THE IMPACT OF MEDICAL TOURISM AS A PRESSURE TO CHANGE TO HOSPITALS IN MEDAN

Destanul Aulia, Ph.D student of IKMAS, UKM Malaysia
Sri Fajar Ayu, DBA, Lecturer of University of North Sumatera, Indonesia

Abstract

Medical tourism is where people often travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers (Connell, 2006). Hospitals in Medan facing an environment pressure to change because of medical tourism. It is a reality that almost 150,000 peoples per year go to Malaysia to seek for medical treatment. In order to find out the point of view of each hospital about medical tourism as the environment pressure to change, the impact of medical tourism in Medan to each hospital and each hospitals reaction (what they are going to do) due to the pressure of change to each hospital (initiate the change, sluggish to respond or just stuck in the mud) this study conducted a semi-structured in-depth interviews with the key person in three hospitals in Medan. The result of interview basically shows that government hospital and small private hospital didn’t really understand about the phenomenon, while the international hospital really understands the change pressure. The government hospital has no reactions to the pressure, while the small private hospital is sluggish to respond.

Keyword: Organizational Change, Medical Tourism, Hospital Change
Introduction

1.1. Backgrounds

In today’s environment, change in organization is usually taking place; although with different amount depend on the organization situation. In the dynamic, unpredictable and tighter competition, the amount of change taking place in organizations can be overwhelming compare to organization with more stable environment. Just as described by Warrick (2009), in efforts to be competitive in a global marketplace, organizations are changing their missions, strategies, goals, cultures, processes, systems, practices, technologies, who owns them and who they own, and in some cases, even their core values. They are flattening their organizations, downsizing, restructuring, redefining roles of people from top to bottom, and struggling to keep up with constantly changing technology and environment.

It is the external environment that both directly and indirectly influences the design and functioning of organizations. The forces driving and demanding change appear in a variety of guises, the pressure such as the openness of the market because of globalization that can wider the choice of a customer or a patient can change the organization. More sophisticated and more educated customer in their purchasing behavior or pressure of information technology dictated organization to change. Other environment pressure proposed by Bainbridge (1996) is the emergent of new industries. At that time, the example of new industries is service industries that replace manufacturing. The industrialized world fight to develop new island of capability based on knowledge rather than production. In the service sector new industries in leisure, healthcare, travel and tourism, such as medical tourism continue to grow, and now, medical tourism becomes a promising new industry.

All of the examples of forces that driving and demanding change discusses which are the globalization or openness of the market, more sophisticated or educated customer, information technology and pressure of the emergent of new industries are exists in Medical tourism. Medical tourism exists because of patients are now learning more and more about their own illnesses, and becoming more familiar with the available treatment options. Informative website with pricing schemes or advertising placements such as within in-flight magazines can be basic information besides as advertising platforms.

Several ASEAN countries according to Arunanondchai and Fink (2005) have become significant exporters of “medical tourism” services, especially Malaysia, Singapore, and Thailand. Thailand is the largest exporter in the region, followed by Malaysia and Singapore. Interestingly, in the case of Singapore and Malaysia, the majority of foreign patients come from other ASEAN countries. In Malaysia, according to the data from association of private hospital Malaysia (APHM) 72 percent of their foreign patients are from Indonesia while 10 percent from other ASEAN countries.

Medan is one of the largest cities in Indonesia and also the nearest one to Malaysia. People in Medan would prefer to seek medical treatment to Malaysia and Singapore compare to Jakarta, as the capital city of Indonesia. Most of the reason is because Malaysia is closer to Medan than Jakarta. The social networking and similarity in culture can be added as factors contributing to this phenomenon. With free fiscal policy for people living in Medan fell free to go to Malaysia and Singapore. There are more and more Indonesian especially from Medan seeks medical treatment to Malaysia and Singapore. Based on the data from Immigration office,
in the last five months, from January to May 2008, there are 56,196 passengers leaving from Medan to Malaysia and Singapore. While the number of passengers in the previous year (2007), based on their records are 138,079 passengers. Beside pro and con opinion about this phenomenon, as admitted by the head of immigration office and local government, this number grows every year.

Although the momentum for medical tourism is growing, there is still a positive and negative impact just like the pros and cons of medical tourism. The impact can be divided between impact on the individual and impact on institution. Impact for individual basically can be traced by individual patient comment on the satisfaction measurement. However, according to Wachsman an American physician medical tourism is dangerous (Talan, 2009). While the impact for institution can be positive or negative. The negative comment such as from Chanda (2001) that the practice of medical tourism can lead to international patients receiving a higher standard of care than residents of the country where it is being given. This is from point of view the provider of service. The positive side come from the argument of Bookman and Bookman (2007) that if the industry is properly regulated, medical tourism can provide a viable means by which developing countries can gain access to needed revenue and developed countries can lessen ‘bottlenecks’ in their health systems.

The impact of medical tourism for the origin country of the medical tourist is interesting to find out. Realizing that over the past several years American patients have sought medical and surgical care on an internationally competitive basis, the US Senate Special committee investigates why American patients are seeking treatment internationally. Rising US healthcare costs, accreditation of hospitals and infrastructure outside US, increase quality care for hospitals outside US and the increase of physician of outside US do the training in US contribute to the choice of international facility for medical treatment for US citizens (Smith and Forgione, 2007). The policy makers, legislator and especially the hospitals will use these factors to evaluate and develop policies or implementing change in order to stay compete in today’s global, consumer-driven healthcare market.

In the case of Indonesia, specifically Medan, as the city where there are so many of its people choose to leave the country in order to seek treatment abroad while being a tourist, it is also interesting to see the impact of the medical tourism to the hospitals in Medan. Whether hospitals see the medical tourism as a threat or opportunity and decided to change. Change is challenging and difficult. The failure rate for change initiatives is close to 80% (Black & Gregersen, 2008). On the other hand according to Heine and Maddox (2010) hospitals are simultaneously the most complex of purposeful organizations and they exist in the most turbulent industry environment. The structure also always a problem because hospital administrators and managers often have little say in the major decisions made and the medical service providers rarely are even employees of the organization. Griffith et al. (2006) studied the performance trends of 2,500 community hospitals over a 5-year period ending in 2003, concluded that hospitals were “operating well below benchmark possibilities and without any promising trends for breakthroughs in the future.” So, change is not an easy decision.

However, according to Zucker (1987) there are two kinds of change in organization, the one that increases the risk of organizational failure and the change that will increase organizational performance. When control of change is taken away from the organization and located in the environment, as suggested by the environment as institution approach, then selection favors organizational inertia and organizations often resist change even when
threatened with extinction. But, in contrast, organizations that have high levels of control exploit opportunities provided in the environment by selectivity and strategically adopting changes that evidence (or intuition) suggests will improve performance and survival chances. So, it is interesting to find out more whether hospitals in Medan realizing the current situation and being particularly attentive to change.

1.2. Statement of Problems

The forces that driving and demanding change in hospital in Medan in the form of the globalization or openness of the market, more sophisticated or educated customer, information technology and pressure of the emergent of new industries that exists in Medical tourism is a reality. For only five months, from January to May 2008, there are 56,196 passengers leaving from Medan to Malaysia and Singapore. So, it is interesting to find out more how hospitals in Medan view these environment pressures. After finding out their point of view about the pressure, it is also important to know what the impact of the pressure to their hospitals is and finally what are their reactions to the pressure of change, whether they decide to change and initiate the change, or now they’re in the stage of awareness of the need for change (just realizing) or sluggish to respond, or do nothing, paralyzed by their existing infrastructure, just stuck in the mud.

1.3. Purposes

The purposes of this paper basically to solve the problems proposed in the statement of problems section which is:
1. To find out the point of view of each hospital about medical tourism as the environment pressure to change
2. To find out the impact of medical tourism in Medan to each hospital
3. To find out their reaction (what each hospital going to do) because of the pressure of change to each hospital (initiate the change, sluggish to respond or just stuck in the mud)

Literature Review

1. Environment and Organization

Ziegenfuss (2011) defined environment of the organization as forces outside the boundaries of the organization which affect the organization’s structure and processes. Environmental impacts on organizations are varied in type, intensity and duration of presentation. He believed that present and future organizations must be able to analyze this increased complexity of external demands.

The general characteristics of organizational environment according to Kast and Rosenzweig (1973) include in nine general characteristics of organizational environment which are cultural, technological, educational, political, legal, natural resource, demographic, sociological and economic. The external environment both directly and indirectly influences the design and functioning of our public and private organizations. Effects range from the types of products and services desired to the availability of labor for production. Analysis and understanding of expected environmental influence is a key component of strategy formation and future-oriented design.
2. Medical Tourism

Medical tourism according to Connell (2006) is a new form of niche tourism. Medical tourism as a niche has emerged from the rapid growth of what has become an industry, where people often travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense. Forgione and Smith (2007) defined the medical tourism phenomenon as the condition where the patient along with both insurers and employers such as in United States are seeking to reduce the costs of treatment through international outsourcing of medical and surgical care. This definition quite the same with the definition from Bies and Zacharia (2007) that the medical tourism is simply the outsourcing of medical services, primarily expensive surgeries, to low-cost countries, such as India and Thailand.

From the three definitions discussed above, it is important to notice according to Connell (2006) that the medical tourism has largely reversed an earlier pattern of wealthy patient traveling to rich world center. Before 1997, according to MacReady (2007), the USA and Europe were “the centers of the health care universe”, especially for cancer and neurological therapies, and host to wealthy people from other countries where care lagged behind that available in developed nations. Asians could go to Singapore, which offered excellent treatment to those who could pay for it, but when Asia slide into economic crisis between 1997 and 2001, many Asians could no longer afford to travel to Singapore, much less the USA. Bumrungrad hospital in Thailand senses and gets benefit from this opportunity. The trend intensified in 2001 after the terrorist attacks in the USA on September, 11, when people from Arab countries were discouraged from traveling to the USA. In that year, the hospital saw 5000 patients from Arab countries. By 2006, the number of Arab patients at Bumrungrad had grown nearly 20 times to 93,000. Forgione and Smith (2007) noted that more than 55,000 Americans visited Bumrungrad hospital in Thailand for various selective procedures during 2005 alone.

In recent years, health tourism has received growing attention due to its economic importance (Garcia-Altes 2005; Teh and Chu, 2005; Connell 2006; Forgione and Smith 2007; Bies and Zacharia 2007; MacReady 2007). Chaynee (2003) noted that in Malaysia medical tourism becoming the second largest income earner for the national economy. Bies and Zacharia (2007) estimate that medical tourism in India increasing at a rate of 30% per year, and it will bring $20 billion to India by 2012. MacReady (2007) believed that medical tourism is already a US$60 billion global business, and it is growing by 20% every year.

Newman (2006) describes that the scope of this activity is surprising, with Asian countries of Thailand, Singapore, India, South Korea, and Malaysia attracting a combined 1.3 million medical tourists per year from around the world, and increasing annually. The estimated worth in Asia alone will be at least $4 billion by 2012. India attracted an estimated 100,000 medical tourists in 2005, Singapore an estimated 300,000, and more than a million in Thailand. Meanwhile, the Philippines are vying to become the “new hub of wellness and medical care in Asia” as stated by their Health Secretary Francisco Duque III in January 2006, during the launch of the countries campaign to increase their share of the market. They offer competitive prices as well as highly skilled and trained physicians (most trained in the United States), who speak English. They advertise competent, compassionate, and caring people; world class, accredited health care facilities; and a chance to visit breathtaking tourist spots in the country. The travel industry saw this opportunity, and put together packages that include airfare, hotel
accommodations, and surgery expenses, with the claim of saving up to 80% compared with what it would cost in the United States.

It has grown dramatically in recent years according to Connell (2006) primarily because of the high costs of treatment in rich world countries, long waiting lists (for what is not always seen institutionally as priority surgery), the relative affordability of international air travel and favorable economic exchange rates, and the ageing of the often affluent post-war baby-boom generation.

Further Connell (2006) describes that the growth of medical tourism has been facilitated by the rise of the Internet, and the emergence of new companies, that are not health specialists, but brokers between international patients and hospital networks. It has also grown because of rapidly improving health care systems in some key countries, where new technologies have been adopted. Above all, it has run along with the deliberate marketing of health care (in association with tourism) as medical care has gradually moved away from the public sector to the private sector, ensuring that a growing majority of people, especially in the richer countries, and particularly in the United States. Those must be paid and often considerable for health care. Finally, the growing interest in cosmetic surgery, involving such elective procedures as rhinoplasty, liposuction, breast enhancement or reduction, LASIK eye surgery and so on, or more simply the removal of tattoos, have created new demands. Various forms of dental surgery, especially cosmetic dental surgery, are not covered by insurance in countries like the UK and Australia; hence dental tourism has been common.

Bies and Zacharia (2007) argues that the reasons behind medical tourism in the UK are that the patients sometimes cannot wait for treatment from the National Health Service, and they cannot afford to see a private physician either. As a result some patients choose to follow medical tourism, combining medical treatment with exotic vacations. In Asia, the medical tourism growth according to Levett (2005) because of new global realities such as the fallout of terrorism, the Asian economic downturn, internet access to price information, and the globalizations of health services.

The demand for medical tourism is predominantly consumer-driven, including patient, employers who pay the bill, and insurance companies seeking to identify low cost provider networks. According to Committee Chairman Smith, rising health care cost in the United States is a “contributing factor” to the demand for medical tourism. The special Committee was established to investigate the implication of medical tourism for the US health care system. The export of patient to international hospitals is primarily based on the significantly lower cost of procedures offered outside the United States (Forgione and Smith 2007).

Finally, according to García-Alte’s (2006), some of the challenges and opportunities ahead, as health tourism found its prominence in the practical and conceptual domains of tourism are population aging, lifestyle changes, tourism alternatives, particularities of healthcare systems, restrictions on entry. Those are practiced by foreign health service providers, restrictions on foreign direct investment in health and other related sectors, regulations in insurance, education, and telecommunications; domestic regulatory infrastructural, and capacity related constraints; infrastructural, financial, and human resource constraints; and market competition. However, in response to such challenges, many strategies can be used (Chanda, 2001), regulations, commercial strategy, and quality of care, professional licensing, technologies, taxes, labor and infrastructure.
The biggest hurdle that medical tourism has had to face, and continue to face, is the challenge of convincing distant potential visitors of which that medical care in relatively poor countries is compared to something available at home, in outcome, safety and even something dealing with pain thresholds. The medical care systems in countries such as India, have been conventionally regarded in the west as inadequate, ‘even’ for India itself. As the German radio station, Deutsche Welle, has pointed out ‘India is not exactly known for health and hygiene’ yet it nonetheless anticipates a major market in Germany. This condition is the parallel to perception ‘you get what you pay for’, hence cheap medical care may well be inferior. While such situations have now radically changed the perception of inadequacy remains (Connell, 2006).

3. Organizational Change

The definition of organizational change by Roark and Freemyer (2010) is a process that changes the behavior of followers by speaking to their feelings, hearts, and minds. Changing behavior is not influencing followers’ thinking through rational analysis. Instead, it involves thinking, feeling, and emotions to reach their hearts.

In organizational change followers must first change and the organization follows (Black & Gregersen, 2008). Change influences followers’ belief systems. It is difficult to change the mental maps of followers, especially when they are entrenched in past beliefs. McMillan (2004) noted that there is a built-in resistance to change that emerges as a kind of organizational inertia. Similarly, Dunoon (2008) purported that the hidden aspects of an organization’s culture can present a major challenge to the change process. Followers’ mental maps are like gravitational forces that hold them back.

4. Organization Change in Hospitals

According to Heine and Maddox (2010) hospitals typically display stagnant, impersonal and historical data on various aspects of hospital performance. In one study examining the effect of change interventions in hospitals, “only 38% of executives believed that their initiatives were successful and only 30% thought these initiatives contributed to the sustained improvement of their organization (Erwin 2009). Also, not surprisingly, initiatives to provide training in teamwork for error reduction efforts did not result in improved outcomes. Changing basic practices in massive, complex healthcare organizations will be especially challenging. However, Mohr, Burgess and Young (2008) suggest that a teamwork culture in a hospital can reduce turnover thus providing cost savings and, perhaps, higher quality service to patients.

Furthermore, Heine and Maddox (2010) argue that there are two realities about hospital culture and practices serve to hinder many efforts at continuous efforts to improve patient healthcare outcomes. First, the status difference among providers, for example, in hospital medical/surgical wards, is often a hindrance to improved quality of service delivery and unit interpersonal communications. Physicians, of course, rightly bear all of the authority and responsibility for patient-related decisions. But physicians, because of this status, are not intimately involved in teaming with other providers when intervention efforts are undertaken. Floor group meetings which are held by provider staff typically do not involve physicians in discussions of individual patient bedside care. When physicians make rounds to attend to patients, usually they first review medical records, view recent test data and other measures, then consult with the patient directly. A nurse or aid is rarely consulted for face-to-face
communication and, perhaps surprisingly, the physician rarely reviews nursing notes written in the patient records (Mohr, et al., 2007). The second hospital cultural factor that may hinder improvement efforts is the variation in techniques or practices caused by variations in maturity of the organization, technology used and, of course, individual differences in personality amongst hospital service providers. Such differences obviously apply to all organizations, their cultures and their practices (Fahey, 2008). When external consultants are used in an organizational development effort, these individuals are rarely familiar with internal processes and procedures. Professionals are left to develop their own improved methods and implement them proactively, unlike the traditional “fix” model. Even threats of legal action and other environmental forces are not stimulating improvement and that the overall picture is one of randomness rather than of enlightened management (Griffith et al., 2006).

Methodology

Conceptual Framework

Medical tourism is where people often travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense (Connell, 2006). The impact of medical tourism on the origin country of the medical tourist is interesting to find out. However, no impact can be recognized in the origin country if the decision maker (such as key person of a hospital) can’t recognize that environment pressure to change. Environment organization according to Ziegenfuss (2011) is the forces outside the boundaries of the organization which affect the organization’s structure and processes and environment will both directly and indirectly influences the design and functioning of organizations. If the purpose of the paper is to find out the reaction of hospitals in the origin country because of the pressure of change (medical tourism), then it is important to understand first how each hospital sees medical tourism or their point of view about medical tourism and its impact to their hospitals. Finally, it is can be find out the reaction of each hospitals to this pressure, whether they will initiate the change, sluggish to respond or just stuck in the mud.
Data Gathering

Data gathered through (1) personal observations of and continual interactions and discussions among the executive team, managers and staff (2) semi structured in-depth interviews conducted with key persons, managers and owners of hospital. The hospitals chosen in this study must be located in Medan. In order to considered the representativeness of variety of hospital in Medan, this study choose three kinds of hospital as sample, hospital A is the government owned hospital, hospital B is small private hospital and hospital C is an international chain hospital.

Analysis

The method of study is comparative method or comparative case analysis. Each one hospital considered to be one case study. So, there are three case studies. The comparison made for three case studies, basically based on their perception about medical tourism, the impact and their reaction toward it. The steps needed to complete all of information are including defining and describing the essential qualities or characteristics of the organization chosen for study, to report the perception of each hospitals about medical tourism and its impact and finally comparing the three case studies.

Findings and Discussion

Findings

The result of interview with the key person manager and owner of the three hospitals chosen to study in this paper is as below:

1. Hospital A (a government owned hospital)
   a. The description of hospital:
      The hospital first operation is on 11 August 1928, by Dutch government and when Japan governed the country the hospital named also change to Japanese name but it is directed by an Indonesian. Since 1952, this hospital is a teaching hospital. In 2001, the ownership transfer from provincial government to the city government. This government owned hospital caters for patients from low to middle income. Most of the patients are civil servant, poor people and patient with government insurance. The technology and product of this hospital is just standard as other government hospital in Indonesia.

   b. Hospital views about medical tourism as the environment pressure to change:
      - The manager admit that he doesn’t specifically understand about medical tourism
      - According to him medical tourism in Medan can’t be considered as the new trend or syndrome. It is absolutely not a phenomenon.
      - He believed that most of the people go to Malaysia just for sightseeing which is their main purpose. To seek medical treatment is just their last reasons. In relation to medical purpose, according to him, most of them go for second opinion regarding their health status. This is legal by law because everyone has the right to look for the treatment themselves. So, medical tourism is just about second opinion.
      - Further discussion, he cannot differentiate between medical tourism and people who seek second opinion regarding their health status. He believed that if a patient wants to seek
medical treatment or second opinion, they should come to destination country with the result of diagnostic tests or accompanied by their doctors.

- If the patients just go to the destination countries without the proper documents such as the result of the diagnostic test, according to him, that is not the medical tourist, and this is wrong.
- The people that should do the medical tourism are peoples with severe, chronic or high killing power illness or rare illness.
- He concluded that medical tourism is about the readiness of a country to align the concept of healthcare with tourism, so people come to the hospital with warm feeling because they are treated or served like a tourist.

c. The impact of medical tourism in Medan to the hospital

- According to the manager of hospital A, if only 56,196 passengers leaving from Medan to Malaysia and Singapore in the first five months in 2008, then this figure is just a small number, without any impact to his hospital, that is why he refuse to call the medical tourism as phenomenon.
- With the increasing number of people in Medan to seek medical treatment outside the country, the manager concerned about its impact on the process of education of doctors. He is afraid that people in Medan will underestimate the doctor’s education process.
- He admit that medical tourism gave no impact to the number of patients visited to his hospital because he believed that most of the medical tourist is the middle and higher social class patients which is not this hospital target patients. According the top five rank of his hospital patients are:
  1. patient of government insurance ASKESSOS (Asuransi Kesehatan Sosial) which is for civil servant funding by central government,
  2. followed by JAMKESMAS (Jaminan Kesehatan Masyarakat) patients funding by central government for poor people only,
  3. then, patients under MEDAN SEHAT insurance funding by district government for every people live in Medan,
  4. after that, the general patient without insurance, and
  5. the least patients is the patient under JAMKESDA (Jaminan Kesehatan Daerah) insurance, funding by provincial government for poor people.

d. The reaction toward the pressure of change

- He believed that there is no real impact of medical tourism to his hospital so, he feels that no need to react to medical
- He believed that he has already loaded with day to day problems including the rigidity of bureaucracy, it is quite impossible for him to start thinking about change
- Most of the decision is depend on the political will
- Although he admit that there should a change in human resources and infrastructure should be built more

2. Hospital B (small private hospital):

a. The description of hospital:

The B Hospital begins its operation since July 9, 1988. This is a famous and familiar hospital, located in the center of Medan city. When people in Medan asked about private hospital, they will certainly remember the name of this hospital and most of them describe this hospital as clean and fast services but quite expensive. There are 220 beds and 204
paramedic and 185 non medic work as employee in this hospital. While there are 13 full time general doctors and a few part timer expert doctor

b. Hospital views about medical tourism as the environment pressure to change:
   - Most of medical tourist from Medan come to Malaysia is for second opinion
   - It seems that patients always thought that there is a miracle in hospitals in Malaysia and they can cure faster if they go to Malaysia
   - The number of people who live in Medan is more than two million people, if there is 150,000 peoples per year go to Malaysia seek for medical treatment, then it is just a small number
   - The medical tourism is just a temporary syndrome
   - Medical tourism will grow or not depend on whether many people will believe that there are also many failure case in Malaysia
   - It is because of government do not want to interfere before and too late to interfere now, people already go to Malaysia to seek for medical treatment

c. The impact of medical tourism in Medan to this hospital
   - The impact of medical tourism is that there are less and less wealthy patient visited this hospital
   - They can’t compete based on technology and decided no need to

d. The reaction toward the pressure of change
   - Create new segments for this hospital which is the middle class patients from other district, in North Sumatera Province, or outside the province, such as from Tebing Tinggi, P. Sidempuan, Nias, Lhokseumawe, Labuhan Batu and then make this new segment proud to be treated in Medan, give discount for accommodation (hotel, which is also owned by this group) for their family if they wants to accompanied the sick person.
   - Increasing services, invite the consultant to increase the services
   - Increase consumer loyalty through personal touch from the manager
   - Building the sense of family bonding between manager and employee
   - Trained the doctors to be the marketer too
   - Increase training

3. Hospital C (international chain private hospital):
   a. The description of hospital:
   Hospital C is a 220 bed-hospital, it is owned by an international company engaged in the delivery of modern healthcare services across Asia. The company currently has operation and development in Malaysia, Vietnam, Indonesia, the Philippines and in India. The company's model hospitals claimed as the result of 10 year development effort that combined best care practices with best technology utilization. This hospital changes their names for the third times in 2009, means that the owner of this hospital has changed from previous with the new one, although the theme of this hospital is still an international hospital.

   b. Hospital views about medical tourism as the environment pressure to change:
   - It is a lost for us to let 150,000 peoples per year go to Malaysia seek for Medical Tourism
   - Medical tourism is a phenomenon that start in a few years a go
   - It is like a fire that we should stop that fire
   - Government has to realized this phenomenon and do something
   - The medical tourism is the phenomenon of people seek medical treatment outside of the country wrapped with tourism, which is jut additional things, what is the core here is people seek treatment outside of the country
It is the lifestyle factor (prestige) that people in Medan do the medical tourism
c. The impact of medical tourism in Medan to the hospital
   - Medical tourism will grow even faster or not depend on what we are doing to stop this, if the input and process is still the same then its means that we do nothing to stop this phenomenon.
   - Hospital agent (agent of outside the country’s hospital) which can be a doctor, always makes things worse in Indonesia, they eroded the trust of people in Medan to their hospital
   - Because this hospital is a relatively new in their operation, the number of patient
d. The reaction toward the pressure of change
   - It is a lost for us to let 150.000 peoples per year go to Malaysia seek for Medical tourism, so, we have to do something in order to attract them or to make them stay, not being busy looking for someone to blame
   - We need to increase our reputation, taking back the “trust” from people in Medan
   - It is the existence of this new hospital to increase the trust of people in Medan to their hospital
   - Invite feedback from patients, presented in forum meeting, learning from feedback from patient
   - Recruiting the expert doctors, to stay as full time doctors, almost 20 doctors, in house expert doctors, almost 8 hours stay in hospitals
   - The systems need to be change, especially related to doctors existence and hours, their double job
   - The recruitment process is now in the process of change
   - They will invest every year in technology

Discussion
One of the purposes of this paper is to find out the impact of medical tourism on the origin country of the medical tourist, to find out the reaction of hospitals in Medan because of the pressure of change to their hospital or because of the medical tourism. However, as it is mention before, no impact can be recognized in the origin country if the decision maker (such as key person of a hospital) can’t recognize that environment pressure to change. Based on the findings for Hospital A and B, and just like what they admitted in the interview that they didn’t clearly understand what medical tourism is. Both of this hospitals thought medical tourism is just a temporary syndrome of people in Medan. There is a sense of denial here. The two hospitals A and B believed that medical tourism is not a phenomenon and the number of people leaving this city to seek medical treatment out of the country which is an approximately 150.000 peoples per year is just small number, hardly has impact to their hospital. The reactions of physicians to their competition are quite the same everywhere and it is understandable. Even an American physician believed that medical tourism is dangerous (Talan, 2009). So, is the physician and manager from the two hospitals that argue that there are many failure case in the destinations country which is unexposed now and that is not true that patient will getting better quicker compare to if the patient seek treatment in the origin country.
Although hospital A believed that medical tourism has no impact on the number of patient visited this hospital, the impact is exist in the form of the decreasing confident of people in Medan to the education of physician because this hospital also a teaching hospital. Unfortunately it is as if there is nothing this hospital can do to this situation, just because this hospital is the government owned hospital. They have to face the bureaucracy and it is quite impossible especially if the government has no concern on this matter.

Hospital B is sensing the problem but they are still hesitated to change. The manager try to be more creative by making a new segment for his hospital but all of the new strategies are kind of avoiding the problem. It is understandable because this hospital admitted that this hospital doesn’t have enough fund to do the further development.

Hospital C is a new hospital that just begins their operation after the third time change name or ownership. Although this hospital still in the same theme as the previous one which is international hospital. The manager seems to understand better about medical tourism compare to other two hospitals. However, because this is a brand new hospital, which offers a luxurious treatment, this hospital can’t yet measure its performance. This hospital doesn’t know the real impact of medical tourism to the number of patient visited the hospital. If the number of patients visited this hospital is becoming smaller it might be not because of medical tourism but it might be because this hospital is just in the phase of introduction of its life cycle phase.

Conclusion

- Hospital A and B seems has the same point of view about medical tourism and they both see medical tourism as not the environment pressure to change. On the contrary Hospital C sees the medical tourism as the environment pressure and this hospital believed that this hospital existence is to attract the market segment and stopping them to go abroad.
- The impact of medical tourism almost nothing to the hospital A except the image of this hospital as teaching hospital, while hospital B loose a small number of high class patient. The impact to Hospital C is immeasurable because this hospital is a brand new hospital
- It is also can be concluded that the reaction of Hospital A to the pressure is almost nothing or Bainbridge (1996) calls it as stuck in the mud. Hospital B reaction is very slow and still hesitated to change or sluggish to respond. Finally, Hospital C is not in changing condition but this hospital exist because of the opportunity the owner saw in medical tourism.

References


