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Collaborative Governance in Medical Tourism Development Policy: A Document-Based Policy Analysis of Bali International Hospital in the Sanur Special Economic Zone

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ABSTRACT

Medical tourism has become a strategic policy that integrates healthcare, tourism, and investment to promote economic growth and public value. Indonesia has established the Sanur Special Economic Zone (SEZ) — inaugurated in June 2025 with Bali International Hospital (BIH) as its anchor — as its first health SEZ, a response to the substantial outflow of citizens seeking treatment abroad, estimated by the government at around USD 11.5 billion (≈ Rp 180 trillion) annually. This study analyses collaborative governance in the medical tourism development policy of the Sanur SEZ, identifies the factors that shape cross-sector collaboration, and proposes a conceptual model for sustainable development. Using a qualitative, document-based policy analysis, the study synthesises government regulations, official reports, and peer-reviewed literature through the Collaborative Governance Regime (CGR) framework of Emerson, Nabatchi, and Balogh, integrated with Moore's Public Value Theory and situated within cross-sector and network-governance scholarship. The analysis proposes that collaborative leadership, institutional capacity, regulatory support, and stakeholder coordination are the conditions most likely to enable effective implementation, and that collaboration among government, state-owned enterprises, private investors, healthcare providers, academia, and communities can advance healthcare quality, destination competitiveness, and economic benefit only when its gains are equitably distributed and the two-tier risks characteristic of medical tourism are actively managed. The study contributes the Medical Tourism Collaborative Value Network (MTCVN), a conceptual model that positions public value creation as the proposed mediating mechanism linking collaborative governance to sustainable medical tourism development, together with six testable propositions and policy recommendations for Indonesia's medical tourism ecosystem.

Keywords:
Public Value; Medical Tourism; Bali International Hospital; Collaborative Governance; Healthcare Governance; Special Economic Zone

A. INTRODUCTION

Tourism is a strategic sector that contributes to economic growth, employment, foreign-exchange earnings, and regional development. Over the past decade the paradigm of tourism development has shifted from maximising arrivals (mass tourism) towards improving destination quality (quality tourism) — an approach that emphasises service quality, sustainability, innovation, and the creation of added value for society and the economy. One expression of this paradigm is medical tourism, the practice of travelling across borders to obtain medical treatment, which integrates health services with tourism to strengthen destination competitiveness while supporting the national health-service system (Connell, 2011; Hildayanti et al., 2025). Following Connell (2011, 2013), this study treats "medical tourism" as travel undertaken primarily to receive medical treatment, distinguishing it from the broader categories of health and wellness tourism.

The global medical tourism market has expanded rapidly, and Southeast Asia has become one of its most competitive arenas. Thailand, Singapore, Malaysia, and India have built mature ecosystems through improved service quality, international hospital accreditation, medical-technology investment, active destination marketing, and with close coordination between government, the private sector, and healthcare institutions (Ganguli & Ebrahim, 2017; Pocock & Phua, 2011). The comparative evidence indicates that a destination's success depends not only on clinical quality but also on the effectiveness of cross-sector governance that aligns competing interests within a single development ecosystem. Where that governance is weak, the same industry can strain the domestic health system rather than strengthen it. This is a tension that has shaped the policy debate in every established destination in the region (Pocock & Phua, 2011).

For a late entrant, this competitive context is doubly consequential. Indonesia is not creating a market but contesting one already served by regional incumbents with two decades' lead in accreditation, specialist depth, and international patient services (Ganguli & Ebrahim, 2017). Catching up therefore depends less on any single hospital than on whether the state can orchestrate a whole ecosystem (regulation, workforce, financing, and promotion), quickly and coherently. This is precisely the governance problem that collaborative and network theory address, and it is why the Sanur SEZ is best analysed not as an infrastructure project but as a test of Indonesia's capacity for cross-sector coordination in a contested regional market.

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For Indonesia, developing medical tourism has become a national priority driven by a large and persistent outflow of patients. The Indonesian government estimated that the country loses approximately USD 11.5 billion (≈ Rp 180 trillion) each year to citizens seeking treatment abroad. A scoping review by Asa et al. (2024) attributes the outflow to the perceived availability of specialist services, higher service quality, competitive pricing, and limited trust in some domestic providers. In response, the government designated the Sanur SEZ — a 41.26-hectare zone attracting roughly Rp 3.7 trillion in investment and projected to generate some 43,647 jobs — as the country's first health SEZ, anchored by Bali International Hospital (BIH), which was inaugurated in June 2025 and is intended to become an international-standard centre capable of retaining domestic patients and attracting foreign ones (Peraturan Pemerintah No. 41/2022; Sanur SEZ Management Agency, 2024).

The choice of Bali, and of Sanur specifically, is not incidental to the policy logic. Bali is Indonesia's most internationally connected destination, with established air links, hospitality capacity, and global brand recognition. Notably, assets that lower the cost of assembling a medical tourism ecosystem and that a health SEZ can convert into clinical demand. Locating the country's first health SEZ in an established tourism hub reflects a deliberate strategy of building medical tourism on existing tourism linkages rather than from a standing start (Connell, 2013), while concentrating the coordination challenge in a single, high-visibility site whose success or failure will be closely observed and will shape the national roll-out of further health SEZs.

The development of the Sanur SEZ is a multidimensional policy involving the central government, local governments, state-owned enterprises (SOEs), the private sector, international health institutions, academia, professional organisations, and local communities. The complexity of these relationships demands collaborative governance that fosters coordination, trust, role allocation, and shared decision-making (Ansell & Gash, 2008; Bryson et al., 2006; Emerson et al., 2012). Collaborative governance is therefore an appropriate lens for explaining how cross-sector processes can improve the implementation of medical tourism policy and, equally, for diagnosing where those processes may fail. Yet the effectiveness of collaboration cannot be assessed in a vacuum: it must be judged against the public value it produces (Moore, 1995), a criterion that is especially demanding in a sector where private investment and public-service obligations can pull in opposite directions.

Prior scholarship establishes two relevant strands that rarely meet. In the tourism-governance literature, studies of Indonesian destinations, mostly on community-based tourism villages (Matthoriq et al., 2021) to the Mandalika SEZ (Imran & Wijaya, 2025) show that success turns on stakeholder synergy, community involvement, capacity building, and adaptive regulation. In the medical tourism literature, destination-country analyses (Pocock & Phua, 2011; Supriadi et al., 2024) demonstrate that governance, financing, delivery, regulation, and health-workforce capacity jointly determine whether a health-export strategy strengthens or strains the domestic system. What is missing is an integrated treatment that connects the collaborative process to the public value it is meant to create in the specific context of a health SEZ.

Against this background, three gaps motivate the study. First, collaborative-governance research in Indonesia remains concentrated on tourism villages, smart governance, and conventional destination development, with very little attention to health SEZs as medical tourism destinations. Second, existing work tends to describe the collaboration process without linking it to public value. This is the ultimate test of a public policy's success. Third, no study has integrated the Collaborative Governance Regime (CGR) with a Public Value perspective to analyse a flagship case such as BIH within the Sanur SEZ. Addressing these gaps, the study asks: how is collaborative governance being constituted in the Sanur SEZ; which factors condition its effectiveness; and how does it translate into public value?

The study makes three contributions. It extends the CGR to the under-examined context of health-SEZ medical tourism; it integrates Public Value Theory to specify what collaboration is ultimately for; and it proposes the Medical Tourism Collaborative Value Network (MTCVN). It is a conceptual model, accompanied by six testable propositions, that positions public value creation as the mechanism linking collaboration to sustainable development. Accordingly, the objectives are: (1) to analyse the constitution of collaborative governance in the Sanur SEZ; (2) to identify the factors that condition cross-sector collaboration; and (3) to formulate the MTCVN as a public-value-based framework and policy guide. The remainder of the paper reviews the theoretical and empirical literature, sets out the document-based method, presents the analysis, develops the MTCVN and its propositions, discusses implications for theory, practice, teaching, policy, and society, and concludes.

B. LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Collaborative governance and the Collaborative Governance Regime

Collaborative governance describes arrangements in which public agencies engage non-state actors in collective, consensus-oriented decision-making to address problems that no single organisation can resolve alone (Ansell & Gash, 2008). Ansell and Gash (2008) show that such arrangements are shaped by starting conditions (resource and power asymmetries, incentives, prior history), by facilitative

leadership and institutional design, and by an iterative collaborative process of face-to-face dialogue, trust-building, commitment, and shared understanding. Bryson et al. (2006; 2015) extend this into a propositional inventory of cross-sector collaboration, emphasising that initial agreement on the problem, sponsorship and championing, formal and informal governance structures, and explicit attention to accountability and to the tensions between partners are decisive for whether collaboration produces public value rather than gridlock.

Emerson et al. (2012) synthesise this scholarship into the Collaborative Governance Regime (CGR). It is a broader system context that generates drivers of collaboration (leadership, consequential incentives, interdependence, and uncertainty). These set in motion collaboration dynamics comprising the interacting components of principled engagement, shared motivation, and capacity for joint action; and these dynamics produce collaborative actions and, ultimately, outcomes and adaptation. Two clarifications are essential for the present study. First, principled engagement, shared motivation, and capacity for joint action are the three interacting components of collaboration dynamics, not a sequence of parallel stages; treating them as a checklist is a common misreading that flattens the framework. Second, outcomes are the point of the regime, not an afterthought — the CGR is explicitly oriented to what collaboration achieves for the public. These clarifications discipline the analysis in Section D.

Because the Sanur SEZ mobilises many organisations around a mandated purpose, the network-governance literature is also pertinent. Provan and Kenis (2008) distinguish three ideal-typical modes of network governance (participant-governed, lead-organisation, and network administrative organisation (NAO)) and argue that effectiveness depends on the fit between mode and contingencies such as trust density, the number of participants, goal consensus, and the need for network-level competencies. In the Sanur case, the government and the SEZ management agency function as a brokered, lead-organisation/NAO hybrid: authority is centralised in designated bodies that coordinate a diverse set of actors. This framing helps explain both the coordination strengths of the arrangement and its characteristic risks. Notably, it depend on the broker, and the danger that mandated networks impose a governance form ill-suited to their contingencies (Provan & Kenis, 2008).

A recurring theme across this literature is accountability. Cross-sector collaborations diffuse responsibility across organisations, which can obscure who answers for outcomes and to whom (Bryson et al., 2006). In a public health-export setting this problem is acute, because the ultimate accountability is owed not to the partners but to the citizens whose access to care the arrangement can either widen or narrow. The model developed later in this paper therefore treats accountability as intrinsic to public value rather than as a separate compliance layer bolted on after the fact.

Public value and the strategic triangle

What the CGR does not by itself specify is the substantive value that collaboration should produce. Moore's (1995) Public Value Theory supplies it. Moore's "strategic triangle" holds that public managers create value only when three elements align: (i) an authorising environment that confers legitimacy and support; (ii) the operational capacity to deliver; and (iii) public value itself as the outcome that justifies the enterprise. Subsequent scholarship reframes public value as a governance paradigm that moves beyond both traditional public administration and New Public Management, foregrounding democratic legitimacy, relational trust, and outcomes co-produced across sectors (Bryson et al., 2014). For a health SEZ, this perspective is demanding: it insists that investment volumes and tourist arrivals are inputs and intermediate outputs, not public value, and that the policy must ultimately be judged by improvements in access, quality, equity, welfare, and sustainability.

The CGR and Public Value Theory are complementary rather than redundant. The CGR explains how cross-sector actors build the legitimacy and capacity that Moore's triangle requires, while Public Value Theory specifies the outcomes against which the collaboration must ultimately be judged. This study integrates them by mapping the CGR's drivers and principled engagement onto Moore's legitimacy-and-support leg, the CGR's shared motivation and capacity for joint action onto operational capacity, and public value outcomes onto the third leg — an integration operationalised in Table 1 and formalised in the MTCVN in Section D.

Medical tourism, competitiveness, and the two-tier risk

The medical tourism literature gives this integration its empirical stakes. Connell (2011, 2013) documents the rapid rise of the industry while cautioning that its definitions and figures are unstable and that its growth is bound up with the commodification and privatisation of health care. Ganguli and Ebrahim (2017), analysing Singapore, show that destination competitiveness rests on a bundle of coordinated capabilities (clinical excellence, accreditation, connectivity, and a supportive policy environment) rather than on price alone. Most importantly for a destination country such as Indonesia, Pocock and Phua (2011) develop a conceptual framework organising the policy implications of medical tourism around core health-system functions (governance, financing, delivery, regulation, and health human resources) and warn that, absent deliberate policy, a health-export strategy can entrench a two-tier system in which paying foreign patients are served at the expense of local consumers' access and equity.

Recent Indonesian scholarship reaches a compatible conclusion. Supriadi et al. (2024), applying

a multi-level (helix) framework spanning academics, government, professional organisations, the private sector, and media, find that advancing medical tourism requires coordinated action at the macro level (regulation, branding, infrastructure), the institutional level (hospital quality and facilities), and the micro level (workforce competence). Hildayanti et al. (2025) likewise emphasise service-quality improvement, workforce distribution, technological modernisation, international accreditation, and cross-stakeholder collaboration as prerequisites for global competitiveness. Public value, in short, is not automatic; it is contingent on how collaboration is governed and on whether its benefits are equitably shared. This is a contingency the present framework makes explicit and central.

The demand side reinforces this contingency. Asa et al. (2024) show that Indonesian medical travellers are drawn abroad not only by clinical capability but by a trust deficit — perceptions of inconsistent quality, communication, and service in parts of the domestic system. This matters for the Sanur strategy in two ways. First, retaining these patients requires not merely building an international-standard facility but visibly closing the trust gap, a systemic and reputational task that exceeds the reach of any single hospital. Second, because much regional medical travel is short-distance and diasporic rather than long-haul (Connell, 2013), Indonesia's realistic near-term market includes its own returning outbound patients as much as new foreign arrivals — a framing that places domestic public value, not only export earnings, at the centre of the policy's rationale.

Special economic zones as policy instruments

Special economic zones are bounded areas within which a state offers regulatory, fiscal, and administrative incentives to attract investment and accelerate development. In Indonesia, the general SEZ framework (Government Regulation No. 40/2021) establishes the institutional architecture of national and zone-level councils and administrators, while sector-specific instruments designate individual zones and their permitted activities. The Sanur SEZ, established by Government Regulation No. 41/2022, is Indonesia's first health-oriented zone, and Ministry of Health Regulation No. 1/2023 sets out the conditions under which hospitals may operate within SEZs, including provisions that facilitate the participation of diaspora and foreign health professionals and the entry of medical technology. Viewed as a policy instrument, an SEZ is not merely a fiscal container but a governance experiment: it concentrates cross-sector actors around a defined territory and mandate, which makes the quality of collaborative governance — and its orientation to public value — decisive for whether the zone delivers broad benefit or narrow capture (Dredge & Jenkins, 2007; Howlett et al., 2020).

Health-oriented SEZs differ from conventional industrial or logistics zones in ways that raise the governance stakes. Their core output is a public good where health has been delivered to individuals whose welfare is a matter of public responsibility, so the ordinary SEZ logic of maximising investment and export earnings collides directly with obligations of access and equity. They are also unusually dependent on a specialised, mobile, and scarce workforce, which ties the zone's success to the wider health-system labour market rather than allowing it to operate as a self-contained enclave. And because clinical trust is built over years yet destroyed in a single scandal, reputational governance (accreditation, transparency, and complaint handling) is not peripheral but central to competitiveness. For all these reasons, a health SEZ cannot be governed as a fiscal instrument alone; it must be governed as a cross-sector public-service system, which is precisely the analytical stance this study adopts.

Synthesis and analytical framework

Synthesising these strands yields the study's position. Collaborative and network-governance theory explains how a mandated, multi-actor arrangement such as a health SEZ can be organised for collective action; Public Value Theory specifies the outcomes such an arrangement must produce to count as successful; and the medical tourism literature identifies the specific value domains at stake and the equity risks that can undermine them. The integration of these strands is operationalised in Table 1, which maps Moore's three public-value elements onto the corresponding CGR components and onto the analytical focus of this study, and which provides the coding structure for the analysis that follows.

Tabel 1. Integrated CGR–Public Value framework used in this study

Moore's Public Value element	Corresponding CGR component	Analytical focus in this study
Legitimacy & support (authorising environment)	Drivers; principled engagement	Shared policy problem; regulatory mandate; inter-agency dialogue and role allocation
Operational capacity	Shared motivation; capacity for joint action	Trust and leadership; regulation, workforce, infrastructure, investment
Public value outcomes	Collaborative actions & outcomes	Service quality, economic value, social, institutional, sustainability

Sources: Emerson et al. (2012), Moore (1995), and Bryson et al. (2014)

C. RESEARCH METHOD

Design and rationale

This study uses a qualitative, document-based policy analysis. Because BIH and the Sanur SEZ are recent and still consolidating, and because primary access to the full set of institutional actors was not feasible within the study's scope, the design synthesises publicly available policy documents, official reports, and peer-reviewed literature rather than generating primary field data. The approach is

therefore best understood as a conceptual desk analysis oriented to theory-building (the MTCVN), not as an empirical evaluation of realised outcomes; this scope condition is stated plainly so that the analysis in Section D is read as analytically grounded propositions rather than measured effects. A literature-based design of this kind is well established for synthesising dispersed evidence and developing conceptual understanding in public administration and policy studies (Snyder, 2019; Sitorus & Nooraini, 2025), and it is appropriate where the aim is to integrate existing theory and documentary evidence into a testable model rather than to estimate parameters.

Object, corpus, and selection

The object of analysis is the constitution of collaborative governance in the development of BIH within the Sanur SEZ. The analysis focuses on the collaboration process among stakeholders, the factors conditioning its effectiveness, and the creation of public value. The corpus comprised secondary sources with academic or institutional credibility, summarised in Table 2. Sources were retrieved from Google Scholar, Scopus, ScienceDirect, SpringerLink, Taylor & Francis, Emerald Insight, and Garuda using the keywords "collaborative governance", "medical tourism", "public value", "health tourism", "Special Economic Zone", "Sanur Special Economic Zone", "Bali International Hospital", and "tourism policy". Selection applied three criteria. It is relevance to the research question, source credibility, and recency (with peer-reviewed material prioritised from 2021–2026 and foundational theory drawn from original sources) — and excluded non-attributable commentary, promotional material without institutional standing, and duplicates. Priority was given to Scopus/SSCI-indexed outlets and to primary policy and regulatory documents.

Table 2. Summary of Documentary Data Sources

Source type	Examples	Analytical use
Regulations	Gov. Regulation 41/2022 (Sanur SEZ); 40/2021 (SEZ framework); Ministry of Health Regulation 1/2023	Mandate & rules
Official reports	Ministries of Health and Tourism; Coordinating Ministry for Economic Affairs; National Council for SEZs; SEZ Management Agency	Actors & implementation
Peer-reviewed literature	Collaborative-governance, public-value, and medical-tourism scholarship (2011–2026)	Theory & evidence
International & institutional publications	UN Tourism; comparative destination studies	Benchmarking
Project publications	Official material on BIH and the Sanur SEZ	Case detail

Source: Authors findings

Analytical procedure

Analysis followed Miles et al. (2020) qualitative procedure of data condensation, data display, and conclusion drawing and verification. In condensation, material was coded against the integrated framework in Table 1, using two coordinated coding schemes: (i) the CGR components (drivers; principled engagement; shared motivation; capacity for joint action) for the collaboration process, and (ii) Moore's public-value elements (legitimacy and support; operational capacity; public value outcomes) for the substantive results. Coded material was then displayed through the analytical matrices in Tables 3–5, which juxtapose findings and their policy implications so that cross-cutting patterns could be identified. In the final stage, conclusions were drawn by interpreting these patterns against the theoretical framework and consolidating them into the MTCVN and its propositions. Because the study builds theory, the propositions were formulated to be falsifiable and to specify the direction of the relationships they assert, so that subsequent empirical work can test them.

Trustworthiness and limitations of the approach

Given the reliance on secondary data, trustworthiness rests on documentary and theoretical triangulation rather than on member checking. Documentary triangulation cross-checked each substantive claim across regulations, official reports, and independent scholarship; theoretical triangulation interpreted the evidence through two coordinated lenses (the CGR and Public Value Theory) to reduce single-perspective bias (Creswell & Creswell, 2023). Reflexively, the authors treated government estimates (for example, of foreign-exchange leakage) as claims to be attributed rather than facts to be asserted, consistent with Connell's (2013) caution about inflated figures. The approach nonetheless has clear limits: it cannot measure realised outcomes , incorporates no primary stakeholder testimony, and centres on a single, recent case. These limits are acknowledged in Section F and translated into a testing agenda rather than concealed

D. RESULTS AND DISCUSSION

Consistent with the study's scope, the results below are presented as analytically grounded propositions about the conditions for effective collaborative governance and public value creation in the Sanur SEZ, not as measurements of achieved impact. Where the document record describes

designed features or stated intentions, these are reported as anticipated rather than realised.

The Sanur SEZ as a cross-sector policy instrument

The Sanur SEZ marks a shift in Indonesian tourism policy from maximising arrivals towards improving destination quality by integrating the health, tourism, investment, and public-service sectors. Its anchor, BIH, is intended to reduce the foreign-exchange leakage associated with outbound medical travel and to raise Indonesia's competitiveness as a destination. From a public-administration standpoint, such a policy cannot be delivered by any single agency; it requires collaboration across the central and local governments, SOEs, investors, international health institutions, professional bodies, academia, and communities (Bryson et al., 2006; Hildayanti et al., 2025; Pocock & Phua, 2011). The document record identifies four strategic objectives — improving national health-service quality, reducing outbound health spending, increasing investment and foreign exchange, and creating a new growth centre — which together signal an orientation towards public value, not economic growth alone. Read through Provan and Kenis (2008), the arrangement approximates a lead-organisation/NAO mode of network governance, in which the government and the SEZ management agency broker a diverse set of actors around a mandated purpose; this concentrates coordinating authority but also makes the network dependent on the competence and even-handedness of the broker.

Framed this way, the Sanur SEZ is a deliberate attempt to internalise, within Indonesia's borders, a value chain that currently leaks abroad. Its logic is not only to build a hospital but to assemble the surrounding conditions (regulatory ease, workforce, financing, promotion, and hospitality linkages) that together make an internationally credible destination. That assembly is inherently collaborative: each condition sits with a different set of actors, and none can deliver the whole. The policy's coherence therefore rests on the quality of the connective tissue between actors the coordination, trust, and shared purpose that the CGR analysis below sets out to examine.

Collaboration dynamics: a CGR reading

Analysing the SEZ through the CGR's collaboration dynamics yields the following reading, in which the three components interact rather than proceed in sequence.

Drivers. Collaboration is propelled by a shared policy problem: the need to raise the competitiveness of national healthcare and to curb foreign-exchange leakage, activated by the regulatory mandate creating the Sanur SEZ. Interdependence and consequential incentives — no single institution can supply the regulation, capital, clinical capability, and land assembly the project requires — draw the actors together, exactly the condition Emerson et al. (2012) identify as generative of a regime (see also Howlett et al., 2020).

Principled engagement. Coordination among ministries, regional governments, SOEs, investors, and hospitals proceeds through policy formulation, spatial planning, infrastructure provision, and facility development — the discovery, definition, deliberation, and determination that principled engagement denotes. Consistent with Bryson et al. (2006), early agreement on the problem and visible sponsorship have helped launch the collaboration; the persistent risks are divergent institutional interests and bureaucratic complexity that can slow or distort implementation.

Shared motivation. A common commitment to making Indonesia a regionally competitive destination underpins the regime; mutual trust, mutual understanding, internal legitimacy, and shared commitment reinforce inter-institutional ties. Their durability depends on policy consistency, transparency, and sustained communication — the relational capital that, once eroded, is costly to rebuild.

Capacity for joint action. Capacity is visible in regulation, financing, infrastructure, health-workforce development, and medical-technology support, with government acting as both regulator and facilitator. Yet capacity is uneven: workforce competence, cross-sectoral regulatory harmonisation, and durable coordination structures remain the binding constraints, and it is here that the collaboration is most likely to succeed or fail.

Table 3. Collaborative Governance Regime analysis of the Sanur SEZ

CGR component	Analytical finding	Policy implication
Drivers	Foreign-exchange leakage, unmet demand for quality care, SEZ mandate, interdependence	Sustains the case for cross-sector collaboration
Principled engagement	Dialogue and role allocation across government, SOEs, investors, hospitals	Needs a standing coordination forum with clear authority
Shared motivation	Commitment to regional competitiveness; trust and leadership	Requires transparency and consistent communication
Capacity for joint action	Regulation, workforce, infrastructure, investment in place but uneven	Priority: workforce competence and regulatory harmonisation

Source: Authors' synthesis of policy documents and literature.

The reading supports Emerson et al. (2012) view that success depends on the interaction of drivers, engagement, motivation, and capacity rather than on any one of them — and, in this case, on the quality of interaction, the level of trust, and institutional capacity more than on the mere existence of regulation or investment. This yields the first two propositions.

Proposition 1. *A shared policy problem (foreign-exchange leakage and quality gaps), activated by a regulatory mandate and reinforced by*

interdependence, drives cross-sector collaboration in health-SEZ development.

Proposition 2. *Principled engagement and shared motivation strengthen collaboration dynamics, which in turn build the capacity for joint action.*

Stakeholder configuration

Implementation involves actors with differing roles, interests, and influence (Table 4). The central government sets policy and regulates; provincial and city governments provide administrative support, spatial planning, and local services; SOEs — notably the zone manager, PT Pertamina Bina Medika–IHC — lead infrastructure and investment; private and international hospital partners bring capital, technology transfer, and service standards, with BIH's collaboration with SingHealth an illustrative channel; universities and professional bodies supply human resources, research, and innovation; and communities are both beneficiaries and custodians of social and cultural sustainability. The recurring risks are sectoral egos, overlapping authority, regulatory harmonisation, workforce readiness, and insufficient community participation — precisely the constraints and contingencies that Bryson et al. (2006) identify as decisive for cross-sector collaboration.

Table 4. Stakeholder Analysis

Stakeholder	Role	Primary interest	Influence
Ministry of Health	Regulation, accreditation, quality standards	Service quality	High
Ministry of Tourism	Destination development and promotion	Competitiveness	High
Local government	Facilitation, spatial planning, licensing	Local revenue (PAD) & welfare	High
State-owned enterprises	Zone and investment management	Investment	High
Private investors	Capital provision	Return on investment	High
International hospitals	Technology and knowledge transfer	Service quality	Moderate
Academia	Education, research, innovation	Human-resource development	Moderate
Local community	Beneficiary and social custodian	Welfare & equity	High

Source: Authors' synthesis.

The configuration confirms that outcomes depend not on any dominant actor but on complementary interaction managed by government as orchestrator. It is consistent with the CGR emphasis on structured, public-value-oriented collaboration (Ansell & Gash, 2008; Emerson et al., 2012) and with the lead-organisation logic of network governance (Provan & Kenis, 2008). Two features warrant emphasis. First, the moderate influence of international partners and academia marks the workforce and knowledge-transfer channel as the pathway most in need of deliberate strengthening, since it is through this channel that clinical capability and local competence are built. Second, the high stake but often low structural power of local communities is a governance vulnerability: unless participation is institutionalised, the arrangement can satisfy investors and agencies while marginalising the very public whose welfare defines the policy's success.

Government-as-orchestrator is the linchpin of this configuration. In a lead-organisation network, the broker must not only convene actors but actively manage the tensions between them — between investors' returns and public access, between central mandate and local autonomy, between speed and inclusiveness (Bryson et al., 2015; Provan & Kenis, 2008). The BIH–SingHealth partnership illustrates both the promise and the demand of this role: such collaborations can transfer clinical protocols, training, and management systems that raise national capability, but only if the state deliberately structures them as capacity-building arrangements with local absorption and diffusion in mind, rather than as reputational endorsements that leave competence concentrated in a single flagship. The orchestrator's task, in short, is to convert isolated partnerships into a networked capability that outlasts any one project.

Public Value Creation

Basaed on Moore (1995) triangle, the SEZ's public value rests on legitimacy and support. It is secured through the regulatory mandate and inter-agency engagement analysed above and on operational capacity. It is realised as public value outcomes across five domains. Because the study is document-based and BIH is new, these outcomes are framed as anticipated conditions rather than measured results (Table 5).

Service quality. International-standard facilities, modern technology, and partnerships with global institutions are expected to widen access to high-quality care and to reduce dependence on treatment abroad, while enabling knowledge transfer that lifts national workforce competence (Ganguli & Ebrahim, 2017; Hildayanti et al., 2025; Pocock & Phua, 2011).

Economic value. The zone is expected to raise investment, create jobs, and retain foreign exchange; integration with hospitality, transport, and the creative economy can generate multiplier effects — provided the benefits reach MSMEs, local workers, and surrounding communities rather than investors alone, a proviso the destination-country literature treats as central rather than incidental (Pocock & Phua, 2011).

Social and institutional value. Delivery depends on, and in turn strengthens, cross-agency institutional capacity for transparent, accountable public service (Bryson et al., 2014), alongside welfare gains from employment and workforce upgrading.

Sustainability. Long-term value depends on adaptive regulation, environmental safeguards, and community participation, evaluated continuously against public-value indicators rather than against investment or arrival targets.

Table 5. Public value analysis of the Sanur SEZ (Moore's outcome domains)

Outcome domain	Anticipated finding	Policy implication
Service quality	BIH is expected to enhance international-standard care	Strengthen national health-service quality
Economic value	Anticipated gains in investment, foreign exchange, employment	Strengthen competitiveness with equitable distribution
Social value	Employment and workforce-competence gains	Improve community welfare
Institutional value	Stronger cross-sector collaboration	More effective, accountable governance
Sustainability	Long-term growth potential	Strengthen regulation and public participation

Source: Authors' synthesis.

Two risks qualify these outcomes and give the analysis its critical edge. First, if investment logic dominates public-service logic, the zone could commercialise care and entrench a two-tier system that disadvantages local consumers — the central caution of the destination-country literature and, more broadly, of Connell (2013) account of medical tourism as a commodifying force (Pocock & Phua, 2011). Second, workforce-capacity gaps could cap the very quality gains the policy promises. Public value is thus contingent, not automatic, yielding two further propositions.

Proposition 3. *Capacity for joint action (regulation, workforce, infrastructure, investment) enables public value creation.*

Proposition 4. *Equitable benefit distribution and safeguards against commercialisation and two-tier access are necessary conditions for collaboration to translate into sustainable public value.*

Operationalising the equity condition is therefore concrete rather than rhetorical. It implies reserving a defined share of BIH's capacity and cross-subsidised services for domestic patients, including those of modest means; ring-fencing a portion of zone revenues or incentives for strengthening surrounding public facilities; and monitoring the health-workforce market so that the SEZ develops and attracts talent rather than draining scarce specialists from the public system it is meant to complement. Each measure directly counters a specific two-tier mechanism identified by Pocock and Phua (2011) — in access, financing, and workforce respectively — and each is a testable commitment against which the policy can be held. Absent such measures, the very success of the zone in attracting paying patients could widen the domestic inequities that motivated its creation in the first place.

The Medical Tourism Collaborative Value Network (MTCVN)

Synthesising the analysis, the study proposes the MTCVN (Figure 1). The model holds that developing a medical tourism destination requires a collaborative value network in which government (as regulator, facilitator, and orchestrator), the private sector, hospitals and international institutions, academia, professional bodies, and communities operate within a governance system oriented to public value. Crucially, the relationship between collaborative governance and policy success is modelled as indirect: collaboration produces outcomes through the intermediate creation of public value, which functions as the proposed mediating mechanism. Because the present study is conceptual, this mediating role is advanced as a proposition for empirical testing, not as a demonstrated effect.

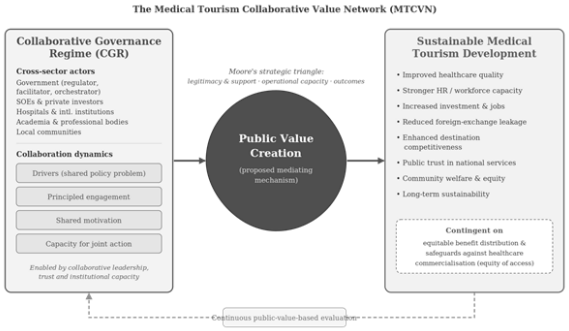

Figure 1. *The Medical Tourism Collaborative Value Network (MTCVN)*

The MTCVN extends the CGR in three ways. It specifies public value as the mediating outcome the regime exists to produce; it draws on network-governance theory to characterise the government's role as a lead-organisation orchestrator whose even-handedness conditions the network's legitimacy (Provan & Kenis, 2008); and it makes the collaboration-to-outcome pathway conditional on collaborative leadership, inter-actor trust, institutional capacity, community participation, and continuous evaluation. Two final propositions formalise the model's core claims.

Proposition 5. *Public value creation mediates the relationship between collaborative governance and medical tourism policy success (competitiveness, healthcare quality, welfare, sustainability).*

Proposition 6. *Collaborative leadership and community participation strengthen the collaboration-to-public-value pathway, while continuous public-value-based evaluation sustains it over time.*

Taken together, the six propositions convert the conceptual model into a testable research programme. P1–P2 concern the formation and internal dynamics of the regime; P3–P4 concern the translation of capacity

into public value and the equity conditions on that translation; and P5–P6 concern the mediating and moderating structure at the heart of the MTCVN. This structure is the study's principal theoretical contribution: it specifies not only how collaboration is built but why, and under what conditions, it can produce effective and sustainable policy.

Conditions and challenges for effective implementation

Bringing the analysis together, the effectiveness of the Sanur SEZ turns on four conditions, each of which is simultaneously its principal risk. The first is coordination: as a mandated, lead-organisation network, the arrangement concentrates authority for efficiency but depends on the broker's capacity to synchronise the health, tourism, investment, and education portfolios and to prevent overlapping authority from stalling decisions (Provan & Kenis, 2008). The second is workforce capacity: internationally competitive medical tourism requires clinicians and support staff with advanced competencies, language skills, and technological fluency, so the moderate-influence academia–international-partner channel identified in Table 4 must be deliberately elevated through education, training, certification, and joint research. The third is community participation: because communities hold a high stake but often limited structural power, participation must be institutionalised across planning, implementation, and evaluation if the policy is to retain legitimacy and avoid both the perception and the reality of capture (Ansell & Gash, 2008; Bryson et al., 2015). The fourth is evaluation: without a public-value-based monitoring system, success will default to the metrics that are easiest to count — investment and arrivals — crowding out the outcomes that define the policy's purpose, namely access, equity, quality, welfare, and sustainability. These four conditions are the practical content of the MTCVN's contingency claims and the focus of the recommendations that follow.

E. IMPLICATIONS OF THE STUDY

The study makes three theoretical contributions. It extends the CGR to health-SEZ medical tourism, a context in which it has not previously been applied; it integrates Public Value Theory and network-governance theory to specify the outcome the regime should produce and the orchestration mode that produces it, positioning public value as a mediating mechanism; and it offers the MTCVN with six propositions that render the argument testable. These propositions define a clear research agenda: P1–P4 can be examined through comparative case study and qualitative process tracing, while P5–P6 — the mediating and moderating claims — are suited to Structural Equation Modeling (SEM) or Partial Least Squares (PLS) once primary data are gathered, and the network structure to Social Network Analysis (SNA). In this way the paper contributes to the body of knowledge not only a model but an operationalisable one.

For SEZ managers, IHC, investors, and hospital partners, the MTCVN reframes coordination as a value-creating asset rather than an administrative cost. Practically, it recommends institutionalising a public–private coordination mechanism; treating international partnerships (for example, with SingHealth) as deliberate knowledge- and technology-transfer channels that build local workforce competence rather than as marketing badges; and designing benefit-sharing arrangements with MSMEs and local suppliers so that the zone's projected economic gains — retention of a share of the estimated USD 11.5 billion outbound spend, roughly Rp 3.7 trillion in investment, and some 43,647 jobs — are realised inclusively rather than captured narrowly. The commercial case and the public-value case, on this reading, are complementary: a destination that is trusted and inclusive is also more competitive and more durable (Ganguli & Ebrahim, 2017).

The Sanur case and the MTCVN provide ready-made teaching material for public administration, tourism governance, and health-services management. The integrated CGR–Public Value framework (Table 1) and the six propositions support case-based and problem-based learning on cross-sector collaboration, network governance, public-value assessment, and the governance of special economic zones, giving students a concrete Indonesian exemplar of theory applied to a live, high-stakes policy problem — and a worked example of how to build a testable model from documentary evidence.

The analysis yields four actionable recommendations. First, establish a standing cross-ministry coordination forum with clear authority to synchronise health, tourism, investment, and education policy, reducing the overlapping-authority risk inherent in a lead-organisation network. Second, prioritise health-workforce capacity through certification, training, and university and international partnerships, since this is the binding constraint on quality. Third, build formal community-participation mechanisms across planning, implementation, and evaluation, converting communities' high stake into real voice. Fourth, adopt a public-value-based monitoring and evaluation system whose indicators extend beyond investment and arrivals to service quality, equity of access, employment, environmental impact, and public trust — with an explicit safeguard against the commercialisation and two-tier risks flagged by Pocock and Phua (2011). Together these recommendations operationalise the MTCVN as a policy instrument, not merely an analytical device.

If governed for public value, the zone can widen access to advanced care, reduce the financial and personal burden of travelling abroad, and lift community welfare through employment and skills — with a plausible secondary effect of rebuilding public trust in the national health system, the very deficit that

drives outbound travel in the first place (Asa et al., 2024). These gains are conditional: without equity safeguards, a health SEZ can deepen disparities in access and entrench a two-tier system, so that the same policy that promises inclusion delivers exclusion. The study's contribution to society is therefore to make that conditionality explicit and to supply indicators for holding the policy to a standard of shared, sustainable benefit — influencing not only what is built but whose welfare it is built to serve.

F. CONCLUSION

This study analysed collaborative governance in the medical tourism development policy of the Sanur SEZ, identified the factors that condition cross-sector collaboration, and proposed a public-value-based conceptual model. The Sanur SEZ represents a shift towards quality tourism that integrates the health, tourism, investment, and public-service sectors, and its delivery depends on collaboration among the central and local governments, SOEs, the private sector, international institutions, academia, professional bodies, and communities, orchestrated through a lead-organisation network mode. A CGR reading shows the components of drivers, principled engagement, shared motivation, and capacity for joint action taking shape, while persistent challenges — sectoral egos, regulatory complexity, workforce readiness, cross-organisational coordination, and limited community participation — condition their effectiveness.

The study's central argument is that the success of such a policy should be judged by its creation of public value, and that public value mediates the relationship between collaboration and outcomes. This logic is formalised in the MTCVN and its six propositions, which extend the CGR by integrating a Public Value perspective and a network-governance account of orchestration, and by making equitable benefit distribution a necessary condition rather than a by-product. In doing so, the paper offers both a theoretical contribution to the study of collaborative governance and medical tourism and a practical framework for policymakers seeking to build a health-export sector that strengthens, rather than strains, the domestic health system.

In term of limitations, the analysis is document-based, so it advances propositions rather than measured effects and does not incorporate primary stakeholder data; it centres on a single, recent case, which bounds generalisability; and the MTCVN remains conceptual and untested. Government estimates used for context should be treated as indicative rather than precise. As such, subsequent work should test the MTCVN using case-study, mixed-methods, or policy-evaluation designs with government, SEZ managers, hospitals, investors, health workers, tourism businesses, and communities as informants, operationalising P5–P6 through SEM/PLS and the network structure through SNA, and comparing the Sanur SEZ with established destinations in Thailand, Malaysia, and Singapore to sharpen policy transfer and to test the boundary conditions of the model.

BIBLIOGRAPHY

Ansell, C., & Gash, A. (2008). Collaborative governance in theory and practice. Journal of Public Administration Research and Theory, 18(4), 543–571. https://doi.org/10.1093/jopart/mum032

Asa, G. A., Fauk, N. K., McLean, C., & Ward, P. R. (2024). Medical tourism among Indonesians: A scoping review. BMC Health Services Research, 24(1), 1–11. https://doi.org/10.1186/s12913-023-10528-1

Bryson, J. M., Crosby, B. C., & Bloomberg, L. (2014). Public value governance: Moving beyond traditional public administration and the New Public Management. Public Administration Review, 74(4), 445–456. https://doi.org/10.1111/puar.12238

Bryson, J. M., Crosby, B. C., & Stone, M. M. (2006). The design and implementation of cross-sector collaborations: Propositions from the literature. Public Administration Review, 66(s1), 44–55. https://doi.org/10.1111/j.1540-6210.2006.00665.x

Bryson, J. M., Crosby, B. C., & Stone, M. M. (2015). Designing and implementing cross-sector collaborations: Needed and challenging. Public Administration Review, 75(5), 647–663. https://doi.org/10.1111/puar.12432

Connell, J. (2011). Medical tourism. CABI.

Connell, J. (2013). Contemporary medical tourism: Conceptualisation, culture and commodification. Tourism Management, 34, 1–13. https://doi.org/10.1016/j.tourman.2012.05.009

Creswell, J. W., & Creswell, J. D. (2023). Research design: Qualitative, quantitative, and mixed methods approaches (6th ed.). SAGE Publications.

Dredge, D., & Jenkins, J. (2007). Tourism planning and policy. John Wiley & Sons.

Emerson, K., Nabatchi, T., & Balogh, S. (2012). An integrative framework for collaborative governance. Journal of Public Administration Research and Theory, 22(1), 1–29. https://doi.org/10.1093/jopart/mur011

Ganguli, S., & Ebrahim, A. H. (2017). A qualitative analysis of Singapore's medical tourism competitiveness. Tourism Management Perspectives, 21, 74–84. https://doi.org/10.1016/j.tmp.2016.12.002

Hildayanti, S. K., Nurjana, A., Rachman, M. R., & Abdullah, W. (2025). Menjadikan Indonesia sebagai destinasi unggulan wisata medis di dunia global. JPNM Jurnal Pustaka Nusantara Multidisiplin, 3(4).

https://doi.org/10.59945/jpnm.v3i4.872
Howlett, M., Ramesh, M., & Perl, A. (2020). Studying public policy: Principles and processes (4th ed.). Oxford University Press.
Imran, A., & Wijaya, R. (2025). Community participation in sustainable tourism development. Jurnal Ilmu Administrasi, 22(1), 75–90.
Matthoriq, M., Zauhar, S., & Hermawan, H. (2021). Collaborative governance dalam pengelolaan desa wisata berbasis masyarakat. Jurnal Administrasi Publik, 17(2), 145–160.
Miles, M. B., Huberman, A. M., & Saldaña, J. (2020). Qualitative data analysis: A methods sourcebook (4th ed.). SAGE Publications.
Moore, M. H. (1995). Creating public value: Strategic management in government. Harvard University Press.
Peraturan Menteri Kesehatan Republik Indonesia Nomor 1 Tahun 2023 tentang Penyelenggaraan Kegiatan Usaha Rumah Sakit di Kawasan Ekonomi Khusus.
Peraturan Pemerintah Republik Indonesia Nomor 40 Tahun 2021 tentang Penyelenggaraan Kawasan Ekonomi Khusus.
Peraturan Pemerintah Republik Indonesia Nomor 41 Tahun 2022 tentang Kawasan Ekonomi Khusus Sanur.
Pocock, N. S., & Phua, K. H. (2011). Medical tourism and policy implications for health systems: A conceptual framework from a comparative study of Thailand, Singapore and Malaysia. Globalization and Health, 7(1), 12. https://doi.org/10.1186/1744-8603-7-12
Provan, K. G., & Kenis, P. (2008). Modes of network governance: Structure, management, and effectiveness. Journal of Public Administration Research and Theory, 18(2), 229–252. https://doi.org/10.1093/jopart/mum015
Sanur Special Economic Zone Management Agency. (2024). Laporan perkembangan Kawasan Ekonomi Khusus Sanur. Badan Pengelola KEK Sanur.
Sitorus, R., & Nooraini, N. (2025). Smart governance dalam pengembangan kawasan ekonomi khusus. Jurnal Kebijakan Publik, 16(1), 30–47.
Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. Journal of Business Research, 104, 333–339. https://doi.org/10.1016/j.jbusres.2019.07.039
Supriadi, Al Aufa, B., Nurfikri, A., & Koire, I. I. (2024). Exploring the potential of a multi-level approach to advance the development of the medical tourism industry in Indonesia. Health Services Insights, 17. https://doi.org/10.1177/11786329241245231
United Nations World Tourism Organization. (2023). International tourism highlights: 2023 edition. UN Tourism.