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Factors Associated with Healthcare Providers' Readiness for Health Tourism in Bali, Indonesia: A Cross-Sectional Study

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Abstract

***Background**: Health tourism requires healthcare facilities and professionals to meet high-quality and internationally oriented service standards. However, evidence regarding healthcare providers' readiness to support health tourism remains limited. This study aimed to identify factors associated with healthcare providers' readiness for health tourism in Bali, Indonesia.*

***Method:** This study used a cross-sectional design involving 208 healthcare providers in Bali Province. Participants were recruited using non-probability consecutive sampling. Data were collected using an online questionnaire from June to July 2025. Univariate analysis was conducted using frequencies and proportions, bivariate analysis using the chi-square test, and multivariable analysis using binary logistic regression. Adjusted Odds Ratios (AORs) with 95% confidence intervals (CIs) were reported.*

***Results**: Of the 208 respondents, the majority (63%) demonstrated high readiness for health tourism in Bali, while 37% demonstrated fair readiness. Multivariable analysis showed that workplace [AOR = 2.85; 95% CI: 1.16–6.99; p = 0.022], educational level (AOR = 2.19; 95% CI: 1.066–4.51; p = 0.034), length of work (AOR = 0.49; 95% CI: 0.27–0.93; p = 0.029), and attitude towards health tourism (AOR = 5.21; 95% CI: 2.41–11.29; p < 0.001) were independently associated with high readiness.*

***Conclusion:** Although the majority of healthcare providers showed high readiness, a considerable proportion remain inadequately prepared. Workplace, educational level, length of work, and particularly attitude were independently associated with high readiness, with attitude showing the stronges associaton. These findings underscore the importance of behavioral and motivational aspects, indicating that policymakers and healthcare managers should strengthen both organizational support and targeted training to strengthen readiness for health tourism services.*

***Keywords**: Healthcare providers, Health tourism, Readiness*

INTRODUCTION

Health tourism has become a growing global phenomenon characterized by cross-border travel to obtain medical services. As a subset of the tourism industry, medical tourism contributes not only to healthcare delivery but also to national economic growth and international competitiveness.[1,2] Several Southeast Asian countries, including Malaysia, Singapore, and Thailand, have successfully positioned themselves as leading medical tourism destinations through strong government commitment, well-developed infrastructure, and skilled healthcare professionals.[3] Malaysia, in particular, has demonstrated significant progress in developing its medical tourism sector. The country offers comprehensive healthcare facilities, internationally trained specialists, advanced medical technologies, transparent administrative systems, and strong governmental and institutional support through coordinated medical tourism councils.[4,5] In addition, Malaysia strategically utilizes demographic and market data to strengthen its competitiveness in attracting international patients.[1] Consequently, Malaysia has emerged as one of the major tourism destinations, especially for Indonesians who seek

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healthcare services abroad. Indonesia is known for its rich natural resources, cultyral diversity, and range of traditional and modern healthcare services. The country has considerable potential to develop the medical tourism sector as part of its economic development and public service strategies. The Indonesian government has identified medical tourism as a national strategic agenda; however, challenges remain in its implementation, particularly regarding human resource readiness.[6] Healthcare providers play a central role in delivering safe, high-quality, and culturally competent services, making their readiness a critical determinant in the successful development of health tourism.[7,8]

A considerable number of Indonesian patients, particularly from higher socioeconomic groups, continue to seek healthcare services abroad, especially in Malaysia. This trend has been associated with perceptions of differences in service satisfaction and quality. Administrative inefficiencies, limited availability of specialists, and concerns about transparency have also been recognized as contributing factors.[4] Access to quality healthcare services, affordable prices, and shared cultural and linguistic characteristics have encouraged many Indonesians to choose Malaysia as a medical tourism destination.[2,5] Some evidence suggests that more than 60% of Malaysia's foreign medical tourists originate from Indonesia, with annual growth rates of 12–18%.[9,10] This trend reflects not only patterns of patient mobility but also potential economic implications for Indonesia.

In Indonesia, Bali Province is a famous global tourism destination. Its international reputation, established tourism infrastructure, and multicultural environment provide a strategic opportunity for the development of health tourism. However, several challenges remain, particularly regarding the readiness of healthcare providers.[11] Previous studies have shown that healthcare provider readiness is influenced by both internal and external factors. Internal factors include foreign language proficiency, communication skills, cultural competence, knowledge of health tourism, and the ability to provide patient-centered care for international patients. Meanwhile, external factors include healthcare infrastructure, institutional support, government policies, international accreditation, intersectoral collaboration between the healthcare and tourism sectors, and the availability of training programs and technological support. In Bali, disparities in English proficiency, limited understanding of health tourism concepts, and insufficient readiness to meet international service standards may hinder the optimal development of health tourism services.[12,13]

Previous studies have reported that healthcare professionals, particularly nurses, demonstrate limited knowledge and awareness of health tourism practices and require further capacity development.[14,15] Although these studies highlight important concerns, empirical evidence examining the factors associated with healthcare providers' readiness for health tourism, particularly in Bali, remains limited. The existing literature tends to focus on policy discourse and infrastructure development rather than systematically assessing workforce preparedness as a determinant of health tourism competitiveness.[16] This gap underscores the need for context-specific research in emerging medical tourism destinations. Understanding healthcare providers' readiness is crucial because knowledge, attitudes, clinical competencies, cross-cultural communication skills, and familiarity with international standards may contribute to the quality of healthcare services and the competitiveness of health tourism destinations. Therefore, adequate human resource readiness is essential alongside investments in infrastructure and policy reform to support the sustainable development of health tourism.[3,17] Hence, this study was conducted to analyze the factors associated with healthcare providers' readiness for health tourism in Bali, Indonesia. By providing empirical evidence on workforce preparedness in an emerging destination, this research seeks to contribute to the literature on health tourism development and inform policy strategies for strengthening Indonesia's competitiveness in the regional health tourism market.

METHOD

Study Design and Participant

This study used a cross-sectional design to identify factors associated with healthcare providers' readiness for health tourism. The study was conducted in Bali Province, specifically in Badung Regency and Denpasar City. These areas recorded the highest numbers of international tourist visits, making them highly relevant to the development of health tourism. The study population consisted of healthcare providers, including medical doctors, nurses, midwives, and other licensed health professionals working in hospitals, clinics, and primary healthcare centers in the selected areas.

Based on data from local health authorities, the total study population was approximately 11,591 healthcare providers. The sample size was calculated using Daniel's sample size formula, yielding a required sample of 208 participants. The inclusion criteria were actively working in a healthcare facility, having at least 2 years of professional experience, and being willing to participate in the study. A minimum of 2 years of experience was required to ensure adequate exposure to healthcare service delivery and potential interaction with international patients.

Respondents were recruited using consecutive sampling. All eligible healthcare providers who were approached during the data collection period (June–July 2025) were invited to participate until the required sample size was achieved. The online questionnaire link was distributed through healthcare facility administrators and professional networks. Only complete responses were included in the final data analysis.

Measurements and Procedure

Data were collected using a structured, self-administered online questionnaire distributed to healthcare providers working in health facilities in Badung Regency and Denpasar City. The instrument consisted of four sections: (1) respondent characteristics (age, gender, profession, highest educational level, workplace, length of service, and foreign language proficiency); (2) readiness for health tourism, consisting of 10 questions with answer choices of very ready, ready, unsure, not ready, and very not ready; (3) knowledge about health tourism, consisting of 10 questions with answer choices of true, false, and do not know; and (4) attitudes toward health tourism, consisting of 10 questions with response options based on a Likert scale ranging from strongly agree to strongly disagree.

The questionnaire was developed based on a review of relevant literature and previously validated instruments. Several experts in public health and health services management assessed its face validity. A pilot test was conducted among 30 healthcare providers to assess the reliability of the instrument. Cronbach's alpha coefficient of ≥0.70 was obtained, indicating acceptable internal consistency. Readiness, knowledge, and attitude scores were categorized into three levels. The variables were categorized using Bloom's cutoff points as follows: high/good (80–100%), moderate/fair (60–79%), and low/poor (<60%).

Statistical Analysis

Descriptive statistics, including frequency and proportion, were used for univariate analysis. Bivariate analysis was performed using the chi-square test to assess the associations between independent variables and readiness for health tourism. Variables with p-values <0.25 in the bivariate analysis were included in the multivariable model. Binary logistic regression analysis was conducted to identify factors independently associated with readiness. Adjusted odds ratios (AORs) with 95% confidence intervals (CIs) were reported. Statistical significance was set at $p < 0.05$. Multicollinearity was assessed using variance inflation factors (VIFs), with VIF <10 indicating no significant multicollinearity. Model fit was evaluated using the Hosmer–Lemeshow goodness-of-fit test and Nagelkerke R^2.

RESULT

A total of 208 healthcare providers participated in this study. Most respondents were female nurses working in hospitals, aged over 30, holding a bachelor's degree, and with more than 10 years of work experience. The majority also reported proficiency in English. Of the 208 healthcare providers, 63% had high readiness for health tourism, while the remaining 37% had fair readiness. Figure 1 presents a pie chart showing the readiness of healthcare providers for health tourism.

Table 2 shows the associations between respondent characteristics and readiness for health tourism. Regarding age, respondents aged ≤30 or >30 years had similar proportions of high readiness, with no significant association between age and health tourism readiness ($p = 0.096$). Similarly, no significant associations were observed between health tourism readiness and gender ($p = 0.062$), educational level ($p = 0.062$), or profession ($p = 0.187$).

Regarding workplace, most respondents had high readiness for health tourism, but those who worked in hospitals had a lower proportion of high readiness than those working outside hospitals. Workplace was significantly associated with health tourism readiness ($p = 0.010$). Respondents with ≤10 years of service had a higher proportion of high readiness than those with >10 years of service. The

length of service was significantly associated with health tourism readiness (p = 0.010). Regarding foreign language proficiency, respondents who were proficient in English had a higher proportion of high readiness than those who were proficient in languages other than English. There was a significant association between foreign language proficiency and health tourism readiness (p = 0.014).

Table 1. Characteristics of Respondents

Characteristics	Frequency (n)	Percentage (%)
Age (years)		
≤30	62	29.8
>30	146	70.2
Gender		
Male	63	30.3
Female	145	69.7
Education		
Diploma	45	21.6
Bachelor degree	149	71.6
Master degree	14	6.7
Profession		
Nurses	151	72.6
Doctors	22	10.6
Midwifery	21	10.1
Others	14	6.7
Work place		
Hospitals	164	78.9
Others	44	21.1
Foreign languages mastered		
English	127	80.3
Others	41	19.7
Length of Work (years)		
≤10	201	47.9
>10	219	52.1

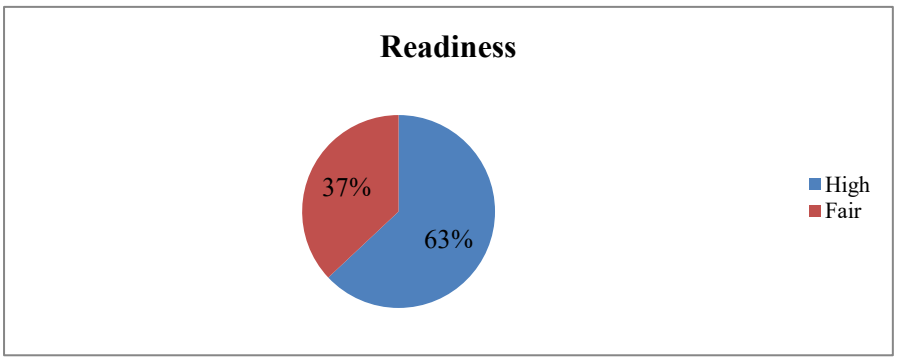


Figure 1. Healthcare Providers' Readiness for Health Tourism in Bali, Indonesia

Knowledge was not significantly associated with health tourism readiness (p = 0.909), with respondents in the poor/moderate and good knowledge categories showing similar proportions of high readiness. In contrast, respondents with a good attitude toward health tourism had a substantially higher proportion of high readiness than those with a sufficient attitude. Attitude was significantly associated with health tourism readiness (p <0.001).

Table 3 shows the result of multivariable logistic regression analysis. Four variables were independently associated with health tourism readiness. Respondents who worked outside hospitals had higher odds of high health tourism readiness than those who worked in hospitals (OR = 2.85; 95% CI: 1.16–6.99; p = 0.022).

Table 2. Associations of Characteristics of Respondents, Knowledge, and Attitudes with Healthcare Providers' Readiness for Health Tourism in Bali, Indonesia

Variable	Readiness for Health Tourism				OR (95% CI)	P-value
	Fair		High			
	n	%	n	%		
Age (years)						
≤30	17	27.4	45	72.6	0.541	0.062
>30	60	41.1	86	58.9		
Gender						
Male	18	28.6	45	71.4	0.583	0.096
Female	59	40.7	86	59.3		
Education						
Diploma	22	48.9	23	51.1	1.878	0.062
Bachelor's/Master's degree	55	33.7	108	66.3		
Profession						
Nurses	60	39.7	91	60.3	1.551	0.187
Others	17	29.8	40	70.2		
Work place						
Hospitals	68	41.5	96	58.5	2.755	0.010
Others	9	20.5	35	79.5		
Length of work (years)						
≤10	28	28.0	72	72.0		
>10	49	45.4	59	54.6	0.468	0.010
Foreign languages mastered						
English	55	32.9	112	67.1	0.424	0.014
Others	22	53.7	19	46.3		
Knowledge						
Poor/moderate	61	36.3	107	63.7	0.855	0.664
Good	16	40.0	24	60.0		
Attitude						
Fair	27	69.2	12	30.8	5.355	<0.001*
Good	50	29.6	119	70.4		

* Significance: α<0.05

Table 3. Model of Factors Associated with Healthcare Providers' Readiness for Health Tourism in Bali, Indonesia

Variable	B	Standard Error	P-value	Adjusted OR	95% CI	
					Lower	Upper
Work place	1.048	0.458	0.022	2.85	1.162	6.994
Education	0.783	0.370	0.034	2.19	1.060	4.515
Length of work	-0.699	0.320	0.029	0.49	0.266	0.931
Attitude	1.651	0.394	<0.001	5.21	2.407	11.290

Respondents with a bachelor's or master's degree had higher odds of high health tourism readiness than those with a diploma. There was a significant relationship between education and health tourism readiness (OR = 2.19; 95% CI: 1.066–4.51; p = 0.034). Respondents with >10 years of work experience had lower odds of high health tourism readiness than those with ≤10 years of work experience (AOR = 0.49; 95% CI: 0.27–0.93; p = 0.029). Finally, respondents with a good attitude towards health tourism had higher odds of high health tourism readiness than those with a fair attitude (AOR = 5.21; 95% CI: 2.41–11.29; p < 0.001).

DISCUSSION

This study revealed that 63% of healthcare providers in Bali Province demonstrated a high level of readiness for health tourism, while 37% demonstrated a fair level of readiness. Although the majority of healthcare providers showed a high level or readiness, the proportion with fair readiness indicates that gaps in preparedness remain. Regarding health tourism, limited readiness may affect service consistency and competitiveness, as international patients expect not only clinical excellence but also

seamless service experiences. Successful implementation of health tourism requires comprehensive preparedness, since service quality depends substantially on the quality and capacity of the healthcare workforce. Readiness extends beyond clinical competence to include cross-cultural communication, proficiency in foreign language, particularly English as a widely used international language, and coordinated teamwork among doctors, nurses, midwives, pharmacists, and other healthcare professionals.[11]

Knowledge is considered a fundamental component of the Knowledge-Attitude-Practice (KAP) framework, which suggests that adequate knowledge may contribute to the development of attitudes and subsequent professional practice. In the context of health tourism, knowledge encompasses an understanding of travel to various destinations to improve mental, physical, and spiritual well-being through medical and wellness activities.[18] Meanwhile, previous studies have reported varying levels of knowledge regarding health tourism among healthcare providers, ranging from 38% demonstrating good understanding in one study[19] to approximately 73% in another.[14] These discrepancies may reflect variation in institutional exposure, training opportunities, and integration of health tourism-related content into professional curricula. In addition, limited knowledge among tourists regarding preventive vaccination, insect-bite prevention, and food safety[20] underscores the potential role of healthcare providers in delivering accurate health education and evidence-based counseling. Hence, strengthening and improving knowledge through structured training and continuing professional development may support the provision of safe and competitive health tourism services.

However, in this study, knowledge was not significantly associated with healthcare providers' readiness for health tourism in Bali. This finding suggests that knowledge alone may not be sufficient to develop operational readiness for health tourism services. Although healthcare providers may understand the basic concepts of health tourism, they may have limited practical experience in serving international patients, applying international service standards, or participating in health tourism programs. Readiness for health tourism may also be influenced by organizational and systemic factors, such as institutional support, the availability of standard operating procedures, international accreditation, foreign language training, managerial commitment, and healthcare infrastructure. In Bali, where health tourism implementation is still developing, healthcare providers may possess adequate theoretical knowledge without necessarily feeling fully prepared to apply such knowledge in real practice settings. Therefore, readiness should be considered a multidimensional construct that involves individual competencies, organizational preparedness, and broader healthcare system support.

In this study, four variables were independently associated with readiness: workplace, education level, length of service, and attitude. Healthcare providers working in hospitals had lower odds of high readiness than those working outside hospital settings. This finding may reflect the organizational complexity and bureaucratic structure of hospitals, where heavy workloads and rigid administrative systems may limit flexibility and innovation in health tourism services. In contrast, non-hospital facilities may have more adaptable service models that align with hospitality-oriented care. However, these explanations should be interpreted cautiously because organizational characteristics were not directly assessed in this study.

Education level was also independently associated with readiness, with healthcare providers holding bachelor's or master's degrees having higher odds of high readiness than diploma graduates. Higher educational attainment may be associated with greater exposure to critical thinking, international standards, and accreditation systems, which may be relevant to healthcare delivery in international service markets. Similarly, healthcare providers with less than 10 years of service had higher odds of high readiness than those with more than 10 years of service. This may indicate that more recently trained professionals are more adaptive to emerging concepts such as health tourism, digital healthcare systems, and patient-centered care models. However, the cross-sectional design does not allow these explanations to be interpreted as causal mechanisms.

Attitude was strongly associated with readiness. Healthcare providers with good attitudes toward health tourism had higher odds of high readiness than those with fair attitudes. This finding is consistent with behavioral theories suggesting that attitudes are related to motivation and willingness to adopt new practices.[18] Positive perceptions of health tourism may be associated with greater engagement, openness to service innovation, and commitment to quality improvement. However, because attitude and readiness were assessed concurrently, the direction of this association cannot be established.

From an international perspective, several countries in Southeast and South Asia, including Singapore, Malaysia, Thailand, and India, have demonstrated strong competitiveness in health tourism sectors. These countries attract international patients through combinations of high-quality and relatively affordable healthcare services, shorter waiting times, established accreditation systems, and well-established international promotion strategies.[4,6,21] Compared with these countries, Indonesia continues to face challenges in infrastructure readiness, international accreditation coverage, foreign language proficiency, especially English, regulatory harmonization, and cross-sector collaboration.[7,22] Although Indonesia is a major international tourism destination, strengthening institutional preparedness and professional competence may be necessary to translate this tourism advantage into a more competitive health tourism sector.

Previous studies have identified critical factors influencing patients' decisions regarding medical travel, including service quality, accreditation status, staff expertise, transparent cost structures, patient safety, and reduced waiting times.[21,23,24] Barriers such as limited foreign language skills, communication challenges, regulatory constraints, and insufficient promotion.[22,24] Further emphasize that readiness is not solely an individual attribute but may also be shaped by broader policy and governance conditions.

In terms of policy implications, these findings suggest the need for structured capacity-building programs, the integration of health tourism into health professional education curricula, and the expansion of certification, accreditation, and standardized service protocols. Regulation, standardization, and certification[25,26] should be prioritized because they can strengthen healthcare providers' readiness by improving service quality, clarifying professional roles, enhancing competency standards, and increasing confidence in delivering services to international patients. Standardized protocols and accreditation systems may also help healthcare providers better understand international service expectations and operational procedures in health tourism settings. Furthermore, intersectoral collaboration among health authorities, tourism agencies, immigration services, and the transportation sector is essential to support healthcare providers' readiness through integrated service coordination, smoother patient mobility, and the development of a comprehensive health tourism ecosystem.

Although most healthcare providers in Bali exhibit a high level of readiness, notable gaps remain. A multifaceted approach incorporating institutional transformation, supportive public policy, and human capacity building may be needed to close these disparities. In addition to improving service quality, strengthening healthcare workforce readiness is crucial for bolstering Indonesia's standing in the increasingly competitive global health tourism sector.

Strengths and Limitations of the Study

This study employed a cross-sectional design, enabling an efficient assessment of factors associated with healthcare providers' readiness for health tourism; however, causal relationships could not be established. A major strength of this study was the inclusion of diverse healthcare professionals from various healthcare settings, providing a broader perspective on readiness for health tourism in Bali. However, the use of non-probability sampling may have introduced selection bias and limited the representativeness and generalizability of the findings. In addition, data were collected using self-administered questionnaires, which may have introduced information bias, recall bias, and social desirability bias. Since the study was conducted only in Badung Regency and Denpasar City, the findings may not be generalizable to healthcare providers' readiness in other regions with different healthcare systems and tourism characteristics. Despite these limitations, the study provides important preliminary evidence regarding healthcare providers' readiness for health tourism and factors associated with it in Bali.

CONCLUSION

Most healthcare providers in Bali demonstrated a high level of readiness for health tourism. Workplace, educational level, length of service, and attitudes were independently associated with readiness, with attitude showing the strongest association. These findings suggest that strengthening health tourism in Bali should include targeted strategies to enhance healthcare workforce preparedness. Policymakers and healthcare facilities should implement structured training on international service standards and cross-cultural competencies, foster supportive organizational environments, and integrate health tourism-related competencies into professional education and training. Particular attention should be directed toward hospital-based healthcare providers and those with less favorable attitudes

towards health tourism. Future qualitative or mixed-method studies are recommended to explore the cultural, organizational, and contextual factors underlying healthcare providers' readiness for health tourism in greater depth.

ETHICS APPROVAL

Ethical approval was obtained from the ITEKES Bali Ethics Commission (Ethical Clearance No. 04.186.1/KEPITEKES-BALI/VI/2025). Electronic informed consent was obtained from all participants before completing the questionnaire. Participation was voluntary, and data confidentiality and anonymity were strictly maintained.

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COMPETING INTEREST

The authors declare no conflicts of interest related to this study.

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UNDERLYING DATA

The underlying data cannot be publicly shared due to ethical and confidentiality considerations. However, anonymized data may be available from the corresponding author upon reasonable request, subject to ethical approval.

DECLARATION OF ARTIFICIAL INTELLIGENCE USE

During the preparation of this manuscript, the author used an AI-assisted tool solely for language refinement, including spelling correction and improvements to sentence structure and clarity.

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