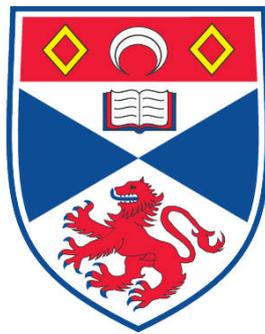


**INTERNATIONAL MEDICAL TRAVEL AND THE POLITICS
OF THERAPEUTIC PLACE-MAKING IN MALAYSIA**

Meghann Elizabeth Ormond

**A Thesis Submitted for the Degree of PhD
at the
University of St. Andrews**



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International medical travel and the politics of therapeutic place-making in Malaysia

A thesis submitted to the University of St Andrews
for the Degree of Doctor of Philosophy

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31 January 2011

Declaration

I, Meghann Elizabeth Ormond, hereby certify that this thesis, which is approximately 76,902 words in length, has been written by me, that it is the record of work carried out by me and that it has not been submitted in any previous application for a higher degree. I was admitted as a research student in September 2006 and as a candidate for the degree of PhD in Geography in May 2007; the higher study for which this is a record was carried out in the University of St Andrews between 2006 and 2010.

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Abstract

This thesis examines the shifting relationship between the state and its subjects with regard to responsibility for and entitlement to care. Using Malaysia as a case study the research engages with international medical travel (IMT) as an outcome of the neoliberal retrenchment of the welfare state. I offer a critical reading of postcolonial development strategies that negotiate the benefits and challenges of extending care to non-national subjects. The research draws from relevant media, private-sector and governmental documents and 49 semi-structured, in-depth interviews with IMT proponents and critics representing federal, state and urban governmental authorities, professional associations, civil society, private medical facilities and medical travel agencies in Malaysia's principal IMT regions (Klang Valley, Penang and Malacca). Across four empirical chapters, the thesis demonstrates how 'Malaysia' gets positioned as a destination within a range of imagined geographies of care through a strategic-relational logic of care and hospitality. I argue that this positioning places 'Malaysian' subjects and spaces into lucrative global networks in ways that underscore particular narratives of postcolonial hybridity that draw from Malaysia's 'developing country', 'progressive, moderate Islamic' and 'multiethnic' credentials. In considering the political logics of care-giving, I explore how the extension of care can serve as a place-making technology to re-imagine the state as a provider and protector within a globalising marketplace in which care, increasingly commodified, is tied to the production of new political, social, cultural and economic geographies.

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List of abbreviations

ADB	Asian Development Bank
AEC	ASEAN Economic Community
AFAS	ASEAN Framework Agreement on Services
AFC	Asian Financial Crisis
AFTA	ASEAN Free Trade Area
APHM	Association of Private Hospitals of Malaysia
ASEAN	Association of Southeast Asian Nations
ASQua	Asian Society for Quality in Health Care
BIMP-EAGA	Brunei Darussalam-Indonesia-Malaysia-Philippines East Asian Growth Area
CAHP	Coalition Against Healthcare Privatisation
CAP	Consumers' Association of Penang
CBR	Cross-border region
CEPT	Common Effective Preferential Tariff
CHI	Citizens' Health Initiative
CT	Computed tomography
ECER	East Coast Economic Region
EPU	Economic Planning Unit
EPZ	Economic Production Zone
FAZ	Free Access Zone
FOMCA	Federation of Malaysian Consumers' Associations
FTA	Free trade agreement
FTZ	Free Trade Zone
GATS	General Agreement on Trade in Services
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
GBP	British pounds (currency)
GHG	Global health governance
GPRD	Greater Pearl River Delta
GT	Growth triangle
HMI	Health Management International
HICOM	Heavy Industries Corporation of Malaysia
IDR	Indonesian rupiah (currency)
IIB	Iskandar Invest Berhad
IHG	International health governance
IJN	Institut Jantung Negara / National Heart Institute
IMS-GT	Indonesia-Malaysia-Singapore Growth Triangle
IMT	International medical travel
IMTA	International Medical Travel Association
IMT-GT	Indonesia-Malaysia-Thailand Growth Triangle
IOFC	International Offshore Financial Centre
IRDA	Iskandar Regional Development Authority
ISO	International Organization for Standardization
ISQua	International Society for Quality in Health Care
JCI	Joint Commission International
KLCC	Kuala Lumpur City Centre
KLIA	Kuala Lumpur International Airport
KPJ	KPJ Healthcare Berhad

LTBB	Batu Berendam International Airport, Malacca
MAB	Medicine Advertisement Board
MATRADE	Malaysian External Trade Development Corporation
MATTA	Malaysian Association of Tour and Travel Agents
MDA	Malaysian Dental Association
MHTC	Malaysia Healthcare Travel Council
MITI	Ministry of International Trade and Industry
MM2H	Malaysia My Second Home Programme
MMA	Malaysian Medical Association
MMC	Malaysian Medical Council
MP7	Seventh Malaysia Plan
MP8	Eighth Malaysia Plan
MP9	Ninth Malaysia Plan
MRI	Magnetic Resonance Imaging
MSC	Multimedia Super Corridor
MSQH	Malaysian Society for Quality in Health
MTA	Medical Tourism Association
MYR	Malaysian ringgit (currency)
NCCIM	National Chamber of Commerce and Industry of Malaysia
NCER	Northern Corridor Economic Region
NCP	National Cultural Policy
NCPHT	National Committee for the Promotion of Health Tourism in Malaysia
NDP	National Development Policy
NEAC	National Economic Action Council
NEP	New Economic Policy
NET	Natural economic territory
NVP	National Vision Policy
OHSAS	Occupational Health and Safety Advisory Services
OIC	Organisation of the Islamic Conference
OPP	Outline Perspective Plan
PBB	<i>Patients Beyond Borders</i>
Petronas	Petroleum Nasional Berhad
PCMC	Prince Court Medical Centre
PHCFSA	Private Health Care Facilities and Services Act
PHG	Penang Health Group
PM	Prime Minister
PR	Permanent Resident
SCORE	Sarawak Corridor of Renewable Energy
SDC	Sabah Development Corridor
SERI	Socio-Economic and Environmental Research Institute
SEZ	Special Economic Zone
SIJORI	Singapore-Johor-Riau Growth Triangle (currently the IMS-GT)
SJMC	Sime Darby Medical Centre Subang Jaya
SMC	Sunway Medical Centre
STPB	Singapore Tourism Promotion Board
T/CM	Traditional and complementary medicine
THE	Total health expenditure
THONEH	Tun Hussein Onn National Eye Hospital
TRIPS	Agreement on Trade-Related Intellectual Property Rights
UNCTAD	United Nations Conference on Trade and Development

UNWTO	United Nations World Tourism Organization
USD	United States dollar (currency)
WHO	World Health Organization
WTO	World Trade Organization

A note on language

Throughout the thesis I use the common English spelling for particular place names, like Penang (which would be Pulau Pinang, in Bahasa Melayu) and Malacca (Melaka), in order to maintain coherency with existing English-language promotional materials and media coverage. Non-English terms that have particular relevance and currency in Malaysian daily life, such as *bumiputera* ('sons of the soil', an ethnicised category used in positive discrimination policy and discourse) and *Bangsa Melayu/Bangsa Malaysia* ('Malay nation'/'Malaysian nation'), appear italicised in their original forms.

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Eu não sou eu nem sou o outro,
Sou qualquer coisa de intermédio:
Pilar da ponte de tédio
Que vai de mim para o Outro.

*I am not me nor am I the other,
I am something in between:
Pillar of the bridge of weariness
That extends from me to the Other.*

- Mário de Sá-Carneiro, Lisbon, 1914

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This thesis is dedicated to all of you who have made it possible.

‘Thresholds are the very scenes for the drama of responsiveness, hospitality and responsibility’.

- *Clive Barnett (2005:16)*

Chapter I. Introduction

Figure 1.1 A video still from *Patients Beyond Borders - Malaysia Edition* launch ceremony on 23 July 2009

(image removed)

Source: Xinyiduan (2009)

1.1 Introduction

In a dimmed room of the Kuala Lumpur Convention Centre, part of the vast urban complex that includes the iconic Petronas Twin Towers, spotlights are directed with dramatic flair towards a stage. Inspirational music, reminiscent of the theme songs from the futuristic *Star Wars* films and the talent-spotting *Star Search* programme of the 1980s, floods the space. A two-metre replica of the cover of the new Malaysia edition of the *Lonely Planet*-style medical travel guidebook series, *Patients Beyond Borders: Everybody's Guide to Affordable, World-Class Medical Tourism* (Woodman 2009), slowly emerges from between large stage panels announcing the publication's launch, propelled forward by a substantial globe. The globe, partially hidden from view, is positioned at just the right angle, contrasting the green finger of Peninsular Malaysia with the long scarlet stroke of Indonesian Sumatra. Taking to the stage is the Deputy Secretary General of Tourism Malaysia, fitted in the everyday dress worn by Malay women, flanked by the American author of the guidebook and the suit-clad chairmen of the Association of Private Hospitals of Malaysia (APHM), the International Society for Quality in Healthcare (ISQua) – the prominent international healthcare accreditation umbrella association – and its new Malaysian-led regional offshoot, the Asian Society for Quality in Healthcare (ASQua). The Deputy Secretary General raises the flag, resplendent with its Islamic crescent and federal stripes, in the air. Inserting it into the globe provokes a shower of festive confetti from above, thus closing the brief ceremony (see Figure 1.1).

The guidebook's release at the APHM's 2009 annual conference that morning had been strategically timed as part of the most aggressive promotional campaign in Malaysia since international medical travel (IMT) first was identified by the government in 1998 as an engine for national development. It was to be followed only months later by the establishment of the government-backed Malaysia Healthcare Travel Council, meant to unite and coordinate medical travel industry players' activity along the lines of the 'Malaysia Healthcare' brand concept. The Malaysia edition of *Patients Beyond Borders* (Woodman 2009) – like the Korea, Singapore, Taiwan, Thailand and Turkey volumes it joins – principally contributes to a broader nation-branding exercise. Though available through major online booksellers, it is tacitly understood that the guide's prime channels of distribution are those who funded, and provided much of the material for, its undertaking: the Malaysian Ministries of Health, Tourism, and Trade and Industry and the APHM. Its

readers are informed that ‘the government and private sectors have worked hard to bring the highest quality standards of healthcare to its people, as well as to those who visit its shores for medical care’ (*Ibid.* 2009: xiv). Its colour photos place smiling professionals in white coats and cutting-edge medical equipment side-by-side with rice paddies, jungle treks and dancers in traditional costume to frame Malaysia as ‘an intriguing blend of the modern world and the developing world’ (*Ibid.* 2009: 158), offering the personalised touches and ‘creature comforts’ that guarantee ‘welcome relief from the sterile, impersonal hospital environments so frequently encountered at home’ (*Ibid.* 2009: 5). The coming years will see complimentary copies handed out during promotional exercises and official trade missions around the globe in order to demonstrate that this upper-middle-income ‘developing’ country’s medical travel ‘street cred’ is a legitimate alternative among diverse healthcare markets.

Stripped of the dramatic lighting, soundtrack, polystyrene globe and confetti, a number of interpretations could be made of the ceremony. Some might observe a high-ranking Malaysian government official who represents a ministry dedicated to generating foreign exchange income by flaunting the country’s hospitality and heritage teaming up with a host of elite Malaysian and non-Malaysian healthcare industry players with significant stakes in the international expansion of privatised healthcare to avail Malaysia’s already unevenly distributed health resources to foreign patient-consumers. Other viewers might read that same ceremony as part of a broader strategy, taken by a savvy government alert to the ‘inevitability’ of globalisation, towards further integrating a flexible Malaysia into the global marketplace through transnational public-private partnerships in the lucrative arena of healthcare that will move the country up the ‘development’ ladder. Whichever way we look at it, however, this flag-wielding display seeks to plot ‘Malaysia’ as a node of medical excellence within an imagined geography of ‘world-class’ healthcare.

This curious performance – a campaign for a *country* to be recognised as a ‘world-class’ care provider at a moment when the status of the nation-state is undergoing profound transformation – is provocative. Considering that ‘so many important historical reterritorializations of citizenship have been made and marked through the changing scales of health citizenship’ (Sparke 2009a: 8), I advance that the extension of a flexible neoliberal ‘health citizenship’ to select non-citizen consumer-subjects significantly revises the ‘traditional’ relationship between the nation-state and its citizenry, opening the door to re-imaginings of the role of the nation-state. At the core of this thesis, therefore, is the question:

- How does the ‘extension of caring’ (Barnett and Land 2007: 3) manifested in IMT relationships link up with discourses and practices reconfiguring the relevance of the nation-state in a globalising context?

I seek to trace broader changes between countries, groups and individuals as they negotiate their positions within increasingly commodified relationships of care. To do this, I explore how IMT flows and their selective harnessing by the state and the private sector become part of a new postcolonial nation-building project in Malaysia by asking the following questions:

- What does the 'extension of caring' through the provision of private healthcare to non-citizens in Malaysia accomplish, and what sorts of power relations does this expedite?
- What 'Malaysia' is put 'on the map' to qualify for 'world-class' IMT destination status? Which characteristics are promoted as national credentials for expert care-giving and which are suppressed, ignored or rendered obsolete?

In examining these questions across four empirical chapters, I offer up a critical interpretation of claims made to specific forms of care expertise, the construction of such expertise and the manners in which select others are invited to draw upon it – in other words, through whom, for whom, how and where care exchanges are sanctioned. In so doing, ultimately I seek to denaturalise these claims by unravelling the complex processes and layers of identity politics that serve as the foundation for relationships which determine the conditions for care. Through a reading of the production of a national therapeutic landscape, I argue that the framing of a *country* as an IMT destination constitutes a fundamental reterritorialisation of care aligned with the pursuit of greater 'global' economic, political, social and cultural integration.

1.2 International medical travel

People have travelled long distances hoping to restore their spiritual and physical well-being for millennia. Across the globe, our ancestors sought out natural sites perceived to be sacred due to their healing properties (e.g., River Ganges, Epidaurus, Bath and Lourdes) around which places of worship and travel infrastructure were built to access them (Connell 2009; Gesler and Kearns 2002; Smith 2008). Among the more familiar examples for Western readers are the resorts harnessing warm mineral waters (e.g., Baden Baden) for wealthy 19th-century Europeans and North Americans to address a range of ailments and escape industrialising cities, the mountain and countryside sanatoria and seaside resorts exploiting the fresh air and sunshine sought by sufferers of tuberculosis and other illnesses (Ben-Natan *et al.* 2009; Turner 2007a) and colonial hill stations harbouring those working to expand the Empire who would periodically flee the 'oppressive' climate of the lower-lying tropics (Arnold 1993; Connell 2006; Gesler 1991). With the expansion of biomedicine, and coinciding with shifting conceptualisations and spatialisations of disease and illness, health-motivated travel gradually extended beyond places endowed with natural morphologies held as therapeutic to include places like biomedical hospitals and clinics in which the 'specific geographical location [is held to be] of less significance in its therapeutic role than the physical, social and symbolic organisation of the space itself' (Smyth 2005: 488). Biomedical (or simply medical) travel constitutes yet another point on the broad spectrum of travel motivated by the pursuit of health and well-being (Smith and Puczkó 2009: 254), as a 'contemporary elaboration' on earlier and existing pursuits of beneficial health outcomes, with the outcomes of biomedical intervention 'expected to be substantial and long-term' (Connell 2006: 2). Given medicine's privileged relationship to liberal discourses of modernity, science and progress, it comes as little surprise that the 'centres of the health care universe' (Torral, in MacReady 2007) have been thought to be concentrated in North America and Western Europe (e.g., Mayo Clinic, Johns Hopkins Hospital, Harley Street Clinic, etc.). For decades, wealthy patient-consumers from far and wide have made 'pilgrimages' (Wachter 2006: 661) to these biomedical meccas, sites of 'miraculous' achievements of modern medicine that 'boast unrivalled medical facilities and funds to fuel research and innovation in many aspects of medical treatment' (Jenner 2008: 237; Turner 2007a).

While many travel within their countries to access better medical care, I wish to focus on *international* medical travel (IMT), which comprises those 'movements by persons from one country to another to obtain healthcare services' (Pennings 2007: 505). Specifically, I want to consider what is thought by many as the *novelty* of IMT today, namely, its massification and the corresponding respatialisations of care provision catering to this growing demand. Crossing borders for medical care itself is not particularly new. IMT in order to save money on treatment and pharmaceuticals,

avoid waiting lists and access different treatments has long been routine and essential practice in many parts of the world (Bergmark *et al.* 2008; Bertinato *et al.* 2005; Casner and Guerra 1992; Guendelman 1991; Katz *et al.* 2002; Kesteloot *et al.* 1994; Korcok 2000; Krosnar 2005; Morgan 2003; Pennings 2002). Yet, as Wachter (2006: 661) suggests, 'Although there have always been patients who choose to travel for care... they were exceptions'. When it began to be noticed that a growing number of middle-class patient-consumers from 'developed' countries began to seek out distant 'developing' countries as destinations for medical care over the last decade (Carrera and Bridges 2006; Smith 2008; Turner 2007a), however, the tide turned and significant political and media attention began to be trained on IMT. With the middle classes, 'frustrated by their own diminishing entitlements' (Sparke 2009a: 295) as citizens affected by welfare state retrenchment, now involved, IMT no gets longer explained away as an escape valve for 'exceptions' but, rather, discursively reincarnated as a harbinger of social crisis where 'centres and peripheries will not hold' (Hooper, in Soja 1996: 115).

With a return to 'classical' liberalism following a period of 'embedded' Keynesian-style liberalism and the collapse of socialist planned economies (Sparke 2009b), neoliberal rationalities of governance have manifested themselves in the retreat of the welfare state along with projects of economic liberalisation that have reterritorialised care in fundamental ways. Much of the disquiet surrounding IMT derives from profound uncertainties regarding the future of care – both responsibility for it and entitlement to it – in light of this shifting relationship between the state and its subjects. Within the modern nation-state model, healthcare has been typically exercised and received within national boundaries. It was only during the heights of embedded liberalism and socialism (1920s-30s to the end of the 1970s) that 'universal' access to healthcare, along with other measures of ensuring a national population's social and economic welfare, was enshrined in many nation-states (particularly with the advent of decolonisation) as a constitutional right. With medicine speaking 'the language of civilization...', it served as a mediator in the articulation of a particular relationship between individuals (citizens) and a society (nation)' (Dole 2004: 273), part of a great modernist narrative uniting a 'fixed' community (Soja 1996: 116; Anderson 1991).

Following Foucault (1978), concern for the physical well-being of an imagined 'national' population stretches back further, to the 18th century, and coincides with the emergence of liberalism and the industrial era. Seeking to 'maximise life' (Foucault 1978: 123), nation-states incorporated 'the task of protecting the health of citizens as one of [their] basic functions' (Briggs 2003: 288; see Foucault 1994; Rabinow and Rose 2003; Sieveking 2000). Governments united pastoral power with sovereign power (the 'right to *take* life or *let* live' (Foucault 1978: 136)), administering to and disciplining life that was of political 'worth', with their power being directly

'linked to the living bodies of [their] subjects' (Dean 2001: 51; Rose 2006: 57). The affirmation of life as a universal political object gradually 'grant[ed] a body' (Foucault 1978: 126) to all citizen-subjects, which implied becoming a life that mattered and existed in the eyes of the state (cf. Agamben 1998 on 'bios'; Butler 1993 on 'bodies that matter'). This ushered in biopolitical modes of governance 'directed towards the performances of the body, with attention to the processes of life' (Foucault 1978: 139) (e.g., birth, death and longevity) that intended to maximise subjects' bodies' capabilities and to integrate them into efficient systems of reproduction to ensure the conditions for production. '[H]istorically bound to the construction and strengthening of the nation-state, to the affirmation of the bourgeoisie... [was] the formation of a medico-judicial device geared towards the medicalisation and normalisation of society' (Ortega 2003: 10). With attention focused on subjects' valuable embodied existence, 'technologies of control were devised to keep them under surveillance', assuming the form of the welfare state, 'a product of both a police function and of liberalism, permitting power to individualize and totalize at once' (Nye 2003: 118). Taking charge of life through formalised education and healthcare provision made it possible to more efficiently control the population, 'distributing the living in the domain of value and utility' (Foucault 1978: 144) as well as naturalising authority over them, while disciplinary apparatuses common to sovereignty (e.g., the police and military) assumed a multiplicity of forms to control and protect the population (Dear and Wolch 1987: 14). It is in these extensive ways that the nation-state came to discipline the vital processes of life and ensure its subjects' welfare.

Given the profound manner in which healthcare has been bound up in defining both the legitimacy of the nation-state and the value of its citizenry, it is no wonder that the contemporary '[e]xtension of caring over geographical space to people different from oneself' (Barnett and Land 2007: 3) has created a stir. Yet the imagined boundaries to the terrains and subjects engaged in the provision and receipt of care have changed significantly over time. The notion of healthcare as a core competence of nation-states is a relative newcomer to the vast genealogy of care. I wish to draw at length from one of Sparke's (2009b) most recent works to underscore this point.

Historically it is clear that preceding regimes of health governance have been characterised by their own distinctive spatial assumptions about the geographies of health, including the territorial sweep of infection and vulnerability, as well as the spatial organisation of medical and public health interventions. City spaces, colonial control zones, 'natural regions' and national-state territories, have all served in this way as influential historical-geographical horizons for visualising both health challenges and arenas for medical action. However, in the context of economic globalisation, and specifically in relation to today's increasing extension and entrenchment of pro-market 'neoliberal' approaches to government, these older geographical horizons are being revised and reterritorialised. They have by no means been replaced altogether, and the place of the nation-state as an influential imagined community of health

and sickness continues to shape health governance in obvious ways. Indeed, as the basic 'unit' of health statistics, as the taken for granted 'community' wherein sickness and health are understood as communally related, and as the epidemiological 'population' of record that is counted, compared and considered for control in international health planning, the nation-state with its borders and internal administrative areas is still a very prominent space amidst the overlapping spatial frameworks of health governance around the world. But none of this alters the basic fact that... 'new spatial configurations of health and disease are emerging as a consequence of globalization'. Moreover, the global reterritorialisation of governance driven by market-based globalisation has also obviously led to a series of reappraisals of the national territorialisation of health governance. As market-forces have come to both open and curtail access to health care across the transnational spaces regulated by free-trade agreements, concepts of health citizenship have also been transnationalised in uneven and contradictory ways. In turn new global norms for inclusion in and exclusion from health interventions have been established based on varying visions of how disease, health and socio-economic ecologies intertwine globally. All these developments have involved distinctive forms of reterritorialisation, remapping and retitling. (Sparke 2009b: 132-133)

National systems of healthcare governance are in the process of being reconceptualised and reorganised in order to 'overcom[e] fragmented policy competencies' by 'align[ing] their national interests with the diplomatic, epidemiological and ethical realities of a globalised world' (Drager and Fidler 2007: 162). As healthcare is increasingly framed as a tradable commodity via international, regional and bilateral trade agreements (e.g., TRIPS and GATS) and the involvement of transnational agencies and companies, it is less enshrined as a public good (generally considered to merit special protective treatment in the market). Consequently, and as a result of a discursively 'inevitable' process of neoliberal economic globalisation, governments are coming to terms with the need to reimagine healthcare as an industry, with regard to both goods (e.g., equipment, pharmaceuticals and intellectual property) and services (e.g., IMT and telemedicine). Reflecting this shifting set of power relations is an 'ongoing redistribution of care across places and spaces' (Raghuram *et al.* 2009: 6), resulting in the production of increasingly hybrid, transnationalised spatialisations of healthcare that I wish to address here.

As the relationship between the state and its subjects gets reconfigured, the onus of acquiring and maintaining healthy bodies is increasingly placed on individuals in a context of neoliberal 'risk shift' (Turner 2007a: 305), wherein 'philosophies and practices of collective care and treatment [shift] to a more individualised health culture where promotion and illness prevention are key, and where health is seen as primarily the responsibility of individual human subjects' (Parr 2002b: 77; Nye 2003; Rose 2006). This 'redefine[s] the social sphere as a form of the economic domain' and serves as a 'rational model for justifying and limiting governmental action' (Lemke 2001: 197). In order to achieve 'health', individuals are enjoined to possess ever greater amounts of knowledge

about medicine and their bodies, effectively renegotiating ‘traditional’ distributions of medical power as patients become self-advocating health consumers (what I wish to call here ‘patient-consumers’), no longer silently deferring but rather actively putting ‘their own bodies under surveillance for the detection of abnormalities as well as seeking to delimit perceived “differences” in bodily size, shape and texture’ (Parr 2002a: 245). This characterises a new phase in surveillance medicine, denoting the ‘gradual extension of the medical gaze into the spaces of everyday life’ and the ‘dissolution of the distinct clinical categories of healthy and ill as it attempts to bring everyone within its network of visibility’ (Armstrong 1995: 395). As such, and given ‘the degree to which healthcare has been normalised and commodified in... consumer culture’ (Gesler and Kearns 2002: 149), the growth of IMT has been attributed to the potent combination of a rapidly ageing demographic and evolving morbidity profile around the world, increased and facilitated transnational mobility and communication, the commodification of ‘health’ and ‘healthcare’, rising consumer expectations and a growing demand for cost-effective care solutions (Díaz Benavides 2002: 58).

With the movement of people, goods and services rapidly redrawing the geographical boundaries to medical care and services, IMT ‘sits at the growing intersections of technology, economy, cultural and other global relations’ (Jenner 2008: 247; Sparke 2009b). It is symbolic of the increasing globalisation of healthcare, representative of a shift from what were previously imagined as nationally-bound locally-based care settings to what are now commonly held as ‘chaotic global networks, controlled by large mega healthcare corporations, consumer demand, employers, governmental offices of economic development and increasingly insurers... in an era of ever deteriorating national, technological, mental and physical boundaries in the delivery of healthcare services’ (Jenner 2008: 242). Emerging from this is ‘a range of new relations between capital and labour, bodies and the state, belonging and extraterritoriality, transformations in political governance, and realignments of medical citizenship and the meanings of public health’ (Whittaker 2008: 273). A prime example of this is the inclusion of disparate places as IMT destinations that, due to prevailing geographical imaginaries long plotting the West at the centre of ‘the health care universe’ (Toral, in MacReady 2007) and great socio-economic disparities (see Appendix 1), might not readily spring to mind. Towards the end of the 1990s, several hospitals and clinics in ‘developing’ and former socialist countries (e.g., Thailand’s Bumrungrad¹), sometimes backed by their national and provincial governments, began to launch their own strategies and programmes to attract foreign patient-consumers as well as to retain their own domestic elite by promoting value-for-money

1 Medical travellers from over 150 countries have sought medical care at the Mayo Clinic in the United States (Mayo Clinic 2009), while Bumrungrad Hospital, alone responsible for 31% of all IMT to Thailand, has been declared to have hosted patient-consumers from 190 countries (Bumrungrad 2009).

services and an abundance of high-quality private medical facilities and highly-trained human resources (Connell 2006; Whittaker 2008). Whereas the elite in ‘developing’ countries commonly used to turn to ‘developed’ countries for care, this demand now appears to have abated somewhat with the proliferation of a new constellation of ‘world-class’ private facilities in many countries of origin. This, along with the growing volumes of patient-consumers from ‘developed’ and other ‘developing’ countries, is held to signal a partial reversal of the direction of ‘traditional’ flows in the pursuit of medical expertise (see Table 1.1).

Table 1.1 Price comparison among IMT destinations for common surgical procedures in USD (2006-2009)

<i>Procedure</i>	<i>Costa Rica</i>	<i>India</i>	<i>Jordan</i>	<i>Korea</i>	<i>Malaysia</i>	<i>Mexico</i>	<i>Singapore</i>	<i>Thailand</i>	<i>USA (insured)</i>	<i>USA (retail)</i>
Angioplasty	13,000	11,000	5,000	19,600	11,000	16,000	13,000	13,000	25,704- 37,128	57,262- 82,711
Gastric bypass	n/a	11,000	n/a	n/a	n/a	n/a	15,000	15,000	27,717- 40,035	47,988- 69,316
Coronary bypass	24,000	10,000	10,000	24,000	9,000	22,000	20,000	12,000	54,741- 79,071	122,424- 176,835
Heart-valve replacement	30,000	9,500	12,000	36,000	11,000	30,000	13,000	10,500	71,401- 103,136	159,326- 230,138
Hip replacement	12,000	9,000	8,000	16,450	10,000	14,000	12,000	12,000	18,281- 26,407	43,780- 63,238
Hysterectomy	5,500	2,900	2,500	9,000	3,000	6,675	n/a	4,500	9,591- 13,854	20,416- 29,489
Knee replacement	11,000	8,500	7,000	17,800	8,000	12,000	13,000	10,000	17,627- 25,462	40,640- 58,702
Mastectomy	n/a	7,500	n/a	n/a	n/a	n/a	12,400	9,000	9,774- 14,118	23,709- 34,246
Spinal fusion	15,000	5,500	10,000	17,350	6,000	7,000	9,000	7,000	25,302- 26,547	62,778- 90,679

Source: India, Singapore, Thailand, USA - Kher (2006); Korea - Piper (2009); Jordan, Mexico, Costa Rica - Medical Tourism Association (2009b); Malaysia - Ooi (2009)

Opinion on the reterritorialisation of care accomplished through IMT is highly divided. Proponents focus on what (a very narrow understanding of) ‘we’ stand to gain from the expansion of a ‘global healthcare’ industry, envisioning the benefits for ‘entrepreneurial’ patient-consumers as well as sending and receiving societies. The divide in perception also extends to scholarly treatment of IMT, where, in the fields of law, business and economics, there is a tendency towards complacency and complicity that considers IMT an ‘inevitable’ consequence of economic globalisation with which to be reckoned. Concern is thus generally focused on the transnational regulation of private healthcare in order to ensure consumer protection and future industry growth (Carrera and Bridges 2006; Cortez 2008; Herman 2009; Horowitz *et al.* 2007; Terry 2007). ‘Outsourcing’ and ‘off-shoring’ are increasingly common and uncritically used in relation to IMT

(Horowitz *et al.* 2007; Turner 2007a), implicitly indicating that control is in the possession of those entities sending patient-consumers abroad and not those attracting them. Evocative of Mexican *maquiladoras*, Indian call centres and remote island tax havens, these terms now also come to encompass not only the back-office diagnostic, transcription, financial and administrative services fundamental to healthcare provision that astonish Friedman (2006) but also face-to-face healthcare transactions. Horowitz *et al.* (2007: 4), for example, envisioning a global healthcare marketplace shaped along US terms and standards, suggest that ‘there may be novel opportunities to use low-cost off-shore medical destinations to provide care for unfunded low-income patients while simultaneously relieving the burden on domestic healthcare facilities and philanthropic organizations’. The underlying neo-colonial rhetoric suggesting a unidirectional transfer of medical knowledge, expertise and technology from the ‘developed’ to the ‘developing’ world has gone largely unaddressed.

At the same time, IMT is imagined to contribute to ‘build[ing] health care economies in developing countries’ (Turner 2007b; see Mattoo and Rathindran 2005; Bookman and Bookman 2007), cast as both a ‘democratising’ force (Hadi 2009: 6) and an ‘enabling environment’ (Wolvaart 1998: 63; Díaz Benavides 2002) for ‘developing’ countries to improve their economies by attracting foreign exchange income and revamp their healthcare services (García-Altés 2005; Janjaroen and Supakankunti 2002: 92-95). Wolvaart (1998: 64), advising UNCTAD and WHO on the implications for international trade in health services, early on suggested that ‘developing’ countries promote themselves as IMT destinations by making strategic use of their ability to provide services at lower costs when compared to ‘developed’ countries, their ‘unique services due to local expertise’, ‘their potential to combine health and tourism’, ‘the availability of natural resources with perceived curative powers’ and the ‘increasing popularity of non-Westernised medicine’, thus reinforcing a range of stereotypes regarding ‘developing’ countries’ reliance on ‘their natural, geographical and cultural characteristics’ (UNCTAD 1997: 10) as their principal source of wealth. More recently, several national governments have incorporated IMT as part of their broader economic development strategies (e.g., Malaysia, 1998; India, 2002; Thailand, 2003; the Philippines, 2004; Taiwan, 2007) (García-Altés 2005; Sengupta 2008; Smith 2008). IMT gets used as a way to demonstrate countries’ ascendancy along the ‘development ladder’, ‘trying to distance themselves from the negative connotations associated with being labelled “Third World” health care facilities’ (Turner 2007a: 310), with the acquisition and display of high-tech medical equipment and skills that rival, or ‘even’ improve upon, those available in ‘developed’ countries.

Detractors, on the other hand, call attention to what (an otherly constituted) ‘we’ have lost or stand to lose with IMT and its potential to further exacerbate already severe inequities in the health

systems of countries promoted as IMT destinations. Treatment of IMT in medical anthropology, sociology, bioethics, medicine, public health, public policy and tourism studies generally echoes this critical preoccupation with the demise of the welfare state, the commodification of health, the growth of biotechnology, the circulation of patient-consumers and their effects on the places and providers that care for them (Chambers and McIntosh 2008; Chee 2006, 2007, 2008; Chee and Barraclough 2007b; Drager 2002; Henderson 2004; Jenner 2008; Kangas 2002, 2007; Milstein and Smith 2006, 2007; Pennings 2002, 2004; Scheper-Hughes 2000, 2005; Turner 2007a, 2009, Whittaker 2008, 2009). The most salient critiques of IMT relate to the redistribution of scant national medical (human and material) resources that privileges wealthier (foreign) patient-consumers over poorer citizens. The investment in technology-intensive tertiary care attractive to foreign patient-consumers and the diversion of state funds and resources from strained public health systems to support the development of private healthcare is suggested to come at the expense of universal access to primary care (Bennett 2009a; Chee 2007; Chinai and Goswami 2007; Díaz Benavides 2002; Henderson 2004; Jenner 2008; Ramirez de Arellano 2007; Saniotis 2007; Sengupta 2004; Smith 2008). Furthermore, although IMT has been proposed by proponents as a tool with which to stem the outward flow of medical professionals (Mattoo and Rathindran 2005), several authors like Arunanondchai and Fink (2007) suggest that it may prompt more intensive internal brain-drain, from rural to urban areas and from the public to the private sector.²

In light of all of this, IMT necessitates further and more in-depth study of ‘the interaction of people from across remote sites, the trade in technologies and how these are negotiated and reassembled in different places, the experiences of personnel and patients, and the implications for health infrastructure and interactions’ (Whittaker 2008: 286; Hopkins *et al.* 2009). These concerns are all inherently geographical, engaging the politics of care with fundamental ongoing debates in the discipline on scale, space and place. In spite of this, IMT has not yet elicited sustained attention from geographers, though a few have begun to touch upon it in sub-disciplinary work in tourism, health, population and political geographies (Bochaton and Lefebvre 2009; Connell 2006, 2007, 2009; Lee *et al.* 2010; Sparke 2009a, 2009b). With my own work on the positioning of Malaysia as an IMT destination, I seek to bring overdue attention to the relational politics of healthcare provision and the discursive and material construction of ‘national’ therapeutic landscapes. In so doing, I want to contribute to thinking on broader questions of care, interdependence and mobility, concerns that

² Doctors and nurses originating from countries that are now promoted as IMT destinations have long served patients in ‘developed’ countries. The high number of medical professionals from India and the Philippines working abroad, for example, is marketed as a strength for IMT destinations (e.g., Honors Integrated Marketing Communications 2008). Raghuram (2006) observes that ‘[t]he health of the nation [has been] bought at the expense of the other’, with foreign medical professionals filling skilled employment gaps in order to keep healthcare systems like the UK’s NHS afloat.

crosscut political and health geographies today. At the same time, I also see my research contributing to a growing body of work that pushes beyond the pronounced Ameri-centrism that currently dominates studies of IMT by decentring the focus from Western industry interests and medical travellers through acknowledging the significance and nuanced diversity of other populations constituting IMT flows and destinations. To do this, I seek to take into account broader shifts underway in healthcare provision and its regulation, recognising IMT destinations not as passive receptacles or victims of Western hegemonic interests in IMT but as active providers, negotiating complex change in health governance and the benefits and challenges of extending care beyond national borders.

1.3 Cross-border mobility and the ‘social construction of identity-in-place’

With IMT implying mobility across healthcare jurisdictions, multiple terms are in circulation that attest to its varied manifestations. ‘Health/medical tourism’ and ‘healthcare/medical travel’ invoke smooth border-crossings for an elite few, while the use of neoliberal concepts such as ‘patient outsourcing’, ‘international patient mobility’ and ‘healthcare service market for the international consumer’ contrast with, but are intimately linked to, the dejection embodied in the terms ‘medical migration’ and ‘medical refugees’. Undergirding these mobilities are discourses of individualisation of risk, healthcare commodification and the waning role of the nation-state in care provision that shape the ways in which those who cross borders get constituted.

Engaging in what Rose (2006: 27) calls the ‘moral economy of hope’, medical travellers are thought to go abroad in order to more easily sidestep obstacles that are perceived to inhibit their access to medical attention in their countries of residence. Four categories of obstacles are most often cited in literature on IMT. Firstly, prohibitively high medical care costs and inadequate insurance coverage effectively keep essential and elective care and treatments financially out of reach (e.g., invasive surgeries, dental and cosmetic work) (Connell 2006; Rajeev and Latif 2009) (see Table 1.1). Secondly, long waiting lists may significantly delay treatment (e.g., hip and knee replacements) (Hadi 2009; Katz *et al.* 2002; Turner 2007a). Thirdly, states’ regulatory controls may deny access to surgeries and therapies, for reasons of limited supply (e.g., transplantations (Budiani-Saberi and Delmonico 2008; Ghods and Nasrollahzadeh 2005; Shimazono 2007; Scheper-Hughes 2000, 2005; Turner 2009; Whittaker 2008)); on moral grounds³ (e.g., gender reassignment, IVF procedures for single women, pre-implantation sex selection of embryos for IVF, commercial

³ Most IMT is undertaken to take care of routine medical and dental conditions faster and more inexpensively. However, a range of IMT is also driven, as many of the above authors identify, by the pursuit of care and procedures in the legal jurisdictions permitting them, allowing patient-consumers access to ‘moral pluralism in motion’ and states to adopt a policy of ‘external tolerance’ (Pennings 2002), thus highlighting the multiple ethical issues being worked out within the regulatory patchwork of a globalising healthcare marketplace.

surrogacy, abortion, euthanasia, etc. (Connell 2009; Pennings 2002, 2004; Whittaker 2009)); or due to their experimental status (e.g., cutting-edge surgeries, stem cell therapies (Horowitz *et al.* 2007; Kiatpongsan and Sipp 2008) and fertility treatments (Blyth and Farrand 2005; Clarke 2009; Whittaker 2008, 2009)). Finally, care providers may be perceived to lack sufficient responsiveness or sensitivity to linguistic, cultural and religious needs (Bergmark *et al.* 2008; Lee *et al.* 2010).

Different subjectivities are forged in the act of crossing borders, relative to the spatial variegation of regulation. In bypassing local healthcare jurisdictions as a response to perceived insufficient care, the crossing of national borders has the potential to produce significant shifts in political and socio-economic status that directly condition access for the few able 'to both circumvent *and* benefit from different nation-state regimes' (Ong 1999: 112, original emphasis) to particular forms of healthcare, such that care not accessible in one country may be within reach in another. As a result, IMT often gets cast as a 'democratising' force for both healthcare consumers and providers (Jenner 2008; Turner 2007b), exemplifying a "disruptive innovation" that can transform traditional processes and relationships' (Deloitte 2008a; see Brooker and Go 2006; Wachter 2006). With English-language IMT literature's overwhelming focus on the cross-border pursuit by and delivery of care to Western (often American) patient-consumers (Bennett 2009b; Carrera and Bridges 2006; Cortez 2008; Jenner 2008; York 2008), proponents' rhetoric of the power of consumer choice pervades. Indeed, IMT has even been hailed as having 'the potential of doing to the US health care system what the Japanese auto industry did to American carmakers' (Reinhardt, in Kher 2006). For them, the global 'marketplace' is a space of distributive justice, the means through which fairness (fair price) is measured and through which goods/services can be attained by all (along a sliding scale of quality). Framed as a neoliberal mode of resistance, IMT enables patient-consumers to 'boycott' (Fischer 2007) unresponsive healthcare systems in their countries of residence by symbolically 'shopping' abroad for their medical needs. IMT proponents, like Horowitz *et al.* (2007: 4), are unequivocal: '[L]eaders must recognise that patients, like all consumers, will search for providers who offer them maximal value, and medical tourism is an explicit declaration about what patients value most'.

This sort of uncritical celebration of 'deterritorialised' care provision, however, indiscriminately constructs mobile patient-consumers as agents of their own emancipation and IMT destinations as mere nodes of internationally standardised care provision, ignoring the violence inherent to such reterritorialisation processes. 'Implicit here is that one is entitled to travel since it is an essential part of one's life. Cultures become so mobile that contemporary citizens... are thought to possess the rights to pass over and into other places and other cultures', observes Urry (2002: 157). Cresswell (2001), however, is cautious of this romantic gloss of resistance linking mobility and

consumption. While some mobilities may be transgressive, others support existing power structures. There is, therefore, a need to examine the production of mobilities, including their limitations and the ways in which they get differentiated. Accordingly, Ang (1993: 34) enjoins researchers to avert the

formalist, poststructuralist tendency to overgeneralize the global currency of so-called nomadic, fragmented and deterritorialized subjectivity in the postmodern world... [serving] to decontextualize and flatten out 'difference' as if 'we' were all in fundamentally similar ways always-already travellers in the same postmodern universe, the only difference residing in the different itineraries we undertake. Such a gross universalization of the metaphor of 'travel' runs the danger of reifying, at a conveniently abstract level, the infinite and permanent flux in subject formation, thereby foregrounding... an abstract, depoliticized, and internally undifferentiated notion of 'difference'. Against this tendency,... I would like to stress the theoretical importance to keep paying attention to the particular historical conditions and the specific trajectories through which actual social subjects become incommensurably different and similar. That is to say, in the midst of the postmodern flux of nomadic subjectivities we need to recognize the continuing and continuous operation of 'fixing' performed by the categories of race and ethnicity, as well as class, gender, geography, etc. on the formation of 'identity' (although it is never possible, as determinist theories would have it, to decide ahead of time how such markers of difference will inscribe their salience and effectivity in the course of concrete histories, in the context of specific social, cultural and political conjunctures). It is in this, overdetermined sense that the precariousness of any identity construction should be theoretically understood.

While the 'deterritorialisation' of care achieved through IMT may actively call into question and renegotiate the relationship between the pursuit of health and the assumedly 'traditional' bounded settings of its provision, it is through simultaneous processes of reterritorialisation that other sets of values inform the contours of access to care and relationally constitute the medical traveller and care provider, 'foreground[ing] the social construction of identity-in-place' (Dahlman 2008: 496).

Thompson (2008), calling for greater acknowledgement of the breadth of influences that drive people across borders for health, distinguishes what she calls *medical tourism*⁴, 'with its emphasis on

4 The choice of the commonly used term 'medical tourism' to describe empowered travellers perpetuates already existing 'assumptions of race, nation and class, with the emblematic medical tourist a wealthy white western or East Asian tourist who combines cosmetic surgery with a beach holiday' (Whittaker 2009: 323). As 'tourism' is widely held as an experience of leisure and escape in which everyday obligations are inverted (Urry 2002), 'connotations of the term are negative when considered in a medical context (recreation), thus devaluing the motivation for the journey, implying that the... tourist goes abroad to look for something exotic and strange' (Pennings 2002: 337). While travellers seeking out traditional and alternative medicine treatments may desire the 'exotic' and ludic, the logic goes, those pursuing medical treatment, with biomedicine wrapped in a mantle of universal authority and reliability, are more likely seeking the familiar and trustworthy. While a 'traditional' tourism component (e.g., post-operative safaris, tours of the Taj Mahal and recuperation at beach resorts) may often be used in place-imaging techniques to attract patient-consumers to particular destinations (Saniotis 2007; e.g., Tourism Malaysia 2008a), the 'recreational value of travel' is

the movement of empowered, biosocial citizens⁵... seeking medical care by travelling down scientific, regulatory and/or economic gradients', from *medical migrations*, those 'movements across regional and national boundaries in ways relating to health status and care and to immigration... status and the freedom from various kinds of persecution' (Thompson 2008: 435). Thompson's conceptual distinction between these categories of medical mobility, while useful for drawing attention to the less-than-elite nature of the vast majority of IMT, creates a superficial dualism between a savvy self-regulating post-national healthcare consumption on the one hand and displacement in desperation on the other.⁶ While critical of this, I appreciate her highlighting of the nuanced structural influences that produce these mobilities, variably and multiply 'fostering' and 'disallowing' subjects (Foucault 1978: 138). I want to suggest here that the very diversity of terms in circulation – evoking such non-neutral mobilities as tourism, outsourcing, migration and refugees – points to a broad range of social, cultural, political and economic imaginings and interpellations of the spaces and subjects engaged in this cross-border movement. Such a rich lexicon offers substantial material to critically explore a broad range of identity-based power dynamics which, while mediated by the market and new biotechnologies, ultimately pivot around, challenge and reassert the relevance of national borders in accessing care.

Mobility generally is perceived to destabilise, de-centre and undermine what Sheller and Urry (2006: 209) term 'sedentarism', which 'locates bounded and authentic places or regions or nations as the fundamental basis of human identity and experience... rest[ing] on forms of territorial nationalism' (see Cresswell 2001). As such, transnational mobility constitutes a critical arena heavily subject to state discipline. As 'the nation-state... continues to define, discipline, control and regulate all kinds of populations, whether in movement or in residence' (Ong 1999: 15), infrastructures of surveillance and social sorting practices intervene in order to imagine and enforce notions of community and differentiate between 'strangers' and 'familiar' (Morgan and Pritchard 2005; Rytgiel 2006; Sheller and Urry 2006). Heightened concern with reinforcing a state's territorial sovereignty can be understood as a response to the shifting contours of citizenship and challenges to the territorial relevance of nation-states. The state exercises its sovereignty by discriminately controlling

thought to decrease in importance the more serious the medical condition being treated (Horowitz *et al.* 2007), whittling down the travel component to little more than 'long distance migration for surgery' (Connell 2006: 6).

⁵ Distinct from the relationships fostered by classical state biopolitics, biosociality involves '[s]trategies for intervention upon collective existence in the name of life and health, initially addressed to populations that may or may not be territorialized upon the nation, society or pre-given communities, but may also be specified in terms of categories of race, ethnicity, gender or religion, as in the emerging forms of genetic or biological citizenship' (Rabinow and Rose 2003: 13).

⁶ Gesler and Kearns (2002: 147) warn of the inappropriateness of assuming that patients will always act as consumers, as when 'faced with acute pain or a family injury, a patient may be neither ready nor equipped to navigate the subtle variability of standards brought about by competitive practice and "shop around" as a consumer'.

access to mobility 'tools' (Sheller and Urry 2006), by issuing visas and passports, engaging in racial profiling, patrolling territorial borders, charging exit tax, setting immigration quotas, expatriating foreigners and so on.

These initiatives are part of biopolitics because they construct categories of populations like 'high' and 'low risk' travellers for the purposes of being better able to regulate mobility. Constructions of 'high' and 'low risk' travellers are highly gendered, racialized and class-based. They enable populations to be subdivided into groups and managed according to differential mobility rights. (Rygiel 2006: 155)

Unfettered transnational mobility is the privilege of few, to the exclusion of many others for whom national borders remain very real boundaries, even from within.

Medical travellers get discursively cast, whether positively or negatively, as mobile agents transgressing national biopolitical categories which normatively define, privilege and defend the well-being of particular lives over others. The significance of this can be illustrated by the political debate some years ago in Britain over asylum-seeking 'health tourists' who entered the country allegedly with intentions to benefit from the National Health System for care the equivalent of which they may not be able to receive in their countries of origin, generating protectionist reaction from within the government, keen to crack down on these 'interlopers' and erect greater barriers to precious care resources reserved for citizens and those outsiders actively contributing to British society (*The Evening Standard* 16/02/2005; Frith 18/05/2006; Kundnani 26/05/2005; see Sparke 2009a on 'hospital deportation'). Not coincidentally, around the same time, the mass media also began to cover the growth of the so-called 'medical tourism' industry, fuelled by so-called 'medical refugees' (Milstein and Smith 2006) or individuals hailing from richer, generally Western, countries fed up with their dysfunctional public and private health systems who resolve to visit faraway countries to tackle medical issues they were not able to adequately resolve at home.⁷ Effectively two sides of the same coin, both of these groups are produced through the desire for and pursuit of 'health' and the care perceived to be necessary for its achievement and maintenance. Though interrelated, however, their mobilities are highly differentiated (Cresswell 2001: 21), construed in starkly different ways. The so-called 'medical tourists' here are characterised as offending outsiders illegitimately taking advantage of a vulnerable social system to which they do not belong, while the 'medical refugees' are cast as victims of the very same inhospitable system not adequately responding to them, thus prompting them to seek (privatised) medical 'refuge' abroad. The paradoxical and highly politically charged language shapes the performativities of both of these

⁷ In an interview, one of the article's authors implied that the decision to employ the word 'refugee' was to differentiate real, urgent medical needs from discretionary ones: 'This is not what is sometimes snootily referred to as "medical tourism", in which people go abroad for elective plastic surgery... People are desperate' (Smith, in Ansorge 2006).

categories of international medical traveller, by normatively reinforcing or rejecting the primacy and legitimacy of the drive to cross borders for medical care, 'clearly point[ing] to the ways in which neoliberal sorting systems structure access to health citizenship' (Sparke 2009a: 10). As Butler (2004: 26) poignantly observes, 'Although we struggle for rights over our own bodies, the very bodies for which we struggle are not quite ever only our own. The body has its invariably public dimension. Constituted as a social phenomenon in the public sphere, my body is and is not mine'. To employ such terms as 'tourist' and 'refugee' within the scope of IMT is to effectively see in it a challenge to national sovereignty by 'wandering peoples who... are themselves the marks of a shifting boundary that alienates the frontiers of the modern nation' (Bhabha 2004: 256), those who, in the words of Rose (1996: 345), 'elude the bonds of citizenship' through the transgression into healthcare delivery that has until recently been widely understood as a decidedly national resource and domain of action.

1.4 Care and interdependency

With many of the countries being promoted as IMT destinations holding 'developing' status, IMT seemingly inverts and diversifies the directions of flows of caring about and caring for, reterritorialising these flows for greater political and economic leverage for some and greater exploitation and exclusion of others. My examination of IMT builds on an intersection of feminist and postcolonial scholarship that seeks to challenge embedded assumptions about the sources, directions and political value of care.

Throughout the 20th century, questions of care have been made 'public' through government action and the market (Tronto 1993: 173). Feminist geographers like Lawson (2007), however, point to the marginalisation of care and care-work that coincides with the feminisation of the labour force and the declining institutionalisation of care that has accompanied the retrenchment of the welfare state in many countries and heavily impacted care-giving expectations (McKie *et al.* 2002). Care-giving is highly gendered, with a disproportionate amount of the physical and emotional labour it entails dependent upon the commitment of women (Conradson 2003). In response, a well-established body of feminist literature exists that deconstructs normative constructs of care-giving and recognises the multiplicity of care experiences and the nuanced power dynamics conditioning care relationships, contextualised within an interplay of socio-spatial processes at a range of scales. This alertness 'informed by care' (Milligan and Wiles 2010: 8) permits critical engagement with the tensions of interdependency in ways that refuse 'to place the emotion, the mess, and the softness of care in some prepolitical zone' (Staeheli and Brown 2003: 774).

The 'relocation of care from the private to the public sphere and back again' (Raghuram *et al.* 2009: 7) is argued to have led to the redomestication, individualisation and commodification of care,

which 'remain intimately intertwined with the ongoing and incomplete rescaling of citizenship' (Sparke 2009a: 11). These processes increasingly draw on globalised 'care chains' (Yeates 2004) of paid and unpaid work to fill the gaps left by the state. As such, foreign domestic (care) workers and IMT, where the provision of 'offshore' or 'outsourced' private healthcare to foreign patient-consumers is largely set in the 'developing' world, could be framed as characteristic of the socio-economic and political marginalisation of care-work, via the 'outsourcing' of this service industry to people and places where care can be had more cheaply due to stark wage differentials and to the advances in, and expanded access to, technology and transport that serve to increasingly 'deterritorialise' care provision (Horowitz *et al.* 2007; Jenner 2008; Mattoo and Rathindran 2005; Turner 2007a; York 2008). The now familiar body of work on Filipinas involved in the provision of 'affective labour' (Lopez 2009) at home and abroad, employed in a spectrum of care-work as entertainers, nurses, nannies and domestic workers (Ball 2004; Parreñas 2000; Pratt 1999; see Silvey 2004 on Indonesian domestic workers), supports this view.

In this vein, I seek to contribute to the unfolding body of literature concerned with a politics of care that asks: Who does the caring? Who decides what that care comprises? And who receives it? Feminist philosopher Joan Tronto (1993) conceptualises care – 'the response to a need' (170) – as doing fundamental political work. For Tronto (1993: 168-169), 'Care as a political concept requires that we recognise how care – especially the question, who cares for whom? – marks relations of power in our society and marks the intersections of gender, race and class with care-giving'. Central to her argument is that liberal concerns with securing autonomy from relationships of dependence have erected boundaries privileging and separating 'autonomous' individuals 'productively' pursuing their 'interests' in public life over the private realm in which humanity's fundamental interdependencies and 'needs' which require the care and support of others in different ways at different points of the life-course are obscured and devalued. 'This image of what constitutes responsible human action misses entirely the care work that is necessary to keep human society functioning, except insofar as that work is also paid work... [though] caring work is the least well paid and respected work, with the exception of doctors' (*Ibid.* 1993: 165-166). She pushes for the redrawing of such boundaries in order to produce caring subjects that 'recognise their situations vis-à-vis others' and 'rethink questions of autonomy and otherness, what it means to be a self-sufficient actor, and so forth' (*Ibid.* 1993: 170, 172).

Of particular value to my thesis argument is Tronto's use of the relational concept of care as an analytical tool for revealing unequal relationships of power, recognising the conflict inherent 'in deciding who should care for whom and how' (*Ibid.* 1993: 169). She identifies two principal dangers in care: paternalism and parochialism. In regard to paternalism, care provision has the potential to

reinforce power inequalities when care-givers ‘come to see themselves as more capable of assessing the needs of care-receivers than are the care-receivers themselves’ (*Ibid.* 1993:170). This relationship of subjection is well documented in postcolonial studies of colonial powers and development agencies that interpret the ‘needs’ of their recipient subjects through the filter of their own interests and investments, ‘reposition[ing] groups as “cases” for the state and the development apparatus’ (Escobar 1995: 225) to legitimise their intervention. Raghuram *et al.* (2009) problematise the ethics of relationality in the provision and receipt of care by recognising the power relations underlying and driving the manifestations, apparatuses and flows of care as embedded in long histories of exploitation and inequality that have set a precedent for, and continue to define, contemporary global relationships of care and responsibility. In line with Tronto, assuming an autonomous care-giver and dependent recipient relationship obscures who benefits and how from *providing* care and what is required to *sustain* that care.

Underlying much geography of care and responsibility literature have been constructions of an ostensibly Western, ‘developed’ and privileged ‘us’ existing in dialectic relationship to a subaltern ‘distant Other’ for whom ‘we’ should care more, calling for responsible restitution for past and more current reprehensible acts of colonisation and slavery and the inequality such structures have perpetuated into the present day (Malpass *et al.* 2007; Massey 2004). De-centring and complicating ingrained assumptions about the source of the flows out of which care ‘should’/‘should not’ and ‘does’/‘does not’ radiate allows us to move beyond a predominant focus on care from a Western core and responsibility for the ‘distant Other’.⁸ By adopting a critical framework in which ‘interdependency is not cosy but is seen as contested, complicated and productively unsettling’ (Raghuram *et al.* 2009: 10-11), a richer geopolitics of care, vulnerability and responsibility is revealed that allows us to analyse ‘who cares for whom and for what’ (Tronto 1993: 175).

In arguing for the political valorisation of human interdependency, Tronto also warns of the danger of parochialism, or partiality, in care relations: ‘Those who are enmeshed in ongoing, continuing relationships of care are likely to see the caring relationships that they are engaged in, and which they know best, as the most important’ (*Ibid.* 1993: 171). Central to much of the geography of care and responsibility literature inspired by Tronto’s work is the call for an ‘us’ to actively care for (and not simply, passively about) the ‘distant Other’ as part of a broader relational ethics, dissolving partiality through an ethics of universalism. For example, Massey (2007: 43)

⁸ Valuable and timely contributions are being made to debates within the geography of care and responsibility, using a relational politics rooted in universalism to call for greater social justice via attention to the livelihoods and needs of non-Western others (e.g., on the provision of humanitarian assistance and development aid, the consumption of fair-trade products and hosting of asylum seekers - see Silk 2004; Malpass *et al.* 2007; Darling 2010). As Raghuram *et al.*’s (2009) work highlights, a nuanced postcolonial critique of this relational engagement is necessary.

suggests that London has been able to reinvent itself as a 'world city' by embedding itself into the fundamental processes of neoliberalisation taking place seemingly 'everywhere', by strategically emphasising its distinctive role in global financial services made possible by both its historical status as the seat of the British Empire and 'the current phase of the world economy'. In recognising London as a 'world city', she simultaneously responsabilises both London and Londoners, as nodes articulated through the flows and relations they – through their actions and what they represent – render possible, foster and perpetuate. She calls for 'a politics of place beyond place' (*Ibid.* 2007: 15), uniting a territorialised politics with another geography of flows and connections that instills responsibility through awareness of collective interdependence and 'the inequalities within that interdependence' (*Ibid.* 2007: 193).

In seeking to transform people's 'moral imaginations' 'by showing how their actions are entangled in spatially and temporally extended networks of unintended consequences' (Barnett and Land 2007: 5), these authors seek to override the partiality and locality of care that limit an 'us' from caring for everyone, everywhere, equally, by reframing the global as the local 'universal everywhere' in which we are all implicated and inextricably bound as much to those we 'know' as to those we do not. The 'far', this body of literature suggests, can be overcome by enfolding 'distant others' into the expanding scope of the 'near' based on recognition of the mutuality of existence. While I value the broader political project to which this approach adheres, I am at the same time critical of how such a radically non-partial universalist politics of 'global-localism' (Gregory 1994: 190, in Soja 1996: 151) is to be applied. Instead, and to avoid tying my discussion of care to an ethics of universalism, I prefer to focus on relations of proximity, or what could be called 'nearness', that are articulated through 'the construction of bundles or clusters of identities in and through the cultures of transnational capitalism' (Kaplan 2007: 159) and wish to suggest that places are constituted through partiality in order to foster the further development of these intersections.

I want to pay attention, therefore, to the 'space-specific subject-production' (Spivak 1996, in Soja 1996: 151) present in (privatised) care transactions. With ever-increasing numbers of people crossing borders in search of care, IMT poses a significant challenge to popular assumptions about who provides and receives care. As Derrida (2000b: 45) observes, 'It is often techno-political-scientific mutation that obliges us to deconstruct; really, such mutation itself deconstructs what are claimed as these naturally obvious things or these untouchable axioms'. Instead of the 'distant Other' interpellating an 'us' as monolithic care providers, when a corporally vulnerable 'we' stand at 'their' doorsteps, waiting to be welcomed and cared for, the brutal inadequacy of supposing unidirectional, hierarchical care relationships and obscuring the myriad forms of care already fundamental to making such grand gestures possible is exposed (Massey 2007; Raghuram 2006).

Through the lens of interdependency, at the moment when that ‘distant Other’ – perhaps educated in ‘our’ university systems, accredited by ‘our’ international organisations, speaking ‘our’ languages, sharing ‘our’ religious beliefs – extends hospitality to an ‘us’, it becomes clear that ‘we’ and the ‘distant Other’ are in fact already ‘near’. This recognition of hybridity challenges dichotomous thinking that separates proximate/here from distant/there, the Self from the Other. Who is ‘near’ and who is ‘far’, and how does the selective provision of care bring those who are ‘far’ ‘nearer’? In asking ‘where is the centre from which distance and proximity are measured?’, Raghuram *et al.* (2009: 9) propose a revised and more nuanced consideration for what comprises the ‘distant Other’ and for whom, revealing more complex processes of ‘othering’ that are bound up with post- and neo-colonial relations and hybridities (Bhabha 2004).

A cross-cutting theme of the thesis attends to the place-based claims of providing care to select groups and to the benefits foreseen to follow from this, premised on a relational conception of subjectivity. Contrary to Lawson’s (2007: 5) assertion that neoliberal discourse has ‘effectively privatised responsibility rather than politicised it’, I support the idea that ‘[m]arkets do not have to be exempt from an ethic of care’ (Smith 2005, in Popke 2006: 507). I wish to illustrate how care, even in the commercialised forms of IMT, can be a highly political act, constitutive of a response by both international patient-consumers and destinations to the political, social, cultural and economic barriers to care in consumers’ countries of residence and to the situations in the receiving countries that facilitate the provision of such care. In so doing, I try to respond to Parr’s (2003: 219) call ‘to deconstruct further what we understand to be “healthy care and caring”... [by probing] the very conceptions that underlie health-care terminologies, as well as to unpack the economies, politics, practices, relations, assumptions and discourses that construct care work’.

1.5 National therapeutic landscapes and selling healing ‘in place’

Central to the practice of ‘new cultural geography’, the concept of landscape refers to the interrelationship between spatial form, meaning and representation (Mitchell 2005: 49). Landscape can be understood as ‘an ideologically infused mode of representation’ (Lilley 2004: 87), with space playing an active role in the structuring of social conduct. Both a subject in its ‘material’ form (*a* landscape) and a verb (*to* landscape) in its discursive shaping of particular ‘ways of seeing’, landscapes – as ‘sites’ and ‘sights’ – are actively produced (Bunnell 2006: 28-29), establishing ‘what *is* and what *can* be’ (Mitchell 2005: 50, original emphasis). As there are multiple ways of seeing and representing space, landscapes are constantly evolving, with ‘sites’/‘sights’ constituting, reproducing, contesting and reconstituting ‘geographical selves’, ‘shaping individual and collective socio-cultural practices... [and] (re)defin[ing] norms, ideals and objectives’ (Bunnell 2006: 28-29; Gesler 1992; Till 2005). Yet landscape’s naturalising tendencies also ‘mask the relations that go into

its making' (Mitchell 2005: 51; Fannin 2003). To interpret their assemblages of invested meaning, landscapes can be 'read' as 'texts' unfolding within specific geohistorical contexts and fields of relations of 'ongoing transformation' (Bunnell 2006: 27-28), as relational nodes – 'articulated moment[s] in knowledge networks stretching across spaces' (*Ibid.* 2006: 29).

Given my concern with the promotion of a 'Malaysia' as an IMT destination, I wish to 'read' its unfolding 'therapeutic landscape' (Gesler 1991) in order to identify and trace the social, economic, cultural and political forces and processes involved in the country's move towards acquiring 'an enduring reputation for achieving physical, mental and spiritual healing' (Gesler 1993: 171). The concept of 'therapeutic' is multi-faceted, a quality that invokes the provision of security, edifying recognition, relief, reassurance, comfort, continuity, well-being and healing. Acknowledging that 'therapeutic' status is historically contingent, caught up in the evolution of dominant discourses regarding what is 'healthy', Gesler and Kearns (2002: 125) advance that a 'therapeutic' reputation is constructed through historical events, promotional efforts and the experiences of visitors that over time accrete and become 'fixed as "understood truths"' in the public imagination.

With cultural theory informing an 'opening-up' of medical into health geography, a growing engagement with distinguishing the specificity of 'place' from abstract 'space' calls for greater sensitivity to how 'language, symbolism, ideologies, and meaning all play a role in creating specific therapeutic landscapes' (Gesler 1991: 182). Geographers have since critically engaged with the concept of 'therapeutic landscape', taking diverse approaches. They study the harnessing and exploitation of the 'therapeutic' properties of 'natural', physical landscapes (e.g., spas, colonial hill stations, rural settings, parks, etc.) (Gesler 1991, 1999; Williams 1999). Landscapes of institutionalised care (e.g., mental health facilities, elder care facilities, hospitals and hospices) (e.g., Fannin 2003) are deconstructed. Insight is sought from the reclamation of spaces for emotional healing after periods of political violence (Frazier and Scarpaci 1998). In the face of neoliberal reform, with de-institutionalisation and the retreat of the welfare state, geographers also have expanded the scope of study to include spaces of informal care-giving (e.g., the home, voluntarism, support and advocacy groups, etc.) (Bondi 2005; Milligan 2003; Milligan and Wiles 2010), the individualised search for spaces of self-expression and security in the public realm by people with mental ill-health and intellectual disabilities for whom institutionalisation and state support have become less of an option (Hall 2010; Parr 1999) and increasingly commodified places of healing (e.g., walk-in clinics, private hospitals, alternative medicine practices, etc.) (Kearns and Barnett 1997, 2000; Kearns *et al.* 2003). My study of IMT, attuned to the reconfigured relationships between the state, citizenship and commodified healthcare, seeks to build on this work.

If the 'complex geographies of caring work at a range of scales' (Popke 2006: 505), then what scales are privileged in the configuration of places of health and healing? While, as we have seen above, much scholarly work has attended to therapeutic landscapes at the micro-scale, little has explicitly conceptualised such landscapes at the national scale. Yet, in pondering 'the bounds of a place that has significance to those within it', Gesler (1991: 166) suggests that "'place" comes into being... when it embodies meaning' and engenders attachment. Therapeutic landscapes are those places that fundamentally help people 'maintain an identity', which, as Bunnell (2006) argues below, certainly occurs at the national scale.

The 'lure of the local' in cultural geography has not precluded analyses of the work of landscape at the level of whole (national) populations. Landscapes in various media have been shown to articulate national identity which is, in turn, reworked and reconstructed through practices of individual and collective consumption... [L]andscapes are powerful 'technologies of nationhood' making known authoritative aims of and means to national development. Idealised national landscapes demonstrate appropriate or exemplary, individual and collective conduct which is folded into the (self-)regulating judgements and calculations of citizens. (Bunnell 2006: 29)

Enabled and legitimised by 'national' authority, a specifically *national* therapeutic landscape can be understood as offering a unique 'package' of regulation, human resources, political and economic stability and cultural credentials. In their study of Korean immigrants' preferred use of 'homeland medical services', for example, Lee *et al.* (2010: 110) suggest that they experience the return to *Korea* as 'especially therapeutic'. Familiarity with the structures and hierarchies of their 'native' national health systems, expectations of medical authority and patient-handling, proximity of family and friends, and the lack of linguistic obstacles serve to both comfort and empower these transnational patient-consumers, returning a sense of control over their health and bodies. Whittaker (2009), in her work on reproductive tourism, examines the decision by some Thai migrant women married to Western men (*farangi*) to return to Thailand for IVF. Her respondents underscore the importance of receiving care 'at home', though the urban clinics they patronise are located far from their families' villages. 'Home' here instead translates into ease in communication and familiarity with specifically national healthcare practices. The decision to return 'home' is a 're-assertion of place' (Whittaker 2009: 320) that redresses a sense of 'placelessness' experienced through migration by selecting a health system 'sensitive to culture and the social construction of health and illness' (Elliot and Gille 1998: 337). These findings correspond to recent work that suggests that the perceived *place* of healing extends 'beyond the formal spaces of care' (Smyth 2005: 493).

The promotion of national therapeutic landscapes as IMT destinations can be understood as a 'technology of nationhood' (Bunnell 2006), a place-marketing technique used to reassert the

relevance of the nation-state within a globalising context, where the elements that set one country apart from others are thought to be increasingly indistinguishable (Van Ham 2008: 129) and the 'legitimacy of government and other public institutions as purveyors and protectors of a place's cultural and economic vitality' are perceived to be waning (Aronczyk 2007: 109). Through its claims to 'therapeutic' status, the nation-state can be re-imagined as both a legitimate actor and territorialised entity able to compete in a globalised world by attracting tourism, trade, investment and generating jobs. Its claim to uniqueness and authority is premised upon the conjuring of

landscape as object, as container,... the poetic veneer that the nation-state adopts to colour its calculated translation of places into (national) space,... furnish[ing] the nation-state with a useful model for an orderly and meaningful composition of the various 'parts' of this same world... [a] 'harmonious composition'... able to 'put in order' the national 'heritage', to embody national 'essence'... (Minca 2007:438)

We see this objective at work among national councils that have been created throughout Asia in recent years to promote their countries as IMT destinations to both foreign and diasporic patient-consumers. Taglines, such as 'Korea: Hospitality in healthcare', 'Malaysia Healthcare: Quality of care for your peace of mind', 'Philippines: The heart of Asia', 'Singapore Medicine: Peace of mind when health really matters' and 'Taiwan cares for your health', welcome private patient-consumers across the globe (see Figure 1.3). Each campaign boasts specifically national expertise in providing 'world class' care, hospitality and peace of mind, as assured through an auspicious combination of territorialised factors. These include a high level of economic development at the national level or sub-national zones that are on par with 'developed' countries; affordability; internationally accredited facilities; highly skilled and innovative professionals with recognised credentials; short waiting times; social, cultural, economic and political stability; ease of entry into, and mobility within, the country via comfortable and safe, modern transport; and high-quality tourism infrastructure and offerings (Honors Integrated Marketing Communications 2008; KIMA 2010; MOH 2009; SingaporeMedicine 2007; Taiwan Taskforce for Medical Travel 2010).

1.6 Hospitality

Both travel (as bodily displacement) and health (as bodily ailment), as moments of corporeal vulnerability, have been intimately linked over time to the concept of hospitality, of 'being moved to respond' (Barnett 2005: 15) to the precarious situation of another (Butler 2004). Until some centuries ago, travel had been held as an experience of suffering, penitence and hardship that exposed the traveller to myriad dangers (e.g., exposure to weather and other natural dangers, crime and violence). Hospitality is therefore premised upon the traveller's displacement from his/her home, and involves the interaction between a provider (host) and receiver (guest) in which the host

offers a mixture of tangible and intangible factors that fulfil the guest's security, psychological and physiological needs and expectations (King 1995: 220). This relationship emerged in many cultures around the world as a code of conduct, wherein the host was obliged to protect the traveller from harm and, in turn, the traveller-*cum*-guest would not harm the host. Temporarily welcomed across the threshold into the host's domestic space, the guest would be afforded both security and a degree of comfort, in return for the obligation to reciprocity of hosting in the future. This relationship facilitated commerce, security and stability. It also functioned as a space within which power relations were played out, with the practice of hosting doubling as a demonstration of religiosity⁹ and/or social status (*Ibid.* 1995: 223).

Figure 1.2 Imagery used in campaigns promoting countries as IMT destinations

(images removed)

Promotional imagery accompanying IMT destination narratives is awash with Asian doctors and nurses demonstrating their dedication to their smiling patients of multiple origins surrounded by cutting-edge technology within modern facilities, nestled among each country's 'traditional' landmarks and ultra-modern cityscapes. Some logos even include country maps, suggesting a homogeneous national space dedicated to the care of foreigners. *Source (top-bottom):* Honors Integrated Marketing Communications (2008); SingaporeMedicine (2007); MOH (2009)

The concept of hospitality permits an examination of the spatial and temporal relations articulating the identities of 'host' and 'guest' within IMT. Contrasting with an unconditional Levinasian hospitality to the unexpected visitor in which responsiveness may 'not [be] straightforwardly an attribute of a subject at all' (Barnett 2005: 13) and a Kantian 'cosmopolitan right to universal hospitality' (Derrida 2000a; Dikeç 2002), I wish to advance that national IMT destinations, as hosts, extend a conditional hospitality that is partial to 'a guest whose identity is already attributed' (Barnett 2005: 13; Derrida 2000b), an ideal subject that requests recognition and responsiveness with his/her ability to pay. Not passive receivers, hosts actively identify to whom their services are geared, under what conditions they are to be provided and how to attend to the particularities of the guest. Receiving the guest as a 'Somebody, [and] not as a serialised nobody' (Barnett 2005: 15) is essential to the extension of hospitality as part of a conditional 'pact' between the host and guest that insists on mutual recognition and the reciprocity of exchange between the 'named' to 'give place' to the claims of both parties (Derrida 2000b: 23-25). Invitation is offered through the assertion of 'a secure sense of self-possession... [and] premised on a logic of unrelinquished mastery over one's own space' (Barnett 2005: 13; Derrida 2000a). The nationalised hospitality achieved through the harnessing of IMT flows reinforces the host's sovereignty through an 'active reciprocity' (Silk 2004: 234) of naming, premised upon foreign patient-consumers crossing

⁹ This includes the recognition of being equal before the gods, accepting the stranger as a messenger, facilitating access to holy sites, etc.

the border, a 'threshold across which relating is made possible' (Barnett 2005: 16). As the courted Other, foreign patient-consumers can thus be considered an 'intervention of the "beyond" that establishes a boundary' useful for the elaboration of 'strategies of selfhood – singular or communal – that initiate new signs of identity, and innovative sites of collaboration, and contestation' within the world of travel (Bhabha 2004: 2, 12-13).

Much focus has been given to the question of hospitality, that welcoming extended to a foreign Other across a sovereign threshold, in 'developed' Western societies grappling with hosting asylum-seekers and extending the benefits and responsibilities of citizens to refugees and immigrants (e.g., Darling 2010; Dikeç 2002). By contrast, and perhaps because of the sovereign foundations that the relationship of hospitality assumes and upon which it builds, little work has used it as a means with which to interrogate the extension of care from within 'developing' countries to outside others and the recognition this act affords both host and guest. In this thesis, therefore, I wish to contribute to the existing body of work by offering a reading of the commercialised hospitality embodied by the international tourism 'industry' within which IMT destinations – largely concentrated within 'developing' countries – participate and the ways in which this participation complements and colludes with a vast range of potent social, cultural, economic and political logics.

Governments of 'developing' countries are increasingly reliant upon international tourism, a common means with which to increase economic diversification and secure an inflow of capital investment and foreign currency in contexts tempered by the inequalities of international trade and the 'international politics of debt' (Enloe 1989: 40). As a tertiary industry, tourism lessens dependence on agriculture and manufacturing and permits national economies greater integration into the lucrative global service and knowledge economies. Labour-intensive, it employs the 'traditionally underemployed' (Richter 1980: 240), and the building of tourism infrastructure helps keep the construction and real estate industries afloat. Though there may exist concerns as to the uneven distribution of the wealth it generates, international tourism is oft celebrated as a 'passport to development' (Wood 1993: 48) and engine of modernisation, via the "'trickle-down" of modern skills, new technology and improved public services... imagined to follow in the wake of foreign tourists' (Enloe 1989: 40). Thought by some to play an intermediary socialising role that brings the 'traditional' into direct contact with the 'modern' world, there is also significant resistance to what are seen as neo-colonial projects of cultural objectification and homogenisation, recalling tourism's links to imperial travel and exploration (Wearing *et al.* 2010). While this dualism is critiqued for perpetuating a rigid tourist/local dialectic that ignores their hybrid and mobile subjectivities (since, as Crang (2005: 39) notes, increasingly 'those who are tourists one day are the toured the next'),

such a vision frequently persists in policy and practice. With Malaysia, for example, international tourism has made the country the ninth most travelled destination in the world (UNWTO 2010), and it is today the most economically productive service sector, second only to manufacturing in its contribution to GDP. Accordingly, it has earned a prominent place in Malaysia's long-term national development plans, with an express view to helping the country acquire 'developed' status by 2020 (Henderson 2008, 2009).

At the same time, international tourism holds potent declarative and interpellative value for destinations involved. Serving as a powerful communicant of 'being' (Hollinshead 2004: 32), it gets mobilised as a prime method with which to improve countries' international visibility and prestige. '[B]ecoming a tourist destination', suggests Urry (2002: 143), 'is part of a reflexive process by which societies and places come to enter the global order'. Chang and Yeoh (1999: 103) demonstrate this with their work tracing the discursive shift from tourism campaigns in the 1970s that framed Singapore as a self-contained (if internally diverse) destination to the 1990s 'New Asia – Singapore' campaign that communicated Singapore's vital reliance on the outside world and its positioning as the heartland of Asian values and a privileged gateway to a thriving Asia. They demonstrate that tourism policy, as a 'symbolic means of framing space' (Zukin 1991, in Chang and Yeoh 1999: 102), goes frequently hand-in-glove with national authorities' broader political objectives and aspirations. There are countless other examples of this. In the Philippines under Marcos during the period of martial law in the 1970s, for instance, the government rapidly developed a national-scale tourism apparatus to sell the country as a 'safe and delightful' destination (Richter 1980: 242), so as to neutralise both internal and external opposition to Marcos' leadership and to demonstrate to foreign investors that martial law would not interfere with the flow and stability of foreign investment and aid. This underscores governments' 'willingness to meet the expectations of those foreigners who want political stability, safety and congeniality when they travel' (Enloe 1989: 31). International tourism, with its success pivoting on responsiveness to the invited Other, therefore, works as a powerful mode of surveillance and control over the behaviours of subjects.¹⁰

In their study of private and corporatised hospitals in New Zealand, Kearns *et al.* (2003: 2305) argue that neoliberalism has ideologically transformed healthcare landscapes, resulting in the production in the built environment of 'overt symbols of exclusionary consumption' which reflect 'new sets of power relations'. IMT destinations can be symbolised by the 'hospitel', a chimerical

10 The commercialised host-guest relationship, in which the guest is prioritised, is far from a balanced exchange between equal participants, further polarised by social, cultural and economic differences between providers and recipients. In correlation with a state's reliance on international tourism, its nationals often are enjoined to be smiling, helpful, friendly, respectful and courteous 'ambassadors' to international tourists as well as tolerant and considerate of their customs, behaviours and wishes (see Tee 21/02/2009). See Chapter IV.

space of commercialised hospitality uniting the luxury, exclusivity, comfort and attentiveness to customer service of high-quality hotels with the medical skill and practices found within 'traditional' hospitals (see Bochaton and Lefebvre 2009; Kearns *et al.* 2003; Rodrigues and Meera 16-30/06/2006). The hospital, historically an institution of protection and refuge as much as of partition and surveillance, under the eye of religious orders, communities and charities, and later on the state (Pelling and Harrison 1995; Turner 1995)¹¹, merges with commercialised hospitality. Exclusive international patient wards, hotel-style suites, special extended-stay visas for IMT, personal assistants, dedicated language interpreters, private transportation, in-house foreign exchange kiosks and menus catering to diverse dietary requirements and tastes are just some of the ways in which foreign patient-consumers are made to feel welcome. Kearns and Barnett (1997: 179) suggest that places such as these 'project caring social relationships which are often absent in their home environments'. As we saw with Woodman's (2009) evocation of the personalised touches and 'creature comforts often offered abroad' that guarantee 'welcome relief from the sterile, impersonal hospital environments so frequently encountered at home' (Woodman 2009: 5), the desire for more caring exchanges within a medical context makes private healthcare and IMT appealing, with a greater amount of time expended on individual patients' needs and comfort. Driving patient-consumers to certain providers are not only 'rational' factors of cost and distance but also this 'irrational' desire for comfort, care and dignity, as we saw with the taglines employed by national councils seeking to promote their countries as IMT destinations.

Many patient-consumers are thought to travel with emotional baggage 'packed' by the healthcare systems they were motivated to leave behind. As the then Director of SingaporeMedicine, Dr Jason Yap (interview 15/02/2008), suggests, IMT destinations do not thrive because they are 'the best in the world' but because they are considered the best available alternative to what is accessible closer to home. In other words, the healthcare systems in patient-consumers' countries of origin are generally perceived to be somehow at fault – meaning that the success of a particular IMT destination is not a measure of its individual excellence but, rather, is contingent on perceived gaps and failures elsewhere. IMT destinations' market-mediated responsiveness to paying foreign subjects' (presumed) suffering/distress results in targeted extensions of care to specific clienteles. This reveals a temporal politics of hospitality 'conditionally extended as a right to certain categories of person, implying an apparatus of laws, states and borders' (Barnett 2005: 14). Such a politics is contingent upon 'the differential capacities and dispositions of individual or collective actors to be affected by and moved to respond to certain

11 Early hospitals also involved confinement of those representing 'social' ills (e.g., poor, unemployed, criminals, insane), not necessarily to 'cure' them but primarily to segregate them and maintain order outside (Gesler 1991: 173).

claims and not to others' (*Ibid.* 2005: 20). As such, hospitality hinges on a 'distinction between *invitation* and *visitation* [that] indicates that the category of the Other... is not primarily understood with references to a position in space' (*Ibid.* 2005: 18) but rather to the social, economic, cultural or political value of the Other at the time – leading, as we saw earlier with the debate about asylum-seekers receiving care in the UK's NHS, the host to engage in the 'hostile dynamic of incorporation and exclusion' (*Ibid.* 2005: 8) in deciding the 'near' and the 'far'.

In the case of Malaysia, marketing efforts over the last decade have focused on healthcare consumers from the West, Middle East and neighbouring Southeast Asian countries, emphasising the various plights these prospective clienteles encounter in seeking care in their habitual places. Un(der)insured middle-class Americans are simply 'priced out' of adequate medical care (Cannon and Tanner 2005; Turner 2007a). Impoverished nearby 'developing' countries, like Indonesia, are unable to offer necessary resources and skills for quality care (Hulupi 16/04/2006; Gunawan 01/11/2007; Praptini 31/10/2007). Middle Easterners are turned away from their traditional IMT destinations in the West as a result of post-9/11 racial and religious discrimination (Chua 25/09/2004; Connell 2006; Ehrbeck *et al.* 2008). In highlighting the problems these target markets have encountered in their pursuit of care elsewhere, IMT promotional strategies focus on demonstrating why 'Malaysia', at the national level, is capable of responding specifically to their unmet needs. 'Medical tourism', observes Tan Lee Cheng, Principal Assistant Secretary for Health Tourism of the MOH's Corporate Policy and Health Industry Division (interview, 17/01/2008),

may be a business, but that doesn't mean that it's solely for business purposes. It's still very much based on the very foundation that healthcare is for all, that healthcare should be affordable, equitable and of quality. We [Malaysia] are based on those kinds of premises.

As a reterritorialisation of care, IMT undertakes very explicit political work, mediated through a globalised market, that helps places promoted as therapeutic to 'do very well by doing good' (Henrikson 2007: 68) for, in Barnett's (2005) words, certain 'Somebodies'.

1.7 Medical diplomacy

IMT holds the potential to be an 'important piece of armoury' for postcolonial states and populations to articulate 'revered or targeted strategic essentialisms' in order to replace or fuse 'old textualities underpinning place-ness and nation-ness' with 'new imaginary essences of place and a new diversity in the possibilities of collective/national being' (Hollinshead 2004: 31, 33) (see Figure 1.3). Hollinshead's emancipatory enthusiasm locates a source of political agency for postcolonial subjects in their self-conscious re-working of essentialisms on which tourism is premised through the mobilisation of their hybridity. In Bhabha's (2004) terminology, the 'third space' of hybridity transcends the containment of culture (via colonial mimicry or pre-colonial parody) and opens up a

strategic 'in-between' space of multiplicity, overlap and negotiation, 'provid[ing] a process by which objectified others may be turned into subjects of their history and experience' (Bhabha 2004: 255) and 'conceptualising an *international* culture, based not on the exoticism of multiculturalism or the *diversity* of cultures, but on the inscription and articulation of culture's *hybridity*' (*Ibid.* 2004: 56, original emphasis).

Figure 1.3 IMT imaginaries

(image removed)

National therapeutic landscapes of IMT may often mobilise the gendered stereotypes of 'naturally' hospitable, dedicated and servile 'natives' waiting to meet one's every need and of the 'exotic', peaceful tropical settings in which many destinations are located. At the same time, however, they also develop and reproduce images – like this one – of diligent, intelligent and reliable 'home-grown' medical talent. *Source:* Tourism Malaysia (2008)

The official promotion of Malaysia as an IMT destination builds upon broader agendas for positioning and allying Malaysian subjects and spaces in strategic ways that underscore the strengths of this 'modern, moderate and fast-developing nation' (Sya 2005: 7). This depends on the strategic cultivation, enforcement and deployment of a particular narrative of Malaysian postcolonial hybridity that draws from its 'upper-middle-income developing country', 'progressive, moderate Islamic' and 'multiethnic' credentials.¹² Chang and Yeoh (1999: 105) note that the 'past, present and future... legitimately serve as foraging ground' for resources that can be reconfigured and reinterpreted in order to assert a country's uniqueness and to compete internationally. In this way, Malaysia's fraught colonial legacy is translated into the valuable linguistic, administrative, educational and medical 'heritage' that has enabled it to act as a privileged gateway and intermediary between the East and West. Its complex multiethnic composition and migratory history, long a source of tension and conflict, now becomes its crowning glory, with Malaysians praised for being 'naturally' able to navigate, tap into and relate to the nuances of cultural difference that condition international exchanges (PM Najib Abdul Razak 20/11/2009). In the chapters that follow, I seek to deconstruct claims, made by a broad range of stakeholders keen to turn Malaysia into an international hub of medical excellence, about the *country's* credentials for providing care to specific markets of foreign patient-consumers as well as the processes being undertaken on several fronts to ensure their materialisation. In so doing, I wish to engage with the varied and overlapping (post)colonial, development and ethnic/religious discourses through which they are imagined and performed.

12 'Diversity', proclaimed (then Deputy) Prime Minister Najib Tun Abdul Razak (Sya 2005: 11), 'is how we [Malaysians] would define our national identity, combined with a moderate outlook and progressive practice of Islam'.

The positioning of Malaysia as an IMT destination can be conceptualised as a form of ‘medical diplomacy’ (Feinsilver 1989), which fits under the broad umbrella of ‘public diplomacy’, defined here as a process that promotes ‘national interest and national security through understanding, informing and influencing foreign publics and broadening dialogue between citizens and institutions and their counterparts abroad’ (Nelson and Izadi 2009: 334). Medical diplomacy is a ‘soft power’ (Nye 2004) tactic consistent with a government’s ideological tenets that involves the provision of medical care to select populations outside of its normal jurisdiction in order to boost its credibility (or ‘symbolic capital’) domestically and abroad. Feinsilver (1989, 1993) developed the concept to describe the Cuban government’s efforts since the 1960s to make ‘the ideological point that socialism can produce a healthy population’ (Gesler and Kearns 2002: 130) and to be recognised as a ‘world medical power’ by deploying its medical expertise abroad as foreign aid to the ‘global South’¹³ and to the more ‘Southern’ parts of the ‘global North’¹⁴ as well as its own promotion as an IMT destination.^{15,16} Unlike traditional diplomacy, which focuses on relations *between* states and international actors, this mode of public diplomacy is concerned with appealing to specific groups of the general public outside of one’s country in ways that ‘accentuate a country’s identity and reflect its aspirations’ (Melissen 2007: 20), appealing to them as ‘consumers’ who have choices to make about the places they wish to invest in, trade with and travel to (Szondi 2009: 301).¹⁷

13 The Operation Miracle programme improves the sight and health of citizens from the Caribbean and Latin America through bilateral agreements (Ministerio de Comunicación y Información 2004; Voss 20/05/2009).

14 The offer of 1,586 Cuban medical doctors and more than 25 tons of medical supplies to care for the victims of Hurricane Katrina was rebuffed by the US administration under G.W. Bush (Stephens 09/09/2005).

15 This has come, however, at the expense of ensuring care of equal quality to its own citizens through the prioritisation of human resources and technology over the stock of basic care supplies (Scarpaci 2001).

16 Cuba has not been alone. Medical diplomacy has long been used to placate populations and seal strategic alliances, grounded in 19th century imperialist and colonialist expansion throughout the world (Dole 2004). Under US President Jefferson, for example, the treatment of common afflictions and provision of vaccines for diseases that were to ultimately eradicate much of the Native American population in the early 19th century served a dual purpose: ensuring a semblance of peace as settlers pushed deeper into native lands and keeping ‘the apparently benevolent intentions of the United States in the news at home and abroad’ (Pearson 2004: 109). In recent years, the US has woven health into foreign and defence policy further afield, deploying ‘medical diplomacy’ as a method for winning over the hearts and minds of people in ‘vulnerable countries’, the ‘battlefields where we [the US government] will be able to win the war on terror – at a relatively low cost’ (Thompson 24/10/2005). Going ‘beyond moral imperative and, yes, beyond even charity and humanitarianism’, this strand of diplomacy is concerned first and foremost with ‘self-protection’ (Frist 2008: 213) from the ‘breeding grounds’ of infectious disease and terrorism to which an American ‘we’ are made vulnerable in an ever more interdependent world (Frist 2008: 215). With these examples, spanning two centuries of American history, the extremity of the extensions of ‘care’ across borders exposes the strong ideological drives motivating their deployment.

17 Its main functions are to distance a country from failed or unpopular economic/political systems; to position the country as a ‘reliable and eligible “candidate” of the new system’ in which it wishes to participate; to do away with negative stereotypes and strengthen positive ones; to ascend the development ladder; to position the country as a regional leader; and to (re)define and (re)construct national identity (Szondi 2009: 294-295).

Thinking about IMT in this way helps to tease out the ideological and political agendas for positioning countries as IMT destinations and conditioning their subjects as care providers. In this light, IMT has the ability to accomplish far more than securing a direct source of income for a select few in the healthcare and hospitality industries. It has the potential to generate ‘prestige and goodwill outside the country’ via ‘a new form of consumer diplomacy, whereby foreigners who receive medical services... help the country to promote itself as a business and tourism destination’ (Chinai and Goswami 2007: 164). Derived from trust and credibility, IMT feeds into broader policy orientations, generating the country’s ‘moral authority as a good citizen’ and as a benevolent ‘caring society’ (Ong 1999: 202), reducing misconceptions, creating goodwill and bolstering its overall reputation. As a tool used to generate specifically national returns, the harnessing of IMT is part of a ‘very careful selection of the policy-product lines... [that depends] on an accurate reading of global political-market conditions’ (Henrikson 2007: 67-68), which involves ‘identifying, prioritising and segmenting publics and stakeholders’ (Szondi 2009: 297) in order to produce a mutually beneficial relationship. Winning ‘hearts and minds’ through IMT requires stable engagement with foreign patient-consumers and consideration of their interests through responsive policy (see Figure 1.4).

Figure 1.4 Symbolic gestures of ‘Malaysian’ hospitality

(images removed)

The placing of one’s right hand over one’s heart is a typical Malaysian gesture of welcome and hospitality. It is used prominently in Malaysian IMT hospitals’ promotional materials, alongside mottos such as ‘Taking care of your heart’ and ‘Service from the heart’. The three images above of a doctor, nurses and front-line staff demonstrate the significance of hospitality to healthcare consumers across the institutional hierarchy of private hospitals. *Source (clockwise)*: National Heart Institute (2008); Prince Court Medical Centre (2010a); Pantai Kuala Lumpur Hospital (2007)

The promotion of Malaysia as an IMT destination contributes to the four foreign policy priorities identified by Barraclough and Phua (2007) as topping the Malaysian government’s ‘medical diplomacy’ agenda. Firstly, the government is keen to strengthen socio-economic and political connections within its immediate geographical region, particularly with the members of the Association of Southeast Asian Nations (ASEAN). Secondly, much effort is made to self-identify as a modern, progressive Islamic country, through the politically-charged domestic enforcement of practices and establishing cultural, political and trade solidarities and linkages with a transnational Muslim community (as represented by the OIC) and the economically powerful GCC countries. Thirdly, it seeks to reinforce its ‘commitment to global citizenship’ through membership to, and active participation in, international bodies (see Commonwealth Secretariat 17/02/2010). Finally, Barraclough and Phua (2007: 225) suggest that, ‘[w]hile seeking an engagement with, and openness to, the global economy, Malaysia also reserves the right to criticise what it sees as the unjust

consequences of economic globalisation, many of which have ramifications for human health'. These priorities correlate to the foreign patient-consumer markets identified and targeted by Malaysian IMT stakeholders: neighbouring ASEAN countries; majority Muslim countries in Asia and the Middle East; and Western countries, especially the United States.

This type of medical diplomacy, marrying the relationality of care with the territoriality of hospitality, is a strategic manner with which to reposition the country and forge expedient alliances, linking Malaysia into global networks that further growth – 'nationalis[ing] transnationalism' (Camroux 2008) via the promotion of a fluid yet coherent nation-state image or 'brand' that transcends borders, in order to compete for investment, trade and tourism. Setting Malaysia apart from other IMT destination countries are, as noted above, its claims to home-grown integrated diversity, religious expertise and lived experience/familiarity with the places and customs of those to whom they are targeting their care-work. This is representative of a development agenda that diverges markedly from a previously more inward-looking focus on containment and self-sufficiency. Governmental promotion of Malaysia as an IMT destination can be understood as part of an expansive 'postdevelopmental state strategy' (Ong 1999), whereby the government 'cede[s] more of the instrumentalities connected with development as a technical project to global enterprises but maintain[s] strategic controls over resources, populations and sovereignty' (Ong 1999: 21; Sidaway 2007). Far from lessening its relevance, this strategy entails a 'qualitative reorganisation of the strategic emphases and capabilities of the nation-state' (Bunnell 2006: 24) in response to transnationalism and globalisation. As hopes for economic growth and development shift their focus from manufacturing to the knowledge and service-based economy, a new form of national development project gets conjured. '[N]ew spatialities of bio-political power' (*Ibid.* 2006: 25) are produced in the extension of care to subjects that, outside of the boundaries of the nation-state, previously were not within its remit. Furthermore, specific forms and practices of Malaysian-ness deemed expedient to engaging in globalising care networks are emphasised and nurtured. The realisation of development through the medium of the nation-state, via the nationalisation and protection of resources and services, fostering and privileging home-grown industry with an ethic of self-sufficiency, has given way to one increasingly articulated through explicit interdependency. It is through this type of 'strategically selective' care-giving and hospitality that the 'distant' are drawn nearer and rendered more familiar, establishing privileged linkages and a base for reciprocal support (see Edwards 2008).

1.8 An outline of the study

This thesis argues that the promotion of a country as an IMT destination signals a fundamental reterritorialisation of care aligned with the pursuit of greater 'global' economic, political, social and

cultural integration and legitimacy. It is fundamentally concerned with how the 'extension of caring' (Barnett and Land 2007: 3) via the provision of private healthcare to select non-citizens links up with discourses and practices reconfiguring the relevance of the nation-state. Following a chapter on methodology (Chapter II), the four empirical chapters (Chapters III-VI) that comprise the body of this study offer a critical reading of the political work that the harnessing of select IMT flows seeks to accomplish and for whom. Each of these chapters in turn traces a different reterritorialisation of increasingly commodified healthcare provision by a multi-faceted 'Malaysia', recognisable by and accessible to a range of target audiences, that contributes to the re-imagining of the postcolonial state's relevance and the scope of its influence in a globalising context domestically (Chapter III), in relation to the 'West' (Chapter IV), in relation to the transnational Muslim community (Chapter V) and, finally, in relation to the Southeast Asian regional context (Chapter VI).

Chapter III, entitled 'Shifting subjects and territories of healthcare', situates the promotion of Malaysia as an IMT destination within a genealogy of healthcare provision contextualised in relation to four phases of development policy. I trace the shift in postcolonial development approaches from an inward-looking 'developmental' focus on nation-building to a more outwardly-articulated 'postdevelopmental' agenda concentrated on attracting global capital for survival (Bunnell 2006; Ong 1999; Sidaway 2007). With IMT framed as a response to the discursively 'unavoidable' external pressures of economic globalisation on Malaysia, I suggest that the promotion of IMT to Malaysia serves as a model and 'test-bed' in which the state experiments with cultivating a healthcare system responsive to neoliberal subjects and dissuading reliance on a 'démodé' public healthcare infrastructure characteristic of a developmental state.

Chapter IV, entitled 'Plotting Malaysia on the "flat world base-map" of global healthcare', examines neoliberal governance techniques that shape IMT destinations and plot them on a 'flat world base map' (Sparke 2009b) of 'international' legitimacy suited to the standards of medical travel for Western healthcare consumers and corporate investment. The chapter situates IMT within the shift from 'international' healthcare governance (IHG), with its focus on the state's responsibility to ensure the health of its subjects, to 'global' healthcare governance (GHG), which takes into account the growing involvement of non-state actors in healthcare provision and the spectrum of public/private relations in healthcare that, with economic liberalisation, transcend and complicate the 'traditional' territorialisation of the nation-state (Fidler 2007; Levi-Faur 2005). This neoliberal rescripting of healthcare requires that subjects, both providers and consumers, be marketised and responsabilised. In light of this, I take a look at the intermediaries that govern and regulate healthcare as a commodity and that 're-educate' or shape consumer recognition of and demand for these new markers of quality and legitimacy in the therapeutic landscapes of IMT (Gesler and Kearns

2002; Larner and Le Heron 2004). The chapter takes stock of the technologies of this incomplete 'bull-dozing' in the Malaysian IMT landscape: the categorisation and quantification of IMT destinations' quality and flows to facilitate industry-wide comparison; the standardisation of IMT medical facilities' structures, processes and outcomes via pressure for internationally-recognised accreditation; partnerships with world-famous medical facilities; and the promotional deployment of medical professionals' credentials earned in prestigious Western educational and training establishments.

Chapter V, entitled 'Strategic cosmopolitanism and "Muslim-friendly" care expertise', focuses on the expediency of cultural competence in the customer-focused care that is central to the success of IMT (Yúdice 2003). It examines highly contested identity politics underlying claims to culturally-specific care expertise and the interpellation of 'strategic cosmopolitan' (Mitchell 2003, 2007) Malaysian care-giving subjects. In its engagement with global capital, the postdevelopmental state has begun to revalue and identify national diversity as central to Malaysian identity. While a multi-ethnic, multi-lingual and multi-religious Malaysia was framed as particularly threatening to nation-building efforts in the early period following independence, recent decades have witnessed growing state awareness of the economic value of its ethnically diverse population, capable of plugging 'Malaysia' into lucrative transnational flows and networks. Here I consider Malaysian IMT stakeholders' focus on specific patient-consumer markets and examine how strategic cosmopolitan cultural expertise/credentials are constituted and deployed in IMT promotional strategies to attract medical travellers of select origins by tapping into a range of trans-, supra-, sub-and post-national belongings, alliances and values. While authors like Ong (1999) and Bunnell (2006) have addressed the 'plugging-in' of Malaysia's ethnic Chinese population into global diasporic networks, I turn to the 'plugging-in' of the country's majority Muslim population into the transnational Muslim community (or *'umma'*). Specifically, I look at 'strategic cosmopolitan' claims to, and the cultivation of, Malaysia's 'Islamic credentials' for IMT (Connell 2006; Henderson 2004).

Chapter VI, entitled "'Complementarities" and regionalised landscapes of medical travel', focuses on IMT's discursive and material contributions to the redrawing of development terrains – specifically cross-border development regions, triangles and corridors – as test-beds of 'graduated sovereignty' (Ong 1999). It contemplates the significance of regional cross-border healthcare in sub-national, national and regional development agendas. Shifting the pursuit and provision of healthcare outside of the national domain leads to re-conceptualisations of healthcare's ties to citizenship and of the significance of regionalised belongings/affiliations. Healthcare plays an important role in extending Malaysia's political, cultural and socio-economic spheres of influence by establishing and reinforcing regional 'complementarities' (Kakazu 1999; Sparke 2005) within the

landscape of ASEAN. Two cross-border regional case studies contextualise IMT industry emphasis on the 'sibling-like' cultural, linguistic and physical proximity between (parts of) Malaysia and its neighbours from Indonesia (particularly the adjacent island of Sumatra) and Singapore that have turned to private healthcare providers in Malaysia for affordable, quality care. At the same time, they point to the significant economic differentials that primarily drive the (highly uneven) development within these regions.

I then conclude in Chapter VII with reflections on the research questions and point to some relevant paths to explore in future studies.

Chapter II. Methodology

2.1 Background to the scope of this study and positionality

My personal experience has served as the driver for my research interests and tempered the politics of my intellectual engagement with international medical travel (IMT). Using IMT as a lens through which to examine healthcare's role in linking people and making places has permitted me to work through a broad spectrum of categorisations of human mobility and the equally broad spectrum of care-giving and -receiving relationships to which such categorisations fundamentally relate.

As someone who considers herself somewhat of a global nomad, I have tended to think that I have been rather fortunate to hold an American passport. It has been relatively easy to pass in and out of many countries as a tourist because of it. Yet, while categorised in many moments and places as a 'tourist', in many others crossing borders with different intentions and more extended time-frames has rendered me subject to many new and different levels of surveillance and regulation. 'Even' as an American, I have had to have my lungs checked for TB in the presence of a notary in order to enter Belgium on a student visa. I have waited in many day-long queues at immigration authorities' headquarters to receive the assortment of documents and rubber stamps that attested to my legal status as an economic migrant in Portugal, only to, years later, use my blood donor ID and library card to help prove my active 'membership' and demonstrate to the Portuguese state that I was worthy of that country's citizenship. Armed with two passports these days and benefiting from the entitlements that Portugal's membership to the European Union has afforded me, I now live and work in the Netherlands and enjoy accessible, quality healthcare that my family in the United States can only dream of. While I have been able to more permanently escape the woes of the US healthcare system, they have not. My grandfather used to cross the border into Mexico for affordable arthritis medication. My aunt has been bankrupted by a liver transplant. My mother worries about whether she will be able to afford health insurance as she gets older. Undertaking these journeys, performing different mobility categories and coping with these disparities, I have often wondered about what sorts of belonging permits a sufficient exchange of recognition to occur to allow for a relationship of care to take root.

If simply being a citizen of a country was, in most places throughout the world, not sufficient to secure adequate access to quality healthcare, then what was? With the privatisation of healthcare throughout the world, having enough money to pay for care is clearly quite an effective lubricant for access. Yet it is not always sufficient. In the wake of 9/11 and tighter entry restrictions into many Western countries, 'even' wealthy passport-holders from Muslim (especially Arab) countries that had long been medical tourism habitués in Western countries found that, because they were Muslims, they and their money were no longer as welcome as they had been just a year before.

Several countries with Muslim majorities or significant minorities, already promoting themselves as IMT destinations (e.g., Dubai (UAE), India, Jordan, Thailand, Singapore and Malaysia) to Western and regional markets, began to tout their 'Muslim-friendly' expertise and advertise their more relaxed entry requirements to capture this temporarily detoured market. With my educational and research backgrounds in Middle Eastern and migration studies sensitising me to the challenges of religious and ethnic discrimination to fulfilling basic needs, I was compelled to develop a PhD proposal that initially focused on IMT destinations that promoted themselves as offering 'Muslim-friendly' healthcare in the years after 9/11, as places that extended recognition and care (albeit in a commodified form) to people in otherwise economically comfortable positions that had been turned away elsewhere. I sought to explore how the emerging IMT care sector intersects with shifting notions of transnational identities and belongings (e.g., building stronger relationships with the transnational Muslim community [*umma*]) and the ways in which these changes are linked to broader geopolitical changes in relationships between nations, groups and individuals, even in instances in which those relationships are commodified.

Malaysia – with its multiethnic society, ongoing projects to promote itself as a modern, moderate Muslim-majority country and strong state support of 'medical tourism' – stood out as the most fitting case through which to explore relationships produced through the extension of recognition and care to select non-citizen Muslim others. It was while undertaking the early fieldwork in Malaysia that I came to grasp the bigger picture – to recognise that the 'Muslim-friendly' IMT campaign I had first sought to explore was only one facet of the many fascinating ways in which 'Malaysia' was being promoted both within and outside of the country by IMT proponents. The media coverage I read and the interviews I had with state, private-sector and civil society stakeholders revealed a wealth of 'Malaysias' that demonstrated complex layers of colonial, religious and regional discursive and material linkages being used to frame correspondence to, and legitimise the harnessing of, lucrative and otherwise strategic global flows. The fieldwork expanded my initial focus and ultimately resulted in the thesis chapters that follow, each grounded in empirical material that correlates to different supply-side framings of 'Malaysia' projected to and upon perceived allies and markets through the extension of care. While the scope of the research ultimately expanded, the rationale has remained the same: with this thesis, I seek to contribute timely insight into the dynamic and rapidly expanding IMT sector by broadening the field of theoretical inquiry around IMT through introducing a critical cultural reading that has often proven absent in the literature and by decentring the dominant narratives of IMT often cast in terms of a neo-colonial 'metropole'/periphery dichotomy that only serves to obscure the significant underlying interdependencies inherent to care exchanges.

2.2 Data collection and analysis

In order to offer a reading of the Malaysian therapeutic landscape produced through the promotion of the country as an IMT destination, I undertook discourse analysis of primary (e.g., interviews) and secondary (e.g., international and domestic media coverage, private-sector and governmental documents and statistics) data in order to interpret claims made to specific forms of care expertise, the construction of such expertise and the manners in which select others are invited to draw upon it. Sections 2.2.1 and 2.2.2 below go into specific detail about the experiences of, and challenges faced in, the various facets of the data gathering process itself.

The analysis generally assumed a ‘grounded’ approach, though my post-structural engagement with representations of scales and sites of ‘care’ led me from the start to conceptualise ‘care providers’ in a way that transcended the micro-scale by encompassing not only individual health and allied care workers but also hospitals and hospital groups, governmental units, private-sector service providers, civil society groups and a host of intermediaries engaged in relating to foreign patient-consumers across scales. Following the fieldwork period, I transcribed my interviews and organised my secondary data in order to open-code the material. This allowed me to get a feel for the overall contours of the body of material and identify significant people, events, places, issues and discourses. I then moved to an interpretive stage, identifying structures and linkages between these codes and refining these linkages into broader conceptual categories. Finally, relationships were established between these categories, feeding into a larger theoretical scheme.

The resulting narrative I have woven together is – like all work based upon observation and interpretation – a product of a researcher who recognises that her study is necessarily limited, specific and partial in scope because it is produced not from a distant and anonymous perspective – Haraway’s (1991: 587) ‘god trick’ – but rather from a situated perspective. As Nast (1994: 64, in Rose 1997: 310) astutely observes, a written text, like this thesis, ‘is merely a point amidst a continuous fabric of other texts that includes all communicative forms through which researcher, researched, and institutional frameworks are relationally defined’. Given the impossibility of fully representing all types of engagement with IMT in Malaysia, I have sought instead to offer up a grounded reading of how some stakeholders involved in various manners as ‘hosts’ and care providers conceptualise IMT through circulating discourses and act to influence the course of its development in Malaysia, impacting on the status of Malaysia itself as a therapeutic destination.

2.2.1 Primary data

As my empirical research focussed on the apparatus extending care and hospitality to turn Malaysia into an IMT destination, I first concentrated my primary data collection within Malaysia. Entering Malaysia on a special visa reserved for researchers in November 2007, I undertook the bulk of my six

months of fieldwork in the Klang Valley (the region around Kuala Lumpur), given the concentration of IMT stakeholders identified there by a preliminary web-based inventory prior to arrival. This was supplemented by shorter visits to two other areas of the country catering to significant numbers of foreign patient-consumers, Penang and Malacca, just prior to and following the historic national elections in March 2008. While in the field, however, the transnational nature of that apparatus necessary for making Malaysia an IMT destination grew abundantly clear, and I was often pointed in the direction of stakeholders outside of the country that were linked to the development of IMT to Malaysia. As a result, I also undertook interviews in Singapore and the United States.¹⁸ A brief follow-up trip was made to Kuala Lumpur and Singapore in September 2009 to track some of the major changes to the face of the Malaysian industry (e.g., launch of the Malaysia Healthcare brand and website and the Malaysia edition of *Patients Beyond Borders* (Woodman 2009)).

2.2.1.1 Unstructured non-participant and participant observation

Attendance at the Monitoring the Right to Health Regional Training Workshop (December 2007) and the World Medical Travel Congress (February 2008), both in Kuala Lumpur, allowed me to observe a spectrum of healthcare stakeholders addressing topics as varied as the everyday healthcare concerns of the poor in the Global South and strategies for, and challenges faced in, harnessing elite IMT flows. These events also allowed me the opportunity to visit medical facilities promoting IMT with their attendees (e.g., National Heart Institute (IJN), Prince Court Medical Centre (PCMC) and Damai Service Hospital). Guided tours of other medical facilities (e.g., KPJ Damansara Specialist Hospital, Mahkota Medical Centre, Sime Darby Medical Centre Subang Jaya and two anonymous facilities) took place within the scope of interviews, with the interviewees themselves selecting the equipment, operation theatres, examination spaces, patient rooms and common spaces that they wished to display in order to represent their institutional facilities to me as a foreign 'outsider'. Finally, personal use of two other facilities as a foreign patient-consumer myself (e.g., as an inpatient at Pantai Hospital Kuala Lumpur during an unexpected illness and as an outpatient at Tun Hussein Onn National Eye Hospital for planned elective Lasik corrective sight surgery) further contributed to this study, allowing me to experience these facilities and the accessibility of their staff from a different vantage point.

2.2.1.2 Interviews

I undertook purposive sampling, selecting sites throughout Malaysia and organisations that would allow me to make comparisons and discover variations among concepts and practices of care-provision (Strauss and Corbin 1998: 201, in Bryman 2008: 415). I did not include foreign patient-

¹⁸ Though, for logistical reasons, it did not happen in the scope of research for the thesis, future research will be undertaken in Indonesia (the most important sending context in terms of volume).

consumers in Malaysia for several reasons. Ethically, they constitute a vulnerable group while hospitalised and in the special places (e.g., resorts, hotels, long-stay apartments, etc.) chosen for convalescence in Malaysia, and it is commonly held that one of the draws for seeking treatment away from one's own country is the wish to ensure one's privacy. Furthermore, studies of foreign patient-consumers' experiences (see Kangas 2002, 2007; Ono 2008) generally trace them prior to, during and after their care pursuits over a lengthy span of time. This sort of scope was not economically feasible nor would it have helped me explore how 'hosts' and care providers conceptualise IMT and mobilise 'Malaysia' as an IMT destination. Therefore, prior to commencing the fieldwork in Malaysia, I undertook a preliminary Internet-based search in Malaysian newspaper articles, medical travel industry websites and press releases and official reports to compile an inventory of prospective interviewees spanning governmental bodies, professional organisations, civil society and private-sector interests throughout the country that held some type of published link to the development of IMT to Malaysia.

Once in Malaysia, I proceeded to send letters, emails, make telephone calls and visit the groups and institutions identified in the preliminary search. The number of non-replies, disconnected phone numbers and bounced e-mails to my initial interview requests is indicative not only of the precarious and ephemeral existence of many entities involved in IMT (e.g., from small-scale medical travel facilitators like Medical Service Coordination International to heavyweights like the nebulous National Committee for the Promotion of Health Tourism (NCPHT)), but also the number of references made in published materials to entities only nominally implicated in the industry and/or unwittingly associated with it (e.g., Malaysian Association of Tour and Travel Agents (MATTA) and Tung Shin Hospital) or that leverage the trendy terminology of IMT to attract media attention. The emergent status of IMT as a tool for development, therefore, translates into a relatively small yet dynamic constellation of proponents and promoters, spanning federal, state and urban governmental authorities, international and national professional associations, private and corporatised hospitals and specialist clinics, and medical travel facilitators in Malaysia. An even smaller number of vocal detractors – largely civil society representatives – exists. Furthermore, in light of IMT's politically contested status as a state-endorsed driver for national economic growth, I had been advised by anonymous Malaysian insiders early on that it would be difficult to gain access to stakeholders, particularly government representatives, willing to discuss the development of an industry characterised as much by its fragmentation as by its glossy veneer. This was sometimes the case, with several requests for interviews with government officials declined. However, this was partially attributable to internal structural reorganisation within both the Ministries of Health and

Tourism during my period of fieldwork that produced a reshuffling of competencies, generating guarded reluctance and unwillingness to speak on the matter.

This preliminary Internet trawl, however, yielded many of the early interviews, permitting engagement from the start with multiple entry points to a range of actors variously involved with IMT (Valentine 1998: 116). Following this, contacts from interviewees, interview content and identifying linkages with the secondary data led to use of the snowballing technique to recruit other interviewees. Limited time and resources and the above-mentioned political sensitivity surrounding IMT restricted access to a number of interviewees and hindered my ability to undertake additional interviews with interviewees. Future research, however, will attempt to gather perspectives from a larger number and variety of interviewees throughout Malaysia – with special attention to international and domestic patient-consumers, health workers across the ranks, the health insurance industry and international transport providers – as well as to revisit many of this study's interviewees to gain insight into the ever-shifting dynamics involved in the project of harnessing IMT.

My reliance on largely elite institutional gatekeepers implied that I had limited access to the doctors, nurses and other health workers directly engaged in caring for foreign patient-consumers 'on the ground'. It proved difficult to get the permission of CEOs and public relations and marketing staff to move beyond the front-line and witness and discuss 'everyday' healthcare encounters in medical facilities. At the same time, however, the ability to hold interviews with these institutional elite – who are responsible for identifying and engaging with particular markets, creating policy and promoting IMT – indicated the social and political sensitivity and, at the same time, the prestige of engaging as a provider with IMT. These interviews also provided a wealth of valuable insight into the myriad types of less-obvious 'everyday' hospitality and care practices that take place in IMT provision both within and outside of the facilities themselves (e.g., outreach abroad to inform prospective patient-consumers of the availability and accessibility of care in Malaysia, arranging travel and accommodation for patient-consumers and their visiting family members, ensuring the presence of interpreters and local transportation, negotiations over pricing with families unable to cover the full economic costs of treatment and care, etc.). Keeping in mind the ways in which I was able to access interviewees, it is important to avoid reifying the authority and influence of the array of IMT proponents and detractors that I refer to herein as 'stakeholders' and 'agents'. Recognising that those perceived to be 'exercising power in a particular field may be a disparate, informal or even invisible network of people, dispersed across a variety of locations and professions' (Smith 2006: 646) has helped me situate said 'stakeholders' within a context that renders their interdependencies and vulnerabilities more apparent.

Ultimately, single in-depth, semi-structured interviews, lasting between 40 minutes and three hours each, were held with 49 interviewees (see Appendix 2) representing the following types of institutions:

- Top-level executives and administrators (e.g., CEOs, directors, senior managers, board members and advisors) for governmental, private and not-for-profit bodies;
- Research, business development, marketing, policy, public relations and customer service executives and officers;
- Medical travel facilitators and
- Medical professionals.

In recognition of the influence of place in conditioning the interview experience (Kesby 2007), interviews were most frequently held in interviewees' private offices, closed-off meeting rooms or in urban public spaces selected by the interviewees themselves to ensure their comfort. This permitted us to talk without the interviewees needing to feel very concerned about whether their colleagues would overhear them. With the exception of a few cases in which recording was not permitted or where official commentary was sent to me by e-mail, the interviews were recorded and transcribed.¹⁹

Throughout the interview process, the subjectivities of both researcher and respondent proved integral to the knowledge produced. Since, as an interview develops, 'we are constantly (re)producing "ourselves" so that researcher and interviewee may be multiply positioned during the course of an interview' (Valentine 2002: 121, in Smith 2006: 647), I sought to be alert to both interviewees' and my own multiplicity of positions engaged with or silenced in the research process. Studying in Scotland, having lived in Portugal for several years and coming originally from the United States, interviewees – oftentimes asking where I came from – received a not-so-simple answer that drew from these formative international experiences. Most all interviewees were in situations similar to myself – growing up in Malaysia and having studied abroad (e.g., Singapore, the UK, the United States, Australia, New Zealand, Hong Kong and Japan), working in many of these as well as the Gulf countries, and with family members spread across the globe. Still other interviewees were expatriates and transnational entrepreneurs of non-Malaysian origin seeking to tap into the country's promise. It appeared that the harnessing of IMT as providers gave many an outlet for sustaining and building upon the linkages they had developed previously elsewhere.

19 With most all respondents being multilingual, English served as the lingua franca. Respondents were informed verbally and in writing about the scope and purpose of the study in which they were voluntarily participating. Some preferred to speak with anonymity, while others were comfortable with associating their names to their comments. In order to ensure the formers' right to anonymity, I have anonymised their comments in the thesis.

Yet, while at times our shared transnational trajectories generated rapport and respectful recognition of our varied engagements with IMT, I was at times explicitly identified by some Malaysian interviewees as representative of the European imperial and American hegemonic arrogance against which they were seeking expressly to situate both their institutions and themselves as Malaysians as responsive, more caring alternatives (see Valentine 1998). In conflating me with the 'West' more generally (e.g., '*you* in the West') or specifically with massive institutions with 'ageing technology' like the British NHS, the ailing U.S. healthcare system and post-9/11 invasive anti-terrorism measures in the U.S. (e.g., 'they don't like *your* sniffing dogs'), these interviewees drew attention back to the ways in which I am perceived relative to the topic I am researching. As Gokariksel (2003: 41) notes, 'Self-reflexivity during and after the fieldwork means thinking about how the relations between the researcher and research participants have been constructed and negotiated'. These experiences underscore how interviewees' accounts were situated and co-constructed in the moment of the interview.

Overall, these varied interview encounters offered valuable insight into how the industry stakeholders I interviewed constructed their target foreign patient-consumer markets and their respective needs and concerns, as well as into the lenses through which they construct the providers and systems with which they see themselves competing. At the same time, however, endorsement from the Prime Minister's Economic Planning Unit (EPU) and my visiting researcher affiliation with the University of Malaya also sometimes seemed to put me in an odd in-between position, with some interviewees being at greater ease with my research objectives due to their familiarity with these institutions, facilitating or enabling access to official data and interviews, particularly with state and quasi-state authorities. Furthermore, I conducted interviews at the same time as three different major international consulting companies were undertaking studies on IMT, meaning that some interviewees had been interviewed already multiple times prior to meeting with me and sometimes would align my research with that of the consulting companies – their answers at times feeling well-rehearsed.

I loosely employed an interview schedule with three sets of questions, covering the general development of the IMT industry in Malaysia, changes in the pursuit and provision of medical care and the overall customer base (see Appendix 3). The same interview schedule was used with all interviewees as a point of departure to prompt open-ended responses and discussion. To begin, I first asked interviewees to tell the story of how IMT to Malaysia began and what prompted the industry to emerge as a response. I sought to trace interviewees' normative constructions of the IMT industry's development, paying attention to the landmark events, practices and values they identified as having significantly shaped its contours. Interviewees were asked to describe how their

institution fits within this process and the factors driving institutional interest in developing and promoting IMT to Malaysia. The identification of linkages and networks with which the respondent's institution is engaged served as a way to get interviewees to point out the players they deemed pivotal to the industry, who and what they consider to be authorities in the field, and the alliances and disconnects they identify as relevant to their progress. They were then asked to identify the strengths, weaknesses, opportunities and threats (SWOT analysis) for the broader industry as well as their own institutions' engagement with IMT. Specifically, I posed questions concerning the overall effects of IMT on the public and private divide in the national healthcare system that have been critically addressed in media coverage and academic literature. These included IMT's potential to exacerbate rising healthcare costs and privatisation, brain-drain (public/private, rural/urban and domestic/foreign) and influence on the quality of healthcare provision and access to it by local patient-consumers. These narratives demonstrated the discursive processes through which the stakeholders negotiate their position in healthcare in relation to others as part of 'the ethical problematisation of consumption' (Barnett *et al.* 2008).

The second set of questions addressed the changes taking place in the provision and pursuit of medical care in an increasingly globalised context. Questions were posed about the consumption of healthcare, particularly how patient-consumers acquired health knowledge and advocated for their health interests. Interviewees were asked to reflect on the influence of medical technology and developments in biomedicine on the ways in which medical professionals and patients understand 'health' and the ways in which it is pursued. They were asked to comment on the extent to which they feel the impact of international political relations and trade agreements (e.g., GATS, ASEAN, etc.) on healthcare practices. Interviewees were also asked to identify how they see IMT articulating with the Malaysian government's overarching development ideals in light of IMT's enshrinement as a driver for national economic growth and development. I sought here to identify overlaps and disjunctures between visions of development at a range of scales and stakeholders' everyday practices that accept, appropriate, coincide with or resist them.

The patient-consumers fuelling IMT to Malaysia were discussed in the final set of questions. Interviewees were asked to estimate the number of medical travellers handled by their institutions and how they were counted and categorised. They were then asked to list and discuss the reasons that foreign patient-consumers might go abroad for medical care. Issues addressed included facilitated transnational mobility, the quality of Malaysian healthcare, combinations of care with conventional types of tourism and the compulsion to sidestep obstacles perceived to inhibit care 'back at home'. Rationale for the targeting of particular patient-consumer segments (e.g., East Asia, Middle East, ASEAN, North America, etc.) at the national and institutional levels was solicited. I then

queried them about the means used for attracting foreign patient-consumers (e.g., television and Internet advertising, brochures, special trade missions, trade fairs, etc.) and if/how these techniques are adapted to the different segments targeted. Interviewees were asked to reflect on the effectiveness of these methods and how they have evolved over time. Had they identified different needs and concerns (e.g., language barriers and the satisfaction of dietary needs, religious needs, cultural specificities, etc.) among the segments they pursued? If so, what were the means they had at their disposal for catering to these (e.g., interpreters, religious guidance, *halal* food/medication, rooms equipped to accommodate accompanying guests, same-sex medical staff, etc.)? These questions were posed in order to examine how foreign patient-consumers and their needs get imagined and these constructions are deployed by stakeholders to further their interests and develop niche market positioning.

2.2.2 Secondary data

2.2.2.1 Documentary sources

In addition to undertaking interviews and visiting hospitals promoting IMT, I gathered secondary data in the form of published documentation. Printed and online promotional and informational materials (e.g., websites, brochures, newsletters, flyers, fee schedules, lists of affiliated medical professionals, annual reports, etc.) from each institutional stakeholder interviewed in Malaysia as well as from other neighbouring countries were gathered systematically. These texts produced by or on behalf of the promoters of private healthcare permit us to 'read the underlying discourses that reveal evidence of the cultural economy of health care' (Kearns *et al.* 2003: 2305). Given medicine's privileged relationship with modern configurations of knowledge/power, the promotional channels of private healthcare increasingly serve as a vehicle to new ways of understanding the pursuit and provision of care, prompting an awareness among both public and private sectors for the need to raise their profiles and market themselves. Throughout the thesis, I deconstruct the imagery and text from a sampling of these materials to examine the discourses into which they tap in order to make claims to authority, legitimacy, authenticity and innovation in a dynamic, globalising healthcare context. Yet, while this type of documentation provides cross-sectional evidence of how stakeholders themselves promoted the IMT industry in Malaysia and overseas during the period of my fieldwork, it captures neither critique nor the evolution of IMT over the decade since it first arrived on the Malaysian government's economic development agenda.

It became clear that the addition of a longitudinal perspective was necessary to provide content for an analysis of the conceptual evolution that has accompanied the development of IMT in Malaysia. Though the 'imagined worlds of development writing and speaking often appear to bear very little resemblance to any commonsense reality... [comprising] a textual field so laden with

evasion, misrepresentation, dissimulation and just plain humbug' (Crush 1995: 4-5, in Rigg 2003: 50), the shifting representations present in such plans – the ways in which they enshrine assumptions, uphold ideologies and articulate aspirational formulae for what the state believes can be achieved – still have significant repercussions (Rigg 2003). Frustrating attempts at acquiring a more longitudinal perspective, however, is the limited government-generated information on IMT released publicly in official reports. Beyond scant references made in official development documents (e.g., five-year Malaysia Plans, ten-year Industrial Master Plans and annual national budgets) and on the Ministries of Health and Tourism websites, the development of the IMT industry in Malaysia has been primarily documented and promoted via political speeches, statements released by the state's communications arm (Bernama), and other media outlets within and outside the country.

In his work on the power of Southeast Asian media, Yao (2001: 48; see Anderson 1991) suggests that national mass media coverage serves as 'an instrument for disseminating politically contingent information for nation-building, as it is a sign of a nation's arrival in the modern world'. With Malaysia currently ranking 141st in the world in terms of press freedom (Reporters Without Borders 2010), as Yao observes, domestic mass media coverage often constitutes the privileged site through which national development plans – those objects through which 'landscapes, territories of "development space" and subjects are conjured' (Sidaway 2007: 350) – are developed, disseminated and fostered. It offers a privileged lens through which to analyse how Malaysia gets portrayed as an 'international centre of medical excellence' to a national audience. Therefore, to complement the interviews and the limited information released by private medical care providers via communiqués and official outlets, I consulted the online archives of the Malaysian New Straits Times Press' (NSTP) eight English-language newspapers to grasp the evolution of media coverage on IMT – which grew three-fold from the moment IMT entered the national development agenda in 1998 until the end of 2009 (see Appendix 4). NSTP is a subsidiary of the Media Prima Group owned by Malaysia's dominant political party, UMNO, and its publications are widely held as government propaganda tools.

The eight NSTP newspapers included *New Straits Times*, *New Sunday Times*, *Computimes*, *Business Times*, *Malay Mail*, *Sunday Mail*, *Weekend Mail* and *Malaysian Business*. A search for the exact terms 'foreign patient', 'healthcare travel', 'health tourism', 'healthcare tourism', 'medical tourism', 'medical travel' and 'medi-tourism' altogether yielded 720 articles for the period between 1 January 1998 (the year and 31 December 2009). The articles were then accessed via the internet,

using newspapers' websites and the High Beam Research archive service to access older articles not available to the public on the respective newspaper websites.²⁰

2.2.2.2 Statistics

In addition to published documentation, I also gathered published and previously unpublished statistics on foreign patient numbers and revenue in Malaysia and other countries promoting themselves as IMT destinations. However, a series of caveats must be addressed here in order to contextualise my analysis and use of this type of data in the thesis.

IMT industry stakeholders repeatedly note that the lack of standardised terminology, absence of unified methodologies for data collection and poor reporting practices constitute a 'risky trap' that inhibits countries from publishing their IMT figures and stymies productive international comparison on industry growth (Whittaker 2008). Even the most 'reliable' sources on world-wide IMT figures to date produce figures that are light-years from one another. Two large-scale independent studies the first of their kind were released in 2008 by the Deloitte Center for Health Solutions and McKinsey & Company. Deloitte (2008c: 7), defining 'medical tourism' broadly as 'the act of travelling to another country to seek specialized or economical medical care, well being and recuperation of acceptable quality with the help of a support system', found that roughly 750,000 Americans alone travelled abroad for medical care in 2007 and predicted that the industry would 'experience explosive growth' (2008c: 4). Meanwhile, McKinsey generated highly conservative estimates of only 60,000 to 85,000 patient-consumers *globally* (Ehrbeck *et al.* 2008: 2), with 'medical travel' confined to non-resident foreigners that enter a country specifically for treatment by McKinsey (Ehrbeck *et al.* 2008: 2).

In the absence of a global industry-wide standardised system, therefore, a disparate range of practices are used to produce figures on the dimension of IMT. These then repeatedly get reported in the media and academic literature without being sufficiently problematised, making it 'unclear whether their numbers are accurate or just another marketing device to generate "buzz"' (Turner 2007a). Most often released as rounded figures not discriminated below the national level, they construct a false vision of objectivity and legitimacy, while at the same time privileging the methodological construction of a homogeneous 'national' territory of care (see Table 2.1). These

²⁰ The results of a cursory content analysis of the articles during the above-mentioned period (see Appendix 4) demonstrate, particular nomenclatures have come in and out of fashion over time, indicative of shifting conceptualisations within the Malaysian and international industries of how IMT flows were constituted and what they – as 'tourists' or 'travellers', as 'health-seekers' or pursuing 'medical' intervention – meant and to whom. The term 'healthcare travel', for example, only came into more common usage in 2009, coinciding with the launch of both the Malaysia Healthcare branding exercise and the Malaysia Healthcare Travel Council (MHTC). While 'health tourism' was favoured by government policy documents until 2009, both 'health tourism' and 'medical tourism' have been used interchangeably in media coverage since 1998.

figures tell us little about which foreign patients are counted, how they are counted, which bodies are responsible for reporting, the level of reporting and the politics behind their dissemination.

Table 2.1 Foreign patient figures among select Asian IMT destination countries (2002-2008)

	2002	2003	2004	2005	2006	2007	2008
India	150,000					450,000	
Korea				10,000		16,000	40,000
Malaysia	84,585	102,946	174,189	232,161	296,687	341,063	374,063
Singapore	210,000	230,000	320,000	374,000	410,000	348,000	370,000
Thailand			600,000	1,280,000	1,000,000	1,400,000	1,500,000

Sources: India - Whittaker (2008), Health-tourism.com (2009a); Korea - IMTJ (22/10/2009), Vequest and Valdez (31/10/2008); Malaysia - APHM (2008); Singapore - Hospitals.sg (28/01/2009), IMTJ (27/10/2010), Yap (2006); Thailand - Whittaker (2008), Health-tourism.com (2009b)

Which patients are counted depends on the intention of the quantification exercise. In Malaysia, data collected for the purpose of describing the volume of medical travellers do not sufficiently discriminate. The practice lumps all foreigners receiving care from a set of 35 private hospitals endorsed by the MOH for IMT together, irrespective of whether they have purposely come to the country in pursuit of medical care, whether they have fallen ill while in the country and sought care out of necessity, whether they are primarily residing in Malaysia or abroad, whether they are conventional tourists or migrant workers, and so on. This blurry definition of ‘foreign patient’ in Malaysia encompasses all patients holding foreign passports, complicating attempts at better understanding the dynamics of the IMT market.

A further challenge is *how* ‘foreign patients’ are counted once it is decided *who* is being counted. Along the most standard lines, the Malaysian private hospitals reporting to the Association of Private Hospitals of Malaysia (APHM) record individual patient/hospital episodes, meaning that patients are counted each time they go to a hospital and not by how many staff they see during that time. Meanwhile, Southeast Asian IMT destinations have been quick to pick apart the impressive though polemically inflated foreign patient figures of their competitor, Thailand’s premier IMT facility, Bumrungrad Hospital (which, by extension, inflates the national figures) (2008 Medical Travel World Congress proceedings). Instead of counting individual patient/hospital episodes, Bumrungrad counts the number of patient/medical staff contacts.²¹ Neither of these approaches allows for conclusive figures on the absolute number of foreign patients because it does not control for repeat hospital episodes or visits by the same patient. These sorts of categorisation practices account for the difficulties in quantifying the phenomenon.

²¹ In other words, an individual patient is counted each time he/she meets with hospital staff – meeting with a gastroenterologist counts as one, meeting with a radiologist counts as two, and so on.

Compounding the inconsistencies in data-gathering are irregular and inadequate reporting practices. Methods of gathering data on IMT are highly variable, taking place at the level of the medical institution providing care and, depending on the destination country, potentially upon declaration of visitors' intentions to pursue medical care at immigration control points when they enter a country (e.g., Singapore). In Malaysia, the APHM is charged with compiling statistics from the 35 IMT hospitals, collecting information on the origins and number of foreign in- and out-patients, the procedures undertaken and the revenue generated. In practice, however, hospitals' lax reporting practices have meant that IMT data is far from complete (see Appendix 7). Reporting practices are slowly improving year on year, possibly due to increased pressure by APHM and warnings by the MOH that the facilities risk being dropped from the official list if they do not submit data regularly (Chua 19/07/2004) (see Table 2.2). Plans to make IMT a success have been reportedly under threat due to the hospitals' practices since foreign patient data is considered crucial for the MOH to craft its marketing strategy (*The New Sunday Times* 20/02/2005). As an anonymous Malaysian governmental tourism representative (interview, 24/01/2008) observed,

Everybody is so secretive and not willing to share! That's why when we, at the Ministry and marketing levels, have a difficult task in getting figures. But not figures alone, because we must get data on the original countries and the kind of treatments. They keep it to themselves! This makes it very difficult for us to know in which part of the world we can promote certain kinds of treatment and which parts of the world on which to concentrate more. If we don't have this information flow, then how are we going to promote health tourism?

To date, there exists no manner to legally enforce reporting, though there have been discussions about putting forth legislation to require it.

Table 2.2 IMT-endorsed hospitals reporting data to APHM on foreign patients and revenue generated²²

Year	2002	2003	2004	2005	2006	2007
Patients	19-22	19-21	19-20	19-25	27-28	29
Revenue	10-14	n/a	11-13	13-16	20-23	23-25

Source: APHM (2008) *Note:* See Appendix 7 for a list discriminated by contributing hospital.

The politics behind the dissemination of figures constitute yet another obstacle. Most authorities promoting their countries as IMT destinations are wary of publishing their figures. While authorities in other countries do not possess centralised databases and/or do not choose to release this information publicly, the APHM and the Singapore Tourism Board go against the grain by compiling and releasing annual figures. The limited statistics on IMT in Malaysia included in this

²² The range indicates that the number of hospitals reporting varied from month to month. Furthermore, while hospitals have been more forthcoming with data on foreign patient numbers, they remain more guarded regarding the revenue they generate.

thesis were provided by the APHM, individual medical facilities and state-level government representatives, thus countering the paucity of statistics released by the government media outlet, Bernama (overall national figures), and published in Tourism Malaysia's *Key Performance Indicators* yearbook (overall national figures disaggregated by foreign patients' country of origin). None of these statistics, however, are to be taken at face-value. Considering the role of foreign patient statistics in the production and circulation of knowledge about IMT, the way in which they came about and the stories they are used to tell merit deeper consideration and reflection, since '[t]echniques of enumerating, tabulating and correlating' constitute cultural projects in their own right (Shurmer-Smith 2002: 97).

In spite of the multiple pitfalls of IMT statistics, I have opted to include them – if cautiously – herein in order to illustrate how such data is employed to (re)present the Malaysian industry's growth and success, given the immense explanatory authority of such comparative quantitative techniques in the globalising healthcare economy. They are employed not only to tout political successes but also as a platform upon which to base future development policy (see Chapters III and IV). As such, through the gathering of statistical data from a range of sources, I have sought to deconstruct the unified national image of Malaysia as an IMT destination produced through the release of national-level statistics by presenting the data disaggregated by region and by listing the individual hospitals that have contributed their figures since the early 2000s.²³ While the reliability of figures themselves are questionable, the broad regional trends they indicate do correlate with the claims and challenges that emerged in the interviews undertaken with stakeholders.

²³ Note that the APHM, having provided much of the statistical data, has expressly requested that I not publish the foreign patient-consumer revenue generated by each of the contributing hospitals and I have honoured their wishes.

Chapter III. Shifting subjects and territories of healthcare

3.1 Introduction

Malaysia's national oil company, Petroliam Nasional Bhd (Petronas), responsible for Malaysia's most symbolic landmark (and, albeit briefly, the world's tallest building), the Petronas Towers, came under fire in the summer of 2008 after the government significantly raised consumer petrol prices. Calls were made for transparency about its spending of revenue generated from the country's natural resources. The spotlight turned to Petronas' broad range of investments, including its development and ownership of the luxurious 'five-star' Prince Court Medical Centre (PCMC), situated on premium real estate ceded by royalty in Kuala Lumpur's Golden Triangle, not far from the Towers themselves.²⁴ The company justified an expenditure of MYR 1.2 billion (GBP 248 million) of ostensibly public money on a private hospital catering mostly to Petronas employees and a 30% foreign patient load, among them many regional elite and expats, by explaining that it was contributing to the nation's international medical travel (IMT) destination aspirations, and that, as part of its corporate social responsibility initiative, 'the aim of setting up Prince Court Medical Centre was to provide Malaysians with health services of international standard' (Bernama 25/06/2008).

IMT to Malaysia did not begin with its official inclusion in Malaysian development policy in 1998. To be sure, many Asians and Westerners had been going to Malaysia for a range of medical procedures long before. Yet, in considering what the 'extension of caring' (Barnett and Land 2007: 3) via the provision of private healthcare to non-citizens accomplishes and for whom, I argue that it was with its inclusion in this development framework that a new discursive space of IMT came into being, coming to play a prominent role in the country's development imaginary that extends well beyond its own economic contribution.²⁵ IMT has been cast in national and state-level development plans as a prime locus for government and private sector cooperation (EPU 2000: 498, 2005: 413; Rohaizat 2004: 35), present in a broad range of economic growth strategies that hinge on attracting foreign capital into the country. In these strategies, it is consistently conceived of as a 'catalyst' for the 'optimisation' of the country's related services, industries and human resources. It is regarded as a 'high-end' service that attracts 'high quality' foreign visitors and, as such, is used to justify the further expansion of the country's private healthcare system, the acquisition by private hospitals of cutting-edge technology and the need for training more medical professionals in Malaysia (EPU 2000, 2005; MITI 2006; Khazanah 2007). This move has signalled what Chee (2008: 2147, emphasis

24 See Bunnell (2006) on the 'lavish monumentality' of the Petronas Towers and Putrajaya.

25 While the government has great expectations for IMT's continued contribution to the national economy, forecasting that it will generate MYR 390 million in annual earnings by 2010, though foreign patient numbers grow steadily, the average hospital expenditure per capita remains low (Frost and Sullivan 14/04/2010).

added) refers to as 'a new phase in the development of private sector medicine... marked by a joint effort between government and private hospitals to market healthcare as a *national enterprise*'.

The national development agenda has positioned the sites/sights of IMT as nodes whose inherently transnational nature contributes to the enterprise of 'postdevelopmental' nation-building (Ong 1999). These nodes are cast as symbolic of the future in medical care, mobilised by the state to underscore the discursive 'inevitability' of neoliberal globalisation coming from outwith Malaysia to which the country must adapt in order to survive, with national success judged by the country's ability to attract foreign patient-consumers. The state's framing of IMT as an engine of development not only supports a homogeneous image of high-tech, high-quality medical care to better attract foreign exchange but also contributes towards the construction of an 'ideal' health-seeking subject. IMT is used to alter how private medical care is perceived within the country itself, part of 'strategies developed for the nation's vision of health' (NST 18/05/2002) that hinge on greater privatisation of healthcare.

This chapter focuses on IMT's contribution towards the reconfiguration of the national therapeutic landscape. I argue that the state's espousal of IMT should not be considered an outward-looking respite for Malaysians from the polemics of domestic neoliberal reform but rather a strategic platform from which to launch and entrench further systemic change to healthcare within the country at a moment in which the state has encountered obstacles to its domestic healthcare privatisation agenda. While ostensibly meant to bring the healthcare system's offerings on par with those in 'developed nations' (Cruetz and Soosayraj 14/04/2004), I suggest that foreign patient-consumers involved in IMT, cast as model neoliberal healthcare subjects embodying the values of 'flexibility, mobility and entrepreneurialism' (Ong 2006: 501), serve as symbolic capital for industry players also seeking to 're-educate' *domestic* subjects, by steering them away from reliance on a developmental state's public healthcare infrastructure and towards active engagement as responsabilised healthcare consumers in a postdevelopmental context.

To frame this argument, I first offer a reading of transformations in state discourse on healthcare, identifying three phases of care in Malaysia's history that have (re)imagined and (re)configured spaces of intervention and governable subjects in distinct ways. I start with healthcare in colonial Malaya, where a public hygiene and healthcare infrastructure set up by the British fed into a colonial hierarchy that reinforced ethnic and class-based divisions. I move on to the expansion of state-provided universal healthcare following independence, considering the ways in which healthcare provision was bound up with a broader postcolonial nation-building project that contributed to the developmental state's biopolitical construction of national borders and citizens. I then follow the state's retreat from the direct provision of healthcare through privatisation, public

healthcare finance reform and the shift in focus from the 'healthy citizen' to the 'healthcare consumer'. These three phases provide the context out of which IMT emerges onto the agenda, linking healthcare consumption with a new phase of nation-building that is articulated through acquiring international recognition.

3.2 Colonial healthcare – Subjects of the colonial economy

Under British colonial rule (1824-1957)²⁶, masses of migrant workers from India and China were brought in to sustain the colonial economy, which was based upon the labour-intensive extraction of natural resources like rubber and tin. This translated into spatialisations that constituted, segregated and reinforced ethnic divisions, with Malays largely in rural areas, Indians on large plantation estates and Chinese in plantation and mining areas, concentrated along what is today the western edge of Peninsular Malaysia, that later developed into urban areas and led to the latter's urbanisation (Bunnell 2006: 36-37). At the same time, in conjunction with the colonial administration's reliance on the traditional Malay sultanates to legitimise and extend its authority and economic interests, official recognition of an 'indigenous' Malay heritage with claims to the Peninsula privileged these 'indigenous' peoples over their immigrant counterparts. A healthcare infrastructure existed for British colonial administrators and military as well as the Malay elite in the early colonial period (1824-1874), with resources concentrated in the strategic Straits settlements of Penang, Malacca and Singapore.²⁷ Migrant workers, living in poorly-built settlements with inadequate sanitation, however, had access to treatment only if their conditions were considered potentially threatening to the productivity of the overall workforce (Manderson 1999: 103). Community-funded traditional Chinese medicine clinics were organised to respond to the dearth in care (Ooi 1991).

In the late colonial period (1875-1957), colonial/tropical biomedicine and public health measures became an integral part of the colonial infrastructure, tied up with the administration's goals to establish 'the preconditions for capitalist expansion' and to maintain the viability of its economic interests by extending 'civilising' surveillance and control over colonised populations (Manderson 1999: 104; Rajakumar 2007; Ramesh and Holliday 2001). Like other mechanisms of surveillance and categorisation, the biomedical 'gaze' (Foucault 1994) did not develop exclusively in the Western metropole and expand outwards but rather gained much from colonial 'laboratories', which served as thriving sites for developments in tropical hygiene and medicine that engaged with colonies' climates, peoples and cultures to grasp the environmental, social and cultural determinants

26 British rule followed in the footsteps of partial Portuguese (1511-1641) and Dutch (1641-1824) colonisation, which are thought to have had 'little impact' (Ooi 1991: 161) on locals beyond the Malacca Sultanate. Chinese, Malay and Arab traders have also, for many centuries prior to this, influenced and peopled the territory that today comprises Malaysia.

27 These very sites are today the privileged centres for IMT, joined in stature only by Kuala Lumpur in the Klang Valley.

of disease and illness (Arnold 1993: 14-43; Stoler 1995). While an economical 'tool of empire', the biomedical gaze was simultaneously an important part of the 'ideology of empire' (Arnold 1993: 15). In Stoler's (1995: 39) work on colonial racisms, she notes that '[a]s populations were being enumerated, classified, and fixed, "peoples" were being regrouped and reconfigured according to somatic, cultural and psychological criteria that would make... administrative interventions necessary and credible'. The body came to constitute a prime site of colonising power, with a

diverse array of ideological and administrative mechanisms by which an emerging system of knowledge and power extended itself into and over... [colonial] society, a process in many respects characteristic of bourgeois societies and modern states elsewhere in the world. (Arnold 1993: 9)

Therefore, along the course of the 19th century, concern with the lives of colonial subjects began to be not only rooted to economic and confessional interests but also entwined with liberal humanitarian ideals and morals that identified in them greater biopolitical value. As such, they became 'improvable' targets of administrative and social intervention through the extension of the gaze into increasingly intimate realms, 'tainted by racist and moral judgements [that] became a feature of the delivery of public health' (Manderson 1999: 104; Ooi 1991).

Such was the economic importance of Britain's colonies in this later colonial period that public health programmes and infrastructure (e.g., urban sanitary boards, quarantine practices, vaccination, infant and maternal health, dispensaries and medical education) were for a time more advanced than within Great Britain itself. Patient numbers multiplied with the proliferation of public facilities and Christian missionary charity hospitals (see Figure 3.1). Yet these public health measures meant to improve living standards and ameliorate the image of colonial authorities 'came too late to change the political tide' (Manderson 1999: 106). By the Second World War, British Malaya was occupied by the Japanese and the severity of the Sino-Japanese conflict meant that the Chinese, who had previously been understood as temporary migrant workers, began to have greater aspirations to settle permanently and not return to mainland China. The British colonial administration, in compensation for the anti-Japanese stance adopted by many of the Chinese during the war, sought to advance citizenship rights for Chinese and Indians equal to those of Malays in its post-independence vision of the territory. The outcry it generated among Malays, who feared becoming a minority in 'their own land', is at the root of the Malay nationalist movement following the end of the War, paradoxically drawing upon 'colonial scientific racism as the basis for communal categories and even conceptions of Malay indigenous rights' (Bunnell 2006: 38; Fenton 2003). British Malaya became the Federation of Malaya in 1948 (gaining full independence only in 1957), based upon a constitutional monarchy that featured a power-sharing structure between nine Malay sultanates. As such, though non-Malays had citizenship, they were not part of the new *de facto* Malay 'nation'. Malays, Chinese and Indians came to be represented by ethnically-segregated

democratically elected political parties that continue to dominate Malaysian politics today as part of the Barisan Nasional.

Figure 3.1 The colonial predecessor to the present-day Penang Adventist Hospital, one of Malaysia's hospitals endorsed for IMT

(image removed)

Source: Penang Adventist Hospital (2007)

3.3 Nation-building and healthcare – Patient-citizens

Though grounded in 19th century imperialist and colonialist expansion, biomedicine continues to be the dominant medical model throughout much of the world, with potent ideological links to modernity's promise of national and individual prosperity. As such, legacies of colonial healthcare have persisted through their adaptation and application to 'anti-colonial discourse' (Arnold 1993: 15) and national development programmes. Upon independence, the Federation of Malaya (renamed Malaysia after 1963 – see Figure 3.2²⁸) inherited from the British colonial authorities 'a relatively well functioning administrative structure and civil service, which extended into the public health service' (Chee 2007: 2). This infrastructure, which included sanitation, preventive health bodies and public hospitals, laid the basic foundations upon which the post-independence national healthcare system was built. Yet the new postcolonial state was also deeply entrenched in the ethnicised politics consolidated under British rule and heightened by the Japanese occupation during the Second World War, the Emergency guerrilla war (1950s) and the Sino-Malay ethnic riots (13 May 1969).

Differences in class and ethnic origin had been so salient to the organising structure of colonial society that they were played out in the distribution of healthcare, from the location of facilities to differential access to them to the segregation of hospital wards (Manderson 1999: 103). The new postcolonial state's promise of universal access to healthcare to its citizens, therefore, proved a significant tool in countering these differences and generating national unity (Chan 2000). Chee (2008: 2148) tempers this with the observation that

the Malaysian state's investment in healthcare stems from a calculated pragmatism that [has] require[d] it to cater to its electoral constituency rather than from any ideological adherence to welfarism or social partnerships.

28 Malaysia, in terms of the territory it holds today, has existed since 1965. Singapore, Penang, Malacca, Labuan and Dindings became British Straits Settlements in 1824, with the Anglo-Dutch Treaty. Following the Second World War, Penang, Malacca, Labuan and Dindings came together with the Malay Peninsula in 1946 to form the Malayan Union, which would in 1948 become the Federation of Malaya. Meanwhile, Singapore acquired Crown colony status. The Federation of Malaya was granted independence from Great Britain in 1957. In 1963, Singapore and the two north Borneo states of Sabah and Sarawak, which had been British protectorates, united with the Federation to become Malaysia. Two years later Singapore separated and became independent, giving Malaysia its present-day borders.

This pragmatism was deemed essential in the wake of the Emergency when the new government sought to allay socialist sentiment and glean much-needed legitimacy from the satisfactory extension and provision of essential social services, like healthcare and education, to the entire population. Consequently, heavy investment was made to develop healthcare infrastructure across the country, ensuring adequate access to quality care nearly free of charge for urban and rural populations alike.

As with the colonial government before it, the new state's concern with its subjects' health was similarly rooted to their capacity to contribute to the development of the new national economy. Correspondingly, great achievements in population health, characterised by dramatic improvements in the prevention and treatment of vector-borne disease, the infant mortality rate and life expectancy – all classic variables used in assessing a country's level of development – were made. These efforts, combined with vigorous growth in income, industrialisation and urbanisation (Chee 2008; United Nations 2003), brought national health statistics to levels comparable to those of 'developed' countries by the early 1980s. Such impressive results were achieved, in spite of comparatively low state spending on healthcare in proportion to the country's GDP (<2%)²⁹, that an IMF health economist considered the Malaysian healthcare model 'extremely effective' in providing care across ethnic lines and the urban/rural divide (Heller 1982, in Chan 2000: 5; EPU 1995: 538; Ramesh and Holliday 2001).

Figure 3.2 Peninsular and East Malaysia, by state name

(image removed)

Source: CIA (1998)

The Malay-dominated government's endorsement of citizens' universal access to healthcare starkly contrasted with policies that perpetuated ethnic categories and further segregated them along ethnic lines. From the time of British colonisation until the 1970s, the economy had been rooted in the exportation of primary commodities. The first decade following Malaysia's independence was characterised by a nation-building agenda that was honed to the heartland of the government's political support and concerned with rural development (e.g., credit, business training and redistribution of land favouring rural Malays) and largely *laissez-faire* in regard to the private sector, maintaining an 'open-door' policy stance for foreign capital (Bunnell 2006: 40; Khoo 2003). Though Malaysia was politically independent, its economy continued to be dominated by foreign interests, with 63% of equity held by non-Malaysians. It was in the wake of the 1969 Sino-Malay

²⁹ It was a still low 4.3% in 2006 (WHO 2008).

ethnic riots that the government stepped in to firmly intervene, with a far-reaching policy instrument ostensibly intended to do away with poverty and ethnic inequity by levelling out highly spatialised and ethnicised socio-economic imbalances that had favoured foreign capitalists and an economically powerful urban Chinese minority. Launched in 1970, the New Economic Policy (NEP) was understood as a postcolonial 'response to discontent among the majority Malays..., with their lack of ownership and control of the economy, and with the slow pace at which economic development had delivered any gains to them' (Chee 2008: 2149).

The NEP prescribed a series of direct redistribution and positive discrimination policies and quotas in business, the civil service, higher education and property designed to foster greater economic standing among the *bumiputera* ('sons of the soil', denoting an ethnicised category comprising Malays and groups indigenous to the Malay Peninsula, Sabah and Sarawak). Countering the country's previous openness to foreign capital, the NEP was envisaged as a temporary 'social contract' meant to ensure 'intercommunal harmony' by redistributing economic ownership from the 2.4:33:63 ratio for *bumiputera*, other Malaysian and foreign equity to a 30:40:30 ratio. Its effects were further bolstered by controversial policies (e.g., 1971 National Cultural Policy) that enshrined ethnic Malay privilege and emphasised the primacy of 'indigenous' Malay language and Islam over the diversity of cultural, religious and linguistic practices among the country's other ethnic communities, exacerbating ethnic segregation within the country. With these policies, the government effectively subsidised the development of an educated ethnic Malay middle class that, though venturing into the private sector, came to be disproportionately employed by the strong centralised state's expanding bureaucracy.

3.4 Neoliberalism and healthcare – Responsibilised healthcare consumers

In line with a developmental state strategy, Malaysia's highly centralised government assumed a strong role in driving national economic and social modernisation (Bunnell 2006: 21). As a result, the economy began to diversify and grew rapidly throughout the 1970s, due to an increase in manufacturing and services as well as the export of oil and palm oil, commodities that came to replace tin and rubber. The government began to open up to foreign capital once again in controlled areas of 'graduated sovereignty' (Ong 1999), which led Penang's Bayan Lepas to become home to the country's first Free Trade Zone (FTZ) in 1972 in which multinational corporations concentrated labour-intensive manufacturing industries (largely in electronics) (see Chapter VI).

At the same time, Verma (2004: 151) observes, 'after a decade of the NEP, state economic interventionism had led to the proliferation of nonfinancial public enterprises characterised by inefficiency, lack of accountability and poor management'. In response to this, within the first years

of Mahathir Mohamad's term as Prime Minister (1981-2003), a neoliberal agenda began to reshape national development policy with a view to

facilitate the economic growth of the nation, relieve the financial and administration [*sic*] burden of the Government, reduce the Government's presence in the economy, decrease both the level and scope of public spending and to allow market forces to govern economic activities and improve efficiency and productivity. (EPU n/d)

Underscoring the importance of the private sector's contribution to the growth of the national economy, the government ushered in a range of measures (e.g., Malaysia Incorporated Policy) that encouraged the 'corporatisation' and privatisation of state assets and permitted increased FDI in private entities.

This move marked a shift in focus from a more inward-looking, ethnically-based and territorially-bound discourse of 'national development', concerned with 'homogenising spatial practices on a national scale' (Bunnell 2006: 25), to a 'postdevelopmental state strategy' (Ong 1999). The latter implies a different type of state engagement, characterised by governments

ced[ing] more of the instrumentalities connected with development as a technical project to global enterprises but maintain[ing] strategic controls over resources, populations and sovereignty. (Ong 1999: 21)

This signalled the advent of a different spatialisation of development, one concerned with other scales, particularly urban and (increasingly transnational) regional nodes through which to connect to lucrative globalised networks and markets. The Malaysian government's new postdevelopmental agenda sought to break with the past by streamlining the state, strengthening partnerships with the private sector and opening up further to foreign capital flows (EPU 1995: Chapter 7) – though the transition from a developmental to a postdevelopmental strategy has been neither linear nor complete.³⁰

The new agenda did not trump the country's ethnicised politics. Rather, it was used as a vehicle through which to increase *bumiputera* participation in the private sector, evidenced by the requirement that at least 30% of state assets sold off were to go to *bumiputera*. In practice, this meant that the Malay-dominated government was able to establish a patronage system through which it could foment strategic public-private sector relations that would secure its claims to power. These 'smart partnerships' were a vehicle for perpetuating 'mutual dependence between the business elite and the political rulers' (Chee 2008: 2150). By the 1990s, the country, along with others in the region, became a model 'Asian tiger' economy through its success with manufacturing. Industrialised and attracting FDI with its high rates of growth, Malaysia acquired 'upper middle

30 For instance, while Malaysia's postdevelopmental strategy began to take shape starting in the early years of Mahathir's rule, the state also experimented with a range of typically developmental interventions (e.g., National Car Policy).

income economy' status. Yet the goal for *bumiputera* to hold 30% of the country's equity had not been realised. The NEP was replaced by the National Development Policy (NDP, 1991-2000). Its ethnicised redistributive goals were maintained, though now pursued through neoliberal channels that sought for *bumiputera* to not only hold onto a sufficient amount of assets but also to hone the 'quality of [their] participation' and improve their profitability (Khoo 2003: 20; Jomo 2004).

'Statist' capital investment over time has been complicated and partially substituted by 'rentier/cronyist' and transnational investment (Chee 2008: 2146). Transformation within the Malaysian healthcare system is linked to the 'contending social and political forces' reflective of the country's ethnicised politics which have steered 'ownership interests' in the domain of healthcare over the 50 years since independence and parallel broader changes in the pursuit of economic development over time (*Ibid.* 2008: 2146). Healthcare privatisation coincides with these ownership trends. Malaysia's healthcare system today would be best described as a 'mixed public-private system', with the majority of primary care provided by the private sector and the public sector predominantly responsible for tertiary care. There are, however, significant imbalances when it comes to specialised care that render the private sector even more prominent (Barraclough and Phua 2007). For instance, approximately three-fourths of all registered medical specialists are concentrated in the private sector (Devaraj 2009; EPU 2000). While taxation was long the main source of healthcare funding, private funding (e.g., insurance and out-of-pocket expenditure) became increasingly relevant in correlation with neoliberal reform in the 1980s. By 2002, for example, private spending came to account for 46.2% of total healthcare expenditure (Chee 2008: 2148).

While the state remains today the central figure in healthcare regulation, financing and provision, over the last two decades it has stepped away from welfarist policies and towards fostering the role of privatised healthcare providers. As a result, the Ministry of Health (MOH) spins an ever-larger number of plates: maintaining a public system whose object is to ensure universal access to basic healthcare, protecting the population from endemic disease and potential epidemics (e.g., SARS and H1N1) and, at the same time, acting as a regulating body to ensure the quality of the human resources, facilities, practices and outcomes in both the public and private sectors (see Chapter III). While the Malaysian government has formally espoused a neoliberal doctrine, it – like many other countries – has encountered difficulties in applying it to the sensitive issue of healthcare (Arunanondchai and Fink 2007). Chee (2007: 1) suggests that, because Malaysia is '[a] larger country, with a more differentiated population and a more complicated polity, the Malaysian state has been less able to make drastic changes to its healthcare system despite its intentions and avowals'. Therefore, in contrast to the Singaporean government, which asserted early on that it was not a

welfarist state and swiftly corporatised and privatised healthcare, Malaysia's disengagement has been more measured, complicated by popular dissent in light of the centrality of universal healthcare to citizens' sense of national belonging.

Table 3.1 Growth in GDP per capita and in private hospital beds (1980-2003)

Year	GDP per capita (PPP) (USD 2005)**	Private hospital beds (% of total)*	Year	GDP per capita (PPP) (USD 2005)**	Private hospital beds (% of total)*
1980	2178	1171 (5.8%)	1992	5433	
1981	2484		1993	5947	5799 (18.2%)
1982	2721		1994	6460	6492 (19.7%)
1983	2927		1995	7054	7192 (19.4%)
1984	3187		1996	7706	7471 (21.5%)
1985	3164	3666 (14.5%)	1997	8199	8963 (24.7%)
1986	3188		1998	7493	9060 (25.1%)
1987	3364		1999	7880	9098 (21.1%)
1988	3728		2000	8570	9547 (21.9%)
1989	4113		2001	8619	10,348 (28.4%)
1990	4536	4675 (15.1%)	2002	8951	9849 (n/a)
1991	5008	4898 (15.7%)	2003	9468	10,405 (26.7%)

Source: * Chee (2008: 2147), Chee and Barraclough (2007b: 24), EPU (1995: 540; 2001: 486); ** CIA (2009), Nationmaster (2009)

The path towards the privatisation of healthcare in Malaysia began already in the 1980s, with a rapidly expanding private hospital sector that saw a nine-fold increase in private hospital beds within a decade (Chee and Barraclough 2007b: 24; Chee 2008) (see Table 3.1). Yet it was only by the 1990s that the state took definitive steps to retreat from its role as principal healthcare provider. Its focus began to shift towards promoting greater 'integration' and 'smart partnerships' between the public and private sectors. Taking its cue from broader neoliberal processes, the MOH laid out its 'Vision for Health' in order 'to support actively the Government's national development effort and to contribute to the economic well being of the country' (Rohaizat 2004: 36). The objective was

to develop a nation of healthy individuals, families and communities, through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer-friendly, with emphasis on quality, innovation, health promotion and respect for human dignity, and which promotes individual responsibility and community participation towards an enhanced quality of life. (*Ibid.* 2004: 35)

This transition, however, has been far from smooth, as healthcare providers and recipients alike have been 'required to assimilate new values, attitudes and behaviour[s]... [and to] overcome the resistance to change' (*Ibid.* 2004: 40). Symbolically, aspects of healthcare provision once important to the task of nation-building, such as public healthcare facilities in rural areas³¹, fall to the wayside

³¹ The facility to population ratio in rural areas has gone into decline (EPU 2005: 417). Furthermore, as private

as the government repositions itself as 'provider of last resort' and shifts support to the privatisation of the healthcare system (Chan 2000: 3).

Civil society and professional groups supporting the continuation of public healthcare have joined up with medical professionals and consumer rights associations calling for equitable and affordable access to healthcare for all. The Malaysian Medical Association (MMA), the Citizens' Health Initiative (CHI), the Coalition Against Healthcare Privatisation (CAHP), the Consumers' Association of Penang (CAP) and the Federation of Malaysian Consumers' Associations (FOMCA) have all taken critical stances, demanding the right to participate in rare government-organised public forums/consultations in order to voice concern and temper the terms of new policies geared towards the 'inevitable' further privatisation of healthcare. These acts of resistance emphasise the contribution that public healthcare provision has made to Malaysia's overall nation-building project, underscoring how it serves doubly as protection for all socio-economic levels of its populace, irrespective of ethnicity, and as a symbolic indicator of the country's overall level of development.

Four strands of healthcare reform meant to advance in parallel with one another (Chan 2000) indicate the direction of the government's scaling-back efforts to partially relieve itself of its care-derived financial 'burden'. Firstly, an alternative healthcare financing scheme proposes to shift patients from an 'overloaded' public system to private healthcare facilities. Secondly, essential medical and non-medical services in government-owned hospitals are to be farmed out to private companies. Thirdly, government-owned hospitals are to be corporatised and new and existing private healthcare facilities to be fostered via tax incentives. Finally, citizens are to be recast as healthcare consumers. I briefly describe each of these four strands below.

Still in the early years of PM Mahathir's regime, the government first let its concern with the rising costs of healthcare be known. The Midterm Review of the Fourth Malaysia Plan (1981-1985) called for alternative modes of healthcare financing, and a resulting study suggested the implementation of a mandatory, sliding-scale, income-based social health insurance scheme, dubbed the National Health Security Fund. The Fifth Malaysia Plan (1986-1990) made explicit mention of the proposed fund, along with the government's intentions to contract private companies for the supply of certain healthcare-related services and identify further services that could be privatised (Chee 2007: 5). Thus began the 'dismantling [of] the public healthcare sector out of an obsessive faith that market-based solutions will invariably deliver higher efficiency and lower unit costs' (Chan 2000: 6). In the spirit of promoting what is referred to repeatedly in development

facilities concentrate in urban areas to benefit from sufficiently large and profitable catchments, and given the high concentration of doctors in the private sector, privatisation has aggravated an already unequal distribution of healthcare services and shortages of medical personnel (EPU 2000: 486-489; Lim 16/12/2006). In 1999, some 97.8% of private facilities were located in urban areas (EPU 2000: 486).

policy documents as ‘greater cooperation’ between the public and private sectors, and ostensibly meant to increase the efficiency of hospital services, long-term concessions were granted in the scope of the Sixth (1991-1995) and Seventh (1996-2000) Malaysia Plans in tendering processes that favoured government-linked companies for the provision of essential healthcare-related services (e.g., government drug procurement and distribution, facilities management and maintenance for government-run healthcare institutions, and health screenings of foreign workers) (EPU 2000: 486). At the time of what has been referred to as ‘the largest privatisation exercise ever in hospital support services’ (Chan 2000: 4) in Malaysia, some of these services accounted for at least 14% (MYR 143 million) of the MOH’s budget. The government was to spend more than treble that amount (MYR 468.5 million) on them only a year later, ‘with no commensurate expansion of services or improvements in quality’, and the privatisation of the government’s medical stores, responsible for the procurement, storage and distribution of pharmaceuticals and medical supplies, led to similar increases in pricing (*Ibid.* 2000: 4).

Corporatisation began in 1994. The National Heart Institute (IJN – *Institut Jantung Negara*) and some public teaching hospitals underwent this ‘change in status from a governmental department to a free-standing corporate entity with substantial operational and financial autonomy, typically non-profit and fully government owned’ (Chan 2007: 98). This was ostensibly meant ‘to expand and provide better services... as well as to attract and retain experienced medical personnel’ (EPU 1995: 540). Since corporatised facilities charge fees that approximate the real operating costs for care provision, the logic here is that doctors’ salaries can improve and, therefore, they will be willing to stay and not migrate to the fully private sector.³² The Seventh Malaysia Plan (1996-2000) laid out an agenda for the further corporatisation and privatisation of public healthcare facilities (EPU 1995: 533), suggesting that the implementation of a new healthcare financing scheme could ‘provide the funds for the higher user charges at corporatised government hospitals, and could also lead to an expansion of usage of private healthcare’ (Chee 2008: 2154). Yet, both corporatisation and the proposed healthcare financing scheme have been received by an ambivalent public, many seeing it as an intermediary step towards fully privatised healthcare (Quek 2009b). As a result of public outcry and in light of the difficulties encountered by private healthcare providers to stay afloat during the 1997 Asian Financial Crisis (AFC), the proverbial wind was taken out of the sails of government efforts towards further privatising an already dual-tiered system. By 1999, the MOH was forced to put its corporatisation agenda on hold (MMA 1999: 24).

32 Corporatised healthcare facilities do not receive operating funds solely from private sources. Rather, the government draws from the National Health Fund to partially (though, unlike with public facilities, not fully) subsidise treatment for citizens financially unable to cover the higher fees.

From the time the government made its first gestures towards healthcare reform to the present, it is estimated that healthcare spending in the country has increased ten-fold (Ooi 16/09/2006). Because of this pressure, the government has dedicated greater and more urgent attention to consolidating the health services provided by the public and private sector. With the National Health Insurance Scheme (formerly the National Health Financing Scheme) likely to come to fruition in the coming years, the MOH – while it felt the need to dissipate doubt in the Ninth Malaysia Plan that it would ‘continue to be the lead agency and the main provider of healthcare services for the nation’ (EPU 2005: 434) – will gradually continue to ‘reduce its role in the provision of health services and increase its regulatory and enforcement functions’ (EPU 1995: 544) as it makes individuals more responsible for pursuing their own healthcare solutions. As such, patients are increasingly cast in the neoliberal terms of ‘clients’ and ‘customers’ for which the MOH exists more so to protect through regulation than to provide through direct service provision (see Chapter III). Furthermore, over the last 15 years the MOH also increasingly has become a customer in its own right, not only by outsourcing hospital services to private businesses but also, within a framework of ‘complementarity’, by sending public sector patients to private hospitals and practitioners for certain diagnostics and procedures for which public facilities and personnel are not suitably equipped (EPU 1995: 549, 2005: 420, 431). Therefore, by the Eighth Malaysia Plan (2001-2005), some 20 years and four Malaysia Plans after initial concern was voiced for the future of public healthcare spending, the National Health Financing Scheme was touted as ‘provid[ing] *consumers* with a wider choice in the *purchase* of health services from both public and private sectors’ (EPU 2000: 495, emphasis added). The Ninth Malaysian Plan (2006-2010) went a step further, asserting that the scheme would ‘further enhance accessibility and equity for the people’ (Ooi 16/09/2006).³³

This about-face has thus set up a rivalry between public and private care provision, casting the private sector as the desirable healthcare model to follow, with public facilities framed as the cash-strapped ‘laggards’ forced to play catch-up since ‘[t]he private establishments’ high standards and cutting-edge technology seem to be the yardstick’ (NST 20/04/2009) against which to measure quality healthcare provision. Prince Court Medical Centre’s CEO Stuart Rowley’s comments are illustrative of this:

We [the private sector] implement designs in our hospitals and when these standards are viewed by the Health Ministry, it gets implemented for their new systems. (Rowley, in NST 20/04/2009)

The Coalition Against Healthcare Privatisation (CAHP), however, finds the situation ironic:

33 A new study was called for to indicate how to finally implement the scheme. Recommendations were presented to the government towards the end of 2007 but not released to the public. In 2008 the new Health Minister Liow Tiong Lai voiced interest in opening debate on the scheme’s future to a public forum but, to date, this has not occurred.

There is an over-emphasis on economic incentives and ‘market discipline’ in the healthcare financing scheme... Instead of going down [that] path, the government should improve state-run hospitals, which have been undermined by the promotion of for-profit private hospitals since the 1980s... The weaknesses that have developed in the welfarist model were not internal to the model, but were brought on by the promotion of for-profit private hospitals on a large scale since the 1980s... It is indeed ironic that free-market solutions are being suggested to solve problems that originated from the implementation of free-market policies in the healthcare sector 25 years ago! (Devaraj 17/07/2007)

Whereas the public healthcare system had been praised in the past for its contribution to Malaysia’s overall development (e.g., via the extension of care services into rural areas, declining rates of infant mortality and increases in life expectancy), private healthcare now takes the lead in a context in which public health concerns have changed along with the growth of the Malaysian middle class. An earlier focus on sanitation and control over contagion³⁴ has shifted to preventive healthcare measures regarding lifestyle-induced and chronic illnesses (Li 07/01/2010). The government has therefore endorsed ‘a shift from the traditional focus on providers, facilities and illnesses to *consumer empowerment*, health promotion, lifelong wellness as well as disease prevention and control’ (EPU 2005: 413, emphasis added), which, as discussed in Chapter I, translates into a different type of surveillance medicine.

With private healthcare providers taking the reins in benchmarking healthcare delivery in the country (see Chapter IV), a clear message is sent out that the public healthcare sector is ‘struggling’ to provide universal care almost entirely free of cost because it is discursively ‘overburdened’ by the weight of the masses who can afford to take care of themselves elsewhere, even though the government has made little effort over the years to increase taxation and user fees to mitigate the problem (Quek 2009b). Those who can afford to pursue private healthcare are encouraged to do so in order to ‘relieve’ the national system of its burden. As such, the state has increasingly cast unhealthy people for whom it is obliged to provide care as ‘taking advantage’ of the public healthcare system, responsible for ‘draining’ resources away from those ‘in need’. The tenets of universal entitlement, so useful for an earlier phase of nation-building, have made way for a neoliberal rhetoric that recasts ‘welfarism’ as a ‘charity’ reserved for the ‘truly disadvantaged’. Thus, as the state abandons its ambition to act as a safety net for all and retreats from its provider role, Malaysian individuals, families and communities are increasingly ‘empowered’ to assume a more

34 The government continues to struggle to combat stereotypes of a tropical developing country. In response to a 2007 Australian travel advisory cautioning its citizens about the risk of dengue fever in Malaysia, the Malaysian Health Minister criticised the Australian government (which did not issue a similar advisory on Singapore), ‘They are not well-acquainted with conditions in countries like Malaysia, where dengue is endemic. Their warning is not based on facts and knowledge of the situation here’ (NST 21/07/2007). Malaysia has nearly eradicated malaria (though Indonesian construction workers are blamed for carrying new strains into the country), but – as evidenced in recent years – it remains vulnerable to threats like A(H1N1), SARS and avian influenza.

proactive role to not only maintain but also 'enhance their overall health and well-being' as responsabilised healthcare consumers (EPU 2005: 426). Stressing that 'health does not entirely depend on health services alone' (Rohaizat 2004: 36), Tan Lee Cheng of the MOH's Corporate Policy and Health Industry Division suggests:

The lesson we want to impart to the general public is that healthcare is *your* responsibility. You must start to take care of your health. You cannot rely on the government to take care of your health. It doesn't work that way. (Tan interview, 17/01/2008)

Her comments are illustrative of the role this drive towards health promotion and community participation plays in the crafting and governing of a new type of ideal healthcare-seeking subject in Malaysia.

3.5 Globalisation and healthcare – International medical travellers

The liberalisation of services and integration into the global marketplace constitute one of the principal strategies for Malaysia's ascent along the 'ladder of development', from a 'middle income' to a 'high income' country. National economic prosperity has been argued to have led to greater focus on the country's bright future and its widely-felt benefits to have progressively diminished interethnic recrimination. There was growing interest in 'discarding a past and inward-looking obsession with ethnic divisions [in favour of] adopting an outward oriented strategy of "harmonising our entire country [Malaysia] with the global forces"' (Khoo 2003: 35). With the NDP's predecessors, the National Vision Policy (2000-2010) and Vision 2020, endeavouring to 'establish a united, progressive and prosperous *Bangsa Malaysia* [Malaysian nation]' (EPU 2000: 4) instead of perpetuating the privilege of the *Bangsa Melayu* ('Malay nation'), the government sought

to instil a sense of common identity and national pride built upon Malaysia's heritage and past achievements as well as to harness and optimize existing potential. This sense of common identity and shared purpose continues to be crucial to nation-building and capitalises on the strategic value of Malaysia's multiethnic status in a globalising world. (*Ibid.* 2000: 19)

This move towards what Hilley (2001: 131) calls 'a more inclusive concept of community' essentially aimed to redraw the ethnicised biopolitical contours that have so profoundly shaped the direction and the subjects of 'national development'. The objective was no longer only focused on making the *bumiputera* competitive within their own country and among their own countrymen and women. Rather, it was for all Malaysians, regardless of ethnicity, to contribute towards the government's aspirations for Malaysia to reach 'developed' country status by the year 2020 (Vision 2020) (Khoo 2003; cf. Edwards 2008 for a discussion on similar approaches in India). Within the context of globalisation, 'Bumiputeraism was becoming an anachronism', and the shift in development policy and biopolitical value 'offered a new millennial context within which to address and manage these

changes: a new type of nationalist project for a new international age' (Hilley 2001: 131). In a historic step taken within the context of further implementing the ASEAN agreement on the liberalisation of the services sector, in April 2009 the Malaysian government withdrew the 30% *bumiputera* equity requirement for 27 services sub-sectors that included health and social services, tourism, transport, business and computer-related services.³⁵ It is with this final move towards the end of the *bumiputera* welfare state that, '[d]espite being part of many discussions at international levels, including ASEAN and the WTO (World Trade Organisation), Malaysia is seen as last in terms of having an open market' (International Trade and Industry Deputy Minister Mukhriz Mahathir, in *NST* 27/04/2009).

With this fundamental shift in the country's broader development framework and its expression in the national healthcare system, international medical travel (IMT) entered the national development agenda. Throughout the 1990s Malaysia had been seen as an Asian 'economic miracle', attracting ample FDI. Floating buoyantly on a strong wave of economic growth that doubled GDP per capita from 1989 to 1997 (see Table 3.1), the government furthered privatisation of the country's healthcare system. Yet, as in the case of Thailand (Janjaroen and Supakankunti 2002; Vijaya 2010; Whittaker 2008), the 1997 Asian Financial Crisis (AFC) crippled the private hospitals that had proliferated across the 1980s and early 1990s, leaving them in a state of underutilisation, as cash-strapped citizens turned once again to the public healthcare system for treatment. Only months after the start of the AFC, 'health tourism' was proposed by the National Economic Action Council (NEAC), as a way to bring about economic recovery and sustainable post-crisis growth in Malaysia. This reflected the Prime Minister Mahathir's call for a measure of interventionism so as to 'avoid the tyranny of free markets': 'Globalisation, a borderless world, is already a fact...', he observed, 'But the fact that globalisation has come (and is apparently irresistible) does not mean we should just sit by and watch as the predators destroy us' (Mahathir 2002: 148). The national economy was discursively cast as a victim of predatory and unethical proponents of liberalisation and free trade, leaving the state to step up as the player most apt to best defend its people's interests and rebuild the economy through an alternative engagement with global capital.

Contrasting with the optimism of the Seventh Malaysia Plan (1996-2000) that took ambitious steps towards privatisation, policy following the AFC was more cautious. With 'corporatisation' efforts and healthcare finance reform temporarily on the backburner due to popular protest, IMT was primarily introduced to achieve two urgent principal objectives: firstly, to assist private hospitals that had suffered lower domestic patient numbers and higher pharmaceutical and supply costs as a result of the AFC by encouraging the entry of foreign patient-consumers willing and able to pay

³⁵ It was retained in areas of heavy state involvement or classified as politically sensitive (e.g., utilities and air transport).

premium private hospital fees and, secondly, to bolster tourism industry income, operating off the logic that foreign patient-consumers and those accompanying them stay longer in Malaysia than other more conventional tourists (Whittaker 2008; Anonymous Malaysian governmental tourism representative interview, 24/01/2008). The Eighth Malaysia Plan (2001-2005) then marked the first appearance of the phrase 'health tourism' in a national economic development instrument³⁶, framing the exportable service as an economic growth catalyst useful in fostering the transition to a knowledge-based economy, evidence of the continued 'interfacing [of] national developmental priorities with changes in the global structure of production' (Khoo 2003: 32).³⁷ Within the scope of the government's 'wider effort to reduce the country's over-reliance on manufacturing' (Tata 2007: 25), the service sector was emphasised as strategic in fostering economic growth that would help to keep manufacturing from entering into decline through its strengthening of inter-sectoral linkages (Hong Leong Bank 2006).³⁸ Healthcare services in particular were considered a strong 'growth area' due to three factors: firstly, the rising domestic income and education levels that would 'increase consumer awareness of healthcare services' (EPU 2006: 557); secondly, the future adoption of a national health insurance scheme; and, finally, the increasing demand for healthcare services by foreigners.

Following the National Economic Action Council's (NEAC) recommendation for IMT to enter the agenda in early 1998, the National Committee for the Promotion of Health Tourism in Malaysia (NCPHT)³⁹ was set up to promote Malaysia as a 'centre of medical excellence' (Chua 11/04/2002) that would 'further raise the standards of care and of the caregivers' (Tata 2007: 24). It brought together a range of institutional bodies to accomplish this: the MOH, the Ministry of Tourism, Tourism Malaysia (the Ministry of Tourism's unit charged with carrying out promotional ground-work), the Ministry of International Trade and Industry (MITI), the Malaysian External Trade Development Corporation (MATRADE), the Association of Private Hospitals of Malaysia (APHM), the Malaysian Association of Tour and Travel Agents (MATTA) and the Immigration Department. The NCPHT began by formulating a strategic plan of action for the promotion and development of 'health tourism' in the country, which hinged on public-private partnerships and the forging of

36 However, the Seventh Malaysia Plan (1996-2000) had already earmarked the corporatised National Heart Institute (IJN) 'as a service for export to meet the rise in demand from neighbouring countries' (EPU 1995: 549), though this was done in an isolated manner without including other national medical facilities as well.

37 It was later further enshrined as a pillar of development in the Ministry of Finance's Economic Report (2009-2010), the Ninth Malaysia Plan (MP9, 2006-2010), the Third Industrial Master Plan (IMP3, 2006-2020) and the Tenth Malaysia Plan (MP10, 2011-2015).

38 Of the IMP3's 20 target growth industries to promote and develop, eight were in the services sector: business and professional services, logistics, ICT services, distributive trade, construction, education and training, healthcare services and tourism services.

39 The Committee was later renamed from the 'National Committee for the Promotion of Medical and Health Tourism in Malaysia' (NCPHT) to the current National Committee for the Promotion of Health Tourism in Malaysia in 2001.

‘strategic alliances and linkages with renowned overseas centres of excellence for mutual benefit’ (Chua 11/04/2002; MOH 2002).

By 2002, subcommittees had been organised to set up guidelines for IMT in five areas: identify suitable sending countries, formulate fiscal incentives for the development of private healthcare, design fee packages, come up with accreditation principles and lay out an advertising strategy (MOH 2002: 106). Underlying their choices was the objective of framing Malaysia as a ‘value for money’ destination to tap into a transnational bourgeoisie and not the up-market foreign patient-consumers already targeted by Singapore, a strong regional competitor. Sending countries to be targeted were selected and classified into four market segments (Chee 2007: 10; MOH 2002), corresponding to the country’s broader foreign and domestic policy and economic interests (see Chapter V). The advertising strategy was to be largely private sector-led, with the government bolstering their efforts by promoting Malaysia, an entire country, as an IMT destination at international trade missions and fairs as well as with an IMT-specific nation-branding campaign. Immigration procedures for foreign patient-consumers were simplified, leading to Fast-Track Clearance⁴⁰ and the introduction of a six-month IMT in-country visa extension (Bernama 08/01/2008; Kanapathy 2003). Tax incentives were granted to private hospitals in return for their promotion of IMT, which included the Industrial Building Allowance for hospital facilities, service tax exemption for expenses derived from medical advice and the use of medical equipment, income tax deductions for expenses on pre-employment training and the promotion of exports, fiscal incentives for investment in information technology and the latest medical equipment, and incentives for attaining internationally recognised accreditation (Bernama 23/10/2009; EPU 2006: 589; MOH 2002: 107). The acquisition of internationally recognised accreditation was encouraged, with an initial push towards ISO standards that was later replaced by pressure to adhere to the national Malaysian Society for Quality in Health (MSQH) and Joint Commission International (JCI) accreditation schemes (see Chapter IV). Two national-scale IMT ‘packages’ were also launched: the ‘Disease Paradigm’, for patient-consumers with already existing conditions, and the ‘Wellness Paradigm’, consisting of gender-specific health screening packages aimed at disease prevention and ‘lifelong wellness’ practices, in keeping with Malaysia’s Vision for Health. Ranging in price and composition, these ‘paradigms’ were to be set by medical facilities and medical travel facilitators themselves, though the NCPHT recommended a fee cap ‘to ensure that tourists coming to Malaysia for medical reasons get value for their money’ (*Healthcare International* n/d).⁴¹

40 Hospitals planning to receive foreign patient-consumers need to inform the Immigration Department at any point of entry to Malaysia at least three days prior to arrival (Tourism Malaysia 2008a).

41 The same screening packages were launched at a lower price for local Malaysians in order to make it attractive and accessible to the domestic private healthcare market.

Due to the combination of a lack of sustained, dedicated ministerial leadership,⁴² disagreement over how to conceptualise and promote 'health tourism',⁴³ and the political sensitivity surrounding the MOH's promotion of private hospitals and care for non-citizens, official support for IMT succumbed to the 'policy inaction' characteristic of the government's steps towards the privatisation of healthcare in Malaysia (Chee and Barraclough 2007), translating into a tacit dearth of regulation of the sector instead of its organised endorsement.⁴⁴ Thus, though IMT has been invoked in numerous government development plans as a desirable catalyst for regional and national growth, it has been largely left up to the private sector to steer the emerging industry and to contribute towards the nationally-defined, though vaguely interpreted, objectives of promoting 'Malaysia' as an IMT destination. Over the last decade, individual private hospitals have been largely responsible for devising and funding their own IMT marketing endeavours, only turning to MATRADE for international networking assistance in trade missions and the Ministries of Health and Tourism for participation in trade fairs. Yet destination marketing for IMT to 'developing' countries differs with that in 'developed' countries, where there are fewer negative stereotypes about medical care to dispel. An anonymous major Malaysian hospital group management representative responsible for improving the group's image abroad (interview, 18/12/2007) explains:

What is lacking is the branding of Malaysia's healthcare. People need to have confidence in your country for healthcare. Only then will it come to which hospital they want to go to.

Since Malaysia has not achieved 'developed' status, the success of the IMT industry is thought to depend on how prospective patient-consumers perceive the overall quality of medical care and associated services in *Malaysia* before seeking out individual hospitals.

While this public-private sector arrangement is 'in keeping with the policy of Malaysia Incorporated, under which the government encourages a partnership approach with private capital to further national economic goals' (Chee and Barraclough 2007b: 28; see Gonzales 26/11/2009), private-sector interviewees repeatedly emphasised that the government's hands-off attitude had not been beneficial to the development of the industry, to the point of hindering the ability of

42 The MOH stood at the helm of the NCPHT from the start, chaired by Health Minister Chua Jui Meng (1990-2004) who was eager to see the IMT industry develop. Ministerial interest reportedly waned when the bar was passed to Chua Soi Lek (2004-2008), though it revived with the new Health Minister Liow Tiong Lai (2008-present).

43 In spite of the development of concrete guidelines for promoting 'health tourism', there was contention over just what it was in the first place, with divergence in the conceptualisation of 'health tourism': should the *health* or the *tourism* aspect prove more central? After establishing its Corporate Policy and Health Industry Division in 2005, the MOH came to assert greater influence, as the basic mechanics of IMT (save its successful promotion abroad) were framed as ultimately not that different from the regulation and monitoring of the privatisation of care provision for Malaysian citizens already under way.

44 Indeed, interviews with representatives of the many institutional members of the NCPHT rarely referred to it, speaking (when they did at all) of it in the past tense, thus indicating the NCPHT's waning relevance today following on its early fundamental work in setting up the industry's 'national' IMT framework.

'Malaysia' to compete with its regional rivals and global IMT heavyweights, Singapore and Thailand, which is indicative of the extent to which even individual industry players see competition in *international* terms. Such a national-scale project demands a high level of coordination and cooperation as well as significant financial investment in order to render personnel and facilities 'world-class'. The centralised national promotional model of SingaporeMedicine, a 'multi-agency government-industry partnership' launched in 2003, was widely seen in interviews as a model to emulate in order to produce a more unified national therapeutic landscape (SingaporeMedicine 2007). Meanwhile, similar public-private partnerships have emerged in the Philippines, South Korea and Taiwan (see Table 3.2). These structures exist to unite healthcare providers 'with a view to developing common strategies and raising awareness of international developments in the health service sector', act as a 'knowledge broker' for the local industry, identify obstacles to market access and develop strategies to overcome them, establish joint trade promotion strategies and marketing plans, develop public-private collaboration, promote market access via trade missions and 'applying leverage to existing political access', and develop strategies to minimise potential negative effects on national health systems (Wolvaart 1998: 70).

In the case of Malaysia, although the NCPHT laid the ground work for many of the above tasks and while the Ministries of Health (MOH), Tourism (MOT) and International Trade and Industry (MITI) have been variously involved in the promotion of IMT over the last decade, much was ultimately undertaken by the Association of Private Hospitals of Malaysia (APHM), a professional umbrella organisation whose objective is to facilitate cooperation between the MOH and private hospitals. The APHM emerged as the face of IMT in Malaysia, coordinating the key private hospitals and medical travel facilitators for trade missions and fairs abroad as well as promotional publications. In 2009, a single IMT promotion council akin to SingaporeMedicine was called for to reduce overlapping of promotional efforts by the various bodies involved (IMTA 23/04/2009). In response, the MOH launched the 'Malaysia Healthcare' brand campaign⁴⁵ in June 2009 and proposed to develop a new master plan that would include 'a proper framework and guidelines for the industry' (Bernama 06/12/2008, 11/05/2009), leading to the establishment of the Malaysia Healthcare Travel Council (MHTC) in December 2009.

Even prior to the 'Malaysia Healthcare' brand and the MHTC, however, the government had sought to conjure a cohesive national therapeutic landscape, overshadowing the power struggles, fragmentation and competition present not only among the hospitals themselves but also between national and regional levels that had been communicating different messages about IMT to Malaysia

45 It was first coined 'Health Malaysia' in the Ninth Malaysia Plan (EPU 2005: 431). An unnamed agency was contracted by the government to assist in the branding exercise, though interviews indicate that sector stakeholders were unaware of this process.

with little coordination (see Chapter V). Only a fraction of Malaysia's more than 200 private hospitals were considered by the government to be up to snuff for foreign patient-consumers. A group of 35 private hospitals,⁴⁶ symbolically spanning the country's territory (see Table 3.3), was ultimately selected to represent the highest standards of private medical care in Malaysia. Nearly two-thirds of the private hospitals chosen for the role had been established during the heyday of the government's push to privatise healthcare provision in the 1980s and 90s, while the remainder generally comprises not-for-profit hospitals established initially as Christian missionary charity hospitals and ethnic Chinese community clinics prior to and following Malaysia's independence from Great Britain (Ong 2007) (see Figure 3.1).

Table 3.2 Public-private partnerships in select Asian countries promoting IMT

	Malaysia	Philippines	Singapore	Korea	Taiwan
Body	National Committee for the Promotion of Health Tourism (1998); Malaysia Healthcare (2009)	Philippine Medical Tourism Program (2004)	Singapore Medicine (2003)	Council for Korea Overseas Medicine Promotion (2007); Korea International Medical Assoc. (2010)	Taiwan Taskforce for Medical Travel (2007)
Tag	Quality of care for your peace of mind	Philippines: The heart of Asia	Peace of mind when health really matters	Korea hospitality in healthcare	Taiwan cares for your health
Public sector	- Health Min. - Tourism Min. (Tourism Malaysia) - International Trade and Industry Min. (MATRADE) - Immig. Dept. - Malaysia Healthcare Travel Council	- Health Dept. - Tourism Dept. - Foreign Affairs Dept. - Trade and Industry Dept. - Philippine Retirement Auth. - Public-Private Partnership Task Force on Globally Competitive Service Industries	- Health Min. - Economic Development Board - International Enterprise Singapore - Singapore Tourism Board	- Korea Health Industry Development Institute - Korea Tourism Organization Supported by: - Health, Welfare and Family Affairs Min.	- Health Dept. - Taiwan External Trade Development Council
Private sector	- APHM - MATTA - 35 private hospitals	- 41 private medical facilities - 5 medical travel facilitators - 48 spas	- 16 hospitals - 14 speciality centres and institutes - 16 specialist groups	- More than 30 medical facilities	- Taiwan Nongovernmental Hospital and Clinics Assoc. - Chuang-Hua Institution for Economic Research - 14 private hospitals

Source: KIMA (2010), Honors Integrated Marketing Communications (2010), MOH (2009), SingaporeMedicine (2007), Taiwan Taskforce for Medical Travel (2010)

46 The Eighth Malaysia Plan noted that some 44 hospitals were initially identified. These were later whittled down to 35 (EPU 2000: 442), though interviews and Woodman (2009) indicate that not all of the 35 actively promote IMT.

These 35 medical ‘ambassadors’ to a modern Malaysia effectively comprise the legitimate sites/sights (Bunnell 2006) of the official national IMT product. Nodes of the government-sponsored, private sector-driven project of a homogenised ‘Malaysia Healthcare’ landscape, they can be thought of as ‘monuments’ employed in the process of ‘geographic mythmaking with a vista of financial gain’ (Sparke 2005: 79). These are the hospitals that feature most prominently in domestic and international media coverage about IMT in Malaysia. These are the hospitals that are most often selected to represent Malaysia in official trade missions and trade fairs. And, finally, these are the hospitals whose ‘foreign patient’ numbers and receipts get reported, tallied and released, forming the exclusive universe on which official ‘national health tourism statistics’, compiled by APHM, are based (see Chapter II). All 35 are APHM member-hospitals and more than half possess Malaysian Society for Quality in Healthcare (MSQH) accreditation, the home-grown gold standard geared towards ensuring the uniformity thought necessary to produce a harmonised therapeutic landscape.

Yet, in spite of efforts to homogenise, the 35 hospitals are far from equally promoted in this commercial ‘nation-building’ activity. IMT hospitals are disproportionately clustered around the capital in the Klang Valley region, even though the vast majority of IMT activity has been and, to date, remains concentrated in foreign-owned or independently-run hospitals based outside of this region. In 2007, for instance, Penang and Malacca were responsible for 80% of all foreign patients receiving treatment in Malaysia (see Table 6.1) (APHM 2008). The big corporate players concentrated in the Klang Valley – better able to afford investing financial resources to attract patient-consumers from abroad than smaller, independent private hospitals – have come to dominate the national IMT landscape (see Table 3.3). Most of the selected hospitals represent prominent corporate entities and government-allied investment interests, with some owned by national bodies and states governments which have benefited financially from the retrenchment of the welfare state. KPJ is fully Malaysian-owned with links to the State of Johor; IJN, a revenue-generator for the Ministry of Finance, is a model of ‘corporatisation’; Pantai Hospitals are 60% owned by Khazanah, the state’s investment arm, with the remainder held by the Singaporean Parkway Holdings; Sime Darby Medical Centre-Subang Jaya is owned by Sime Darby, of oil palm fame; and Sunway Medical Centre is part of the vast Sunway Group that has developed its own township in the Kuala Lumpur suburbs.⁴⁷ This unbalanced representation has provoked state governments (e.g., Malacca, Penang and Selangor) to take additional promotion into their own hands to compensate, thus demonstrating the regional fragmentation.

47 The directors of these hospitals also double as APHM’s board members.

Table 3.3 35 private hospitals endorsed for IMT by the MOH (2010)

	Medical Facility	Ownership	For profit	Beds	Est.
Region: Greater Klang Valley (18/35, or 51%)					
1	Ampang Puteri Specialist Hospital	KPJ Healthcare Bhd.	✓	230	1995
2	Assunta Hospital	Franciscan Missionaries of Mary	×	350	1957
3	Columbia Asia Medical Centre	CPH Acute Care Sdn. Bhd.*** and Malaysian Employees' Provident Fund (30%)	✓	77	1999
4	Damansara Specialist Hospital	KPJ Healthcare Bhd.	✓	155	1997
5	Gleneagles Intan Medical Centre	Parkway Holdings Ltd (Singapore) (30%) and Pantai Irama Ventures (70%)****	✓	330	1996
6	National Heart Institute (IJN)	Ministry of Finance	✓	432	1992
7	NCI Cancer Hospital	Asiaprise Sdn. Bhd.	✓	n/a	1999
8	Pantai Hospital Kuala Lumpur	Pantai Holdings Bhd.**	✓	264	1974
9	Prince Court Medical Centre	Prince Court Medical Centre Sdn Bhd (Petronas)	✓	300	2007
10	Selangor Medical Centre	KPJ Healthcare Bhd.	✓	252	1998
11	Sentosa Medical Centre	KPJ Healthcare Bhd.	✓	212	1972
12	Sime Darby Medical Centre Subang Jaya	Sime Darby Group	✓	375	1988
13	Sunway Medical Centre	Sunway Group	✓	175	2000
14	Taman Desa Medical Centre			128	1996
15	Tawakal Hospital	KPJ Healthcare Bhd.	✓	147	1984
16	TMC Fertility Centre	TMC Life Sciences Bhd	✓	11	1994
17	Tun Hussein Onn National Eye Hospital	Malaysian Association for the Blind	×	46	1986
18	Tung Shin Hospital	Tung Shin Hospital	×	282	1881
Region: Ipoh (3/35, or 9%)					
18	Fatimah Hospital	Brothers of Mercy	×	219	1974
19	Hospital Pantai Putri	Pantai Holdings Bhd.**	✓	121	1996
20	Ipoh Specialist Hospital	KPJ Healthcare Bhd.	✓	210	1981
Region: Johor (1/35, or 3%)					
21	Johor Specialist Hospital	KPJ Healthcare Bhd.	✓	215	1981
Region: Malacca (3/35, or 9%)					
23	Mahkota Medical Centre	Health Management International Ltd (Singapore)	✓	228	1994
24	Pantai Hospital Ayer Keroh	Pantai Holdings Bhd.**	✓	250	1995
25	Putra Specialist Hospital	Malacca State Gov. (Healthcare Division), United Medicorp Pte. Ltd. (Sing.), Mediquest and Apex Pharmacy	✓	200	1995
Region: Penang (7/35, or 20%)					
26	Gleneagles Medical Centre	Parkway Holdings Ltd (Singapore) (70%)	✓	212	1973
27	Island Hospital	Island Hospital	✓	240	n/a
28	Lam Wah Ee Hospital	Lam Wah Ee Hospital	×	422	n/a
29	Loh Guan Lye Specialists Centre	Loh Guan Lye Specialists Centre	✓	250	1975
30	Mount Miriam Cancer Hospital	Sisters of Franciscan Missionaries of the Divine Motherhood	×	40	1976

	Medical Facility	Ownership	For profit	Beds	Est.
31	Pantai Hospital Penang	Joint venture: Pantai Holdings Bhd.**, Koperasi Tunas Muda Bhd. and Geh Sim Wah Sdn. Bhd.	✓	180	1997
32	Penang Adventist Hospital	Adventist Health Network	×	216	1924
Region: Sabah and Sarawak (3/35, or 9%)					
33	Normah Medical Specialist Centre	Sarawak Medical Centre Sdn. Bhd.	✓	130	1988
34	Sabah Medical Centre	Sabah Medical Centre Sdn. Bhd.	✓	150	1986
35	Timberland Medical Centre	Mestika Unik Sdn. Bhd.	✓	72	1994

Source: APHM (2008) and respective medical facilities' websites (2009). *Notes:* * Holding Malaysian Society for Quality in Health Accreditation (as at 09/04/2009); ** Pantai Holdings Bhd is a joint venture between Khazanah and Parkway Holdings Limited (Singapore); *** CPH Acute Care Sdn. Bhd. is a joint venture between Chemical Company of Malaysia Berhad and Columbia Pacific Management (USA); **** Pantai Irama Ventures Sdn. Bhd. is a joint venture between Khazanah and Parkway Holdings Limited (Singapore).

Furthermore, beyond these MOH-sanctioned 35, many other private healthcare facilities promote IMT, spanning an array of medical interests and customer bases, ranging from 'premium' facilities like HSC Medical Centre, Regency Specialist Hospital and International Specialist Eye Clinic (ISEC) to the Muslim-friendly Islamic Hospital Pusrawi to the Damai Service Hospital geared to lower middle-class patient-consumers. One of APHM's directors and, until 2009, spokesperson for IMT in Malaysia, Dr Kula Kulaveerasingam (interview, 29/02/2008; cf. Goh 28/11/2005), revealed the organisation's frustration that these hospitals have not been endorsed for IMT by the MOH but still 'insist' on promoting themselves as 'legitimate' IMT destinations. In the eyes of the APHM, these rogue hospitals and the diversity they represent undermine efforts at creating a homogenised national therapeutic landscape brand. Indeed, in the decade after the 35 hospitals were selected by the NCPHT, the list has been revised only once in order to exclude Kedah's Metro Specialist Hospital and, in its place, incorporate the new Petronas-owned Prince Court Medical Centre (PCMC), now framed as the national IMT showpiece.

The MOH's caution to distance itself from the direct promotion of particular private hospitals initially led it to publicly endorse only select Malaysia-based IMT portals, facilitators and clearinghouses (e.g., MalaysiaHealthCare⁴⁸, MediTravel and APHM) (Ponnudurai interview 18/12/2007; Tourism Malaysia 2008b). Notes Suresh Ponnudurai, the CEO of Tropical Flow – MalaysiaHealthcare Networks, a prominent Malaysian medical travel facilitator (interview, 18/12/2007),

When I set up this [web] platform, I had a hard time trying to get all the hospitals to come on board.

The Ministry of Health was very, very supportive because they realised that they couldn't basically

48 The IMT facilitator, MalaysiaHealthCare, should not be confused with the MOH's 'Malaysia Healthcare' national IMT branding campaign.

market a particular healthcare provider or else the others would get all bent out of shape. So, they said that this [web platform] was perfect and that they wanted all the hospitals that had been vetted for medical tourism to be on my portal and that they would market and support me.

Only with the advent of the MOH's 'Malaysia Healthcare' website did the government itself finally start to list the hospitals endorsed for IMT (MOH 2010). This new openness correlates with the increasingly prominent position of IMT on the national agenda (evidenced by the high-powered figures at the helm of the MHTC today⁴⁹) to help the country 'make the transition to the "high income" status' (Bernama 30/03/2010) achieved already by the likes of Korea, Poland and the Czech Republic. 'Healthcare travel has been identified as one of the new sources of growth within the context of the country's new economic model premised on high income' (Minister of the Prime Minister's Department Nor Mohamed Yakcop, in Foong 19/11/2009), alongside education tourism,⁵⁰ Islamic finance, renewable energy, logistics and information and ICT (Kok 21/11/2009). The MOH's explicit and active engagement in this new set of measures to consolidate IMT has sent a clear message to Malaysians that 'its priority is turning more towards business' (Mohamed 06/08/2009).

Yet, as noted earlier, the MOH's endorsement of public investment in IMT is a politically controversial position to assume (*Ibid.* 06/08/2009). 'Even as the state is directly involved in expanding private healthcare', Chee (2008: 2153) suggests, 'it has found it less possible to extricate itself from the welfarist healthcare provider role'. Accordingly, the provision of healthcare to non-citizens has become a point of contention for some national subjects, given that healthcare has been considered a national resource and domain of action for the 'developmental' state. For Dr Teoh Siang Chin (interview, 11/01/2008), the former chair of the Malaysian Medical Association (MMA) who served on the NCPHT when IMT was first put on the development agenda:

The MMA is not fully convinced that health tourism is without its negative effects, especially as regards equity in health. Whilst it may offer glamorous profits to the private sector... healthcare is a social service and remains within the public sector. We must first serve the needs of our populace and, until we do so, public resources should not be diverted for whatever economic purposes. All these actions

49 The MHTC is co-chaired by the Health Minister and the Minister of the Economic Planning Unit, with its CEO the former MITI Deputy Secretary-General.

50 As with the logic behind the 'health tourism' product, the government promotes 'education tourism' as a way to increase revenue for private higher education establishments, attracting a range of foreign students from throughout the world with English- and Arabic-language instruction and low enrolment fees and cost of living when compared to more traditional overseas higher education destinations like Australia, the UK and the US (McBurnie and Ziguas 2001: 95; Tourism Malaysia 2009b). Parallel with the healthcare sector, prior to the mid-1990s, 'the Malaysian government was opposed to private universities, fearing that the private sector would undermine the nation-building efforts of the public sector' (McBurnie and Ziguas 2001: 93). Though it has made no formal commitments under GATS, a government-regulated free-market policy has been in effect now since 1995, permitting the proliferation of private universities in Malaysia and promoting transnational education schemes.

will have medium- and long-term effects on the public health sector *unless* there are corresponding actions to balance. Many of our peoples are still deprived of quality health services.

The most prominent critics of IMT are also the most vocal opponents to the privatisation and commodification of healthcare in Malaysia, seen to challenge the equitable delivery of care to all classes and categories of Malaysians (Devaraj 2009; Mohamed 06/08/2009, 06/11/2009; Quek 31/10/2009). Arguments, such as ‘If a nation cannot provide healthcare for the poor and needy, then something must be seriously wrong’ (Ooi 16/09/2006), pivot around whether a government can claim legitimacy if it cannot take adequate care of its citizenry.

Table 3.4 Foreign patient-consumers treated in Malaysian private hospitals endorsed for IMT (1998-2009)

Year	Foreign patients	Growth rate	Income (MYR millions)	Income per patient (MYR)	Income growth rate	Hospitals reporting	Total tourists (millions)	Tourism growth rate	Foreign patients as % of tourists*
1998	39,114	<i>n/a</i>	14.1	360.48	<i>n/a</i>	13	5.5	<i>n/a</i>	0.71%
1999	77,000	96.86%	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	13	7.9	43.6%	0.97%
2000	56,133	-27.1%	32.64	581.42	<i>n/a</i>	10	10.2	29.1%	0.55%
2001	75,210	34.0%	44.28	588.77	1.3%	10	12.7	24.5%	0.59%
2002	84,585	12.5%	35.88	424.43	-27.9%	19-22	13.2	3.9%	0.64%
2003	102,946	21.7%	58.90	572.14	34.8%	19-21	10.5	-20.5%	0.98%
2004	174,189	69.2%	104.98	602.22	5.3%	19-20	15.7	49.5%	1.11%
2005	232,161	33.3%	150.92	649.98	7.9%	19-25	16.4	4.5%	1.42%
2006	296,687	27.8%	203.66	698.63	7.5%	27-28	17.5	6.7%	1.69%
2007	341,288	15.0%	253.84	743.77	6.5%	29	20.9	19.4%	1.63%
2008	374,063	9.6%	299.10	799.60	7.5%	<i>n/a</i>	22.0	5.3%	1.69%
2009	425,500	13.8%	<i>n/a</i>	861.93**	7.8%	<i>n/a</i>	23.6	7.3%	1.80%
2010	519,000	22.0%	390.00	1117.53	29.7%	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>

Source: APHM (2008). Notes: Figures for 1998 and 1999 hail from Wong (19/04/2003) and Bernama (02/12/2009); for 2000 and 2001, from Tengku Adnan Tengku Mansor (2006; but see EPU 2004: 12 for competing figures); for 2002 to 2007, from APHM (2008); for 2008, from Ng (14/02/2009); for 2009 and 2010 (estimates), from Frost & Sullivan (14/04/2010). * Due to a lack of statistics, it cannot be discerned whether foreign patient-consumers live in Malaysia or not and, therefore, the weight of foreign patient-consumers having crossed borders for treatment is unknown. However, the Ministry of Tourism treats foreign patient-consumer figures as part of the overall tourism figures (see Tourism Malaysia 2008c, 2009c). Therefore, these percentages represent their weight in the overall tourist figures. ** This figure is based on Q1/Q2 foreign patient-consumer numbers and revenue cited in Liow (21/12/2009).

Paradoxically, the promotion of Malaysia as an IMT destination draws from the domestic health achievements made possible by the very existence of a national public healthcare system in order to lend national-level legitimacy to the private healthcare facilities engaged in the IMT industry. A state’s ability to ensure the health of its own populace plays a role in attracting foreign patient-consumers willing to place their bodies in the hands of a relatively unknown system, with public health measures and established healthcare systems emerging as ‘an independent marker of good governance’ (Fidler 2007: 6). The need to sustain a country’s national healthcare reputation

therefore gets used to support pro-IMT arguments. SingaporeMedicine, for example, claims its country's promotion of IMT to be a necessity, drawing from a nationalised logic of 'medical ecology' based on 'economies of scale' necessary to make efficient use of its surplus of talent, technology and facilities in order to continue providing high quality, already semi-privatised, healthcare for its own small population (Yap interview 15/02/2008; Henderson 2004). In so doing, it suggests that foreign patient-consumers are not depriving citizens of the opportunity to receive care and that the government is first and foremost concerned with the healthcare needs of its own population.

Proponents of IMT suggest that foreign patient-consumers be used to foster greater linkages between the public and private health sectors, even 'cross-subsidising' one another. As such, private hospitals are encouraged to provide free or subsidised beds to locals in need from foreign-sourced revenue, while public hospitals are pushed to 'augment [their] financial capacity with direct payments by foreigners' for the use of their facilities (Bookman and Bookman 2007: 73; Chanda 2001). In a move to keep the private sector from 'just focus[ing] on reaping profits from the foreigners at the expense of healthcare services for the people' (Bernama 11/05/2009), the Malaysian government decided to include corporate social responsibility clauses in its proposed master plan for IMT as a way to regulate the 'charity of the clinics' (Pennings 2007: 69) and bring benefit to locals.

Officials are quick to remind that foreigners are directed to private medical facilities and steered away from public ones. This approach is illustrated by comments by an anonymous Malaysian governmental tourism representative (interview, 24/01/2008):

We always stress in our promotion of medical tourism that it's only for the private facilities, not for the public ones. Even expats working in Malaysia frequent private hospitals. We do not encourage their use of the public ones. When we get foreigners coming for treatment, it's as tourists. Public facilities are meant for *us*, for the citizens of the country. They are not meant for foreigners, except in emergency cases.

Promotional materials (e.g., Tourism Malaysia 2008a; Melaka Tourism Promotion Division 2006) distinguish public hospitals from private facilities which, already catering to a more 'affluent class of Malaysian society' (State Implementation Directorate of the Malacca Chief Minister's Department 2006: 31), are those explicitly meant for foreign patient-consumers. The government also symbolically (though not substantially) raised public healthcare fees for foreigners in 2000 in a token gesture to endorse the future of public healthcare in Malaysia for Malaysians at a moment in which it, paradoxically, was pursuing an aggressive overhaul of that very system. This move purportedly was

aimed at ensuring that Malaysians benefited from the 97 per cent subsidy on healthcare provided by the Government... tak[ing] into consideration the call by many Malaysians that *this generous subsidy*

should not be enjoyed by foreigners at the expense of Malaysians. (Martin and Fazleena 11/11/2000, emphasis added)

When some 35% of arrears in medical bills at public facilities were blamed on foreigners (mostly economic migrants) not paying up, for example, a national newspaper bemoaned: 'This is not the kind of medical tourism we want' (*The New Sunday Times* 06/01/2008). This contentious divide between Malaysian and foreign patients' entitlement to care by the government-funded healthcare system recalls the debate in Chapter I where the phrase 'health tourism' was used pejoratively to describe asylum seekers 'taking advantage' of the national healthcare system. Such debate, illustrating the 'dichotomy in a health service where both costs and rights are emphasised more than ever before' (Borman 2004: 60), constructs the national healthcare system as a symbolic pillar of national progress in which citizens are supposed to feel considerable pride and yet, at the same time, provides an outlet for critical mourning for its weakened and overburdened state, displacing the source of some of its present woes to its (ab)use by 'ungrateful' foreigners. This contrasts sharply with media reports of the grateful ones produced through the 'good' kind of IMT fuelled by responsabilised patient-consumers.

Meanwhile, though promoters may so far direct foreign patient-consumers to private facilities, no official sanctions exist to date regarding the inclusion of public hospitals for IMT (Chee and Barraclough 2007b: 29). In 2002, the Malaysian government began to consider the opening of private wings for full fee-paying patient-consumers, domestic and foreign alike, in a handful of public hospitals scattered throughout the country (Chan 2007; Chee 2004; Nadason 2007).⁵¹ This move was endorsed by the MMA as a measure with which to stem domestic public-private brain drain and retain essential medical staff tempted to move to the more lucrative private sector. Apprehension that it would create a 'two-queue system', prioritising those able to pay over the 'poor', however, led to the proposal's deferral (*NST* 20/07/2004). With this proposal now slowly being phased in, it has effectively enabled the government to lay the groundwork for the further corporatisation and privatisation of public facilities (*Aliran* 08/06/2010; *NST* 01/12/2002). Select public hospitals are now being constructed, expanded and equipped with the latest medical technology, rendering them more attractive to private patient-consumers with a view to facilitate their eventual switch-over (*NST* 20/11/2002). Such experimentation, undertaken in the name of IMT, suggests that there is

51 The public hospitals earmarked for the introduction of private wings included Hospital Selayang, Hospital Putrajaya, Hospital Serdang, Hospital Ampang, Hospital Sungai Buloh, Hospital Alor Setar, Hospital Sungai Petani and Hospital Pedan. Of these, some are home to major medical specialisations: Hospital Putrajaya (cancer, nuclear medicine, breast and endocrine services) and Hospital Selayang (ophthalmology, hepatobiliary surgery and liver transplant services, geriatric services). MP9 indicated that 'Health promotion and wellness activities including affordable screening at selected hospitals and clinics will be marketed to attract more tourists to utilise these services. In addition, centres of excellence in ophthalmology at Hospital Selayang in Selangor and endocrinology at Hospital Putrajaya will be promoted' (EPU 2005: 431).

ample reason for concern that ‘the glamour and profitability of medical tourism tend[s] to “crowd out” public health’ (Bennett, in Loh 02/05/2009) as the government not only re-channels funding to provide incentives for the growth of private medical facilities but also takes definitive steps to distance itself from being the country’s principal healthcare provider. The National Heart Institute (IJN), mentioned earlier as a corporatisation ‘success story’, has been at the heart of recent debate on this matter. In 2009, IJN struck a deal with eight companies (e.g., CIGNA International and lesser-known affiliates of AIG and Europ Assistance) for referrals of North American patient-consumers (later recognised to be regional expatriates), proclaiming a victory that ‘would help put the country on the medical travel industry map’ (MHTC, in Cruz 03/11/2009). When a Malaysian consumer group criticised IJN, a facility launched with public funds and largely sustained by them, for potentially forsaking the Malaysian people by ‘providing treatment for rich foreigners from a First World country, when medical care for serious diseases is not even affordable by many in Malaysia’ (Mohamed 06/11/2009), IJN’s response was simply that the ratio between foreign and Malaysian patients was insignificant and would not jeopardise care provision to Malaysians (*NST* 22/11/2009).

While there is little doubt that IMT *exacerbates* already existing inequalities in domestic healthcare systems (e.g., locating private hospitals mainly in urban areas) and undermines the public healthcare system (e.g., drawing medical professionals away from the public sector, etc.) (Pennings 2007; Phua n/d; Smith 2004; Smith 2008; Whittaker 2008), it remains essential to contextualise its impact. In their concern about the potential of IMT to generate a two-tier healthcare system in destination countries, many ignore the extent to which privatisation has already shaped healthcare systems in these countries (Chanda 2001), as the Malaysian case clearly demonstrates. Prescribing IMT as a route to development, for example, Bookman and Bookman (2007: 75) erroneously suggest that it was the ‘growing importance of medical tourism’ in the late 1990s that drove private capacity in Malaysia to increase at nearly treble the rate of the public sector. As this chapter’s genealogy of healthcare in Malaysia demonstrates, such was not the case. An aggressive healthcare privatisation campaign had come into being fully more than a decade before IMT came onto the agenda. Indeed, Smith (2004) and Whittaker (2008) suggest that the principal threat to public healthcare systems is the privatisation of healthcare in general, and it is the strength of the regulatory environment that determines the impact of foreign investment – not simply the presence of foreign capital in healthcare systems. As Pennings (2007: 507) notes,

The medical tourism industry should not be blamed for all the deficits of the healthcare systems of the developing countries. The inequity, lack of access, low quality and so on existed before this development and are largely due to internal factors.

It is important to remember that, while foreign patient-consumers may account for 30% of all patients in exclusive private facilities like Petronas’ Prince Court Medical Centre (Rowley interview,

17/03/2008), elsewhere foreign patient-consumers generally comprise from less than 1% to 11% of the total annual patient load in facilities involved in IMT (see Table 3.5). Casting IMT in exaggerated terms as an ‘outside invasion’ displaces focus from more profound transformations of which IMT is more symptomatic than the cause. IMT here acts as the ‘carnival mask that diverts and entertains, leaving the social problems that lie behind the mask unseen and uncared for’ (Harvey 1989, in Kearns *et al.* 2003: 2305).

Were IMT promotion only geared towards prospective patient-consumers outside of Malaysia, then the Sunday morning airing of the ‘Malaysia: The New Frontier of Medical Tourism’ documentary series in the ‘Healthy Living’ slot on the Malaysian state television channel (RTM) in April 2009 might not have occurred (Vijayan 20/03/2009). When it first began to promote IMT as a viable sector to stimulate economic growth in 1998, the Malaysian government explicitly identified the policy’s potential to not only attract greater tourism and treatment revenue from foreigners but also to *retain* Malaysians in Malaysia for their advanced healthcare needs (Chan 2000: 3; Hanizah 24/01/1998). It was announced that

[t]he Health Ministry will promote Malaysia as an international centre for medical excellence as a way to *prevent the outflow of funds*... [T]he ministry wants to encourage Malaysians and foreigners to seek medical treatment in the country as Malaysia has the advantage of lower costs and good medical facilities and doctors. (*Business Times* 20/01/1998, emphasis added)

This is particularly salient when considering that, for many years, the Malaysian elite would themselves seek out medical care in more ‘developed’ countries (e.g., Australia and Singapore), having little faith in the quality of the Malaysian healthcare system (see Figure 5.5). Indeed, while 20% of foreign patients in Singapore in 2002 came from Malaysia (Khoo 2003), only 1.6% of foreign patients in Malaysia came from Singapore the same year (APHM 2008) – indicating that Malaysia has yet to be able to fully cast off its ‘under-developed’ image not only among foreign patients but also among its very own nationals (Arunanondchai and Fink 2007: 61).

Table 3.5 Patients at three private hospitals endorsed for IMT in Malacca (2001-2006)

Year	Domestic	Foreign	Total	Weight of foreigners in overall patient load (%)			
				Malacca	Mahkota Medical Centre	Pantai Hospital Ayer Keroh	Putra Specialist Hospital
2001	248,400	27,856	276,256	10.08	5.29	1.51	3.28
2002	257,162	32,339	289,501	11.17	7.46	1.80	1.92
2003	411,749	32,652	444,401	7.35	5.01	1.41	0.93
2004	384,440	47,591	432,031	11.02	9.07	0.59	1.35
2005	373,152	54,204	427,356	12.68	10.73	0.77	1.19
2006	381,013	55,221	436,234	12.66	11.00	0.72	0.94

Source: Melaka Tourism Promotion Division (2005: 37, 2006: 39, 2008)

In response, private hospitals, like the NCI Cancer Hospital and Prince Court Medical Centre, have been built with the 'aim of helping Malaysians receive superior medical treatment without having to travel abroad' by fashioning themselves as premier centres of healing not only within Malaysia but for all of Asia (*Business Times* 12/06/2008; Chan 2000). New wards for the transnational elite are being built in private hospitals endorsed for IMT, with special suites and wards dedicated to serving foreign and domestic royalty and VIPs. Outlets of conspicuous consumption, like Starbucks and Baskin Robbins, are multiplying in this type of hospital, saying as much about the socio-economic status of their clientele as about the growing normalisation of consumption practices in therapeutic landscapes (Kearns and Barnett 2000; Rokiah 2000). Private hospitals also are investing increasingly in making their facilities 'friendlier' to foreign and domestic patient-consumers alike by including more signage in English and other major languages, creating special menus, dedicating administrative and medical staff and cordoning off exclusive patient lounges (Najib 21/12/2009). The differences are not only in the quality of accommodation and catering but also extend to the patient-to-nurse ratio and availability and rank of medical staff serving patient-consumers. This hierarchy increasingly fostered *within* private hospitals reinforces and creates new layers that further complicate the simplistic 'two-tier' public-private divide.

The decision by PM Mahathir (1981-2003), himself a medical doctor by training, to undergo cardiac surgery first in 1989 and later in 2007 in Kuala Lumpur proved to be a highly strategic move imbued with both nationalist and neoliberal undertones. Mahathir's first operation took place in Kuala Lumpur General Hospital's cardiac unit, a unit which was corporatised three years later only to become, in 1992, the National Heart Institute (IJN), today one of the 35 hospitals endorsed for IMT by the MOH. If PM Mahathir trusts his life to Malaysian healthcare, the logic goes, then Malaysians can be proud of their national healthcare assets enough to trust the care of their bodies to it.⁵² 'Locals', a proud Malaysian Masters student notes in her dissertation (one of the few so far written on IMT to Malaysia),

are beginning to believe in the medical treatments offered in Malaysia. The much publicised bypass done on *our own PM... by our very own local doctors* has given much confidence to the local public when they see that *our own high-ranking government members* choose to have operations done locally. (Azra 2003: 93, emphasis added)

This inculcation of patriotic consumption of Malaysian healthcare services stands shoulder-to-shoulder with the post-AFC 1998 Buy Malaysian Made Campaign, reincarnated in April 2009 as the Buy Malaysia Campaign in order to once again

⁵² Today, the Malaysian medical travel facilitator Wellness Visit profiles and markets the expertise of Dr Yahya Awang, the lead surgeon for both of Mahathir's surgeries and founder of the IJN (Wellness Visit 2008). Highlighting the surgeries he performed on the former Prime Minister on his web profile seals his 'doctor to the stars' reputation, marketable to foreign and domestic patients alike.

encourage the consumers to buy Malaysian-made products at reasonable prices as well as to help the local entrepreneurs in facing the slow economic growth. It is also to increase awareness among the public concerning the products and services offered in Malaysia that are on par with the international standard and retailed at reasonable prices... [because] the economy of a country will continue to be generated and stabilized despite turmoil if there is money flow and domestic expenditure within the country. (Ministry of Domestic Trade and Consumer Affairs 23/04/2009)

The objective of these campaigns was to *make domestic consumers realise* that Malaysian-made products are of as good, or better, quality than their foreign counterparts, and thus reduce dependency on foreign producers. Mahathir's surgeries in Malaysia were meant to teach Malaysia's budding private healthcare consumers the very same lesson.

Yet, while '[t]he Buy Malaysia Campaign is [focused] more on goods made in Malaysia... [t]here are international brands... made in this country [that provide] jobs for Malaysians', noted campaign organisers (Bernama 15/04/2009). Malaysians' involvement in the production of international brands of products and services increasingly allows them to 'take ownership', to lend more equal weight to the phrases 'made by' and 'made in', 'while simultaneously acknowledging the implicit superiority (i.e., "made in") of the company's home location, from wherein such membership in the technological or economic elite is founded' (Chio 2008: 175). This understanding of the national self sits squarely upon 'tenets of neo-liberal development discourses connecting the foreign direct investment policies of multinationals to the development of newly industrialising nations like Malaysia' (Chio 2008: 176). Foreign confidence in Malaysia as an IMT destination contributes to its place-based prestige, advancing the 'country of origin' effect (Szondi 2009: 300). If the quality of healthcare attracts significant FDI, inspires expat Malaysian doctors to return home and entices foreign patient-consumers from halfway across the world who are willing to pay top dollar for this simultaneously 'home-grown' and sufficiently 'international' care, then local Malaysians also might start to feel more confident about consuming private healthcare 'at home' (Lee 02/09/2009; Majawat 12/07/2009). With the 'self-promotion of places... operating as a subtle form of socialisation designed to convince local people... that they are important cogs in a successful community' (Philo and Kearns 1993: 3), IMT is wrapped 'in an envelope of local meaning' (Oakes 1999: 124, in Crang 2004: 1) that is tied to the cultivation of national pride and belief in the pervasive 'Malaysia *boleh* [can]' and 'Vision 2020' empowerment and development slogans (Khoo 2003).

I close this discussion with a brief illustration of how the promotion of Malaysia as an IMT destination infuses into the medical imaginaries of domestic healthcare subjects by examining IMT's role in shaping how private healthcare now gets advertised. Malaysia reportedly has some of the strictest regulations on health-related advertising in the world, ensuring the dissemination of

accurate information 'about the type and nature of healthcare services that are available' to the Malaysian public (MAB 18/12/2007). The MOH's Medicine Advertisement Board (MAB) is responsible for upholding these regulations, through the monitoring of all advertisements that make claims to benefiting the health of Malaysian citizens in order to protect against healthcare becoming 'just another commodity on sale in the market' (Health Minister Liow, in Foong *et al.* 05/04/2009). To date, advertising within Malaysia requires official approval by the MAB of all forms of promotional material (see Figure 3.3).⁵³ In 2005 regulations were slightly relaxed, out of concern that such 'strident' regulations were inhibiting the growth of IMT in Malaysia based on the logic that foreigners were encountering barriers to retrieving enough information for them to select hospitals and doctors (Cruetz 22/05/2005; *The New Sunday Times* 17/07/2005). This is illustrated by Director-General of Health Dr Ismail Merican's comment:

We thought that it was an important move because previously we seem to have lost out to the likes of Singapore and Thailand in terms of health tourism. There were many who thought Malaysia did not have the expertise and facilities. This is because advertisements were thought to be taboo. (Merican, in Cruetz 31/12/2005; see Mohamed 06/08/2009 for a critique)

In spite of the 2005 relaxation, advertising regulations continue to be targeted as 'petty', 'rigid' rules amounting to little more than a 'stumbling block' for the development of an industry that must get MAB approval even for promotional materials destined for other countries, thus inhibiting the industry's 'healthy competition' in the free market (Abdul Latiff interview, 06/12/2007; Bernama 12/04/2010; Foong *et al.* 05/04/2009; *IMTJ* 23/04/2009).

In practice, however, it has become increasingly difficult to regulate and police cross-border promotional content, and the MAB now more heavily relies on outside reporting of regulatory infringements. Private hospitals, for example, will monitor and 'inform on' the wrong-doings of their competitors should they step out of line (anonymous Malaysian governmental health representative interview, 24/03/2008). Peer-surveillance and self-policing practices will ultimately come to assume greater importance in the future, as MAB progressively pulls away from its traditional policing role (*ibid.*, 24/03/2008). Foong *et al.* (05/04/2009) also have observed that 'the intense race for a piece of the global medical tourism pie has given rise to more creative promotions and advertisements',

53 The guidelines on public information by medical service providers maintain controls over their appearance in print media, off-premises display boards and websites. Radio, television and film advertising are not permitted, with the exception of videos which may be shown on hospital and hotel premises. Photographs of doctors can be no larger than identity card-sized and are expressly prohibited from showing doctors conducting procedures on patients. Promotional materials can include listings of doctors' professional competencies and facilities' accreditations and awards, cutting-edge equipment and accommodation are permitted. However, their attributes may not be overemphasised or compared to any other institution and the use of superlatives and celebrity endorsements is not permitted. The frequency of their publication is controlled and no claims can be made as to the outcome of the care they are able to provide (MAB 18/12/2007). It is interesting to note, then, that the Ministries of Health and Tourism in their support of IMT flout these regulations by showing 'medical personnel' interacting with 'patients' in promotional material.

citing situations in which foreign healthcare facilities wishing to advertise to a Malaysian audience have gone the route of publishing in *foreign* magazines sold in Malaysia so as not to be subject to MAB regulations. Meanwhile, IMT agencies act as promotional intermediaries for doctors and medical facilities. With their largely deterritorialised internet-based presence, they have been able to circumvent MAB's strict rules. For a remote audience, the doctors, facilities and patient testimonials they choose to profile ultimately prove paramount to patient-consumers' decision-making processes. Thus, while the promotion of individual medical practitioners to a Malaysian audience is prohibited by MAB, foreign and Malaysia-based medical travel facilitators (e.g., Gorgeous Getaways, Malaysia Dentist, Malaysia Healthcare, MediTravel, Perfect Enhancement and Wellness Visit) as well as individual doctors themselves use the internet to advertise their qualifications to 'foreign' patient-consumers. The transnational nature of IMT and its reliance on the internet is ultimately coming to undermine protective measures meant to distance Malaysian citizens from overexposure to aggressive healthcare marketing.

Yet the MAB's restrictions also apply to foreign medical facilities advertising in the country, which largely accounts for the weak penetration of foreign private medical facilities' influence in Malaysia. Prior to the government's promotion of Malaysia as a IMT destination in 1998, home-grown media coverage could be encountered from time to time that mentioned the merits of medical care facilities outside of the country, ranging from IVF in Jordan to traditional medicine in Sri Lanka to low-cost medical treatment in Hungary (e.g., *Business Times* 13/05/1997). While articles are beginning to appear in the Singaporean media that openly discuss residents opting for medical care in Malaysia, Taiwan and Thailand (e.g., Toh 19/10/2008), reflecting the Singapore government's recent move towards encouraging its citizens to pursue care abroad (see Chapter V), this has not been the case in Malaysia. Indeed, the specific promotion of healthcare facilities outside of Malaysia is generally considered off-limits, to the extent that 'the media has been made to understand that such promotion may pose a threat to the local medical tourism as well as encouraging locals to seek treatment overseas' (Foong *et al.* 05/04/2009).⁵⁴ Therefore, instead of waxing positively about the merits of other IMT destinations, domestic media coverage now pits them against their Malaysian 'equivalents' or remains silent about the Malaysians that continue to go elsewhere for care.⁵⁵ While

54 An early exception to this calls for Malaysians to consider heading to Thailand for 'a package trip that combines a health check with a trip to the River Kwai, or an ECG (heart check) with a visit to a sacred temple - all in the same holiday' (Paccaud 18/04/2000), while a more recent exception touts the luxury hotel-like atmospheres of Bumrungrad Hospital and Bangkok Medical Centre that 'cater to a new breed of traveller' looking for 'fast, affordable but high quality medical services' (Velasco 26/10/2008). However, both of these examples entered the Malaysian media through international press wires, reinforcing Foong *et al.*'s (05/04/2009) observation that the local media steers clear of promoting other destinations.

55 There was very little coverage by the Malaysian press of the Malaysian airline AirAsia's May 2010 launch of new flight routes between Malaysia and India, with a symbolic inaugural flight carrying 15 Malaysian children

the MAB's guidelines may strictly regulate what kind of healthcare advertising is permitted, domestically-orientated journalists covering Malaysian private hospitals are largely left to their own devices, taking a convenient detour around the regulations through a plethora of thinly-veiled 'advertorials' profiling the virtues of Malaysia's top private medical facilities and 'educating' Malaysians about the internationally sought-after medical excellence in their own backyards (cf. Cruz 04/08/2008; Mohanlall 21/08/2004; Ng 17/04/2007).

Figure 3.3 Private hospital signboard advertisements of the type permitted by the MAB, Malacca ferry terminal and airport



Source (top to bottom): Author (2008), Courtesy of Tim Bunnell (2008).

with congenital heart defects waiting for surgery in Bangalore. While an online Indian newspaper read that 'AirAsia sees a huge demand from the health sector with patients seeking medical assistance from institutions based in Bangalore' (*The Economic Times* 21/05/2010), Bernama's coverage (20/05/2010) gave fewer details.

3.6 Conclusion

This chapter has sought to contextualise the promotion of Malaysia as an IMT destination within broader developmental transitions, demonstrating the linkages over time between the work that healthcare does and the different political regimes and economic phases through which it is articulated. Shifts in healthcare correlate to different premises for inclusion and exclusion. Whereas access to care correlated more explicitly to ethnicised divisions during colonial times and later to citizenship-based entitlement in the post-independence period of nation-building, today – where ‘development’ is defined through engagement with global market fundamentalism – it increasingly corresponds to individuals’ ability to pay, largely regardless of their ethnic and national affiliations. Yet, as we have seen, medicine not only asserts authority over, and generates knowledge of, subjects but also plays a significant role in the internal differentiation among the subjects themselves, bringing to light the ‘subaltern politics and middle-class hegemony’ (Arnold 1993: 10) that produce a multiplicity of nuanced layers to claims for and to care.

As in the times when colonies served as laboratories for scientific discovery and social change to be applied in the metropole (Arnold 1993; Stoler 1995), the adaptation of Malaysian hospitals to discerning patient-consumers and shifts in medical advertising regimes demonstrate how IMT, in the name of providing ‘world-class’ care to foreign patient-consumers, select facilities have become experimental pilot sites for neoliberal approaches to healthcare, contributing to the further reshaping of domestic care delivery. Scripting ‘Malaysia’ as a privileged arena for ‘world-class’ care generates a reputation legitimised by a discriminating foreign ‘other’ that appeals to foreign and Malaysian patient-consumers alike. IMT ‘perpetuates and trades on’ assertions of the country’s improving development status, taking ‘dreams and myths and inscrib[ing] them onto places’ (Crang 2004: 76).

Chapter IV. Plotting Malaysia on the ‘flat world base-map’ of global healthcare

4.1 Introduction

‘The world is flat!’ This provocation hails from Thomas Friedman’s (2006) book of the same name, which – full of market fundamentalist awe at the ‘democratic potential’ of equalising and diversifying the ‘playing field’ by plugging into the requirements of mobile capital – is treated like gospel by many in the international medical travel (IMT) industry. It served as the mantra for the 2008 Medical Travel World Congress, which was itself held in the ‘flattest’ of transnational circumstances. Set in a luxurious Kuala Lumpur hotel, much of the conference was sponsored by SingaporeMedicine, the public-private partnership promoting Singapore as an IMT destination, and Vamed, the Austrian-led operators of the Malaysian national oil company-owned Prince Court Medical Centre (PCMC) not far down the road from the hotel itself. It attracted delegates from the most renowned Asian hospitals, government representatives and policy advisors from Asian countries that have (or seek to) become IMT destinations, and private medical travel agencies and intermediaries from throughout the United States and Asia. Speakers, flown in from around the globe, addressed a range of shared concerns about the mechanics of reconciling healthcare provision with the demands of the global marketplace. At the top of the agenda were topics like public-private sector collaboration, the secrets of tapping into culturally diverse ‘health consumer’ markets, accreditation and portability of insurance, and challenges presented by the lack of standard definitions and reliable statistics with which to make sound international comparisons and set benchmarks.

The event provided a timely snapshot of the major issues and key players not only comprising Asia’s burgeoning IMT industry but also actively engaged in the very governance of its shifting contours. Invoking the smooth spaces polished by global flows championed by Deleuze and Guattari (1987), the conference presentations revealed a rich neoliberal lexicon that lends insight into how all types of providers conceive of and help to discursively produce the subjects and spaces of this young industry by projecting them onto an imaginary ‘flat world base-map’ (Sparke 2009b) shaped by the requirements of market fundamentalism. Throughout the conference, medical travellers were portrayed as ‘global health consumers’ and praised for being ‘health literate’ and pioneering ‘early adopters’. Because ‘the patient is a very special species of customer’, quality customer-driven care, accreditation and security were deemed essential for future expansion among ‘less-resistant customers’, underscoring the importance of the spread of standardisation practices. The medical travel terrain was frequently cast in transnational terms, sustained by arguments that ‘protectionism

or territoriality over patients is [rooted in] misguided nationalism', demands for the 'removal of cultural barriers' and calls for 'regional cooperation' and 'collaborative competitiveness' (own transcription of the 2008 Medical Travel World Congress proceedings, 02/2008).

While the bulk of presenters enthusiastically emphasised the need for 'flatness', at the same time another set of seemingly contrasting narratives persistently surfaced. Talks by newer players in the IMT industry, such as representatives from Malaysia, Taiwan and the Philippines, were strikingly indicative of the extent to which their interpretations of success remain explicitly couched within and interpreted through nation-state frameworks. Self-orientalising nationalist stereotypes like 'naturally nurturing Filipinos', 'Islamic Malaysia' and 'hospitable Thais' abounded. The clamour to secure the publication of country-specific editions of *Patients Beyond Borders* (Woodman 2007b, 2008b,c, 2009) medical travel guidebooks, a multitude of national IMT 'hub' aspirations and claims, and descriptions of national 'regulatory environments' conducive for IMT investment (e.g., 'special development regions and belts') emphasised the relevance not of the world's *flatness* but rather instead its *graduated* quality (Ong 1999): the imagined and real spatial, regulatory, economic, ethical and cultural diversity and hierarchies that underlie the success of IMT destinations and propel people to visit these places.

The coexistence of narratives on the 'flattened'/'smoothing' and 'graduated' features of IMT destinations, as evidenced by the conference, renders them a dynamic field of inquiry for exploring the governance of IMT practices that transcend relationships with and between discrete national spaces. The previous chapter outlined how the Malaysian state's harnessing of healthcare as a way to bring about national developmental progress, now defined through engagement with global market fundamentalism, brings about new forms of inclusion and exclusion, with access to care no longer correlating necessarily to national citizenship (which itself constituted an attempt at 'flattening' different access to care through belonging to a nation-state). This chapter now looks deeper into how 'Malaysia' is 'put on the map' to qualify for 'world-class' destination status. It argues that IMT stakeholders mitigate Malaysia's 'developing' status through engagement with 'international' standards in specific care sites and among medical professionals to ensure the existence of pockets of 'development' in which Western medical travellers, increasingly trained to look for particular markers of 'quality', can trust their bodies and their pocketbooks. Specifically, I engage with responses by national IMT stakeholders to hegemonic pressures to conform to 'global' healthcare standards in order to participate in an elite geographical imaginary of 'world-class' healthcare that grants access to potentially lucrative Western consumer markets.

With the chapter divided into three sections, I first sketch out the governing assemblage forming around this transnational phenomenon, by tracing the discursive and material shifts from

international to global governance of healthcare that guide a 'flattening' of the medical travel terrain. In the second section, I turn to the multiplicity of transnational agents intermediating between patient-consumers and medical providers in order to bring them together in the healthcare marketplace. Through the navigation and exploitation of the simultaneously 'flat' and 'graduated' meshwork of therapeutic landscapes, these intermediaries play an essential role in articulating the newly governable subjects and spaces of medical travel. In the final section, I examine how efforts to 'flatten' the industry through various means of accreditation and standardisation interact with the varied qualities that have made destinations like Malaysia competitive in the first place by looking at the disciplining practices that involve the quantifying and categorising of foreign patient-consumer flows, medical facilities and healthcare professionals.

4.2 From international to global health governance

Attention to trans-border health concerns traditionally has been concentrated mainly on public health issues (e.g., the containment of epidemics, disease prevention and treatment, reproductive health and infant mortality, substance abuse, famine, etc.) from a state-centric perspective under the guise of *international health governance* (IHG). Underpinned by the view that the nation-state functions as a container, national governments have been considered the appropriate scale of intervention and shouldered the 'primary responsibility for the health of [their] people', working together to protect their domestic populations from trans-border health risks (Dodgson *et al.* 2002: 8). It is within this framework that international bodies emerged in the 19th century to ensure vigilance over international health concerns by facilitating and managing intergovernmental cooperation. While the earlier regimes of IHG were characterised by a narrow biopolitical focus on protecting domestic populations from health risks that would threaten national prosperity made possible by industrialisation and heightened world trade, by the 1920s IHG began to be couched in a philosophy of humanitarianism, informed by the experience of setting up national public health systems that entailed the adoption of a vision of universal entitlement to health. Such notions of entitlement were actively projected and extended beyond national borders, applied in conjunction with the spread of Western-style development models for global prosperity. As a result, the World Health Organisation (WHO), established in 1948 as the UN special agency for health, set as its goal 'the attainment by all peoples of the highest possible level of health', with its underlying universalism being consistently reasserted in the years to follow (with the 1978 'Health for All' Declaration of Alma Ata figuring most prominently). Prescribing standards for states to adopt into their national healthcare practices, the WHO's 'pledge to universality, however, has been strongly defined by the sovereignty of its member states' (Dodgson *et al.* 2002: 11), along with their varying levels of governmental dedication, stability and resources.

In response to 'deterritorialising' neoliberal reforms in the form of deregulation and increased transnational flows of people, goods and services, the significant reterritorialisation of the pursuit and provision of healthcare over the last decades has called for the reconsideration of previous scales and modes of national/international intervention. In a report for the WHO, Dodgson *et al.* (2002: 7-8) advance that IHG is no longer suited to the current globalised context because of the increased volume and influence of non-state actors in health governance, states' own reduced capacity to provide for their populations' health (which has, by extension, limited intergovernmental cooperation on health matters), the introduction/intensification of transborder health risks and the exacerbation of socioeconomic factors that negatively impact health. With IHG increasingly less relevant, Dodgson *et al.* (2002: 12) propose in its wake the post-national concept of *global health governance* (GHG), which recognises the 'new fault lines and allegiances' that have 'emerged to form an increasingly complex milieu for health cooperation, with interests divided within and across countries and organisations'. As health has become increasingly bound up with a range of 'global' concerns, it has been extended into the political arena as an 'integrated global public good' providing benefits to and intersecting with the policy areas of security, trade, development, environmental protection and human rights. This, Fidler (2007: 5) argues, has made 'global health governance something of a sentinel area for how governance in international relations develops generally in the early 21st century'.

While IHG sought to address the challenge of coordinating states' behaviour as regards transborder health concerns, Fidler (2007) suggests that GHG is confronted with 'open-source anarchy' – a dynamic, unstructured and plural space of governance populated by state and non-state actors representing a broad range of interests and purposes engaged with rationalising and harmonising the terrains and subjects of global health. Non-state actors, like civil society groups, social movements, religious missions and philanthropic foundations (e.g., International Red Cross, the Bill and Melinda Gates Foundation, Médecins sans Frontières, etc.), have made significant contributions to the global health landscape with public health interventions complementing and sometimes challenging or marginalising national efforts, targeted often at trans- and sub-national levels. Furthermore, with the advent of WTO free trade agreements that framed health as a trade issue (e.g., the 1994 Agreement on Trade-Related Intellectual Property Rights (TRIPS) and General Agreement on Trade in Services (GATS)), the transnational private sector (e.g., pharmaceutical industry, multinational private hospital groups, etc.) has also become increasingly involved in GHG (e.g., influencing the production and availability of medicines, telemedicine, practice by foreign medical professionals, etc.). As the state's relationship with its citizenry is recast, these non-state actors have increasingly picked up the slack left by the state as well as forging new terrains of their

own, revealing new ‘governance potential in the diversity of actors, interests, norms, processes, initiatives and funding streams’ (Fidler 2007: 4) reflected by the scripting of health as an essential factor in the domains of security, economics and universal rights. The spaces they constitute ‘do not represent a “spatial fix” that replaces the national economy’ – instead, their involvement in new forms of governance comprises ‘a composite of spatialities reaching back into and out from the webs and circuits of the nation-state’ (Larner and Le Heron 2004: 212, 227).

States themselves are fundamental actors in this ‘deterritorialisation’. Governments ‘choos[ing] to trade health services to achieve their national health objectives’ (Shimazono 2007), committing to GATS to varying extents, partially surrender sovereignty over healthcare regulation in exchange for a stronger stake in the ‘flat world base-map’ of global healthcare (Sparke 2009b; see Adlung and Carzaniga 2002; Shaffer *et al.* 2005). These commitments are structured around four principal modes of service supply: Mode 1 – Cross-border supply, Mode 2 – Consumption abroad, Mode 3 – Commercial presence and Mode 4 – Movement of natural persons (see Table 4.1). While most clearly reflected in Mode 2 (Consumption abroad), the IMT industry is articulated through all of these modes, namely the existence (or lack) of restrictions on entry and practice by foreign healthcare providers (Mode 4); restrictions on foreign direct investment in health and other related sectors (e.g., insurance, education and telecommunications) (Modes 1, 2 and 3); and domestic regulatory, infrastructural, financial, capacity and human resources constraints (Chanda 2002; García-Altés 2005: 263).

Since 1994, Malaysia has committed to varied extents to the above four modes in the domains of health services, business and financial services, private higher education and certain professional activities (Blouin *et al.* 2006: 30; Mahani 2005). While from the outset the government did not limit market access for services carried out under Modes 1 and 2, the same was not true for the more sensitive terrains covered by Modes 3 and 4. The establishment of individual or group practices by foreigners was not permitted. The presence of foreign suppliers was possible for large hospitals, pending an economic needs test and on the condition of joint venture so as to limit foreign participation and ensure Malaysian (particularly *bumiputera*) shareholding. The heaviest restrictions were on the movement of foreign labour in order to protect Malaysian jobs, limited to intra-corporate transferees and medical professionals for whose specialities the country was in dire need (Khoo 2009: 4). Such was the situation during the time I was undertaking fieldwork in Malaysia in late 2007 to early 2008, when struggles with the direct impacts of restrictions on Modes 3 and 4 were clear. Managing the chronic shortage of medical and nursing professionals, for example, led to intensive investment in the development and retaining of Malaysian human resources and acquisition of new technology (e.g., the in-country proliferation of nursing schools and a

government-sponsored incentives programme to lure back Malaysian professionals living abroad). The Malaysian government's reticence with regard to further liberalisation stemmed not only from protectionism but also served as a critique of the uneven character of liberalisation. For Tan Lee Cheng, spokesperson for the MOH's Corporate Policy and Health Industry Division, the solution hinges on reciprocity:

This is globalisation, a bilateral trade issue. If you want a share of our market, you should open your market to us, too. But a lot of the first-world countries are not offering healthcare services as part of liberalisation. (Tan interview, 17/01/2008)

Table 4.1 International trade in services – the four modes of supply

Modes	Supplier/consumer relation	Types of health-related services	Examples present in Malaysia
Mode 1: <i>Cross-border supply</i>	The service crosses the border, while the supplier and consumer remain in different countries	Analysis of laboratory samples, diagnosis and clinical consultation via telemedicine, teleconferencing, teleconsultation, tele-education, etc.	Educational twinning programme between Tun Hussein Onn National Eye Hospital and Birla Institute of Technology & Science (India); Provision of consultative assistance by the Mayo Clinic (US) to Normah Medical Specialist Centre
Mode 2: <i>Consumption abroad</i>	Consumers move to the supplier's location and consume the service there	On-site consumption of medical and dental care	Sumatrans and Americans receiving medical care in Penang's private hospitals
Mode 3: <i>Commercial presence</i>	The supplier enters the country of consumption and establishes a commercial presence there	Foreign investment in hospital operation, medical and dental services and management of healthcare	KPJ Healthcare Group's pursuit of endorsement by Harvard Medical International; Shareholding by Parkway Group (Singapore) in Gleneagles and Pantai Group hospitals; Management of Prince Court Medical Centre by Vamed (Austria)
Mode 4: <i>Movement of natural persons</i>	The temporary cross-border movement of labour into the country of consumption	Migration of healthcare personnel from one country to another, whether as a result of intra-corporate transfers, self-employment or salaried labour	International 'expertise-transfer scheme' at Prince Court Medical Centre; Debate over whether Malaysia should permit Japanese doctors to practice in the country at the request of the Japanese expat community

Source: Herman (2009: 3); UNESCAP (2007: 9)

The situation has since changed. Binding commitments to the 1995 ASEAN Framework Agreement on Services (AFAS) and other regional and bilateral FTAs, along with further autonomous liberalisation, led the Malaysian government to withdraw the 30% *bumiputera* equity rule for services in 2009 in the areas of health, social services, tourism, transport, business, IT and financial services in order to 'strengthen our [Malaysia's] economy to face the increasing challenges of

globalisation' (MITI 2009). Furthermore, in the scope of the AFAS, liberalisation designed to improve regional efficiency and competitiveness has extended beyond GATS commitments to foster greater regional cooperation and integration in preparation for the future ASEAN Economic Community (AEC) to be formed in 2015, with signatories obliged to undertake 'complete' liberalisation of the services sector by 2010 so as to render the region a 'more level playing field' and more stable venue for investment (Reuters 16/12/2008). Within the scope of Mode 3 (Commercial presence), the 51% limitation on ASEAN participation switched at the start of 2010 to permit 70% ASEAN equity for healthcare and tourism (MITI 2009). As for Mode 4 (Movement of natural persons), AFAS signatory member-states have entered into Mutual Recognition Arrangements (MRAs) to ensure equal national treatment for service suppliers in ASEAN, facilitating market access by, and therefore the mobility of, registered and certified professionals engaged in engineering, architectural, surveying, accountancy and nursing services as well as medical and dental practitioners through the official recognition of their qualifications (Khoo 2009: 3).

In the midst of such major change, a significant disconnect exists between governments, directly engaged in the trade negotiation process, and local healthcare stakeholders 'on the ground', with many coming belatedly to realise that their work has been recast as a service industry subject to international trade relations. This is illustrated by former Malaysian Medical Association President (2007-2009), Dr Khoo Kah Lin's (2009: 4-5) observations:

International trade in services is a relatively new development as compared to trade in goods and it is inherently different from goods trade: it is intangible, is governed through complex rules and regulations, and its cross-border trade can be provided through different modes of supply. Services cover a very diverse and large number of sectors and sub-sectors, they are under the purview of numerous government agencies and ministries, and some of them may not have (or probably even need) a regulatory framework in place. Healthcare is an even more unique service facing tremendous challenges as it is being transformed into 'another service industry' with all its connotations... A number of packages of liberalisation commitments have been scheduled, MRAs have been concluded, and a number of other works are well underway. These negotiations and legislation have been conducted over many years with minimal lukewarm input from the stakeholders of healthcare delivery [in Malaysia].

As we saw in this chapter's introduction with the issues raised by participants at the 2008 Medical Travel World Congress, as healthcare goes increasingly 'global' and more consumers pursue medical care outside of their countries of residence, IMT discursively transcends conventional state-centric conceptualisations of the terrain of healthcare pursuit and provision. This has resulted in a dearth of governance suited to this branch of trans-border health concerned less with the well-being of national populations and more with that of individual transnational patient-consumers. The current

challenge, therefore, is seen as coming up with effective governance of this fluid ‘flattened’ terrain of globalised health. Because national governments have been careful in outwardly displaying their involvement in the development of IMT (see Chapter III), this industry specifically demonstrates the relevance of non-state and transnational private sector actors in shaping the contours of GHG. It has led Cortez (2008: 73-74) to make the radical claim that the IMT industry has developed ‘almost entirely independently of lawmakers and regulators’, with market interests driving the development of private sector-led mechanisms for industry governance.

It is perhaps no surprise, then, that ‘global healthcare’, which requires the ‘open-source anarchy’ that Fidler (2007) observed, has become the newest term in vogue to describe the ‘new political space’ (Kickbush, in Sparke 2009b: 134) that encompasses what has been variously referred to as ‘medical/health tourism’, ‘cross-border care’, ‘healthcare/medical outsourcing’ and ‘international medical travel’. Its conscious promotion by global industry groups signals a significant shift in the discursive contours of the transnational movement of individual foreign patient-consumers, from one that initially conceptualised it as a temporary patch while imbalances in national healthcare systems get resolved (what Josef Woodman (interview, 17/06/2008), author of *Patients Beyond Borders* and CEO of the Healthy Travel Company, calls the ‘Band-Aid effect’) to something that now reaches beyond the individual scale and grows increasingly more pervasive, lasting and institutionalised. A recent influential Deloitte Center for Health Solutions report goes as far as describing this private sector-led ‘global healthcare’ spatial imaginary as ‘a manifestation of globalisation and a *natural* stage in the lifecycle of the healthcare industry’ (Deloitte 2008c: 7, emphasis added). It embraces the pioneering individual medical traveller as well as the insurers, employers and governments sending those in their care abroad for cost-effective treatment; the transnational expansion of medical institutional subsidiaries and the enhanced possibilities of cross-border referrals; and the material and virtual networks necessary to provide equipment and pharmaceuticals, ensure follow-up care and transfer medical records – all the resources and infrastructure necessary to make the industry function as seamlessly, as borderlessly, as possible. Therefore, while other monikers of the medical travel phenomenon inherently imply flows across the borders of sovereign nation-states, the rhetoric of ‘global healthcare’ instead undertakes the ‘political bull-doing work’ (Sparke 2009b: 137) necessary to evoke the utopian, flattened playing field celebrated in Friedman’s (2006) bestseller that ‘helps him [Friedman] naturalize neoliberal norms and pro-market reforms as the only options available for governance in a flat world’ (Sparke 2009b: 137).

Cortez’s (2008) earlier suggestion that market-based governance has emerged in domains where national regulators and policymakers fear to tread eclipses the significant multifaceted

linkages between the private sector and governmental authorities in the form of public-private partnerships that have fostered and facilitated the liberalisation of healthcare services and expanded flows of patient-consumers, providers, capital and goods. The nation-state's gradual retreat from its role as principle healthcare provider has left it instead to assume the role of regulator and intermediary of private sector healthcare provision, entailing involvement in multi-level transnational regulation that, far from rendering the nation-state less powerful, rescripts elements of nation-states that 'can be plugged into new global arrangements while retaining linkages to their previous national functions' (Porter 2008: 2). Indeed, as we have seen in previous chapters, the national governments of many medical travel destinations (e.g., Barbados, Cuba, India, Malaysia, the Philippines and Singapore) actively collaborate with the private sector in the promotion and regulation of 'global' medical travel (Caballero-Danell and Mugomba 2007). Yet, healthcare provision has so long been articulated within national confines that it has proven particularly difficult to harmonise across borders, meaning that the mechanisms and scale of harmonisation are being constantly re-configured. For this to occur, such paths require adherence to what Levi-Faur (2005) calls 'regulatory capitalism' which, on the heels of deregulation, demands extensive state *re-regulation* linked to other technologies and scales of regulation (e.g., self-regulation, corporate compliance systems, etc.).

4.3 Intermediaries and the governance of 'flat world' healthcare

Underpinning the development of the 'global' medical travel industry is the requirement for simultaneously 'graduated' and 'flat' regulatory environments. 'Graduated' regulation at a range of scales, particularly the national, serves as a catalyst for increasing particular types of transnational patient flows by lending medical travel destinations an attractive 'space of exception' status, thriving off of their uniqueness in order to drive the mobility itself. It provides an enabling spatial context by granting certain patient-consumers access to treatments and procedures not available in other countries, whether due to a lack of expertise and equipment, their experimental status or the moral polemics they provoke (see Chapter I). Depending on the origin of the foreign patient-consumers and the IMT destination, it may also offer comparatively more affordable medical care as a result of national regulation fostering lower overall labour costs, ceilings on doctors' fees, reduced medical legal liability, and preferential entry and visa regimes. The coexistence of diverse national regulatory spaces allows for 'pluralism in motion' (Pennings 2002), wherein, by crossing from one space into another, people, capital and ideas may accomplish different things and permit places to maintain diversity.

At the same time, flat (symmetrical) regulation – the adoption and application of 'international' standards to ensure the same level of quality care across borders – facilitates

transnational flows in different ways. The proliferation of such standards and accreditation schemes within the 'global' medical travel industry attest to this. Conceptualised in Latourian terms as 'immutable mobiles', these standards are often cast as 'objects transferred from one community of practice to another, which have profoundly transformative effects without being transformed themselves' (Dunn 2005: 176-177). Dunn's (2005) work looking at the European Union's standardisation of Poland's food processing industry provides insight into what she terms 'normative governmentality' and the production of 'technozones' – 'technologically homogeneous spaces which cut across geographic and social divisions, thereby ensuring a greater flow of capital, people and goods' (Dunn 2005: 177). The 'flattening' use of standards by the EU is shown by Dunn to be explicit in its objective to fundamentally restructure the industry. The Polish state, driven by its desire prior to accession to join the EU, created its 'Euro conform identity' (Szondi 2009: 295) and ultimately became 'the transmitter and the enforcer of rules that benefit multinational corporations at the expense of its own citizenry' (Dunn 2005: 180). Standardisation thus, at its extreme, has the potential to overshadow and foreclose the competitive advantages derived from the coexistence of 'graduated' regulatory spaces.

Peck and Tickell (2002: 387) have suggested that 'neoliberalism has played a decisive role in constructing the "rules" of inter-local competition by shaping the very metrics' of performance, compliance and competitiveness. Indeed, fundamental to what Sparke (2009b) would call the 'flat world base-map' of commodified healthcare provision is the institutionalisation of standardisation, quality control and accreditation that are held to benefit principally the transnational mobile elite: patient-consumers, corporations and capital (Chee 2007: 4). As with quality control for the food production industry (Dunn 2005; Larner and Le Heron 2004), this has materialised largely in the form of standards derived from practices hailing from 'developed' countries (considered to be leaders in spite of any systemic ills that may be present) that are then disseminated into 'developing' countries.

As a result, the international standardisation of quality in healthcare and medical education is cast by IMT proponents as a progressive step towards increased 'outsourcing', which allows 'developing' countries, the principal spaces in which IMT has taken root, 'to adopt [the] standards, processes and language of developed countries' (Segouin *et al.* 2005: 277) in order to 'credibly signal their quality' and allay fears of medical risk and negligence (Mattoo and Rathindran 2006: 366). Calls are being made for increased private-sector governance and benchmarking measures 'to meet the consumer demands and expectations of medical tourists from the United States, Canada and Western Europe' and help them make 'appropriate' choices in identifying the professionals and facilities that consistently provide high-quality care (Jenner 2008: 243). These include international

accreditation and professional certification, partnerships with renowned Western medical establishments, adoption of international standards for management and laboratories, and disclosure of procedure-specific success rates and hospital infection rates to permit more transparent comparison (Cortez 2008; García-Altés 2005; Horowitz *et al.* 2007; Turner 2007a).

Larner and Le Heron (2004: 216) advance that 'the language of international standards is used by economic actors to confirm membership of international knowledge communities' and that 'such knowledge flows may have important impacts on which activities can be reterritorialised'. Correspondingly, the fulfilment of international standards for healthcare provision brings those holders of accreditation 'not already globally centred' into an exclusive realm, redefining 'core and periphery by linking up those organisations and people understood to have "value" and discarding the rest' (*Ibid.* 2004: 219). Larner and Le Heron suggest that

[c]omparative quantitative techniques such as indicators, standards and benchmarks now play a central role in constituting globalising economic spaces... [T]hese global comparisons have come to make global imaginaries material... [As such,] benchmarking is hybridising as an integral part of evolving systems of globalising (not international) competition, and plays a key role in constituting new placements of capital and labour in new spaces of competition. (*Ibid.* 2004: 212-213)

For traditional commodities, this has meant a shift in focus from increasing volume for greater profit to value-added production focused on nuanced consumer requirements. Similarly, with IMT, 'the patient-consumer' is at the core of calculative practices adopted into the governance of freshly commodified healthcare services. The citizen's entitlement to healthcare within the scope of the nation-state gets rescripted as the consumer's right to 'world-class' quality healthcare services around the world, derived from a 'rights' regime rooted less to a nation-state and more to an internationalised consumer-based entitlement, which frames medical travellers as engaging in acts of resistance in their pursuit of healthcare which, for a range of reasons, are not satisfied in their local healthcare jurisdictions (Milstein and Smith 2006).

IMT highlights the challenge faced by patients and doctors who increasingly must learn to engage with one another as consumers and providers of a commodified service in a globalising economy (Gesler and Kearns 2002). The industry's dominant rhetoric of ensuring the quality of care increasingly requires that patient-*cum*-consumers themselves know how to recognise quality, interpellating an ideal subject that is well-informed and self-advocating, and providers to produce quality that is recognisable to consumers. Industry stakeholders consistently refer to the need to 'educate' and 'empower' patients, translating into a call for the training or disciplining of discerning healthcare-consuming subjects (Rose 2006: 10). As a result, consumer-orientated 'educational' (read 'promotional') campaigns have grown, mobilised by a range of actors employing techniques that bring consumers and providers together on the premise of care for a mutually valued body/self. The

new relationship between patient-consumers and care providers has led to a proliferation of specialised intermediaries intervening on behalf of both and uniting them. While many individual hospitals (e.g., the National Heart Institute (IJN) and Pantai Hospital Kuala Lumpur in Malaysia) are directly involved in courting foreign patient-consumers and taking care of their travel and accommodation arrangements through purpose-built international patient departments and services, a plethora of intermediary services have also emerged in a range of entrepreneurial forms and along a spectrum of involvement (see Table 4.2), seeking not only to close the geographical and knowledge-based gaps between patient-consumers and providers but also to set up and referee the rules establishing their relationship and mutual expectations.

As medical travellers possess varying amounts of (typically lay) knowledge about their medical conditions and solutions, when travelling abroad for care they are thrust into positions in which they must decide upon what is 'necessary' and 'relevant' (Kangas 2002). Patient-consumers are thus increasingly targeted by 'educational' campaigns by medical travel intermediaries to help them better 'understand what they should look for in finding a provider overseas and considerations that should be taken seriously to ensure patients' safety' (MTA 2009a) amid a sea of medical information made accessible via the media and Internet (Parr 2002b). With a view to offering patient-consumers and providers a frame of reference for the establishment of a 'successful cross-border working relationship', the International Medical Travel Association (IMTA) developed an International Patient's Bill of Rights and Responsibilities in accordance with its mission, drawing on human rights language, 'to see [that] all patients, everywhere in the world, have access to affordable, high-quality healthcare' (IMTA 2008). Similarly, Woodman's⁵⁶ expansive *Patients Beyond Borders: Everybody's Guide to Affordable, World-Class Medical Travel (PBB)* series seeks to 'educate' the pioneering individual American medical traveller who has taken matters into his/her own hands, currently the central archetype for the global industry.⁵⁷ The most influential medical travel guidebook on offer (cf. Hancock 2008; Marsek and Sharp 2009; Shult 2006), *PBB* has been compared to *Lonely Planet* for its presumed impact on the growing IMT industry (NST 07/07/2009), providing information on hospitals, IMT facilitators and luxurious long-stay accommodation and giving broad advice on what to look for, ask and expect, and who and what to bring.⁵⁸

56 Josef Woodman has become the de facto spokesperson for international patient-consumers and a permanent fixture at international conferences, giving interviews with major international media outlets and influential American institutions and associations from the highly-valued consumer perspective that private-sector medical care providers and policy-makers desperately crave.

57 While the international guide has been translated into several languages, including Japanese and Arabic, these editions have not been adapted to respond to patient-consumer requirements or concerns different from those that are covered in the original guidebook geared towards an archetypal American patient-consumer.

58 The book is organised by country, and then by hospital, accommodation provider and medical travel

Intermediaries such as these concerned with the issue of ‘quality of care’ both develop patient-consumers’ expectations of medical experiences abroad and tune providers into the relevance of catering for their needs. ‘Quality of care’ concerns revolve predominantly around the risk of receiving sub-standard medical care, navigating unfamiliar legal systems, limited liability and restricted medical negligence and malpractice coverage among providers in IMT destinations largely located in ‘developing’ countries (Hopkins *et al.* 2009; Mirren-Singer 2007; Turner 2007b). Patient-consumers are thus entreated to find out about hospital accreditation, affiliations and partnerships; disclosure of success rates, the number of surgeries performed; technology available; doctors’ professional credentials and membership to professional associations; the volume of patients they treat, both overall and for patients with similar conditions; efforts made to ensure continuity of care; and rights to legal recourse (AMA 2008; Milstein and Smith 2007; Tam and Lim 2007; Woodman 2008a).

Figure 4.1 Covers of some of the Patients Beyond Borders country-specific editions: Malaysia (English), Singapore (Arabic) and Thailand (English)

(images removed)

Source: Healthy Travel Media (2010)

On the heels of the international guidebook, country-specific editions of *PBB* were compiled by Woodman in collaboration with local industry and governmental stakeholders in Korea, Malaysia⁵⁹, Singapore, Taiwan, Thailand and Turkey (see Figure 4.1). As noted in Chapter I, these country-specific editions of *PBB* serve more as prestigious national marketing tools than planning instruments used by prospective medical travellers. Taiwan and Korea, for example, currently hold negligible shares of the IMT market. However, these countries’ governments and private sectors have injected substantial funds for the promotion and development of the IMT industry, leading them to use *PBB* as a way to establish their authority early on. Since a *PBB* profile is held to amount to tacit endorsement of these destinations for American medical travellers, Woodman’s company, Healthy Travel Media, capitalises on *PBB*’s status to help medical enterprises ‘succeed’ via guidebook sales, a solid internet presence, Woodman’s public relations activities, the potential for establishing strategic partnerships and branding (Healthy Travel Media 2009). As evidenced by Woodman’s extensive promotional apparatus, a powerful group of intermediaries is growing up around advising and linking IMT destinations in ‘developing’ countries with potential ‘gold mine’ markets (e.g., the

agency. The first edition featured 13 countries (Antigua, Barbados, Brazil, Costa Rica, Czech Republic, Hungary, India, Malaysia, Mexico, Singapore, Thailand and the United Arab Emirates) and the second edition includes 20 (adding Israel, Jordan, Korea, New Zealand, Panama, the Philippines, Taiwan and Turkey).

⁵⁹ The APHM was largely responsible for endorsing and helping to produce the Malaysia edition of *PBB* (Woodman 2009), prepared under the coordination of Andrew Burr of the KPJ Hospital Group.

American un(der)insured) and their corporate and governmental gatekeepers. This industry involves professional associations, like the US-based Medical Travel Association (MTA, a.k.a. Global Healthcare Association), which organise large-scale global business-to-business conferences and publish magazines promoting segments of the industry and industry-focused newsletters. Others function more as lobby groups for IMT destinations, like the (now defunct) Singapore-based International Medical Travel Association (IMTA) which established a memorandum of understanding with the Pacific Asia Travel Association (PATA) to strengthen linkages between travel search engines, IMT-friendly hotels and hospitals serving foreigners (IMTJ 16/06/2009).

While healthcare institutions and professions are subject to state regulation and private-sector accreditation schemes to uphold their quality, there is a dearth in control over the medical travel intermediaries. Prospective international patient-consumers are confronted with choosing which types of intermediaries to turn to or whether not to use them at all and instead opt to make arrangements directly with hospitals themselves. An anonymous executive of a Malaysia-based medical travel intermediary headquartered in the Klang Valley (interview, 10/03/2008) suggests that,

Using medical tourism companies is very sensible. But the whole thing is that there are so many – I don't want to call them necessarily 'rogue' medical tourism companies – inexperienced small mom-and-pop stores that don't really know what they are doing. They're just in it for the buck and can actually damage the reputation of the medical tourism industry. So, we, in the long-term, want to try, together with the [Malaysian] Ministry of Health, to make some kind of a regulation for medical tourism companies that have to meet a certain criteria to be involved, to be licensed, because at the moment you can licence yourself and be in this game and claim to be the best and the finest and that you know what's going on – even if you don't. Regulation in the medical tourism business is not there. It's 'self-regulated', if you'd like to call it that. So, if you come from the outside, how do you know which is a serious medical tourism company and which isn't?

Private sector initiatives to standardise the role of intermediaries are murky at this early stage in the industry's development. As few medical travel intermediaries actually possess clinical expertise, there is concern that they are not sufficiently qualified to broker interactions between patient-consumers and medical providers (Horowitz *et al.* 2007; Turner 2007a, 2007b; Whittaker 2008). Though they may increasingly perform functions akin to those of managed care organisations, by evaluating patient-consumers and screening them for risk, negotiating discounts with hospitals and affiliating themselves with particular doctors and medical institutions, the serious risk of legal liability leads to a slew of disclaimers. The MedRetreat (2009) website, for example, includes this disclaimer:

Table 4.2 Medical travel intermediaries

Type	Function	Examples with involvement in Malaysia
Industry-specific professional associations	<ul style="list-style-type: none"> • Arrange business-to-business networking opportunities (e.g., conferences, internet social networking) to link up media, medical travel intermediaries and medical care providers; develop industry guidelines and standards for patient-consumers and providers • Publish materials (e.g., newsletters discussing industry developments and concerns, media profiling operators and destinations, etc.) • May host information on member providers, allowing prospective patient-consumers to directly contact them • Lobbying • Physical, online and print formats 	International Medical Travel Association; Medical Tourism Association
Medical travel information clearinghouses	<ul style="list-style-type: none"> • Host information that has been sponsored by patient brokers and healthcare providers, allowing prospective patient-consumers to directly contact brokers and providers themselves • May allow for posting of independent 'travel reviews' • Online format 	RevaHealth; Treatment Abroad
Medical travel guides	<ul style="list-style-type: none"> • Include information on selecting procedures, medical care providers, patient brokers, accommodation • Discuss travel concerns and features of the IMT destination • May independently gather information or feature information sponsored by providers • May lobby on behalf of patient-consumers to the media and providers • Print and online formats 	<i>Patients Beyond Borders: Everybody's Guide to Affordable, World-Class Medical Travel</i> (Woodman 2007, 2008, 2009); <i>An Idiot's Guide to Medical Travel</i> (Marsek and Sharpe 2009)
Medical travel insurers	<ul style="list-style-type: none"> • Provide comprehensive coverage for medical travellers (e.g., medical procedure coverage, travel companion coverage and coverage for medical complications, trip cancellation, interruption/delay, acute medical treatments, evacuation and repatriation) 	Companion Global Healthcare; Bordercross Worldwide (Seven Corners); Angelis
Travel operators	<ul style="list-style-type: none"> • Arrange conventional travel services to facilitate and supplement medical care received (e.g., transportation, accommodation, organised tours, etc.) • May be hired directly by hospitals • Physical and online formats 	Trade Winds Travel and Tours (serving the KPJ Hospital Group); Jejak Warisan Tours & Travel (serving Mahkota Medical Centre)
Medical travel facilitators, brokers and concierges	<ul style="list-style-type: none"> • Pair patient-consumers with affiliated medical institutions and/or individual doctors for specific procedures • Negotiate special prices for procedures in exchange for securing a particular patient volume • May offer conventional travel services and supplementary tourism packages • May provide door-to-door concierge service (e.g., visa assistance, airport pick-up, local transportation, pre-op/post-op accompaniment, etc.) • Physical and online formats 	Cure on Tour; Gorgeous Getaways; Malaysia Healthcare; MediTravel; MedRetreat

We are not medical professionals and will not discuss or advise any issues relating to medical treatment. We facilitate contact with, and provide information about doctors outside the US and provide information about their credentials in order for you to make informed decisions. We do not, however, recommend any preferred or specific doctors for your desired medical treatment. We encourage and advise you to discuss all medical issues with your medical doctor in the United States, before making a decision on medical treatment outside the United States. Through our medical tourism affiliates around the world and our in-depth research we provide information about available medical treatment and recuperation and packages to assist you making an informed decision. You agree to assume all responsibility in connection with choosing any doctor for your desired procedure. We assume no responsibility or liability for any treatment or other services rendered by any doctor, or for any malpractice claims and other claims that may arise directly or indirectly from any such advice, treatment or other services.

‘We clearly define where our boundaries are. If the patients want specific medical information, first we’ll give them information from the specialist and then we’ll organise a conference-call with the specialist’, observes Danny Jee (interview, 12/02/2008), manager of the Kuala Lumpur-based Holiday Travel agency which expanded to include medical travel in 2007. Pilot efforts are being undertaken by some governments, professional associations and information clearinghouses to identify quality indicators and implement a system of certification for medical travel intermediaries. The Singapore Workforce Development Agency, for example, created a three-month certification course, while the MTA and Treatment Abroad (a for-profit medical travel information clearinghouse) have both launched fee-based medical travel facilitator certification programmes (MTA 2008; Singapore Government 2009; Treatment Abroad 2008). While MTA certification involves an ‘outside objective’ evaluation process, Treatment Abroad relies on self-assessment of compliance with a check-list for informing and ‘reassuring’ medical travellers. Still, many facilitators still find it safest to restrict themselves to handling low-risk, routine treatments for non-chronic conditions.

4.4 Forging landscapes of ‘international legitimacy’

The campaign to ‘educate’ patient-consumers has spurred providers to demonstrate greater responsibility, being more forthright in their reporting practices, and to turn away risky patient-consumers whose health outcomes might ‘skew’ their impressive figures and damage

reputations. It has also led to calls for a single 'transparent' methodology for the identification and reporting of clinical and quality indicators⁶⁰ in order to boost the confidence of prospective patient-consumers, employers and insurance companies in IMT facilities' attention to patient safety. Observations by the MTA (2007) highlight the perceived core of the problem:

One of the biggest obstacles to the growth of the medical tourism industry is that no one in the world can compare international hospitals in terms of quality of care or outcomes because every hospital has their own 'methodology' on how to obtain that information and different quality indicators.

The paving process of standardisation, however, has been unsurprisingly far from smooth-going. For this reason, multiple standardisation schemes, benchmarks and quality indicators, whether formally recognised and developed or informally transposed and adopted, are emerging to regulate medical facilities, professionals and equipment. As such, IMT destinations in 'developing' countries seeking to overcome the stigma of their location use 'international' standards to forge fragmented sites or pockets of 'development' in which individual patient-consumers can trust their bodies and pocketbooks and, more significantly for future IMT flows out of 'developed' countries, to facilitate the portability of health insurance coverage (UNCTAD 1997: 10).

4.4.1 Hospital accreditation

Extensive media coverage of two cases of medical negligence in Malaysian hospitals (which were not endorsed by the MOH for IMT) in mid-2007 prompted one local commentator to note: 'To a certain extent, these incidents, especially if reported overseas, could have an adverse effect on Malaysia's ambition to be a major player in the medical travel market – where there is significant competition from Singapore, Thailand, the Philippines and India' (George 29/6/2007).

His solution? Hospitals with

international accreditation would have a significant competitive edge in attracting medical tourists from both developed and developing countries as there is an assurance of certain standards being

60 For hospitals, indicators commonly include medication errors, hospital re-admissions, returns to operating theatre, pressure ulcers, patient falls, patient deaths, blood transfusions, day of surgery admissions and thromboprophylaxis, five treatment areas (e.g., heart attack, heart failure, community acquired pneumonia, pregnancy and related conditions) and surgical infection prevention. The Australian Council on Healthcare Standards (ACHS) Clinical Indicator Programme and JCI Hospital Quality Indicator Project have been used to guide facilities in IMT destinations as they develop quality control programmes of their own.

maintained... It would also be a welcome reassurance to Malaysians when seeking medical treatment to know that Malaysian hospitals are internationally accredited. (George 29/06/2007)

With accreditation's focus on structures, processes and outcomes, this risk-aversion measure contributes towards ensuring that Malaysia's overall reputation goes untarnished and permits the country to compete with other IMT destinations and retain Malaysian patient-consumers (see Chapter III). Accreditation can be characterised as both patient- and organisation-focused, aimed at cultivating a working culture of continuous improvement, identifying effective leadership, promoting greater transparency as regards evidence of outcomes and striving for best practice in clinical, support and corporate areas. Its standards verify access, assessment and continuity of patient care, management of medication, patient rights and education, hospital infection control, continuous quality improvement, responsibilities of management, facility management and safety, human resource management, and information management systems.

As the MOH steps away from being the country's primary provider and supports the expansion of private medical care in its stead, it assumes an even greater regulatory role. This is reinforced by the MOH's new attention to the quality of both public and private healthcare service provision. For all the country's private hospitals, the MOH currently enforces the licensure and quality control requirements set forth in the 1998 Private Health Care Facilities and Services Act (PHCFSA), which requires facilities to conduct 'quality improvement activities', which include incident reporting, infection control and mortality review, in order to 'correct the imbalances in standards and quality of care as well as rationalise medical charges in the private health sector to more affordable levels' (EPU 2000: 486; Malaysian Government 2004; Merican 17/03/2008). External, non-governmental accreditation, however, was cast early on by government authorities themselves as 'invaluable testimony to the quality of our [Malaysian] healthcare services' (Chua 11/04/2002; *Business Times* 02/10/1999). While all private and public hospitals in the country require basic MOH licensure in order to be operational, official statements like these effectively translate into the government's tacit recognition that the basic standards it enforces for all medical facilities may not be sufficient for those competing at the 'global' level.

Medical facilities in Malaysia began to comply with – and subsequently advertise their successful acquisition of – internationally recognised quality standards. These at first included the ISO 9000 family of standards for quality management systems, which certify organisations'

application of these processes but not the quality of their end-products; ISO 15189, which specifies requirements for quality and competence in medical laboratories (T. 02/10/2006); and OHSAS 18001, which provides requirements for occupational health and safety management systems. Yet, because ISO certification is geared towards administration and less suited to monitoring hospitals' clinically-based work, in recent years the MOH has urged hospitals to stop 'chasing after ISO certification and instead concentrate on serving patients and attaining accreditation of international standard' (NST 21/07/2007), specifically those issued by the 'home-grown' Malaysian Society for Quality in Health (MSQH) and the US-based Joint Commission International (JCI) (see Table 4.5).

Accreditation attempts in these early years of the sector's development have resulted in a market of rival benchmarks, with a range of national and international schemes competing for pride-of-place among health service providers (see Table 4.6). Parallel to this, the WHO encouraged the development of national healthcare accreditation bodies, resulting in the proliferation of councils developing national standards in the late 1990s (e.g., India's National Accreditation Board for Hospitals and Healthcare Providers (1997) and the Institute of Hospital Quality Improvement and Accreditation Thailand (1999)). In 1997 the Malaysian MOH, together with the APHM and the Malaysian Medical Association (MMA), developed a national-level accreditation programme to be monitored and carried out by a purpose-built independent body, the Malaysian Society for Quality in Health (MSQH). With board members including representatives of the above bodies and private hospital groups, the MSQH is a product of governmental recognition of the need to share power with the private sector in the national regulation and provision of healthcare:

Quality patient care must be the fundamental value of a nation's health system. As Malaysia is moving towards the attainment of the objective of Vision 2020, i.e. to be a developed industrialised nation, and as the thrust is towards privatisation, corporatisation and decentralisation, it becomes imperative that we develop a systematic approach to monitoring and evaluating the quality of healthcare provided. (MSQH 2008)

MSQH CEO Dr M.A. Kadar (interview, 12/03/2008) hints at an additional motive:

The entire population was becoming more litigious. They're becoming very educated. There was an explosion of information on the internet. With easy access, people know what is going on in other countries and what other patients have been experiencing.

As a result of this growing global awareness, MSQH standards draw from those established by the Australian Council on Healthcare Standards, touted as part of 'the reason foreigners and locals alike have placed their confidence in Malaysia's hospitals' (Tourism Malaysia 2008b; Khor interview, 06/03/2008). These benchmarks, 'adapted to local conditions', focus on five areas: organisation and management, human resources and management, policies and procedures, facilities and equipment, quality improvement activities and safety. Yet, while strongly advised to attain MSQH accreditation, only 22 of the 35 IMT hospitals currently hold it. The slow uptake has proven worrisome to officials, leading the MOH to threaten that only accredited hospitals would be included in the national government's IMT promotional campaigns (though this has not occurred in practice) (Jegasothy 03/07/2007).

MSQH accreditation faces its stiffest competition in Malaysia from the US-based JCI. While MSQH and JCI are both of 'international stature', as members of the International Society for Quality in Healthcare (ISQua) which effectively holds them to an equivalent benchmark (*IMTJ* 07/05/2009), JCI accreditation increasingly serves as the principal 'golden seal' for the IMT industry. Set up in the late 1990s by the Joint Commission on Accreditation of Healthcare Organizations, an independent not-for-profit body which evaluates and accredits over 15,000 US-based healthcare organisations, JCI accreditation was 'designed to respond to the growing demand around the world for standards-based evaluation in health care' (JCI 2003: 1). JCI accreditation is currently held by 250 facilities across 36 countries wishing to 'demonstrate their commitment towards quality' (Treatment Abroad 17/04/2009). Compared with the lesser-known MSQH, JCI benefits from far greater brand recognition due to its association with the United States' renown as a site of medical excellence (for those who can pay for it). US stakeholders have demonstrated keen interest in investing in the IMT industry from its early stages, seeking to set the standards that serve to maintain the country's international benchmark status. For instance, Cortez (2008: 75) suggests that,

given the limits of regulating a global market unilaterally... the United States guide the market by cooperating with other countries to harmonise insurance standards, quality standards, physician licensing, and hospital accreditation.

Other IMT proponents see great economic opportunity for American medical schools and professional societies' participation in 'the brave new world of globalized medicine' – in

shar[ing] information across cultures and offer[ing] courses to foreign physicians, researchers and clinicians, possible performance gaps might be reduced in *helping to assure the quality of care worldwide for US and other patients*. (York 2008: 102, emphasis added)

Hospitals throughout the world invest heavily in their pursuit of JCI accreditation because it is portrayed as *the* ticket for attracting foreign – especially the ‘gold mine’ American and Middle Eastern – patient-consumers who have been trained by medical travel intermediaries to expect IMT facilities to hold international accreditation. In the spirit of the Cold War ‘Space Race’, the then Health Minister Choi Soi Lek voiced his concern in 2007 that, while many hospitals in neighbouring competitors Thailand and Singapore were already JCI-accredited, no Malaysian hospital at that time had applied for it: ‘If we want Malaysia to build up the health tourism sector, hospitals must work towards getting JCI accreditation, as it is a quality benchmark and will give confidence to foreign patients’ (*The Star* 21/07/2007). Notes Penang Adventist Hospital’s Marketing Director, Khor Thean Heng (interview, 06/03/2008),

Commercially, JCI is obviously better known. So, we have no choice but to embark on attaining JCI accreditation. We felt that it was good for the hospital, for us, as part of a learning process and our continuing quality improvement. It’s not about getting the JCI, it’s the process of preparing, the journey, which actually brings the hospital’s awareness of safety and communication to the next level.

To date, six facilities in Malaysia – Hospital Pantai Kuala Lumpur International Specialist Eye Centre (ISEC), National Heart Institute (IJN), Penang Adventist Hospital, Prince Court Medical Centre and Sime Darby Medical Centre Subang Jaya – hold JCI accreditation. While several more are on their way towards acquiring it (*NST* 27/08/2007; *The Star* 08/03/2009), this continues to constitute only a fraction of the JCI-accredited facilities that can be found in regional IMT competitors like India (18 facilities), Singapore (18) and Thailand (20) (JCI 2010).

Table 4.5 Publicised accreditation and certification among the 35 endorsed IMT facilities

<i>Hospital name</i>			<i>ISO</i>	<i>MSQH</i>	<i>JCI</i>	<i>Hospital name</i>			<i>ISO</i>	<i>MSQH</i>	<i>JCI</i>
Klang Valley (18/35)						Johor (1/35)					
1	KPJ Ampang Puteri Specialist Hospital		✓	✓		22	KPJ Johor Specialist Hospital		✓	✓	
2	Assunta Hospital		✓	✓		Malacca (3/35)					
3	Columbia Asia Medical Centre			✓		23	Mahkota Medical Centre			✓	
4	KPJ Damansara Specialist Hospital		✓	✓		24	Pantai Hospital Ayer Keroh			✓	×
5	Gleneagles Intan Medical Centre		✓	✓	×	25	Putra Specialist Hospital				
6	National Heart Institute (IJN)		✓	✓	✓	Penang (7/35)					
7	NCI Cancer Hospital		✓			26	Gleneagles Medical Centre			✓	×
8	Pantai Hospital Kuala Lumpur		✓	✓	✓	27	Island Hospital		✓		
9	Prince Court Medical Centre			✓	✓	28	Lam Wah Ee Hospital		✓	✓	
10	KPJ Selangor Specialist Hospital		✓	✓		29	Loh Guan Lye Specialists Centre		✓	✓	
11	Sentosa Medical Centre		✓			30	Mount Miriam Cancer Hospital		✓		
12	Sime Darby Medical Centre Subang Jaya		✓	✓	✓	31	Pantai Hospital Penang		✓	✓	×
13	Sunway Medical Centre		✓	✓		32	Penang Adventist Hospital			✓	✓
14	Taman Desa Medical Centre					Sabah and Sarawak (3/35)					
15	Tawakal Hospital		✓			33	Normah Medical Specialist Centre			✓	
16	TMC Fertility Centre		✓			34	Sabah Medical Centre				
17	Tun Hussein Onn National Eye Hospital		✓			35	Timberland Medical Centre				
18	Tung Shin Hospital										
Perak (3/35)											
19	Fatimah Hospital		✓	✓							
20	Hospital Pantai Putri		✓								
21	KPJ Ipoh Specialist Hospital		✓	✓							

Source: MSQH (Apr. 2010); JCI (Jan. 2010)

✓ = Accredited/Certified

× = Working towards accreditation

Table 4.6 Prominent international healthcare accreditation schemes

Accreditation	Origin	Est.	Adopted
Joint Commission International	US	1999	36 countries
Trent Accreditation Scheme	UK	1999	UK, Hong Kong, the Philippines and Malta
Australian Council on Healthcare Standards International	Australia	2005	Bahrain, India and New Zealand
Accreditation Canada International	Canada	1995	Bahrain, Kuwait, Saudi Arabia and the UAE
Council for Health Services Accreditation of Southern Africa	South Africa	1996	South Africa, Botswana, Swaziland and Zambia

Petronas-owned Prince Court Medical Centre's (PCMC) dealings with accreditation hints at the importance of JCI in shaping budding reputations. Borne out of, in the words of its Australian CEO Stuart Rowley (interview, 17/03/2008), 'a Malaysian vision to be the forerunner in the provision of clinical services and patient care delivery in Asia', PCMC has been explicit in its aspirations to become a benchmark facility on par with the likes of the Mayo Clinic. PCMC constitutes the next iconic landmark project to follow on the heels of the Petronas Towers built in the 1990s. In his discussion of the Towers' symbolism, Bunnell (2006: 78) suggested that they are not only representative – a centrepiece in the 'national showcase of modernity' – but also performative: shaping 'the way others see – or [are] said to see – Malaysia add[s] "global" legitimacy to new ways in which Malaysians [a]re intended to see themselves'. As the Towers demonstrate, domestically and abroad, that Malaysia(ns) can compete on the global stage when it comes to business and industry, so PCMC's 'world class' healthcare aspirations make this assertion in the realms of patient/customer care and medical science and technology with the construction of a medical 'monument' (Kearns *et al.* 2003: 2304) and the contracting of Vamed.⁶¹ Having opened in 2008, the grandiose 300-bed facility with seven centres of excellence, designed by an Australian architect to look and feel more like a luxury hotel or conference centre than a hospital, is purported to host some of the most technologically cutting-edge facilities in Southeast Asia as well as an upscale café, restaurant and a selection of Petronas' extensive art collection (see Figure 4.2). PCMC generates its high-profile image by playing it safe. Not aggressively tapping into the individual foreign patient-consumer market, it carefully hand-picks the medical travel facilitators with which it wishes to be allied. It aspires to maintain a 30% average foreign patient-consumer load derived mostly from memoranda of

⁶¹ Vamed has plans for further development of the country's medical management and professional skills, expanding its involvement in IJN and facilities in future IMT hot spots (Ganesan 08/03/2008).

understanding between the hospital and corporations and governments wishing to send their employees and citizens abroad for routine low-risk procedures, allowing it to turn away patient-consumers that might not yield positive medical outcomes. The careful cultivation of the hospital's image in the early years of its operation has been paramount to its success, now strategically positioned as the showpiece of the 'Malaysia Healthcare' brand. Part of constructing this image of excellence meant that it opted to acquire JCI accreditation prior to getting on the MSQH bandwagon because of the perspective that '[t]he Malaysian Society for Quality in Health standard that most hospitals have may convince locals but it will not be enough to attract medical tourists' (Rowley, in *NST* 20/04/2009).

At the same time, ever-increasing pressures to acquire JCI accreditation have frustrated some IMT stakeholders in Malaysia. Not only are JCI application fees expensive (averaging USD 41,000 for the survey alone (Helen Ziegler & Associates 2009)) but the application process implies additional costs associated with heavy investment of hospitals' time and human, financial and material resources. In light of the burden that JCI represents, several stakeholders note that escalating costs would ultimately be shouldered by patient-consumers and consequently reduce Malaysia's appeal as a value-for-money destination. Notes an anonymous Penang-based marketing representative for a major private Malaysian medical care facility (interview, 04/03/2008),

At the end of the day, you have to be serving it up one way or another... The patients are bearing [the costs]... But, if you don't have JCI, some patients might not feel comfortable with you, because you don't have that standard they feel they should have when they come here.

Furthermore, there is concern that focusing on 'just JCI-accredited overseas hospitals is short-sighted as... doing so... is in essence ruling out many other first-world country-based hospital providers' (Watson, in *Merican* 17/03/2008), such as the Australian Council on Healthcare Standards on which MSQH is modelled. This situation prompted *PBB* author Josef Woodman at the 2008 Medical Travel World Congress in Kuala Lumpur to voice the widely-held concern that JCI may increasingly function 'more as a marketing tool than a "Who's Who" in international medical care'.⁶²

⁶² Still, the *PBB* guides, geared to an American readership, include information on whether or not facilities are JCI accredited, though national accreditation schemes are also explained and held in high regard.

Figure 4.2 Prince Court Medical Centre (PCMC) building and promotional image of staff

(images removed)

Sources (Clockwise): PCMC's exterior (hoonmeng 2007); Staff photo on the PCMC website (PCMC 2010); Hydrotherapy pool (Author 2008); Detail of a patient suite (Author 2008)

Furthermore, in spite of the widely-held belief that JCI accreditation roughly translates into possessing facilities, management and clinical practices up to 'American standards' (Merican 17/03/2008), JCI standards are not equivalent to those used to assess US institutions. Rather, instead of constituting some 'immutable mobile', they were derived from a set of standards from various parts of the world and adapted to local needs, accommodating countries' legal and cultural factors while maintaining uniform standards for clinical services and safety, rendering them comparable to but not the same as those of the Joint Commission (*Medical Tourism Insight* 2008). For Dr Kadar, the focus on 'flat world base-map' accreditation runs contrary to adapting to the requirements of a 'graduated' medical landscape:

That's the reason that the WHO encourages every country to develop their own accreditation programmes with their own standards because you always need to address your local issues. (Kadar interview, 13/03/2008)

To him, JCI has strategically co-opted the word 'international' to create the illusion of its reigning legitimacy in the global arena.

In response to what some see as hegemonic American involvement in the burgeoning industry, the APHM and MOH also have pushed for the formation of an Asian branch of the International Society for Quality in Health Care (ISQua) known as ASQua, bringing together a diverse array of Asian accreditation councils and chaired by APHM's former president, Dr Kulaveerasingam. This move reflects Malaysia's antagonism to perceived US dominance over the industry, the core relevance of Asian destinations in IMT flows to Malaysia (see Chapter VI) and Malaysia's own regional hub aspirations. Standardisation via accreditation has been a central technique to accomplish this, resisting the American-dominated 'global'. Accordingly, Friedman's (2006) suggestion that the great flattener of 'democratic capitalism' renders 'all four corners of the flat world' as real players holds great allure:

Globalization now belongs to everyone who can figure out how to take advantage of its opportunities and minimize its dislocations. America-bred technology may be its midwife, but

Americans are no longer solely the parents. That's a big power shift indeed. (Gardels, in Friedman 2006: 488)

MSQH, having 'figured out how to take advantage of its opportunities and minimise its dislocations' (Kamarul 28/04/2009) is, as a result, positioned increasingly as an accreditation body equivalent to JCI because of its link to ISQua. 'Malaysia', emphasises APHM President Dr Jacob Thomas,

is emerging as a significant destination for affordable, quality healthcare as its hospitals have been accredited to International Healthcare Standards by the International Society for Quality in Health Care (ISQua). (Thomas, in *Business Intelligence – Middle East* 01/09/2009)

The next step is for MSQH to expand into nearby countries, like Brunei, without national accreditation schemes of their own.

4.4.2 Medical professionals

The ways in which IMT destinations demonstrate their credentials are proliferating. Global networking among medical professionals becomes increasingly important to facilitate cross-border referrals and arrange appropriate follow-up care once patient-consumers return to their countries of residence. Suresh Ponnudurai, the CEO of medical travel intermediary Tropical Flow – MalaysiaHealthcare Networks (interview, 18/12/2007), demonstrates this with his observation,

How do you tell somebody oceans away that you have good doctors? You can look at a hospital, yeah – but it's about building credibility by communicating with the doctors before they come, through the information flow.

While the industry's focus has been largely concentrated on promoting hospitals as IMT destinations, there are moves towards recognising individual medical professionals as being just as relevant to patient-consumers' choice of destination. Doctors are held to possess particular drawing power. It is common practice among the Malaysian hospitals most aggressively promoting IMT to send doctors – the 'rockstars' of healthcare provision – on talking-engagement road-shows in Indonesia to meet, for example, with Lions' and Rotary Club audiences in order to promote their services. 'We can get instant results from that', notes an anonymous major Malaysian hospital group manager (interview, 18/12/2007) heavily involved in promoting her group's image in Asia and the Middle East. Further afield, with Western patient-consumers and their doctors back home increasingly 'educated' by industry associations,

online medical travel facilitators and guidebooks, they have begun to demand the credentials of medical professionals that will be responsible for treatment. Because of the physical distance that separates these prospective medical travellers and their local doctors from the IMT destination, doctors' educational credentials and membership to professional associations as well as the volume of patients they treat become increasingly relevant 'at-a-glance' remote indicators, permitting their engagement in the global healthcare marketplace just as accreditation does for medical facilities.

An internet presence is particularly key to the promotion of IMT destinations among Western patient-consumers. With significant proportions turning to online medical travel promotional clearinghouses and facilitators in order to decide whether to go abroad and where to pursue care, how care provision itself gets depicted is of the utmost importance. MedRetreat (2010), using an image of Penang's luxurious Eastern & Oriental colonial-era hotel to represent Malaysia, waxes,

Multi-ethnic, multi-cultural, and multi-lingual, Malaysia is an excellent choice for meeting the healthcare needs of international medical tourism patients... Being a former British Colony, English is spoken everywhere. The favorable exchange rate of the US Dollar to the Malaysian Ringgit makes the already low cost medical treatment an incredible value to medical tourists. Many of the private hospitals in Malaysia are also applying for JCI accreditation in order to attract more international patients. Our partner hospitals in Malaysia are either already JCI accredited, or are in their final stages, are American managed, or are sponsored by some of the largest American companies.

This non-Malaysia-based Western-orientated intermediary touts the country's colonial past, evidenced by explanations for Malaysians' ability to speak English and their medical training in the UK and other Anglophone countries as well as the images of colonial-period architecture, in order to situate Malaysia as a destination in which patient-consumers from 'developed' countries can feel at home (see Figure 4.3). While sites like this often nod to the colourful and exotic, with imagery of 'traditional' costume and assertions of the country's vibrant cultural diversity, at the same time significant effort is made to underscore that Malaysian medical care providers were trained and abide by standards and codes established elsewhere. Prospective patient-consumers from 'developed' countries, thus, are reassured that Malaysia is sufficiently integrated into the right kinds of global networks to guarantee an excellent 'world-class' (read 'sufficiently "first-world"') care experience.

Figure 4.3 MedRetreat web profile of Malaysia

(image removed)

Source: MedRetreat (2010)

While all doctors must be licensed members of the Malaysian Medical Council (MMC) to practice in Malaysia, prestigious foreign-based educational credentials are increasingly turned to as indicators of quality in the absence of formal international standards. However, there have been pushes towards the development and implementation of formal standards. For example, steeped in the Ameri-centrism dominating much of the cross-border trade in healthcare discourse that reflects the reticence of lawsuit-fearing US employers and insurers to send American patients abroad for outsourced care, some suggest that

doctors and nurses in export-oriented health care organizations could credibly signal quality by passing, respectively, the U.S. Medical Licensing Exam (USMLE) and the National Council Licensure Examination for Registered Nurses (NCLEX-RN). Since foreign medical graduates who practice medicine in the United States are obliged to pass these examinations, a *natural* extension from a trade in health care perspective would be to institute a similar requirement for foreign physicians in export-oriented health care organizations abroad. (Mattoo and Rathindran 2006: 366, emphasis added)

Short of such requirements, however, and from Malaysia's own Commonwealth-orientated perspective, foreign medical diplomas and fellowships with the royal colleges (e.g., Royal College of Surgeons, of Obstetricians and Gynaecologists, of Ophthalmologists, of Radiologists, etc.) in Edinburgh, Glasgow, Ireland and England – indicated by the 'FRCS' acronym following doctors' names – have come to be internationally recognised benchmarks against which they can be assessed and stand out from among their peers.

As we saw in Chapter IV, a strong competitive advantage for Malaysia derives paradoxically from the country's colonial legacy, with its current healthcare system owing much to the way in which healthcare provision was set up during the colonial period and its continued practice of British-style medicine (Chee and Barraclough 2007a: 3). This affiliation, compounded by the government's long-standing positive discrimination policy in higher education favouring

the *bumiputera*,⁶³ also has meant that many doctors continue to receive at least part of their medical training outside of Malaysia, sustaining the 'long, friendly, professional association with the royal colleges that lasted beyond British colonial rule' (Rajakumar 2007: xv-xvi). A high percentage of Malaysian doctors receive their education, training and professional qualifications in the UK, Australia, Singapore, India and the US. Indeed, it is estimated that 90% of the doctors working at the seven private hospitals endorsed for IMT in Penang have received postgraduate training from the UK, US, Australia and Canada (NCER 2007: 64). A cursory assessment of the nearly 50 individual medical specialists affiliated with and profiled by seven of Malaysia's eight most advertised medical travel facilitators⁶⁴ confirms that, while a few have stayed in Malaysia throughout the course of their academic and professional careers, the vast majority has received educational and work experience in the UK, Australia, Singapore, India, Japan and the US. Of these, most all hold fellowship status with the Royal College of Surgeons and/or their specialist equivalents. The prominent Western institutions in which medical staff have received training are frequently used as selling points, as illustrated by the International Specialist Eye Centre promotional brochure (see Figure 4.4) geared towards an Indonesian audience (ISEC 2010). Therefore, while *pro-bumiputera* policies have fomented a sense of disenfranchisement for many, Malaysia's exclusive public higher education policies that have compelled many to go abroad have also generated rich social capital and participation in networks with Western and other Asian countries that have been fundamental to developing transnational industries like that around IMT, permitting strategic business alliances and opportunities for expansion on which the government is eager to capitalise.

Figure 4.4 ISEC promotional material in Bahasa Indonesia

(image removed)

Source: ISEC (2010)

63 A direct impact of the New Economic Policy (NEP), the Malay language policy, different entrance requirements and quotas for non-Malay students in public Malaysian universities for decades have translated into difficulty for non-Malay students to access higher education establishments in Malaysia. This has resulted in many non-Malays having no other option but to pursue their studies in private Malaysian universities and establishments outside the country at their own expense (Altbach 2004). Accordingly, in 2001, approximately 90% of private enrolment in Malaysia comprised Malaysian Chinese and Indians (McBurnie and Ziguras 2001: 94).

64 These are Malaysia Dentist, Malaysia Healthcare, Gorgeous Getaways, MediTravel, Wellness Visit, Health Horizon Holidays, Health Tourism and Wellness. Cure on Tour does not name the medical specialists affiliated with the company.

Linkages and partnerships also have been emphasised in order to 'signal quality by establishing affiliations with reputed hospitals in industrial countries and mirroring their procedural standards, guidelines, and clinical pathways' (Mattoo and Rathindran 2006: 366; Bookman and Bookman 2007; Milstein and Smith 2007; Warner 1998). Through telemedicine, for example, doctors at Pantai Hospital Kuala Lumpur are linked to Johns Hopkins Medical Centre, Duke University Hospital, Cleveland Clinic and the Harvard-linked Massachusetts General Hospital, while Normah Medical Specialist Centre receives consultative assistance from the Mayo Clinic. Yet perhaps the clearest example of strategic partnerships with foreign providers is, once again, taking place within Prince Court Medical Centre (PCMC). Even before it fully opened its doors for business, PCMC was positioned on the market as a premium facility, featured in the *PBB* international guidebook (Woodman 2007) and touted as one of the world's top seven hospitals for IMT by *Forbes* (Davidson 2007). Fundamental to this reputation was a deal sealed in 2005 between Petronas and Vamed Healthcare Services (linked to the Medical University of Vienna) for the latter to assume the roles of general contractor and consultant for all of the aspects of hospital planning, development and management (*NST* 03/12/2005).⁶⁵ In purposely selecting an operator from outside of Malaysia, Petronas sought to import successful international corporate models that would force local providers to 'think outside of the box' and ultimately raise the bar to foster a 'culture of care' of a different sort from that currently found in Malaysia (Rowley interview, 17/03/2008). With an 'expertise-transfer scheme' set up at the hospital wherein a team of top Western experts guide Malaysian staff in all realms of healthcare provision and hospital operation, the hospital symbolically serves as a test-bed for techniques that actively reshape the ways in which top Malaysian medical professionals perform their work and understand themselves as contributing towards a new culture of care, ultimately meant to spread to and spur on other Malaysian healthcare providers.

Yet, while expertise from abroad is valued at a premium, for the team of Western medical specialists brought to PCMC in the scope of this 'expertise-transfer scheme', the Malaysian government's tight restrictions on the practice of foreign doctors in the country has prohibited

⁶⁵ Vamed already had similar project experience in Libya, the United Arab Emirates and Central/Eastern Europe and was already familiar with Malaysia through its earlier involvement with the National Heart Institute (IJN).

them from working directly with patients. This stance is rooted to the Malaysian government's uncomfortable relationship to the country's dependency on foreign labour. While migrants make up 12% of its workforce⁶⁶ – playing a crucial role in manufacturing, construction, agriculture and the domestic and unskilled service sectors, skilled jobs generally remain the privileged reserve of Malaysians (Castles and Miller 2009; IOM 2008).⁶⁷ A policy launched in early 2008 in which locals have been required to replace foreigners on the visible 'frontline' in airports and in the hospitality industry in order 'to give tourists a truly *Malaysian* welcome... [as part of] reducing our dependency on foreign workers' (*NST* 10/01/2008, emphasis added) highlights how the inclusion and exclusion of foreigners gets used to galvanise and portray 'Malaysian' identity and authority.

In light of this preoccupation with promoting the 'real' face of Malaysia (see Chapter V), it becomes clear that the recruitment of foreign medical professionals to fill in the gaps has been an option of last resort for the government. While Chee and Barraclough (2007) observe that the public healthcare sector – suffering from an immediate need for medical personnel – already has turned its sights abroad, the private sector has been closed until recently to foreign medical personnel, particularly to foreign doctors trained outside of Malaysia. Over the last decade, the government has used IMT to cultivate 'home-grown' Malaysian expertise instead of importing foreign talent. This is evidenced in commentary from Tan Lee Cheng, the MOH's Corporate Policy and Health Industry Division:

If there is an influx of [IMT] market demand from abroad coming to Malaysia, the solution is not to close the gate. This [influx] helps you to provide a more conducive environment for people who want to invest in the healthcare sector and set up more facilities. More employers will be willing to train their employees because there will be more money to be made. Our challenge is how to produce the quality people we want in order to catch up with the number of facilities that are

66 Malaysia is home to the largest share of regular foreign workers in Asia only after Singapore. Some 1.6 million regular migrants and an additional estimated 600,000 irregular migrants lived in the country in 2005. Indonesians are the largest group, comprising 65% of regular migrants in 2006, followed by Nepalese (11%), Indians (7%), Filipinos (of which approximately 70% are irregular), Thais, Bangladeshis and Burmese (IOM 2008: 443, 448). In spite of stricter border controls and repatriation meant to reduce the size of the foreign workforce during economic crises, the migrant population has remained steady (BBC 22/02/2009, 11/03/2009; Castles and Miller 2009; *The Sunday Times* 22/02/2009).

67 Malaysia also attracts a number of skilled migrants to its exclusive high-tech zones (e.g., Multimedia Super Corridor (Bunnell 2006)), areas of graduated sovereignty in which quotas on foreign workers are suspended (Ong 2006) (see Chapter VI).

going to be added to the market. You can build a hospital in three years. But you cannot train a doctor in three years! So, there's a gap. How can we manage that? How can we catch up? Here's what we do: if the government infrastructure for training cannot train enough [people], then we go to the private sector for that. We recruit more students, and we ask the private sector to set up medical colleges, health sciences colleges and universities, and train them for us. (Tan interview, 17/01/2008)

That IMT serves as a catalyst for the growth of private medical education in Malaysia is evident with the number of private hospitals endorsed for IMT (e.g., Penang Adventist Hospital and the National Heart Institute) that provide nursing and medical training within 'world class' environments that are JCI and/or MSQH accredited (Bernama 22/11/2008) (see Figure 4.5).

Tapping into the Malaysian medical diaspora is another strategy. Seeking to resist dependency on specialised foreign labour, there is significant interest in reversing international brain-drain (see Table 4.7). An anonymous hospital executive of a major private Malaysian medical care facility in the Klang Valley (interview, 29/02/2008) describes his institution's struggle with keeping Malaysian talent, conveying an acute sense of loss:

Any slightly better personnel will go down to Singapore. It's a big issue in Malaysia. We are the biggest exporters of medical workers in the world... It's a huge brain-drain... I think the [Malaysian] government is incapable of retaining good doctors. I've got good doctors coming here – some wanting to come to work but who cannot get their work permit. They were educated abroad and they don't come back. They get married to a Brit and it's difficult for their spouses to get a work permit or residency permit [in Malaysia]. So, they just choose to not come back. But Singapore is a very successful example. They were short on workers. So, they went to parliament, and they knew of an easy way to bring in more Malaysian doctors. You know what they did? They said, 'From now on we recognise UKM [Universiti Kebangsaan Malaysia]'. Because of one simple decision, many hundreds made it into Singapore.

Until recently, the Malaysian state would not resort to Singapore's tactics to attract foreign talent in order to mitigate its shortage of medical professionals. Therefore, with the Ministry of Human Resources' 2001 Programme to Encourage Malaysian Citizens with Expertise Residing Overseas to Return to Malaysia, the government sought to appeal to the estimated 10,000 Malaysian professionals abroad to return and contribute to 'their' country's economic development (IOM 2008: 445). Three of the 21 pages listing the programme's sought-after fields of expertise were dedicated to medical professions, ranging from epidemiologists to medical

and dental practitioners and specialists to pharmacy specialists (Ministry of Human Resources 2001). The programme offers a small number of incentives (e.g., tax-exemption and facilitated immigration) to expatriate Malaysians in exchange for their return for a period of at least five years (Ministry of Human Resources 2008). Yet it has met with limited success, only managing to lure back around 500 specialists from the UK, Singapore, the US and Australia after seven years (*The New Sunday Times* 06/01/2008). Additional incentives, such as exemption from or reduction of mandatory public service for returning doctors, have now been introduced (Bernama 12/04/2010).

Figure 4.5 International Medical University advertisement

(image removed)

Source: NST (2008)

Table 4.7 Expatriation rates for health workers in OECD countries among select sending countries that promote IMT (2000)

<i>Country of birth</i>	<i>No. of nurses in OECD countries</i>	<i>Expatriation rate (%)</i>	<i>No. of doctors in OECD countries</i>	<i>Expatriation rate (%)</i>
India	22,786	2.6	55,794	8.0
Malaysia	7569	19.6	4679	22.5
Mexico	12357	12.2	4234	2.1
Philippines	110,774	46.5	15,859	26.4
Singapore	1,913	9.9	1,256	19.1
South Africa	6,016	3.2	7,355	17.4
Thailand	3050	1.7	1390	5.8

Source: OECD (2007: 211-215)

Successful or not, the very existence of this programme is indicative of a broader interpretation of citizenship that recognises the relevance of the diaspora (Edwards 2008), implicitly suggesting equal 'Malaysian-ness' for citizens living both in the country and abroad. Elsewhere, promoters of IMT to India and the Philippines, two countries with large medical diasporas, have explicitly evoked target markets' familiarity with their diasporas (their 'ambassadors') in healthcare delivery 'back at home'. In drawing upon Americans' acceptance of Indian doctors and Saudis' comfort with Filipina nurses, for example, promoters extend this image to the countries of origin themselves, casting them as founts of, and training grounds for, abundant human resources expert in care provision. Accordingly, the logic goes, they are 'natural' destinations for the high-quality services foreign patient-consumers have come to

expect from these diasporas. As with India and the Philippines, IMT promoters seize upon the experience of the Malaysian medical diaspora, which has been summoned 'back home' to contribute to the state's 'new techno-economic imaginings' (Bunnell 2006: 97) of national development. High value is placed on the currency of their foreign qualifications earned abroad as well as their transcultural 'in-betweenness' (Bhabha 2004), framing Malaysia not only as a place that cultivates high-quality medical professionals but also as a place that is articulated through linkages that stretch beyond its borders. Akin to the testimonial articles typical of IMT promotion in which happy foreign patient-consumers wax positively about their healthcare experiences in Malaysia, domestic media salutes 'patriotic' Malaysian medical professionals who have chosen to 'come home' to contribute to their country's development. Take, for instance, '[w]orld-renowned scientist Prof Liew Choong Chin, a pioneer in disease-specific genomics, [who] had always dreamed of doing something for his homeland, *unlike most Malaysians who stayed overseas* and carved a name for themselves after finishing their studies there' (*The Edge Daily* 29/10/2008, emphasis added).

Yet, this debate over the primacy of 'home-grown' medical care is already taking on new contours with the 2009 AFAS liberalisation of the services sector discussed earlier that permits foreign medical professionals from ASEAN countries to export their expertise and practice in Malaysia once registered with the Malaysian Medical Council (Bernama 30/03/2009; Chen 03/07/2010). Health Minister Liow Tiong Lai has suggested that this contested move was 'inevitable' in the context of a globalising world and that further liberalisation would make Malaysia a more attractive IMT destination, recognising that patient-consumers like to be treated by medical professionals from home (Foong 30/03/2009; Ono 2008; Tan interview, 17/01/2008).

4.5 Conclusion

Though representing only 10% of the total foreign patients in Malaysia in 2008 – a share far lower than those hailing from ASEAN's 'developing' countries (Tourism Malaysia 2009c) –, those from 'developed' Western and East Asian countries that face hefty insurance premiums and exorbitant medical costs in Bismarckian healthcare systems and those waiting for essential procedures or willing to pay for procedures uncovered in Beveridgean systems were identified as a patient-consumer market segment by the National Committee for the Promotion of Health

Tourism (NCPHT) in 2002. This segment endures long-haul flights to access more serious, invasive 'big-ticket' procedures that have the potential to contribute more IMT revenue per capita than Malaysia's neighbours. Courting this segment is thought to require techniques that appeal to different concerns, since 'back at home' the problem is not necessarily the availability of high-quality medical care – as it has been for Middle Easterners until recently (see Chapter V) and continues to be the case for most of the ASEAN countries (see Chapter VI) – but rather the economic and bureaucratic obstacles to it. So, what 'Malaysia' has been 'put on the map' here? Which characteristics are promoted as credentials for expert care-giving? We have seen in this chapter that successful promotion hinges on being able to convince these increasingly healthcare-savvy consumers and their gatekeepers that Malaysia provides a viable low-cost alternative to more 'developed' countries. This is thought to be accomplished by offering 'world-class' facilities and multi-lingual staff beholden to 'international' standards and trained abroad.

In her critical review of health geography's engagement with questions of care, Parr (2003: 219) encourages us to question 'the assumptions that we hold about whether certain geographies (hospitals and communities) somehow contain the "right" sort of care'. In this chapter, I have taken on board Parr's entreaty by examining the ways in which IMT is used to enfold destinations in 'developing' countries, like Malaysia, into a discourse of an elite 'flat world base-map' (Sparke 2009b) of care provision. In so doing, I have sketched out the contours of a fledgling transnational industry attempting to set the standardised terms of access for both patient-consumers and medical providers within a geography of the 'right' sort of care imagined to suit patient-consumers in 'developed' countries. This has led to a push to convert the private facilities endorsed for IMT into elite islands of demonstrable 'development', highlighting the interruptions and disconnections in care that persist around them. Dr David K.L. Quek, President of the Malaysian Medical Association, admonishes those seeking to use Malaysia's involvement in IMT

as a benchmark, an alternative key performance indicator or an ego-boosting, chest-beating symbol of having come of age! Being a preferred destination for "cheaper" medical treatment does not necessarily mean and certainly does not imply that our [the Malaysian] health care system has attained the standards of the First World. (Quek 03/11/2009)

At the same time, the 'globalising' standardisation brought about with IMT, meant to 'bull-doze' the subjects and spaces involved in care provision into conformity and complicity, has not

produced the expected uniform effects. It turns out to be rather more complicated. As we have seen, along with the push towards 'international' accreditation and the growing relevance of foreign (especially Western) training credentials, IMT has also helped to generate national and regional accreditation schemes as well as greater investment in, and the expansion of, medical education within the country, pushing for equal recognition and pride of place in relation to standards imposed from 'outwith'. Ultimately contributing to Malaysia's modern image, the sites/sights of IMT exhibit the technological trappings and cultural hybridity that enable the country to compete as an alternative to 'developed' countries for their own patient-consumers, leveraging to Malaysia's benefit 'developed' countries' own healthcare systems 'in crisis', as their citizens increasingly seek out 'medical refuge' (Milstein and Smith 2006) in Malaysia and other IMT destinations.

Chapter V. Strategic cosmopolitanism and ‘Muslim-friendly’ care expertise

5.1 Introduction

In recent decades, significant attention by the Malaysian government has been given to the overseas promotion of Malaysia’s internal ethnic, linguistic and religious diversity in order to strategically weave the country into lucrative and productive cross-border networks and alliances via cosmopolitan claims to belongings that seem to transcend those of the nation-state (Bunnell 2002). This pursuit of transnational capital and geopolitical recognition has engendered a re-scripting of national identity along newly valorised multicultural lines, concealing ethnic tension with its emphasis on ‘unity in diversity’. Malaysia’s burgeoning international medical travel (IMT) industry is profoundly entrenched in this task, engaging in ‘strategic cosmopolitanism’ (Mitchell 2003, 2007) to court patient-consumers from around the globe by tapping into a range of belongings that are shared by Malaysians themselves. Touted right alongside promises of significant savings, ‘world-class’ medical facilities and cutting-edge technology and procedures is Malaysia’s ‘cultural expertise’ in catering to the equally relevant yet diverse lifestyles of international patient-consumers (e.g., linguistic needs, religious practices and dietary requirements). With healthcare increasingly commodified, such non-medical, culturally-orientated patient-centred care factors play an expedient role in destinations’ ability to capture the ‘right’ markets (see Yúdice 2003).

In continuing to explore what ‘Malaysia’ is put ‘on the map’ to be recognised as an IMT destination and what sorts of power relations this expedites through the recognition of certain care credentials over others, this chapter is divided into two sections. I first discuss theoretical work on diversity, multiculturalism and cosmopolitanism to examine the calculated use of state-sponsored cultural diversity. This then informs an examination of the cultural-political stakes in the fostering and portrayal of the ‘Malaysian provider’ through the interpellation of a range of subjects through (reconfigured) state discourse on diversity. The second section traces the commodification of cultural difference by looking at how select foreigners, constituted within cosmopolitan state visions, are targeted and cultivated as prospective consumers of a particularly ‘Malaysian’ private healthcare. As valuable resources, these ‘ideal’ health-seeking

subjects confer prestige upon, reflect and reinforce a variety of cultural, social, economic and political attributes that link Malaysia into diverse global flows and networks and position it as an expert in the provision of culturally competent care. I illustrate these ideas by focusing on attempts to attract Middle Eastern patient-consumers through claims to 'Muslim-friendly' care expertise and consider their value in the Malaysian state's broader efforts to assert an image of a moderate and modern predominantly Muslim country against a multiethnic background and within a globalising economic context.

5.2 Cultural diversity and 'strategic cosmopolitanism'

A multiethnic country, with Malays (53.4%), Chinese (26%), Indians (7.7%) and indigenous peoples (11.7%) comprising the population in 2000 (Saw 2006: 15), Malaysia's strength in the global economy is increasingly discursively centred on its cultural diversity. With his '1Malaysia' platform, current PM Najib Razak (2009c) asserts that 'What makes Malaysia unique is the diversity of our peoples... [T]his unity in diversity... has always been our strength and remains our best hope for the future'. As we saw in Chapter III, this has not always been recognised as being the case. Internal ethnic tension symbolised by the 1969 ethnic riots and the resulting 1970 New Economic Policy (NEP) favoured the ethnicised category of *bumiputera* ('sons of the soil'), and more specifically Malays, through positive discrimination over other ethnic groups in the highly strategic arenas of business, employment, education and property ownership. Over the last three decades, the Malaysian state has begun to place value on the country's *de facto* diversity with its increasing involvement in the global market, discursively reframing the ethnic divide as multicultural wealth. Under PM Mahathir Mohamad (1981-2003), state discourse was transformed, shifting the focus from protecting the *Bangsa Melayu* ('Malay nation') to 'establish[ing] a united, progressive and prosperous *Bangsa Malaysia*' ('Malaysian nation') (EPU 2000). New policies recognised and sought to capitalise on the strategic value of Malaysia's ethnic pluralism, with economic globalisation and the re-configured postdevelopmental nation-state discursively serving to de-legitimise the notion that being ethnically Malay was sufficient to merit positive discrimination (Bunnell 2002). By 2009, with the government's withdrawal of the 30% *bumiputera* equity requirement for 27 services sub-sectors, the new PM Najib finally announced that the '*bumiputra* have the ability to compete with the rest. I am not worried that they will become "extinct" or lose out in competition' (*The Star* 23/04/2009; MITI 2009).

In spite of progressive liberalisation's discursive levelling of the ethnic playing field, the *significance* of ethnic, linguistic and religiously-based difference has not dissolved. Rather, we see its reinforcement and re-articulation through other channels, since, as Yúdice (2003: 23) observed, the 'representation of and claims to cultural difference are expedient insofar as they multiply commodities and empower community'. With the gradual withdrawal of the state from its role as main provider of a social safety net, cultural identity has been reified as an ever-more important variable in identity politics through which to make needs-based claims, as the market becomes the major forum for the satisfaction of social needs. This does not imply, however, that the nation-state's intervention has receded. Rather, it has been reconfigured, imbricated in facilitating its subjects' deeper entrenchment in the market. In her work on 'flexible citizenship' practices which traces the 'complicated accommodations, alliances and creative tensions between the nation-state and mobile capital' tied to ethnic Chinese diasporic activity, Ong (1999: 16, 19) observes that the nation-state remains key in determining the terms of 'the new modes of subject-making and the new kinds of valorised subjectivity' that are relevant to successfully attracting such capital. Just as Mitchell (1996) has demonstrated how multiculturalist policy in Canada has served as a means through which to legitimise, cultivate and capitalise on its cultural diversity in order to attract transnational investment, the Malaysian state's strategy similarly has been to turn its population's diverse ethnic, linguistic and religious backgrounds into a platform from which to selectively foster lucrative and socio-politically advantageous transnational linkages (Khoo 2003).

While Bunnell (2002: 106) refers to this as the 'multicultural "rescripting" of the nation or national identity', I wish to distinguish here between multiculturalism and, what Mitchell (2003, 2007) terms, 'strategic cosmopolitanism'. Discourses of *multiculturalism* are employed by the state to construct a 'multicultural self' that is conditioned to 'work with and through difference, and... to believe in the positive advantages of diversity in constructing and unifying the nation' (Mitchell 2003: 388). In this postdevelopmental time and space where governments increasingly turn to global enterprise for achieving development objectives, however, Mitchell posits a shift in the scale of citizenship, from the state's previous focus on fostering citizen-subjects to the biopolitical cultivation of self-regulating subjects whose belongings are increasingly multiple and reach beyond the national domain, though they remain articulated by its rationalities (see

Chapter III). These postdevelopmental subjects are trained to engage in what she calls '*strategic cosmopolitanism*', with the neoliberal state involved in the cross-border promotion of its subjects' 'expertise' derived from their diverse cultural backgrounds in order to more effectively disseminate the state's ideals and desires at home and abroad (Mitchell 2007: 709). I therefore interpret this 'cosmopolitanism' not in the sense of an elite, rootless liberal universalism, but rather, as Jeffrey and McFarlane (2008: 420) have conceptualised it, as '[a] repertoire of imaginaries and practices' that 'involves symbolically or physically crossing defined boundaries and claiming a degree of cultural versatility'.

While Mitchell's model suggests a more or less unidirectional shift from an inward-looking, multicultural nation-building orientation to one of strategic cosmopolitanism, the Malaysian case complicates this directionality. Here, the re-scripting of multicultural discourse within the country derives from the desire for increased profit made possible through the harnessing of transnational flows. Since the 1980s with the focus shifting toward the more inclusive *Bangsa Malaysia* concept, multiculturalism has served as a key political instrument within the scope of, what Hilley (2001: 131) calls, a 'new type of nationalist project for a new international age'. The broader context for this shift is highly significant, as it occurred in parallel with the introduction of neoliberal policy that substantially redefined the relationship between the state and its citizenry in multiple basic socio-economic domains. This multicultural shift gave the state legitimate control over its subjects through the recognition, categorisation and regulation of such difference on the basis of a narrative of national coherence through tolerance of the citizen Other. As a result of this transformation, the Malaysian state today increasingly anchors its international legitimacy in its 'expertise' in mediating between a range of cultures and social realities domestically, by acting as 'a unifying ground' (Yúdice 2003: 89-90) in which difference, hybridity and transnationalism are recognised, valued and politically and economically exploited (Khoo 2003).

After decades of the New Economic Policy (NEP) and similar policies enforcing positive discrimination favouring Malays, competition for transnational capital plays a fundamental role in the official recognition and inclusion of subjectivities that had been marginalised within the developmentalist conceptualisation of the nation-state. Now of greater strategic value in sustaining the country's economy in a globalised context, previously marginalised ethnic,

linguistic and religious affinities are tapped and exploited for the establishment of new markets abroad.⁶⁸ This neoliberally-inspired inclusiveness, 'unsettling Malay-centred state constructions of post-colonial national identity' (Bunnell 2002: 106), serves as a stark reminder of the extent to which non-Malays, as citizens with fewer national privileges than their Malay counterparts, had not been considered equals prior to this cosmopolitan turn that has discursively cast domestic diversity in the positive light of 'multiculturalism'. Indeed, as Chapter III pointed out, with the liberalisation of the services sector in the scope of Malaysia's Association of Southeast Asian Nations (ASEAN) membership, it was not a response to internal dissent over ethnic discrimination that led to such profound change but, rather, sustained international economic pressure in the form of binding free trade agreements and expanding markets that the Malaysian government dissolved the 30% *bumiputera* equity rule that ironically benefits non-Malaysians and non-Malay Malaysians in fairly equal measure.

Strategically embracing the country's internal 'unity in diversity', then, allows the Malaysian state to reap political and economic benefit by allying segments of its newly empowered population to, and engaging with, three increasingly important international markets that loosely correlate to the country's largest 'communities': Chinese, Indian and Muslim (Bunnell 2002; Khoo 2003). Ethnic Chinese and, to a lesser extent, Indians⁶⁹ are imagined as vital to positioning Malaysia as a key partner in the development of Asia's emerging superpowers and important global diasporas (e.g., ethnic Chinese in Indonesia and Singapore closer to home as well as those further afield). Similarly, through actively recasting Malay identity by equating it with being Muslim, the state banks on its substantial Malay Muslim population's ability to capitalise more on its religious identity and less on ethnicity in order to

68 For example, it is assumed that ethnic Chinese Malaysians, though many are not familiar with Mandarin, have a more 'natural' affinity with mainland Chinese in business dealings because of their shared origins. Rather, ethnic Chinese Malaysians are more often conversant in a range of dialects (e.g., Hokkien, Hainanese, Hakka, etc.) spoken at home and in their communities in addition to Malay and English than to Mandarin, a language learned and used in state-sponsored Chinese schools not attended by all ethnic Chinese pupils. Internal diversity becomes masked as they are grouped together as 'ethnic Chinese' and, as in Singapore and China, encouraged to adopt Mandarin as a lingua franca in the scope of strategic cosmopolitanism.

69 Ethnic Indians in Malaysia have begun to protest against the discrimination and exclusionary politics that have meant the persistence of significant levels of poverty and general political disenfranchisement for the community (e.g., the late 2007 HINDRAF protests called for Great Britain to make reparations to the nearly 8% of Malaysia's population of Indian origin for its role in taking Indians to what was during colonial times British Malaya to perform civil service duties and work in the rubber plantations).

attract investment and improve trade with other predominantly Muslim countries, particularly the wealthy Gulf states and fellow Organisation of the Islamic Conference (OIC) member-states (Ong 1999; Kahn 2006).

As we saw in Chapter III, ethnic diversity, a result of centuries of trade, migration and colonial rule, is sustained today by the administrative models and infrastructure set up during colonial times and incorporated post-independence. As such, Malaysia has been cast as a privileged territory – Yúdice's (2003) 'unifying ground' – in which East and West can harmoniously unite under the guiding expert hand of uniquely cosmopolitan Malaysians – fluent in 'Asian values', setting out the contours of a progressive Islam and confidently managing postcolonial linkages that have permitted Malaysians to acquire valuable expertise in and regarding the West. Therefore, Malaysia's 'home-grown' hybridity, or 'in-betweenness' (Bhabha 2004), guides state discourse in navigating the post-Cold War 'civilisational' political context popularised by Huntington (1996), allowing it to work the East/West dialectic to its benefit (Ong 1999: Chapter 8). Kaplan (2007: 187) notes in her postmodern reading of travel that 'discourses of location can be used to naturalise boundaries and margins under the guise of celebration, nostalgia or inappropriate assumptions of sameness'. Accordingly, what we see with Malaysia is a complex rhetorical use of 'sameness' not based upon a supposed internal homogeneity but rather drawing upon assumptions of ethnic, linguistic and religious affinities that extend beyond Malaysia's borders, permitting engagement in a range of transnational networks made possible by such diversity.

The strategic cosmopolitan use of domestic diversity is particularly clear with the 'Malaysia, Truly Asia' tourism campaign launched in 1999. Faced with declining tourism figures in the late 1990s, a nation-branding exercise was deemed necessary to remedy the country's

lack of 'distinctiveness' in the global tourism sphere. Analysts thought that Malaysia did not have a unique image in the minds of people and there was nothing to set it apart from any other Asian country. Some of them went to the extent of saying that Malaysia's diverse population was its shortcoming, as it prevented it from creating a distinct identity globally. (Prakash 2007: 3-4)

Turning this very diversity into a selling point, the Malaysian government decided 'to promote Malaysia as a melting pot of three major Asian cultures (Malay, Chinese and Indian)... convey[ing] the idea of unity in diversity' (Prakash 2007: 4). The popular tourism campaign has had far-reaching impact, wedging the slogan, jingle and imagery firmly into the minds of

potential foreign tourists as well as disciplining Malaysians themselves. 'Malaysia is truly Asia', so affirms an anonymous Malaysian governmental tourism representative (interview, 24/01/2008) in a statement echoed by so many others throughout my fieldwork,

With so many races inside Malaysia, we have to observe each other's ways of life and be bearable with one another. It's not like the UK or Singapore or Thailand, for that matter, where it's one race and that's it! In Malaysia, there are many Asias inside!

Promotional material displayed prominently within and outside of Malaysia portrays 'a bevy of local beauties' that includes Malays, Chinese and Indians and indigenous groups "'selling" its multiculturalism and cultural diversity [by] representing all the major civilisations in Asia as its tourism image' (Amran 2004: 2) (see Figure 5.1). With Visit Malaysia Year 2007, marking 50 years of independence, 'saluted as a chance to welcome the world and showcase the country's many admirable qualities' (Henderson 2009: 141), Malaysia was rapidly recast as a mini-Asia, home to '[t]he wonders of Asia in one exciting destination' (Tourism Malaysia 2009), by touting its centuries-long heritage that brought a diverse range of peaceable peoples together – peoples, of course, made peaceable through the strong arm of state intervention. This strategy of "'visualisation" for global audiences' (Bunnell 2002: 108) has been mobilised to extend Malaysia's "'Truly Asia" persona' (MOTOUR 2004: 111, in Henderson 2009: 142) beyond the realm of conventional tourism to play a key role in, what O Tuathail (1997, in Bunnell 2002: 108) calls, 'a new "power projectionism"' that re-scripts the country's diversity as a cornerstone in both its attractiveness to mobile capital and geopolitical relevance. The development of the 'Truly Asia' persona draws not only upon the commodification of difference within the country but also contributes towards Malaysia's further geopolitical entrenchment as a platform between East and West, demanding the conscious act of balancing its self-orientalisation with its postcolonial expert grasp of the West, with the 'Asian subject' 'strategically implicated in a discourse that invents both the East and the West' (Yao 2001: 58).

Figure 5.1 Original 'Malaysia, Truly Asia' campaign imagery

(image removed)

Source: Tourism Malaysia (2007)

The construction of Malaysia's pan-Asian identity began long before the 'Truly Asia' tourism campaign began. It is 'alloyed to an incipient regionalism' (Khoo 2003: 34) linked to engagement with 'Asian values' in the 1980s. This period was characterised by Malaysia's Look

East policy, which sought inspiration from Asian models of modern economic development from the region's most powerful economic players of the time: Japan and South Korea. 'Asian values', such as deference to strong authority and respect for communal welfare, were pinpointed as key to producing this new string of 'tiger economies' (Khoo 2003; Nye 2004). For nearly two decades, along with his Singaporean contemporary, Lee Kuan Yew, PM Mahathir would constantly revisit, craft and mobilise the 'Asian values' rhetoric to justify the state's authoritarianism as characteristic to 'Asian tradition' but also to contest and problematise the Western model of development with an 'Asian' alternative capable of wresting from it claims of development expertise. PM Mahathir played a fundamental role in the country's rapid economic transformation, credited with introducing an alternative, outward-looking perspective on development that paved the way for the emergence of a 'new commercial and technocratic culture' (Verma 2004: 151) that de-centred hegemonic Western-style modernisation and development values and practices in favour of a model more suited to an 'Asian' reality. These efforts came to fruition when Malaysia itself was dubbed an 'Asian tiger' in the mid-1990s – apparent proof (at least until the 1997 Asian Financial Crisis) that 'Asian values' were effective at producing not only economic miracles but also market-orientated subjects.

Far from seeking to categorically reject the West, however, there was recognition of 'the need for measured assimilation' (Hilley 2001: 49) of Western influence and strategic engagement with capitalism as a way to acquire the benefits of modernity while simultaneously asserting Malaysia's relative independence from its influence. As PM Mahathir (1986, in Hilley 2001: 49) observed,

The East is now going through a phase in which independence in the physical sense has been achieved, but the influence of Western imperialism is still pervasive... This makes it difficult to screen such influence so that only the good aspects are assimilated. [At the same time, there is] no reason why the influence of the ex-colonialists, or more accurately, Western influence, cannot be analysed and systematically and judiciously assimilated by a nation or group.

A symbolic link was drawn between the West's floundering economic performance in the early 1980s, what PM Mahathir perceived as its decaying moral standards and the neoliberal conservative measures undertaken as a solution. Critical of liberal democracy, the West was framed as having veered off the righteous path of true development into a decadent

individualism. Malaysian society had to be 'distanced' from these 'undesirable imports from the West' (Yao 2001: 59; Rigg 2003). This perspective hinged on the construction of the West

as an object that articulates something of our [Asians'] desire and anxiety in the modern world. If the Western perception of Asia is never innocent, neither is our understanding of the West. We too build agendas in our enterprises. These agendas... are about asserting an Asian voice in the post-colonial world. They have, at least in the hands of Southeast Asian states like Singapore and Malaysia, come out of the attempt to wrestle the centre of hegemonic influence from the West. The East or 'Asia' now emerged as a sovereign subject while marking the West as the Other residing in the foreign space, possessing all the qualities we are not, or that we wish to have. The West is the Other discursive space in which Asia can find its new destiny... [Thus,] [c]asting the West to the outside, and putting in place instead Asia as the sovereign subject in the new global exchange, the strategy signal[led] Asia's coming of age. (Yao 2001: 55-56)

It was during this time that Malaysia assumed greater leadership of supranational organisations the likes of the Non-Aligned Movement, ASEAN and the Organisation of the Islamic Conference (OIC), acting on the platform of its expertise as a majority Muslim, postcolonial Asian country possessing the values characteristic of the world's strongest non-Western economies along with the internal diversity to substantiate such claims.

Involvement in the discursive geopolitical space of 'Asian values' did not distract the state from its continued focus on the welfare of the Malay Muslim population. Rather, the 'Asian values' rhetoric was modified to serve important national development objectives premised upon the cultivation of a uniquely Malaysian interpretation of a modern, 'moderate Islam' capable of reconciling with a culture of consumption necessary for the country's economic growth as well as 'circumscribing notions of "progress" with ethnic interests' (Chong 2006: 34) that would help build the capacity of the *bumiputera* in a post-NEP context and wean them off of reliance on the state (Rokiah 2000). The 1991 National Vision Policy, which presented a set of ambitious long-term objectives necessary for Malaysia to reach 'developed' country status by the year 2020, hinged on moralising agendas set out by policies like the National Integrity Plan to naturalise the coupling of Islam with 'development', which translated into asserting 'its accommodation of modernity, western science and capitalism' (Chong 2006: 35-36). 'Muslims', PM Mahathir suggested,

should regard industry as a means to strengthen the Muslim states and the Muslims so that they are better respected and capable of defending themselves. Ignorant Muslims cannot contribute towards the greatness of Islam. On the other hand, industrial capacity, as well as the extensive command of all kinds of knowledge necessary for industrialisation, will make Islam and Muslims more respected. (Mahathir 1993, in Chong 2006: 35)

As Rigg (2003: 60) observes, 'The use of Islam to promote and endorse modernity has been... explicit in the case of Malaysia. Here, Prime Minister Mahathir Mohamad sees Islam not as a conservative force retarding development but as a means, a tool, to achieve his dream of creating a fully developed nation by 2020'.

This state-sanctioned 'progressive' interpretation of the religion that persists today is concerned with improving human welfare through focusing on cultural and moral integrity and balanced and comprehensive economic development 'in the here and now' in a globalising capitalist framework of 'nomadic societies', emerging as 'a legitimate space where the *Melayu Baru* (new Malay) may retain his or her "Muslim" character while engaging in cosmopolitan practices' (Chong 2006: 39, 41). As we shall see below, this endorsed vision of Islam has proven particularly foundational to Malaysia's positioning in the global 'awakening' to the economic potential of Islamic consumption as moral consumption, standing at the forefront of the conceptualisation, marketing and production of goods and services in compliance with Islamic law (*halal*), such as Islamic banking and finance and even international medical travel (IMT) (Pollard and Samers 2007) (see Figure 5.2). Explains the President of the Islamic Medical Association of Malaysia, Dr Abdul Latiff bin Mohammed (interview, 06/12/2007),

Muslims throughout the world have become one of the largest consumer groups. Yet, for a long time, Muslims have not been really concerned with what they consume or use with regard to religious law. So, things like Islamic banking or Islamic finance, or what we call *halal* products, have not been of great concern to Muslims in general. When Muslims wanted to save money or put their money in the bank, they were not concerned about whether or not the money would be involved in anything not permitted by the religion. Even when we were trained to become doctors, religion was not an important issue – what was most important was how you would achieve or arrive at a diagnosis and how you would treat a patient in light of that diagnosis. But for the past maybe 20 to 30 years, the trend of incorporating religion and being more conscious about what is allowed and not allowed by Islam has been growing. People are [now] concerned about whether the food we eat is actually *halal*, what happens to our finances and whether the [medical]

treatment we receive is permitted or not... This awareness has created a new ideology of consumerism, such that people move from conventional banking to Islamic banking. Any conventional bank will now have an Islamic counter or at least an Islamic component. People were not concerned about whether insurance and health insurance are permitted by Islam or not. But nowadays there is *takaful* – Islamic insurance... which demonstrates the trend of people looking for Islamic alternatives, for something more acceptable in the eye of the religion.

The growing industry built around Islamic consumption practices provides an additional platform for allowing the state to consolidate and capitalise on its cosmopolitan Islamic identity both within the country and to the outside world. A modern, moderate and tolerant Islam contributes towards the state's ability to legitimately tout a majority Muslim yet multiethnic Malaysia as both a model to emulate and a political and economic partner standing a reliable middle-ground between 'East' and 'West'.

Figure 5.2 Guide to buying halal in Malaysia

(image removed)

Source: Consumers Association of Penang (2008)

5.3 Reaching out and linking up with Islamic credentials

Among the greatest concerns in IMT is ensuring that patient-consumers receive safe, high-quality medical treatment in a politically secure and stable environment. The mass political protests in Thailand from 2008 to the present and the 2008 terror attacks in Mumbai targeting foreigners and the 'five-star' places in which they congregate have not only rocked national stability and security but also have called into question their broader suitability as IMT destinations (Einhorn 09/11/2008; *Bangkok Post* 02/12/2009). Since many '[h]ospitals and medical travel agencies [have been] focused on economic, not political, tumult', the combination of the current global economic crisis with 'the one-two punch of Bangkok and Mumbai' (Cohen 24/12/2008) has been feared to make these destinations stumble slightly backwards as distraught foreign medical travellers have inevitably cancelled or postponed their trips. The consulting group Deloitte Center for Health Solutions (2008b: 6), advises that,

While the real situation may not be as severe as portrayed by the media, continued negative publicity on the perceived state of political stability and safety could cause patients to hesitate to

travel to the country in the long run. While the industry cannot control such issues, providers should consider these factors and mitigating strategies in their business planning.

In the immediate aftermath of the Mumbai attacks, response strategies came from a range of stakeholders. Upscale private hospitals in Mumbai were 'being turned into fortresses', enforcing tight security in order 'to send out a strong message to their international clientele' (Krishnan 30/12/2008) that they were safe. In seeking to reassure prospective patient-consumers, the Wockhardt Hospital Group asked 'the already operated patients (during that terrible week and also later) [to] talk to those who wish to undergo surgeries, boosting their confidence' (Shah 18/12/2008). Finally, with IMT in India expected to bring in at least USD 1.5 billion in 2010, the national government was also quick to respond, declaring the following year of 2009 a 'Visit India Year' and injecting funds into the promotion of accredited hospitals (TravelBizMonitor 28/12/2008). Thai authorities, meanwhile, are planning IMT promotional roadshows and other public-private initiatives 'to restore the confidence in safety among foreign patients' in the wake of the anti-government riots that at one point led protesters to 'invade' a private hospital in search of hidden soldiers (Treatment Abroad 05/07/2010).

One of Malaysia's main competitive advantages as an IMT destination is portrayed as residing in its long-term political stability and peaceful environment (Sya 2005: 5). Recalling Chapter 1's example of its use in the Philippines under Marcos, tourism often can be an 'industry critically dependent on stability and relatively unconcerned about political freedom' (Richter 1980: 243). During recent moments of political protest in Malaysia, for example, strong state policing and an appeal to 'Asian values' concerned with communal and financial well-being were deployed by the national government to admonish citizens for fomenting civil unrest that could disrupt business as usual, inhibit prospective tourists from selecting the destination or returning to it, and tarnish its international reputation for stability (see Leong 2009). This desire for stability is underscored in commentary by an anonymous executive of a Malaysia-based medical travel intermediary of foreign origin based in the Klang Valley (interview, 10/03/2008),

I think this [Malaysia] is a very politically stable country. There is no democracy anywhere in the world, including Malaysia – not even in the USA. It's corrupt everywhere. But Malaysia is definitely the most politically stable country out of all the Asian countries... They don't have an overthrow here every few years, like most Asian countries. They've been in power for 50 years and will

probably be in power for the next five to 10 years. And that's all I need, and that's all the country needs as well.

The IMT business has been shown to be even more sensitive to political and social unrest than that of conventional tourism, since patient-consumers seeking treatment abroad are presumed to be more physically vulnerable than other types of more 'able-bodied' travellers.

Through the efforts of no less than three ministries (Health, Tourism, and International Trade and Industry), the Association of Private Hospitals of Malaysia (APHM), the Malaysia Healthcare Travel Council (MHTC) and several of the more entrepreneurial private hospitals selected by the state to represent the 'Malaysia Healthcare' brand, a variety of prospective foreign patient-consumers are receiving the official message at trade fairs and missions and in their local press about just what makes Malaysia 'a centre of medical excellence in the region' (Tourism Malaysia 2007). Ranking right alongside its wide range of 'world-class' facilities endowed with state-of-the-art technology, 'highly qualified, experienced and skilled consultants with internationally recognised qualifications', an internationally recognised quality and safety system, and 'affordable pricing and favourable exchange rate' are factors such as Malaysia's status as a 'safe and politically stable country', home to a 'tolerant multicultural and multiracial society' that 'accommodates patients of different cultures and religions' and ensures ease in communication with its multilingual professionals (Tourism Malaysia 2007a) – thus 'erasing any alien feeling for the foreign patient' (MOH 2009).

Figure 5.3 The 'Truly Asia' persona of Malaysia Healthcare

(image removed)

Source: MOH (2009)

The 2009 launch of the 'Malaysia Healthcare' IMT campaign further enshrined the notion that it is not enough to provide affordable, top-notch medical care to attract international patient-consumers. Conveying a more holistic healing experience with its tagline, 'Quality of care for your peace of mind', it draws upon the centrality of cultural sensitivity and overall political stability in ensuring patient-consumers' comfort and satisfaction (MOH 2009). Echoing the 'bevy of local beauties' (Amran 2004) in the 'Malaysia, Truly Asia' campaign in what Yúdice (2003: 177) has dubbed a 'human rainbow ad', the government's main webpages dedicated to IMT (MOH 2009; Tourism Malaysia 2009) urge, 'It must be Malaysia!', against the dramatic backdrop of cutting-edge medical equipment, inviting tropical landscapes and an array of

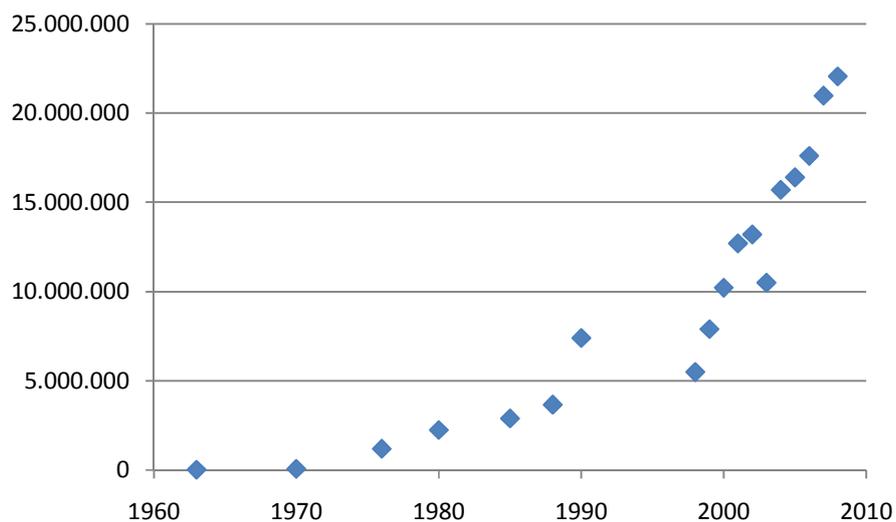
concerned yet spirited multiethnic medical staff, portraying Malaysians as unified by their common concern for ensuring the best for international visitors (see Figure 5.3). The effort to embody the 'Truly Asia' persona of 'unity in diversity' in the realm of IMT deftly glides over the country's underlying linguistic, ethnic and religious tensions, allowing, as Jansen (2008: 132) suggests, for 'the feel-good illusions of community participation and solidarity that nation branding can cultivate [to] function ideologically to position nation branding as a pro-social force enhancing the public sphere rather than depleting and superseding it'. Indeed, in light of the fact that tourism is the second largest contributor to the country's GDP (Henderson 2009: 141), the suggestion by the then Tourism Minister Azalina Othman that 'all of us [Malaysians] need be aware that Malaysia is a tourist country – a "tourist star" – and it is the equal responsibility of ALL Malaysians to see that our tourism products and facilities are well maintained' (Kok 21/02/2009) effectively enjoins all Malaysians to act as ambassadors of a commodified 'Malaysia'.

The country has long been a popular tourism destination thanks to its image as a tolerant, safe and moderate majority Muslim country that accommodates the lifestyles and wishes of Muslims and non-Muslims alike (see Figure 5.4). As such, 'Malaysia promises to be a "home away from home" for most visitors due to its cultural and ethnic diversity', where '[a] wide variety of religions are freely practised and this freedom is accepted by the peoples of Malaysia of various origins' (Palany 01/07/2004). How, then, is this 'home away from home' constructed and mobilised through IMT – and for whom?

Following the National Economic Action Council's (NEAC) recommendation for IMT to be used as an economic driver following the Asian Financial Crisis, the National Committee for the Promotion of Health Tourism in Malaysia (NCPHT) set up guidelines for identifying suitable sending countries (MOH 2002: 106; Chee 2008), identifying three market segments of ideal IMT patient-consumers. The first comprises patient-consumers from neighbouring ASEAN countries (e.g., Indonesia and Vietnam), who are perceived to lack sufficient access to quality medical care. The second focuses on the Middle Eastern middle class, hailing mainly from the United Arab Emirates, Bahrain and Saudi Arabia, that for a range of reasons do not access quality care in their home region or have been diverted from the IMT destinations they traditionally frequented in the West. The third includes those from countries in which medical care is

expensive enough to make patients look abroad to save money (e.g., the United States, Singapore and Japan) and those frustrated with their socialised healthcare systems in which waiting times for procedures are common (e.g., the United Kingdom and Canada) (Chee 2007: 10; MOH 2002). Underlying the choice of these segments was the desire from the outset to portray Malaysia as a ‘value for money’ destination, thus appealing to a transnational bourgeoisie instead of the up-market foreign patient-consumers targeted already by one of Malaysia’s strongest regional competitors, Singapore. The homogenised class factor permits focus on cultural diversity, allowing for Malaysia’s internal diversity to be touted as a marketing strength with which to attract broader segments of the global market via appeals to cultural similarities with Asians, Middle Easterners and Westerners (Yúdice 2003).

Figure 5.4 Overseas visitors to Malaysia (1960-2008)



Source: Tourism Malaysia (2010)

There are significant differences, however, between the NCPHT’s plans to target these segments they believe they are able to capture and the markets that actually exist (see Figure 5.5). The race to tap into the Western and Middle Eastern markets, for example, is spurred on by numerous industry reports and international trade conferences geared toward the future prospects of IMT that have stoked interest in two sought-after ‘gold mine’ groups of international patient-consumers: Arabs from the Gulf countries and North Americans. Yet the

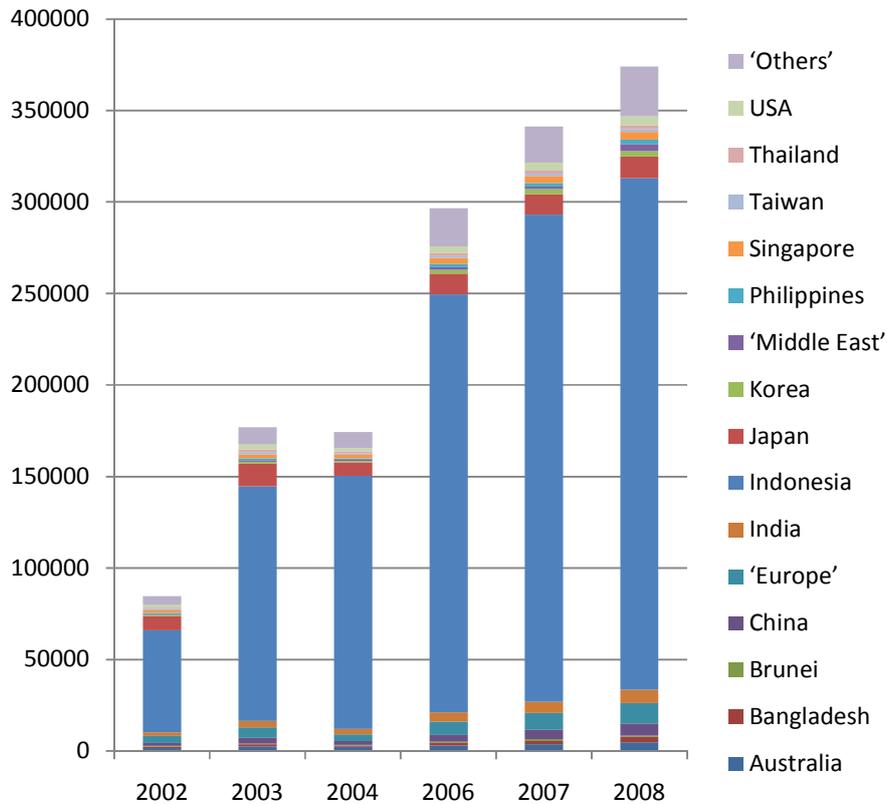
vast majority of international patient-consumers going to Malaysia hail from its immediate neighbours, a reality that attracts less attention and lends less prestige (see Chapter VI; Hamid 03/06/2010). In Chapter IV, I examined how stakeholders seek to attract patient-consumers from 'developed' countries by touting the receipt of internationally-recognised hospital accreditation and showcasing doctors' international training credentials. In the present chapter and in Chapter VI, I take a more in-depth look at the ways in which IMT stakeholders have sought to pursue the other principal market segments identified by the NCPHT. Here, in Chapter V, I focus on those coming from Middle Eastern countries, while, in Chapter VI, I concentrate on appeals to 'developing' and neighbouring countries, respectively. In so doing, I seek to engage with these varied patient-consumer segments' relevance to the national postdevelopmental project of 'strategic cosmopolitanism' and the promotion of diverse 'Malaysian' subjectivities that are both potentially lucrative and contribute to the state's geopolitical interests.

Middle Easterners⁷⁰ comprise one of Malaysia's fastest growing tourist segments (see Figures 5.4 and 5.6). In terms of average per diem tourist expenditure, they are in a league of their own: though comprising only 1% of the overall tourist arrivals in 2002, they generated an impressive 44% of overall tourist revenue in the country that year (Yim and Ho 2005).⁷¹ Escaping to a consistently Malaysian 32°C during the stiflingly hot summer months of July to September back home, throngs of Middle Easterners fill the numerous upmarket shopping centres selling luxury brands in Kuala Lumpur's Golden Triangle and the Arab restaurants, bakeries, barbers, perfumeries and *shisha* cafes dotting the bustling Bukit Bintang area that lies at the heart of their activity in the capital city.

70 'West Asians' is the term uniformly used by Tourism Malaysia (and frequently by the media) to refer to those coming from the region encompassing Bahrain, Cyprus, the Democratic Republic of Yemen, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Qatar, the Republic of Yemen, Saudi Arabia, Syria, Turkey and the United Arab Emirates. This nomenclature symbolically incorporates the group of countries into an expanded vision of Asia.

71 In 2006, tourists from Saudi Arabia and the United Arab Emirates spent an average of MYR 791.60 and MYR 656 per day, respectively, ranking first and second, with the average Saudi tourist spending more than twice as much as many of the top 10 biggest spenders (Tourism Malaysia 2007b). Australian tourists, for example, spending an average of MYR 458.3 per day, ranked fifth (Tourism Malaysia 2007b). Due in part to their tendency to stay for extended lengths of time, total expenditure by Middle Eastern tourists is also growing steadily at an additional MYR 1,000 each year, with their MYR 6,070 significantly trumping the average MYR 2,196 tourist expenditure in 2007 (Malaysiakini 29/05/2008).

Figure 5.5 Distribution of foreign patient-consumers by nationality in Malaysia (2002-04/2006-07)



Source: APHM (2008), Tourism Malaysia (2009c) Note: Categories of foreign patients listed here are those used by the APHM; more discriminated origins for patients from 'Europe', the 'Middle East' and 'Others' are not available. Figures by nationality are not available for 2005. For detailed statistics, see Appendix 5.

Stakeholders have sought to accommodate this economically valuable group in a range of ways. Part of the Bukit Bintang area was specially redeveloped into Ain Arabiya ('Arabian Centre') by city planners and Tourism Malaysia in order to create spaces that would be familiar to Arab tourists who visit Malaysia in extended family groups that often occupy multiple rooms for long periods and engage in sustained and high-level consumption (Khalilah 2006). A similar project, a joint venture between investors from Dubai, Saudi Arabia and Malaysia, replete with shopping 'bazaars', 'Arab themed' restaurants and cafes, 'Arab' health and beauty spas and an 'Arab village' and museum, has been planned for Malacca, which to date has been less successful than Kuala Lumpur in attracting Middle Eastern tourists (*Al Arabiya* 22/06/2009; *Bernama* 03/03/2009). Confirms an anonymous Malaysian governmental tourism representative (interview, 24/01/2008), 'To bring them here, we have to have some similarity with their

countries'. The summer exodus, referred to as 'Arab season' by those working in the hospitality sector, leads airlines to multiply the number of flight connections between Malaysia and the region, the more expensive hotels to temporarily take on Arabic-speaking counter staff and tour guides, tourism authorities to organise special events featuring famous Arab entertainers (e.g., Ziryab International Music and Arts Festival) and to moot the possibility of introducing Arabic language street signs in areas popular among tourists (*The Malaysian Insider* 24/11/2008). To encourage them to spend Ramadan (which currently falls in peak 'Arab season') in Malaysia, tourism and religious authorities have teamed up to bring Middle Eastern imams to lead prayers and religious talks (Muin 07/05/2009) and promote Malaysia's equatorial location, where 'the length of your fasting time is quite constant' (Tourism Minister Ng, in Muin 06/05/2010), as a selling point.

As noted above, the question of safety and feeling at ease is paramount for international tourism and even more so for IMT. The events of 11 September 2001 (hereinafter '9/11'), and the ensuing US-led 'war on terror' served to severely aggravate an already widespread stigmatisation and vilification of Muslims, casting them as embodied threats to 'security' and challengers to 'Western values'. Muslims, particularly those from the Middle East, have been frequently the target of discriminatory practices. Placed under the disciplinary gaze of heightened state and societal surveillance, they have seen their mobility restricted throughout the world (see Butler 2004; Rygiel 2006). In the aftermath of 9/11,

[m]any people, especially Middle Eastern people, felt that it was no longer safe to travel as tourists or even to work or stay very long in the West. There was also a lot of suspicion about money being used to finance terrorism, such that some innocent wealthy people suddenly got their money frozen in banks in the West. They felt that what they had been used to all this while was no longer secure. So, they tried to take out as much as possible and shift to a safer, more secure place – we're talking about their *physical well-being or safety and the safety of their wealth*. (Dr Abdul Latiff interview, 06/12/2007, emphasis added)

Fears of and anger and frustration regarding racial profiling, discrimination, mistreatment and the enforcement of tighter visa restrictions for entering Western countries therefore have had significant ramifications on the ability and willingness of Middle Easterners, and Muslims more generally, to travel to, reside in or consume products and services from the West.

This has led to a crossroads in tourism and travel trends. In the wake of 9/11, '[t]he spontaneous reaction of Arab and Muslim tourists, who spent their holidays in the [Middle Eastern] region and avoided European and North American destinations, saved many national tourism industries from collapse' (Al-Hamarneh and Steiner 2004: 173), sustaining growth in Egypt, Lebanon, Syria and the UAE and boosting tourism to non-Arab Muslim countries like Turkey and Malaysia (Cainkar 2004). The change in choice of destinations has overlapped with an increase in the number of tourists from Middle Eastern countries (HospitalityNet 2006) (see Figures 5.6 and Table 5.1). Correspondingly, destinations have been driven to respond to growing demand for goods and services tailored to Muslim consumer specificities in parallel with the growing significance of the Islamic market and the wider availability of *halal* products and services. As the Malaysian Tourism Board's 2005-2007 Promotional Plan suggests,

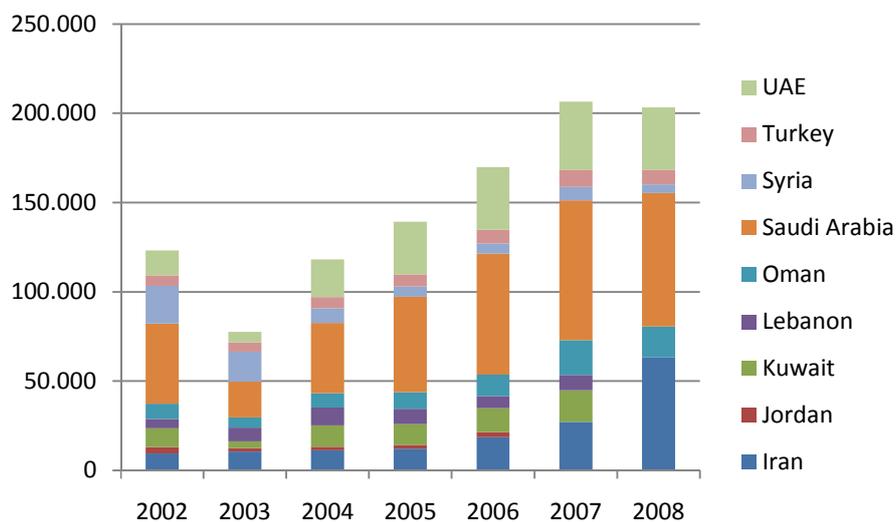
The West Asian market's shift in preference is due to less interest in travelling to Europe and the US caused by general hostility towards Arabs... The potentials are [*sic*] more apparent after 9/11. The total Muslim population around the globe is estimated at more than 1 billion and not restricted to one geographical area. *The need is not so much to find solace in destinations that are friendlier but also to experience the religion wholly as a lifestyle.* (Tourism Malaysia 2004: 8, emphasis added)

Thus, these destinations have emerged doubly as (sometimes temporary) replacements for Western markets in light of the 'war on terror' and as new markets geared towards tourists seeking the comfort of a larger Islamic 'community'.

'Islamic tourism' (or '*halal* tourism') practices have grown more salient in recent years particularly among conservative Muslims alienated from the Western-dominated tourism market that seek out destinations that are less 'Western-culture loaded' (Al-Hamarneh and Steiner 2004: 180; see Al Arabiya 22/06/2009). It fosters innovative concepts that combine leisure with faith, intending to unite tourism with a broader notion of pilgrimage that places value on Islamic cultural diversity and common religious heritage. This celebratory recognition contributes towards the construction of a pan-Islamic identity, bolstering a cross-cultural religious solidarity through which a postnational 'imagined community' (Anderson 1991) is assembled, physically uniting the '*umma*, 'the ultimate supratribal (transnational) unity and equality of all believers before God' (Esposito 1999: 29). Proponents of Islamic tourism anticipate its promotion of greater tolerance among Muslims themselves with increased

recognition of the great diversity of religious expression that Islam assumes throughout the world that coincides with a broader re-imagining of ‘community’ (Anderson 1991; Enloe 1989).

Figure 5.6 Growth in Middle Eastern tourists to Malaysia (2002-2008)



Source: Tourism Malaysia (2009c)

Table 5.1 Outbound tourism by generating region (millions) (1990-2004)

	1990	1995	2000	2001	2002	2003	2004	Share (%) 2004
World	441.0	538.1	680.6	680.4	700.4	689.7	763.2	100
Europe	252.5	307.2	389.5	390.4	401.6	406.7	431.3	56.5
Asia and the Pacific	59.8	88.8	118.3	120.6	130.8	120.6	151.2	19.8
Americas	99.3	108	130.7	125.5	121.2	115.4	127.7	16.7
Middle East	8.5	10.4	15.2	16.3	18.3	17.9	22.0	2.9
Africa	9.9	13.0	16.5	16.5	17.6	17.6	18.2	2.4
Origin not specified	11.1	10.8	10.5	11.2	15.5	11.5	12.8	1.7
Within same region	351.9	430.5	537.9	546.0	566.8	560.2	617.2	80.9
To other regions	78.0	96.8	132.2	123.3	122.7	118.0	133.2	17.5

Source: UNWTO (2005)

With these post-9/11 transformations, we have seen the Malaysian tourism industry shift away from conceiving of Islam as unmarketable, where ‘removing the Islamic religion from the

forefront of Malaysian life may be seen as part of the effort to reduce any sense of tourist unease and insecurity' (Henderson 2003: 451). Instead, the Malaysian state has claimed a stake in the Islamic tourism market, emphasising its utility 'as a vehicle for reinforcing the solidarity of the Islamic community' (Henderson 2003: 453; Associated Press 2006b). Already, Tourism Malaysia (2009) promotes an 'Islam in Malaysia' product, highlighting the country's Islamic Arts Museum and mosques which have adopted a range of architectural styles and cultural influences over time since the religion was introduced in the 13th century by Arab and Indian traders. Bringing these landmarks into the 'Malaysia' that is embraced and sold by official tourism entities sets up a landscape that recognises and endorses the area's longstanding Islamic heritage as central to national identity, while simultaneously signalling the country's interest in framing its Islamic credentials as a marketable product. Political efforts to encourage pan-Muslim tourism⁷², the move towards easing visa restrictions among Muslim countries and the image the state seeks to convey of a moderate, modern Islamic country all contribute to raising the country's profile as an attractive destination for Muslims abroad (see Figure 5.7).

Figure 5.7 Video stills from a Rotana Dubai television interview with Arab-Muslim tourists in Kuala Lumpur

(images removed)

Source: Rotana Dubai (2009)

When it comes to IMT, middle- and upper-class Middle Easterners have long travelled abroad, chiefly to Western countries (e.g., the US, the UK and Germany), for medical care (Kangas 2002). Yet, as with conventional tourism, demand changed significantly after 9/11. To illustrate this, in 2001 some 44% of medical travellers from one Middle Eastern country went to the US to receive medical care yet, by 2003, this figure dropped to a mere 8%, attributed by an influential McKinsey & Co. report (Ehrbeck *et al.* 2008: 8) to the difficulty encountered by these prospective patient-consumers and their companions to obtain visas to enter the US. It took six years for these numbers to return to their pre-9/11 levels. For Tan Lee Cheng of the MOH's Corporate Policy and Health Industry Division, this was a prime example of increasingly empowered transnational consumers 'boycotting' (Fischer 2007) injustice:

⁷² As a member of the OIC, the Malaysian government hosted the Organization's 2001 Islamic Conference for Ministers of Tourism (ICMT) in Kuala Lumpur.

With the 9/11 incident, Middle Easterners have been ostracised and discriminated in the Western world. So, even though they have been good customers to all the Western economies, I don't think their money is that welcome anymore now because of terrorism and other reasons. These Islamic countries are also developing and growing well under the oil boom. They have more economic power now, and now they are also more vocal to demand equal treatment anywhere else in the world. Those who can exercise their rights are merely doing so to protect their interests. They have the right to choose to go anywhere in the world. If they don't like you [Western countries] searching them... and they hate your sniffing dogs – if they don't want to go through that procedure – it's entirely their freedom to do so... (Tan interview, 17/01/2008)

If they could no longer easily access Western IMT destinations, then other destinations were all too pleased to welcome Middle Easterners and their money. It was thus during this in-between period before flows to the West again stabilised that eagerness to get a slice of the Middle Eastern pie grew among private medical care providers in a range of countries. Prominent IMT conferences around the world carried interest in the Middle Eastern market, especially the Gulf countries, with experts advising on how to best appeal to them by 'satisfying their Islamic sensibilities' and curing their 'disorders of affluence' (Jagyasi 2008) (e.g., controlling obesity and its effects and tapping into the high demand for cosmetic surgery) which had yet to be adequately met in the existing Middle Eastern healthcare market. IMT destinations in Dubai, India, Jordan, Lebanon, Singapore⁷³ and Thailand all launched campaigns to attract Middle Easterners, with the destinations peripheral to the region highlighting not only their cultural and religious tolerance and sensitivity but also their very own Islamic credentials (Associated Press 2006a, 2006b; Connell 2006; Husain 2007; *Islamic Tourism Magazine* 2005; Montlake 2004).

Malaysia was also on the bandwagon. While a trade mission to Middle Eastern countries in May 2001 made it clear that the Malaysian IMT industry had already sought to tap into the Middle Eastern market prior to the events of 9/11 (Chua 11/04/2002), among the many IMT destinations on offer, it was difficult to attract their attention. This common concern with

73 In its pursuit of the mighty petrodollar, for example, neighbouring Singapore has considered it 'a matter of survival' to 'reinvent and make itself relevant to the Middle East', since the small island state considers that it has 'no traditional affinities with the region' (Namblar 21/06/2005). The Singapore government, in its attempt to strengthen ties, has sought to provide Islamic financial services, create luxurious IMT packages and even extend permanent resident status to Middle Easterners wishing to invest in the country.

Malaysia's invisibility is raised in an interview with an anonymous Malaysian governmental tourism representative (interview, 24/01/2008):

It's been a habit among Arabs to turn to the West for treatments, to Europe or to the USA. Of course, they do realise that Malaysia is a Muslim country in a way, comparable with the Middle East. But I think that they do not know much about us. Of course, they know on the surface: 'Oh, yes, Malaysia, Kuala Lumpur... a Muslim country. Hot weather'. But they don't know much about us. So, we have to go and tell them. That's why we always participate in certain events in the Middle East, like the Arab Travel Mart, to make our presence known there. That's also why there are tourism offices in Dubai, Jeddah and Istanbul. It's a long way for us. But we have to make some impact on them.

A 2003 report by the Malaysian Institute of Economic Research suggested that Malaysia 'bank on its Islamic credentials to attract medical patients from the Middle East' in light of the fact that, in addition to the abundance of tasty *halal* food and the likelihood of prayers recited before surgery, 'also working towards Malaysia's advantage is the current geopolitical situation' (Wong 2003). The entrepreneurial spirit of the years following 9/11 is clearly embodied in a speech by the then Health Minister Chua Soi Lek:

We have identified the Middle Eastern countries as a potentially big market for our health tourism drive. At the time of our survey in 2002, Middle Eastern patients made up less than 0.3% of our total foreign patient admissions. However, since the September 11, 2001 incident, Malaysia has become a popular, alternative tourist destination for people from these countries, and we should be able to take advantage of this positive development, aided by *our good Islamic credentials*, excellent medical facilities and services, political stability and the ability of our people to communicate in English. *Middle Eastern countries are also reputable healthcare spenders.* (Chua 25/09/2004, emphasis added)

Throughout countless academic (e.g., Connell 2006; Henderson 2003), mainstream and industry-orientated articles and reports as well as political speeches, the events of 9/11 and their repercussions provided a galvanising theme for debate on Middle Easterners' presumed motivations for opting (or why they should opt) for Malaysia as an IMT destination. In them, Malaysia appears not merely as an alternative to the West but also as an *Islamic* alternative. Commentators repeatedly suggested that it was 'the *natural* target segment for Malaysia's tourism service providers' (Yim and Ho 2005, emphasis added), emphasising not only religious but also cultural similarities among Muslims from very different parts of the globe. Malaysia's

'Islamic credentials' were to grow in relevance to the ways in which the IMT industry has been portrayed both within and outside of the country, drawing on select discourses about the political relevance of Islam and its practice in the context of a multiethnic Malaysia.

This 'golden opportunity' seized on healthcare to showcase Malaysia's claims to 'being a modern and progressive Muslim nation' (Palany 01/07/2004). It shaped the contours of how the religious practices and expectations of prospective Middle Eastern patient-consumers were imagined, giving stakeholders a chance to tout a particular set of religious and culturally-based customer services that articulate a state-endorsed vision of the country's progressive religious 'expertise'. A Malaysian daily suggests, for example, that

[m]any of them [Middle Eastern Arab patient-consumers] find the religious and cultural linkages reassuring – *doa* [prayer] recitations, the familiar sound of the *muezzin* [the voice calling Muslims to prayer], *halal* food, the *surau* [place of worship] and Muslim staff are much appreciated when one is facing surgery. (Mohanlall 21/08/2004)

This is further evidenced by a testimonial from

Heart patient Ali Ahmed Al-Seri of Abu Dhabi, who underwent heart surgery at the Damansara Specialist Centre, KL [Kuala Lumpur], [who] wrote: 'My operation by Dr Yahya Awang⁷⁴ was a success. I thank doctors, staff and nurses for providing healthcare services that were so impressive and beyond my expectations. I am proud that we have this quality care in a Muslim country, in a safe environment, with high technology facilities and honest professionals'. (*Ibid.* 21/08/2004)

This example demonstrates how the extension of care to these temporarily displaced IMT habitués and a new crop of Middle Eastern students⁷⁵ boosted IMT promotional claims about the 'world-class' quality of care in Malaysia: 'While patients used to go to the US and the UK for medical treatment previously, these are not favoured choices anymore and Malaysia, with its international-class medical facilities and as a Muslim majority nation, is the perfect alternative' (*TTG Asia* 09-15/01/2004). Offering treatment attentive to religious commonalities, a less

74 Dr Yahya Awang was former PM Mahathir's cardiac specialist. See Chapter 2 for more details on his foray into IMT.

75 It is estimated that of the over 70,000 foreign students in Malaysia enrolled at institutions of higher education today some 21,000 are of Middle Eastern origin (Muin 11/05/2009). Saudi Arabia, for example, sends many students overseas on scholarships each year and Malaysian private universities and colleges have become among the top destinations for studies. On top of university fees, Saudi students get a monthly MYR 4,000 stipend which allows them a very comfortable lifestyle in Malaysia, can bring along an adult member of their immediate family to take care of them and have medical insurance that fully covers all non-elective treatment.

restrictive visa regime following 9/11 and the provision of a safe, 'Muslim-friendly' alternative thus served as the basis for political solidarity at a particularly dark geopolitical moment.

Yet what forms does 'Muslim-friendly' care assume? Based upon respect for Islam and its followers, such care can be interpreted as sensitivity to Islamic medical ethics and the role of religion in everyday practices, such as dietary needs (e.g., *halal* catering and the absence of alcohol), differences among the sexes (e.g., medical staff of the same sex as their patients, separate facilities for men and women, modest dress codes, etc.), on-duty imams, recitation of prayer before surgery and the adequate provision of space for prayer (see Figure 5.8). It does not incorporate 'traditional' forms of healing that would entail rejection of or divergence from the 'scientific' and technological innovation enshrined by contemporary biomedical practices (Adib 2004; Morsy 1988). Rather, as Morsy (1988: 355), writing about Islamic clinics in Egypt, observes, 'Stripped of its cultural facade, Islamic health care does not appear to stand on its own but is firmly supported by the well-entrenched pillars of high-tech, curative, individually centred biomedicine'. Take *halal* certification, for example, which, like the international accreditation standards discussed in Chapter IV, lends hospitals additional stature and promotional value. Explains Dr Abdul Latiff,

It's like having an ISO, a protocol to ensure quality. Eventually *halal* certification became a real necessity for people to trust in an institution. It means that there is some form of a system in the hospital that makes sure that whatever is done there does not transgress the *Shari'ah*, the law of Islam, be it in the form of the medications used, the methods of treatment or the regulations around procedures. If we do in-vitro fertilisation, for example, we must make sure that the egg and the sperm are from a legally wed husband and wife. A [*halal*] hospital cannot have a sperm bank where women can just come and say, 'I would just like to have nice sperm to fertilise my egg so that I can have a baby'. If the hospital does not allow this, then it is *halal*. (interview, 07/12/2007)

Building upon biomedical practices, 'Muslim-friendly' care therefore focuses on incorporating the religion into the ethics grounding care and the type and quality of care provided (Kangas 2010) as well as returning the increasingly commodified and 'deteriorated' practice of medicine to a site of a 'noble' relationship of trust between patient and provider that is critical of consumption and excess (Dr Abdul Latiff interview, 07/12/2007).

'Muslim-friendly' atmospheres conducive for healing those who consciously seek out therapeutic landscapes in which their religious, cultural and linguistic specificities are

recognised, honoured and perhaps shared are likely to be increasingly sought after abroad, as establishments located in the West have grown less hospitable and willing to accommodate such differences, in spite of efforts to promote greater cultural competences among health workers.⁷⁶ Such care sites are not pursued just because certain patient-consumers can no longer access their habitual care destinations. They are also sites/sights through which 'boycotting' is enacted, as an 'expression of distinction, taste, individuality, ideology or resistance to globalisation seen as cultural imperialism' (Fischer 2007: 34) in what is already a pivotal moment in which codes of moral behaviour among Muslims throughout the world are being re-examined, in relation to a host of extreme geopolitical predicaments. This performance of 'public morality is inseparable from the desire to control and purify the body' (Fischer 2007: 39), to take back control over the self in a context of moral ambiguity. It, like the consumption of other Islamic goods and services and the practice of veiling, can be understood as reinforcing 'boundaries in social relations through regulating bodily practices in public spaces... serv[ing] as a public display of Islamic subjectivity' (Göle 2002: 189; see Gokariksel 2003). In other words, the pursuit *and* provision of 'Muslim-friendly' care is a public performance of collective difference enacted through corporeal and spatial practices where controlling the ways in which the medical or therapeutic gaze is practiced assumes particular symbolic and political salience.

Figure 5.8 Image of a Muslim female doctor meeting with one of her patients featured in the National Heart Institute brochure

(image removed)

Source: National Heart Institute (2008)

Yet, while it would seem to make good business sense to encourage Middle Easterners to receive 'Muslim-friendly' medical care in Malaysia, in reality very few have chosen Malaysia. Though the absolute number of Middle Eastern patient-consumers nearly doubled from 2002 to

⁷⁶ Exemplifying contemporary Western discomfort with providing 'Muslim-friendly' medical care is the controversy generated by Dutch hospital magnate Paul Sturkenboom who, in 2006, proposed to open a private hospital for Muslim patients in Rotterdam in the Netherlands, a country where 5% of its population Muslim. Dutch ultraconservatives criticised the plan as modern 'apartheid' and 'a step backwards to the Middle Ages'. For Sturkenboom, however, it was an opportunity to tap into an unsatisfied niche market, noting that '[t]here are approximately one hundred hospitals in the Netherlands today founded on Christian principles, but not one for Muslims' (Cessou 2006; Rennie 2006).

2008, they represented only 1% of all foreign patients treated in 2008 (Tourism Malaysia 2009c) (see Figure 5.4).⁷⁷ As the earlier cited McKinsey & Company report (Ehrbeck *et al.* 2008) observes, the IMT habitués who traditionally went to Western countries used Malaysia principally as a detour in the early years following the post-9/11 persecution of Middle Easterners and have largely returned to their old IMT haunts. This is corroborated by an anonymous Malaysian governmental tourism representative (interview, 24/01/2008) who observes:

When September 11 happened, we thought we could divert them to Malaysia for treatment and vacation. But it's not the same. What they expect is not the same. Arabs like to shop. They like nightlife. They don't want to come here: it's dull and there's nothing to see. They're not like Westerners who are happy just because they eat better food and get to read a few books. Not the Arabs; they're very active. They are used to the US and Europe, and they expect something like that if you want to get them over here... But, while there are limited numbers already coming here for treatment and to shop, when it comes to shopping we can't beat them. If they've been going to the UK, to Paris, they may want to go to Malaysia. But maybe only once or twice. That's all. Then they'll head back to London, Paris or Frankfurt... but not to Malaysia.

Furthermore, whereas IMT was considered necessary because many Middle Eastern countries did not have high-quality medical facilities at close reach, governments paid for their citizens' medical treatment abroad. In Southeast Asia, Singapore and Thailand benefited from this most (Bernama 17/03/2009; *The Halal Journal* 22/07/2006; Yap interview, 15/02/2008). Now, however, a plethora of top-notch facilities are sprouting up throughout the region, prompting greater focus on the region itself. Access to high-quality specialist care in Saudi Arabia, Oman and the UAE is improving (Ehrbeck *et al.* 2008), Jordan and Lebanon are becoming respected IMT destinations in their own right and Dubai has proven adept at attracting special partnerships and hosting branches of world-renowned medical centres (e.g., Harvard Medical International) in its Healthcare City. As a result, few Middle Eastern patient-consumers go to Malaysia for care, their share rising only barely from 0.5% in 2002 to 1% six years later (Chua 25/04/2004; Tourism Malaysia 2009c). Stakeholders interviewed thus found that Middle Eastern patient-consumers seek out healthcare in Malaysia for three simple reasons. Firstly, private medical care remains comparatively inexpensive. Secondly, they – more than other patient-

⁷⁷ No statistics are available on the IMT revenue they generate.

consumer groups – are thought to be more drawn to the possibility of mixing treatment with conventional leisure tourism activities. Finally, the majority receiving care in Malaysia already lives there as expatriates and students, settling in ever larger numbers over the last decade after 9/11 when it became increasingly difficult to get student visas to the UK and the United States. Furthermore, and somewhat surprisingly in light of the significant discursive focus on Malaysia's Muslim credentials, most private-sector stakeholders interviewed felt that while the country's 'moderate, progressive Islamic' status has been a selling point for IMT, it is cast a secondary one – little more than a 'lifestyle perk'.

Ultimately, regardless of actual foreign patient numbers, the provision of Muslim-friendly care retains significant value in the context of the Malaysian state's broader efforts to assert an image of a model modern Muslim country and remains at the heart of promotional efforts today (*Al Arabiya* 22/06/2009; *Bernama* 17/03/2009). As we have seen, Malaysia's niche potential in IMT is oft attributed to the presence and tolerance of diverse cultural and religious expression within its borders, seen to extend hospitably to foreign visitors. This relaxed hybridity is presumed attractive to wealthy Middle Easterners who, tired of the discriminatory hassles elsewhere, can more easily 'be themselves' and feel 'at home' in the country, 'instead of going somewhere which may not be as physically safe, somewhere where they feel that they have to really confine themselves to specific places' (Dr Abdul Latiff interview, 06/12/2007).

For Arabs, multi-faith Malaysia presents an alternative face of Islam - one that is more relaxed, open, and Western than many Middle Eastern regimes. But the *comfort of the familiar* is the initial lure for most tourists... Part of the attraction for Muslim visitors is Malaysia's easy-going blend of Islamic customs, modern conveniences, and tropical scenery... But perhaps the biggest selling point is visa-free access. Unlike the US and Europe, which have tightened immigration rules, Malaysia throws open its doors to Muslim visitors, a policy that has drawn criticism in the past. (Montlake 2004, emphasis added)

At the same time, Malaysia's 'easy-going blend' of tradition and modernity offers insight to 'Western people who want to know more about how people of an Islamic cultural background are able to live alongside other cultures', suggests Tan (interview, 17/01/2008).

We are a country where a majority of the population is Muslim and, in our country, our practices don't harm anyone. People can come to Malaysia to understand how Islamic people are living and practice their religion in this form or another. And it's true that Malaysia understands Islam more

[than the West]. Therefore, hopefully this knowledge will ease Westerners off of their fear and misunderstanding of Islamic culture. As for people who are from Islamic countries, even if they are ostracised and, in a way, now unwelcome to these Western countries, they still want to travel and enjoy themselves. So, they can go to a country that welcomes them. They also will want to know how Malaysia, being an Islamic country, can be so open, accommodating all other cultures and beliefs and ethnicities and still live in peace without having any problem with the Western world... We are not specifying a difference between Western culture and Islamic culture, but hopefully we are making it possible to interpret both through Malaysia. (Tan interview, 17/01/2008)

This positioning of Islam within Malaysia's ethnic and religious diversity contributes to the government's mission to change global perception about Muslims by acting as a bridge in promoting understanding between Islam and the 'West'.

Yet, authorities are also working to dispel popular Middle Eastern views on Southeast Asian Muslims rooted to 'holier than thou' assertions of superiority and authenticity of their home countries' own (often very strictly interpreted) Islamic practices over the diversity of those found in Malaysia, Indonesia and elsewhere in the region. While *halal* food and mosques are certainly in abundance, interviewees repeatedly took the moral high-ground in suggesting that Malaysia is not a 'truly' Islamic country due to a conviction that 'easy-going' Malay Muslims do not subscribe to the 'true' Islam but rather a hybrid form resulting from the country's multiethnic composition. Seeking to put to rest such stereotypes, the promotion of Malaysia's 'Muslim-friendly' IMT niche is intimately linked to the country's positioning as a legitimate political and economic leader within the international Islamic community and claims to the title of 'the most developed Islamic country in the world' (Bernama 13/05/2010). The expanding production and provision of standardised *halal* products and services, such as medicinal products⁷⁸ and Muslim-friendly IMT (Barraclough and Chua 2007: 224), thus contribute to place-making assertions of 'the compatibility of the ethnicised state, modern Islam, business and proper Muslim consumption' (Fischer 2008: 11). This is illustrated in commentary from Dr Abdul Latiff (interview, 06/12/2007):

78 The production of halal medicinal products generates a new ethical niche of consumption. If medicine must be used to save a Muslim's life, then, according to the Holy Qu'ran, the question of whether or not the medicine is halal is not relevant. However, if the patient is not in a life-threatening situation, and if there is a halal alternative, then it should be used. This rule applies not only to medicine but also for anything a Muslim uses or consumes (Tan interview, 17/01/2008).

Because Malaysia has developed tremendously fast in the past 20 to 25 years, among the Muslim countries, it is seen as the closest they [Middle Easterners] can get to a developed Western country. Malaysia has started a lot of trends: from Islamic financing to being the *halal* hub for manufacturing, with systems for making sure that the products are manufactured from start to finish according to religious guidelines... So, it is important for us to start a different trend. It cannot be the same health tourism as other countries, not the same as Thailand or Singapore or anything. Instead we start a new trend and play on why we are distinct... We have got to find this identity, and providing Islamic medicine is just one of the many distinct identities we can find. And we market ourselves as such, so that they [Middle Eastern patient-consumers] feel comfortable and not worried about *halal* food and *halal* treatments and whatnot: 'These people will take care of everything and they will advise me'... It's about trendsetting leadership: Malaysia has the potential to be number one, to make everyone realise that we are able to do this. We recently sent someone to space – we spent a lot of money, just to show that we can. So, why not?

With its linkages in the OIC, the Malaysian government benefits from advantageous trade relationships with a range of Middle Eastern countries in manufacturing and services (e.g., tourism, education and healthcare) (*NST* 02/10/2005), serving as a strategic channel through which Malaysia promotes its international '*halal* hub' status. This status thus serves as a focal point for legitimising Malaysia's progressive Islamic identity, reflecting ethical (re)interpretations of consumption and consequent growth in halalisation in places where Muslims may constitute a minority of the population (e.g., the UK and Singapore) or be a majority in a religiously mixed population (e.g., Malaysia and Indonesia) with expanding consumption capacity (Fischer 2008; L. Wong 2003).

5.4 Conclusion

In rooting IMT to the effects of neoliberalism on what had previously been understood as domains of the nation-state and entitlements of its citizenry, international patient-consumers have often been cast as pioneering self-advocates, with influences on their selection of IMT destinations being largely attributed to 'push' factors that make the pursuit of medical care in their countries of residence unattractive. This chapter has sought to complement and complicate such notions about who moves where and why by calling attention to the strategic efforts by stakeholders representing IMT destinations to draw more – yet select – international patient-consumers. As I have argued, these efforts are not based solely upon the economic or

time-sensitive factors to which their successes are often attributed but also oftentimes upon the promise of fulfilling the diverse culturally-specific requirements of international patient-consumers.

In this chapter, I have drawn from work on diversity, multiculturalism and cosmopolitanism to think through how the extension of 'culturally competent' healthcare to non-nationals permits a spectrum of reconfigured and newly valorised Malaysian subjects to tap into potentially lucrative markets by investing in and naturalising similarities with those very markets. Reaching beyond borders to attract international patient-consumers, IMT promotion is premised upon destinations' ability to effectively demonstrate their openness to the use of their healthcare system by non-nationals. Increasingly, the display of this openness calls upon a 'repertoire' of claims to 'cultural versatility' (Jeffrey and McFarlane 2008) as much as the international standardisation of medical practice. This requisite versatility has been naturalised and discursively couched in the expertise of a postcolonial, multicultural Malaysia. With its re-scripting of the value of internal linguistic, religious and ethnic difference in order to be more attractive to mobile capital, the state creatively casts itself as a prime facilitator for its subjects' diversity, serving as the 'unifying ground' upon which 'unity in diversity' is made possible. It follows, then, that the country would have ample 'natural' experience in catering to the needs of a broad range of international patient-consumers because those needs are shared by Malaysians themselves. Malaysians understand the importance of having access to *halal* food. They already converse in a variety of languages and dialects. They have gained experience in prestigious universities and medical facilities from around the globe. Their similarities with their international clientele derive from the diversity found, and made possible, within Malaysia. This 'strategic' brand of cosmopolitanism I describe breaks with universalising conceptions of cosmopolitanism that favour the cultivation of a deterritorialised 'global citizenship' which transcends cultural difference. Rather, it thrives by reifying and commoditising particular expressions of cultural difference – capitalising on the production of related goods and services rendered more valuable through the niche differences they appear to represent and satisfy.

Attention to the politics behind the construction of these 'pull' factors – as we have seen them being deployed (and at times, exaggerated) in the promotion of Malaysia as an IMT destination to Middle Easterners on the premise of a common Islamic bond – offers insight into

this lesser explored 'expedient' role of culture (Yúdice 2003) in the provision of commodified care, or the 'turn[ing of] care for human life into care for human capital' (Sparke 2009b: 135). Malaysia's positioning as a 'Muslim-friendly' IMT destination contributes to constructions of the country's proactive leadership in yet another area of progressive 'capitalism-friendly' Muslim expertise, alongside Islamic finance and the development of other *halal* goods and services (Bokhari 27/05/2007; Fischer 2007). This fomenting and expansion of Islamic consumption practices are evidence of the self-conscious development of a 'postcolonial political economy' (Pollard and Samers 2007; Sun 02/10/2005) based upon an alternative re-imagining of the 'global' that decentres the 'core' and multiplies the sites out of which care knowledge and expertise – whether 'economic' or 'religio-cultural', as this chapter has sought to demonstrate – are thought to flow.

Chapter VI. 'Complementarities' and regionalised landscapes of medical travel

6.1 Introduction

The region as a scale holds particular relevance to international medical travel (IMT). While most work on IMT to date has largely attended to the concerns and impacts of Western patient-consumers pursuing care in far-flung 'developing' countries, IMT stakeholders involved in on-the-ground promotion and care provision acknowledge that the bread-and-butter of the industry is cross-border regional medical travel. Though their per capita expenditure may be lower than those requiring a long-haul flight to reach an IMT destination, it is generally regional – and particularly cross-border – patient-consumers who are responsible for generating the consistent volume that produces impressive-looking IMT figures (Hamid 2010). Home to a high concentration of the world's major IMT destinations, Asia receives the lion's share of medical travellers. According to an influential McKinsey & Company industry report, some 93% of Asian medical travellers stay within Asia, an overwhelming figure compared to the relatively meagre 27% of North Americans, 10% of Europeans and 2% of Middle Easterners that stay within their regions for care (Ehrbeck *et al.* 2008: 5). Acknowledging Asia's intra-regional flows, this chapter seeks to shed some light on the wealth of regional medical travel practices that have forged and sustained Asian IMT destinations as well as their impacts on these places, particularly in the context of free trade agreements in the scope of the Association of Southeast Asian Nations (ASEAN) (Arunanondchai and Fink 2007; Smith *et al.* 2009; Whittaker 2008).

Throughout the thesis so far, I have sought to draw attention to the ways in which IMT is conjured and harnessed to contribute to 'attempts at deterritorialisation *through* reterritorialisation' (Sparke 2005: 58, original emphasis) and their reframing of the spaces and subjects of healthcare. After tracing IMT's involvement in broad discursive shifts privileging the patient-consumer over the patient-citizen (Chapter III), globalising standardisation over graduated diversity (Chapter IV) and strategic cosmopolitan responsiveness over insular ethnic protectionism (Chapter V), this chapter explores IMT's relevance to the fostering of cross-border care relations among neighbouring countries and their regional geographical imaginaries and identities by turning the exploitation of significant economic disparities, or 'territorial

differentials' (Jessop 2003), between countries into beneficial regional 'complementarities' (Kakazu 1999). To do this, I examine (re)territorialisations of healthcare that hinge on belongings to a range of regional forms, namely supra-national regions (e.g., ASEAN), cross-border regions (e.g., Indonesia-Malaysia-Thailand Growth Triangle (IMT-GT)) and sub-national regions (e.g., Iskandar Malaysia).

This chapter is divided into two main parts. In the first section, I place IMT within the context of 'diverse forms of interdependencies and entanglements between transnational phenomena and nation-states' (Ong 1999: 16) that have 're-envisioned' the 'region' as a site of intervention in its domestic and cross-border forms in development plans over the last decades. The second section focuses on two cross-border regional landscapes of 'graduated sovereignty' – those graduated modes of rule which aim to 'establish the transnational linkage of sites' (Ong 2006: 88) through the blurring of national borders. I look at the cultivation of Iskandar Malaysia, and Malaysia more broadly, as a prospective healthcare hinterland for Singapore residents seeking cost-effective healthcare alternatives and as an overflow site for Singapore's own IMT industry. Then, I turn to Malaysia's current IMT heavyweight destinations, Penang and Malacca, to examine their leveraging of regional cultural similarities and their management of the Indonesian island of Sumatra's poor quality healthcare in the context of the IMT-GT. I draw attention to the biopolitical value of the different cross-border regional flows and how this shapes the contrasting ways in which 'borderless' development is discursively and materially practiced in each of these zones. This chapter thus takes an in-depth look at the constructions of these cross-border regional therapeutic landscapes as another manifestation of the shift towards a postdevelopmental politics of national representation.

6.2 Regionalisation

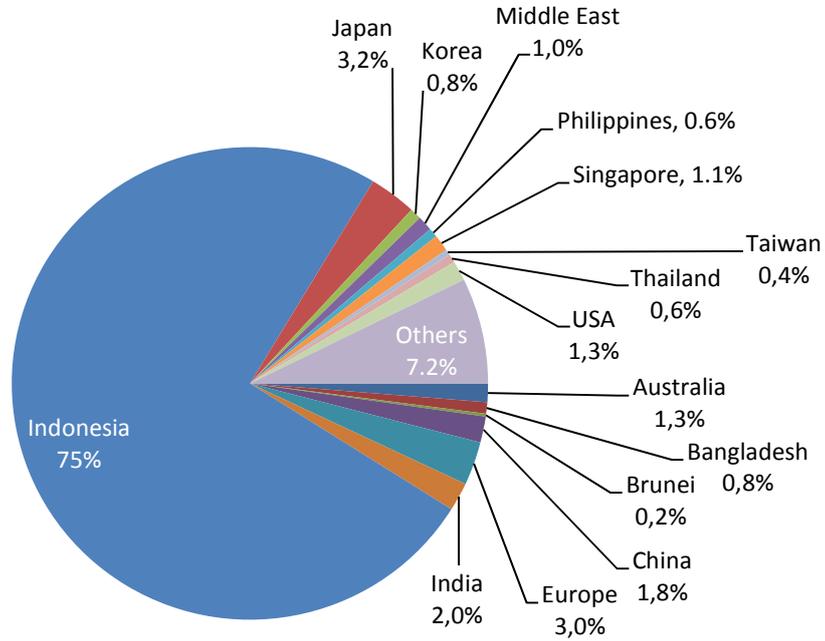
Changing demographic and socio-economic structures as well as cultural and linguistic similarities among countries have been shown to foster regionalised flows highly relevant to IMT destinations (Díaz-Benavides 2002; Janjaroen and Supakankunti 2002; Kangas 2002, 2007; Smith *et al.* 2009; Whittaker 2008; Hopkins *et al.* 2009). Studies of regional medical travel have traced flows of desperation within North America, Southern Africa and Central Asia (e.g., Bergmark *et al.* 2008; McDonald *et al.* 2000; Walraven *et al.* 2009) and documented harmonisation efforts to facilitate the portability of increasingly mobile European Union citizens' health coverage

(Kesteloot *et al.* 1995; Morgan 2003; Pennings 2002). Other work points to how small and 'developing' countries may benefit from economies of scale by pooling resources and patient-consumers with their neighbours. In the Maghreb, El Taguri (2007), for example, demonstrates that sparsely-populated Libya on its own cannot achieve the economies of scale necessary to provide all types of medical services to its citizens and must turn to Tunisia, where 81% of its foreign patient-consumer population in 2003 was Libyan (Lautier 2008), to fill in the gaps. As such, authors like Wolvaart (1998: 64) find that 'outsourcing to other developing countries, especially for specialist, high-technology, diagnostic and rehabilitation services, may be a more cost-effective approach than attempting to develop national self-sufficiency'.

Regional medical travel and the 'economies of scale' into which it plays hold striking relevance for Malaysia. Official figures for 2008 indicate that at least 86% of foreign patient-consumers seeking care in Malaysia hailed from Asian countries, with 77% coming from many of its immediate ASEAN neighbours (Tourism Malaysia 2009c). This sets Malaysia apart from Thailand, one of its main competitors for regional medical travel hub status in Southeast Asia which hosts comparatively smaller percentages of ASEAN and Asian patient-consumers (Arunanondchai and Fink 2007: 12; Chinmaneevong 18/08/2008) (see Figures 6.1 and 6.2).⁷⁹ In recognition of the significance of this regional market, Malaysia's National Committee for the Promotion of Health Tourism (NCPHT) identified ASEAN countries home to emerging middle-classes, like Indonesia, Cambodia and Vietnam, as its principal market (MOH 2002: 106). This move reflected the routine promotional efforts taken by some of the 35 private hospitals endorsed for IMT (e.g., participating in trade fairs, distributing brochures, hiring local agents to recruit prospective patient-consumers, taking doctors on talking-engagement 'roadshows') largely already geared towards ASEAN countries, with particular emphasis on the Indonesian island of Sumatra.

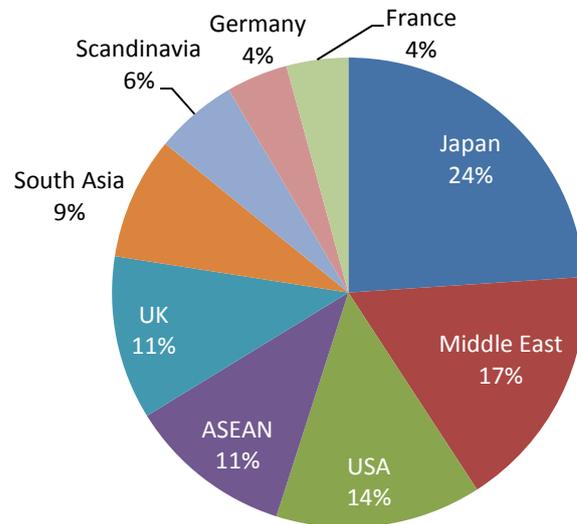
⁷⁹ While Malaysia and Singapore's foreign patients came chiefly from ASEAN countries (70% and 74%, respectively) in 2002, the case of Thailand was quite different, with less than 50% from Asia and only 7% from ASEAN countries (Khoo 2003; Piravej 2009; Tourism Malaysia 2009c).

Figure 6.1 Breakdown of Malaysia's 374,063 foreign patients by origin (2008)



Source: Tourism Malaysia (2009c)

Figure 6.2 Breakdown of Thailand's 1.4 million foreign patients by origin (2007)



Source: Piravej (2009)

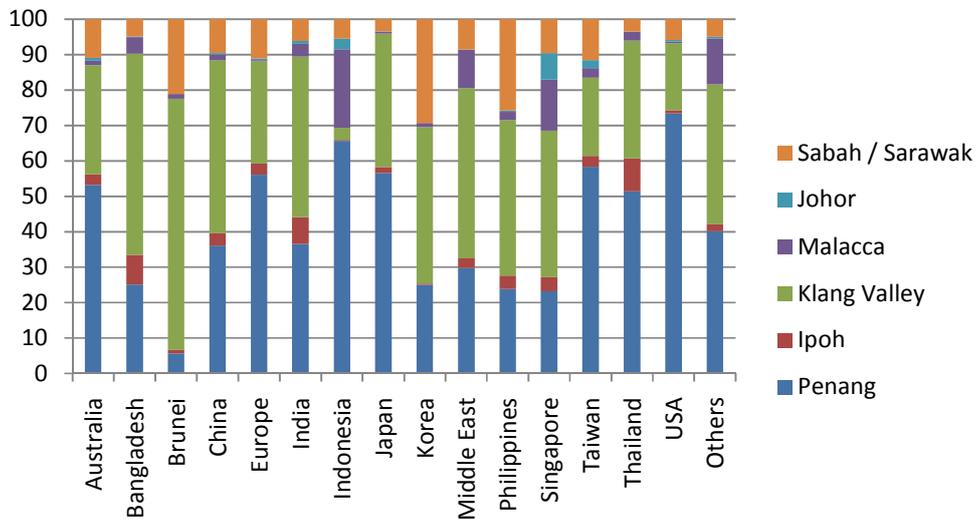
As Chapters IV and V have demonstrated, attracting medical travellers from Western 'developed' countries and the Middle East is believed to generate prestige and advance broader cultural, economic and political interests and linkages. Indeed, key IMT industry players throughout Asia seem to focus much energy on learning how to best appeal and cater to these small yet potentially lucrative patient-consumer segments and their 'disorders of affluence' (Jagyasi 2008). Danny Jee, manager of the Kuala Lumpur-based Holiday Travel agency that started a medical travel branch in 2007, suggests:

It adds to their [care providers'] resumé's. They can say, 'I get patients from the UK and Australia', rather than 'I've merely got patients from Indonesia'. (Jee interview, 12/02/2008)

Yet, attracting regional medical travel flows is also of great strategic value. ASEAN patient-consumers' choice of Malaysia for care has far-reaching impacts on Malaysia's positioning within Asia, ASEAN and among its neighbours, contributing to long-standing efforts at asserting the country's economic, political and cultural relevance to the region. Government concern with the resilience of Malaysia's IMT industry during the current economic crisis, for instance, reveals a rhetoric that emphasises its medical prowess in, and solidarity with, a more broadly defined Asian region, seeking out ASEAN markets 'to cushion the impact of fewer arrivals from other markets' (*IMTJ* 27/11/2008) and echoing broader efforts at improving and diversifying Malaysia's tourism and trade position with a greater Asian region which encompasses ASEAN countries, China, India and the Middle East (*The Star* 24/1/2009).

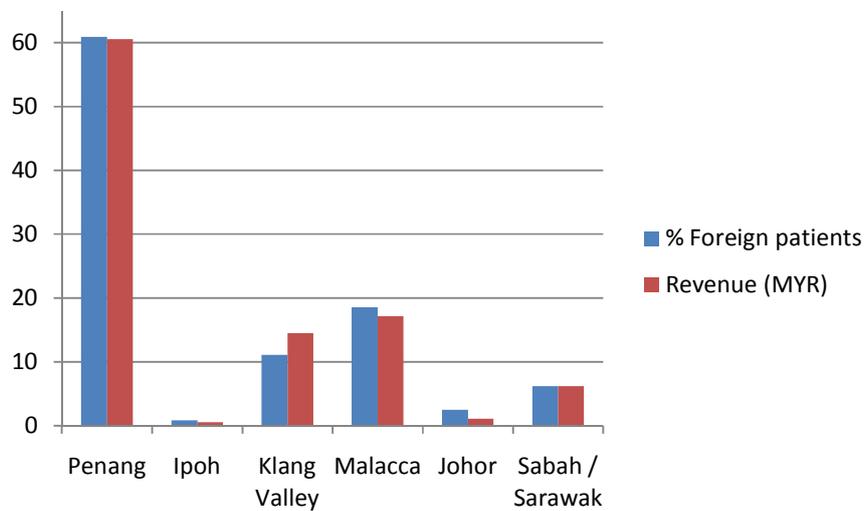
While IMT is used to foster and strengthen Malaysia's strategic transnational linkages within ASEAN, certain destinations within Malaysia endorsed for IMT have been more effective than others at attracting and building on the intra-regional networks fundamental to the industry's success. Foreign patient-consumer flows are far from evenly distributed among the 35 private hospitals endorsed for IMT (see Figures 6.3 and 6.4 and Appendix 6). To illustrate this, while the Klang Valley (the metropolitan area comprising Kuala Lumpur) is home to no less than 17 IMT hospitals, this region was responsible for treating only 11% of all foreign patient-consumers in 2007 (APHM 2008). The bulk pursued care elsewhere, mostly along the western peninsular coast: 61% in Penang (home to seven IMT hospitals), 19% in Malacca (three), 2% in Johor (one), with the rest going to Ipoh, Sabah and Sarawak.

Figure 6.3 Regional distribution of foreign patients by nationality (2007)



Source: APHM (2008). Note: Figures are based on the 35 hospitals endorsed for IMT in 2007. For detailed statistics, see Appendix 6. For information on reporting hospitals, see Appendix 7.

Figure 6.4 Regional distribution of foreign patients (2007)



Source: APHM (2008). Note: Figures are based on the 35 hospitals endorsed for IMT in 2007. For detailed statistics, see Appendix 6. For information on reporting hospitals, see Appendix 7.

This significant internal diversity, played down by efforts to consolidate the homogenised image of ‘Malaysia’ as a national therapeutic landscape, can be attributed to the 80% of foreign

patient-consumers that hail from Malaysia's immediate neighbours who make use of the physical proximity and naturalised cross-border cultural, economic and political linkages to some of these destinations, to the exclusion of Klang Valley facilities in spite of efforts to portray it as the national (and 'natural') anchor for the IMT industry. With the national government's appropriation of IMT as a 'National Key Economic Area' (EPU 2010), the reality of the internal differences in attracting IMT has made the national government more active (if reluctantly so) in its endorsement and fostering of greater cross-border regionalisation. IMT has now been adopted into official policy and rhetoric at a range of scales, facilitating experimentation with 'restructurings of the nexus of relations between practices and discourses of sovereignty and development' (Sidaway 2007: 346) such that select territories and scales through which 'national' development is purportedly achieved are effectively being re-scripted by governmental authorities and private-sector stakeholders in order to better connect up with foreign patient-consumer flows (Ong 2006).

Japanese neoliberal economist and advocate of post-national regionalisation Ken'ichi Ohmae was former PM Mahathir Mohamad's globalisation strategy advisor throughout most of his time in power, from the inception of the Look East policy in the early 1980s until 1998 in the wake of the Asian Financial Crisis (AFC) (see Chapter III). Known for his hyper-globalist critiques of the 'nation-state fetish', which framed the nation-state as an 'obsolete geographically cosy' concept (Ohmae 2005: 82), Ohmae saw the future as being parcelled into entities such as region-states and micro-regions where states would no longer be 'political monoliths'. The future belonged to 'amalgams of regions' that

look to the rest of the world for capital, technology and markets. They do not need to possess all the elements of economic prosperity, as long as the world works for them and with them... What is happening is that economics and technology are enforcing a new scale of geopolitical organisation. There will remain boundaries, but these will be transparent and will represent opportunities and support diversity. (Ohmae 2005: 93)

Ohmae's thinking shaped development policy not only in Malaysia but also throughout Asia and other parts of the world, privileging the region as a useful scale of intervention for the purposes of neoliberal development and investment.

Experimentation with cross-border regional development can be traced back to the early 1980s, with the crisis of the post-war model of economic growth that had been largely

concentrated within a national economy and territory, resulting in economic liberalisation (Jessop 2003; Sparke *et al.* 2004). With the end of the Cold War, a climate of economic primacy transformed the nature of political and security risk to permit a re-imagination of the porosity of borders that would privilege particular types of flows of people, goods, services and information and provide a platform from which the rising 'Asian tiger' economies of the 1980s and 90s, like Malaysia, could take off. This involved a 'relativisation of scale' (Jessop 2003), in which

different economic and political spaces are competing to become the new anchorpoint around which other scales (however many, however identified) can be organized to produce a suitable degree of structured coherence. This involves economic and political projects oriented to different scales and has not yet produced consensus on how these are to be reconciled – reflected in continuing debates and active contestation over the relative importance of global, national, and various regional sites and spaces of economic action. In this context it is important to note that there is no pre-given set of places, spaces, or scales that are simply being reordered. For places, spaces, and scales are not pre-given but subject to discursive struggles over mapping and naming and more substantive struggles over their social, material, and spatiotemporal institutionalization. Thus we find that new places are emerging, new spaces are being created, new scales of organization are being developed, and new horizons of action are being imagined. (Jessop 2003: 2)

Amid the proliferation of places, spaces and scales of organisation and action overlapping and mixing with one another in Southeast Asia, Bunnell (2006: 25) suggests that

states in the region are re-envisioning their territories in... newly differentiated ways... [T]his rescaling forms part of a broader break-down of (bounded) national territories of government... [though] this is not to suggest a wholesale diminution of state capacities, but is perhaps more accurately understood in terms of the emergence of new spatialities of bio-political power.

As we have seen in previous chapters through the lens of healthcare, out of this 'relativisation of scale' has emerged a broad range of reterritorialisations *displacing* (though not *replacing*) the primacy of the nation-state in economic, political and social relations. The articulation of these alternative spatialities has disrupted the values, interests and identities fostered within the previously more discursively and physically bounded nation-state.

A fundamental shift in Malaysian development policy was the move towards practices of 'graduated sovereignty', wherein 'the nature of state sovereignty must be rethought as a set of coexisting strategies of government within a single national space' (Ong 2000: 72), to render the state's relationship with FDI more flexible. While hastening down the *laissez-faire* path in the

1980s with the privatisation of state assets and opening of the country to further FDI, the state came to assume a particularly pivotal role in bringing business to Malaysia and selectively tying its subjects and territory into global economic networks. This at first led to the proliferation of economic production zones (EPZs) in coastal pockets of the country that functioned as neoliberal 'zones of exception' (Ong 2007), requiring situational 'legal compromises in national sovereignty' (Ong 2000: 66) that suppressed rights and entitlements (e.g., unionisation and positive discrimination benefits) so that masses of nimble-fingered young Malaysian women could work for the low wages in East Asian- and Western-owned textiles and electronics factories that ultimately propelled the country to 'Asian tiger' status.

Seeking to consolidate and build upon this status, new development projects in the 1990s and 2000s were proposed to raise Malaysia higher on the skill ladder of the knowledge-based economy. Most symbolic of this transition was the Multimedia Super Corridor (MSC) mega-project, touted as the 'Malaysian' answer to Silicon Valley, for which Ohmae held an advisory role from 1993 to 1998. In and around Kuala Lumpur, this technological park was meant to promote local research and development favouring the grooming of a crop of business- and tech-savvy *Melayu Baru* ('New Malay') and to link them up with the transnational research and development community. Conceived of as a special 'test-bed' economic zone in which 'to experiment safely with "modernisation without undermining... traditional values"' (Wysocki, in Ong 2000: 68), in the MSC quotas for the employment of and investment by *bumiputera* were lifted, the internet was not subject to censorship and myriad financial incentives were used to appeal to big-name multinational companies the likes of Microsoft, Ericsson, ExxonMobil and HSBC. To delineate this new laboratory of graduated sovereignty, the state of Selangor in which Kuala Lumpur is located was officially divided in 2001 and enfolded into the MSC were the newly created Federal Territory of Putrajaya and Cyberjaya, stretched between two newly erected monuments to Malaysian modernity, the Petronas Twin Towers in Kuala Lumpur City Centre and Kuala Lumpur International Airport (KLIA).⁸⁰ As Bunnell (2006: 10) suggests,

Official representations of the MSC as a pioneer 'test bed'... performed an important political function. On the one hand, what were cast as potentially harmful social effects of the 'global' MSC

⁸⁰ The MSC was expanded in December 2006 to include the Klang Valley.

experiment could be contained; on the other hand, official discourses suggested that 'successful' Malaysian constructions of technology could (and would) be extended across the national territory. Over a decade after the MSC's launch, and after the Klang Valley metropolitan area (comprising the state of Selangor and the MSC) was judged to have had sufficiently 'reached its [development] momentum' (Bernama 28/01/2008), in 2005 Selangor was officially declared the first 'developed' state in Malaysia. With the extension of this model across national territory, the states of Penang and Malacca are now set to acquire 'developed' status by 2010 and Johor by 2030. It is precisely these 'developed' and 'development-track' states that comprise the major sites in which the IMT industry is (either already or planned to be) highly concentrated.

Not by chance, then, the well-performing states of Selangor, Penang, Malacca and Johor also host some of the most dynamic cross-border regional economic zones in ASEAN, serving as gateways through which wealth is brought from the rest of the world so that 'the central government [can] concentrate on the development of the rest of the country to which it [is] difficult to attract foreign capital' (Ohmae 2005: 214). Since 1967, ASEAN has promoted regional cooperation in matters of security, trade, investment and human resources, shaping the direction and scope of development policies at a variety of scales throughout the region. With the ASEAN Free Trade Area (AFTA) established in 1992 as a 'macro-linkage' economic bloc (Kotler *et al.* 1997, in Henderson 2001: 80), its objective has been to establish a free trade zone along the lines of NAFTA or the EU to prepare for the start of the ASEAN Economic Community in 2015. To this end, a 'cross-border region' model (Jessop 2003) has been used to facilitate AFTA integration by encouraging the gradual formation and/or rediscovery of linkages between areas encompassed in 'sub-regional' units situated within the macro-regional political framework of ASEAN/AFTA to foster claims of 'natural economic territories' (Ohmae 2005) in which 'free economic activities are formed in such a way as to interpenetrate and spread *naturally* to adjoining areas with *complementary* relationships' (Kakazu 1999, emphasis added). The cross-border regional development model proliferated during the 1990s in East and Southeast Asia, manoeuvring naturalised cultural and ecological affinities, or 'roots', into 'routes' of economic development (Sparke 2005: 74). Among the most familiar examples of cross-border regionalisation world-wide are the Cascadia Region, bringing together the American states of Oregon and Washington with Canada's British Columbia; the Greater Pearl

River Delta, comprising nine municipalities of the Guangdong Province in mainland China, Hong Kong and Macao; and the Indonesia-Malaysia-Singapore Growth Triangle (IMS-GT).

The growth triangle, a type of cross-border region, has been particularly relevant to Malaysian development over the last decade. Growth triangles are transnational economic zones that comprise a geographically contiguous area spanning three or more countries in which differences in factor endowment and economic complementarity are exploited to promote external trade, domestic and foreign investment, tourism, natural and human resource development, infrastructure development and also [its] regions' political stability. (Kakazu 1999)

As such, they differ from other earlier models of graduated sovereignty (e.g., EPZs) nested within one country. Because growth triangles span contiguous countries, they are projected as being more induced to take a 'prosper thy neighbour' approach that builds upon 'complementarities'. Thus, they are thought to hold fewer political and economic risks than *international* trading blocs and are considered useful spaces in which to experiment with trade liberalisation, enhancing FDI and export opportunities, serving as ideal units in which cross-border regional concerns (e.g., labour migration, tourism, and food and energy security) can be best addressed and consensus on broader regional economic integration within the scope of ASEAN can be more easily reached.

To best exploit the 'complementarities' within these growth triangles, the Malaysian government has launched five *domestic* regional 'development corridors' that encompass nearly all of the national territory since 2007 in order 'to achieve equitable distribution of quality development and services' (Bernama 28/01/2008): Iskandar Malaysia, the Northern Corridor Economic Region (NCER), East Coast Economic Region (ECER), Sarawak Corridor of Renewable Energy (SCORE) and the Sabah Development Corridor (SDC) (see Appendix 8). Each overlaps with broader cross-border regional development regions: Iskandar Malaysia is nestled within the Indonesia-Malaysia-Singapore Growth Triangle (IMS-GT); MSC, NCER and ECER are in the Indonesia-Malaysia-Thailand Growth Triangle (IMT-GT); and both SCORE and SDC lay within the Brunei Darussalam-Indonesia-Malaysia-Philippines East Asian Growth Area (BIMP-EAGA).

While much has been written on growth triangles, particularly on the IMS-GT (see Tang and Thant 1994; Grundy-Warr *et al.* 1999; Macleod and McGee 1996; Sparke *et al.* 2004), the bulk has concentrated on the 1990s optimism that growth triangles were well attuned to the needs of regional cooperation (Henderson 2001: 83). There have been few subsequent studies

about their effectiveness after the AFC (but see Hampton 2010). Growth triangles, it turns out, present a series of challenges. Firstly, as triangles are discursive constructs, 'loose structures with only very limited authority' (Henderson 2001: 87), member-states' political and economic interests at other scales may trump or conflict with cross-border regional objectives, with each side 'preoccupied with its own development strategies', especially at times of economic crisis. As such, there tends to be unequal participation among members of a growth triangle and, as a result, benefits get unevenly distributed. Secondly, imbalanced power relations, aggravated by the pre-existing economic and political dominance of particular member-areas over others, may lead to relationships of exploitation, even instances of neo-colonialism (Sparke *et al.* 2004). Finally, in fostering the formation of transnational 'natural economic territories', central governments must cede some of their sovereignty over the areas involved and 'risk losing control over the provincial and regional governments that constitute the GTs [growth triangles] once they generate momentum of their own' (Kakazu 1999).

6.3 Experiments in graduated sovereignty

In the pages that follow, I explore the challenges presented by growth triangles in two landscapes of graduated sovereignty involving Malaysia where international medical travel (IMT) has come to play an instrumental role in furthering the cross-border region as a legitimate postdevelopmental territory of intervention. The first landscape I turn to is the unfolding Iskandar Malaysia development region on the southern tip of Peninsular Malaysia, pegged as Singapore's future hinterland. I then visit Penang, the small but economically powerful northern state that has long been culturally and economically turned outwards to see how IMT strengthens its position as a regional hub and its autonomy relative to Kuala Lumpur. Both of these landscapes of cross-border regionalisation tap into the rich pre-colonial and colonial geographical and cultural imaginaries of the Straits of Malacca and Singapore out of which they derive legitimacy as important nodes in 'natural economic territories' that pre-date the nation-state to which they belong. By making strategic use of the cross-border infrastructure fostered in the scope of the IMS-GT and IMT-GT, Iskandar Malaysia and Penang have been able to enhance their place-based competitiveness as IMT destinations through their (differentiated) openness to cross-border mobility by harnessing and channelling 'naturalised' transnational patient-consumer flows from what are today Indonesia and Singapore (Jessop 2003: 4). The

biopolitical shifts brought about through regionalised experimentation with graduated sovereignty have, in both cases, ultimately served to reformulate traditional notions of national sovereignty and challenge nationalising controls wrought by the federal government.

6.3.1 Singapore's healthcare hinterland

In 1994 the Singapore-Johor-Riau Growth Triangle (SIJORI-GT) first brought together Singapore, Malaysia's state of Johor and Indonesia's Riau Archipelago. Its name was later changed to the Indonesia-Malaysia-Singapore Growth Triangle (IMS-GT) in order to revise the moniker's polemic 'hierarchy' and to expand the Triangle to include the Malaysian states of Malacca, Negri Sembilan and Pahang, and the entire Indonesian island of Sumatra. Singapore – whether at the front or the end of the region's title – continued to serve as its main metropolitan anchor, an aspect considered by Kakazu (1999) to be necessary for a triangle's success due to its capability to create 'dynamic spill-over effects for trade and investment to the adjoining areas'. While Singapore's dominance in the Triangle has proven beneficial for economic growth within the cross-border region, it has also revealed the hollowness of the triangle model's objectives of addressing stark economic unevenness and fostering more balanced partnerships between the three areas.

Singapore's global competitiveness is framed as depending upon its ability to foster a 'dynamic hinterland' into which it can expand (Sparke *et al.* 2004; Bhaskaran 2008). As such, the country has leveraged its participation in the IMS-GT to ensure its survival. The nature of the Singaporean economy, Macleod and McGee (1996) argue, is no longer simply urban but rather 'part of a larger regional production and distribution complex'. Thus the IMS-GT is framed as Singapore's 'extended metropolitan region'.

[T]he economic complementarity that Singapore's economic planners envisage as a result of increased cross-border cooperation is one that enhances its own opportunity for growth without posing any threat to its advanced industrial activities, business and logistics services. Indeed, it is envisaged that there will be a net addition to national economic growth as new investment can be attracted by marketing the region as an integrated production base combining low-cost production with advanced managerial, logistic and operational networks, and as Singapore is able to draw on neighbouring territory for additional resources (water, energy, leisure space) to fuel its continued economic growth. (Grundy-Warr *et al.* 1999: 322)

Singapore turns to the nearby Indonesian islands of Batam and Bintan (20km and 45km away,

respectively), with five times Singapore's land size and one-fifth its labour costs (Kakazu 1999), to fulfil a wide range of needs: from quarrying earth in order to enlarge Singapore's own physical territory and securing fresh water resources for the water import-dependent city-state to offshoring low-waged, unskilled manufacturing jobs and building tourist attractions for Singaporeans' weekend getaways (Sparke *et al.* 2004; Hampton 2009). The wage differential has permitted a densely populated Singapore to shift some of its low value-added industry to the Indonesian part of the IMS-GT which, prior to the Triangle, had been set up as a free trade zone by the Indonesian government as part of a bilateral agreement with Singapore.

While the relationship developed between Singapore and the Indonesian part of the IMS-GT is relatively straightforward, the role of the Malaysian portion of the IMS-GT has been less clear, attributed to a divergence between 'national priorities and provincial interests' (Kakazu 1999). Due to its antagonism with the island city-state that once was part of Malay(sia), the Malaysian government lacked enthusiasm over Johor State's Economic Plan (1990-2005) to twin with Singapore (Henderson 2001: 83; Sparke *et al.* 2004: 489). However, it ultimately grew more enthusiastic and willing to put historical tensions aside with its recognition that Johor, a mere 1.2 km from Singapore, has much to gain from its 'gateway' status to the country. That the Malaysian government now favours using the IMS-GT as a context in which to privilege bilateral cooperation between Malaysia and Singapore becomes patent with Iskandar Malaysia, the southern development region in Johor three times the size of Singapore, which was launched by the Malaysian government in early 2007 as a Special Economic Corridor (see Figure 6.7). Evidence of this conversion is the 2008 nationalising re-branding exercise that saw the 'Iskandar Development Region' become 'Iskandar *Malaysia*' (emphasis added) so as to 'prevent confusion among investors' (Bernama 11/04/2008) about its national allegiances. Having displaced the Johor State Government as the principal broker for the project, the national government has allocated significant funding for major infrastructural improvements (EPU 2005, 2010) and also indirectly oversees the project via participation by the Prime Minister's Economic Planning Unit (EPU) and the national sovereign wealth fund, Khazanah. Foreseeing a return of MYR 336 billion over the next 20 to 25 years, tax incentives and support packages have been introduced to attract manufacturing, trade and service industries, particularly in the 'strategic growth areas' of education, creative industries, business and finance, logistics, healthcare and tourism

(Damodaran 15/08/2007; Bernama 28/01/2008).

Like the Indonesian islands of Batam and Bintan, Iskandar Malaysia is being positioned as a 'complementary' site to which Singapore can relocate jobs and from which it can draw valuable natural resources. Toh (2006: 6) suggests that this has meant that the Malaysian and Indonesian portions of the Triangle have 'competing complementarities', leading to separate Singapore/Riau and Singapore/Johor axes that inhibit the equalising geometric relations envisioned by the growth triangle model. While economic relations do tend to move predominantly along these axes, the area comprising the Malaysian portion of the Triangle does not 'compete' with its Indonesian counterpart, because its workforce performs a range of essential – though also lower value – semi-skilled support services that differ from the low-wage unskilled jobs to be had within the scope of the Singapore/Riau relationship. The Triangle's benefits for Southern Malaysia, however, are derived less from a Singapore/Johor 'partnership' and more from the economic contrasts between these two areas. Investment coming in from throughout the world (particularly Malaysian, Japanese, Spanish, Singaporean and Middle Eastern sources (Bland 26/05/2009)) intends to make 'much more complementary than competitive' use of Iskandar Malaysia's proximity to Singapore as both a physical gateway and strategic overflow space for the island city-state where economic growth is threatened by capacity constraints (Bhaskaran 2008; Macleod and McGee 1996; Sparke *et al.* 2004). A regional developer's commentary confirms this:

The single most important factor driving... [the zone's] success is Singapore. Modelled after the Shenzhen hinterland for Hong Kong [in the Greater Pearl River Delta cross-border region], we foresee the South Johor hinterland befitting the bill for Singapore. (Peterson 01/05/2008)

In light of this, Iskandar Malaysia aims are to develop a 'strong, sustainable metropolis of international standing' that makes use of its 'strategic location and proximity to some of the world's most rapidly growing and important economies' to reduce trade barriers and increase the flows of people and capital (Khazanah 2007: 5). Accordingly, the region has been divided into 'flagship' zones, each endowed with its own unique set of industries and services designed to 'establish South Johor as an international address' (*Ibid.* 2007: 4) and carved up into real-estate parcels, as Figure 6.5 illustrates. Enfolding Iskandar Malaysia into Singapore's hinterland is hoped to reap serious economic benefits and propel the region to 'developed status' (Bernama 28/01/2008).

In spite of this opportunity, the Malaysian government's relationship with Singapore continues to be haunted by historically-rooted ethno-political tensions (to some extent shared by Indonesia, which is also home to a significant number of ethnic Chinese) over the potentially significant influence held by Singapore's ethnic Chinese majority over the areas encompassed in the Triangle. Malaysian governmental promotion of Iskandar Malaysia as a Singaporean hinterland provoked public outcry in 2008, with concern expressed by former PM Mahathir and ultra-Malay nationalists alike about Singapore's encroachment upon Malaysia's national sovereignty and its supposed designs for a '*Singapura Raya*' ('Greater Singapore'). The deep-set ethnicised fears that Singapore could deprive Malaysians – particularly *bumiputera* – of what is 'theirs'⁸¹ has made Singaporean investors reticent to get involved in Iskandar Malaysia for fear of hostile reception (Reme 21/11/2009). Commentary by Dr Jason Yap (interview, 15/02/2008), the then director of SingaporeMedicine, illustrates this:

Singaporean involvement make things *emotional*. With Iskandar Malaysia, some Malaysians say, 'The Singaporeans are coming – we don't want them!' Other Malaysians are happy about this and say that they need us.

In light of the backlash within Malaysia, Iskandar Malaysia promoters seek to recast the project not as 'a large property play for wealthy investors' (particularly 'acquisitive' Singaporeans) but rather as one that will benefit locals, by highlighting the estimated 800,000 jobs for locals which are to be generated by the project (Bland 26/05/2009).

Figure 6.5 A real-estate company's projection of the Iskandar Malaysia development

(image removed)

Source: Top Hills Realty (2010)

While political relations between the two countries have not always been on the friendliest of terms, Malaysia and Singapore have long been intimately bound to one another through constant cross-border flows of people with roots in both territories – flows that have

81 The territorial dispute between the two countries over the tiny Pedra Branca island that was settled in favour of Singapore the same year only served to reinforce misgivings. Indeed, in the days leading up to the Pedra Branca decision, former PM Mahathir, controversially revisiting the nationalist ethnicised rhetoric central to his early political career, suggested that the Malaysian government was playing with fire in regard to the Iskandar Malaysia project: '[A]fter the land is sold, Malays will be driven to live at the edge of the forest and even in the forest itself' by a powerful Singapore and its ethnic Chinese majority (*The Star* 18/05/2008).

helped to foster their mutual development over time.⁸² When Singapore separated from Malaysia to become independent in 1965, the country turned to an intensely outward-looking development approach for survival. Today Iskandar Malaysia looks outward for its survival. This is thought to require more porous borders to permit efficient border-crossings for workers and tourists travelling between Johor and Singapore as well as more liberalised foreign exchange controls (Parameswaran 2008). Two Free Access Zones in the 'flagship' areas of Johor Bahru (73 acres) and Nusajaya (1029 acres) have been proposed to permit Singaporeans to move in and out of the zones at all hours with little to no checks by immigration and customs officers and no limit to the duration of stay (*NST* 09/11/2008; UOB Kay Hian 2006: 8). Planned, then scrapped, only to once again appear on the drawing board, passport-free travel within Iskandar Malaysia has proven highly polemic (Vijayan 05/04/2007).⁸³ Still, there are plans underway to facilitate mobility, including the construction of a second causeway and a new railway connecting Johor and Singapore, an increase in the number of cross-border bus services and Malaysia's implementation of an Automated Clearance System that comprises biometric verification and fast-track clearance lanes for frequent travellers involved in Iskandar Malaysia projects (*Business Times Singapore* 25/11/2009; *Channel News Asia* 05/04/2009).

With Singapore's GDP per capita almost three times that of Malaysia, its population of just over four million – considered by developers to be 'part of the extended Iskandar Malaysia population threshold' (IRDA 2008b) – is a major target group for the purchase of second homes in Iskandar Malaysia. As tourism is Malaysia's second largest foreign exchange earner and Singaporeans comprise half of the 22.1 million tourists entering Malaysia in 2008 (Tourism Malaysia 2010), the Ministry of Tourism seeks to boost flows and 'synergies'. There are now efforts to 'cross-promote' Malaysia with Singapore, in order to increase not only cross-border regional tourism but also to promote the two countries as a single destination to external markets. This is underscored by the then Tourism Minister Azalina Othman's comments:

The mountains, the rivers, the seas, the islands, what we have in Malaysia should be complementary to the neighbouring countries, for example Singapore. So when I say, 'one

82 Indeed, due to their complex historical ties, many Singaporeans have Malaysian roots and of the nearly 20% of Singapore's population that is foreign-born, nearly half (9.4%) were born in Malay(sia) – more than all other Asian countries combined (Yeoh 2007).

83 Yet arrangements such as this are not entirely new: in the late 1970s a daily work permit system was introduced, allowing Malaysians to commute to Singapore (Hui 1997: 114).

destination, two countries', I believe we should be working together on some kind of strategies.
(Othman, in Tan 02/01/2009)

This reflects a new discursive trend taken up by the national government that encourages bilateral cooperation for the purpose of joint development, seeking to constitute a united front in order to compete globally (see *Channel News Asia* 05/04/2009; Sparke 2005: 85). It marks a significant departure from former PM Mahathir's wariness of Singaporean neo-colonialism, constituting evidence of a transition in the dominant political stance over how borders are interpreted and enforced in light of the shifting biopolitical value of the subjects crossing them.

When it comes to IMT, Singapore has long been the premier regional medical hub in ASEAN, with the majority of its foreign patient-consumers still today hailing from neighbouring Indonesia, Malaysia and Brunei. As we saw in Chapters III and V, Singapore's 'developed' status has fed the brain-drain of educated Malaysians and also led to some (of the particularly wealthier) Malaysians trusting the Singaporean health system more than their own, with Malaysians comprising approximately 20% of foreign patients in Singapore in 2002 (see Figure 6.6).⁸⁴ It has long served as the role model of flexible capitalist development for Malaysia, with the latter's own policies often (though belatedly and with little consideration for differences in scale) following on trends set by the island city-state. This relationship was constantly discussed in interviews with IMT industry players in Malaysia who repeatedly look to SingaporeMedicine as a model to emulate and are frustrated with Malaysia's status as an industry 'straggler', in the shadow of the innovative IMT powerhouse that served 411,000 'deliberate healthcare seekers' in 2006 and aspires to attract one million annually by 2012 (Dogra 16/07/2005) (see Figure 6.6). Singapore's official narrative used to justify its positioning as an IMT destination pivots on the 'paradox' derived from a logic based on its 'developed' status: 'Singapore welcomes international patients because, beyond simply earning revenue, [it seeks] to maintain its medical ecology and (paradoxically) to serve its own population sufficiently' (Yap 2006: 25). In other words, the Singapore government frames its IMT destination status as a way to ensure that its citizens – who are too few to maintain critical mass for its more than 30 hospitals to function

84 The percentage of Malaysians seeking care in Singapore dropped by 5% after the 1997 AFC and after IMT began to be promoted in Malaysia (Khoo 2003). This may indicate that more Malaysians opted to receive care at home instead of pursuing it abroad.

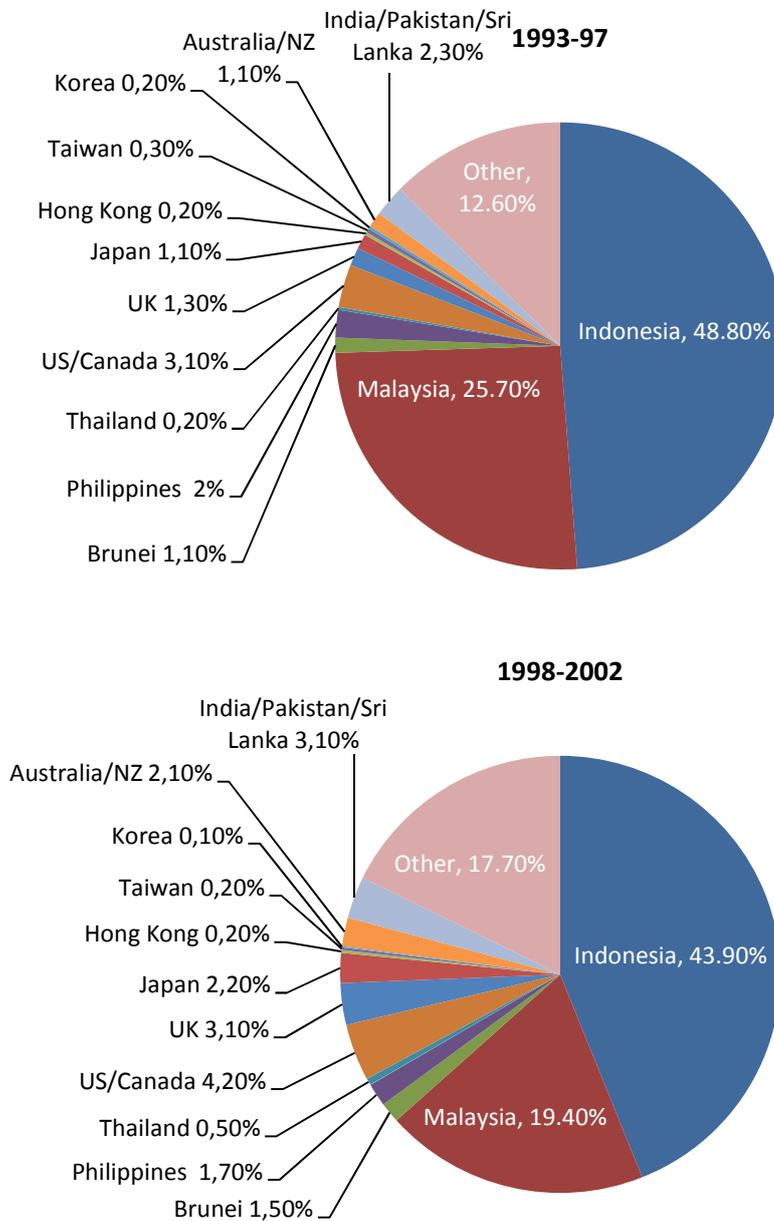
efficiently – access to the extensive, highly specialised and high-tech medical infrastructure and internationally enviable doctor-to-patient ratios it boasts (see Table 6.4).

Revealing holes in Singapore's IMT 'paradox' argument, however, the Singapore Health Ministry announced in 2010 that Singapore residents would be able to draw from their personal medical savings plans (Medisave) for day surgery and in-patient medical procedures in hospitals in Malaysia that are branches or subsidiaries of Medisave-accredited healthcare providers in Singapore (Ganesan 13/02/2010; *The Straits Times* 10/02/2010). Some of the previous resentment towards Singapore has now been replaced by efforts to articulate with it and benefit from 'cooperation', an approach that may bode well for Iskandar Malaysia. Johor, though by no means a heavyweight, is already an IMT destination for Singaporeans (see Figures 6.3 and 6.4). 'If you see our hospital in Johor Bahru on Saturdays and Sundays, it's like a fish market. People from Singapore flock in', notes an anonymous manager of one of Malaysia's major hospital groups responsible for shaping the group's image abroad (interview, 18/12/2007). Elsewhere, a newspaper article reads:

Fertility clinics are the latest medical fad here [in Johor Bahru], with four centres opening in the past year. Almost all of them are believed to be eyeing the lucrative Singapore market for childless couples. (Namblar 28/07/2005)

Comments such as these illustrate the Malaysian industry's excitement at the prospect of carving into a Singaporean IMT pie. Singaporean-owned Health Management International (HMI), which owns a 48.95% share in Malacca's successful Mahkota Medical Centre (see below), identified the potential of locating a facility closer to Singapore and in early 2009 opened the high-end specialist tertiary care facility Regency Specialist Hospital. It is pursuing JCI accreditation to attract Singaporean patient-consumers who are already trained to look for this type of accreditation back home as a standard of quality, given the plethora of JCI-accredited facilities there (Ng 20/03/2009) (see Chapter IV).

Figure 6.6 Breakdown of Singapore's foreign inpatients by origin before (1993-97) and after (1997-2002) the AFC



Source: Khoo (2003: 2); see also Lim and Tsai (2009)

The Singaporean government's endorsement for its residents to seek lower-cost non-emergency medical care outside of Singapore has generated outcry that healthcare has become too expensive for average Singaporeans and raised concern over the paradoxical situation of

foreign patient-consumers travelling to Singapore for the high-quality routine ‘discount’ treatment that many Singaporeans themselves can no longer afford (see Table 6.1). Suggestions by Singaporean Health Minister Khaw Boon Wan in early 2009 that elderly Singaporeans may consider moving across the bridge into Johor for more affordable nursing homes and healthcare riled parliament, with critics reading the proposal as ‘quite a bad indication of affordability of our [Singapore’s] own health care services here, and also a reflection of our national values’ (Workers’ Party Chair and MP Sylvia Lim, in Salma 10/02/2009), amounting to nothing less than ‘outsourcing’ the country’s elderly. The Health Minister was forced to qualify his statements, grounding his defence in the now familiar rhetoric of the inevitability of globalisation, suggesting that to encourage citizens to cross the border into Johor is not a way for the government to shed responsibilities of care provision for the poor but rather a means to providing a cost-effective alternative for the middle-income groups already responsible for paying for their own care:

[S]ince many people visit the elderly in homes only on weekends, it makes little difference whether the person is housed here [in Singapore] or in nearby Johor. It is part of globalisation and is happening with Singaporeans going to Bangkok for Lasik to treat short-sightedness and Americans and Russians coming here for treatment... It is also not something that should, or can, be prevented... Singaporeans are crossing the Causeway for cheaper petrol and medicine. By allowing the flexibility of consumers walking across the Causeway... they benefit. I don't think we should constrain them from doing so. (Health Minister Khaw Boon Wan, in *The Malaysian Insider* 11/02/2009)

Notes Dr Yap (interview, 15/02/2008), ‘The Singaporeans are going to move in. So, it’s great if they go there [Malaysia] and it’s cheap and of good quality. But nationalistic fervour is a problem’.

Table 6.1 Prices in GBP of select routine procedures for which Singapore residents might consider receiving care in Malaysia

Procedure	Malaysian hospitals	Singaporean hospitals
Removal of haemorrhoids	753.71 (RSH)	1420.54 (SGH)
Total knee replacement	3767.63 (RSH)	7579.62 (SGH)
Stent for blocked vessels	3390.85 (RSH)	8920.13 (NHC)

Source: Salma (11/02/2010) Note: RSH – Regency Specialist Hospital; SGH – Singapore General Hospital; NHC – National Heart Centre. Note: Prices are in GBP as at 15/02/2010

The Singapore Health Ministry's arrangement permitting Singapore residents to use Medisave abroad is initially limited to 12 medical facilities in Malaysia that are partially owned by Singapore healthcare groups (Salma 11/02/2010). These include the two HMI facilities, Regency Specialist Hospital and Mahkota Medical Centre, which envision 20% growth in Group revenue by 2011 (Vanesan 13/02/2010), and ten facilities owned and operated by Parkway Holdings, a Singaporean group which controls 16 hospitals and nearly 50 medical and referral centres throughout Asia (Foo 01/05/2008). In Malaysia, Parkway operates the Gleneagles hospitals in Kuala Lumpur and Penang and owns a 40% stake in Pantai Holdings, which operates nine hospitals in Malaysia under the Pantai brand (see Chapter III). The Malaysian government's national sovereign wealth fund, Khazanah, owns the other 60% of Pantai. Yet, as part of Khazanah's 'regional healthcare investment strategy',⁸⁵ it has also significantly increased its shares in Parkway Holdings, lending legitimacy to the Singaporean company's presence in Malaysia (Chee 2008: 2151; Ganesan 13/02/2010; Chin interview 29/01/2008).⁸⁶ Though it has no facilities in Iskandar Malaysia, Parkway is interested – as comments from its Executive Vice-President, Daniel Snyder (in Ganesan 10/03/2008), indicate: Malaysia has wonderful plans for growth in the Iskandar Development Region and in specific sectors like healthcare and tourism. As Malaysia is growing, so do we look to growing in Malaysia'. This fits with the company's broader agenda to 'maximise operational synergy benefits' in Singapore and Malaysia (Parkway Holdings 2009).

Meanwhile, Singapore's own thriving IMT industry, paired with its companies' increasing presence in private healthcare in Malaysia, may also boost non-Singaporean IMT flows to southern Malaysia, an area which has traditionally concentrated on attracting patient-consumers from nearby Singapore and Indonesia. SingaporeMedicine, the national IMT promotional agency, has strategically campaigned for greater regional cooperation in the development of the IMT sector. This recalls the Singapore Tourism Board's 1996 *Tourism 21*:

85 This international diversification strategy includes a 10.87% share in the Indian Apollo Group hospitals outside of Malaysia.

86 When Mokhzani Mahathir (son of former PM Mahathir) sold his personal shares in Pantai to a businessman who in turn sold them off to Parkway Holdings, some Malaysian MPs attempted to block the controversial acquisition because, as Chee (2008: 2150) observes, 'Lucrative government concessions meant for Bumiputera rentiers... ended up in the stables of a foreign company' (see also Ashwin 30/11/2005).

Vision of a Tourism Capital plan, which 'outlines how Singapore can exploit tourism in the wider region' if 'tourism industry members break free of their traditional geographical boundaries and boldly expand their tourism activities beyond the shore of Singapore' (STPB 1996: 6, in Henderson 2001: 84). Its rhetoric is premised on the idea that a 'maturing' national economy must expand to survive and needs a dynamic hinterland in order to maintain its carefully-cultivated regional IMT hub status, particularly as players in the region grow more competitive (Chang 1998; Henderson 2001). This discourse is evidenced in comments by economist Linda Lim in Singapore's daily, *The Straits Times* (13/03/2009):

The way forward for Singapore is to allow the market to 'diversify on its own', with resource allocation done by market forces and entrepreneurs, instead of the state and bureaucrats. Do we devote our carefully husbanded national savings, accumulated over generations, to letting the state make big bets on a few major, capital-intensive, risky and expensive projects? Or do we privatise the economy, releasing capital and talent to local entrepreneurs to create value in smaller but nimbler enterprises? At least, if they fail, it will take only small parts, rather than big chunks, of the economy down with them.

Instead of competing with Malaysia for foreign patient-consumers (as is suggested to have begun to happen (Lim and Tsai 2009)), the Singaporean strategy shifts to encourage the growth of Malaysia's IMT industry and increase private Singaporean investment in it in order to reap the potential benefits. Interviews indicate that Malaysian healthcare facilities could be used in the future as overflow sites to which saturated Singaporean facilities would re-route moderately priced routine medical procedures (e.g., knee and hip replacements) in order to be able to focus on providing bigger-ticket, higher-profile treatments and interventions. This could happen if more employers and insurance companies in Western and Middle Eastern countries jump on the IMT bandwagon and start to mass 'outsource' care to Singapore.

Healthcare is one of the nine pillars of development in Iskandar Malaysia.⁸⁷ Nusajaya, one of its five 'flagship' zones, has been selected as the site for the 'clean industries' of biotechnology, nutrition and health research. It is slated as the future home of Iskandar Malaysia's Medical Hub, an aspiring 'leading centre in Asia for medical excellence' in treatment, teaching and research (IRDA 2008a), 'tailored specifically to meet the increasing regional

⁸⁷ The nine 'pillars' unite manufacturing with services. Electrical and electronics, petro- and oleo-chemical, food and agro-processing, and tourism are joined by healthcare, educational, financial and ICT and creative services, logistics and related services.

demand for better healthcare services' (Nusajaya Malaysia 03/07/2009). Within the hub, the Malaysian and Singaporean governments plan to collaborate to develop a wellness centre in the Medical City (Bernama 21/11/2009). A Medical Park also will 'cater to three distinctive areas under the health spectrum, namely modern medicine, traditional and complementary medicine and wellness' (IRDA 2008a), and comprise specialist clinics, screening centres, a nursing college, a traditional medicine academy to be operated by experts from China and India, a retirement village and a hospital owned by Columbia Asia, the subsidiary of a developer and operator of healthcare and retirement housing facilities worldwide (Zazali 14/04/2009a, 16/07/2010). Additionally, the Medini development, fully owned by Middle Eastern investment companies⁸⁸, is slated as the future home to another medical complex called the Inner Wealth Medical and Wellness Village. Vamed, the hospital management group for Prince Court Medical Centre, has manifested interest in Iskandar Malaysia (Ganesan 03/08/2008) and the UK's Newcastle University plans to open a medical school there (Bland 26/05/2009). These multiple facilities will join the ranks of already existing hospitals such as KPJ Johor Specialist Hospital in Johor Bahru (the only facility currently endorsed for IMT in southern Malaysia) and Regency Specialist Hospital.

The inclusion of healthcare facilities with which to promote IMT into Iskandar Malaysia can be interpreted as a response to Singapore's call for greater 'regional cooperation', synchronising interests and efforts with Singapore instead of belatedly trying to duplicate and compete with it. Iskandar Malaysia is thus positioned as having the potential to fill in the gaps produced by the Singaporean healthcare system, benefiting both foreign patient-consumers that use Singapore as a medical hub and Singaporeans themselves. Accordingly, the zone's investment agency envisions the multiple Nusajaya projects as serving 'the immediate needs of private healthcare in Iskandar, catering not only to locals but also Indonesians and Singaporeans' (Zazali 14/04/2009b; Bernama 21/11/2009). This attention to regional healthcare 'needs' (Escobar 1995) through the extension of the scope of private healthcare provision constitutes a significant postdevelopmental shift in the realm of biopolitical intervention.

88 These include Mubadala (Abu Dhabi), Kuwait Finance House and Millennium Development International Company (Dubai).

6.3.2 Sumatra's healthcare hub

The Indonesia-Malaysia-Thailand Growth Triangle (IMT-GT) is described by the Asian Development Bank (2008) as

a classic growth triangle, characterised by many economic complementarities, geographical proximity, and close historical, cultural and linguistic ties... [with] large amounts of land, rich natural resources, abundant labour and a sizeable internal market, which gives it a vast potential for development.

It has expanded a great deal since it began in 1993. It currently encompasses 100 million people across the Indonesian island of Sumatra, nine Malaysian states and 14 Thai provinces (see Figure 6.7 for an official Triangle map). Though home to agriculture and manufacturing and tourism industries, the GDP per capita of some of the peripheral areas initially involved in the IMT-GT was significantly lower than their respective national averages. Thus, the role of the Triangle has, from the outset, been to identify and capitalise upon 'complementarities' that could boost the income of an economically marginal area when compared with the IMS-GT. Disparities between Triangle member-areas are significant, with the Indonesian portion of the IMT-GT home to wage levels that are a mere fraction of those in the Malaysian and Thai parts of the Triangle, leaving the relatively better-off Malaysian part to swing the most political and economic weight (see Table 6.2).

To speed up and even out the IMT-GT's development, four transnational 'economic connectivity corridors' were set up in 2006 to integrate physical infrastructure with production, trade and investment by minimising non-physical cross-border barriers, expanding access to raw materials and external markets (ADB n/d). These corridors are overlapped by the domestic Northern Corridor Economic Region (NCER) which aims to close the development and income gap in Kedah, Penang, Perak and Perlis – four of the nine Malaysian states encompassed in the IMT-GT and home to 29% of the country's population living under the poverty line (Salleh 04/08/2007). The national wager on northern Malaysia's development with the NCER has the potential to effectively limit Malaysian authorities' willingness to more fully open borders to labour flows from within the IMT-GT if bringing in lower-cost foreign workers means to delay the area's transition from labour-intensive industries to more capital- and skill-intensive ones (Kakazu 1999). In addition, as is clear with the current global economic crisis which has led the Malaysian government to freeze the recruitment of foreign workers, expectations for significant

growth in jobs for locals serve as a disincentive to experiment with employing foreign workers from other parts of the IMT-GT to mitigate labour shortages (*The Sunday Times* 22/02/2009; BBC 22/02/2009, 11/03/2009). Unlike Singapore which relocates lower value-added industry to the Indonesian and Malaysian parts of the IMS-GT out of necessity, the Malaysian government fears that industry relocation may threaten its more vulnerable positioning in the supply chain. These constitute just some of the non-physical barriers that have led to reduced activity within the IMT-GT.

Table 6.2 Economic profile of IMT-GT member-regions

	Province/State	GDP/capita (USD, 2005)	Structure of production (%)			Total labour force ('000s)	Unemploy. rate (%) (2004)
			Agricult.	Manufact.	Services		
IMT-GT Malaysia	Melaka	5,115	3.4	48.5	45.4	305.0	1.2
	Kedah	2,937	11.8	20.7	64.6	735.0	3.7
	Kelantan	1,974	18.7	2.2	78.1	480.0	3.3
	Negeri Sembilan	4,522	7.2	41.4	48.7	422.0	3.5
	Penang	7,208	1.7	55.1	40.6	702.0	2.2
	Perak	4,068	12.9	25.0	58.7	902.0	3.3
	Perlis	3,237	23.7	5.1	67.9	82.0	2.9
	Selangor	6,140	1.7	43.6	50.4	2,219.0	3.1
IMT-GT Indonesia	Aceh	970	41.0	11.5	10.6	61.8	2.4
	Bangka Belitung	902	25.0	21.3	7.2	209.9	7.1
	Bengkulu	414	32.8	4.9	17.3	713.3	6.3
	Jambi	621	30.2	14.5	16.8		6.0
	Lampung						11.1
	North Sumatra	822	29.6	21.5	7.78		
	Riau		8.7	20.5	3.2		15.3
	Riau Islands	1,351					
IMT-GT Thailand	South Sumatra	763	20.7	20.9	6.8		8.4
	West Sumatra	862	24.4	12.2	16.3	1,196.9	12.8
	Nakhon Si Thammarat	1,517	27.6	12.9	59.5	907.6	1.7
	Narathiwat	1,048	48.2	5.2	46.6	348.8	1.5
	Pattani	1,489	46.8	4.2	49.0	295.8	0.8
IMT-GT Thailand	Phatthalung	1,109	32.7	31.4	35.9	136.3	2.1
	Satun	1,832	48.6	13.7	37.7	744.3	3.8
	Songkhla	2,408	25.4	30.8	43.8	744.3	3.8
	Trang	1,723	45.6	14.2	40.2	342.2	0.4
	Yala	1,395	39.1	9.3	51.6	210.0	1.3

Source: CIMT (2009)

Figure 6.7 Official map of the Indonesia-Malaysia-Thailand Growth Triangle (IMT-GT)

(image removed)
Source: CIMT (2008)

Mobility gets used to increase contact, familiarity and confidence among those living in the IMT-GT and to rekindle an awareness of its shared cultural heritage. Physical connectivity, therefore, has been pinpointed as the first step towards overcoming these 'national' barriers, leading to significant focus on the improvement of air, sea and land transport linkages to facilitate cross-border flows of people, goods and services within a zone that had been more intensely linked prior to the establishment of modern nation-states. In building up these connections, the area's pre-colonial and colonial heritage has been touted to lend legitimacy to the IMT-GT's claims to 'natural economic territory' status. Home of the ancient trans-straits Malay kingdom of Srivijaya and the powerful Sultanates of Malacca and Aceh, the 1,200 km-long Straits of Malacca have long been an essential transport route linking East and West, significant for centuries in political, cultural and economic networks. Along the Straits, 'one of the oldest and busiest shipping lanes in the world' (Evers and Gerke 2006: 3), lay the cities of Malacca and Medan and the island of Penang, long important nodes in these regional trade and cultural exchanges before being overtaken by Singapore as the region's main commercial hub in the 19th century. As a result, these areas are purportedly, in the words of Kakazu (1999), 'anxious to invoke past glory by forming the GT' and to shed their peripheral status.

International medical travel (IMT) is listed in the IMT-GT's action plan as part of a 'flagship project' aiming 'to develop and pursue a joint tourism promotion and marketing program focusing on IMT-GT as a single destination' (CIMT 2007). Emphasising the economic relevance of cross-border mobility, in 2009 leaders from the three countries suggested that tourism, and IMT in particular, would be 'the key for IMT-GT members to get through the current global economic crisis' (*The Bangkok Post* 28/02/2009). One of the most significant measures taken to promote mobility has been the exit tax (*fiscal*) exemption for Indonesians leaving from Indonesian parts of the IMT-GT for other areas of the Triangle (ADB 2007a, 2007b). This has been fostered in line with AFTA's push to reduce import tariffs and other barriers to trade such as quotas, licensing, foreign exchange regulations and administrative procedures (Kakazu 1999). The suspension of the IDR 1,000,000 exit tax has made more frequent travel to Malaysia and Thailand more

economically feasible for Sumatrans, leading to profound impacts on the development of the IMT industry within the Triangle. It was still enforced upon exit from Indonesia everywhere else outside of the Indonesian part of the IMT-GT until 1 January 2009 when the Indonesian government's reformed regulation came into force. By showing their tax identity cards at border crossings, Indonesians can now travel abroad from anywhere in Indonesia without paying the tax. However, if they are without the card and not exempt from taxation, they are required to pay IDR 2,500,000 (the world's highest exit tax) to leave the country (*The Jakarta Post* 24/12/2008). Paradoxically, this policy change adversely affects Indonesian IMT into Malaysia. With many Indonesians unwilling or unable to acquire tax identity cards due to the pervasiveness of the informal economy, some Malaysia-based IMT facilitators have begun to pressure Malaysian hospitals popular among Indonesians to discount the cost of the penalty exit tax from high-ticket procedures in order to ensure that the Indonesian patient flow continues.

The significant percentage of patient-consumers from Malaysia's ASEAN neighbours countries can be attributed to the region's substantial population and wide-ranging diversity of socio-economic realities and healthcare systems that has long led middle- and upper-class nationals of poorer countries like Indonesia with difficult access to quality medical care to seek it abroad (see Figure 6.8). Indonesians have turned to Malaysia for health screenings and tertiary care needs at least since the early 1990s. Though quality healthcare professionals, equipment and facilities are sparse in Sumatra and throughout the rest of the country, Indonesian authorities have done little to manage this cross-border movement of their nationals (Praptini 31/10/2007). As the Indonesian Medical Association (IDI) estimates that one million Indonesians go overseas for medical care each year (IRIN 06/08/2009), 'health without frontiers' has come to be one of the pillars of cooperation between ASEAN member-states, in line with the notion that '[c]ooperation across borders may enable better use of resources, sharing of potential capacity and improving access of patients to quality care' (Pennings 2007: 506).

Figure 6.8 Media coverage of Indonesian patient-consumers in Malaysia

(image removed)
Source: NST (2008)

Table 6.3 Regional comparison of health performance indicators among select ASEAN countries

<i>Indicator</i>	Cambodia	Indonesia	Malaysia	Philippines	Singapore	Thailand	Vietnam
Total health expenditure (THE) as % of GDP (2007)	5.9	2.2	4.4	3.9	3.1	3.7	7.1
General government expenditure on health as % of THE (2007)	29	54.5	44.4	34.7	32.6	73.2	39.3
Private expenditure as % of THE (2007)	71	45.5	55.6	65.3	67.4	26.8	60.7
Out-of-pocket expenditure as % of THE (2007)	84.7	66.2	73.2	83.7	93.9	71.7	90.2
Life expectancy at birth (years) (2008)	62	67	73	70	81	70	73
Infant mortality rate (per 1000 live births) (2008)	69	31	6	26	2	13	12
Maternal mortality ratio (per 100,000 live births) (2000-09)	461	307	28	162	8	14	75
Hospital beds (per 10,000 inhabitants) (2002-05)	-	6	17.6	5	32.2	22	27.5
Physician density (per 100,000 inhabitants) (2000-03)	16	13	71	115	150	31	56

Source: WHO (2009), based on country-reported estimates from 2000-2008

For the Director of the Philippine Association of Health Organizations in Medical Tourism Alma Jimenez, and many other IMT stakeholders, one person's misery is another person's fortune:

Do you know that the biggest market of Thailand and Malaysia is actually neighboring Asian countries? I'm telling the association that we should actually look at our neighbors also. Indonesia, for instance. Why couldn't we market to Indonesia? They don't have decent hospitals. They go to Malaysia or Singapore. Vietnam has grown by leaps and bounds. They have already overtaken us in terms of growth rate. And yet their nationals go to Singapore or Malaysia for health care. Why do we set our sights so far away when we have so many neighboring countries with no decent health-care system? So these are markets that we can fruitfully explore, just ripe for the picking. All we have to do is to make sure that we can interface with them and see how the market will open up for us. And besides, Asians feel more comfortable going to another Asian country. In fact, it sounds like a hard sell when you're talking about Europe or other countries. (Jimenez, in Camus 25/03/2009)

This acknowledgement rings particularly true for Malaysia, where most IMT takes place within the Malaysian part of the IMT-GT. Nearly 88% of all Indonesians receiving private medical care in Malaysia did so at the nine IMT hospitals in Penang and Malacca (see Figures 6.3 and 6.4). These two destinations have long provided healthcare services critical for Sumatrans who lack quality healthcare facilities back home, as they are far more within reach physically and economically

than the national alternative which entails a flight to distant Jakarta and healthcare services costing the same or more than in the Malaysian destinations. Confirms an anonymous hospital executive from a major Malaysian facility in the Klang Valley (interview, 29/02/2008) prior to the 2009 exit tax reform:

Here, we see a lot of Indonesian patients – *a lot, a lot*, and coming from all parts, except Medan [in Sumatra]. Those from Medan will normally go to Penang [in the IMT-GT]. If you're Indonesian and leave the country, then you go to Penang for two reasons. The first is the distance, because it's nearby. And the second is that, when you [Indonesians] leave the country, you [Indonesians] need to pay a levy. But you [Indonesians] are exempt from paying the levy when flying to Penang because of the [IMT] Growth Triangle.

In recognition of this, the NCER domestic regional plan has prescribed the cultivation of Penang's 'regional IMT hub' status (NCER 2008, 2009).

With a poor physician-to-patient ratio and few hospital beds (see Table 6.4), '[l]ittle can be done to limit the practice [of IMT] as the government struggles to provide access to health care for average Indonesians who are financially weaker and generally in greater need' (Hulupi 16/04/2006). In light of these constraints, the IDI has admitted, 'We cannot blame people for seeking treatment overseas' (Gunawan 01/11/2007). Given the push factors responsible for the volume of the flows, therefore, it might be more apt to characterise the mobility of this group along the lines of what Milstein and Smith (2006) have polemically dubbed 'medical refugees' – with Malaysia and Singapore being positioned as extending a hospitable healthcare 'solidarity', albeit in commercialised form, to them. Still, Indonesian patients with urgent needs may be denied admittance by airlines and hospitals if their conditions are too acute or if there is no ICU space to take them. Commentary by an anonymous hospital marketing representative of a major Malaysian hospital based in Penang (interview, 04/03/2008) illustrates commonly-held concerns:

We have to screen them [remotely] before they arrive because otherwise there will be a big shock when you see the patient. Really! Sometimes they report that they have this [degree of medical problem] but when they come in, it's usually worse than they described – people are one degree worse than they actually tell us. And sometime the results aren't so great. We just have to deal with that when the patients come in.

In Indonesia and other poorer ASEAN countries, meanwhile, local medical professionals and authorities have understood this 'solidarity' instead as the patronising flexing of political and economic muscle by more 'developed' countries to poach their 'rightful' patients. Budding efforts to curb the outflow of Sumatrans patient-consumers include the 2010 opening of Zainoel Abidin State Hospital (RSUZA) in Aceh. Aceh Governor Irwandi Yusuf's (in *IMTJ* 03/02/2010) speech at the launch of the RSUZA highlights official Indonesian preoccupations:

RSUZA is the most advanced hospital in Indonesia, and its facilities can match prominent hospitals in Penang and Singapore. I hope the new hospital will put an end to the practice of thousands of Acehnese going to Penang, Malaysia, or Singapore each month for medical treatment. Including myself, who had to opt for Singapore as a place to have medical treatment because the facilities there were far more advanced than what we have had in Banda Aceh. But with this new hospital, I am certain that the equipment we have now can rival hospitals abroad.

Other strategies for keeping Malaysian hospitals from 'poaching' Indonesian patients include Indonesian doctors' unwillingness to refer patients to Malaysian specialist facilities and authorities throwing up barriers to marketing campaigns (e.g., trade fairs, road-shows and the distribution of promotional materials) by Malaysian private hospitals.⁸⁹

Given that Penang was host to over 60% and Malacca 18% of Malaysia's total number of foreign patients and generated equivalent respective percentages of revenue from them in 2007 (see Figures 6.3 and 6.4), IMT's economic influence has significantly impacted the development of infrastructure promoting general cross-border connectivity within the IMT-GT (Suhaimi 07/04/2009). It is estimated that Indonesia's poor medical system leads some 100 Medan residents alone to seek healthcare overseas daily (Gunawan 01/11/2007). Correspondingly, daily flights to Penang from Sumatra are packed with Indonesians, with approximately 80% of those passengers thought to be seeking some form of medical treatment (anonymous interview, 04/03/2008). In response, several hospitals have now dedicated shuttle bus services to pick up and drop off Indonesian patient-consumers at the Malacca and Penang airports. Regionally-based air transport companies carrying Indonesian patient-consumers have also set up routes between major Indonesian sending locations within the IMT-GT and the destinations of Penang

⁸⁹ Today, promotion in Indonesia of Malaysian hospitals requires either local agents working on behalf of the hospitals themselves or Malaysian representatives to first acquire business visas in person at the Indonesian Embassy in Kuala Lumpur.

and Malacca. Penang, with its seven IMT hospitals, is the main hub of activity. Indeed, IMT was even evoked as one of Penang's greatest draws by the Malaysian airline Air Asia's Indonesian Marketing and Distribution Director:

We have done our calculations and by far, Penang has some of the best infrastructure and products for medical tourism within Southeast Asia. It has a great atmosphere, good medical facilities, great hotels and let's not forget the superb food. (*NST* 06/03/2008)

Air Asia began flights between Penang and the Indonesian cities of Medan (40m) and Jakarta (2h20m) in 2008. In addition, the small Indonesian airline Sriwijaya Air plans to transport Indonesian medical travellers to Penang and, to this effect, also began daily flights between Medan and Penang in 2008. With three Penang hospitals as potential partners, it proposes IMT packages which include air travel, local ground transport and hotel accommodation and seeks to adapt its fleet to suit the needs of more acute patient-consumers on stretchers (Emmanuel 09/09/2008). Finally, the strategic presence in Penang of Malaysia Airlines' low-cost subsidiary, Firefly, the self-declared 'official carrier airline of the IMT-GT' – purposely limiting its network expansion to Indonesia, Malaysia and Thailand – can be seen as a move 'in line with [its] efforts in positioning Penang as the international gateway within the Indonesia-Malaysia-Thailand Growth Triangle', using travel as a means to contribute to the boosting of trade, IMT and education within the Triangle (Emmanuel 05/07/2008; *Mathaba* 26/10/2008).

Further south, the Malacca State Government has expanded Malacca's international airport at Batu Berendam (LTBB) to increase IMT flows, lengthening a runway and enlarging passenger facilities in order to receive up to 1.5 million passengers per year. Of the 35 IMT hospitals spread throughout Malaysia, foreign patient-consumers continue to flock disproportionately to Malacca's Mahkota Medical Centre (Bernama 11/01/2006) (see Figures 5.4 and 5.5). The closest large Malaysian city to Sumatra, Malacca can be accessed by air and sea. With its two daily departures and arrivals, the ferry service connects Malacca to the Sumatran cities of Dumai (a duration of 1h45m) and Pekan Baru (6h) across the Straits of Malacca. As for air transport, Air Asia, Firefly, Riau Airlines, Sriwijaya Airlines and Wings connect Malacca to the Sumatran cities of Djambi, Medan, Padang, Palembang and Pekan Baru, all specifically selected for their IMT potential (D-8 Secretariat 19/08/2008; Bernama 13/08/2009).

Figure 6.9 Indonesian patient information desk at Pantai Hospital Penang, endorsed for IMT

(image removed)

The signs read 'Patients and families from Indonesia, we're happy to serve you from the heart. Information centres in Medan and Banda Aceh' (left) and 'Indonesian patients, we cooperate with BNI [National Bank of Indonesia] and Indonesian Protestant Christian Churches. If you or a family member is a BNI or Church credit card holder, you will receive a special discount. Please contact the Indonesian Patient Counter'. *Source: Author (2008)*

Figure 6.10 A currency exchange kiosk next to Malacca's downtown International Ferry Terminal and one at the entrance of Penang Adventist Hospital



Source: Author (2008)

Already for some time, hospitals in Penang and Malacca have facilitated the lucrative flow of Indonesian patient-consumers by providing services catering to their needs, such as special hospital reception areas staffed with Bahasa Indonesia and Hokkien speakers (see Figure 6.9), medical travel facilitators in Indonesia sponsored by Malaysian hospitals and currency exchange kiosks at hospital entrances (see Figure 6.10). Promoters are also quick to emphasise the ethnic, religious and linguistic proximity generated through centuries of trade and migration between Malaysians and their neighbours in sibling-like terms – recalling, for example, Penang's historical hub status and its strong trade links to Medan through long-established Hokkien Chinese networks (King 2002). This is underscored in comments by an anonymous Malaysian governmental tourism representative (interview, 24/01/2008) that point out other basic 'everyday' similarities as unifying:

We have a similar language, which is mutually intelligible – only complicated by differences in pronunciation... They're mostly Muslims. Weather-wise, it's normal – hot there, hot here. Rain there, rain here. Food-wise, it's still the same taste. They are familiar with us and we are familiar with them. That's why I would say that we should concentrate more on our neighbours rather than going out to the US or faraway countries where we don't know the returns... So, how do we get them? It comes down to the comfort that comes from similarity.

Recalling Chapter V's look at Muslim-friendly care, here we see how claims to cultural similarities also play an expedient role in the development of *specific* parts of Malaysia as an IMT destination and culture's function in the nation-state's re-casting of territories of intervention.

While IMT has generated greater regional transport connectivity within the IMT-GT, outside of the Triangle both Penang and Malacca remain poorly connected to other international sending countries, one of the major factors cited for inhibiting access to Penang and Malacca for non-Sumatrans (SERI 2004: 3). Dr Chan Kok Ewe, CEO of Island Hospital and chair of the Penang Health Group, highlights this concern:

the lack of a direct flight influences a patient's decision to travel to a certain place. No patient wants to take longer than necessary to arrive at the destination where they will seek medical assistance. (*Business Times* 29/02/2008)

An anonymous Western executive of a Klang Valley-based medical travel intermediary (interview, 10/03/2008) concurs,

Another flight to get to Penang is a disadvantage. You arrive in Kuala Lumpur and then you've got to go to Penang. To me, if I were a sick person, that's just another frustrating step that I would want to avoid. We have so many great resources here [in Kuala Lumpur]. Why put a person through that if they're already coming such a long way? Why go to another state? Penang is really good at what they do, though. Make no mistake there. Good surgeons, good hospitals. They do things well. The government is great. It's just another step that I want to avoid.

This 'unnecessary extra step' is thus feared to not bode well for Penang's ability to continue to attract medical travellers requiring long-haul flights to reach Malaysia, particularly in light of the new KLIA airport and rising popularity of private hospitals in the Klang Valley.

Still, a hefty majority of non-Asian foreign patient-consumers (e.g., 73% of Americans (due to Penang Adventist Hospital's organisational and denominational ties to the US), 56% of Europeans and 53% of Australians in 2007) receive care in Penang (see Figures 6.3 and 6.4). In

recognition of this and in order to maintain this high proportion of 'long-haul' patient-consumers, the NCER master plan prescribes the cultivation of spaces that attract 'higher-yielding' (i.e., 'big spender') tourists, aiming to be at once a 'world-class getaway' and the 'regional medical tourism hub' (NCER 2009). By positioning the area as an IMT destination at both the regional and more global scales, it is hoped that Penang will attract patient-consumers from both 'near' and 'far'. For several years, the Penang State Government has been committed to establishing Penang – which has consistently drawn Westerners for 'sun, sand and surgery' holidays and attracted a significant number of ethnic Chinese Sumatrans due to geographical, ethnic and linguistic proximity – as a 'centre of medical excellence, with high standards of healthcare' (SERI 2004: 3). Penang's Chief Minister announced shortly after coming to power in 2008 that greater investment in IMT would help to transform Penang's ailing tourism industry. Therefore, in addition to the seven IMT hospitals on the island of Penang (see Chapter III), there are proposals for turning the former island penal colony of Pulau Jerejak into a health tourism resort and for the construction on mainland Penang of the Farrali International Specialist Hospital and Wellness Resort, touted as the first in Asia to bring together Western and Eastern medicines and homeopathy under one roof, that will also host a nursing college, convention centre, hotel, serviced apartments and a herbal farm (Emmanuel 29/09/2008). These upscale medical facilities are meant to help Penang look beyond its immediate surroundings, tapping into a non-Indonesian IMT market and boosting its international prestige as a 'world class' destination.

While the IMS-GT is anchored by Singapore, the IMT-GT lacks an equally powerful metropolitan centre capable of driving sub-regional development in the same way. However, Penang, one of Malaysia's richest states, is being positioned as the Triangle's hub.⁹⁰ NCER plans cast Penang as the 'Gateway to the Northern Corridor', proposing that it 'act as the financial, commercial and services hub for northern Malaysia and for the Indonesia-Malaysia-Thailand Growth Triangle market, where there are notable gaps given its location' (S. 16/10/2007). Due to its unique history, Penang has been exposed to FDI and tourism longer than other parts of Malaysia. Formerly a Straits Settlement Colony, like Malacca and Singapore, it held 'free port' status under the British that lasted until 1969, even after the country's independence. Penang's

⁹⁰ It contributes approximately one-third of the federal government's tax revenues and 30% of the country's exports (Suhaimi 07/04/2009).

Bayan Lepas became a Free Trade Zone (FTZ) in 1972, in response to growing unemployment due to the island's loss of its free port status and the closure of a British military base. As a result, electronics manufacturing for large multinational companies and other industries (e.g., Intel, Hitachi and Agilent Technologies) have been the state's economic mainstay in recent decades. However, with the 1997 AFC came apprehension about Penang's future, given its dependency on the whims of foreign manufacturing companies and the rapid urbanisation and industrialisation that have led to Penang's environmental degradation and resulting decline in tourism. After the AFC, Penang was re-imagined by authorities as a hub nestled within the regional economy, at both domestic (e.g., NCER) and international (e.g., IMT-GT) scales. Further suffering with the current global economic crisis has propelled the restructuring of the state's economy into a 'knowledge-based' economy and privileged the development of its services sector to foster manufacturing-independent growth.

Penang has long been an antagonistic outlier in Malaysian politics, due largely to the state's relative economic autonomy, its distance from the national capital and its ethnic Chinese majority, a status which has frequently earned it a comparison to Singapore. This antagonism is evident in the comments of an anonymous Western executive of a Klang Valley-based medical travel intermediary (interview, 10/03/2008):

Penang has a totally different mentality than here [in Kuala Lumpur] and it's not controlled by the [central] government as much. So, it's almost like another country, another region, another everything.

The March 2008 national elections were thought to usher in major political change throughout Malaysia, with five of the country's most influential states, including Penang, won by the opposition to the Barisan Nasional coalition. Penang's new Chief Minister entered office with radical calls for greater political transparency and an end to the ethnicised cronyism and corruption that had flourished under the New Economic Policy (NEP) and like policies (see Chapter III). The new state development agenda was similarly dynamic, using the IMT-GT as a tool to further turn the state's sights beyond the borders of Malaysia for investment opportunities with immediate neighbours and those further afield 'to serve as a cushion for the state's economy... amid concerns for global security' (Emmanuel 14/06/2008).

Relatively early on in the development of the IMT industry in Malaysia, the Penang State Government's post-AFC think-tank, the Socio-Economic and Environmental Research Institute

(SERI), noted the state's responsibility to provide supporting infrastructure and leadership in marketing Penang as an IMT 'hub', suggesting the state government emulate the highly successful SingaporeMedicine model (SERI 2004). While the state government supports the industry, a Penang equivalent to 'SingaporeMedicine' has not yet come to fruition. Still, exemplifying Penang's relative autonomy is the Penang Health Group (PHG), a unique private sector-led initiative within Malaysia taking the local governance of IMT into its own hands. The initiative unites the seven Penang private hospitals that are endorsed for IMT by the MOH but often not included in official national promotional efforts. PHG, established in 2005, promotes Penang as a single IMT destination, instead of each hospital marketing itself individually and competing with one another. Observations by one anonymous marketing representative from one of the PHG member-hospitals (interview, 04/03/2008) demonstrate the commonly perceived utility of an organisation at the regional level:

We found that it would be easier to work as a group, so that we can promote under one umbrella and manage the ways in which we promote on our own. We're not really relying on any [federal] government effort, just on individual hospitals' efforts. When we want to get assistance from the relevant authorities, like the state government perhaps or a ministry, it's through the Group that we request support because we're not able to just fly [to Indonesia] and promote [IMT] any time [we want]. It would be good if we could have a duty-free arrangement and count on the government management of some things.

IMT has directly contributed towards positioning Penang as a transnational regional hub. Its experience, recalling Kakazu's (1999) earlier caution, demonstrates how involvement in growth triangles can empower regions or parts of them to such an extent that they increase their autonomy from the national governments to which they belong.

With the IMT-GT, we see an experiment in graduated sovereignty that gives greater autonomy to Penang as it (re)gains its transnational sub-regional relevance. This is indicative of a shift from a centralised hierarchy of political power to one that is decentred with multiple nodes of power as a response to emphasis on economic primacy. Yet the growth of such nodes aggravates already uneasy tensions with what remains a very highly centralised government. As such, the NCER can be interpreted as a strategic wager by the Malaysian government on Penang's future significance to the *national* economy, and suggests that Penang's political antagonism with Kuala Lumpur can be conveniently swept to the side as mere 'political

differences' as long as, in the words of the then Minister of International Trade and Industry Muhyiddin Yassin (in *The Star* 03/11/2008), the 'investment flow [keeps] coming in continuously into the country'. However, in early 2009 the MOH announced the setting-up of a Medical Tourism Board in Penang, a shadow state tourism council that would run federally-sponsored campaigns to attract foreign patient-consumers to Penang hospitals (Vinesh 21/03/2009). Recognising Penang's weight in the national IMT industry, in ways that echo the commandeering of Johor's efforts at 'twinning' with Singapore, the national government here again flexes its authoritative muscle in an attempt to harness efforts made at the regional level to promote cross-border economic growth for 'national' benefit.

6.4 Conclusion

States have become increasingly flexible, permitting the coexistence of varied degrees of sovereignty that not only redraw but also redefine boundaries to suit their purposes in response to the 'diverse forms of interdependencies and entanglements between transnational phenomena and nation-states' (Ong 1999: 16). This chapter has demonstrated how involvement in the growth triangles as both cross-border healthcare hinterland and hub is part of the Malaysian state's embrace of postdevelopmental territories of intervention and governable subjects, blurring distinctions made by past inwardly-focused developmentalist approaches (see Chapter III). Cross-border cooperation has contributed towards the naturalisation of the two cross-border economic zones as coherent regions that draw strength from their selective and strategic promotion of an officially endorsed (where economically expedient) shared cultural and linguistic heritage (Yúdice 2003). While such commonalities are emphasised as unifying, the 'complementarities' derived from the stark socio-economic differences between these areas are also used to drive greater regional interdependency.

Regional membership has not meant that national borders have been de-legitimated, rather that they are flexibly – if reluctantly at times, as we have seen in the case of Malaysia's hesitancy at creating Free Access Zones in Iskandar Malaysia and Indonesia's reform of its exit tax – recast in order to sift increasingly mobile flows. Rather than seeing borders as barriers to cooperation, they serve the important function of highlighting the 'territorial differentials' (Jessop 2003: 10) that are ultimately the drivers for these globalised flows. The success of such strategies, Jessop (2003: 10) notes, 'depends on building new governance mechanisms for cross-

border cooperation without, however, eliminating the territorial differentials associated with the border'. While it might appear paradoxical to co-opt 'today's disjunctures of the nation-state into a place-promotional marketing scheme' (Sparke 2005: 54), the cases above illustrate how the national government engages in 'entrepreneurial governance' (Sparke 2005: 77) by concentrating the extension of care to regional neighbours in privileged sites potentially better suited to exploit cross-border flows and co-opting them as national landmarks symbolic of Malaysia's successful entry into a 'knowledge-based' economy.

At the same time, Ong (1999: 11), asks us to reflect upon 'the mechanisms of power that enable mobility, as well as the localisation and disciplining, of diverse populations within these transnationalised systems'. Shifts in spaces of intervention require simultaneous shifts in biopolitical regimes. The above examples of 'deterritorialisation through reterritorialisation' demonstrate the biopolitical enabling and disabling taking place that lead to significant differences in the manifestations of the types of graduated sovereignty encountered in the two zones. Borders are thicker and thinner in different places, differently enacted on different categories of subjects (cf. Sparke 2005).

So, what sorts of power relations does the 'extension of caring' (Barnett and Land 2007: 3) for Singaporeans expedite? IMT from Singapore to Iskandar Malaysia reflects a radical biopolitical shift, with Singaporeans being granted – by *both* Malaysian and Singaporean authorities – privileged status in southern Johor that will facilitate their purchasing of property, expand their government-endorsed medical care options and potentially in the future permit them to freely circulate without a passport between Singapore and Iskandar Malaysia, amounting to what Sparke (2005: 81) calls 'an imagined geography of the region as a form of privileged gated community'. For the subjects implicated in these Schengen-like spaces, the border between the two countries has effectively *divided and multiplied* to encourage frequent and freer mobility for Singaporean residents, with the original border selectively blurred to encourage particularly advantageous types of flows and a new one pushed back to define the limits of this landscape of selective privilege (Balibar 2009). Meanwhile, other foreign patient-consumers today using Singapore as an IMT hub may in the future be re-channelled to facilities in (Iskandar) Malaysia primed to meet Singaporean-imposed international standards, constituting an almost seamless 'Singapore but cheaper' overflow space. While Malaysian

authorities may use a development rhetoric of ‘twinning’ and ‘partnering’ in describing relations of ‘complementarity’ with Singapore, the lower-cost cross-border care to be had in a handful of majority Singaporean-owned facilities in Malaysia at the moment speaks little to the homogenising objectives touted in regional development discourse and appears more akin to Economic Processing Zones (EPZs) where lower-cost human resources and terrain are exploited by multinationals.

Similarly, what sorts of power relations are fostered through the provision of healthcare to non-resident Sumatrans? Unlike the case with Singapore, IMT from Sumatra to Penang and Malacca resulting from participation in the IMT-GT reinforces a more traditional definition of the national border and of the subjects crossing it. While the significance of the flows between Singapore and Iskandar Malaysia lies in the latter’s ability to attract the long-term investment of pent-up Singaporean capital, the flows between Sumatra and Penang/Malacca are largely significant due to their sheer volume. This is evident in the dramatic difference in the numbers of patient-consumers receiving treatment in Malaysia from Singapore (1.12% in 2007) and Indonesia (78%) (see Figure 5.4 and Appendix 6). While Singaporeans are actively wooed with incentives to stick around as long as possible, the value of the constant streams of Sumatrans lies precisely in that they are no more than temporary paying ‘visitors’ or customers. This temporary mobility is valued for boosting income for private hospitals and the entrepreneurial intermediaries (e.g., medical travel agencies and low-cost accommodation and carriers) that have cropped up around them as well as for scoring Malaysia some diplomatic virtue for its extension of care to a group that can make no claims to entitlement to care in the country. While Indonesians entering from Sumatra have benefited from increased transnational connectivity and the reduced barriers to mobility that the exemption from the Indonesian exit tax once afforded them, the Malaysian border remains tangibly intact. For proof we need only look at the Sumatran patient-consumers who lug suitcases of Indonesian *rupiah* (IDR) to exchange for Malaysian *ringgit* (MYR) at money-changing kiosks located at airports, ferry stations and increasingly hospitals themselves in order to access another country’s private hospitals for care that may be inaccessible or even inexistent at home (see Figure 6.10).

Chapter VII. Conclusion

7.1 How far we have come

This thesis has sought to contribute to the rich body of academic work concerned with the reconfiguration of the state and its subjects and territory in a globalising context. The extension of healthcare to non-citizen patient-consumers and the parallel proliferation of a vast range of non-governmental actors engaged in healthcare governance and provision offer an excellent, timely empirical lens through which to address the reterritorialisation of services and relationships upon which ties between states and citizens have been based. Through the crossing of national borders in order to receive medical care, international medical travel (IMT) flows are held to disrupt the position of the state as a coherent, sovereign unit charged with ensuring the welfare of its citizenry.

As 'neoliberal values of flexibility, mobility and entrepreneurialism become ideal qualities of citizenship' and of state functioning, the retrenchment of the welfare state has re-interpreted 'care', individualising responsibility for one's own wellbeing and requiring 'a fundamental shift in the ethics of subject formation, or the ethics of citizenship' (Ong 2006: 501). With the expansion of privatised care, as we have seen with Malaysia, the state's role in healthcare provision has begun to shift from that of principal provider towards that of regulator and promoter – ensuring terms of trade, standards of care provision, labour resources and political and economic stability. Adherence to international trade agreements, accelerating the commodification of healthcare, has further rendered access to care ever less discursively and materially bound within a national framework.

I began the thesis with an anecdote telling of the launch of the Malaysia edition of the *Patients Beyond Borders* guidebook (Woodman 2009), a flag-waving ceremony rich with symbolism seeking to position and endorse 'Malaysia' as a respected international medical travel (IMT) destination. It prompted a set of questions that has guided my study of the strategic-relational logic of care provision and the extension of hospitality by the state in the context of increasingly globalised flows, namely:

- What does the 'extension of caring' (Barnett and Land 2007: 3) through the provision of private healthcare to non-citizens in Malaysia accomplish, and what sorts of power relations does this expedite?

- What 'Malaysia' is put 'on the map' to qualify for 'world-class' IMT destination status? Which characteristics are promoted as national credentials for expert care-giving and which are suppressed, ignored or rendered obsolete?

I now wish to close the thesis with a brief reflection on these questions, on how the work I have undertaken to respond to them contributes to some contemporary debates in Geography and on what aspects might be further interrogated in future studies.

7.1.1 What does this extension of caring to non-citizens in Malaysia accomplish?

While writing up my thesis, seeking to deconstruct the framing of 'Malaysia' as an international medical travel (IMT) destination in policy discourse and by multiple actors involved in its construction, I have frequently revisited this comment made by Tan Lee Cheng, the MOH's Principal Assistant Secretary for Health Tourism:

Medical tourism may be a business, but that doesn't mean that it's solely for business purposes. It's still very much based on the very foundation that healthcare is for all, that healthcare should be affordable, equitable and of quality. We [Malaysia] are based on those kinds of premises. (Tan interview, 17/01/2008)

Her statement pithily frames the contours of an entrepreneurial medical diplomacy extended by the postdevelopmental Malaysian state that is couched in claims to indiscriminate universal access for *consumers*, identifying 'Malaysia' as a moral safe-haven free from many of the barriers to accessing healthcare which remain unsettlingly stark elsewhere and envisioning an 'all' that departs markedly from earlier conceptualisations of the state's biopolitical scope.

I have sought with this thesis to demonstrate how a state's legitimacy is now increasingly derived from successfully attracting and facilitating investment, positioning its territory and subjects as a unique and privileged 'package', simultaneously containerised and globally integrated such that its territorialised differences and selective openness to particular flows of people and capital may foster strategic alliances deemed key to 'national' development interests. As Chapter III illustrated, the discursive scopes and practices of care have always been in flux, with the imagined boundaries to the terrains and subjects engaged in the provision and receipt of care changing significantly over time. Healthcare provision has long served as a technology for controlling and forging alliances across political regimes and economic phases.

The harnessing of IMT flows thus fits within an already dynamic genealogy of care for and about select subjects and territories.

The extension of care to specific categories of non-citizens gets used to reconfigure the role of the state as a 'unifying ground' (Yúdice 2003), expert in cultivating and managing the resources and skills relevant and attractive to mobile capital, at a moment when its relevance has been called into question. With the 'Malaysia Healthcare' therapeutic landscaping project, we have seen

the symbolic resources and resonance of nationalist discourse which perpetuate the nation-state as a necessary frame of identity, allegiance, and affiliation... [work towards] maintain[ing] and extend[ing] the nation as a legitimate entity in the context of globalised modernity. (Aronczyk 2008: 43)

Increasingly in the business of getting business for business, we have seen the ways in which the postdevelopmental Malaysian state is implied not only in investing in, endorsing and showcasing the 35 private hospitals selected for foreign patient-consumers but also in developing national healthcare accreditation schemes, reregulation on the heels of deregulation, incentives to lure back experienced expat Malaysian medical professionals to contribute to the development of their 'homeland' and educational programmes to train a crop of young professionals and provide them with competitive employment opportunities to stem international brain-drain. This intensification of transnational, intersectoral and public-private linkages aids the state's bid for Malaysia to be a player within the global knowledge economy while insinuating itself into the very heart of the action.

We can think about the strategic harnessing of IMT flows in terms of what Escobar (1995) calls 'needs discourses', which render 'the struggle over needs interpretation... a key political arena' (Escobar 1995: 225). As we have seen throughout the previous chapters' studies of entrepreneurial attempts to harness flows of Western, Middle Eastern and neighbouring Asian patient-consumers, these foreign patient-consumers' 'needs' get assessed, measured and subsequently framed by IMT proponents as comprising an emerging transnational social movement motivated by discontent with healthcare 'back home'. This thesis has demonstrated how various foreign patient-consumer market segments are conjured, repositioned and politicised as "'cases" for the state and the development apparatus' (Escobar 1995: 225) to respond to and act upon, translating the 'needs' of foreign patient-consumers 'into potential

objects of state administration...[, with] the means of satisfying “needs” position[ing] people as “clients” in relation to the “state” (Escobar 1995: 224). Significant here is that the state’s territory and subjects are being positioned to host and care for the ‘needs’ not of fellow citizens but those of select non-citizen others, indicative of a profound shift in, and expansion of, the state’s own globalising biopolitical mandate.

The leitmotif running through this thesis has been a concept of hospitality developed by Derrida (2000a,b) and geographers Barnett (2005) and Dikeç (2002) that emphasises mutual recognition derived from acknowledging boundaries as both separators *and* connectors. This marks a departure from the predominant Kantian approach to hospitality. Kant’s ‘anaemic’ geographical imagination (Sparke 2005), coloured by ethnic and gender biases and exclusions, shaped his proposal of a cosmopolitan *right* to ‘universal hospitality’ (to be welcomed, without hostility, as a visitor) (Sarvasy and Longo 2004). ‘[M]otivated by commercial necessities and the need for the nation-state to define itself exclusively’ (Dikeç 2002: 232), Kant’s (2006 [1795]: 82), the assertion of a cosmopolitan right to the ‘earth’s surface’ sought to regulate and ensure the smooth and civilised inter-state passage of select categories of travellers into others’ territories. While I am also concerned with how flows of people get facilitated across boundaries, in contrast to Kant’s hospitality – a concept revisited and adopted in this era of neoliberal globalisation that envisages the cosmopolitan mobility facilitated by market forces as a democratic ‘flattener’ and peacemaker – I have built upon a far bumpier interpretation that attests to the dynamic engagement between, and co-constitution of, the host and guest. In so doing, I have tried to compensate for the disproportionate framing in the IMT literature and media coverage of foreign (particularly Western) patient-consumers as pioneering agents of innovation who, in their pursuit of medical care, actively ‘scape’ or bull-doze ‘disjunctures’ between places to suit their needs. Following on Appadurai (2006), whose five deterritorialised flows or ‘scapes’ – ethnoscapas, mediascapas, technoscapas, financescapas and ideoscapas – contribute to the formation of a ‘postnational’ globality, one could conceptualise this predominant IMT archetype as a ‘bioscape’ (see Inhorn and Shrivastav 2010), ‘smoothing’ spaces with its moneyed pursuit of recognition of the value of its life over those of others. Yet this ‘fascination with the supposedly borderless movements and postnational networks comprising globalisation’ (Sparke 2005: 55) and its oft eager optimism attuned to the

democratising potential of such flows, have been too focused on *de*-territorialisation. Through the disproportionate focus on mobile ‘scapes’, there is a risk of *escaping* the materialities and spatialities of the localities through which these ‘scapes’ pass and with which they engage, which are themselves far from stable or fixed (Sparke 2005).

Throughout the thesis, therefore, I have sought to reintroduce geography into what has frequently been little more than an enthralled foregrounding of a ‘flat world’ of IMT that identifies the socio-spatial contexts out of which these flows evolve as irreparable backdrops of failed/failing welfare systems. I have attempted to de-centre focus on the agency of mobile flows by turning instead to the *host’s* recognition of ‘need’ and the territorialising extension of care to the guest. Instead of focusing on universal rights claims to care that draw from Kant’s emphasis on a common humanity’s indiscriminate right to the ‘earth’s surface’, I have concerned myself with the evolving political work that the extension of care and hospitality accomplish over time and space by exploring the partiality and conditionality of their provision.

De-centring focus on the ‘bioscape’ has implied expanding consideration of the people and places involved in receiving and managing these flows. I chose to focus on the promotion of a ‘national’ therapeutic landscape, that of ‘Malaysia Healthcare’, in order to draw attention to the work achieved by the selective opening up of ‘hospitable spaces’ (Dikeç 2002) within the scope of IMT to non-citizen others. By offering a critical reading of interviews with stakeholders vested in the supply side of IMT, official documentation and promotional materials, I have sought to encourage the reader to contemplate who benefits and how from *providing* care and what is required to sustain that capacity to care (Raghuram *et al.* 2009; Tronto 1993).

7.1.2 What ‘Malaysia’ is put ‘on the map’ to qualify for ‘world-class’ IMT destination status?

While Escobar (1995) may cautiously (and rightly so) read states’ and development apparatuses’ interpretation of ‘needs’ as prone to abuses of authority, I have also signalled the harnessing of IMT flows as a potentially ‘important piece of armoury’ for postcolonial states and populations to articulate ‘revered or targeted strategic essentialisms’ in order to replace or fuse ‘old textualities underpinning place-ness and nation-ness’ with ‘new imaginary essences of place and a new diversity in the possibilities of collective/national being’ (Hollinshead 2004: 31, 33). Postdevelopmental nation-building strategies, reliant on the outward extension and recognition

of resources, are alert to the 'perils... of closing spaces to the stranger' and 'aimed at encouraging engagement with the stranger, allow[ing] the guest to remain a stranger instead of becoming an other (on one extreme) or of being assimilated (on the other)' (Dikeç 2002: 240). This paradox of hospitality involves an 'asymmetrical social relation' that simultaneously honours the guest and keeps him/her at a distance, insisting on maintaining the guest *as a guest* in order to constitute and perpetuate the position of the host.

To dare to say welcome is perhaps to insinuate that one is at home here, that one knows what it means to be at home, and that at home one receives, invites, or offers hospitality, thus appropriating for oneself a place to *welcome* [*accueillir*] the other, or, worse, *welcoming* the other to appropriate for oneself a place and then speak the language of hospitality. (Derrida 1999b: 15-16, in Dikeç 2002: 237, original emphasis)

Extending invitation to the guest constitutes and distinguishes the 'self' of the host.

Correspondingly, the positioning of 'Malaysia' as an IMT destination by many of its proponents has largely been 'a statement about national identity conveyed to both tourists and locals' (Wood 1984, in King 1993: 109), seeking to underscore a narrative of a 'modern, moderate and fast-developing nation' (Sya 2005: 7). The thesis' focus on host-providers has yielded powerful readings of how they construct and imagine foreign patient-consumers and the strategies used to negotiate the benefits and challenges of extending care to them. The empirical chapters have focused on a range of manifestations of the constitutive and enunciative power of hospitality in IMT for forging a set of strategic-relational identities suited for plugging into a globalising economy. They document a set of attempts at knowing and welcoming the selected 'other', the invited guest, through receptiveness and approximation based upon (re)constructed, and consciously exploited, similarities. This ongoing process of approximation – taking 'inspiration from what [one] perceives as the needs of an other self, an other body' (Dikeç *et al.* 2009: 6) to render 'Malaysia' in a utopian light as a safe harbour for 'Somebodies' (see Chapter I; Barnett 2005: 15) – has been explored here in some of its multiple forms.

Chapters III and IV examined the further expansion of Malaysia's private healthcare facilities suited to the perceived 'requirements' of moneyed (foreign and domestic) patient-consumers. The commercialised extension of care to flows of 'high-quality visitors' (EPU 2000, 2005) within the scope of IMT has provided the state with persuasive motive to stimulate

further privatisation through a range of subsidies, fiscal incentives and regulations. In constructing the private healthcare sector as the privileged field and agent of care provision, the biopolitical meaning and scope of care provision are renegotiated, permitting the state to divest from its long-standing principal role in direct, universal and comprehensive healthcare provision to Malaysian citizens. Chapter IV traced the adoption and adaptation of recognisable Western-based regulations, standards and professional credentials to demonstrate the achievement of 'world-class' quality care in order to appeal to market segments hailing from largely Western and 'developed' countries. Calls and efforts have been made to raise the bar for overall healthcare in the country by endorsing a select group of (largely corporate) hospitals to symbolise an internationally-projected and legitimised 'national' landscape of medical excellence that contrasts an ailing public healthcare sector to a vigorous, pioneering private one with which it now suddenly 'competes' (Devaraj 2009). Engagement with processes of internationally-recognised standardisation and the cultivation of a pool of human resources and exclusive 'therapeutic' spaces as fragmented sites/sights of 'development' have attempted to bring Malaysia into the exclusive 'flat-world' club of medical legitimacy, seeking to partially overcome and obscure the stigma of Malaysia's 'developing' country status and drive future economic growth. It is, however, achingly clear that the redistribution of the socio-economic benefits derived from the privatisation of healthcare is biased towards those subjects successfully embodying neoliberal mores.

Chapter V illustrated the assertion and demonstration of 'natural' cultural competence through the positive reframing of domestic religious and cultural diversity and the drawing upon and managing of Malaysia's resulting 'wealth' of expertise to welcome patient-consumers who seek out familiarity and may have encountered hostility to their lifestyles elsewhere. The positioning of majority-Muslim Malaysia as a 'Muslim-friendly' IMT destination coincides with the state's broader political, cultural and economic interests in cultivating the country's image as a *halal* hub that simultaneously re-casts ethnic Malays as innovative cosmopolitan leaders within a supranational community defined along not ethnic but religious lines as well as consolidating the imagined religiosity of Muslim guests as central to their identity when in Malaysia. In conceiving of cultural identity as 'an ongoing process, politically contested and historically unfinished', 'always mixed, relational and inventive' (Clifford 1998, in Wood 1993:

64), we have seen that the performative space of IMT actively 'engenders and becomes implicated in a broad range of cultural politics' (Wood 1993: 57), serving as a field in which to construct and assert the identities, interests and rights of certain groups in relation to others.

Finally, in light of the striking relevance of regional IMT flows for Malaysia, Chapter VI offered a reading of select engagements with Malaysia's regional 'complementarities' (Kakazu 1999) that build upon narratives of historical alliances and moral and cultural similarities and solidarities to exploit the gross socio-economic inequalities that shape access to quality care in and between neighbouring countries. Cross-border cooperation in the scope of IMT contributes towards the naturalisation of sites/sights of a new development approach reflective of a postdevelopmental politics of national representation. Yet, while co-opted as 'national' landmarks symbolic of Malaysia's successful positioning within a globalising economy, the production of Iskandar Malaysia as Singapore's healthcare hinterland and Penang (and Malacca) as Sumatra's healthcare hub also attests to the challenges presented by growing regional identity and autonomy to the homogenisation of a 'national therapeutic landscape'. The harnessing of IMT flows thus brings 'attention to domestic stratification and conflict much more to the fore..., exposing concepts of society-wide interest as naïve and obfuscating' (Wood 1993: 57).

This tracing of the construction of 'Malaysia' as a cohesive IMT destination permitted me to tease apart 'the Malaysian therapeutic landscape' and reframe it as an amalgam of active, contested and asymmetrical involvement among the multiple spaces and subjects it encompasses and excludes, generating multiple and competing projections of 'Malaysia' via the extension of care. The chapters illustrated how 'performances of being' are mutually constitutive, not modes of possession but rather modes of dispossession – relations in which we (voluntarily or involuntarily) submit representations of our 'selves' to, for and by virtue of another (Butler 2004: 24). With transnational mobility's potential to de-naturalise and bring into sharper focus the constructed quality of 'fixed' identities, the arrival of the foreign 'other' calls into question the very notion of the autonomous, contained, homogeneous and pre-existing 'self' and reveals the heterogeneous relations within. In attending to the *various* ways in which 'Malaysia' gets positioned as an IMT destination and mapped onto a *range* of patient-consumers' and providers' therapeutic imaginaries, I therefore sought to recognise the uneven

power relationships that render the host(s) vulnerable in the act of reception and recognition of the guest(s).

Responsiveness to the foreign patient-consumer is 'about opening, without abolishing, these boundaries and *giving spaces* to the stranger where recognition on both sides would be possible' (Dikeç 2002: 229, original emphasis), a conditional extension of hospitality that insists on mutual recognition between the 'named' to 'give place' to the claims of both parties (Derrida 2000b: 23-25). Yet, we must continue to ask, recognition of what 'name'? Who is involved in this naming? And what sorts of other subject-positions does this focus occlude and foreclose? The extension of hospitality is 'not always liberating and emancipatory, but, on the contrary, may conceal an oppressive aspect beneath its welcoming surface' in which both 'the guest and the host are held in tension' (Dikeç 2002: 228, 237) when identities formed at the crossing of the threshold come to essentialise relations in new ways.

7.2 Opportunities for future research

An array of biopolitical distinctions are drawn around people who travel for health by their value to those sending, losing, abandoning, attracting, discouraging, filtering and unified with them. In Chapter I, I pointed to the great diversity of terms being used to describe international medical travel that, in evoking non-neutral mobilities like 'tourism', 'outsourcing', 'migration' and 'refugees', involve a broad range of social, cultural, political and economic imaginings and interpellations of the spaces and subjects engaged and implicated in relating to these health-motivated flows. There is great need to advance conceptualisations of mobility predicated not on smooth flows but rather on their varied production, their limitations and how they get differentiated. My concern has thus been to engage with some of the multiple ways in which those who pursue care abroad get constituted in their crossing of national borders – those thresholds of 'relating' which make up 'the very scenes for the drama of responsiveness, hospitality and responsibility' (Barnett 2005:16) – and how their presence gets mobilised to accomplish a range of political projects.

I have focused here on one very particular manifestation of travel for health. In engaging with the authorised IMT practices that encompass those privileged enough to have the ability 'to both circumvent *and* benefit from different nation-state regimes' (Ong 1999: 112, original emphasis), I sought to de-centre focus on the agency of mobile flows described in earlier

sections by turning instead to the significance of the *host's* recognition of these guests and their 'needs' and the territorialising extension of care to them. To do this, I focused on a kind of travel for health that, based upon mutual recognition, is not only visible and legitimated but also in many places actively courted, to the exclusion of the myriad forms in which travellers' practices and 'needs' are clandestinely received, ignored, disapproved of or rebuked in highly politically-charged, mutually constitutive experiences that conceive of the guest as the uninvited *arrivant* (see Darling 2010; Dikeç *et al.* 2009).⁹¹

While this thesis is necessarily only one possible reading of a complex and dynamic cluster of phenomena, I want to suggest how it contributes a framework for future readings of travel for health. I first briefly discuss my decision to focus on the kind of travel for health that reinforces the universal explanatory and curative power of biomedicine in this thesis. With this, I point to how study of the promotion and development of traditional and complementary medicines (T/CM) within the scope of IMT can help to advance work on how understandings of 'healthcare' are broadening to encompass many other ways of relating to and managing corporal vulnerability. I then discuss how a 'de-centred' focus on IMT destinations sets out a series of considerations for the future study of medical travellers' places of origin and for the multiplicity of ways in which the state is being remade in 'sending' its citizenry abroad.

7.2.1 Including traditional and complementary medicine

This thesis' scope was restricted to biomedicine in order to explore how the extension of this supposedly 'universal' body of knowledge and practice gets translated across borders, used in postcolonial contexts to advance political and economic claims to 'modernity' and 'developed' status, and sustained by a broader range of care practices that help to thwart ingrained assumptions about who can care for whom and the settings in which 'the "right" sort of care' can occur (Parr 2003: 219). At the same time, another part of the landscape of care comprises traditional and complementary medicine (T/CM) knowledge and practices thriving in parallel or in the process of being 'revived' that overlap or contrast with biomedical understandings of health and healing. The WHO's Traditional Medicine Programme has encouraged 'developing'

⁹¹ The refusal to incorporate Malaysia's substantial 'uninvited' (though quietly acknowledged to be essential) population of regular migrant workers as contributors to and recipients of the country's national healthcare system, for example, has not been explored here.

countries, for instance, to formulate national policies on T/CM and facilitate its integration into national healthcare systems. This effectively sanctions the mainstreaming of practices that had long been officially considered secondary, incompatible or inferior to 'modern' biomedicine (Mohamad 14/10/2002), attesting to fundamental changes in perceptions of what 'appropriate' healthcare comprises and who can provide it (Parr 2003) and challenging unidirectional claims to knowledge about and power over the body. I see the future study of T/CM within the scope of IMT as building upon the de-centred groundwork I have sought to lay in regards to thinking about who can care.

With evidence of the effectiveness of T/CM practices originating in Asia sparking interest outside of the region (Mohamad 14/10/2002), 'traditional' expertise is increasingly marketed alongside biomedical skill to international medical travellers (*Business Week* 9/11/2008; *NST* 09/01/2006). Over the last decade, for example, the Malaysian government has been keen to promote the country not only as a destination for biomedical care but also for care that encompasses a more holistic understanding of 'health' that includes spas and T/CM (Tourism Malaysia 2008a, 2009c). It has staked incipient claims to a 'Truly Asia' traditional medicine, seeking to capitalise on its subjects' Chinese and Indian heritages in the practice of already well-known T/CM methods (e.g., traditional Chinese medicine and Indian Ayurveda) as well as lesser-known *bumiputera* herbal medicine and massage in order to contribute to the construction of a national therapeutic image defined and commodified along ethnic lines (Tourism Malaysia 2008).

The promotion of 'home-grown' traditional medicines is ostensibly used to preserve and breathe new life into economically viable 'traditions'. This revitalisation brings cultural, migratory and 'Asian values' rhetorics by now familiar to the reader to the forefront with the cultivation of healthcare practices touted as an 'Asian' alternative and complement to 'Western' biomedicine. This has, for instance, translated into employing mainland Chinese medicine experts from Shanghai to train local ethnic Chinese Malaysian *sinseh*, reminiscent of the biomedical expertise-transfer scheme underway at Prince Court Medical Centre discussed in Chapter IV. A specifically 'Malay' massage has also been actively promoted and is hoped to compete with established 'Thai', 'Chinese' and various Indonesian methods in order to make the Malaysian IMT industry more unique and competitive (Muin 07/05/2009). Finally, competition

with other T/CM practices both abroad and within Malaysia has led to assertions of quality imbued with distinctly nationalist and ethnic undertones derived from claims to authenticity and autochthony through the naturalised expert use of the country's wealth of 'native' flora (e.g., herbs such as *tongkat ali* ('natural Viagra'), *kacip fatimah*, *pati mengkudu* and *air gamat*) by the *bumiputera* (Ahmad 19/04/2000; Comaroff and Comaroff 2001). With Malaysia identified as one of 12 'mega-biodiversity' countries in the world, this entrepreneurial pride in the potential of 'native' medicinal herbs has led to engagement with the long marginalised aboriginal Orang Asli peoples, to use their knowledge and expertise in order to best exploit the forest's 'treasures' before foreigners patent local herbs and sell them abroad (Bernama 20/01/2009; *NST* 11/05/2008). 'Weaving T/CM into the threads of our [Malaysia's] current healthcare system may be our greatest tribute to our national heritage', observed the then Director-General of Health Mohamad Taha bin Arif (14/10/2002). Further studies, therefore, may draw on the wealth of relationships unfolding between biomedicine, traditional medicines and the 'nationalisation' of 'authentic' curative natural and human resources in order to advance thinking on nation-branding practices and the multiple ways in which healthcare gets bound up with identity claims and practices (see Chambers and McIntosh 2008; UNCTAD 1997; Wolvaart 1998).

7.2.2 Considering the 'sending' context

The thesis has delineated some of the ways in which the 'needs' of foreign patient-consumers get identified, imagined and then catered for, based upon assumptions about what drives them to Malaysia – assumptions fundamentally premised upon many IMT proponents' beliefs that patient-consumers are essentially driven out of their local healthcare areas because these are found somehow fundamentally lacking or inhospitable. IMT destinations' intimate bonds to patient-consumers' sending contexts, therefore, have been addressed here by identifying how Malaysian IMT promoters try to appeal to patient-consumers based upon the ways in which conditions 'back at home' are imagined. Given its focus on destinations, however, this thesis has only briefly touched upon the experiences in patient-consumers' places of origin produced through their pursuit and receipt of care abroad.

In her ethnographic work tracing Yemenis' 'transnational therapeutic itineraries', Kangas (2002) recognises the provision and pursuit of care as a global process that spans multiple scales of influence (global, international, state, society and household) and endorses multi-site

fieldwork in order to acknowledge the ‘myriad decisions, procedures and experiences that can occur’ (Kangas 2002: 38-39) between originating countries and treatment sites. Taking a cue from Kangas, the next step in my ‘decentring’ project will attend to the experiences of those people and places traditionally charged with providing healthcare and defending the right to it that are now increasingly ‘sending’ patient-consumers abroad. The use of scare quotes here highlights the multiplicity of conditions and relations under which citizens leave their countries of origin/residence for medical care. I briefly outline below some of the ways in which future studies could approach the ‘sending’ question.

Firstly, what are the implications for existing healthcare provision when a ‘traditional’ care provider begins to lose its ‘therapeutic’ status and portions of the population for which it claims to care instead pursue care elsewhere? Faced by a healthcare system that has ‘priced out’ so many ‘average’ Americans, for example, much of the pressure for adopting American standards as an international benchmark of quality that we saw in Chapter IV can be traced to plans to ‘outsource’ the care of large numbers of American citizens (Carrera and Bridges 2006; Cortez 2008; Horowitz *et al.* 2007; Terry 2007). Should this practice grow more mainstream (and given the proliferation of health insurance schemes that feature medical ‘outsourcing’ as an option, it looks as though this will be the case), it is feared that the first to be ‘outsourced’ will be the most vulnerable – the un- and underinsured. The United Steelworkers Union’s (2006: 5) response to this trend is unequivocal:

No U.S. citizen should be exposed to the risks involved in travelling internationally for healthcare services... The right to safe, secure and dependable healthcare in one’s own country should not be surrendered for any reason... The offshoring of family- and community-supportive jobs is bad enough. Exacerbating this crisis by attempting to outsource healthcare is... shameless.

Already, in Chapter VI, we have seen new modes of healthcare liberalisation in Singapore yield similar critiques and deeply-rooted indignation about ‘offshoring’ care of the elderly to nursing homes that, though only a quick bridge-crossing away, are in Malaysia. Such tensions offer up rich material for further thinking about the production of acceptable boundaries to care and responsibility and how ‘far’ away particular forms of care are permitted or ‘safe enough’ to take place for particular categories of subjects (Smith 1998).

Secondly, what becomes of the bonds between states and their subjects when care is better satisfied in another state? Numerous small countries throughout the world that espouse

ideals of universal access to healthcare routinely send their citizens abroad for treatments and procedures they are unable to provide 'back home'. As I noted in Chapter V, for example, many of the wealthy Gulf governments, alert to their own limitations in providing the necessary medical technology and expertise for certain levels of treatment, have long sent their citizens abroad for fully government-subsidised care. This demonstrates that 'traditional' relations between the state and its citizenry can in fact be reinforced by sending *citizen-patients* abroad for care. These relations complicate neoliberal narratives about citizen-patients being abandoned by the retreating welfare state and fleeing from it as patient-consumers, suggesting that such narratives do not fully acknowledge the ways in which the state can be remade through international medical travel.

Finally, what are the local impacts of out-going IMT flows for places where the state's legitimacy has not necessarily been premised on ensuring universal access to healthcare? In Indonesia, for example, the decentralisation of healthcare funding and resources to regional governments has exacerbated obstacles to care over the last decade for already marginalised populations (Halabi 2009). As Chapter VI illustrated, Indonesian authorities have partially loosened their grasp over what had been presumed to be a 'captive' healthcare consumer market – allowing for an estimated one million Indonesians to pursue care abroad each year (IRIN 06/08/2009). With these patient-consumers financially able to receive care elsewhere, how does their exodus impact access to local health resources for the cash-strapped left behind and how does this 'haemorrhaging' of potential income affect local doctors and facilities? Reliance on medical care outside of Indonesia for even mundane procedures, illustrative of how 'interdependency is not cosy but... contested, complicated and productively unsettling' (Raghuram *et al.* 2009: 10-11), is producing forms of cooperation, competition and overlap that are worthy of study.

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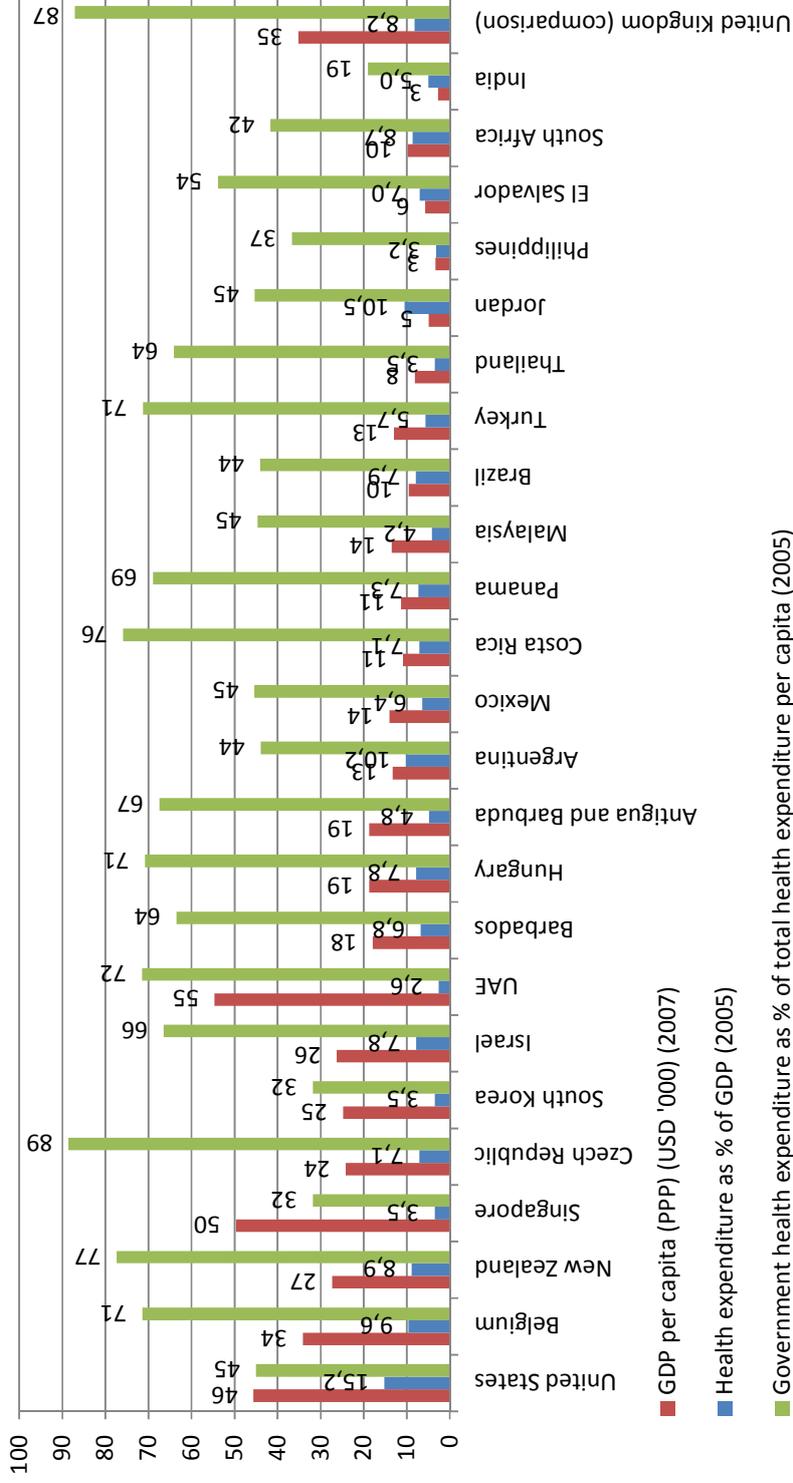
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Appendices

Appendix 1. Medical travel destinations promoted worldwide, by HDI rank



Source: UNDP (2009); WHOSIS (2009). Note: The grouping of countries here reflects those promoted by four established Western market-orientated medical travel facilitators: Planet Hospital, Healthbase, MedRetreat and Patients Beyond Borders. Taiwan, also promoted as an up-and-coming destination, is considered part of China by the UN and WHO and, therefore, cannot be distinguished for the purposes of this graph.

Appendix 2. List of interviewees

Names listed here are those of interviewees not wishing to remain anonymous. Interviewees wishing to remain anonymous are indicated as 'anonymous'.

	Name	Position	Institution	Gender	Ethnic background	Scope of influence	Interview date
1	TAN Lee Cheng	Senior Principal Assistant Secretary, Health Tourism Unit, Health Industry Section	Corporate Policy and Health Industry Division, Ministry of Health (MOH)	Female	Chinese-Malaysian	National	17-1-2008
2	Elizabeth WONG	Chairperson, Standing Committee of Tourism, Consumer Affairs and Environment	Selangor State Government	Female	Chinese-Malaysian	State - Selangor	21-4-2008
3	Dr Jason YAP	Director	SingaporeMedicine	Male	Chinese-Singaporean	National	15-2-2008
4	Anonymous Malaysian governmental tourism representative	A mid-level strategy-making position	Governmental body concerned with attracting tourism	Male	Malay-Malaysian	National	24-1-2008
5	Anonymous Malaysian governmental trade representative 1	A senior-level strategy-making position	Governmental body concerned with attracting international trade	Male	Malay-Malaysian	National	11-12-2007
6	Anonymous Malaysian governmental trade representative 2	A mid-level strategy-making position	Governmental body concerned with attracting international trade	Male	Malay-Malaysian	National	11-12-2007
7	Anonymous Malaysian governmental health representative	A senior-level policy-making position	Governmental body concerned with regulating medical practice	Female	Malay-Malaysian	National	24-3-2008

Name	Position	Institution	Gender	Ethnic background	Scope of influence	Interview date
8 Anonymous state governmental tourism representative 1	An administrative position	State governmental body concerned with attracting tourism	Female	Chinese-Malaysian	State – Malacca	18-3-2008
9 Anonymous state governmental tourism representative 2	A mid-level managerial position	State governmental body concerned with attracting tourism	Female	Malay-Malaysian	State – Malacca	21-3-2008
10 Azreena bt Zahari	Customer Service/Patient Liaison Officer	Tun Hussein Onn National Eye Hospital	Female	Malay-Malaysian	Klang Valley	31-3-2008
11 Dr CHAN Kok Ewe	CEO; Chair	Island Hospital; Penang Health Group	Male	Chinese-Malaysian	Penang	3-3-2008
12 CHIN Yi	General Manager, Group Corporate Communication and Business Development	Pantai Group Hospitals	Male	Chinese-Malaysian	Klang Valley; International	29-1-2008
13 Dr Firdaus B. Hanapiah	Founder; Oral and maxillofacial surgeon	MalaysiaDentist.com	Male	Malay-Malaysian	Klang Valley	17-4-2008
14 Dato' Dr K. KULAVEERASINGAM	KPJ Group Advisor for Medical Services Development & Marketing; APHM Board Member	KPJ Ampang Puteri Hospital; Association of Private Hospitals of Malaysia (APHM)	Male	Indian-Malaysian	Klang Valley	29-2-2008
15 KHOR Thean Heng	Marketing Director	Penang Adventist Hospital	Male	Chinese-Malaysian	Penang	6-3-2008
16 Francis LIM	CEO	Mahkota Medical Centre	Male	Chinese-Malaysian	Malacca	22-3-2008
17 Stuart ROWLEY	CEO	Prince Court Medical Centre	Male	English-Australian	Klang Valley	17-3-2008

Name	Position	Institution	Gender	Ethnic background	Scope of influence	Interview date
18 Dato' Dr Jacob THOMAS	Medical Legal Advisor and former CEO; APHM President	Sime Darby Medical Centre Subang Jaya; Association of Private Hospitals of Malaysia (APHM)	Male	Indian-Malaysian	Klang Valley	12-3-2008
19 Anonymous hospital group management representative	A senior-level strategy/management position	A major private Malaysian hospital group	Female	Malay-Malaysian	International	18-12-2007
20 Anonymous hospital executive	A senior executive position	A major private Malaysian medical care facility	Male	Chinese-Malaysian	Klang Valley	29-2-2008
21 Anonymous hospital marketing representative 1	A senior-level marketing position	A major private Malaysian medical care facility	Female	Malay-Malaysian	Klang Valley	25-1-2008
22 Anonymous hospital marketing representative 2	A senior-level marketing position	A major private Malaysian medical care facility	Female	Chinese-Malaysian	Penang	4-3-2008
23 Anonymous hospital marketing representative 3	A senior-level marketing position	A major private Malaysian medical care facility	Female	Chinese-Malaysian	Malacca	21-3-2008
24 Anonymous hospital marketing representative 4	A senior-level marketing position	A major private Malaysian medical care facility	Male	Chinese-Malaysian	Malacca	21-3-2008
25 Anonymous hospital marketing representative 5	A mid-level marketing position	A major private Malaysian medical care facility	Male	Chinese-Malaysian	Malacca	21-3-2008
26 Anonymous hospital management representative 1	A senior-level management position	A major private Malaysian medical care facility	Female	Chinese-Malaysian	Klang Valley	30-1-2008
27 Anonymous hospital administration representative 1	An administrative position	A major private Malaysian medical care facility	Female	Chinese-Malaysian	Klang Valley	12-3-2008
28 Anonymous hospital administration representative 2	An administrative position	A major private Malaysian medical care facility	Female	Chinese-Malaysian	Klang Valley	28-3-2008

	Name	Position	Institution	Gender	Ethnic background	Scope of influence	Interview date
29	Anonymous hospital administration representative 3	An administrative position	Malaysian medical care facilities of lesser international renown	Male	Malay-Malaysian	Klang Valley	1-4-2008
30	Anonymous medical professional 1	Surgeon and head of a specialist clinic	A major private Malaysian medical care facility	Male	Malay-Malaysian	Klang Valley	28-11-2008
31	Anonymous medical professional 2	Surgeon	A major public Malaysia medical care facility	Male	Chinese-Malaysian	Klang Valley	26-3-2008
32	Rebecca JOHN	Senior Technical Officer	Malaysian Society for Quality in Health (MSQH)	Female	Indian-Malaysian	National	13-3-2008
33	Prof Dr MA Kadar	CEO	Malaysian Society for Quality in Health (MSQH)	Male	Malay-Malaysian	National	13-3-2008
34	Prof Dr Abdul Latiff bin Mohamed	President of IMAM; Cardiologist; Lecturer	Islamic Medical Association of Malaysia (IMAM); Hospital Pakar An-Nur; Cyberjaya University College of Medical Sciences	Male	Malay-Malaysian	National; Klang Valley	6-12-2007
35	Dr TEOH Siang Chin	Former President; Medical doctor	Malaysian Medical Association (MIMA)	Male	Chinese-Malaysian	National	11-1-2008
36	CHEAH Chee Ho	Policy and Research Manager, Health Issues	Federation of Malaysian Consumers Associations (FOMCA)	Male	Chinese-Malaysian	National	23-1-2008
37	Dr JAYABALAN	Activist; Medical doctor	Consumers Association of Penang (CAP)	Male	Indian-Malaysian	National	5-3-2008
38	Anonymous civil society representative	Activist	Anti-healthcare privatisation group	Male	Chinese-Malaysian	National	4-12-2007
39	Danny JEE	General Manager	MediTravel, Holiday Tours	Male	Chinese-Malaysian	Klang Valley; International	12-2-2008

Name	Position	Institution	Gender	Ethnic background	Scope of influence	Interview date
40 Mohamad Khairy Abdul Rahim	General Manager	Trade Winds Travel and Tours	Male	Malay-Malaysian	Klang Valley; International	22-1-2008
41 Suresh PONNUDURAI	CEO	Tropical Flow – Malaysia Healthcare Networks	Male	Indian-Malaysian	Klang Valley; International	18-12-2007
42 Josef WOODMAN	CEO; Author	Healthy Travel Company	Male	European-American	International	28-2-2008
43 Anonymous executive of a medical travel intermediary	CEO	Healthcare facilitator 1	Male	Of European descent	Klang Valley; International	10-3-2008
44 Anonymous medical travel intermediary representative 1	A medical tourism consultant	Healthcare facilitator 2	Male	Indian-Malaysian	Klang Valley; International	12-2-2008, 15-9/2009
45 Anonymous medical travel intermediary representative 2	A patient manager position	Healthcare facilitator 3	Male	Iraqi	Klang Valley; International	17-1-2008
46 Anonymous medical travel intermediary representative 3	A patient manager position	Healthcare facilitator 3	Male	Yemeni	Klang Valley; International	28-1-2008
47 Anonymous medical travel intermediary representative 4	A patient manager position	Healthcare facilitator 3	Female	Egyptian	Klang Valley; International	28-1-2008
48 Anonymous medical travel intermediary representative 5	A patient manager position	Healthcare facilitator 3	Male	Iraqi	Klang Valley; International	28-1-2008
49 Anonymous medical travel intermediary representative 6	A patient manager position	Healthcare facilitator 3	Male	Saudi	Klang Valley; International	28-1-2008

Appendix 3. Semi-structured interview schedule

1. General development of the medical travel industry in Malaysia

- a. Story of the medical travel industry's development process
- b. Ways in which the participant's institution fits into this process and its interest in developing/ promoting the industry in Malaysia
- c. Interconnections between the respondent's institution and other authorities and agencies involved in the industry
- d. Strengths, weaknesses, opportunities and threats (SWOT) for the medical travel industry and the respondent's institution

2. Globalised landscape of medical care

- a. Manners in which medical technology and developments in biomedicine have changed the way we understand and pursue health
- b. Patients' medical knowledge and healthcare consumption practices
- c. Influence of globalised relations and international trade agreements regarding the movement of people, goods and services related to healthcare provision
- d. In what ways the development and promotion of the medical travel industry are envisioned to articulate with Malaysia's broader development ideals

3. Overall healthcare customer base

- a. Estimate of number of foreign patients and how they are counted and categorised
- b. Reasons healthcare consumers might go abroad for medical care
- c. Rationale for targeting particular foreign healthcare consumer segments
- d. Means for attracting these different segments, their effectiveness and their development over time
- e. Recognised interests, needs and concerns of these segments and means for catering to them

Appendix 4. New Straits Times Press articles accessed, by year of publication

Year	1997*	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total (1998-2009)
Articles published	13	34	24	35	36	59	63	95	68	56	60	78	112	720
References**	24	41	29	38	40	68	67	109	81	69	84	118	161	905
Foreign patient	0	0	0	1	0	0	3	3	0	1	4	4	2	18
Healthcare travel	2	1	1	1	1	0	0	0	1	0	1	1	13	20
Healthcare tourism	3	1	1	3	3	3	6	4	5	5	5	8	10	54
Health tourism	11	21	20	23	21	43	35	73	47	39	34	41	47	444
Medical tourism	3	17	4	6	14	22	22	29	25	21	38	57	74	329
Medical travel	5	0	2	3	0	0	1	0	2	3	1	6	14	32
Medi-tourism	0	1	1	1	1	0	0	0	1	0	1	1	0	7

Source: New Straits Times Press (2009) *Notes:* * The year 1997 is included here as a control to highlight difference in coverage after IMT entered the government's development agenda in early 1998. ** The number of references does not coincide with the number of articles published, as sometimes multiple terms were used in a single article.

Appendix 5. Distribution of foreign patient-consumers by nationality in Malaysia (2002-04/2006-07)

<i>Nationality</i>	2002	%	2003	%	2004	%	2006	%	2007	%	2008	%
Australia	1492	1.76	2624	1.48	2153	1.24	3,045	1.03	3,829	1.12	4727	1.26
Bangladesh	837	0.99	1107	0.63	833	0.48	1,319	0.44	1,594	0.47	2958	0.79
Brunei	530	0.63	326	0.18	449	0.26	711	0.24	1,028	0.30	690	0.18
China	1603	1.90	3159	1.78	1974	1.13	3,767	1.27	5,099	1.49	6676	1.78
'Europe'	3629	4.29	5707	3.22	3776	2.17	7,383	2.49	9,219	2.70	11,070	2.96
India	2052	2.43	3558	2.01	2964	1.70	4,800	1.62	6,132	1.80	7322	1.96
Indonesia	55,812	65.98	128,224	72.45	138,387	79.45	228,486	77.01	266,227	78.01	279,509	74.72
Japan	7699	9.10	12,383	7.00	7166	4.11	11,382	3.84	11,210	3.28	11,971	3.20
Korea	747	0.88	1017	0.57	813	0.47	2,005	0.68	2,622	0.77	2895	0.77
'Middle East'	413	0.49	925	0.52	628	0.36	1,496	0.50	1,504	0.44	3879	1.04
Philippines	584	0.69	996	0.56	631	0.36	1,878	0.63	1,902	0.56	2339	0.63
Singapore	1337	1.58	2154	1.22	2184	1.25	3,141	1.06	3,812	1.12	4273	1.14
Taiwan	820	0.97	1251	0.71	765	0.44	1,179	0.40	1,314	0.39	1416	0.38
Thailand	800	0.95	1347	0.76	936	0.54	1,476	0.50	2,029	0.59	2279	0.61
USA	1517	1.79	2717	1.54	1966	1.13	3,618	1.22	4,178	1.22	4975	1.33
'Others'	4713	5.57	9490	5.36	8564	4.92	21,001	7.08	19,589	5.74	27,084	7.24
Total	84,585	100	176,985	100	174,189	100	296,687	100	341,288	100	374,063	100

Source: APHM (2008), Tourism Malaysia (2009c) *Note:* Categories of foreign patients listed here are those used by the APHM; more discriminated origins for patients from 'Europe', the 'Middle East' and 'Others' are not available. Figures by nationality are not available for 2005.

Appendix 6. Regional distribution of foreign patients by nationality (2007)

2007	Relative total weight		Distribution by region						
	Total no.	%	%	%	%	%	%	%	
Patient nationality	Malaysia	Weight	Kedah	Penang	Ipoh	Klang Valley	Malacca	Johor	Sabah / Sarawak
Australia	3,829	1.12	-	53.17	3.00	30.77	1.25	0.78	11.02
Bangladesh	1,594	0.47	-	25.03	8.41	56.78	4.64	0.19	4.96
Brunei	1,028	0.30	-	5.54	0.97	71.01	1.26	0.00	21.21
China	5,099	1.49	-	35.97	3.59	48.72	1.71	0.39	9.63
Europe	9,219	2.70	-	56.01	3.13	28.85	0.39	0.40	11.21
India	6,132	1.80	-	36.51	7.53	45.38	3.64	0.72	6.21
Indonesia	266,227	78.01	-	65.55	0.25	3.42	22.25	2.93	5.60
Japan	11,210	3.28	-	56.52	1.69	37.74	0.53	0.10	3.43
Korea	2,622	0.77	-	24.98	0.34	44.24	1.07	0.00	29.37
Middle East	1,504	0.44	-	29.79	2.66	48.07	10.77	0.07	8.64
Philippines	1,902	0.56	-	23.82	3.73	43.90	2.37	0.32	25.87
Singapore	3,812	1.12	-	23.08	4.07	41.32	14.48	7.45	9.60
Taiwan	1,314	0.39	-	58.30	3.04	22.15	2.74	2.13	11.64
Thailand	2,029	0.59	-	51.40	9.22	33.32	2.46	0.05	3.55
USA	4,178	1.22	-	73.41	0.89	18.88	0.50	0.43	5.89
Others	19,589	5.74	-	40.12	2.07	39.39	12.92	0.42	5.07
Total	341,288	100.00	-	60.87	0.88	11.09	18.52	2.45	6.19
Revenue (MYR)	253,840,603	-	-	60.56	0.52	14.50	17.14	1.11	6.16
Hospis reporting	29/35	-	0/1	7/7	2/3	14/17	2/3	1/1	3/3

Source: APHM (2008). Note: Figures are based on the 35 hospitals endorsed for IMT in 2007. For information on reporting hospitals, see Appendix 7.

Appendix 7. Hospitals reporting the foreign patient numbers upon which Malaysia's IMT figures are based (2003-2007)

Hospital	Endorsed for IMT	Location	2003	2004	2005	2006	2007
Anonymous	n/a	n/a	✓	✓	✓		
Assunta Hospital	Yes	Klang Valley				✓	✓
Bukit Mertajam Specialist Hospital	No	Penang		✓	✓		
Columbia Asia Medical Centre	Yes	Klang Valley		✓	✓	✓	✓
Fatimah Hospital	Yes	Ipoh					
Gleneagles Intan Medical Centre	Yes	Klang Valley					
Gleneagles Medical Centre	Yes	Penang	✓	✓	✓	✓	✓
Island Hospital	Yes	Penang	✓	✓	✓	✓	✓
Kota Bharu Medical Centre	No	Kota Bharu	✓				
KPJ Ampang Puteri Specialist Hospital	Yes	Klang Valley		✓	✓	✓	✓
KPJ Damansara Specialist Hospital	Yes	Klang Valley		✓	✓	✓	✓
KPJ Ipoh Specialist Hospital	Yes	Ipoh		✓	✓	✓	✓
KPJ Johor Specialist Hospital	Yes	Johor		✓	✓	✓	✓
KPJ Selangor Medical Centre	Yes	Klang Valley				✓	✓
KPJ Sentosa Medical Centre	Yes	Klang Valley					
KPJ Tawakal Hospital	Yes	Klang Valley	✓	✓	✓	✓	✓
Kuantan Medical Centre	No	Kuantan	✓				
Lam Wah Ee Hospital	Yes	Penang	✓	✓	✓	✓	✓
Loh Guan Lye Specialists Centre	Yes	Penang				✓	✓
Mahkota Medical Centre	Yes	Malacca				✓	✓
Metro Specialist Hospital	Yes*	Kedah	✓	✓	✓	✓	
Mount Miriam Hospital	Yes	Penang	✓	✓	✓	✓	✓
National Heart Institute (IJN)	Yes	Klang Valley	✓	✓	✓	✓	✓
NCI Cancer Hospital	Yes	Klang Valley		✓	✓	✓	✓
Normah Medical Specialist Centre	Yes	Sabah & Sarawak					✓
Pantai Ayer Keroh Hospital	Yes	Malacca	✓	✓	✓	✓	✓
Pantai Hospital Klang	No	Klang Valley	✓				
Pantai Medical Centre	Yes	Klang Valley	✓	✓	✓	✓	✓
Pantai Mutiara Hospital	Yes	Penang	✓	✓	✓	✓	✓
Pantai Putri Hospital	Yes	Ipoh	✓	✓	✓	✓	
Penang Adventist Hospital	Yes	Penang	✓	✓	✓	✓	✓
Perak Chinese Maternity Hospital	No	Ipoh	✓				
Putra Specialist Hospital	Yes	Malacca	✓				
Sabah Medical Centre	Yes	Sabah & Sarawak	✓	✓	✓	✓	✓
Sri Kota Specialist Medical Centre	No	Klang Valley	✓				
Subang Jaya Medical Centre	Yes	Klang Valley	✓	✓	✓	✓	✓
Sunway Medical Centre	Yes	Klang Valley	✓	✓	✓	✓	✓
Taman Desa Medical Centre	Yes	Klang Valley		✓	✓	✓	✓
Timberland Medical Centre	Yes	Sabah & Sarawak		✓	✓	✓	✓
TMC Fertility Centre	Yes	Klang Valley		✓	✓	✓	✓
Tun Hussein Onn National Eye Hospital (THONEH)	Yes	Klang Valley					
Tung Shin Hospital	Yes	Klang Valley		✓	✓	✓	✓

Source: APHM (2008a)

Appendix 8. Zones of graduated sovereignty involving Malaysia

Type	Zone	Geographic coverage	Est.	Focus	Description
EPZ		Penang state's Bayan Lepas; Selangor state's Sungei Way, Hulu Kelang, Teluk Panglima Garang and West Port; Malacca state's Tanjung Kling and Batu Berendam; Johor state's Senai and Pasir Gudang; Perak state's Kinta	1970s-	Labour-intensive export manufacturing (e.g., electronics and textiles); cargo shipping	Trade tariffs and quotas eliminated; bureaucratic requirements lowered
IOFC	Labuan Offshore Financial Centre	Labuan Federal Territory	1996-	Offshore business, insurance and finance	Free movement of foreign currency; zero/minimal income tax
National regional development corridors	Multimedia Super Corridor Malaysia (MSC)	Between Kuala Lumpur City Centre and KLIA, including: <ul style="list-style-type: none"> • Cyberjaya • Putrajaya Federal Territory 	1996-	'Silicon Valley'-style ICT infrastructure and enterprises	No internet censorship; tax-free for 5 years; facilitated visas for foreign knowledge workers; advanced protection of intellectual property rights
	Iskandar Malaysia (formerly Iskandar Development Region)	Southern Johor state 5 'flagship' zones: <ul style="list-style-type: none"> • Johor Bahru City Centre • Nusajaya • Western Gate Development • Eastern Gate Development • Senai-Skudai 	2006-	Business/finance, residential development, healthcare, logistics, creative industries, education, tourism and transport	Income tax exemption; exemption from FDI equity caps; freer movement of foreign currency; facilitated visas for foreign knowledge workers; entrepreneur support
	Northern Corridor Economic Region (NCER)	Kedah, Penang and Perlis states and northern Perak state 5 sub-corridors: <ul style="list-style-type: none"> • Island • Coastal • Central • Hinterland • Butterworth-Kulim-Baling-Pengkalan Hulu-Grik 	2007-2025	High value-added electronics manufacturing, biotech, agriculture, tourism and logistics	Entrepreneur support; income tax exemption; additional tax exemptions
	East Coast Economic Region (ECER)	Kelantan, Terengganu, Pahang states and the northern Mersing district of Johor state <ul style="list-style-type: none"> • ECER SEZ • Cross-border development • Kuala Terengganu City Centre-Kenyir-Dungun Triangle • Mersing-Rompin • Gua Musang-Kuala Lipis • Bentong-Raub 	2007-2020	Oil and gas, transportation infrastructure, automotive industry, ICT infrastructure, manufacturing, tourism and agriculture; Poverty eradication	Tailored to individual nodes

Type	Zone	Geographic coverage	Est.	Focus	Description
Transnational growth triangles	Sarawak Corridor of Renewable Energy (SCORE)	Sarawak state 5 growth nodes: <ul style="list-style-type: none"> • Tanjong Manis • Mukah • Samalaju • Baram • Tunoh 	2008-	Infrastructure; hydropower, coal and natural gas, energy-intensive industry	Tax exemptions and deductions; attractive energy rates for energy and land
	Sabah Development Corridor (SDC)	Sabah state 6 strategic development areas: <ul style="list-style-type: none"> • Sandakan-Beluran-Kinabatangan Bio-Triangle • Lahad Datu-Kunak-Semporna-Tawau Agro-Marine Belt • Interior Food Valley • Oil and Gas Clusters • Kinabalu Gold Coast Enclave • Brunei Bay Integrated Development Area 	2008-2025	Services and tourism infrastructure, agriculture, fisheries, oil and gas	Customised incentives; entrepreneurial support
	Indonesia-Malaysia-Singapore Growth Triangle (IMS-GT)	<ul style="list-style-type: none"> • Indonesian island of Sumatra • Malaysia: Johor, Malacca, Negeri Sembilan and Pahang • Singapore 	1994-	Tourism, services, manufacturing	Free trade zone to Singapore in the Indonesian part; reduced trade barriers and facilitated travel for Singapore in the Malaysian part (see Iskandar Malaysia above)
	Indonesia-Malaysia-Thailand Growth Triangle (IMT-GT)	<ul style="list-style-type: none"> • Malaysia: Kedah, Kelantan, Malacca, Negeri Sembilan, Perak, Perlis, Penang, Selangor and Terengganu • Indonesian island of Sumatra • Thailand: Chumphon, Krabi Nakhonsrithmmarat, Narathiwat, Pattani, Phang Nga, Phatthalung, Phuket, Ranong, Satun, Songkhla, Suratthani, Trang and Yala 	1993-	Tourism, agriculture and manufacturing; air and land transport linkages	Reduced trade barriers and facilitated travel
	Brunei Darussalam-Indonesia-Malaysia-Philippines East ASEAN Growth Area (BIMP-EAGA)	<ul style="list-style-type: none"> • Brunei Darussalam • Indonesia: Kalimantan, Sulawesi, Maluku, West Papua and Papua • Malaysia: Sabah, Sarawak and Labuan • Philippines: Palawan and Mindanao 	1994-	Tourism, air linkages, sea transport and shipping services, fisheries	Reduced trade barriers and facilitated travel