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The Comparison of Hospital Brand Image Between Indonesia and Malaysia and The Causes

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ABSTRACT

Health service provided by a hospital is categorized as a service that is strong in the credential attribute. Opinions heard from others become an important source for consumers to assess the quality of health services, which can determine their hospital choice. This study aims to discover the brand image of Indonesian hospitals compared to Malaysian hospitals based on the opinions of health experts. This study employs a qualitative approach using in-depth interviews. Based on the data, there are five categories of brand image found. They are the certainty and precision of diagnosis, comprehensiveness facilities, affordability, quality of service, and interactive communication. The study also aims to discover the fundamental problems that hinder the development of health services in Indonesian hospitals. The analysis indicates that there are three fundamental problems faced by Indonesian health services: commercialization, weak service culture, and information asymmetry. The analysis went further to understand the causes from the perspective of higher-level institutions.

Keywords: brand image; medical tourism; hospital; service quality; qualitative approach

INTRODUCTION

Health care is a vital need for everyone. As an entity for delivering health services to the community, hospitals have become an important organization. Thus, the ability of hospitals to deliver health services has become an issue that cannot be ignored. The public certainly wants a health service that can meet their health needs, both physical and mental. Indonesians consider their hospital services to be poor. As a result, many Indonesians seek medical treatment abroad, for instance, Malaysia and Singapore. According to the Ministry of Health, every year, some 14,000 of Indonesians travel to Malaysia for medical treatment (Sulaeman, 2018).

Consumers use three attributes to judge a product: search, experience, and credential attributes (Zeithaml, 1981 in Lovelock & Wirtz, 2011). In assessing the quality of hospital services, consumers rely on experience and credential attributes. Someone who has been to another country for medical treatment may already be able to assess the quality of services. Coupled with supportive comments from relatives, friends, and acquaintances, the patient will become more confident with his/ her judgment. Credential factors also play an important role in encouraging people who have never consumed a service. For example, Mr. A's son

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was seriously sick and suggested by some of his friends to bring his son for treatment in Malaysia, so he did so. Because of the role of the credential factor, research on brand image is relevant to be conducted on hospital services.

The subject of brand image is not only scrutinized among consumers who have never consumed a product or service. This is particularly true especially in the context of medical tourism whereby brand image is still under-study by many of the empirical studies (Cham, Lim, & Aik, 2015; Cham, Lim, Aik & Tay, 2016). A person who has had an experience with a service will have a brand image perception that is different compared to perception before experiencing or consuming. Keller (1993) argues that brand image also includes user/usage imagery attributes. Berry (2000) adds that brand meaning is also influenced by the consumer's experience with the company. It is expected that brand image plays a significant role in influencing medical tourists' perception when selecting medical tourism destination.

Among all the countries in the South East Asia region, Malaysia is one of the favourite destinations of Indonesians in having medical treatment abroad. According to the minister of health, Nafsiah Mboi, there are at least 12,000 Indonesians seeking treatment in Malaysia (Candra, 2012). Indonesian patients have covered 60% of the private hospital market in Malaysia. The advantages of hospitals in Malaysia are quality services at an affordable price (Cham, Lim, Sia, Cheah, & Ting, 2020; Deeparechigi, Ridzuan, & Cham, 2018; Lim, Cham, & Sia, 2018; Wakhidah, 2013). In this sense, Malaysia is successful in developing its medical tourism.

With the background described earlier, it is necessary to study medical tourism and brand image of Indonesian hospital services in comparison with Malaysian hospitals. This study is useful to find out the weaknesses of hospital services in Indonesia compared to Malaysian hospitals. By knowing the strengths of Malaysian hospitals, Indonesian hospitals will have a better grounding on which direction or steps to improve the services provided. This study aims to discover the brand image of health practitioners and experts on hospital services in Indonesia compared to hospital services in Malaysia. Besides, this research also attempts to determine the causes of the weaknesses of hospital services in Indonesia.

The rest of this paper is as follows. The literature review section elaborates on a review of the medical tourism phenomenon and brand theory. The next section is about the methodology section detailing our approach to answer the research question. The result will be presented in both narrative and figure to summarize our findings. Finally, this paper shows the implications and offer future research direction on this topic.

LITERATURE REVIEW

Medical Tourism

International tourism is a foreign trade sector for a country. In some countries in the Southeast Asian region, tourism is an important economic sector (Cheng, Mansori, & Cham, 2014). Goldbach and West Jr. (2010) indicate that tourists no longer visit a country only to travel to a new destination, but also for the health motives due to better health services and facilities in the country of destination. The globalization of information and travel convenience in this era has triggered this trend. As a result, tourism activity is combined with health motives, resulting in the term medical tourism (Singh, 2014). Singh also indicates a

rising trend in medical tourism over the last few years, creating competition in this new domain. Babalan and Marano (2010) define medical tourism as traveling across the border for medical treatment. Nahrstedt (2004) and Connell (2006) indicate that medical tourism should not only cover wellness and preventive treatments but also on curing illnesses. Sandberg (2017) identifies three generic types of medical tourist, i.e.

(1) international medical tourist - originating from foreign or neighbouring countries,
(2) domestic medical tourist - originating from other areas within a country, and
(3) employer-sponsored medical tourist - originating from both domestic or foreign with a sponsor.

Singapore, Malaysia, and the Philippines, for instance, are some of the Asian countries that seek to attract medical tourists as a new income source of foreign exchange (Singh, 2014; Ormond, Moon & Khoon, 2014). Sandberg (2017) argues that a country can look for potential markets by building an excellent and modern health facility in strategic cities and tourist destinations. For example, Malaysia is recognized for its medical tourism activity, which has become a significant source of foreign exchange and contributed to economic advancement. The Government of Malaysia focuses its attention on medical tourism, especially in several popular and frequently visited regions close to neighbouring countries, such as Indonesia and Singapore. Ormond et al. (2014) indicate that two critical issues in Malaysian medical tourism are the participation of private entities in hospital investment and refinement in statistics of the revenue stream from medical tourists. Another example, Thailand enjoyed a 0.4% increase in its GDP from medical tourism. However, the high popularity of medical tourism has also resulted in a lack of competent labour. Hence, they have to import a high-quality workforce from abroad, which has caused increased service prices in both private and government hospitals. Government intervention was required to set rules and restrictions for medical tourism (NaRanong & NaRanong, 2011).

Thus, medical tourism can bring one country into a favourable or unfavourable position due to its ability (or inability) to manage the medical tourism phenomenon. A country needs to understand its potential. From such an understanding, the endowment should be developed and exploited to the country's best capacity. Furthermore, Sandberg (2017) argues that the development of medical tourism requires cooperation and coordination among institutions within a country. For instance, the government should establish good cooperation between the ministries of tourism and health. In this way, both the private and public sectors can supply tourism facilities and health infrastructure.

Brand Equity

Brand equity is a fundamental concept in marketing. Various marketing activities undertaken by the company boils down to one goal, namely, to create good brand equity. Keller (1993: p.8) defines brand equity as: "the differential effect of brand knowledge on consumer responses to brand marketing." This definition means that good brand equity makes consumers react differently (more positively) to the marketing activities of a product than products whose brand equity is worse or unbranded.

Brand equity is divided into several different components. Aaker (1991) divides brand equity into four components: brand awareness, perceived quality, brand associations, and brand loyalty. Another brand expert, Keller (1993), divides brand equity (knowledge) into two components: brand awareness and brand image. Although there are two distinct components

in the opinions of two brand experts, the real difference lies solely in one component: brand loyalty. The brand image component of Keller (1993) is defined broadly so that it also includes perceived quality from Aaker (1991). Thus, the difference in opinion between the two experts only exists in the component brand loyalty (Anselmsson, Johansson & Persson, 2007).

Brand Awareness

Brand awareness includes brand recognition and brand recall. Brand recognition is the ability of consumers to remember whether he/ she has known a brand. Brand recall is the ability of consumers to remember a brand when given cues about a product category (Keller, 1993). The importance of brand awareness lies in its ability to influence the strengths of brand associations created in the minds of consumers (Keller,1993). Thus, a consumer needs to realize or remember a brand well before developing any associations with the brand. For example, if a consumer cannot remember brand A, he or she may consider some associations of a product category to belong to brand A as well, although there are three different brands, A, B, and C exist in that product category. In other words, the consumer mistakenly assumes some association or trait as belonging to a brand because he/ she does not remember a brand well. For example, should such associations or traits be owned by brand B, not brand A.

Brand Image and Service Attribute

Experts give some definitions of brand image in marketing and brands. Aaker (1991) defines brand image as a set of existing brand associations in consumer perceptions. Keller (1993) describes brand image as a collection of meaningful memories of a brand. Kotler (2000) defines brand image as a collection of consumers' beliefs in one brand. In succinct, the brand image develops through a set of stimuli obtained by consumers. If the stimuli are perceived as unfavourable, then the image formed is more likely to be unfavourable. Consumers obtain the stimuli to assess service quality predominantly through experience and credential attributes (Zeithaml, 1981 in Lovelock & Wirtz, 2011). By consuming a service, some consumers will confidently judge the quality of service and thus affects the brand image created. Other consumers would rely on credentials, which is word of mouth reference given by others, to make an assessment that will eventually affect their perception of brand image.

The concept of brand image and credential attribute is relevant to this study because, as noted earlier, there is a set of negative memory of hospital services in Indonesia, especially when compared to hospital services in neighbouring countries. Hospital services in Indonesia are associated with slowness, bureaucracy, being unfriendly, and a considerable amount of other negative memories. Danes et al. (2010) argue that more famous brands tend to have more positive judgments than those of less popular/ inferior brands. In hospital situations in Indonesia, generally, the image is worse than hospitals from abroad. Although the concept of brand image from the consumers' point of view is vital for marketers, there is some difficulty found in using quantitative methods, such as the absence of a standard unit in measuring the effect of memory on brand image (Cham, Cheng, Low, & Cheok, 2020; Cham et al., 2016; Stern et al., 2001). Another difficulty in quantitative methods lies in measuring the non-verbal depth and sub-conscious perceptions of consumers regarding a brand (Supphellen, 2000). Against the background of this measurement difficulty, this study explores the brand image of hospital services based on the experience of its patients. This study will use a qualitative method to explore the strengths and weaknesses of the hospitals studied more profoundly and in more detail. Several findings from previous studies also serve as the basis

for this study; for example, Rindell et al. (2010) suggest the interdependence between past and present experiences in shaping brand image. Rindell et al. (2011) assert that the implementation and practical experience of using products will enrich the strength of a product/service brand.

RESEARCH METHOD

Brand image, as revealed by Supphellen (2000), lies in consumer perceptions that are difficult to measure reliably by standard behavioural measurement. In order to get a picture of the brand image in the minds of the consumers (patients), deep digging is necessary to determine their understanding of the hospital brands they are using. Patients' experience will be explored using an in-depth interview technique. Through the interviews, some experiences can arise, and those experiences are then collected and identified for later comparison between hospitals in Indonesia and Malaysia. Thus, the nature of this research is exploratory by using qualitative methods. The subjects of this study are four experts in the field of health in Indonesia.

The health experts interviewed in the study are as follows:
1. A former health department official from Palangka Raya and director of RSUD Kasongan (Kasongan District Hospital), Kalimantan Island
2. A representative from YLKI (Indonesia Consumer Association)
3. A former member of the Board of Indonesian Doctor Association
4. A representative of a private health insurance company

The questions posed are (1) Brand image of Malaysian hospital services compared to Indonesia, and (2) Problems that lead to unfavourable service in Indonesian hospitals. In general, the data analysis sequence in this study follows these five steps (Orford, 1992).
1. Collecting narrative data (text), which is the transcription of the interviews.
2. Elimination of data not relevant to the subject matter
3. Conducting a grouping of data.
4. Creating keywords that are relevant to the grouped themes.
5. Generalize themes based on interpreted keywords.

After performing steps 1-5, the next step is to compare the two results (for Malaysian and Indonesian hospitals) in one outcome space. The outcome space will indicate the difference (and similarity, if any) found in the brand image of hospital services in both countries. Moreover, how the brand embeds in the minds of patients.

In qualitative techniques, the issue of reliability manifests in adjusting between what is recorded and what actually happens on the ground (Moleong, 2001). This research will select some informants who have enough experience to be explored in the interview, and several examples will be asked so that the interviewer can see whether the questions' objectives are indeed in line with the examples given by the informants. The issue of validity in qualitative research, as pointed out by Moleong (2001), is the similarity between written data and the informant's intent. In each interview, the informant's answers will be confirmed by the interviewer to ensure their similarity. To avoid subjectivity during the analysis, we undertook some iterative discussions to confirm our shared understanding of the data group, keywords, and generalized theme. Hence, differences in opinion and understanding were resolved under the process, either by re-read the transcript or discussing the issue more thoroughly.

RESULTS AND DISCUSSIONS

Based on analysis of health experts' interviews, the categories of brand image appeared are as follows:

1. Certainty and accuracy of diagnosis
The informants studied revealed that Indonesian patients in Malaysia obtained a definite and appropriate diagnosis. A definite and precise diagnosis is an essential part of the treatment process because, with a precise diagnosis, a patient can get the right treatment. The factors that give support for the theme of definite diagnosis and appropriate are professional doctors, proper communication of the diagnosis, and complete equipment. Patients in Indonesia often get a late diagnosis and thus become limped out, and the disease worsens.

2. Comprehensive facilities
Medical devices available in Malaysian hospitals are perceived to be comprehensive, and the facilities available also provide comfort for the patient. Moreover, the informants revealed a rapid process as an image for Malaysian hospital services. Thus, what matters not only about the comprehensiveness of the devices, but more importantly, the rapid medical examination using the existing devices.

3. Affordable cost
The informants argue that the cost of medical treatment in Malaysia is cheaper, both for the use of test devices, treatments, and drugs. The complaint about Indonesian hospitals is the commercialization of health services. Private hospitals are charging a high cost for treatment in order to gain profit. Drugs are also expensive, which is caused by a wide variety of patent drugs. Another advantage of Malaysian hospitals is the certainty of cost.

4. Good service
Good service from Malaysian hospitals can be seen from various aspects: respect to the patient as a human or subject, total service, the certainty of consultation time, right doctor attitude, transparency, and aftercare services.

For example, informant 4 describes the certainty of consulting time:

> *..... then in Malaysia that if we want to visit the doctor the time is definite, so we come to make an appointment that at a specific time I come and the doctor is restraining, he/ she will not be overload if he/ she had a limit that a certain number of people come in the determined hours.*

Furthermore, informant 3 explains the importance of attitude: "Doctors can be differentiators not in terms of intelligence, but terms of attitude."
As for Indonesian hospital services, informants argue that the service culture in Indonesian hospitals is still weak, assuming that the hospital's duties are only to provide treatment and other relevant therapies.

5. Good communication
Informants indicate that communication in Malaysia is better than in Indonesia. Adequate consultation time supports good communication between doctors and patients, openness, and willingness to explain. For Indonesia, the obstacles to good communication are the inequality

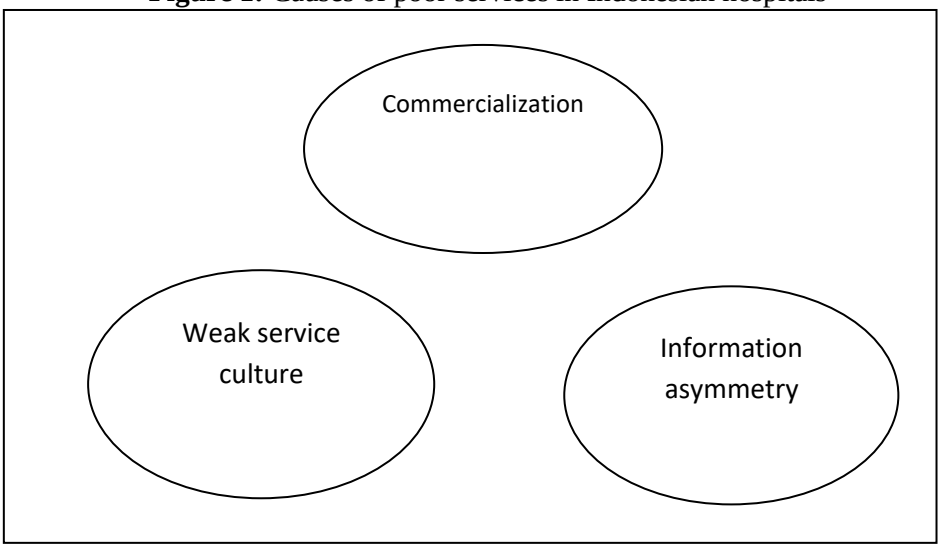
of status between the doctor and the patient, and the limited number of doctors makes the consultation time becomes restricted.

For example, informant 3 explains the communication of Malaysian doctors:

> *Yes, more open, more willing to communicate, explain more, and admits if he/ she did not know. Indonesian doctors are very rarely like that. It is what makes the patient dissatisfied and then cross-checks with a Singaporean doctor or a Malaysian doctor. When the Singaporean and Malaysian doctor's opinions differ, he/ she directly will think the Indonesian doctor is stupid. But not necessarily true.*

After further analysis, three fundamental problems can be identified as the causes of the weaknesses of Indonesian hospital service. See the figure below:

Figure 1: Causes of poor services in Indonesian hospitals



The explanations of the causes of poor services in Indonesian hospitals are as follows:

a. Commercialization.
Hospitals and other healthcare businesses have made patients as the object of making the most of their profits. Because of commercialization, the rights of patients often overlooked, such as the right for affordable treatments. For instance, informant 2 indicates that:

> *In addition to human rights, it is not ethical. If you want to pursue (profit), there are hotel business, mall, or cinema, or restaurant. It is indeed a sick person. People are sick. Because the doctor is professional, he must help, asked, or not. However, it is about the economic system, okay. There is the cost of all kinds. Nevertheless, do not let the commercialization of hospital services like that, even private (hospitals). Well, it happens to us.*

However, according to informant 1, hospital size, capability, and capacity may vary across Indonesia. This lead to the consequence that the level of hospital service and its accreditation index became critical success factors in the healthcare market. Having a high-level hospital service with an excellent accreditation will help the hospital sustain its business in the

healthcare industry. As a result, each hospital may have to find a way to equip itself with the necessary technology and equipment to pursue the level and accreditation index while also bringing up the commercialization issue.

b. Weak Service Culture

Service culture is an essential factor in delivering a good quality service. With a strong service culture, the organization will place the patient as the subject or the central point of the activities it undertakes. The strong service culture will result in the right service attitude. Actors in hospital services, such as hospital management, doctors, and nurses, need to have the right attitude to deliver good services. Based on strong service culture, Malaysian hospitals can provide good patient care. The service culture of the hospital in Indonesia can be observed from the following informant 1 comment:

> *Moreover, the service is not good, plus maybe its human resources are limited, well maybe culture for how to serve this is problematic. Today many employees work according to the usual, not according to what they should be. The righteous ones work according to what they should, not according to the usual ones. Because the usual can be wrong, but 'the should' cannot be wrong. Yeah, right, how about?*

Informant 1 explains that a good service culture is rooted in the motivation of service personnel to work on what should (or ideally) be, not what it usually is.

Informant 3 explains the importance of attitudes in the delivery of services to patients:

> *As the Malaysian doctor communicates with the patient openly and plainly explains what it is, it does not cover up, if asked to answer, even if the question is considered stupid. Because the patient is in a state of distress, that is asking for help. Much confidence in him, his beliefs, his understanding, so he is considered stupid. Do Indonesian doctors answer it well? That is also the problem, become the attitude.*

Hence, the core problem is not about the lacking of medical technology nor knowledge but the willingness to share the truthful situation to the patient or the families that could lead to weak service culture. Informant 2 also said that compassion should be cultivated far back to the medical school curriculum, emphasizing the social skill of being doctors as well as establishing their communication skills to their patients. It is necessary to equip the medical people with the ability to sell their knowledge and competence in a proper manner.

c. Information asymmetry.

Information asymmetry is defined as the patient's weakness from the physical and the information aspects as well as the general outlook in the community that a doctor's position is higher than a patient. This condition makes the patient hesitate to ask and the doctor feels it is not a problem if he/ she is unwilling to communicate well and clearly to the patient. To answer this problem, informants 2 suggested that doctors should actively empower patients:

> *Yes, because the condition of the patient may be..... anywhere, but especially in Indonesia, it is the condition of information asymmetry. It means we do not know..... the patient is in a weak condition right, weak in information, weak in physical. Well, it is a doctor's job for him to empower the consumer or his patient, so at least, say, for example, equal though not precisely.*

Furthermore, the analysis of interviews shows the source of the problems the Indonesian health industry faces concerning commercialization. See Figures 2 and 3 below. Figure 2 shows that low ethics and morality possessed by hospital managers, pharmaceutical entrepreneurs, and doctors have an impact on the commercialization of hospital service. Then, the ethics and morality of the actors of the health industry and commercialization simultaneously have an impact on poor hospital service in the sense that the services provided do not put patients as subjects, but rather as objects for exploitation. Also, hospital management's low ethics and morality could lead to hospital employees' bad service attitude, including the doctors, and then bring out bad hospital service. We infer that poor hospital service is reflected in the hospital governance system, aggressive pharmaceutical companies, and ineffective regulations, as summarized in Figure 3.

Figure 2: The Level of Actors in the Health Industry

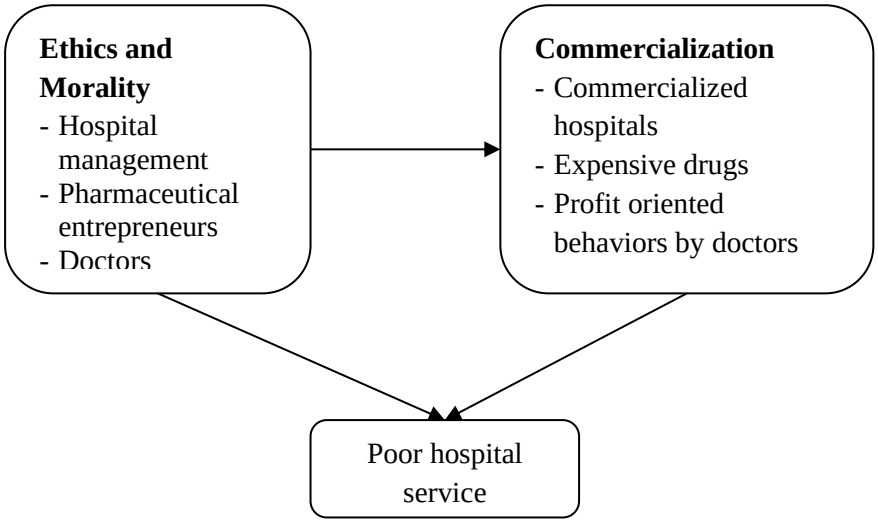


Figure 3: The Level of Higher Institution

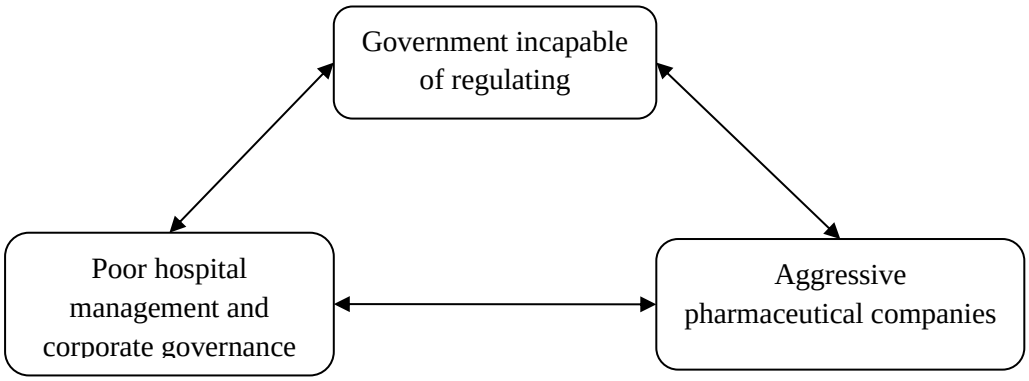


Figure 3 shows the management of hospitals, pharmaceutical companies, and the government as the 3 parties that help create a poor hospital service in Indonesia. Hospitals in Malaysia received positive word of mouth in the community. This is confirmed in this study. Interviews also showed that informants acquired a good brand meaning after they

experienced treatment in Malaysian hospitals. In contrast, the informants revealed a negative brand image and brand meaning of Indonesian hospital service.

To rectify the problems in the Indonesian health sector, there is a need to get the attention of all parties. Reformations can amend the problems in Indonesian hospital services in three central institutions, namely government, hospital management, and pharmaceutical companies. The government has implemented the National Health Insurance program from BPJS (Social Security Administrator Agency). Although not yet perfect, in addition to improving the access of poor citizen to hospital services, National Health Insurance has positive impacts in the form of standardization of medical treatment, service pricing, and enforcement of the reference system (patients should be screened first by a general practitioner before going to a specialist). Other reforms that will be made by the government, hospital management, and pharmaceutical companies should be able to improve the service of Indonesian hospitals.

MANAGERIAL IMPLICATIONS

The brand image of hospital service quality is 'reflected' by business actors and organizations inside it. To improve hospital service in Indonesia, change is needed not only by individuals, such as a doctor but also by all involved. The problem faced is a systemic one. Support from the government to the doctors, such as in the form of scholarships, can assist in developing skills, as well as the spirit of service. Doctors who are skillful and willing to devote themselves to society will, in turn, create a good service to the patients. Thus, whatever conducted on a component or actor in the health industry can influence other components or actors. There is a need for change in mentality and working method among all the actors involved, namely hospital management, doctors, nurses, pharmaceutical entrepreneurs, government, and patients themselves.

In addition to above, this study also offers a preventive action to be taken by a medical and nursing school in Indonesia. It is time to insert social skill lessons into the health education curriculum with an emphasis on practical exercises. Arguably, these skills will enhance their ability to communicate with the patients when they are in the hospital.

FUTURE RESEARCH DIRECTIONS

Future research should be conducted to confirm the result of the current study using a quantitative methodology. Future research may attempt to confirm the influence of a nation's hospital brand image on the visit intention of other nationalities. For the nation which is still lacking behind in its healthcare service, future research can be directed at brand image of hospital service and its impact on patients' trust and intention to use. Future research may also be directed at confirming the problems of the Indonesian healthcare system and how to rectify the problems. In terms of research format, we suggest an action research approach for doing further study. Since the problems mainly come from the implementation of a governance system from downstream (school or university) to upstream (hospital and pharmacy), the action research approach is ideal to be undertaken. The researcher can collaborate with all parties involved, such as in designing curriculum with universities, imposing good governance system with hospital management, starting from the recruitment

process, developing operation procedures, and developing a code of conduct (or code of ethics). All in all, the results can also be utilized as feedback to all parties involved.

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