012; Youngman, 2008). However, Hansen (2008) and MacReady (2007) argued that the global medical tourism size in 2006 alone was US$60 billion and is expected to reach US$100 billion in 2012.

The industry is generally seeing an extensive migration of patients from developed countries – such as the United States, United Kingdom, and Australia – to less developed or under-developed countries – such as Costa Rica, India, Hungary, and Thailand. This trend is liken to the migration of birds during winter seasons and is projected to grow at a rate of between 15 and 20 per cent annually. One of the main reasons for this migration is the significant cost savings in the medical treatments. The savings range between 30 and 80 per cent depending on the procedures and the countries (Forbes, 2007, p. 21; Forgione & Smith, 2007; Hall, 2011; Horowitz, Rosensweig, & Jones, 2007; Marlowe & Sullivan, 2007; Nicolaides, 2012; Taylor, 2007; Wood, 2007).

This industry is also witnessing an increase in the number of players globally due to the lucrative revenue. However, new players who are hopping on the bandwagon may not necessarily be competing for the same market but instead tapping into new and more specialised markets. As of this writing there are 28 players in Latin Americas, Eastern Europe, Africa, and Asia Pacific (Alleman et al., 2011; Hancock, 2006; Schult, 2006; Turner, 2007; Woodman, 2007).

For many industry players, one of the notable problems is the inability to predict the market size as there is no consistent definition, either at the country or provider level and the scope of the industry varies based on the definition. One of the main reasons why medical tourism has gained popularity is due to the cost

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advantages between the exporter country and the consumer. Apart from cost savings, there are also other reasons for the migration – long waiting period, uninsured procedures, uninsured patients, better quality of care, unavailability of certain procedures (due to ethical reasons), and specialised skills (due to home demand) (Carabello, 2008; Connell, 2006; Ehrbeck, Guevara, & Mango, 2008; Forgione & Smith, 2007; Freire, 2012; Gerst, 2008; Hancock, 2006; Hopkins, Labonté, Runnels, & Packer, 2010; Horowitz & Rosensweig, 2007; Marlowe & Sullivan, 2007; Milstein & Smith, 2006; Moody, 2008; *More Americans Uninsured*, 2007; *Record Number of Britons Heading Abroad*, 2007; York, 2008).

2. Literature review

Up until 1997, prior to the Asian Financial Crisis, Asia was the main location of choice for most foreign capital investment, particularly in South East Asia. As a direct result significant sums of money poured into these countries, creating a seemingly unending economic bubble more commonly known as the Asian Economic Miracle. The tremendous economic growth in these countries was also well received and highly praised by the International Monetary Fund (IMF) and World Bank. Such investments were first seen in the First Wave, i.e. direct investment from the Japanese in the mid 1980's until the early 1990's, which totalled about US$48 billion in 1996. The main beneficiaries of these foreign direct investments (FDI) were ASEAN countries such as Singapore, Malaysia, Thailand and the Philippines. After that, came the Second Wave, which was chiefly driven by the financial technocrats from major international financial houses (Bello, 1997; UNU World Industry for Development Economies Research, 1999; Woo, 2000).

The annual growth in GDP for most of these Asian countries before 1997 was hovering around 5–12 per cent (UNU World Industry for Development Economies Research, 1999). At the end of 1997 the GDP of South East Asia recorded a 4 per cent growth. By 1998 the economy in South East Asia contracted by 6.9 per cent and about US$30 billion of capital from Indonesia, Malaysia, the Philippines and Thailand was sacrificed to the financial crisis (Kumar, 1999). The non-performing loans (NPL) in Asia have risen to US$2 trillion in November 2000, which is equivalent to 30 per cent of the region's GDP. By 2001 the NPL was estimated at around 17 per cent of the combined GDP – Malaysia's NPL stood at US$43 billion which was about 35 per cent of the GDP and Thailand's NPL value was US$50 billion representing 41 per cent of the GDP (UNDP, 2002).

Like any other industries the healthcare sector was not spared from the 1997 Asian Financial Crisis. Many private-paying patients had to switch back to the public healthcare system as many businesses were closed down or downsized or experienced drastic cutbacks on healthcare benefits. The public hospitals in Malaysia saw an increase in patients, at least between 10 and 18 per cent, and the private healthcare facilities, both hospitals and general practitioner clinics, on the other hand saw a dramatic decrease of between 10% and 30% (UNFPA, 1998).

The drastic and speedy devaluation of Thai baht in July 1997 also affected a number of other Asian currencies including Malaysian Ringgit. Market speculation further aggravated the problem and caused the Ringgit to fluctuate further posting serious problems in business transactions especially in exports and imports, including essential imports such as pharmaceuticals, medical supplies and medical equipment. The import of pharmaceuticals alone made up about 60 per cent of the drugs in the whole country. New, hi-tech, and expensive institutions were affected the most (UNFPA, 1998).

This compounded problem affected many of the private hospitals, as the locals were moving back to public healthcare, causing many private hospitals to issue "code blue" signals due to low utilisation rates in the clinics, wards, and other facilities. As a result, the 1997 Financial Crisis triggered many Malaysian private hospitals to target foreign patients aggressively in order to make up for the decline. Since then, the number of medical tourists has increased drastically as shown in Table 1.

While the data from Association of Private Hospital of Malaysia (APHM) indicate that the numbers of medical tourists are increasing rapidly, the resources required to promote the industry is limited as the promotion avenues are unlimited. As such, the objective of this paper is to identify the demographics of the medical patients that are seeking medical treatments in Malaysia and to identify the sources where patients are obtaining information about the medical facilities in Malaysia.

3. Word-of-mouth communication

The terminology word-of-mouth (WOM) communication has come a long way and there are many different definitions and frameworks that have been proposed by many. Different words have been used to describe the verb, such as diffusion, transmission, communication, and dissemination of thoughts, information, messages, opinions, evaluations, and comments between at least two persons about some products, services, brands, and related experiences (Dichter, 1966; Gajendra, Ye, Sun, & Li, 2012; Gupta & Harris, 2010; Ha & Im, 2012; Shoham, Gavish, & Segev, 2012; Soares, Pinho, & Nobre, 2012; Sweeney, Soutar, & Mazzarol, 2012).

Xu (2007) argued that individuals who are involved in such form of communications may have direct impact on an organisation and four types of WOM publicity were proposed; consumer to consumer which refers to communication amongst close circle, business to consumer where employers encourages employees to talk about the company products or services, business to business, and facilitated business to business which produces information sharing in industrial purchase.

But generally, the verb can be referred to as an informal (Ha & Im, 2012; Soares et al., 2012) and personal (Arndt, 1967) form of communication. On top of that, WOM can either be positive or negative (Anderson, 1998; Richins, 1983). East, Hammond, and Wright (2007) argued that there are more positive WOM rather than negative whereas, Bailey (2004) argued that negative information significantly influences attitude.

WOM has been given such great emphasis in recent years due to a number of reasons such as the impact of WOM on marketing strategy (Smith, Coyle, Lightfoot, & Schott, 2007), effect on purchase decision by customers (Gajendra et al., 2012; Michelle, 2006; Soares et al., 2012), source of trusted information source (Allsop, Bassett, & Hoskins, 2007; Soares et al., 2012), and immediate feedback (Valck, Bruggen, & Wierenga, 2009). Due to these benefits and also during such hard times, businesses are now more akin to invest in WOM marketing as it helps to reduce the advertising and promotional spending and is considered a more powerful marketing tool that produces better results (Sweeney et al., 2012).

Table 1
Malaysian medical tourism revenue.

	Foreign patients	Revenue (MYR)
1998	39,000	14,100,000
1999	59,926	22,400,000
2000	56,133	32,637,030
2001	76,210	44,281,751
2002	84,585	35,579,051
2003	102,946	58,900,000
2004	174,189	104,980,000
2005	232,161	150,920,000
2006	296,687	203,660,000
2007	341,288	253,840,000

Source: Cruez, 2008; EUMCI Review, 2007; MOH, 2002.