HEALTHCARE SERVICE MARKETING IN MEDICAL TOURISM
An Emerging Market Study

MICHELLE RYDBACK
Abstract
Medical tourism (MT) enables patients to satisfy their healthcare needs by traveling outside their country of residence to obtain medical treatment. The increasing number of scientific publications, different countries’ engagement in providing care for foreigners, and patients heading abroad to receive healthcare indicate the growth and popularity of MT. This industry’s development exposes the healthcare sector to a competitive environment. As a result, marketing has become a significant part of healthcare providers’ operations and survival. Research into how these providers promote their services is limited. This limitation is further apparent for healthcare providers located in less popular destinations, such as emerging market (EM) countries. This dissertation therefore focuses on MT service providers in an EM, the Philippines.

This study aims to examine how service providers in an EM country market healthcare services internationally. This thesis consists of four articles. Through qualitative case-based research, this study concentrates on hospitals, clinics, and medical tourism facilitators that play a central role in service delivery within the MT industry. The results from this thesis show that to efficiently market healthcare, service providers have to build trust, establish reliable networks, and offer customized and supplementary services.

This dissertation is positioned to contribute to relevance and diversity in service marketing research and the budding healthcare service marketing while sustaining MT literature through studying service providers in an EM context. Although this study was based on one EM, it offers an in-depth understanding of how the marketing of healthcare services is being implemented. This knowledge is not only important for the practicing medical tourism destination countries, but also for patients, managers, policymakers, and researchers in the patients’ home country. Future studies could focus on the perspective of consumers. Accordingly, this study is an initial step toward a deeper understanding of the marketing of commercialized healthcare.

Keywords: Healthcare service marketing, medical tourism, emerging market, service marketing, trust, network, customization, word of mouth, supplementary services, Philippines.
Preface

Healthcare is a contested commodity. Commercialization of healthcare is not different from other commodified services like education. Yet healthcare services are scrutinized because of the notion that accessibility to health is a right that should not be sold. But how about education? If we agree on this line of reasoning, schools’ advertising and receiving international students are also wrong and unethical. So it is acceptable to choose which school our children go to but not to select which hospital to go to when they get sick?

My research does not, in any way, imply that healthcare services have to be commercialized. This study explains that healthcare services can and are being commodified and accepted as any other marketed service. Medical tourism’s growing popularity offers a unique context to understand how this is done by providers with limited resources and constrained by environmental settings. The medical tourism industry presents implications in promoting a sensitive service internationally that presumably concerns marketing scholars and practitioners.

Having the chance to be a patient and family member of a patient in two contrasting settings (the Philippines as the home country and Sweden as a country of residence) made me interested in healthcare. During my stay in the Philippines, I witnessed foreign patients entrusting their health to local medical professionals’ hands. I wondered how local healthcare providers attract international patients to come to a foreign country to perform a service that was sensitive and very personal. This fascinated me. It was even intriguing when they labeled them as “medical tourists” and not just patients.

I am lucky to be able to continue and explore my curiosity during my PhD journey. I argue that we in the marketing field have a moral obligation to further our healthcare service investigation, not only because healthcare is a fertile field for scholars but also because our practice can be misunderstood and misused. As I see it, marketing healthcare service can be explained if I focus on the core services and unique features. Thus, service marketing was used as a research lens in this study. Acknowledging that marketing is a context-driven discipline and practice, this study includes and highlights the setting where the business organizations exist. In this study the setting is an emerging marketing country, the Philippines.

Within years of research on medical tourism, I met several scholars and practitioners that were adamant in their notion of marketing healthcare service. Although I sympathize with their arguments, I want to highlight that the MT industry represents not only cosmetic services. It also includes serious medical procedures such as heart surgery. It is a pity that this industry is associated with a shallowness
that is popularized by the media. Moreover, during my research I have also met former medical tourists who share their experiences privately. For these patients, the value of core services is subjective. This means that some may perceive liposuction surgery as superficial and unnecessary, but it is a life-changing procedure as perceived by patients. Patients declining my request to include their stories in this study only confirms the stigma attached to doing specific MT procedures. Critics who say medical tourism promotes health inequality might have some validity. However, without the proper academic analysis, this is an issue that may be theoretically acceptable but empirically invalid.

Writing a compilation thesis exposed me to the reality of the double-edged sword of the publishing process. I have learned how to handle the peer-review process. My two published articles so far indicate that my topic is exciting and has high enough quality. Moreover, it is satisfying to have contributed somewhat to my university’s publication statistic. On the other edge of the sword, I realized how conservative academics are. The limited number of journals that accept articles such as mine suggests why healthcare service marketing still tends to be in its infancy. Although I acknowledge the importance of academic discussion, I would like to add the importance of communicating our ideas to actors outside our domain. Learning from the individuals that work in the field will not only allow us to understand the current status within a real-world context; it will also engender new knowledge that is more interesting and understandable not solely by academics but also by actors outside universities.

This book is written for marketing researchers who are interested in the exciting field of healthcare. However other scholars are just as important. Those who have interest in the medical tourism industry regardless of discipline will also understand the arguments of this book.
When I was just getting started, I clearly remember that almost everyone told me that embarking on a PhD journey was like taking a roller-coaster ride, full of psychological and emotional ups and downs. Indeed it has been. I must admit, though, that I am more afraid of roller coasters now than before. But after all, you are reading this part now because I (we) MADE it.

Through my roller-coaster ride, I met many wonderful people that became my inspiration and motivation. Some people cheered me up before, motivated me during, and stayed until I finished my roller-coaster ride.

To my supervisors, Prof. Akmal Hyder, Prof. Aihie Osarenkhoe, and Prof. Erik Borg, I will never forget what you have done for me. Prof. Akmal, thank you so much for your patience, advice, and inspiration. Prof. Aihie, thank you for believing in my capability and making me smile. Prof. Erik, thank you so much for sharing your interest in the medical tourism industry.

Thank you very much to the Philippine medical tourism industry’s spearheads, especially Eva Trinidad, Cynthia Lazo, Marc Daubenbuechel, and Shirley Songco. Without your help, I would not have able to explore the complex Philippine medical tourism industry.

Thank you to all the magnificent people who provided me all that constructive criticism and guidance. This thesis wouldn’t be in this form without Malin Gawell, Pejvak Oghazi, Bengt Jacobsson, Kjell Ljungbo, Bo Edvardsson, and Sabine Persson’s help.

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I am also forever thankful for all the support of the two respected institutions that invested in and trusted me—University of Gävle, which became my second home for almost 10 years, and Södertörn University, which guided me through my PhD journey. I am also thankful to Maria Strand, the head of the Division of Educational Support of the University of Gävle, who supported my ambition to pursue my academic research interest. I am also grateful to the Royal Technological Institute (KTH), which adopted me and opened an excellent opportunity to continue feeding my academic curiosity.
For all the people who did believe that I would make it through Mehran Jafari, Lolita Orfiano, Lena Gingnell and Gary Dunn, thank you so much. You inspired me!

For all the people who did not believe that I would make it through, thank you all too. You motivated me!

I am so lucky and grateful to my amazing family who show their unconditional love. To my parents, Lolita (her spirit) and Democrito, and my siblings Marjorie, Mark, Mitchell, Maurice, Marah, Muriel, Myrtelle, and Maegelline, thank you all for your love. To my first teacher, my Tatay Jojie, who patiently taught me how to read and write, thank you for being my second father.

To my children Dwight, Brent, and Yanina, you will always be my inspiration. Thank you so much for being the anchors of my life. I love you all. To the person who never left my side throughout my roller-coaster ride, my husband, Per. Thank you so much, Mahal, for making me realize the dreams and possibilities that I never thought I would have. I love you so much!
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List of Appended Articles

This thesis is based on the following articles referred to in the text by the Roman numerals (I–IV):

Article I:

- Accepted 20 November 2017
- An extended version was presented at the EUROMED Conference, September 2015.
- An earlier version was presented at the British Academy of Management Conference, September 2016.

Article II:

Article III:
Rydback, M. (2019). Role of facilitators in the medical tourism industry: A study of medical tourism facilitators in an emerging market. Submitted to the journal *Service Marketing Quarterly*

- An earlier version was presented at EUROMED Conference, September 2018.

Article IV:
# Acronyms and Abbreviations

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<th>Description</th>
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<tr>
<td>AC</td>
<td>Accreditation Canada</td>
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<td>EM</td>
<td>emerging market</td>
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<td>ETC</td>
<td>European Travel Commission</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>ISO</td>
<td>International Standard Organization</td>
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<td>JCI</td>
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<td>MT</td>
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<td>MTF</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Co-operation and Development</td>
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<td>PMTP</td>
<td>Philippine Medical Tourism Program</td>
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Part I
1. Introduction

This introductory chapter primarily presents the research background that forms the foundation of this dissertation. Acknowledging that the medical tourism (MT) industry is a rather complex phenomenon, this part starts with the history and current studies surrounding it. The following section presents on the Philippines as an emerging market (EM) and as the destination of MT. The chapter ends by discussing the knowledge gaps, aim, research questions, contributions of the articles and authors, limitations and the structure of the research.

1.1. Background

The phenomenon of people traveling across countries and continents aiming to rejuvenate or cure their illnesses has long existed (Bookman and Bookman, 2007). Tourism for promoting health and well-being was practiced by the ancient Greeks and Romans, as demonstrated by thermal health spas that still exist throughout Europe (Tresidder, 2011). Nowadays this health-based tourism is called health tourism, an umbrella term with two distinct subsectors: wellness and medical tourism (MT). Recognizing the growth and complexity of this rising phenomenon, World Tourism Organization (UNWTO) and the European Travel Commission (ETC) conducted a study to define health tourism and its subsectors (International Medical Travel Journal [IMTJ], 2019). Wellness tourism encompasses activities that engage in “preventive, proactive, lifestyle enhancing activities such as fitness, healthy eating, relaxation, pampering and healing treatments,” while MT includes “evidence-based medical healing resources and services” that cover both invasive and noninvasive procedures (IMTJ, 2019, n.p.). For this reason, some define wellness tourism as offering minor services compared to MT, which entails essential healthcare services (Connell, 2013). Nevertheless, it is challenging to distinguish between wellness and MT since consumers usually combine services that belong to these subsectors. For instance, after the medical procedure, patients engage in lifestyle-enhancing activities like learning healthy eating during the recuperation period. Also, wellness and MT can overlap in the case of an executive checkup, which includes diagnostics and managing the health and well-being of patients (Global Wellness Institute, n.d.). However, in line with the position of Global Wellness Institute (n.d.) this study holds that “wellness tourism is not medical tourism” because “the types of visitors, activities, services, businesses and regulations involved are very different.” This demarcation is necessary to mitigate misunderstanding and emphasize the direction of this research.

Although wellness tourism is a vital part of health tourism, this researcher chose to focus on MT to frame the study. This is because compared to wellness tourism,
which offers relaxation, meditation, and spa treatments, MT is often under scrutiny since it involves traveling for serious medical procedures like cardiological procedures and orthopedic surgery. Thus, promoting MT is more complex and challenging in comparison with wellness tourism. This has been an issue for all involved entities, particularly for business-oriented providers that rely on attracting international patients for profit. It is important to note that this research is neither about medicine nor about pure tourism. It is about communicating and promoting healthcare by following basic elements of marketing. Thus, marketing is assumed to have a significant role in the dynamic setting of the MT.

In earlier days, MT was considered a luxury product exclusively available to a wealthy population due to the expensive traveling and high-end medical services (Woo and Schwartz, 2014). Moreover, the availability of advanced medical technologies was usually limited to developed nations like the United States and the UK, making these countries ideal destinations for wealthy medical tourists from different parts of the world. In recent years, MT’s characteristics have changed. In the advent of internet development, affordable travel, and the availability of advanced medical technology even in many emerging market (EM) countries, more people have timely, substantial, and cheaper options (Visakh et al., 2017). Thus, this makes the MT offerings reach geographically further by providing more options for price-sensitive customers looking for timely, affordable, high-quality care (Bookman and Bookman, 2007). Although the majority of travelers or medical tourists make their own choices, institutional endorsement favors the procurement of the MT industry (Carrera and Bridges, 2006). For instance, the European Union (EU), and National Health Service (in the UK), give their citizens opportunity to seek medical treatments within EU countries. Corporations and private insurance companies across the globe see the financial benefits of supporting their employees and members to have a medical procedure done in EM countries, where treatment is comparable to international standards yet much cheaper (Turner, 2007). It is important to note that healthcare customers of MT are not only individuals (medical tourists) but also public and private institutions. In sum, there are two differences between the historical and contemporary traveling for medical/therapeutic purposes: (1) now it has a name, MT, and (2) “tourists are traveling farther away, to poorer countries, and for medical care that is invasive and high tech” (Bookman and Bookman, 2007, p. 5).

It is worth noting that despite changes due to the present development in MT, the purpose of consumer travel is still to fulfill their health needs, which is within the scope of marketing. So far, few attempts have been made to incorporate marketing thoughts and theory in MT, specifically on how healthcare providers attract international consumers. Applying marketing concepts in healthcare services has been proven valuable and necessary (Berry and Bendapudi, 2007; Brown, 1983; Hinson et al., 2019; Stremersch, 2008), but studies on this are still limited (Anderson, Rayburn and Sierra, 2019; Balogun and Ogunnaike, 2017). The growing popularity of the MT industry illustrates how healthcare providers evolve toward being business-oriented
entities. Such development results in a competitive environment where many academics and managers believe marketing skills are essential for surviving in their operation (Anderson et al., 2019; Balogun and Ogunnaike, 2017). Assuming the challenges of promoting healthcare services as a product, this dissertation employs the subdiscipline of marketing, namely service marketing to understand how providers in the MT operationalize marketing. Service marketing is the lens used for this research because MT is a service driven sector which promotes a core product (healthcare) that is intangible, heterogeneous, and perishable where the production and consumption have to be done simultaneously. Despite the challenges posed against the inherent characteristics of services as outdated, healthcare still holds and possesses these salient features (Lovelock and Gummesson, 2004). Moreover, service marketing has an underdeveloped subfield that deals explicitly with healthcare services, in which scholars call for further research (Berry and Bendapudi, 2007; Brown, 1983; Fischer, 2014; Lovelock, 1977; Zeithaml et al., 2020). Within the subfield of healthcare services, there are four concepts that constitute the framework of the study; namely trust, network, customization, and supplementary services. Development of these concepts and their relevance to this study is further discussed in the next chapter.

It is important to note that this dissertation is not only initiated due to the inspiration of the earlier studies but also to deliver a statement that the service marketing lens can contribute to understanding this growing industry. Furthermore, taking advantage of the richness of data acquired from a dynamic yet volatile setting of an EM country sheds light on the fragmented knowledge about organizations’ operation within such context (Kumar and Srivastava, 2019; Sheth, 2011). More on the current condition of the MT industry in the EM context is presented in the next section.

1.2. Understanding MT in emerging market context

Started as a niche market, MT is now a multibillion-dollar phenomenon with expected annual growth of 20 percent (Visakhi et al., 2017). The growing popularity of the MT industry indicates acceptance of healthcare service as a product worldwide. Patients’ mobility is often driven by timely access to medical care (Turner, 2011), advanced technology (Ehrbeck et al., 2008), or better quality care, as well as affordability of service (Connell, 2006). Catalyzed by sufficient information on the internet and cheap transportation costs while taking advantage of tourism infrastructure, the MT has become a global industry today that entices nations, particularly those embarking on development and reforms such as EM countries. As for many EMs, MT has become a rational economic strategy that plays an important role for economic and social development (AbuKhalifeh and Faller, 2015; Bookman and Bookman, 2007). The political leaders of India, Thailand, Singapore, Malaysia, Indonesia, and the Philippines understand that MT can increase their financial means through “diversifying their economies, attracting foreign investment, promoting job creation,
building the health services industry and using regional strengths to benefit from the doctrine of comparative advantages” (Turner, 2007, p. 313). However, not all EM countries can easily sustain their ambition in becoming successful healthcare providers due to environmental complexities. Still, EM countries are among the destinations that hold a strong global market position for offering healthcare services (e.g., AbuKhalifeh and Faller, 2015; Beladi et al., 2019; Bookman and Bookman, 2007; Connell, 2013; Virani, Wellstead and Howlett, 2020; Zarei and Maleki, 2019).

The term EM has no clear definition and is sometimes used as a synonym for developing countries and an antonym to developed nations. Efforts have been made to define EM. For instance, Hoskisson et al. (2000) state that these countries “are low-income, rapid-growth countries using economic liberalization” (p. 249). At the same time, Tanusondjaja and his colleagues (2015) characterize EMs as nations with low levels of infrastructure and resources. Rottig (2016), on the other hand, highlights the unique institutional environment of EMs that is not present in developed countries. One major feature of EM is the lack of proper infrastructure and institutions which leads to what Khanna and Palepu (2010) call “institutional voids.” The deficiency in the institutions often relates to “relative importance of informal compared to formal institutions” (Rottig, 2016, p. 4). Failing to develop efficient institutions has slowed down the development process in EMs compared to developed nations. For example, Khanna et al. (2005) observe that the absence of developed institutions complicates the dissemination of reliable information, proper regulation, and economic efficiency in EMs. Despite these unfavorable conditions, many countries such as India, Thailand, Malaysia, South Korea, and the Philippines have emerged as MT destinations.

Enderwick and Nagar (2011) believe that some EM economies even hold a competitive advantage due to a high supply of affordable medical services, and (some countries have) an abundance of young professionals. In fact, the distinctive capabilities of EMs in healthcare delivery were recognized even a few decades ago by the intergovernmental economic association, Organization for Economic Co-operation and Development (OECD) (OECD, 2002). Within the context of this transformation, healthcare providers in these destinations excel effort to (re)build their existing healthcare systems and seek acceptance internationally. Acquiring international accreditations to indicate high-quality standards and increased collaborations with reputed international institutions has been commonly observed among hospitals and clinics investing in MT (Bookman and Bookman, 2007; Connell, 2013).

Governments, healthcare providers, and other private entities are now found to put joint efforts in many EMs to serve global patients. Nevertheless, not all health providers have the capabilities, resources, and full support of government to compete with the global leaders (Enderwick and Nagar, 2011; Pasadilla, 2014). These providers are therefore forced to adapt their strategies based on their resources for them to compete internationally. This is more often the case for hospitals and clinics operating in some EM countries that academics often described as places that have
weak institutions, ambiguous regulations, and inadequate infrastructure (Rottig, 2016; Sheth, 2011; Xu and Meyer, 2013).

In sum, service providers engaged in the MT industry in EM countries have two major concerns: (1) finding ways and means to market healthcare services efficiently, and (2) dealing with environmental constraints inherent from its volatile and complex setting. However, EM countries play a significant role in the MT industry not only as popular destinations but also as places where the “completely new social, political, and business models” are created to encompass the existing demands of the international healthcare market (Bookman and Bookman, 2007, p.4). Focusing on context has become an important issue in (service) marketing research (Sheth, 2020). This study considers that EM context offers healthcare service providers both challenges and opportunities, and also a new perspective in dealing with different concerns (Kumar and Srivastava, 2019). In this investigation, MT is observed in an EM country – the Philippines. This country is one of the known MT destinations (Fetscherin and Stephano, 2016) and one of the fastest growing EM countries according to Oxford Economics (Burroughs, 2019). The MT in the Philippines is further discussed in the coming section.

1.3. MT in the Philippines

The Philippines is one of the current MT destinations in Asia (Turner, 2011). The vision of the Philippine government to be the “hub of medical tourism” started more than four decades ago during the era of the former President Ferdinand Marcos (Picazo, 2013). He commenced the creation of the medical centers of excellence, which introduced four specialized hospitals; namely, Philippines Heart Center (established 1975), National Lung Center (established 1981), National Kidney and Transplant Institute (established 1983), and the Philippine Children’s Medical Center (established 1979). As a result, the country has pioneered stem cell transplantation for kidney and lung disorder since 1990 (National Kidney and Transplant Institute, n.d.). Another advantage at that period was the well-developed air transport services. The country’s flag carrier Philippine Airlines was at that time considered to be the most modern Asian airline, serving passengers to major cities in Asia (Bahrain, Hong Kong, Saigon, Shanghai, Singapore, Taipei) United States (San Francisco), and Europe (Frankfurt, London, Madrid, Rome, Zurich) (Philippine Airlines, n.d.). The realization of this vision was upheld when President Marcos was removed from power in 1986.

In the succeeding years, aesthetic and cosmetic surgery became popular. Realizing the potential economic benefit of the growing industry, then President Gloria Arroyo once again stimulated national interest in MT and imposed an executive order aiming to organize the industry in 2004 (Bookman and Bookman, 2007). The Philippine Medical Tourism Program (PMTP) was initiated to gather public and private entities for developing strategies to make the country “a global leader in quality health care”
(Department of Health, n.d.). The Philippines offers a wide range of high-quality medical services at an affordable price compared to Singapore and Thailand (Porter et al., 2008). There are hospitals in the country that have international accreditations from organizations such as Joint Commission International (JCI), Accreditation Canada (AC), and International Organization for Standardization (ISO). The country has an abundance of highly qualified medical professionals; it is known to be the largest source of nurses working all over the world (Bookman and Bookman, 2007). A large number of Filipinos go abroad to study, particularly in the field of medicine. For instance, Filipinos are the second largest (after Indians) non-American group of medical graduates in the United States (Pasadilla, 2014).

Filipinos are recognized as friendly, hospitable, and English-speaking people, making it easier for tourists to communicate (Pasadilla, 2014). In addition, there are still many unexploited tourist spots that are comparable with other Asian countries that visitors can explore. One of the unique characters of the Philippines’ MT is the significant number of Filipino diaspora patients. Filipinos who are working and living in other countries visit the country and take advantages of the medical services available while visiting relatives and friends in their home country (Picazo, 2013).

1.3.1. Local benefits in the MT industry

Economic growth is the main reason why many EMs invest in the industry (Connell, 2013; Turner, 2007). MT presents a good opportunity for these countries to economically benefit by bringing in foreign currency and the possibilities of a continuous source of expansion that the two labor-intensive sectors (health and tourism) can offer (Bookman and Bookman, 2007). Moreover, the popularity of MT can also attract both local and foreign investment to activate economic growth. Filipino Secretary of Health Dr. Paulyn Rosell-Ubial observes that public and private investments in the health sector are growing (The Worldfolio, 2017). An example of local investment is Centuria Medical Makati, a one-stop outpatient medical facility for foreign and local patients (Centuria Medical Makati, n.d.). Centuria opened to the public in 2016 and planned to accommodate more than 700 clinics. Thailand’s Bumrungrad Hospital showed interest and invested in Asian Hospital and Medical Center, one of the JCI-accredited hospitals in the Philippines (Picazo, 2013). During the initiation of the government program PMTP in the private sector in 2004, tertiary hospitals in particular took advantage of the chance to upgrade their facilities (Pasadilla, 2014). Imposition of government tax holidays and exemptions in duty tax for medical equipment allowed hospitals to import high-end equipment that was not available in the Philippines before (Picazo, 2013). The government’s step in promoting MT thus contributed to the advancement of healthcare services in the country.

Increased MT practices in the country have also caused “brain drain.” Brain drain has been a big problem in the country, since many Filipino professionals like nurses and doctors choose to look for jobs and get better pay outside the country (Bookman
1. INTRODUCTION

and Bookman, 2007). However, there are some indications of “brain gain” in the country as well. There is a reverse movement of highly skilled Western-trained professionals going back to the Philippines and starting to practice in the field of their expertise. Some of them even establish businesses, employ, and train young doctors and nurses in the country. For instance, Dr. Norman San Agustin, a Filipino physician, established the first profit-for-charity ambulatory cancer care clinic in the country, Asian Breast Center, in 2018. Dr. San Agustin is a fellow of the American College of Surgeons and founder and former president of Morristown Surgical Associates in New Jersey in the US (Jambora, 2017). In 2001, a prominent ophthalmologist in Boston, Dr. Felipe Tolentino, played a significant role in starting the Asian Eye Institute (Asian Eye Institute, n.d.). Dr. Tolentino have carefully chosen Harvard-trained ophthalmologists to be a part of the initial core medical team of the center. At present, the Asian Eye Institute is a recipient of international and regional awards and recognition. Both organizations cater international patients and assume social responsibility by providing free high-quality service for those who qualify as recipients of medical care.

1.3.2. Local challenges in the MT industry

MT can be a part of solutions and problems in the destination countries. Although some believe that it can be a good source of income to finance the healthcare of the local population, some still insist that MT’s trickle-down effect is not yet determined (Connell, 2011). Providers in EM countries often highlight their capabilities to offer timely and inexpensive advanced medical procedures. Nevertheless, most local patients can not avail themselves of these services because they are expensive and more focused on international healthcare consumers (Pocock and Phua, 2011), like in India, Thailand, and the Philippines. Enderwick and Nagar (2011) see the importance of adequate soft and physical infrastructure in the growth of MT. In the latter study, the authors recognize that not even the popular MT countries (Thailand, Singapore, Malaysia, and India) have all the elements of the ideal destination. This suggests that despite the challenges, EM countries and providers are able to navigate and overcome the hurdles.

A study conducted by the Asian Institute of Management summarized the issues that restricted the progress of the Philippines in MT (Manila Times, 2014). First, air travel to the country is expensive. Even though the prices are lower than some Asian competitors, the lack of direct flights to the country adds to the costs of the patients’ budget. Furthermore, transfers at airports may contribute to patients’ distress, particularly as they already are in a vulnerable condition due to their illness. Second, the transport infrastructure is inefficient. All of the international accredited hospitals are located in metropolitan Manila, where deficits in the transportation system could be unbearable for medical tourists. Third, concerns surrounding security and public safety can make tourists think twice before choosing the Philippines. Fourth, the strategy of the government in developing a niche that can identify the country’s
competitive advantage is unclear. The country lacks a key selling point compared to its neighboring destinations (Manila Times, 2014). For instance, the National Kidney and Transplant Institute (NKTI) is the pioneer in kidney transplant in Asia, where the first kidney-pancreas and kidney-liver transplants were performed (NKTI, n.d.). This can attract niche market, yet the country fails to exploit it to its own advantage.

Pasadilla (2014) refers to the nation’s strategy as “a stop-go effort” due to the inconsistency in the government’s actions to support the development of the MT industry. As a result, privately owned hospitals and clinics create their own platforms and business strategies that fit their organizations. Well-established medical providers (majority privately owned) that can afford to acquire international accreditation and affiliation, (re)build new structures, employ medical specialists, and invest in state-of-the-art equipment flourish in MT, while the others are left behind. Such actions have resulted in three unfavorable effects on business development. First, it creates a gap between public and private healthcare quality that harms the Philippines as a likely destination (Porter et al., 2008). Second, it causes local brain drain. Improvement in the private healthcare sector becomes more attractive for many young and experienced professionals, which threatens the public healthcare operation. Driven by the concern in the institutional setting, the majority of providers focus on attracting Filipino diaspora. Due to expected cultural affinity and familiarity with the language and setting, many think that targeting Filipino diaspora is a better option. However, Porter and colleagues (2008) claim that concentrating on diaspora can hinder MT stakeholders’ possibility to see the opportunity to attract a majority of international patients. Thus, it contributes to a third unfavorable effect. Local challenges in the MT industry impede the country from reaching its full potential; thus, these challenges need to be addressed. Although some programs are in the pipeline that improve the soft and physical infrastructure of the country (Burroughs, 2019), the outcome that can directly affect the industry is still unknown.

1.4. Knowledge gaps

Employing marketing concepts in healthcare service studies is nothing new (e.g., Berry, 2019; Berry and Bendapudi, 2007; Brown, 1983; Crié and Chebat, 2013; Hunt, 1976; Gallan et al., 2013; Hyder and Fregidou-Malama, 2009; Lovelock, 1977; Ostrom et al., 2015; Zaltman and Vertinsky, 1971). However, unlike the previous studies this research brings a new base of perspective because it focuses on healthcare services that are promoted internationally but performed in local setting. More importantly, this study directly contributes to the underdeveloped subfield of healthcare service marketing, which, according to recent literature reviews, is still considered in its infancy (Balogun and Ogunnaike, 2017; Butt, Iqbal and Zohaib, 2019), and lack of common understanding (Crié and Chebat, 2013). This study does not implies that service discipline is lacking relevance. Considering its rapid development in the global marketplace, there are still phenomena and marketing topics that are under-
reported and important for academics and practitioners (Bolton, 2020). This investigation stresses that MT is one of those underscrutinized phenomena, and healthcare service marketing is one of those marketing topics that need further exploration.

A number of studies on MT industry have been conducted by scholars from different fields such as economics (Bookman and Bookman, 2007), business (Enderwick and Nagar, 2011), epidemiology (Snyder et al., 2011), law (Pocock and Phua, 2011), geoscience (Connell, 2006), public health (Hopkins et al., 2010), tourism (de la Hoz-Correa, Muñoz-Leiva, and Bakucz, 2018) and sociology (Lunt, Horsfall and Hanefeld, 2016). A database search for peer-reviewed literature via Scopus during 1963–2020 shows that most MT-related studies are conducted in medicine, while works from a business perspective are less represented. Further, studies in business are mainly published by tourism scholars, leaving marketing underrepresented. This study therefore does not solely answer the call for further research by the marketing scholar but also bridges the researcher gap between marketing and MT literature (Fischer, 2014; Heung, Kucukusta and Haiyan, 2010; Lim and Ting, 2012; Zarei and Maleki, 2019).

Not surprisingly, most of the scholars who concentrate on MT industry come from the fields of medicine and tourism. However, Alvesson and Sandberg (2011) claim that research should not only be limited to “gap-filling” in the literature but also to question and expand the existing assumptions. For that reason, this study is positioned to challenge and enhance medical and tourism studies’ assumptions by employing a service marketing perspective. Furthermore, this is significant because healthcare is a fertile scholarly field that can sustain academic significance and promote diversity in the area of service and marketing (e.g., Berry, 2019; Berry and Bendapudi, 2007; Butt et al., 2019; Benoit et al., 2017). In addition, performing investigation in healthcare answers the call for research by service scholars that can develop knowledge that is beneficial for both businesses and society (Bolton, 2020).

Although data about the number of international patients and growth of MT is often questioned, there is a consensus about its potential (e.g., Connell, 2013; Fetscherin and Stephano, 2016). In the Bulletin of the World Health Organization (WHO), Ruggeri and colleagues (2015) claim that along with contenders such as Thailand, Singapore, India, Malaysia, and USA, substantial numbers of international patients travel to other emerging nations like Cuba, Egypt, Jordan, and the Philippines. Many EM countries included in the study have drawn more foreign patients than in developed countries. For instance, Australia (in 2010) and Germany (in 2008 and 2009) received average annual medical travelers around 13,000 and 70,000 patients respectively, while the Philippines accommodated about 250,000 (2006, 2009, and 2010) patients per year (Ruggeri et al., 2015). This suggests that healthcare providers located in EM countries can attract more patients despite the unfavorable conditions. The question is how they do it. It turns out that upon conducting studies in EM countries, there is a possibility to gather substantial data that can be used to challenge, assess, and develop theories (Paul, 2019; Sheth, 2011; Xu and Meyer, 2013).
Thus, investigating the MT industry like in the Philippine context answers the call for research in EM to advance marketing as academic discipline and sustain practical significance (Burgess and Steenkamp, 2006; Kumar and Srivastava, 2019; Sheth, 2020; Xu and Meyer, 2013).

The present study contributes by addressing these knowledge gaps. The next section discusses the aim and subaims of this research.

1.5. Aim, objectives and research questions of the study

Worldwide MT is a growing evidence of the patients’ mobility (Ruggeri et al., 2015). This trend of patients traveling a long distance to find services that fit their medical, social, and financial needs suggests that healthcare providers at the destination adapt better than domestic providers. This dissertation strives to shed light on how providers work in complicated settings while selling complex services. The aim of the study is to examine how service providers in an EM country market healthcare services internationally. In order to fulfill this aim, the following objectives are outlined:

1. Search for an EM country that offers healthcare services internationally.
2. Identify providers in an EM country that focus on marketing in offering MT services.
3. Collect and analyze data from healthcare providers through interviews, documentation and direct observation.
4. Develop a theoretical framework that illustrates healthcare service marketing.

Two research questions are addressed in this study:

i. How do MT providers meet the challenges in marketing healthcare services?
ii. How do MT providers in an EM context operate in marketing healthcare services?

Guided by these research questions, this thesis intends to understand the novel role of organizations, specifically the hospitals, clinics, and facilitators, in this growing service-driven sector. Illustration of the contribution of the four appended articles as well as the allocation of task among authors are presented in next section.

1.6. Summary of the contribution of the article and authors

This section summarizes the contributions of each article and the role that each author in the research process. Three out of the four papers appended in this dissertation are co-authored with my three supervisors – Professor Akmal Hyder, Professor Erik Borg, and Professor Aihie Osarenkhoe. Table 1 shows the details.

Table 1. Summary of the contributions of each article and of the authors
### Article I

**Medical tourism in emerging markets:**

*The role of trust, networks and word of mouth*

**Aim**

To analyze how healthcare providers meet different challenges to market MT in an EM setting.

**Type of paper**

Research paper

**Contribution of author/s**

*Hyder, A.* – developed the idea, conceptual framing, assisted with discussion, analysis, finalization, and submission of the manuscript (First author)

*Rydbäck, M.* – assisted in developing the idea, methodology and data collection, writing empirical evidence, help in the analysis and discussion, support in finalization and submission of the manuscript (Second author)

*Borg, E.* – Planning of data collection, critical revision (Third author)

*Osarenkhoe, A.* – Planning of data collection, critical revision (Fourth author)

**Contribution of the article**

This initial phase of the research process identifies the limited academic literature on MT and the scarcity of theoretical frameworks to understand the phenomenon. From a service marketing perspective, this empirical research advances knowledge through studying how healthcare providers in EM settings assume the role as marketers of a high credence service. A theoretical framework using trust, network and word of mouth is proposed.

**Phase of Article**

Published in *Health Marketing Quarterly*

### Article II

**Customization in medical tourism in the Philippines**

**Aim**

Focusing on customization, this research aims to examine how service providers market healthcare in emerging markets through MT.

**Type of paper**

Research paper

**Contribution of author/s**

*Rydbäck, M.* – developed the idea, conceptual framing, method, data collection, discussion, analysis, finalization, submission of the manuscript and critical revision (First author)
### Article III

**Role of Facilitators in the Medical Tourism Industry:**

*A Study of Medical Tourism Facilitators in an Emerging Market*

**Aim**
To examine the role of medical tourism facilitators in the medical tourism industry in the context of an emerging market.

**Type of paper**
Research paper

**Contribution of author/s**
Rydback, M., Single author

**Contribution of the article**
This paper highlights and answers the call for further investigation of medical tourism facilitators. Extending and providing Lovelock's supplementary service model, a model is proposed. This research also sheds light on the understanding of how facilitators operate and their potential contribution to the industry, specifically from an EM perspective.

**Phase of Article**
Submitted to the journal *Service Marketing Quarterly*

### Article IV

**Medical Tourism Networks in an Emerging Market**

**Aim**
This study examines how care providers in an EM setting handle challenges in marketing healthcare using networks.

**Type of paper**
Research paper

**Contribution of author/s**
Rydback, M. – developed the paper, wrote part of introduction, literature, and method, facilitated data collection, discussion, analysis and conclusion (First author)  
Osarenkhoe, A. – helped in writing the introduction and theoretical background, planning of data collection (Second author)
1. INTRODUCTION

Borg, E. – developed the initial idea of the paper through writing the introduction, literature and method partly, as well as planning data collection (Third author)

<table>
<thead>
<tr>
<th>Contribution of the article</th>
<th>This paper contributes to the limited marketing literature tackling the MT industry in a unique EM setting. It sheds light on how double (physical and mental) intangibility and contextual constraints are dealt with through network building in a real-life situation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase of Article</td>
<td>Submitted to the <em>International Journal of Pharmaceutical and Healthcare Marketing</em>.</td>
</tr>
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</table>

1.7. Limitations of the study

The investigation is based on a single geographical context, the Philippines, and from a firm-level perspective. Focusing on the healthcare providers’ managerial viewpoints from one country limits generalizability. Yet constructing a study in one setting allows researchers to go deeper into the subject, which is specifically important with a complex phenomenon like the MT industry. For instance, different supporting organizations from private and public entities are included in the study. This might not be possible if the investigation was conducted from different countries, which was initially planned for this project.

Although healthcare consumers’ point of view can illustrate the effectiveness of the marketing strategy that providers employ, no data were collected from them. This is not to say that the patients’ viewpoint is insignificant. This limitation has been necessary for two reasons: (1) to avoid the ethical issue and (2) to keep the extent of data under control. The focus of this study is service providers; thus, collecting data from patients is left untouched.

1.8. Structure of the thesis

This thesis is composed of a cover essay and four appended papers. There are six chapters in the cover essay. Chapter 1 introduces the background of the study, including the history, current information, the benefits and challenges of MT in the local setting. This is for developing the aim and research questions of this thesis. Limitations of the study are also presented in Chapter 1. Chapter 2 discusses the theoretical background of the study. This chapter further presents the context of the study by defining MT and the EM setting. It further reviews the literature on service marketing, its relevance, and position in this present study. Importance of trust, network building, customization, and the notion of supplementary services are also presented in this chapter. Chapter 3 describes how the research has been conducted. It explains the perspective on the data collection of the study, the research process, and data analysis. This chapter also reflects on the rigor of the research as well as the
limitations and critique of the method used. Chapter 4 provides a summary of the four articles included in the study. A table is also used to illustrate an overview of these four articles. Chapter 5 discusses data obtained from the study in relation to the earlier studies discussed in Chapter 2. Chapter 6 discusses the conclusions and theoretical, managerial, and social implications, as well as limitations and prospects for future research. Figure 1 illustrates the structure of the thesis.

Figure 1. Structure of the thesis.
2. Theoretical Background

This chapter reviews the existing literature to provide a theoretical foundation to understand the overview and purpose of this thesis. Given that the MT industry lacks an established meaning, this chapter starts by giving its operational definition. Then the catalysts for and barriers to MT development are further explored. After that, the complexity of MT operation in the EM context is closely examined. Further subsections of the chapter focus on healthcare service marketing, and the four significant notions, namely trust, network building, customizations, and supplementary services, are further reviewed. Theoretical framing and positioning are illustrated. The presentation of the dissertation overview concludes this chapter.

2.1. Defining medical tourism (MT)

MT is used interchangeably with various terms like health tourism (Hall, 2011), wellness tourism (Visakhi et al., 2017), medical travel (Connell, 2013), and healthcare globalization (Lunt and Carerra, 2010). However, the term MT is considered generic and has been popularized in academic and media publications. While the majority agrees that MT is not a new development, there is still no consensus in its definition. There are many attempts to define MT. Two of the first researchers to tackle the MT industry in business studies claim that it “refers to the practice of traveling across international borders to seek healthcare” (Enderwick and Nagar, 2011, p. 329). Another frontrunner in MT research is human geographer John Connell, who asserts that it happens when “people (often) travel long distances to overseas countries to obtain medical, dental and surgical care while simultaneously being holidaymakers, in a more conventional sense” (2006, p. 1094). From a public health point of view, Visakhi and colleagues (2017) define MT as “the process of traveling outside the country of residence to receive medical care” (p. 73). This is to a certain degree in line with another description of MT as “the organized travel outside one’s natural healthcare jurisdiction for the enhancement or restoration of the individual’s health through medical intervention” (Carerra and Bridges, 2016, p. 449). Although all definitions contain traveling and medical purposes, the previous three explanations are clear on international movement, while Carerra and Bridges add that the travel is prearranged. Another explanation from public health academics indicates a broader and bolder picture of MT as “cross-border health care motivated by lower cost, avoidance of long wait times, or services not available in one’s own country” (Hopkins et al., 2010, p. 185). At this point, the authors list the known reasons that push patients to seek care in other countries. Perhaps the closest definition that can be associated with business studies is from Bookman and Bookman (2007), an economist and a lawyer.
that look at the MT industry from a multidimensional perspective. They state that MT “is an economic activity that entails trade in services and represents the splicing of at least two sectors: medicine and tourism” (Bookman and Bookman, 2007, p. 10).

Despite the myriad definitions from different disciplines, World Tourism Organization (UNWTO) and the European Travel Commission (ETC) still claim that MT, together with health and wellness tourism, have a poor and fragmented definition (IMTJ, 2019). In its present condition, UNWTO and ETC believe it “makes it extremely hard for organizations in the sector to benchmark performance at country, destination or facility level.” Therefore, they propose a taxonomy for health (as an umbrella term), wellness tourism, and MT. MT is defined as “a type of tourism activity which involves the use of evidence-based medical healing resources and services (both invasive and non-invasive). This may include diagnosis, treatment, cure, prevention, and rehabilitation” (IMTJ, 2019, n.p.).

Inspired by the various interpretations, MT is defined in this study as:

systematized medical activity combined with tourism that involves people traveling across borders to seek healthcare services.

The word systematize implies that there are intertwining organizations that bring together the activities for tourism and medical treatment. Even this study acknowledges that the main goal of consumers is to improve their health; tourism activities are included due to the employment of tourism infrastructures like transportation and accommodation facilities. The word people is used instead of patients to mitigate the stigma that all medical tourists are sick. This might not be so inviting for prospective tourists seeking for example, health screening. The notion across borders is employed instead of overseas or international borders to allow for patient mobility within the country or interstate (domestic MT). The word healthcare is used instead of medical care to underline that the focus in the investigation are “the services rendered by members of the health professions” (American Heritage Medical, 2011) and not only “the portion of care under a physician’s direction” (or medical care) (Medical Dictionary, 2009).

Defining MT is positioned to describe what this study finds about this phenomenon. Making such a distinction supports understanding the subsequent discussion about the catalysts, barriers, and operationalization of MT in an EM, as well as its position in relation to the employed theoretical lens.

2.2. Catalysts for and barriers to MT

Although the number of incoming medical tourists is often questioned, the trend shows one thing: the number of healthcare consumers is growing. Empirical studies show that international healthcare consumers look for advanced technology at an affordable price (Lunt and Carrera, 2010). Long waiting lists (Hall, 2011; Turner, 2007) and unavailability of the medical procedure in the country of residence (Heung
et al., 2010) can also motivate healthcare consumers to seek services across borders. In some cases, anonymity and privacy (i.e., a cosmetic operation) (Connell, 2006) and generous bioethical legislation (i.e., legalization of abortion) can encourage healthcare consumers to engage in MT (Borg et al., 2014). Availability of the information on the internet (internet marketing) and cheaper transportation costs also influence healthcare consumers. In the USA, private entities such as medical insurance companies and corporations that seek affordable medical care for their employees which activates the growth of MT (Ehrbeck et al., 2008). Even public entities contribute to the new trend in MT. For instance, in Europe, EU directive 2011/24 was imposed to facilitate patient mobility within the EU countries (Borg et al., 2014). Inclusion of MT as a part of public policy with strong government support has been seen as beneficial to the industry’s popularity (e.g., in Thailand, Singapore, Malaysia, India) (Enderwick and Nagar, 2011).

Bookman and Bookman (2007) claim that the main reasons for the phenomenon’s popularity are demographic (growing number of people living longer), medical (increase in chronic diseases), economic (people better economic status), and social (willingness to travel). The advent of the internet give the possibility for the providers to reach a large number of people and consumers to collect information. It empowers both the consumers to choose the healthcare providers that fit their needs and the providers to decide where they can find their paying consumers. Another motivation for patients to travel away from their residence is the accessibility of state-of-the-art technology (AbuKhalifeh and Faller, 2015). The availability of medically advanced procedures is now enjoyed even in emerging countries (Hall, 2011). Due to cheaper labor costs and simpler regulation, many destinations can offer more affordable services compared to local healthcare providers in developed countries (Lunt and Carrera, 2010). This is particularly important for patients that pay out of pocket or are underinsured. The affordability of travel fare has also offered a possibility for many people to accept the MT destination’s attractive proposal (Saragih and Jonathan, 2019). Connell (2013) has recently observed that patients travel shorter distances and toward destinations that they are culturally familiar with (diasporas). Believing that the MT industry can bring economic and social development, many governments play a significant role in its facilitation (Enderwick and Nagar, 2011). Some of its supporters observe that it can provide local employment, investment, foreign currency reserves, and national healthcare development, as well as counter the brain drain.

The popularity of the MT industry has not been without dispute. The expected infusion of funds coming from international patients to facilitate the trickle-down improvements for the local healthcare system is far from reality (Connell, 2011). The availability and accessibility of modern medical services might be affordable to many medical tourists, but it is not for most local patients (Turner, 2007). While some hospitals, like in India and the Philippines, give domestic patients a lower price, it is still considered expensive for the majority of the population (Enderwick and Nagar,
Thus, the presence of state-of-the-art medical technology in a country cannot be considered complete relief for the local population. Another expectation upon countries’ engagement in the MT industry is to promote brain gain. Although there are professionals that come back and stay to serve the domestic healthcare industry, some decide to work for private providers due to financial benefits (Bookman and Bookman, 2007). Uneven development between public and private hospitals intensifies health inequality (Pocock and Phua, 2011). Thus, some claim that development in MT “challenges rather than complements local health care providers, distorts national health care systems, and raises critical national economic, ethical and social questions” (Connell, 2011, p.260).

The obstacles just discussed are domestic in origin, which makes them easier for local institution to address. Nevertheless, this can be a problem for EM countries, which are often described as lacking well-established institutions and infrastructure to handle such concerns. Failing to make a concrete solution for the local population to realize the financial benefits of MT promotes social concern. The uneven development of private and public health systems can be unsustainable in the end. Addressing timely and fundamental solutions to these issues can not only ease the operation in EMs but also make them attractive destinations. This is particularly essential for the countries in the Asian region, where many destinations are located (Connell, 2013).

2.3. Emerging markets as MT destinations

EM countries in Asia are highly competitive in MT due to the high and stable demand for healthcare from the increasing population in the region. To date, 140,000 hospitals are serving 3.5 billion Asian patients, and the demand is expected to grow (Enderwick and Nagar, 2011). Although the population in EMs is growing, the concerns center on the demographic and diversity of the people. A large part of the population growth in EMs consists of young people belonging to the mass market with low spending power (Burgess and Steenkamp, 2006). Therefore, the increase of population does not guarantee the realization of MT success, if healthcare providers in the region mainly depend on the local market.

According to Bookman and Bookman (2007), EMs usually possess an abundance of young professionals (i.e., doctor and nurses) that is beneficial to the MT industry. Healthcare providers can offer a reasonable price to the consumer due to lower labor costs and elimination of other unnecessary costs, such as commissions to other parties or generous malpractice insurance. Prices are usually circulated for healthcare consumers to compare. The competitive nature of MT creates an efficient market that is particularly advantageous to consumers. Maintaining affordable prices puts pressure on service providers to hold down the labor costs. Consequently, young professionals in EMs are likely to leave their home countries for better pay (and due to lack of job opportunities) which can result in brain drain (Connell, 2011).
rapid social and demographic change can be unbearable for many emerging economies. Due to scarce financial resources in some EMs, governments tend to rely on the active participation of private stakeholders in social and economic development. Involvement of private business in MT illustrates the vitality of the industry (Bookman and Bookman, 2007; Beladi et al., 2019). Yet, lack of government intervention can be problematic in the long term, because a government role is seen as beneficial to MT industry success (Enderwick and Nagar, 2011).

EM countries continue to strive and dominate the MT industry. There are a number of studies that focus on these countries (e.g., Beladi et al., 2019; Bookman and Bookman, 2007; Enderwick and Nagar, 2011; Hinson et al., 2019). Although these studies give comprehensive representation on the present status of the industry, they seldom consider the complexity of the offering itself. The pressures in operating in the MT industry do not solely lie on the context and competition, but also in providing the product that fits the need of consumers. Selling healthcare to patients can pose moral and ethical issues. This is despite the fact that “institutional taboos against advertising in medical professionals” had already started to be challenged four decades ago (Lovelock, 1977, p. 61). The popularity of the MT industry implies that marketing managers contribute in promoting this sensitive product. Therefore, to understand how MT providers operationalize in an EM context, this study looks to the service marketing focusing on its subfield healthcare.

2.4. Understanding healthcare service marketing

The term healthcare marketing is employed in the marketing of life science, social marketing, and service marketing (Butt et al., 2019; Crié and Chebat, 2013). In this study, service marketing lens is applied to see how healthcare is promoted. Thus, healthcare service marketing is used. To appreciate the healthcare services marketing, it is important to understand how the service marketing, a sub discipline of marketing, has developed and relates to the area of healthcare. A brief background of service marketing comes next, followed by operational definition of healthcare service marketing.

The acceptance of service marketing as a sub discipline of marketing was never an easy task, specifically not for young scholars like Robert Judd (1964) and John Rathmell (1966), who initiated and challenged the academics of the marketing mainstream of the time. During that time, research was limited among the conservative academics that questioned the significance and uniqueness of marketing services (Fisk, Brown, and Bitner, 1993). In 1977, Lynn Shostack, Marketing Director of Citibank in New York, pointed out the insufficiency of the mainstream marketing literature in dealing with service issues (Shostack, 1977). Her article made a significant impact not only because it questioned the relevance, and the “ignorance” of practitioners and academics, but also for the criticism that came from outside the academic community (Fisk, Brown and Bitner, 1993). Shostack’s article stimulated
scholars to act. The continuous efforts of John Bateson, Leonard Berry, Stephen Brown, James Donnelly, Christian Grönroos, Evert Gummesson, Eugene Johnson, Eric Langeard, Valerie Zeithaml, and others led to service marketing being seen as an established and growing academic field in the early 1990s (Berry and Parasuraman, 1993).

The evolution of the service marketing discipline generated from (1) interaction between academics and practitioners, (2) strong interdisciplinary orientation, and (3) the contributions of international academics specifically in Scandinavia, United Kingdom, and France (Fisk, Brown and Bitner, 1993). Nonetheless, the legitimacy of its status has to be maintained and nurtured by the present scholars (e.g., Benoit et al., 2017; Edvardsson, Gustafsson, and Roos, 2005). To date service marketing has acquired some subfields like healthcare, finance, professional, nonprofit, education, government, and hospitality. Among the service marketing subfields, healthcare services are considered to be crucial because they are the “backbone of society and human wellness” (Hinson et al., 2019 p.1). However, in recent years healthcare services are transforming due to commercialization, like in the case of MT industry, hence raising more and new questions. As a marketing scholar, this has given an opportunity to the author of this dissertation to explore and apply service marketing thinking to understand this phenomenon. This is even more important since marketing in healthcare service is seen as a nascent field (Crié and Chebat, 2013) and in its infancy (Fischer, 2014).

In the literature, the term “healthcare marketing” “health marketing” and “health-care service marketing” are used interchangeably and often used in different context (e.g., Anderson et al., 2019; Berry and Bendapudi, 2007; Brown, 1993; Butt et al., 2019; Crié and Chebat, 2013; Hinson et al., 2019). Crié and Chebat (2013) define health marketing as the “systematized application of marketing principles within the very broad, heterogeneous, and complex field of health” (p. 123). This definition is somewhat in line with the present study since it highlights the heterogeneous characteristic and complexity of the sector. Nevertheless, it is unclear what marketing principles authors mean to employ. On the other hand, Hinson and colleagues (2019) make an explicit suggestion that academics and practitioners have to integrate service marketing and management concepts to enhance the quality of healthcare service marketing. However, despite underlining the service marketing, the latter statement lacks recognition on the unique requirement of healthcare consumers (Ben Ayed and El Aoud, 2017; Berry and Bendapudi, 2007; Lim and Ting, 2012).

Drawing from the above discussion, healthcare service marketing is defined in this study as:

the subfield of service marketing that involves the application of marketing skills in promoting healthcare services to address the unique needs of consumers in a complex reality.
To emphasize, the lens of this current inquiry *service marketing* has to be mentioned. The word *healthcare services* is included to define what particular service subfield the notion is focusing on. The phase *unique needs of consumers* is incorporated to show that healthcare consumers have special requirements that are not usually demanded by regular consumers because of their conditions (e.g., sick, sensitive, vulnerable). The term *complex reality* is added to the stress that the health sector exists in an environment that is complicated by different organizations’ viewpoints and priorities. This definition aims to establish the position of healthcare service marketing in this present study.

### 2.5. Healthcare service marketing in MT

Service marketing continued to develop because service oriented scholars believed that (1) it filled an important gap in marketing literature and (2) there was an industry that required academics to act (Berry, 2019; Berry and Parasuraman, 1993). Focusing on healthcare service marketing, this dissertation addresses comparable concerns: to contribute to the infancy of this subfield and to answer the calls of further investigation on MT. This section further shows why service marketing lens is an appropriate marketing subfield to conduct this current study. The growth of the MT industry is dependent on care providers, governments, and healthcare consumers (patients) (Crié and Chebat, 2013; Zarei and Maleki, 2019). Care providers are exposed to the competitive environment, price competition, and patients with unique demands. Thus, the role of marketing becomes more critical and significant for the service providers’ survival, as this industry promotes a market orientation for healthcare (Anderson et al., 2019). Although both tourism and healthcare are highly service-oriented sectors, the fundamental purpose of consuming the products differs. A normal tourist seeks pleasure, while healthcare consumers need medical attention. To gain an understanding of the difficulty in MT promotion, this dissertation uses service marketing concept, considering healthcare as the core product, the patients as healthcare consumers, and the hospitals, clinics, and facilitators as healthcare providers. From these three underlying aspects, i.e. core product, consumer, and provider, complications in marketing healthcare services arise in three ways.

First, healthcare service is necessary but not desired (Berry and Bendapudi, 2007). Unlike in hospitality services, healthcare consumers do not feel usually comfortable to travel, even if they find it necessary. Besides the inherent characteristics of services (intangibility, heterogeneity, inseparability, and perishability), this type of service has a high credence factor (Fisk, Grove, and John, 2008; Hyder and Fregidou-Malama, 2009). This implies that assessment of the degree of satisfaction and quality of service is difficult to determine even after consumption. In addition, the patient’s decision is complicated due to inherent medical, emotional, and commercial risks (Enderwick and Nagar, 2011). Therefore, building trust is important to reduce this kind of uncertainty (Rajagopal, Guo and Edvardsson, 2013).
Second, MT relates to nature and complexity around healthcare consumers. Patients are not regular consumers (Crié and Chebat, 2013). Healthcare patients come in contact with MT when they go through a sensitive period of their lives. In most cases, patients are highly involved in the decision-making process, which is unique in the consumer segment (Fischer, 2014). Besides the inherent characteristics, Fregidou-Malama and Hyder (2015) have recognized difficulties related to cultural influences on the international context of health services marketing. Cultural differences between the service providers and consumers regarding beliefs, norms, and attitudes may inhibit the success of service marketing (Millar and Munro, 2012). The impact of how culture influences customers’ perceptions of service has been thoroughly discussed by Wilson et al. (2016). Moreover, due to the abundance of information available on the internet, patients and their families are able to easily access information regarding the illness, its up-to-date treatment, and the price level from different providers. Berry and Parasuraman (1991) observe that patients tend to rely on word of mouth before making a decision. As a result, patients become a knowledgeable, sophisticated, and price-sensitive consumer segment (Connell, 2013), thus making marketing more challenging.

Lastly, healthcare providers such as hospitals and clinics are not traditional business marketers. The health sector is often public-driven, where aggressive marketing is uncommon (Bookman and Bookman, 2007). Therefore, hospitals as a competitive organization attract few scholars’ attention (Fischer, 2014). In the case of MT, healthcare offerings are mostly profit-driven and therefore both private and public entities that see the necessity of rigorous marketing activities for survival. Many healthcare providers create new specialized units, where one focuses on taking care of medical tourists, while the other concentrates on international strategic marketing. Following the standard and institutionalizing medical delivery as it is done in the USA, has become a hallmark of MT providers. Examples of this are care providers that are importing state-of-the-art medical technologies and obtaining an American accreditation like Joint Commission International (JCI), This pattern is also observed in other successful MT destinations like Thailand, Singapore, India, and Malaysia. Thus, the popularity of such an approach becomes the goal of every provider. However, like engaging in MT, westernizing healthcare needs not be considered a generic answer to get the maximum benefits. In fact, as Glick and Vathje (2017) claim, those American practices can result in high costs that patients and organizations may need to avoid. Moreover, unlike other service providers, healthcare workforces are exposed to high levels of stress due to the nature of their jobs, where a single mistake can cost a human life and cause failure to meet the physical and emotional requirements of patients (Berry and Bendapudi, 2007).

In summary, the sensitivity of healthcare, the susceptible condition of the consumers, and the unique functions of service providers make healthcare service marketing different from promoting other services. To tackle and scrutinize the MT industry’s promotion, this thesis uses a service marketing approach, applying theories
on trust, network building, customization, and supplementary services as underlying concepts to examine how service providers market healthcare services. These concepts are discussed in the next sections.

2.5.1. Importance of trust

Success in service marketing “depends on the management of trust because the customer typically must buy a service before experiencing it” (Berry and Parasuraman, 1991, p. 107). This is particularly vital when dealing with sensitive services that involve credence quality, with sick, exposed, and emotional consumers, as in healthcare. The vulnerability of patients and their families is “associated with being ill, the information asymmetries arising from the specialist nature of medical knowledge, and the uncertainty and element of risk” (Rowe and Calnan, 2006, p. 4). Therefore, trust becomes a predominant part of healthcare services, since it increases people’s tolerance and reduces uncertainty at the time of susceptibility (Isaeva, Gruenewald and Saunders, 2020; Luhmann, 1979; Davey and Grönnroos, 2019). Trust exists “when one party has confidence in an exchange partner’s reliability and integrity” (Morgan and Hunt, 1994, p. 23). Due to the inherent service characteristics and the credence factor in healthcare, patients tend to rely on an indication of the trustworthiness of the medical institutions, clinicians, and even the nonmedical personnel (Rajagopal et al., 2013). The relevance of trust has been considered significant in the doctor-patient relationship, patient-nurse relationship, and also toward medical institutions (Anderson et al., 2019; Hall, 2011). Without trust, patients may not consider undergoing medical treatment. Therefore, it is important to build trust quickly, otherwise known as “swift trust.” This means that the providers need to facilitate quick initial judgment that will make the trustee feel secure and safe for trusting (Isaeva et al., 2020).

In the case of the MT industry, Hopkins et al. (2010) claim that patients feel secure if providers have international accreditations and credentials. For example, being accredited by the organization Joint Commission International signifies that the medical institution is up to international standards. The popularity of acquiring international accreditations among MT care providers gives some level of reassurance that patients will receive quality service. This is not to say that accreditation provides an ultimate safeguard for healthcare-related issues, but it somewhat mitigates the risk and uncertainty for both parties. Affiliation with well-known medical institutions offers positive reputational effects as seen in India’s Wockhardt connection to Harvard Medical School (Enderwick and Nagar, 2011) and Singapore’s Raffles Hospital affiliation with Mayo Clinic (Ljungbo, 2019). Therefore, some care providers acquire various accreditations and affiliations to make them attractive, thereby extending their market potential. Number of providers also focus on consumers in nearby countries and diaspora, who are expected to tolerate longer distance traveling due to having a certain degree of familiarity with the language and culture as well as visiting family and friends, along with other reasons (Connell, 2013).
Commercialization of healthcare empowers patients to independently choose which care providers or doctors they will approach. Healthcare marketers with limited medical background may create an effective marketing strategy that can defy the medical side of the service offering. On the other hand, the patients’ capability to determine the providers’ trustworthiness may be difficult due to their limited knowledge. However, Rowe and Calnan (2006) argue that trust is undoubtedly essential to healthcare encounters despite the challenge. Also, trust is even more important in a market-based system, since it can secure loyalty, positive word-of-mouth, and recommendations that secure future profits. Patients’ perceptions of service quality can result in their willingness to voluntarily recommend providers to others (Lien et al., 2014). This is particularly important for MT providers, whose success in attracting consumers is not only based on selling and delivering quality services but also on promoting the place (country) where the service is going to be delivered.

It is therefore reasonable to assume that trust is essential in every stage of healthcare service delivery. However, trust building can be particularly challenging for providers who are located in EM destinations. This is because trust building is not only based on the capacity of the individual provider but also on the broader context, like the setting where an organization operates (Isaeva et al., 2020). Yet the latest literature suggests that MT is actually flourishing in these countries (e.g., AbuKhalifeh and Faller, 2015; Beladi et al., 2019; Zarei and Maleki, 2019). This means that trust is being built up by underlying activities. It seems reasonable to assume that establishment of trust has to be a collective effort among a network of entities within the healthcare industry.

2.5.2. Significance of network building

The applicability of network theory in service marketing has been examined in earlier studies (e.g., Eisingerich and Bell, 2007; Fregidou-Malama and Hyder, 2015). Characteristics of a service influence the operation of an organization (Ostrom et al. 2015; Scott and Laws, 2010). In particular, Bateson (1979) claims that intangibility of services plays the central role that causes all complications and differences in marketing services compared to goods. Service, according to Bateson (1979), is a product that “cannot be touched” and “cannot be grasped,” or what he called double intangibility. Because of physical and mental intangibility, service providers rely on the recommendation of their trusted collaborator while consumers rely on word of mouth (WOM) from their social network. The sensitivity of service and consumers’ vulnerability make both buyer and providers rely on their network to mitigate uncertainty (Eisingerich and Bell, 2007; Rajagopal et al., 2013). For example, medical tourism facilitators (MTFs) collaborate with different hospitals to support patients to find the right hospital, airline, and accommodation facility that fits their requirements. The interorganizational linkage is crucial when the product is complex and within a high level of ambiguity (Eisingerich and Bell, 2007; Vahlne and Johanson, 2017). In the healthcare sector, diversity of organizations within the network is
advantageous, since it allows professionals from different fields to cooperate, enhancing the service offering. As Enderwick and Nagar (2011) claim, the ability of providers to collaborate with related and supporting industries contributes to the advantage of their service offering.

Network can lead to endorsement and indication of good quality (Morrish and Earl, 2020; Rao, 1994). As an illustration, the Mayo Clinic Care Network claims that their member facilities "adhere to the highest standards of professionalism, ethics and personal responsibility, worthy of the trust," in alignment with the institution’s reputation (Mayo Clinic, 2019). For that reason, many hospitals and clinics in EM countries build ties with famous medical associations, facilities, and schools to raise credibility and acceptance (Bookman and Bookman, 2007). Accreditation and affiliation also bring endorsement and open the opportunity for new partnerships. This implies that providers acknowledge the significance of influential actors to safeguard their reputation and extend their reach. Even established multinational companies operating in an underdeveloped setting see the significance of network development to gain acceptance and trust (Johanson and Vahlne, 2009; Osarenkhoe et al., 2020). Contemporary practice in the service industry emphasizes the vital role of interdependency among the stakeholders. However, interconnection with different organizations having conflicting priorities to defend can be problematic (Kay, 2007; Butt et al., 2019). For example, in healthcare context the viewpoints of insurance companies and care providers might differ in how to accommodate patients’ welfare. The medical side of the business has to be given priority over the economic goal when dealing with healthcare. Hence, engaging into partnerships have to be made with precaution (Connell, 2011). This is specifically crucial when marketing highly sensitive services where consumers play a vital role.

The plethora of data on the internet can create confusion particularly for patients and their families who look for dependable providers. As a result, patients seek recommendation from their informal (social) network, family and friends, through WOM. This is apparent on Nielsen’s global trust survey result where 83% of the respondents trust the recommendation from friends and family (Nielsen, 2015). In fact, WOM is becoming a significant primary source of information for patients traveling abroad, with use of internet as a secondary source (Connell, 2013). Such dependency has something to do with the high-perceived sensitivity of the service and the vulnerability of the consumers’ condition (Lovelock and Wirtz, 2011; Zaltman and Vertinsky, 1971). By the same token, today’s technological advances fuels social media like “WOM on steroids” because it reaches larger number of people promptly (Sheth, 2020, p.4). Thus, enhancing informal ties is as vital as formal network in the context of healthcare service marketing (Granovetter, 1973; Scott and Laws, 2010).

Succinctly, having a dependable network is crucial in healthcare operations. However, unlike earlier research (e.g., Morrish and Earl, 2020; Osarenkhoe et al., 2020; Rao, 1994; Vahlne and Johanson, 2017) this study focuses on how local pro-
providers employ network building to handle challenges in promoting sensitive service internationally. Thus, the network in this study is extended and explored from a different perspective.

Consumers’ positive perceptions about the providers are not enough if their expectations are not correctly delivered. Therefore providers still need to know how to satisfy the individual requirements of their consumers upon interaction. Thus, customization is a noteworthy notion in healthcare service marketing that needs further attention.

2.5.3 Relevance of customization

Customization and standardization are often compared with each other as two extremely diverse strategies (Sundbo, 2002), yet some researchers see it as "poles of a continuum of real-world strategies" (Lampel and Mintzberg, 1996, p.21). Although the latter statement is well grounded, it might be debatable since Lampel and Mintzberg (1996) exclusively test their concept with manufacturing products. Creating service offerings requires a chain of activities. In healthcare services a clinician can apply standard procedures (e.g., weighing patients, taking their body temperature) and then customize the rest of the activities to satisfy the patients’ comprehensive requirements. This is not to say that a tailor-made solution is necessary for all services. Nonetheless, customization is considered important in providing complex professional services, because of the focus to the active and demanding consumer in the process (Lovelock, 1983; Pallant et al., 2020).

Customized products generate higher benefits for customers than standard products because they fit their preferences better (Lampel and Mintzberg, 1996; Silander et al., 2019). The success of customization is achieved “if customers have (1) better insight into their preferences, (2) a better ability to express their preferences, and (3) greater product involvement” (Franke et al., 2009, p. 103). This means that customization strategy can be challenging in the case of the healthcare sector, where consumers are sick, reluctant, emotional, and have limited understanding on the service being offered. Moreover, the ability of consumers to express their preferences may be affected by information asymmetry, wherein patients are less informed than the provider about the service. Information asymmetry causes uncertainty in healthcare (Bloom, Standing, and Lloyd, 2008). However to deal with the patients holistically, Berry and Bendapudi (2007) state how services need to be customized to “fit not only a patient’s medical condition but also the patient’s age, mental condition, personal traits, preferences, family circumstances, and financial capacity” (p. 115). Service customization aims to fulfill heterogeneous customer needs, which are often found in medical care (Zeithaml et al., 2006).

Sickness adds to patients’ discomfort, stress, and anxiety, thus demanding more care compared to other consumers (Rajagopal et al., 2013). Satisfying individual needs requires direct interaction between consumer and service personnel. Service interaction often becomes a crucial point for two reasons (1) to build patients’ evalu-
2. THEORETICAL BACKGROUND

Theoretical background is essential for any research as it provides a foundation for understanding the context within which the study is set. It is important to understand the historical and theoretical underpinnings of the research question. This can help in identifying key concepts, theories, and existing research that are relevant to the study. In this section, we will explore the theoretical background of the topic under study.

2.1 Theoretical Framework

The theoretical framework is the theoretical concepts, theories, and models that provide the basis for the research. It is important to have a clear understanding of the theoretical framework to ensure that the research is grounded in a well-established body of knowledge. In this section, we will discuss the theoretical framework for the topic under study.

2.2 Literature Review

A literature review is a systematic examination of the existing body of research on a particular topic. It is important to have a clear understanding of the literature review to ensure that the research is not redundant and that it contributes to the existing body of knowledge. In this section, we will discuss the literature review for the topic under study.

2.3 Methodology

The methodology is the approach that is taken to conduct the research. It is important to have a clear understanding of the methodology to ensure that the research is conducted in a rigorous and transparent manner. In this section, we will discuss the methodology for the topic under study.

2.4 Conclusion

In conclusion, the theoretical background of the topic under study is important for ensuring that the research is grounded in a well-established body of knowledge. The theoretical framework and literature review provide the foundation for the research, while the methodology ensures that the research is conducted in a rigorous and transparent manner. The conclusion of the theoretical background section should summarize the key points and highlight the importance of the research.

2.5 Purpose of supplementary services

All products can be augmented and differentiated by adding service supplements (Levitt, 1980). In line with the earlier statement, Lovelock (1995) proposes supplementary service clusters, also known as the flower of service model. This model is composed of eight essential elements, including information, consultation, order-taking, hospitality, safekeeping, exceptions, billing, and payment, for the benefit of the consumers. A limited test is done on this model. Despite questioned legitimacy, the model’s potential contribution is acknowledged, due to its structured approach suitable for closely examining supplementary services (Frow et al., 2014). Understanding supplementary services is vital to the MT industry, wherein auxiliary services are sometimes performed by intermediaries and not by core providers. As an example, hospitals collaborate with hotels, travel agencies, or medical tourism facilitators to assist their patients with services that they themselves cannot provide. Thus, core providers share the responsibility with other nonmedical organizations to meet different requirements of the patients. Supplementary services “aid in the use of the core product” and “add extra value for customers” (Lovelock and Wirtz, 2011, p. 108). Therefore, supplementary services are expected to enhance the value of the core product and alleviate healthcare consumer’s satisfaction, which is significant for both providers and patients (Chee et al., 2017).

Despite the benefits, the effectiveness of supplementary services may be limited by the nature of the product being offered. This means that not all products require all the supplementary service clusters suggested by Lovelock. In the case of sophisticated
and professional services like MT, the model has to be modified as “specialized products may require specialized supplementary elements” (Lovelock, 1995, p. 46). Employing such a model can help academics and practitioners to choose what particular cluster they need to satisfy an international client. For instance, the internet has been a useful tool (in information dissemination, consultation, order-taking, exceptions, billing, and payment) to accelerate the internationalization of medical services (Borg and Ljungbo, 2018). This might be a source of concern when these supplementary services are offered and prepared by another organization like a facilitator. This creates issues in the MT industry, wherein MTFs play a vital role in connecting care providers and patients, yet are portrayed as firms with inadequate medical expertise, short-lived, operating under weak regulation, and having limited obligation in case of malpractice (Park et al., 2020; Snyder et al., 2011). It is reasonable to suggest that it is even more alarming when offering credence service in EMs, where the institutional environment is often described as immature and not well developed.

2.6 Summarizing the theoretical framing and positioning

In this section, I present a summary of theories that serve as the foundation to address the overall aim of the study, to examine how service providers in an EM country market healthcare services internationally. A service marketing lens is an appropriate theoretical starting point to capture the purpose of the investigation. According to Dubin (1978), a good theory clearly illustrates the constructs that will explain the phenomenon and how and why these constructs are interrelated in a particular context. This study conforms to Dubin’s recommendation. Figure 2 shows the theoretical framework. Within the confines of service research, theoretical concepts, trust, networks, customization, and supplementary services are considered relevant to explore how the service providers promote healthcare services. The four theoretical concepts employed to address the aim and the research questions are presented by the four circles connected by a circular line surrounding healthcare service marketing. It is important to note that the circulating arrows (in blue and black) indicate the dynamic interrelation between theoretical concepts. The MT industry and EM country are study settings, placed on the upper and lower outside the healthcare service marketing and enclosed by big rotating arrows to illustrate the dynamic setting of the research. Building trust is considered to be the hallmark of healthcare marketing services. However, establishing trust is challenging and requires assistance from the service providers’ network. Thus, the network is regarded as an essential notion to include. In the course of service delivery, providers have to sustain, maintain, and live up to consumers’ expectations. Considering the patients’ complex needs and the ambiguous setting where the services are delivered, providers need to customize offers. Hence, customization assumes adjustments to healthcare consumers’ requirements. Despite the advantages of personalized offerings, customized service can still possess limitations in facilitating and enhancing healthcare as a core product. Thus,
the notion of *supplementary services* is added. To improve the value of theoretical propositions, Whetten (1989) urges that theorists have to gather compelling evidence. In this investigation, I follow Whetten’s recommendation by gathering information on the Philippines’ MT industry.
2.7 Presentation of the dissertation overview

Figure 3 illustrates the overview of this study. The current research project focuses on the phenomenon of the MT industry in an EM country, the Philippines. Overall, this study features a service marketing lens, and the thesis covers four concepts, namely: trust, network building, customization, and supplementary services. Each of the concepts mentioned is used as the theory or part of the theory for the four papers that constitute this thesis.

Trust and network building are in focus in the first paper. Article I aims to analyze how healthcare providers meet different challenges to market MT in an EM setting. Perspectives from two hospitals and an eye clinic are used in this article. By using data from two hospitals, an eye clinic, and two dental clinics, Article II focuses on how customization strategy is implemented in marketing healthcare. Article III looks into intermediaries called medical tourism facilitators (MTFs) using the supplementary service model of Lovelock (1995). MTFs are organizations that act as a bridge between medical care providers and patients. Thus, they are considered to play an important role in marketing healthcare. Three MTFs are investigated in the paper. Lastly, article IV is positioned to examine how care providers face the challenge in the internationalization of healthcare through network building. Data is gathered from two hospitals and three clinics.
Figure 3. Dissertation Overview

Main Phenomenon:
Healthcare marketing in medical tourism in an emerging market country

Aim:
To examine how service providers in an emerging market country pursue international marketing of healthcare services.

Research questions:
i. How MT providers meet the challenges in marketing healthcare services?
ii. How MT providers in an EM context operate in marketing healthcare services?

Overview of Research Project

Aim of Each Article

Article I: This paper analyzes how healthcare providers meet different challenges to market MT in an EM setting.
- Research questions i & ii

Article II: Focusing on customization, this research aims to examine how service providers market healthcare in emerging markets through MT.
- Research questions i & ii

Article III: To examine the role of medical tourism facilitators in the medical tourism industry in the context of an emerging market.
- Research questions i & ii

Article IV: To how care providers in an EM setting handle challenges in marketing healthcare using networks
- Research questions i & ii

Core Concepts

Trust
Network building

Empirical Units of Observation

Hospitals and clinics

Customization

Hospitals, eye clinics, and dental clinics

Supplementary services

Medical tourism facilitators

Network building

Hospitals and clinics
3. Method and Data Collection

This chapter describes the overall research design of the thesis. It includes the research approach, method, and process of this study. Data analysis and rigor of the study are also discussed. The chapter ends with a reflection of the limitations and criticism of the method used.

3.1. Research approach

This study aims to explore the marketing of healthcare services in the Philippines. Considering the explorative nature, we have applied a qualitative approach to conduct this study by following Eisenhardt and Graebner (2007), Ghauri and Firth (2009), and Yin (2011). Due to the complexity of the MT industry in an EM, it is necessary to understand the minds of the people who work in different organizations. Gathering information from different perspectives was therefore crucial in this study (Sinkovics, Penz, and Ghauri, 2008). Empirical evidence was primarily gathered from various sources like face-to-face interviews with professionals at their respective workplaces and direct observations. Spending time at different organizations (hospitals, clinics, and government agencies) gave the advantage of understanding the subject as an insider in the real-life context (Creswell, 2007). Direct observations were done in the respondents’ natural settings to confirm or reveal new information that strengthens the interviews and secondary data. Moreover, observations added dimensions for understanding the complex phenomena. The time invested as an observant with participants at their workplace reflected the author’s genuine interest in learning about the respective organizations. It was apparent that the longer time was spent with participants, the more they became welcoming and open to discussion. Respondents’ trust, which was successively earned, led to obtaining supplementary and undisclosed information that was very helpful in substantiating data and doing reflection.

Having a limited knowledge of the medicine and tourism disciplines did not hinder the author in gathering substantial data. Instead, being naive in the fields of medicine and tourism studies helped in focusing on the aim of my research. For instance, if I had a medical background, questions would most likely have inclined toward medical procedures, medical audits, and patient safety, leaving the marketing concepts unfocused. Also, acknowledging my inexperience in the sector during meetings with respondents opened up the possibility of more relaxed and exciting conversations. For example, most of the respondents took their time to explain terms I found incomprehensible, like malpractice and medical outcome. If the author had a medical background, respondents might have felt cautious about what they would
discuss. It would perhaps have made the meeting more restricted and less spontaneous.

There are three logics of reasoning in research: induction, deduction, and abduction. Induction reasoning is a bottom-up approach, wherein researchers begin collecting and seeking patterns in those empirical data to create new theory (Eisenhardt and Graebner, 2007). On the other hand, deduction logic is a top-down approach that starts with identifying problems from literature and then forming hypotheses and testing them (Van De Ven, 2007). Abduction refers to hybrid logic, which can build a theory based on inductive (real-world observations) and deductive (theoretical viewpoint) rationales (Gregory and Muntermann, 2011). About these three types of reasoning, Reichertz (2013) states: “forms of thinking are not concepts, nor are they methods or tools of data analysis, but means of connecting and generating ideas. Because they represent the intellectual building blocks of research, they are method neutral” (p.123). Scholars claim that these logics are not mutually exclusive and can complement each other (Eisenhardt and Graebner, 2007). To create robust and relevant theories requires a combination of these logics (Van De Ven, 2007).

In this study, inductive reasoning was employed because it supports the qualitative method that involves interaction with relevant informants in generating theory. Unlike the deductive logic that is often based on general theory, inductive logic facilitates building new notions that are close to reality, making them more acceptable than existing theory (Eisenhardt and Graebner, 2007; Gregory and Muntermann, 2011). Thus, inductive reasoning is frequently employed in health and social science research (Thomas, 2006). To some extent, this study was also in line with the inductive “theories-in-use” approach inspired and suggested by Zeithaml et al. (2020). Through capitalizing on data gathered from the managers, this study gleaned first-hand insight into what was happening in their underexplored natural environment, which according to Zeithaml and colleagues (2020) is necessary for both marketing practice and scholarship development. Choosing inductive reasoning for this study did not in any way suggest that it was the best logic. An inductive approach was chosen because it was the ideal option for developing theory from a subject with limited existing literature. Furthermore, this study “is likely to produce theory that is accurate, interesting, and testable” that can enhance future deductive research (Eisenhardt and Graebner, 2007, p.26).

3.2. Qualitative research

Qualitative research is commonly described in reference to quantitative research, describing the qualitative one as research that deals with words, the latter with numbers (Pope and Mays, 2006). For this reason, quantitative researchers can be objective and present measurable data that can be generalized. Those scholars who are inclined toward qualitative research are considered more subjective and examine their subject more in depth yet less generalizably (Miles and Huberman, 1984).
Qualitative research is often criticized for being less systematic and less objective, therefore challenging to replicate (Ghauri and Firth, 2009). However, when seeking a deeper understanding of phenomena, qualitative research seems appropriate. Miles and Huberman (1984) observe that qualitative research is “a source of well-grounded, rich description and explanation of process occurring in local context” and “that is often far more convincing to a reader than pages of numbers” (pp.21–22). For this reason, a qualitative approach of an exploratory nature using multi-case research was considered suitable for this study (Eisenhardt and Graebner, 2007; Ghauri and Firth, 2009; Yin, 1999). Furthermore, this thesis focused on an emerging research area, healthcare marketing, answering “how” questions while “the researcher has little control over events and when the focus is on a current phenomenon in a real-life context” (Ghauri and Firth, 2009, p.30).

Qualitative research was further seen as an appropriate method because this study needed to explore and understand a complex issue (Creswell, 2007). Healthcare service research involves “mega-systems” that are rapidly changing (Yin, 1999, p.1209). Thus, it requires a method that not only produces robust and substantial evidence but also allows flexibility. Qualitative research is known for its flexible and dynamic nature. Using qualitative research means that the study focuses on the socially constructed nature of reality (Denzin and Lincoln, 1994). This suggests that qualitative researchers involve in “empowering individuals to share their stories” (Creswell, 2007, p.40) and engage in “to an interpretative understanding of human experience” (Denzin and Lincoln, 1994, p.3). Hence, interviews were performed. One of the advantages of qualitative research is the opportunity to use a multi-data source that contributes to understanding the phenomena and, at the same time, enhances the credibility of the data (Baxter and Jack, 2008). Although, some scholars claim that qualitative and quantitative research can complement each other, the combination is not employed in this present investigation. Instead, it opens a possibility for future studies.

3.3. Research process

Heading into an industry that was outside the author’s domain (medicine and tourism) was a challenging task, specifically in the initial phase of the study. However, my experience with my master’s thesis on the Philippines Gamma Knife Center (a healthcare provider) generated some confidence to execute the information gathering. In addition, I was to some degree assured of access to substantial data due to familiarity with the local setting (Holstein and Gubrium, 1995) and proficiency in the language (Welch and Piekkari, 2006), as the Philippines is my home country.

3.3.1. Preparing for data collection

Relevant documentation was gathered through desk-based activities (e.g., reviewing documents, websites) providing background about the MT industry. The initial
intention was to investigate hospitals that have international accreditations. This is because international accreditations (i.e. JCI, AC, and ISO) indicate that healthcare providers have high standards and are capable and interested in taking care of international patients. The Philippines has only five JCI-accredited hospitals, all located in Manila. In November 2014, formal communication started with these hospitals through writing and sending letters of introduction (see Appendix 1). Knowing that the Filipinos appreciate high-context communication, a few international phone calls were also made for follow-up purposes. The expectation was to conduct interviews in January 2015 in connection with the planned visit to the Philippines. One of the hospitals promised an interview, but it was canceled when the author came to the facility. Moreover, two of the contacted organizations claimed that they were not prepared to participate, since both were undergoing reorganization.

Coming back to Sweden empty handed, the author examined and reflected upon what went wrong. Documents that were sent to the respondents were reviewed. The author then realized that the letter of introduction may have been too straightforward which might have made them hesitant. Also, the timing might not have been favorable, as it was around the Christmas holiday. The competitive environment in attracting international patients made these organizations protective of their marketing strategy. Missing personal contact made them suspicious regarding the intentions. Another issue noticed was that the interview guide that was sent to them was too long, containing complicated terms. Therefore, a pilot study was conducted.

3.3.1a Pilot study

Yin (2011) defines the purpose of a pilot study in qualitative research as to “help test and refine one or more aspects of a final study – for example, its design, fieldwork procedures, data collection instruments or analysis plans” (p. 37). A pilot study can also serve as a verification strategy (to develop theory) or to improve a data collection strategy (Morse et al., 2002). This is particularly important for qualitative inquiry, where reliability and validity of inquiries are often questioned (Guba and Lincoln, 2005). A pilot study was thus conducted to prepare the research instrument, plan, and strategy for the final research work.

Despite the support provided by my supervisors in developing the initial set of questions, testing the interview questions was a substantial part of the research process. As Yin (2011) claims, a pilot study is not only essential for testing the project but also a significant part of research training, specifically for postgraduate students. Furthermore, pilot (feasibility) study is vital in order to see if the investigator’s chosen research instrument can provide data that can answer the study’s research question (Saunders, Lewis, and Thornhill, 2009). Creswell (2007) argues that further pilot testing can help to “refine the interview question.” More specifically, performing a pilot study can also help in identifying problems that may occur during the actual study (Yin, 1999). Considering the time, money, and effort that a researcher will
spend during the investigation, it is reasonable to test the validity of the process before pursuing the full study. This was especially important for a study that was conducted outside the country of residence. It can also contribute to the accountability of the scholar, something the research climate demands today (van Teijlingen and Hundley, 2001). Nonetheless, conducting a pilot study does not warrant the successful data collection and the study’s validity and feasibility, but it can increase the probability of a valuable outcome (Yin, 1999).

Due to limited time and resources, the preliminary test in the form of a pilot study was conducted in Sweden. The initial intention was to include participants who directly work in the hospitals and clinics, to mimic the real-life context. Yet that was not realized since invitations were declined. Participants were chosen and invited based on their backgrounds and accessibility. Since the explored field was within the health sector, it was, to a certain degree, expected that some of the respondents would have a medical background. There were six respondents who participated in the pilot study; three respondents with a medical background, one studying political science, one working with international students, and one with a marketing background (see Table 2). It is worth noting that five out of the six participants have a background in research. This suggested that their commentary and recommendations were even more valuable. Some argue that all scholars have an ethical obligation to write about their own experiences and what they have learned in the process (van Teijlingen and Hundley, 2001). This is, however, challenging for scholars who are writing articles, due to the journals’ word restrictions. Yet here I am able to present details on what was learned during the pilot study by developing Table 2. Table 2 illustrates information about participants, the date and time of the meeting, the suggestions that they made, and improvements done based on their remarks.

In conclusion, conducting a pilot study served as a practical test regarding what the author would expect during the actual study. Having respondents with medical backgrounds made the author realize the necessity to prepare documents to conform to the formality in hospital settings. Thus, informed consent (see Appendix 2) and interview protocols (see Appendix 3 for 2015 and Appendix 4 for 2016) were created. Following Creswell’s (2007) suggestion, the consent form included the purpose, expected length, and benefits of the interview. The form also indicated the informants’ rights during the interview, including confidentiality aspects where respondents were informed and asked for permission for the audio recording during the meeting. The informed consent form was used in all conducted interviews.

In summary, the pilot study was used to improve fieldwork by refining the research instrument, planning, and data-gathering strategy. Therefore, the pilot study can be considered a crucial part of the research process in this investigation.
<table>
<thead>
<tr>
<th>Name / Background</th>
<th>Date / Time</th>
<th>Remarks</th>
<th>Improvements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eva Karlberg</td>
<td>February 3, 2015 9:30–10:00</td>
<td>Too many questions; questions about the number of patients could be challenging for respondents to answer; a few items need to be explained and simplified; grammatical errors have to be addressed</td>
<td>• Looked into the recommended questions that respondents think challenging to understand.</td>
</tr>
<tr>
<td>Eva Karlberg</td>
<td>February 4, 2015 14:30–15:30</td>
<td>Some questions need to be reconstructed; the focus of the questions has to be clear: i.e., are clients patients or insurance companies (B2B/B2C approach); too many questions</td>
<td>• Shortened and revised the questions from 20 to 9 open-ended questions. This was to make the interview inquiries manageable and realistic, as well as not to overwhelm prospective respondents.</td>
</tr>
<tr>
<td>Yvonne Mårtenson</td>
<td>February 11, 2015 11:10–11:40</td>
<td>The majority of questions have too many subquestions; be clear in which department you are aiming to interview, since some of the questions might be hard for many to answer (i.e., about the number of incoming foreign patients)</td>
<td>• An interview protocol was created to facilitate the interview process.</td>
</tr>
<tr>
<td>Maria Hedman</td>
<td>February 11, 2015 11:50–12:50</td>
<td>Some of the questions are difficult to answer; avoid using marketing jargon; too many questions; consent form can be useful</td>
<td>• The consent form was written to suit a formal setting.</td>
</tr>
<tr>
<td>Gloria Macassa</td>
<td>March 4, 2015 12:00–13:00</td>
<td>Simplify questions by using open-ended ones; develop interview protocol; some of the questions can be done by survey</td>
<td>• Grammatical issues were addressed.</td>
</tr>
<tr>
<td>Anne-Sofie Hiswåls</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Preparatory interview questions

Preparation of effective questions is crucial and essential to maximizing the quality of the data gathering (Turner, 2010). In line with Yin (2003), the research questions were open-ended, neutral, and uncomplicated, allowing the informants to use their own words and express themselves freely. Cross-cultural researchers often face practical issues with language proficiency, specifically in interviews (Welch and Piekkari, 2006), but this was not a problem in this investigation, because the researcher is of the Filipino diaspora and English is all participants’ second language. There were two sets of questions that were used in this project. The first was developed after the pilot study and used during the first fieldwork session in March–April 2015. The first set of questions was composed of nine semi-structured questions (see Appendix 5). During the initial data analysis, it was observed that the respondents were collectively discussing how the institutional environment affected their operations. Thus, an EM context was included in my study.

After that, the second fieldwork session was planned. Interview questions were revised to include inquiries on how the environmental context affected their operations in promoting MT (see Appendix 6). Along with that set of questions, compilation of an overview of countries based on data gathered from the World Bank Worldwide Governance Indicators, World Economic Forum, and the Corruption Perception Index (see Appendix 7). The overview included the Philippines, Thailand, Singapore, Malaysia, and Sweden. The table aimed to illustrate the state of the Philippines compared to their neighboring countries (which are also MT destinations) while seeking reaction from respondents. In contrast, Sweden was employed to represent a developed country. Using the country overview table (Appendix 7) was considered useful to gather diverse reactions and open discussion while addressing a sensitive topic about the country’s institutional environment. This was an extra delicate subject since the second fieldwork session was conducted two weeks before the presidential election in the Philippines in April 2016, when most respondents were concerned about the political instability.

Case selection

In line with Miles and Huberman (1994), Patton (1990) and Yin (2003) cases in this study are identical with the units of analysis, which in this instance, service providers in Medical Tourism. Selecting cases is a significant and complicated phase of the qualitative study (Eisenhardt, 1989). This procedure is strongly influenced by the problem, aim, time and resources of the research (Etikan, Misa and Alkassim, 2016; Perry, 2000). Patton (1990) argues that there are no rules regarding the adequate number of cases. Instead, he suggests two types of choosing information-rich cases: probability sampling and purposeful sampling. Probability sampling is common in quantitative inquiry where the purpose is generalization. On the other hand, pur-
poseful sampling is a nonprobability sampling technique wherein “subjective methods are used to decide which elements are included in the sample” (Etikan et al., 2016, p.1). The purposeful sampling strategy involves selecting information-rich cases through which the researcher expects to illuminate the research question of the study. The latter strategy includes 15 different logics, namely: extreme, intensify, maximum, homogeneous, typical, stratified, snowball, criterion, theory-based, confirming, opportunistic, random, politically important, convenience, and mixed purposeful sampling (Patton, 1990, pp. 182–183).

In this study, mixed purposeful sampling logic was used to facilitate triangulation and flexibility, which were considered necessary in order to understand the phenomena further. Furthermore, this sampling matched the present study’s problems, aim, and limited resources. Mixed purposeful sampling logic is a combination of intensifying, opportunistic, and snowball sampling logics (Patton, 1990). This was systematically used in selecting cases for this research. First, it started by choosing hospitals that have international accreditation, which shows interest and a capacity to accommodate foreign patients (following intensify sampling logic). Second, upon arriving at the fieldwork, the author took advantage of the unexpected opportunity to include different supporting organizations that were involved in the MT industry (following opportunistic sampling logic). For instance, when the author learned that MTFs were a significant part of healthcare service delivery, they were included in the investigation and became unit of analysis in article III. Third, the second fieldwork session was organized through the help of two key persons. These key persons individually made contacts with people and organizations they knew were important in the MT industry and should be included in the study (following snowball sampling). Following mixed purposeful sampling might be seen as unstructured compared to probability sampling. However, Patton (1990) encourages “researchers to take advantage of unforeseen opportunities after fieldwork has begun. Being open to following wherever the data lead is a primary strength of qualitative strategies in research” (p.179). This is, of course, provided that a scholar thinks that including a particular case or cases serves a certain purpose in their study. It was a subjective decision that this thesis’s author took.

In total, data was gathered from 17 different organizations, out of which 12 became information-rich cases. Despite the time and funding constraints, the number of cases was considered adequate to explore the MT industry in an EM context. Variety in the sizes, level of experience, specialization, and involvement in MT provided robust data that captured the phenomena (Miles et al., 2014). Moreover, including supporting organizations and respondents contributed to the study’s external validity (Gerring, 2007). Furthermore, interviewing representatives from supporting organizations enabled the triangulation of the data from the perspective of 12 information-rich cases (Ghauri and Firth, 2009; Gummesson, 2003). A summary of my cases and supporting organizations will be presented later in this chapter.
3.3. Data collection

3.3.2a Selection of respondents

Everyone is capable of providing information. Yet in the case of a qualitative interview, it is crucial that an investigator is guided by his or her topic to properly choose a suitable “reporter of knowledge,” or what we call respondents (Holstein and Gubrium, 1995). Following the assumption that reality is socially constructed, it was decided to interview people holding key positions who possess vast experience in how their respective organizations handle MT services. Thirty respondents participated in this study – 24 from the information-rich cases, while 6 came from the supporting organizations.

The initial plan was to conduct face-to-face individual interviews with preferred respondents who were directly involved in catering to international patients; yet these were not fully realized in the course of the study. When the letter of intent was sent through email to the providers, the recipient of the letter (marketing, corporate communication, and international patient care department) forwarded the email to people who they thought could answer the questions. In that sense, although the plan was to choose informants, it could be said that some of the respondents were to some extent chosen for the researcher. This might lead to some degree of biased information. Nevertheless, conducting the study showed that a variety of respondents was more suitable, since they provided information from different perspectives. On the other hand, the majority of my respondents (and organizations) were tracked by snowball sampling.

Snowball sampling helped locate other respondents (information-rich cases) who were knowledgeable, willing to participate, and had time to meet immediately. This was particularly imperative in a setting like the Philippines, where personal connections and recommendations are considered valuable to access organizations and relevant informants. For instance, without the endorsement by the executive director of Medical Facilitator 2, it would not have been possible to get access to Hospital 3 and Eye Clinic 1. The tourism department’s director recommendation led to meeting respondents from Medical Facilitator 1 and all the dental clinics.

According to Miles and Huberman (1994), substantial data contributed by various respondents from different organizations is vital when investigating complex phenomena. For this reason, supporting organizations were relevant in the present investigation. For instance, both the owner of the spa and the clinical psychologist were interviewed because they played a crucial part in initiating the country’s MT program. The spa owner was the former president of the spa owners’ association of the country. The clinical psychologist was a government consultant who encouraged collaborative efforts within the program. As a known university for educating and training tourism students, the school’s executive director was included in the study. Her input yielded insight into the tourism perspective. These supporting organizations were relevant and significantly contributed to the understanding of the industry.
The intention to do more interviews from each case proved difficult to attain, due to a limited field study time schedule and the size of the organizations studied. This is in line with Perry (2000) claiming that to have “more than one interview in a small business or Asian organization is difficult to arrange” (p. 313) Thus, supporting organizations operating in the context of MT such as government agencies, universities, spas, and nursing homes were included in the study to complement the data. Creswell (2007) acknowledges that informants can be reluctant. This was observed while planning the schedule as most of my participants preferred to be interviewed in pairs. As a result, six interviews were conducted, each with two participants. Establishing rapport with two informants at the same time seemed advantageous. First, they complement each other’s answers, personal bias was minimized, and the method enabled me to use my time efficiently. Although sometimes they got so excited about the topic and had a tendency to interrupt each other, the advantages were more apparent than the disadvantages. Most of the scheduled meetings were carried out except for the two participants (from the same organization) who cancelled an hour before the meeting. Instead, they answered the interview questions and sent their answers via email. Table 3 presents an overview of the organizations and information about the respondents who participated in the study. Next, table 4 shows the overview of the supporting organizations and the informants that contributed to the study.
Table 3. Overview of the organizations and respondents

<table>
<thead>
<tr>
<th>Main Organizations</th>
<th>Position / Yr. Services</th>
<th>Interview Duration</th>
<th>Date</th>
<th>Direct Observation</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td><strong>Senior Manager</strong></td>
<td>90 min</td>
<td>18 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Private tertiary hospital</td>
<td><strong>Years of Service:</strong> 11</td>
<td>Assistant Manager</td>
<td>75 min</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Year established: 1967</td>
<td>Years of Service: 13</td>
<td></td>
<td>20 April 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Senior Manager</strong></td>
<td>75 min</td>
<td>20 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>Years of Service:</strong> 12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Customer Service Manager</td>
<td>* 50 min</td>
<td>18 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>Years of Service:</strong> 11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>International Patient Service Manager</td>
<td>* 50 min</td>
<td>18 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>Years of Service:</strong> 10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manager Corporate Communication</td>
<td>60 min</td>
<td>18 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>Years of Service:</strong> 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital 2</td>
<td>Section Manager</td>
<td>*50 min</td>
<td>24 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Nonprofit tertiary hospital</td>
<td><strong>Years of Service:</strong> 2.5</td>
<td>Senior Manager</td>
<td>25 min</td>
<td>X</td>
<td>Oral</td>
</tr>
<tr>
<td>Year established: 1903</td>
<td><strong>Years of Service:</strong> 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Associate Director</td>
<td>25 min</td>
<td>24 March 2015</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Years of Service:</strong> N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital 3</td>
<td>Sales Services Manager</td>
<td>Email</td>
<td>25 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Private tertiary hospital</td>
<td><strong>Years of Service:</strong> N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year established: 1969</td>
<td>Marketing Manager</td>
<td>Email</td>
<td>25 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td><strong>Years of Service:</strong> 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: * Interview duration in pair ** Respondents interview twice
<table>
<thead>
<tr>
<th>Main Organizations</th>
<th>Position / Yr. Services</th>
<th>Interview Duration</th>
<th>Date</th>
<th>Direct Observation</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Clinic 1</td>
<td>Medical Director</td>
<td>75 min</td>
<td>27 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Private hospital</td>
<td>Years of Service: 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year established: 2001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Clinic 2</td>
<td>PR Manager</td>
<td>60 min</td>
<td>28 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Private clinic</td>
<td>Years of Service: 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year established: 2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Medical Center</td>
<td>Medical Services Manager</td>
<td>50 min</td>
<td>21 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Ambulatory / Outpatient medical center</td>
<td>Years of Service: 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year established: 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assistant Operating Officer</td>
<td>90 min*</td>
<td>19 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dental Clinic 1</td>
<td>Dentist / Owner</td>
<td>120 min</td>
<td>27 April 2016</td>
<td>X</td>
<td>Oral</td>
</tr>
<tr>
<td>Type: Private clinic</td>
<td>Years of Service: 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year established: 2002</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Clinic 2</td>
<td>Dentist / Owner</td>
<td>90 min</td>
<td>27 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Private clinic</td>
<td>Years of Service: 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year established: 1989</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Clinic 3</td>
<td>Dentist / Owner</td>
<td>90 min</td>
<td>27 April 2016</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Type: Private clinic</td>
<td>Years of Service: 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year established: 2003</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: * Interview duration in pair ** Respondents interview twice
<table>
<thead>
<tr>
<th>Main Organizations</th>
<th>Position / Yr. Services</th>
<th>Interview Duration</th>
<th>Date</th>
<th>Direct Observation</th>
<th>Consent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Tourism Facilitator 1</strong>&lt;br&gt;Type: Private&lt;br&gt;Year established: 2008</td>
<td>Founder&lt;br&gt;Years of Service: 6&lt;br&gt;Co-founder&lt;br&gt;Years of Service: 6</td>
<td>75 min *</td>
<td>26 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Medical Tourism Facilitator 2</strong>&lt;br&gt;Type: nonprofit&lt;br&gt;Year established: 2007</td>
<td>Executive Director&lt;br&gt;Years of Service: 7</td>
<td>45 min</td>
<td>24 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Assistant Manager&lt;br&gt;Years of Service: 2</td>
<td>30 min</td>
<td>24 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Medical Tourism Facilitator 3</strong>&lt;br&gt;Type: Private&lt;br&gt;Year established: 2008</td>
<td>Operation Manager&lt;br&gt;Years of Service: 5&lt;br&gt;Sales Marketing Officer&lt;br&gt;Years of Service: 5</td>
<td>60 min *</td>
<td>23 March 2015</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Note: * Interview duration in pair ** Respondents interview twice
Table 4. Overview of the supporting organizations and respondents

<table>
<thead>
<tr>
<th>Supporting Organizations</th>
<th>Position / Yr. Services</th>
<th>Interview Duration</th>
<th>Date</th>
<th>Direct Observation</th>
<th>Consent</th>
</tr>
</thead>
</table>
| Tourism Department       | **Director**  
Type: Government agency  
Year established: 1973 | **Years of Service**: 30+ | 60 min  
80 min     | 27 March 2015  
18 April 2016 | X  
X |
| Health Department        | Manager  
Type: Government agency  
Year established: 1898 | **Years of Service**: 8 | 50 min     | 27 April 2016   | X  
X |
| Spa                      | Owner  
Type: Private spa  
Year established: 2002 | **Years of Service**: 14 | 90 min     | 29 April 2016   | X  
X |
| Nursing Home             | Owner  
Type: Private nursing home  
Year established: 2016 | **Years of Service**: 5 | 90 min     | 28 April 2016   | X  
X |
| University               | Executive Director  
Type: Private school  
Year established: 1952 | **Years of Service**: 11 | 45 min     | 19 April 2016   | X  
X |
| Consultant               | Clinical Psychologist  
Type: Private consultant  
Year established: 1992 | **Years of Service**: 30 | 40 min     | 18 April 2016   | X  
X |

Note: * Interview duration in pair  
** Respondents interview twice
3.3.2b Conducting interviews

Most of the primary sources of information used by social researchers come from interviews (Yin, 2003). Conducting interviews is a sensitive but effective way of exploring the subject (Kvale, 2006). Interviews are often criticized for being a source of bias, misinterpretations, and misdirection (Holstein and Gubrium, 1995). In line with Eisenhardt and Graebner (2007), these issues were mitigated by including various respondents from other relevant supporting organizations who were well-informed about the MT industry. For example, a manager from the health department, a director for the tourism department, owner of a spa, proprietor of a nursing home, and an official of a university were included in the study. Furthermore, since this study considered the interview as social interaction, it is reasonable to assume that the dialogue between the researcher and respondents was a “productive site of reportable knowledge itself” and not a biased story (Holstein and Gubrium, 1995).

Holstein and Gubrium (1995) suggest three different types of interview: survey interview, creative interview, and active interview. The survey interview employs standardized questions wherein the respondents are not given a chance to express their words freely, thus, this type is often criticized for only touching the surface of respondents’ experience. In contrast, the creative interview attempts to know the respondents deeply and is seen as an “emotional wellspring.” The active interview focuses on the interview process, in which respondents are given the liberty to discuss a topic that they find important and proceed from their own experience within the interviewers’ “loose parameters.” In the active interview, the interaction between the respondents and the interviewer is an essential source of opinion building. Yin (2003) states that interviewers have two tasks: (1) to follow the line of the inquiry and (2) to ask the question in an unbiased manner. In line with Yin’s suggestion, a combination of the creative interview and active interview was employed, except with two respondents who preferred email interviews.

Most informants asked for a digital copy of the questions and consent forms a few days before the scheduled meetings. The informed consent forms were presented, explained, and signed before every meeting, except for the two participants who answered and submitted the questions through email, while one informant gave oral affirmation. Using semi-structured questions, the respondents were allowed to discuss the answers freely. Most of the respondents took the role of being an expert (Holstein and Gubrium, 1995). The author was able to ask a follow-up question about unfamiliar terms like litigation cost, malpractice insurance, medical outcome, etc. They also asked questions during the sessions that disclosed their interest in the research. They were encouraged to narrate their experience freely. Allowing informants to talk unconstrainedly provided insightful data that facilitates deeper understanding this socially constructed phenomenon. For instance, the author learned about how government affects their businesses and how these providers manage to solve the issues on their own. Respondents chose the place and time they liked to conduct the interview (e.g., workplace, favorite restaurants). Through the process,
trust was built with the majority of informants. Trust, according to Kvale (2006) serves as “social lubrication of elicit unguarded confidence” (p. 482). Undisclosed and sensitive issues about the local MT industry were provided by some respondents. For instance, three of the respondents unveiled, the reason why one of my prospected hospitals did not grant an interview and how one facility’s accreditation was revoked. These examples are in line with Kvale’s (2006) claims that “creating trust through a personal relationship here serves as a means to efficiently obtain a disclosure of the interview subjects’ world” (p. 482). It was apparent when some of the respondents recommended and introduced the author to other informants.

3.3.2c Observation

One advantage of employing a case study is to have the potential to deepen our understanding of the phenomenon through direct observation (Ghauri and Firth, 2009). Observing people in their natural setting is considered a distinguishing feature and strength of the qualitative method (Pope and Mays, 2006). Creswell (2007) categorizes four types of observations: complete participants (observer fully engages with people), participants as an observer (involving researchers’ participation), observer participants (observing as an outsider), and complete observer (undetectable by people). Different roles were used in the course of the fieldwork. The author changed role of being a complete observer to observer participant before assuming the official role as a researcher (participant as an observer). For example, the author usually came one to two hours before the scheduled interviews to see how people did in the organization and interacted with one another and their patients. This had given the observant time to visit public areas to see the facility (e.g., restroom, lounges, restaurants, café). She often looked for a reception desk or international patients’ service center and asked some questions about the services they offered (e.g., price of an executive checkup, how long a procedure would take). Acting as observer participant, she was able to see how personnel on the ground (i.e., nurse, concierge, receptionist) performed their duties.

Direct observations were conducted during the fieldwork in March to April 2015 and April 2016 in connection with the interview sessions. The author started by looking at the lobby, entrance of the building and how the personnel act upon meeting visitors, where they eat, what kind of restaurants they have in the facility, cleanliness in the facilities, and so on. During these observations, photos were taken. Then, the author usually sat in the patient waiting area watching how people interact with one another – e.g., receptionist welcoming patients, security guards helping outgoing patients to their cars, music played by the pianist in the lobby. The majority of the informants gave a tour of the facilities, but the author preferred to look around on her own so she could observe places that the informants might not want to show. Moreover, it helped the author think of other related questions that she could ask the informants. For instance, the author noticed that the hospital’s security personnel were friendly but very tough in searching even visitors’ personal belongings and
asking for an identity card and the purpose of the visit. For instance, the author needed to present and leave identification to the security guards before she was allowed to come in the vicinity. The informant later confirmed that security measures were crucial for the patients’ and the personnel’s safety. Thus, the actions of the security guards were necessary and indispensable. In line with Creswell’s (2007) recommendation, observational protocol was created (see Appendix 8) to systemize and log my observations.

3.3.2d Secondary and tertiary data

Gathering secondary and tertiary data was a significant resource to understand the growing phenomenon of the MT industry. Yet it was somewhat difficult to see the quality and reliability of the assumptions presented in the studies, since they were executed by other researchers with different aims and intentions (Blaikie, 2010). Thus, secondary and tertiary data employed in the study were collected from trustworthy organizations such as International Trade Centre, McKinsey and Company, Philippine Institute for Development Studies, and WHO. Various documents from desk-based activity gathered from the organizations’ websites, scientific journals, books, magazine articles, and newspaper clippings served as a substantial source of information to have ample initial insight in the industry under scrutiny. Although the majority of the secondary data that were gathered employing healthcare and tourism perspectives, they also provided sufficient inspiration regarding ideas left underreported, specifically in the marketing area.

Magazines and newspaper clippings helped me to create a battery of follow-up questions during my interviews. It was a helpful source, since it captured more current happenings in the MT industry. Printed materials collected from different organizations during fieldwork also helped in triangulating the data that respondents provided me with. Hard copies of brochures, annual reports, hospital magazines, medical outcome data, and patients’ forms were collected and saved in a database.

3.4. Data analysis

Using several units of analysis (cases) enhances the probability of obtaining accurate theory (Yin, 2003). The data gathered was analyzed qualitatively—within the case and across the cases—to identify patterns (Miles et al. 2014; Yin, 2011). This method was employed in all four papers (see Table 4 for details). The only discrepancy among the articles was that in articles I and II, where manual coding was applied. In articles III and IV, the qualitative data was analyzed via the software program NVivo. However, the manual process of coding during the first and second papers helped familiarize the author with the data and facilitated the later coding through NVivo. Knowing that it might take time to learn the software, I pursued the method that I was accustomed to (manual) and then continued data analysis with the software in the succeeding papers.
3.4.1. Data analysis process

Data analysis process commenced by scrutinizing each case separately (Yin, 2011). At the first step, all the data collected in each organization (i.e., transcribing interviews of the respondents, printed materials, documents from the desk-based activity, an observation protocol) were synthesized. These were repeatedly done in all cases (leading organizations) for subsequent analysis. The second step started with coding through searching for words, statements, or activities that were relevant and had the potential to explain research construct. This implied that coding was not solely arranging data but also analysis itself because it involved a deeper understanding of data’s meaning (Miles et al., 2014). For illustration, in Article II (see Appendix 9), the author began by coding phases where respondents found challenges in their operation that could require customization. Inductive coding started by looking for phrases or words that could identify issues that the respondents from five providers (cases) stated. This resulted in codes, namely; emotional necessities, social needs, cultural requirements, inefficient settings, unfamiliarity environment, misunderstanding, and language barrier. The third step devoted in looking for commonalities among the codes. During this stage, the author meticulously gone through the codes few times to reduce and abstract them into themes. For example, codes emotional necessities, social needs, and cultural requirements were found could be in one theme. Appendix 9 showed the data from the transcribed interviews and the creation of one of the themes “personalized services to meet emotional, social and cultural requirements.” Thereafter second and third steps were done repeatedly in all cases.

The next step involved the cross-case analysis. Here, the author attempted to look into the similarities and differences among the codes initially found from the different providers. The author tried to see if the cases shared similar themes that could aggregate the findings (Yin, 2011). At this point, it was found advantageous to use software program NVivo because it allowed easier retrieval and systematic arrangement of codes and themes compared to manual administration of the information. Data collected from the supporting organizations facilitated triangulation (Ghauri and Firth, 2009). Including data gathered from the respondents from supporting organizations enhance the confidence in the accuracy, strength, and the validity of the findings. Moreover, converging data from different sources can provide a better understanding of the complex phenomenon at hand (Ghauri and Firth, 2009; Yin, 2011). It was important to point out that during the coding process and analysis for Article I, II and IV, co-author(s) were also consulted.

In conclusion, both manual and electronic coding is considered have their advantages and disadvantages. As Basit (2003) stipulates, the choice of doing manual and electronic coding depends on “the funds and time available, and the inclination and expertise of the researcher” (p. 143), where both types of coding consist of an intellectual exercise based on academic ability. Table 5 presents the synopsis of the data collection and analysis executed from articles I to IV.
Table 5. Synopsis of the data collection and analysis

<table>
<thead>
<tr>
<th>Data Collection</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Article I</strong></td>
<td><strong>Article II</strong></td>
</tr>
<tr>
<td>● Unit of analysis: Three medical providers</td>
<td>● Unit of analysis: Five medical providers</td>
</tr>
<tr>
<td>● Source: 16 face-to-face interviews with managers (7 from medical providers &amp; 5 from supporting organizations); direct observation</td>
<td>● Primary source: 18 interviews from the managerial position (10 from medical providers &amp; 8 from supporting organizations)</td>
</tr>
<tr>
<td>● Secondary source: Desk-based activity (e.g., reviewing documents, websites)</td>
<td>● Secondary sources: Annual reports, magazine articles, and newspaper clippings</td>
</tr>
<tr>
<td>● Main topic: To see how providers market medical services in an emerging market</td>
<td>● Main topic: To investigate how medical providers adapt to provide service to foreign patients</td>
</tr>
</tbody>
</table>

**Data was analyzed through the following processes:**
- Within each case, interviews were transcribed, direct observation protocols were arranged together with secondary data, and codes were identified for each organization.
- Across the cases, codes were identified, comparing patterns across the cases and the relationship of each pattern to theoretical concepts.
- Supporting organizations’ data facilitated triangulation.

**Conceptual framework:**
- Network, trust, and word of mouth
- Customization of services
Table 5. Synopsis of the data collection and analysis (cont.)

<table>
<thead>
<tr>
<th>Data Collection</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Article III</strong></td>
<td><strong>Data was analyzed through the following processes:</strong></td>
</tr>
<tr>
<td>- Unit of Analysis: Three medical tourism facilitators</td>
<td>- Within each case, primary and secondary data were arranged according to case (interview transcriptions, observation protocols, soft and hard copy of documents). Data were then transferred to NVivo, facilitating the codification process. Codes developed themes that later connected to Lovelock’s supplementary service clusters.</td>
</tr>
<tr>
<td>- Primary source: 16 interviews (6 from facilitators &amp; 10 from supporting organizations)</td>
<td>- Across the case, themes were compared across cases, while triangulating with information gathered from supporting organizations.</td>
</tr>
<tr>
<td>- Secondary sources: Brochures, company websites, articles from various websites</td>
<td>- Conceptual framework: Lovelock’s clusters of supplementary services</td>
</tr>
<tr>
<td>- Main topic: To observe what supplementary services facilitators offer to the incoming patients</td>
<td></td>
</tr>
<tr>
<td>- Period of gathering: March 2015 &amp; April 2016</td>
<td></td>
</tr>
<tr>
<td><strong>Article IV</strong></td>
<td><strong>Data was analyzed through the following processes:</strong></td>
</tr>
<tr>
<td>- Unit of Analysis: Five medical providers</td>
<td>- Within each case, primary and secondary data were arranged according to case, then imported to NVivo. Data were then codified, put together according to themes, and then analyzed and integrated with theoretical concepts.</td>
</tr>
<tr>
<td>- Primary source: 22 interviews (13 from medical providers &amp; 9 from supporting organizations)</td>
<td>- Across the case, themes were compared across cases for replication and compiling findings, while triangulating with information gathered from supporting organizations.</td>
</tr>
<tr>
<td>- Secondary source: documents from internet sources</td>
<td>- Conceptual framework: Network</td>
</tr>
<tr>
<td>- Main topic: To examine how networking helps the medical tourism industry.</td>
<td></td>
</tr>
<tr>
<td>- Period of gathering: March 2015 &amp; April 2016</td>
<td></td>
</tr>
</tbody>
</table>
3.5. Research rigor

Ensuring rigor in a qualitative inquiry is an important task to maintain its value (Morse et al., 2002). Therefore, it is significant for researchers to reflect on the validity and reliability of their actions throughout the research process. As Yin (2003) recommends, this thesis follows consistent self-correction to ensure the reliability and validity of the project. Testing of construct validity, external validity, and reliability were executed as follows.

Construct validity is a test of the foundation of a sufficient set of operations used in the investigation (Yin, 2003). According to Yin (2003) and Lee (1999), there are three ways to ensure construct validity: multiple sources of evidence, chain of evidence, and feedback to key informants. Multiple sources of evidence were used to address this test during data collection (Ghauri and Firth, 2009). In addition to the interviews and direct observation notes, various documents were also gathered from organizations’ websites, books, magazines, articles, newspapers, and scientific journals. Keeping extensive notes during the visits and carrying out follow-up communication were done to establish a chain of evidence (Eisenhardt, 1989). To the same end, additional interviews were performed with supporting organizations in the MT industry (Miles and Huberman, 1994).

External validity refers to testing if the findings can be generalized. This was a challenging task, as this study was based only on a limited number of organizations operating in a single context, the Manila metropolitan area in the Philippines. However, a multiple case study approach was employed to facilitate replication logic through four papers (Eisenhardt, 1989). Thus, cross-case analysis was executed during data analysis. Supporting the argumentation of Yin (2003), this thesis relies on analytical generalization and not the statistical generalization that quantitative study strives for. This study provides compelling support for the theories, which can later on, be tested through a survey.

A reliability test refers to the dependability of the operation of the study that allows other investigators to follow the research procedure and arrive at the same results (Sinkovics et al., 2008). The critical approach to tackle the reliability of the study is to document the research operation properly (Yin, 2003). To lessen the possible mistake and bias in the study, protocols were created for the interviews and observations. These protocols were used not only as guide during the fieldwork but also supported in systematically document the research process. The interviews were transcribed in the original language (English) (Welch and Piekkari, 2006). All data were recorded and kept in the case study database in line with Yin’s (2003) recommendation. A soft copy of documents was saved in a digital database, while the hard copies (brochure, leaflets, forms) were mostly scanned and imported into the database. Clinical outcome reports and magazines were too thick to scan, so they were preserved in a print databank. In the latter part of my study, the software data program NVivo was
employed. By doing so, it was possible to retrieve data in case of a reliability check or assisting an investigator following the course of a study (Ghauri and Firth, 2009).

3.6. Limitations and critique of method

Despite efforts to sustain the reliability of the study, the author cannot guarantee that the succeeding investigators will obtain the same results as my study. This is due to the complexity and ongoing development of the MT industry in the Philippines. The political turbulence and the uncertainty of the country concern my informants. This was especially sensitive, because the last meeting with respondents was two weeks before the 2016 presidential election. These aspects of political changes could reform or damage the landscape of the MT industry, and this could affect the viewpoints of the informants involved in the initial study.

The international patients’ perspective was not included in the study. Securing interviews with healthcare consumers is not easy, due to the challenges of applying ethical approvals that take time and require resources. Even though a number of patients openly write comments on organizations’ social media accounts (i.e., Facebook, hospital’ blog), those comments tend to be very positive and written by local patients. There are two problems. There is a considerable risk of bias due to a positive selection of comments, and the focus of the study is international patients, not local ones.

Originally this project aimed to compare data from the Philippines with data from Dubai and Mauritius. Time and resource constraints made such a study unrealistic. Furthermore, concentration on one setting allows for a profound investigation that builds a foundation for future research.
4. Overview of the articles

This chapter introduces an overview of the articles included in this dissertation, illustrated in Table 6. The succeeding part of the chapter gives synopses of the four papers. This chapter is concluded by the overall contribution of the study.

Table 6. Summary of the articles

<table>
<thead>
<tr>
<th>Article I</th>
<th>Article II</th>
<th>Article III</th>
<th>Article IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Title</td>
<td>Title</td>
<td>Title</td>
</tr>
<tr>
<td>Medical tourism in emerging markets: The role of trust, networks and word of mouth</td>
<td>Customization in medical tourism in the Philippines</td>
<td>Role of Facilitators in the Medical Tourism Industry: A Study of Medical Tourism Facilitators in an Emerging Market Country</td>
<td>Medical Tourism Networks in an Emerging Market</td>
</tr>
<tr>
<td>Aim of the article</td>
<td>Aim of the article</td>
<td>Aim of the article</td>
<td>Aim of the article</td>
</tr>
<tr>
<td>To examine how healthcare providers meet different challenges to market medical tourism.</td>
<td>To observe how service providers market healthcare using customization.</td>
<td>To examine the role of medical tourism facilitators in the medical tourism industry in the context of an emerging market.</td>
<td>To observe how care providers in an EM setting handle challenges in marketing healthcare using networks</td>
</tr>
<tr>
<td>Level of analysis</td>
<td>Level of analysis</td>
<td>Level of analysis</td>
<td>Level of analysis</td>
</tr>
<tr>
<td>Firm-level</td>
<td>Firm-level</td>
<td>Firm-level</td>
<td>Firm-level</td>
</tr>
<tr>
<td>Unit of analysis</td>
<td>Unit of analysis</td>
<td>Unit of analysis</td>
<td>Unit of analysis</td>
</tr>
<tr>
<td>Hospitals and clinics</td>
<td>Hospitals and clinics</td>
<td>Medical tourism facilitators</td>
<td>Hospitals and clinics</td>
</tr>
<tr>
<td>MT activities</td>
<td>MT activities</td>
<td>MT activities</td>
<td>MT activities</td>
</tr>
<tr>
<td>Healthcare providers cater to the needs of international patients and have international accreditation, affiliations, and recognition.</td>
<td>Healthcare providers adapt activities to accommodate the requirements of foreign patients.</td>
<td>Three active and locally based medical facilitators that accommodate the demands of international patients.</td>
<td>Five care providers that have broad networks operating in medical tourism industry.</td>
</tr>
<tr>
<td>Research question</td>
<td>Research question</td>
<td>Research question</td>
<td>Research question</td>
</tr>
<tr>
<td>How medical tourism service is marketed in emerging markets?</td>
<td>How is customization in MT implemented in an EM context?</td>
<td>How do medical tourism facilitators operationalize in an EM country setting?</td>
<td>How does networking enable care providers in an EM country to address challenges in marketing healthcare?</td>
</tr>
<tr>
<td>Aim of the thesis</td>
<td>Aim of the thesis</td>
<td>Aim of the thesis</td>
<td>Aim of the thesis</td>
</tr>
<tr>
<td>To examine how service providers in an emerging economy market healthcare services internationally</td>
<td>To examine how service providers in an emerging economy market healthcare services internationally</td>
<td>To examine how service providers in an emerging economy market healthcare services internationally</td>
<td>To examine how service providers in an emerging economy market healthcare services internationally</td>
</tr>
</tbody>
</table>
4.1. Article I: Medical Tourism in Emerging Markets:
The Role of Trust, Networks and Word of Mouth


Despite the recognition of the MT industry, little is known about how care providers market their services in an international context. This first article aims to fill this gap by analyzing what challenges service providers meet and how they solve those challenges to market MT in an EM setting. The primary purpose for this paper was to investigate the challenges service providers were facing in marketing healthcare services. However, during the first fieldwork in 2015, there was significant primary data (specifically during the interviews) that highlighted the difficulty that service providers needed to address due to the environmental setting. We realized that the healthcare providers in the Philippines were facing two main issues in marketing MT: (1) the complexity of medical offerings and (2) solving challenges in operating in an EM context.

A qualitative method using three cases was employed. Seven respondents holding managerial positions from two hospitals and one eye clinic were interviewed. In addition, three medical facilitators and a government agency were identified through snowball sampling and included in the investigation as supporting organizations. In sum, sixteen respondents participated in the study. In addition to the semi-structured interviews, data was also gathered through direct observation and documentation, which facilitate triangulation. All data were examined manually. Each case was scrutinized individually and in comparison with the others. Three concepts were developed after the analysis: trust, network, and word of mouth.

This paper highlights the challenging task healthcare providers face related to the complexity of healthcare services and operating in an EM setting. To overcome these issues, care providers developed a network with reputed organizations and acquired accreditation from international bodies to build trust. WOM was seen to lessen uncertainty and the insecurity of the incoming patients by creating trust in the service provider. The result showed that trust and network building were necessary for mitigating the unfavorable characteristics, instability, and lack of legitimacy caused by institutional constraints in the EM environment. Article I contributes to the limited research on MT in marketing science. This paper advances the knowledge about healthcare providers’ role as marketers of medical services.

4.2. Article II: Customization in Medical Tourism in the Philippines

Although Article I offers a substantial overview of how healthcare providers operate in the EM setting, it is limited as an illustration of how providers adapt to the individual requirement of international patients. Thus, article II aims to examine how service providers operationalize a customization strategy in marketing healthcare. Besides dealing with the institutional constraints, article II highlights another challenge that service providers deal with in marketing healthcare services: meeting both clinical and nonclinical requirements of incoming international patients. Customization plays the central role in this paper, because it has been seen to enable firms to attend to the individual requirements, behavior, and expectations of consumers.

There were two hospitals and three clinics involved in this qualitative study. Eighteen semi-structured interviews were carried out with five care providers and five supporting organizations in the Philippines. Secondary data were collected to facilitate triangulation. All recorded interviews were transcribed and examined manually. Data were then analyzed within the case and across the cases to see patterns. Three issues were identified: (1) emotional, social and cultural, (2) knowledge difference, and (3) unfamiliar context. Customization plays a crucial role in addressing these concerns. The research shows that hiring medically and culturally knowledgeable, multilingual staff who adapt to the emotional, social, and cultural needs of international patients is advantageous. Customization helps to alleviate the knowledge asymmetry between the care provider and the patient minimizing the negative impact of an unfamiliar context. It underlines the vital role of service employees in the marketing process to fulfill the unique needs of international patients.

The study proposes an empirically grounded, theoretical framework that needs to be tested in different contexts for generalization. Understanding and responding to the needs of international patients must be developed through a joint effort by both the medical and business sides of care providers. This paper shows the necessity to discuss healthcare marketing, as well as the new role of healthcare providers in its operationalization.

4.3. Article III: Role of Facilitators in the Medical Tourism Industry: A Study of Medical Tourism Facilitators in an Emerging Market Country

Rydbäck, M. (In review). Submitted to the journal Service Marketing Quarterly

Articles I and II explain how the core care providers operationalize in the EM setting. But these two previous articles omitted other organizations that play a significant role in marketing healthcare, such as the medical tourism facilitators (MTFs). MTFs are a vital part of the industry in supplying supplementary services that care providers cannot deliver. Therefore, article III focuses on studying how MTFs work in the MT industry. Using Lovelock’s (1995) supplementary services model (also known as
Flower of Services), this paper aims to examine how MTFs operationalize in the MT industry in the context of an EM. Lovelock (1995) presents eight clusters of services that can enhance the core product and add value to customers. They are information, consultation, order-taking, hospitality, safekeeping, exceptions, billing, and payment.

A qualitative approach using a case-study approach is employed in this paper. Three local MTFs were selected for investigation, while an additional three supporting organizations were also included in the study. In total nine interviews were conducted and transcribed. In article III, NVivo, a software qualitative data processing program, was applied. All data (transcriptions, direct observation note, and documents) were then imported into the software NVivo. Data analysis was done using patterns within the case and across the cases. It is worth noting that since I had analyzed my data many times before (for articles I and II), I could not say that that there was a big difference between using manual and electronic software analysis besides, it was easier to retrieve the data using NVivo than looking for it manually.

The result shows that MTFs work as information disseminators, consultation facilitators, order-takers and hospitality providers. The supplementary services billing and payment are placed under information, since MTFs solely notify and are not involved in handling financial transactions. Meanwhile, safekeeping is found to be insignificant and is therefore excluded from the extended model. Empirical evidence shows that MTFs also play a vital role in linking and gathering different stakeholders’ expertise and improving the industry’s reputation for quality. Thus, network developers and industry development contributors are added as a new cluster or supplementary services. This investigation postulates that the MTFs can facilitate and enhance not only the core (medical) service but also the MT industry in an EM. In conclusion, the theoretical and empirical findings of this study led to the construction of an extended model.

4.4. Article IV: Medical Tourism Networks in an Emerging Market


Even though article I offers an understanding of how service providers market healthcare services, it somewhat lacks in explaining how trust, network building, and WOM address particular problems. Thus, Article IV explores the concept of the network more deeply. This study examines how care providers in an EM country handle challenges in marketing healthcare using networks. Focusing on networks, this study intends to explore the problem regarding the (double) intangibility of healthcare services and the unfavorable conditions in operating in a challenging context. Five care providers and six supporting organizations participated in the study. In total, twenty-two interviews from the managerial perspective were gathered, thirteen from five care providers and nine from supporting organizations. Secondary
Article IV shows two issues that healthcare providers face in their operations: (1) the physical and mental double intangibility of services and (2) environmental constraints. Through network building, providers manage to mitigate the adverse effect of environmental constraints. The study suggests that providers collaborate with supporting organizations, build alliances with international accreditation agencies, and affiliate with known international institutions. Collaboration with the related and supporting organizations like medical tourism facilitators, as well as foreign entities like embassies and chambers of commerce, help hospitals and clinics to establish a good reputation and reach a broader market. Working with accreditation entities and affiliation to establish international medical institutions uplifts the status of the local providers in the global arena. Furthermore, accreditations and affiliations generate opportunities for collaboration with international organizations and a bridge to future clientele. However, informal networks are also considered influential in marketing healthcare services. Through collaboration, accreditation, affiliation, and fostering informal ties, healthcare providers can withstand an unfavorable environment setting while overcoming service intangibility issues.

4.5. Overall contribution of the articles

This dissertation collectively contributes to the limited academic literature on MT, especially coming from a service marketing perspective that answers the recommendation of scholars (Balogun and Ogunnaike, 2017; Berry and Bendapudi, 2007; Brown, 1983; Butt et al., 2019; Fischer, 2014; Lovelock, 1977). The four papers individually offer empirically based theoretical frameworks that give ample illustration of healthcare service marketing. Taking advantage of primary data gathered directly from managers in their natural environment, this study is considered to provide interesting and proper concepts (Zeithaml et al., 2020). Conducting investigation on an EM can stimulate new concepts that can challenge existing mainstream theories (Burgess and Steenkamp, 2006; Paul, 2019; Sheth, 2020). These issues have been clearly addressed in the four papers.
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5. Discussion

This dissertation has examined how service providers in EM country market healthcare services. This chapter discusses the findings and results from the four articles to the theoretical background in Chapter 2 in order to address the three research questions of the study. Table 7 illustrates the key concepts and the research questions each article addresses. The relevance of trust and network building in healthcare marketing is discussed first, followed by a discussion on the significance of customization and the relevance of supplementary services. This chapter concludes with a general discussion.

<table>
<thead>
<tr>
<th>Research questions of the thesis</th>
<th>Concept</th>
<th>Article I</th>
<th>Article II</th>
<th>Article III</th>
<th>Article IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. How do MT providers meet the challenges in marketing healthcare services?</td>
<td>Trust</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>i. How do MT providers in an EM context operate in marketing healthcare services?</td>
<td>Customization</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supplementary Services</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7 illustrates the three research questions of the study and the concept(s) covered in each appended paper. To highlight the findings and the literature review, this discussion is organized around three themes, namely: (i) relevance of the trust, and networks in healthcare marketing in the volatile context, (ii) significance of customization in marketing healthcare services, and (iii) relevance of supplementary services in marketing healthcare services.

5.1 Relevance of trust, and networks in healthcare service marketing in the volatile context

The findings demonstrate that acquired international and local accreditation facilitates communication and gives assurance of high-quality healthcare, which in turn helps to build trust (article I). Accreditations guarantee the service providers’ credibility to the patients, which is vital for consumers in buying products involving credence (Berry and Parasuraman, 1991). The empirical evidence in articles I and IV
shows that providing indicators such as a seal of approval or affiliation with renowned medical institutions provide a tangible gesture of being trustworthy. It is essential to build trust quickly (Isaeva et al., 2020), this is particularly important for patients, according to Berry and Bendapudi (2007) and Rowe and Calnan (2006), who are emotional, ill, and have to take risks to undergo the treatment.

In line with Luhmann (1979), this study postulates that trust building is not only important to promote healthcare services but also to help the vulnerable consumer to become comfortable in an unfamiliar geographical place. Direct interaction of staff with patients creates positive impression and trust that helps to ease uncertainty (Berry, 2019). Article I shows that employing clinicians with good international credentials is essential to uplift dependency among hospitals and clinics. Furthermore, as Rajagopal et al. (2013) have found, trust also plays a crucial role in nurturing patients’ relationship with medical and nonmedical personnel.

The evidence confirms that although international accreditation is valuable in the MT industry (Hopkins et al., 2010), local accreditation is as important as foreign ones, since they create local acceptability. This is particularly important in the case of the Philippines, where the majority of international patients are diaspora who rely on advice from their social network, specifically relatives and friends (article I). Therefore WOM proves to be valuable for healthcare providers. Satisfied patients are a natural marketer and an excellent source of positive WOM (Lien et al., 2014). As shown in article I, providers emphasize using social media to facilitate information dissemination and communication with current and new patients.

This study shows that there are no patients who will seek healthcare service from or recommend providers that they do not trust. Providers in healthcare commercialization will not be accepted if they are not trusted and known (Berry and Parasuraman, 1991). Thus, trust building and effective WOM are important for market-focused hospitals and clinics seeking short- and long-term success.

The findings in articles I and IV show that network building is a focal point in healthcare providers’ operations. Providers build networks to gain legitimacy through affiliation and collaboration with outstanding medical facilities. Affiliation with accreditation entities like JCI and collaboration with respected medical institutions like New York Presbyterian Hospital result in a certain level of acceptance in the MT industry (Morrish and Earl, 2020; Rao, 1994) and tangible representation (Bateson, 1979; Ostrom et al., 2015) of providers’ high-quality care. Articles I and IV show that having a network is essential to attract healthcare consumers as well as other potential partners. An international presence is also vital to gain recognition and reach patients in their home country, thereby extending the provider’s connections. This is especially important for providers that operate in a lesser known destination such as the Philippines. Yet not all providers have the capacity and resources to expand.

Article IV underscores the capability of the service providers to sustain good relationships with ancillary industry suppliers as beneficial for survival in a complex
industry. These relationships enhance and maintain quality offerings, as well as resolving the physical and mental intangibility of service offerings (Bateson, 1979; Eisingerich and Bell, 2008; Scott and Laws, 2010). Collaboration with various service organizations allows for the opportunity to enrich service offerings by incorporating various types of expertise (Enderwick and Nagar, 2011). Although articles I and II show that healthcare providers are able to manage supplementary services internally, they still maintain collaboration with other organizations such as facilitators. The connection with medical tourism facilitators (MTFs) helps to lessen shortcomings related to the intangibility of service, as seen in Article IV. Through the recommendation of reliable facilitators, patients and other service providers are guided toward trusted healthcare and hospitality providers, which helps in enriching the industry, as article III revealed.

In line with Rottig (2016), this evidence shows that challenges in operating in less developed business environments hinder service providers from reaching their full potential. The lack of reliable government supervision was found to impede the providers’ ability to compete internationally (Bookman and Bookman, 2007). Articles I and IV highlight challenges like environmental constraints, a lack of formal intermediaries, and infrastructure concerns. Despite the lack of formal intermediaries in the Philippines, service providers have learned to capitalize on inter-organizational linkages to overcome hindrances in their operation, as shown in articles I and IV. However, what is perhaps feasible since providers under study are homegrown and familiar in local context. While the country is still in the midst of ongoing development (i.e. government infrastructure project, formalizing licensing and accreditation) providers concentrate and take advantage of the Filipino diaspora. Besides the cultural proximity, foreign healthcare consumers usually have social support and are familiar with the country. This corroborates the assertion that informal are as important as formal networks in healthcare service marketing (Granovetter, 1973; Scott and Laws 2010), particularly for providers operating in EMs like the Philippines (Paul, 2019).

5.2 Significance of customization in marketing healthcare services

In line with other studies on healthcare services (Berry and Bendapudi, 2007; Bettencourt and Gwinner, 1995; Lovelock, 1983), this thesis’s findings highlight that customization is an essential part of healthcare delivery. In article II three unique needs of international patients that require customization were identified, namely (1) to adapt to patients’ emotional, social, and cultural needs, (2) to help in alleviating knowledge asymmetry, and (3) to moderate the negative impact of the unfamiliar context. Although Berry and Bendapudi (2007) discuss the sensitive condition of healthcare consumers, they overlook the distress when patients need to travel long distances to an unfamiliar place. Article II also shows that having international
patients as consumers highlights the complexity in MT service delivery. Thus, trained personnel who will attend to the tailor-made solution are crucial (Bettencourt and Gwinner, 2007).

The findings also show that the extent to which healthcare providers adapt varies depending on the size and resources of the organization. In line with Lovelock (1983), established hospitals have a department that is manned by trained and specialized personnel in dealing with the needs of international patients. They internally cater to supplementary services like assisting in visa requirements, giving concierge services, and interpreter assistance. As Sundbo (2002) argues, customization can be costly, so small providers like dental clinics, customize the services that are performed by the practitioners. As in article II, dentists pick up their patients from the airport, advising them on what tourism activities they can do, and help arrange a place for them to stay. Thus, service providers that engage in the healthcare industry have to fulfill the demands of the heterogeneous consumer regardless of the level of complexity services (heart operation to dental service) or resources providers possess (Zeithaml et al., 2006).

Article II provides evidence for the necessity that service customization is handled by well-trained staff that have a medical background and understand the emotional, social, and cultural requirements of the patients, similar to the findings of Rajagopal et al. (2013). Article II’s findings also suggest that interaction between hospital staff and the patient is beneficial, since it builds understanding of the quality of the providers, while staff have the chance to examine consumers’ needs closely and attend to them promptly. This finding bears similarities with other studies (e.g., Bettencourt and Gwinner, 1995; Sundbo, 2002) that recognize the benefits of service interaction. The empirical evidence shows that providers consider employing staff members who are multilingual so they can explain the procedure to patients and their families in the language they are accustomed to, and on a level they can understand (in layman’s terms). Just as Zeithaml et al. (2006) suggest, the findings demonstrate the significance of customization in order to attend to the heterogeneous requirements of consumers. The evidence obtained in article II highlights service customization’s ability to facilitate the healthcare journey of patients and their companions. Complimentary airport pick-up, concierge services, and tourism advice help mitigate the exposure of patients to potentially adverse conditions in an emerging market setting.

5.3 Relevance of supplementary services in marketing of healthcare service

Article III shows that while some care providers establish their own departments to adapt to the needs of the patients, the majority of providers also employ MTFs for providing supplementary services. This means that MTFs have a role in the MT industry’s operations, as Chee et al. (2017) and Enderwick and Nagar (2011) state. The structured approach of Lovelock’s supplementary service clusters was used in
article III to illustrate which groups of supplementary services facilitators offer (Frow et al., 2014). Although the study indicates that Lovelock’s supplementary model was useful in defining services, the evidence shows that not all ancillary services are necessary due to the nature of the product and customer requirements (Lovelock and Yip, 1996). Information dissemination, consultation, order-taking, hospitality, and exceptions (problem-solving) are among the supplementary services that are important and require attention. On the other hand, safekeeping, billing, and payment are barely mentioned or explained in article III.

The findings of the study further demonstrate that facilitators circulate information through the internet, their networks, and activities like participation in an international convention to reach the international market (Borg and Ljungbo, 2018). Making services available and accessible for consumers resolves the service intangibility, as seen in article IV. Nevertheless, due to the sensitivity of the core service, accuracy and reliability of information are vital. Thus, the MTFs role in information dissemination is not solely essential but also crucial. The findings highlight that consultation services have to be professionally managed, as Snyder et al. (2011) argue. This means that MTFs have to partner with dependable experts (e.g., hospitals and clinics) to provide adequate service accurately. Maintaining a credible network, as seen in articles I and IV, can help providers to enrich the quality of service. This is specifically important for the MTFs that often criticized for having a limited medical background as stated by Turner (2010). Thus, the core provider’s opinion must be considered when giving advice to consumers. Facilitators also assist in arranging phone or Skype meetings between patients and doctors if needed. Special requests and problem-solving (exception) extend from consultation across the entire process of healthcare service delivery. The ability of the facilitators to adjust to the demands of sick patients with sparse medical knowledge and (sometimes) finances, is found challenging. Due to the tourism aspect of MT delivery, hospitality services are assumed to be mandatory. Empirical evidence in article III is somewhat connected to that in the previous article II: supplementary services are needed when customizing service offerings. The evidence obtained in article III shows that facilitators provide personal assistants who help patients through the entire medical journey. The role of these assistants extends from being patients’ advocates and tour guides to offering moral support and helping to explain the complex system of medical services in an unfamiliar environment, as Chee et al. (2017) also found. By providing assistance, facilitators transform an unfamiliar setting into a convenient place for sick consumers.

Due to their local knowledge, MTFs observe that finding reliable partners is uncomplicated, yet, maintaining a stable partnership can be challenging. Facilitators establish links that catalyze partnerships between reliable stakeholders (Eisingerich and Bell, 2007). Understanding the need for formal certification, one of the facilitators in the study took part in the groundwork for the development of guidelines on how the government should certify intermediaries. Another facilitator took advent-
age of its connections to solicit funds for two projects: (1) independent accreditation of hospital management systems and (2) a directive on quality management systems in nursing homes. This shows that facilitators have the capabilities to alleviate and catalyze the development of the MT industry. Yet these abilities and influence of MTFs are overlooked in the earlier studies conducted by Chee et al. (2017), Snyder et al. (2011), and Turner (2010).

Paper III offers a revised supplementary model. Empirical data gathered from intermediaries operating in the EM context help to develop and revise the Lovelock model (Burgess and Steenkamp, 2006, Kumar and Srivastava, 2019; Sheth, 2011). Some supplementary service clusters such as billing and payment were found to be irrelevant and are therefore placed as subservices under information. The fact that billing and payment are irrelevant may be due to two of the facilitators working on commission while the other one is a nonprofit organization. In addition, safekeeping is seen as irrelevant. The study also shows that facilitators play a vital role in linking and gathering different stakeholders’ expertise and improving the industry’s reputation for quality. Thus, network development and support industry development are added as new supplementary services. This investigation finds that the MTFs can facilitate and enhance not only the core (medical) service but also the medical tourism industry in an EM context.

5.4 General discussion

The findings of this study suggest that building trust within healthcare service marketing is an essential task for MT providers (Berry and Parasuraman, 1991). Trust is needed for inherent characteristics of services (i.e., intangibility, heterogeneity) and credence quality that causes uncertainty in delivering healthcare services (Davey and Grönroos, 2019; Rowe and Calnan, 2006). Further, MT organizations require developing trust in a shorter time. This means that healthcare providers may not enjoy the previously shared understanding by developing trust gradually. It is found that trust building in this study plays an unusual role compared to the findings of mainstream literature (e.g., building customer loyalty and organizational trust). This is because a high level of trust has to be developed quickly, due to the time constraint in relation to healthcare service delivery. Research findings further demonstrate that cultivating trust should be done collectively by all actors in the industry (Isaeva et al., 2020). This suggests that networking is a crucial source in building trust. MT providers have the challenge of uplifting not only the industry but also the country’s reputation. To execute such tasks, providers in this study extend their networks by initiating affiliations, accreditations, and collaborations with international organizations (Bookman and Bookman, 2007; Enderwick and Nagar, 2011). Through extending providers’ networks, the MT providers bring about new collaborations and thereby ensure wider acceptance locally and internationally. Thus, building networks is strongly related to building trust.
5. DISCUSSION

Even though trust and networks are well addressed and incorporated, other factors enable providers to live up to the expectations of healthcare consumers. Acknowledging the sensitivity of service, the unique requirements, and the unfamiliarity of healthcare consumers with the place of delivery, customization becomes significant in healthcare service marketing (Lovelock, 1983; Pallant et al., 2020; Silander et al., 2019). Customizing services to respond individual demands of healthcare patients not only eases the service delivery but also galvanizes the trust that is initially created. This implies that customization is essential to uplift trust further. To manage complexity in healthcare industry, providers also solicit available resources from other organizations like facilitators. These organizations offer supplementary services to aid in the use of core products and add extra value for the consumers (Frow et al., 2014; Lovelock, 1995). It is therefore reasonable to suggest that customization is complemented by the supplementary service to the optimal offering to address the needs of healthcare consumers. It is worth noting that facilitators are often part of the extensive network of the core providers within the context of the MT industry.

In summary, trust, network building, customization, and supplementary services are significant and interrelated in the complex and dynamic field of healthcare service marketing.
6. Conclusion, Implications, Limitations, and Future Research

This chapter concludes the study by addressing three research questions and presenting the updated framework of the study. The next sections discuss theoretical, managerial, and social implications of the study. Finally, the limitations and suggestions for future research are presented.

6.1 Conclusion

This thesis aimed to examine how service providers in an EM country market healthcare services internationally. Two research questions were addressed.

i. How do MT providers market healthcare services internationally?

This question focuses on the issues that providers are facing in marketing healthcare services as a product. Healthcare providers have to address intangibility, heterogeneity, and credence to market healthcare services internationally. This study shows that providers need to build trust, customize, and offer supplementary services. Trust has to be established quickly. By building trust, services become more tangible and acceptable, lessening healthcare consumers’ uncertainties. To meet the heterogeneity characteristic of service, providers need to customize. Customization plays a crucial role in adapting to the patients’ emotional, social, and cultural needs while alleviating knowledge asymmetry. This investigation also shows that the negative impact of the unfamiliar context experienced by international patients is moderated through customization. Healthcare providers also offer supplementary services to address the intangibility and heterogeneity of service features (e.g., proper information dissemination, offering personal consultation, effective planning of patient’s schedule, and providing hospitality services).

ii. How do MT providers in an EM context operate in marketing healthcare services?

This question focuses on the issues that providers are facing in their environmental setting while marketing healthcare services. The empirical findings suggest that these healthcare providers have to deal with unfavorable features, instability, and lack of legitimacy caused by the EM’s institutional constraints. Healthcare providers need to develop trust, reliable networks, customize, and offer supplementary services in their operation to market healthcare services in the EM setting. Through collaboration, accreditation, and affiliation, healthcare providers build trust and, at the same time,
In this study, the detrimental effect of environment setting was mitigated by networks (both formal and informal) which help providers navigate in a volatile context (locally) while engendering acceptance (internationally). Hence, customization addresses international patients' individual needs and modifies the possible unfavorable experience due to their unfamiliarity with healthcare and context. Moreover, supplementary services can also contribute to building a network that can eventually support industry development.

6.2 Theoretical implications

This current study makes several theoretical contributions, discussed below.

- **First**, this research addresses the ongoing call for studies that can add diversity and vitality in service research.

This investigation supports and enhances service research advancement in both practice and scholarship by showing the service marketing lens’s applicability in scrutinizing the underreported healthcare sector. This thesis is a direct and timely response to the call made by scholars like Anderson et al. (2019), Berry and Bendapudi (2007), Bolton (2020), Butt et al. (2019) and Zeithaml et al. (2020) to increase diversity and relevance of service and marketing research.

- **Second**, this thesis offers a theoretical proposition that contains four essential elements, in line with Dubin (1978).

Dubin (1978) states that theory development has to answer four questions: what (constructs are included to explain the phenomenon?), how (these constructs are interrelated), why (they are interrelated) and the who, where, and when (contextual and temporal factors of the proposition). The theoretical framework that is presented in this study (Figure 2 on page 36) includes these elements. This is not to say that a comprehensive model of healthcare service marketing is achieved. However, I argue that the theoretical framework presented in this study is a modest representation of healthcare service marketing’s existing integrated knowledge.

- **Third**, the thesis provides a value-added contribution to theory development, as identified by Whetten (1989).

In line with Whetten (1989), this thesis makes a theoretical contribution by proposing constructs, evaluating their interrelations, and applying them in a new setting. It examines existing concepts and current relationships among trust, networks, customization, and supplementary services. By testing these constructs in a novel industry, namely the complex MT industry, this dissertation demonstrates a “theoretical feedback loop” (Whetten, 1989, p.493) to improve understanding of healthcare service marketing. This means that the theory developed in this thesis has not only presented
four elements, as Dubin (1978) suggests, but is also substantiated by sound empirical evidence that warrants its validity.

- **Fourth, this thesis extends existing constructs.**

This study challenges and extends current knowledge by empirically verifying the concepts in the healthcare setting. For example, my observation shows how trust and network building help providers in healthcare service marketing reduce the effect of unfavorable conditions. It also extends the existing knowledge on how networking creates trust and vice versa in the healthcare setting. Empirical evidence suggests ways in which customization strategy can respond to the comprehensive needs of international patients. Furthermore, this investigation offers the opportunity to revive a model that needs empirical validation, specifically in the case of Lovelock’s clusters of supplementary services (Frow et al., 2014). Thus, this thesis confirms, develops, and extends previous research by presenting an alternative way of understanding healthcare using a service marketing lens. This is line with the recommendations for sound theoretical contribution discussed by Dublin (1978), Eisenhardt and Graebner (2007), and Whetten (1989).

- **Fifth, this thesis responds to healthcare service marketing being in its infancy.**

Previous studies proposed that healthcare service marketing is still in its infancy (e.g., Balogun and Ogunnaike, 2017; Butt et al., 2019; Crié and Chebat, 2013). By developing a theoretical framework that focuses explicitly on healthcare service marketing, this study contributes to the current discussion. The proposed framework can serve as a point of departure for future research, specifically for those academics who are interested in healthcare service marketing. Although the proposed theoretical framework is empirically verified, this does not limit further logical justification.

- **Sixth, this thesis highlights the healthcare sector as a rich field for service marketing research.**

In line with scholars (e.g., Anderson et al., 2019; Berry and Bendapudi, 2007, Butt et al., 2019; Lovelock, 1977, Zaltman and Vertinsky, 1971), this study affirms the potential of the healthcare sector as a rich field for service marketing research. However, unlike earlier studies, this inquiry focused on commercialized healthcare service in an EM, which made the context further unique and complicated. Hospital and clinic participation shows the marketing discipline’s role in their operations, explicitly communicating complex information and delivering healthcare services to the patients.

- **Seventh, this thesis is tested with empirical evidence collected from practitioners outside the mainstream popular EM countries.**
EMs are exceptional laboratories for testing theories and assumptions (Burgess and Steenkamp, 2006; Kumar and Srivastava, 2019; Sheth, 2020; Xu and Meyer, 2013). Thus, gathering and employing data from an EM context challenges and assesses existing service typologies’ validity. As a result, this thesis has also facilitated new insights on what we currently know about healthcare service marketing. The majority of EM research focuses on data gathered from mainstream EMs (like Brazil, Russia, India, and China) (Zarei and Maleki, 2019). The Philippines is an underrepresented country in EM research; thus, this study contributes to filling this gap. Zeithaml et al. (2020) highlight the significance of involving practitioners in adding strength and value to research. Through gathering practitioners’ insights, this study has generated theoretical framework relevant not only for academics but also for managers.

6.3 Managerial implications

With all the technological developments, affordable travel costs, the increasing willingness of people to travel, and the empowerment of consumers through the myriad of choices on the internet, it seems that anybody can be a potential medical tourist. Focusing on the providers’ perspective, this study offers some practical implications worth discussing to understand how these organizations can manage their promotion toward the international global healthcare market and how they may advance their knowledge of this service-driven industry. This is particularly important for providers operating in EMs like the Philippines.

The global healthcare industry challenges the social marketing concept, where the healthcare sector is traditionally excluded. Commercialization of healthcare presents a new image of hospitals and clinics as profit-making organizations that are in contrast to social expectations. To some extent, the relevance of marketing concepts in the care sector suggests that marketing know-how can contribute to human welfare by offering choice and posing an alternative way of efficiently delivering service, as implied by Anderson et al. (2019) and Butt et al. (2019). The professional side of medical care should always be considered above the business side. Managers have to prioritize the (local or international) patients’ well-being before the financial benefits. Promising the luxury of combining medical care and tourism services is tempting but needs to be done with care.

This study has shown that building trust and networks are crucial when engaging in healthcare. Effective networking can be beneficial for all parties involved in the MT industry. We further found that a combination of trust and networking has a positive effect on healthcare delivery. The more trustworthy an organization is, the more likely partners are to work with it. Further, managers must capitalize on positive WOM through personal contact or through electronic sources to generate trust, but they should not underestimate the effect of negative WOM. Unsatisfied consumers tend to spread more information than satisfied ones. Timely attention to a problem can reduce the consequences. Moreover, WOM referral is even stronger if the one
recommending has close social ties (family and friends) to a receiver. Thus, WOM is more crucial when focusing on diasporas.

Another practical implication focuses on how providers can customize their offerings to meet the needs of the patients. The emotional, social, and cultural requirements of patients have to be addressed differently when dealing with international versus local patients. Information asymmetry might not be so dissimilar between local and international patients, yet handling the issue should involve a different approach. Language barriers and the way of communicating are two obvious factors that require handling in different ways. Unfamiliarity with the local setting requires managers to be dedicated to making the facilities pleasant. High quality and affordability of services are not enough, since delivering a pleasant experience to patients is also vital. Lastly, managers also need to focus on supplementary services, whether offered internally or through other organizations. The role of medical facilitators needs to be understood and integrated in the total solution offered to healthcare customers.

6.4 Social implications

Medical tourism’s existence is a reality and can easily be recognized in countries that are openly marketing themselves as a destination like the Philippines. However, MT’s implication in the healthcare system is not limited to the destination countries but also challenges the system in patients’ country of origin. The commercialization of healthcare can encourage consumers, even in countries with an advanced and well-funded healthcare system. Two examples of this development are the growing interest in private insurance and the existence of medical tourism facilitators (MTFs) around the world. The private insurance business is increasing. For example, in Europe, Sweden is the fastest-growing market for private insurance (OECD/European Observatory on Health Systems and Policies, 2017). The existence of a rising number of MTFs is another indication that a market supports their presence. Because of this, MT should no longer be discussed in isolation. Practitioners, policymakers, and other healthcare sector stakeholders have to prepare and deal with the issue seriously. This study is also a direct response to Bolton’s (2020) call for more research that “prioritize[s] studying problems that produce useful knowledge that benefits society” (p.287).

As in the Philippines, one of the primary reasons for many EM countries to engage in MT is economic; they see it as an additional source of income and a way toward social development. On the contrary, some see it as unethical commercialization of local health resources that aggravate health inequalities in many emerging countries (Turner, 2007). However, the knowledge is limited on this issue, due to the lack of evidence-based studies (Connell, 2011; Fetscherin and Stephano, 2016). This suggests that criticism about MT is just speculation. In the end, the beneficiaries of getting
timely and advanced medical services are human, too, needless of whether they are locals or international patients. It is up to us which perspective we choose.

Current rapid development in digital media and the technological landscape has changed how we live and see the world. No doubt money-making entities have prospered by taking advantage of attracting consumers through the internet. The MT industry has proven that healthcare service providers are among these entities. Nevertheless, we cannot deny that healthcare consumers have benefited from MT too. Patients become empowered and enabled. They gain the ability to choose and seek alternatives regarding when, where, and how they get treated. Perhaps it is about time to accept that healthcare delivery’s current structure has changed and will continue changing. During the course of my study, I have seen how providers in underdeveloped settings manage to accommodate patients. It has been interesting yet very alarming to find that their operations are underregulated. Thus, this requires further efforts from political institutions.

6.5 Limitations and future research

This study has examined how service providers market healthcare in an EM. The investigation focused on collecting empirical findings from the firms’ perspective and left out consumers and government agencies’ viewpoints. This is not to say that other stakeholders’ perspectives are irrelevant, but the primary aim had to be prioritized. Also, it is wrong to assume that this study represents a holistic view of what the MT industry looks like in other EM countries. Another theoretical perspective could reveal an alternative direction. For instance, employing the Uppsala Internationalization Model (Johanson and Vahlne, 2009) to explain healthcare service providers’ marketing activities might provide another perspective. It could also contribute to the applicability of the model to the service-intensive industry.

Furthermore, the study is limited by the qualitative research method employed in terms of empirical setting, data collection, case selection, respondent selection, and analysis. These concerns are further discussed in chapter 3. A quantitative approach could reveal data that could be generalized, yet it would miss the qualitative method’s depth and wealth of data. Moreover, the current study does not guarantee that the same outcome would emerge if another researcher collected the data today in the Philippines. This is due to the volatility of the environmental setting in EM countries and other factors and views that can influence the respondents’ mind-set.

The above limitations afford opportunities for future research. First, including different stakeholders involved in the MT industry could give a holistic view. Accrediting bodies like Joint Commission International, Accreditation Canada, and the International Standard Organization play a significant part in demonstrating high-quality services among providers. It is fascinating to learn their role in healthcare service marketing. Their insights can facilitate further understanding on healthcare commercialization. Second, patients’ participation in a future study could pre-
sent new views on their active role in healthcare marketing. Gathering patients’ perspectives through either quantitative or qualitative research could extend and substantiate the validity of the theoretical framework used in this study. Third, studies may also seek to compare empirical data from other underreported destinations like Mauritius, Laos, and Sri Lanka. This could extend the existing knowledge in healthcare service marketing even further. Fourth, investigating a developed country like Sweden has the potential to provide another perspective. Finding how providers prepare for diaspora patients is also interesting to know. Fifth, another aspect that this study has not considered is domestic MT. It is interesting to compare the international and domestic MT industries and see how the provider approaches these distinct markets.
References


REFERENCES


Appendices

Appendix 1. Letter of Introduction

TO WHOM IT MAY CONCERN
We are researchers from University of Gävle and University of Södertörn in Sweden, undertaking a research on Medical Tourism. From our initial enquiry, we have come to know that your organization is one of the leaders in catering foreign patients in the Philippines. For this reason we are interested to include your hospital in our research. Our study focuses on how international hospitals operate in accommodating foreign patients. We are expecting to conduct few face-to-face interviews with different people in your organization who are directly engaged (i.e., Physicians, nurses, International coordinators, interpreters) in offering services to the foreign clients.

It will be a privilege for us to have your hospital as part of our research study together with the other hospitals from United Arab Emirate and Mauritius. Our target date of interview will be during first and second week of January, 2015, right after the holidays. The interview will be taken by Michelle Rydback who speaks the local language.

We can assure you that the data will be used purely in the research and will not be used for any other purpose. It is our expectation that you will kindly extend all possible support to Michelle when she will be in touch with you.

For any further information, please contact us through our e-mails.

Thanks in anticipation.

Best regards,

Erik Borg
Professor
School of Social Sciences
University of Södertörn

Akmal Hydar
Professor
Department of Business & Economic Studies
University of Gävle

Alhie Osarenkhoe
Professor
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Michelle Rydback
PhD Student
School of Social Sciences
University of Södertörn

Department of Business & Economic Studies
University of Gävle
Appendix 2. Informed Consent Form

Purpose and Aim

The purpose of this interview is to gather primary information on how healthcare service providers operate in attracting and accommodating foreign patients. I assure you that all data gathered shall be used for the research purpose only.

Participation

The interview will take approximately one hour. It is our expectation that you address all the questions but, you may leave any question if you don't wish to answer. You can stop the interview and your participation in the study any time you want.

Benefits and Risks

There will be no direct benefit in participating in this study. However, this research expects to highlight information on medical tourism in your institution and the Philippines as the country of destination. There are no foreseen risks related to participating in the study.

Confidentiality

The session will be audio recorded with your permission; however all of your personal information will be kept confidential.

Through signing below you confirm that you understand the above information and agree to participate.

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Signature over printed name __________________________ Date ________

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I have informed the aim and the purpose of the study as well as participant’s benefit and risk. I have confidence that the respondent understands the implications of participation.

Michelle Rydback __________________________ Date ________

INSTRUCTIONS

Good morning/afternoon. My name is ___. Thank you for coming. The purpose of this interview is to gather primary information on how hospitals accommodate, communicate, and adapt to the needs of their foreign patients, in the case of medical tourism in the Philippines.

TAPE RECORDER INSTRUCTIONS

I wish to record our conversation if it’s ok with you? The purpose is to acquire comprehensive details of our conversation while we are discussing. All of your personal information will be kept confidential. We assure you that all data gathered shall be used for the research purpose only.

CONSENT FORM INSTRUCTIONS

Here is a consent form for more detailed information. Kindly read and sign if everything is clear to you.

1. Please tell about your profession.
   a. Functions in the hospital.
   b. Previous working experience (position/s and number of years of employment).

2. Please describe how your hospital informs foreign patients about your services.
   a. Do you market internationally (locally) medical services you offer?
   b. Tell us about how you advertise?
      i. Can you name the countries that you advertise?
      ii. Language adaptation
      iii. Cultural and norms adaptation
   c. Do you use social media (e.g., Facebook, Twitter, etc.)?
   d. Does insurance refer to them?
      i. How many % if possible?
      ii. From what countries?
   e. Do you use healthcare management agency/broker in getting patients?
      i. How many % if possible?
      ii. From what countries?
   f. How do you monitor/know the effectivity of promotional activities?
3. **Please describe the procedure of how you serve international clients.**
   a. In what ways do patients usually contact you e.g., thru email, phone, or a personal visit?
      i. Medical services that you commonly render?
      ii. Medical facilitators? Are they medically trained?
      iii. Medical insurance representatives? Are they medically trained?
   b. Do you have staffs that are specially trained to accommodate international patients?
   c. What language is most commonly used (e.g., English, Filipino, and Chinese)?
   d. How do you see the role of language in the communication process?
   e. Do you use interpreters? (How many languages)?
   f. How do a long time usually the patients wait before you can accommodate them?
      i. Who is assigning a doctor to the patients?
      ii. Do they (patient-doctor) initially communicate through the internet (Skype), phone?
   g. Do you prioritize the international considering i.e., the visa requirement?
   h. Do you have counterparts in your patients’ home countries that accommodate them in follow-up checkups /case of problem occur?
   i. Have your previous patients recommended your hospital? Does it happen often?

4. **Please describe the service package you offer to the international clients and how they are developed.**
   a. Do different organization help them with the service package?
   
   b. Who do they work with?

5. **The service you offer is sensitive and complicated. Please describe how your staffs develop confidence for international patients.**
   a. How does your organization indicate to patients that you are a reliable service provider?
   b. Accreditation (e.g., JCI, ISO, AC, Trent, etc.)
   c. Affiliations (e.g., international medical institutions, research school, etc.)
   d. Doctors international credentials?
APPENDICES

i. What countries?
ii. Does it help?

e. Are you hiring foreign employees?
   i. If yes, from what country?
   ii. Why not?

f. Clinical outcome?

   g. Accessibility and availability of service – how is this managed?

6. **Please describe how you develop and work with external contacts.**
   
   a. Through affiliations (international and local)?
   
   b. How significant are they to you?
   
   c. Are you doing research together?
   
   d. Training for the employees?
   
   e. To legitimize the organization in the international arena?

   f. Medical institution?

7. **Is/are there local or foreign hospital/healthcare providers rendering the same kind of service that you see as competitor/s?**
   
   a. How does the competition look like in the country?

8. **Please tell us what you think about the future of medical tourism in this country?**
   
   a. Is the government helping you enough?

   b. What do you think you can improve?

9. **Any additional relevant information that you want to add?**
   
   a. Does XXX (name of the hospital) have plans to market in Europe?
Appendix 4. Interview Protocol (2016)

INSTRUCTIONS

Good morning/afternoon. My name is ___. Thank you for coming. The purpose of this interview is to gather primary information on how hospitals accommodate, communicate, and adapt to the needs of their foreign patients, in the case of medical tourism in the Philippines.

TAPE RECORDER INSTRUCTIONS

I wish to record our conversation if it’s ok with you? The purpose is to acquire comprehensive details of our conversation while we are discussing. All of your personal information will be kept confidential. We assure you that all data gathered shall be used for the research purpose only.

CONSENT FORM INSTRUCTIONS

Here is a consent form for more detailed information. Kindly read and sign if everything is clear to you.

1. Please tell about your profession.
   a. Functions in the hospital.
   b. Previous working experience (position/s and number of years of employment).

2. Please describe how your organization promotes your services in the international market.
   a. Do you market internationally (locally) medical services you offer?
   b. Tell us about how you advertise?
      i. Can you name the countries that you advertise?
      ii. Language adaptation
      iii. Cultural and norms adaptation
   c. Do you use social media (e.g., Facebook, Tweeter, etc.)?
   d. Does insurance refer to them?
      i. How many % if possible?
      ii. From what countries?
   e. Do you use healthcare management agency/broker in getting patients?
      i. How many % if possible?
      ii. From what countries?
   f. How do you monitor/ know the effectivity of promotional activities?
3. **Please describe the procedure of how you serve international clients.**
   a. In what ways do patients usually contact you e.g., thru email, phone, or a personal visit?
      i. Medical services that you commonly render?
      ii. Medical facilitators? Are they medically trained?
      iii. Medical insurance representatives? Are they medically trained?
   b. Do you have staffs that are specially trained to accommodate international patients?
   c. What language is most commonly used (e.g., English, Filipino, and Chinese)?
   d. How do you see the role of language in the communication process?
   e. Do you use interpreters? (How many languages)?
   f. How do a long time usually the patients wait before you can accommodate them?
      i. Who is assigning a doctor to the patients?
      ii. Do they (patient-doctor) initially communicate through the internet (Skype), phone?
   g. Do you prioritize the international considering i.e., the visa requirement?
   h. Do you have counterparts in your patients’ home countries that accommodate them in follow-up checkups /case of problem occur?
   i. Have your previous patients recommended your hospital?
      i. Does it happen often?

4. **How does your organization indicate to patients that you are a reliable service provider?**

   – Research has been conducted in Malaysia that concludes that “hospital reputation” is the most influential factor.
   a. Accreditation (e.g., JCI, ISO, AC, Trent, etc.)
   b. Affiliations (e.g., international medical institutions, research school, etc.)
   c. Doctors international credentials?
      i. What countries?
      ii. Does it help?
   d. Are you hiring foreign employees?
      i. If yes, from what country?
      ii. Why not?
   e. Clinical outcome?
f. Accessibility and availability of service – how is this managed?

5. **What affiliations (international and local) that your institution has and how significant they are to you?**
   a. Are you doing research together?
   b. Training for the employees?
   c. To legitimize the organization in the international arena?
   d. Medical institution?

6. **How do governance indicator factors affect MT marketing? (Exhibit 1)**
   – The World Bank did the recent study in Worldwide Governance Indicators (WGI) project resulted in unfavorable for the Philippines. However, even though the country doesn’t place in the right place, the trend is that it is getting "better." So what are we doing?

7. **How can you assure the safety of your international patients (within and outside your facility)?**
   – By the Travel and Competitive Index in 2013, we are ranked # 82 in 180 countries, and one of the concern is “safety and security” (103 of 140)
   a. What are we doing? i. Government  ii. Organization

8. **How your business is affected by inadequate infrastructures such as the internet, air, and ground transport facilities? Please describe how you counter if the issue occurs. (Exhibit 2).** -The Philippines is placed 89 in the “business environment and infrastructures” (air and ground transport infrastructure, ICT infrastructure)
   a. Ancillary services?
   b. Accessibility of service (mall base clinics, satellite hospitals)
   c. Relationship of the government?
   d. Progress in MT infrastructure?

9. **Please tell us what you think about the future of medical tourism in this country?**
   a. Is the government helping you enough?
   b. What do you think you can improve?

10. **Any additional relevant information that you want to add?**
    a. Does XXX (name of the hospital) have plans for marketing in Europe?
Appendix 5. Interview Questions (2015)

Name of the Interviewee

Position

Years in the clinic

Location of the interview

Time (Start – Finish)

1. Please tell about your profession.

2. Please describe how your hospital informs external patients about your services.

3. Please describe the process how you serve international patients.

4. Please describe the service package you offer to the international patients and how they are developed.

5. The service you offer is sensitive and complicated. Please describe how your staffs develop confidence for the international patients.

6. Please describe how you develop and work with external contacts.

7. Is/are there local or foreign clinic/hospital/ healthcare service providers rendering the same kind of service that you see as a competitor/s?

8. Please tell us what you think about the future of medical tourism in this country?

9. Any additional important information that you want to add?

Thank you very much for your time and effort!

Michelle Rydback
PhD Candidate

My supervisors are:
Prof. Akmal Hyder
Prof. Erik Borg
Prof. Ahie Osarenkhoe
Appendix 6. Interview Questions (2016)

1. Please tell me about your profession.
2. Please describe how your organization promotes your services in the international market.
3. How does your organization indicate to patients that you are a reliable service provider?
4. Please explain the procedure how you serve international clients.
5. What affiliations that your institution has and how significant they are to you?
6. How the governance indicator factors do affect medical tourism marketing?
7. How can you assure the safety and security of your international patients?
8. How your business is affected by scarce infrastructure such as the Internet, air, and ground transport services? Please describe how you counter if the issue occurs.
9. Please tell us what you think about the future of medical tourism in this country?
10. Any additional relevant information that you want to add?

Ph.D. Candidate Michelle Rydback
Prof. Akmal Hyder
Prof. Erik Borg
Prof. Aishie Osarenkhoe

The University of Gavle is human-centred and develops the understanding of a sustainable living environment.
## Country Overview

<table>
<thead>
<tr>
<th></th>
<th>Philippines</th>
<th>Thailand</th>
<th>Singapore</th>
<th>Malaysia</th>
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<tr>
<td><strong>Governance Indicators</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>(for 2004, 2009 &amp; 2014)</td>
<td></td>
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<tr>
<td>Voice and accountability</td>
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<td>53.4</td>
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</tr>
<tr>
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<td>45.3</td>
<td>31.8</td>
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<td>Political Stability</td>
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<td>Government Effectiveness</td>
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<td>Regulatory Quality</td>
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<td>Rule of Law</td>
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<td>Control of Corruption</td>
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<td>75</td>
<td>97.6</td>
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<td>42.3</td>
<td>97.1</td>
<td>68.3</td>
<td>97.6</td>
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</table>

**Travel & Tourism Index**
(for 2011, 2013 & 2015)

|                      | 94 (of 139) | 41 (of 139) | 10 (of 139) | 35 (of 139) | 5 (of 139) |
|                      | 82 (of 140) | 43 (of 140) | 10 (of 140) | 34 (of 140) | 9 (of 140) |
|                      | 74 (of 141) | 35 (of 141) | 11 (of 141) | 25 (of 141) | 23 (of 141) |

**Corruption Perception Index**
(out of 168 countries; 2015)

|                      | 95          | 76          | 85          | 54          | 3          |
|                      | Scale 0-100 | Scale 0-100 | Scale 0-100 | Scale 0-100 | Scale 0-100 |

* World Bank Worldwide Governance Indicators (WGI) project
** World Economic Forum
***Corruption Perception Index
### Appendix 8. Observation Protocol

#### Observation Protocol

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time:</th>
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</thead>
<tbody>
<tr>
<td>Place:</td>
<td></td>
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</table>

#### Staff

<table>
<thead>
<tr>
<th>Descriptive Notes</th>
<th>Reflective Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
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</tr>
<tr>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td>Concierge</td>
<td></td>
</tr>
<tr>
<td>Security personal</td>
<td></td>
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<tr>
<td>Front office personnel</td>
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<td>Others</td>
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</table>

#### Non-clinical Environment

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Hotel-like lobbies</td>
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</tr>
<tr>
<td>Familiar food chain i.e. McDonalds, Starbucks</td>
<td></td>
</tr>
<tr>
<td>Security Measures i.e. presence of security guards</td>
<td></td>
</tr>
<tr>
<td>Cleanliness</td>
<td></td>
</tr>
<tr>
<td>Furniture standards</td>
<td></td>
</tr>
<tr>
<td>Sanitary condition in cafeterias</td>
<td></td>
</tr>
<tr>
<td>Sanitary clean comfort rooms</td>
<td></td>
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<tr>
<td>Multilingual signage</td>
<td></td>
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<tr>
<td>Family room / Prayer room</td>
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<tr>
<td>Others</td>
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</tbody>
</table>

#### Room Standards

<table>
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<th>Reflective Notes</th>
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</thead>
<tbody>
<tr>
<td>Hotel-like room</td>
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<tr>
<td>Room service</td>
<td></td>
</tr>
<tr>
<td>Quality of the bed and furniture</td>
<td></td>
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<tr>
<td>Comfort of aircon</td>
<td></td>
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<tr>
<td>Hot water shower</td>
<td></td>
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<tr>
<td>Furniture standards</td>
<td></td>
</tr>
<tr>
<td>Fabric i.e. bed sheets</td>
<td></td>
</tr>
<tr>
<td>Different size in robes, wheelchair</td>
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<tr>
<td>TV channels</td>
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<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Internet</td>
<td></td>
</tr>
<tr>
<td>Cultural consideration i.e. Fung shui, bad and good numerology</td>
<td></td>
</tr>
</tbody>
</table>

#### Extra Services

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<tr>
<th>Descriptive Notes</th>
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</thead>
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<tr>
<td>Flight &amp; Visa Assistance</td>
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<tr>
<td>Concierge services</td>
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<tr>
<td>Airport pick up</td>
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</tr>
<tr>
<td>Security personal</td>
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<tr>
<td>Special Ass. Interpreter International</td>
<td></td>
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<tr>
<td>Others</td>
<td></td>
</tr>
<tr>
<td>Case</td>
<td>Participants own language / Primary datum construct</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>“Meeting the patients personally is different. They have different moods. Unlike on the telephone, you can answer directly what they need. In a personal meeting, they are more demanding.”</td>
</tr>
<tr>
<td></td>
<td>“We treat them as a family. We see to it that we talk to them. We have time for them. Yes, that is something special to us. Yes, very Filipino.”</td>
</tr>
<tr>
<td></td>
<td>“They are like Filipinos also. They want to bring their families when they operations here. They want us to keep in touch with their families abroad. We also help them to contact them.”</td>
</tr>
<tr>
<td></td>
<td>“However, if the international patients who are asking how to facilitate the visa extension, we can accommodate that. Our driver, through our transport services. We will assist them to go to immigration to get their visa.”</td>
</tr>
<tr>
<td>2</td>
<td>“Different departments here in the hospital taken into consideration different cultures, religions, needs and requirements of the patients, not just internationals but locally.”</td>
</tr>
<tr>
<td></td>
<td>“We are one of the hospitals that have Patient experience officers; we are the first to have patients experience officers. And these patients’ experience officers are well adept in answering patients’ needs whether it’s medical or non-medical. You know even our engineering department is sensitive. Like for example, patients want a room facing the east or Mecca, they know.”</td>
</tr>
<tr>
<td></td>
<td>“Technology is applied if it is considered necessary and should not replace the human contacts that can ease the delivery of the medical service.”</td>
</tr>
<tr>
<td>3</td>
<td>“The role of our international patients’ service is important to medical delivery; for instance, we accompany patients inside the operating room to make sure that they understand the instruction of the doctors during the surgery.”</td>
</tr>
<tr>
<td></td>
<td>“If they want to go around the city, we can arrange that as long as our staffs are available, our transport is we can do that.”</td>
</tr>
<tr>
<td>4</td>
<td>“We handle these activities, to go out the way of your service to the patients, to make their stay pleasant hassle-free seamless. You fetch them to the airport; then you suggest them to get a place to go like you become a facilitator. Most of our dentists do that; it is a way of showing them how willing to serve beyond the actual dental service that we provide.”</td>
</tr>
<tr>
<td></td>
<td>“You share that information with this patient and then appreciate that extra that you do for them not just for dental needs. Connect them to other trustworthy people, for example, transportation services. You go out of your way to give them extra service beyond what you are doing inside the clinic.”</td>
</tr>
<tr>
<td></td>
<td>“You know what happens to this Norwegian patient, he once took a taxi from my clinic going back to the hotel and met this taxi driver. They eventually become good friends. The taxi driver invited the Norwegian to his hometown and then the whole barangay celebrate with them. The experience becomes authentic and beyond their expectations. It is something that they don’t experience in order countries.”</td>
</tr>
<tr>
<td>5</td>
<td>“For international patients, we communicate through the internet; you discuss how he/she can come here and then we fetch them to the airport. You look for a place for him/her to stay and then you accompanied them where they can eat dinner or you can give suggest a place that they can go after and before the procedure.”</td>
</tr>
<tr>
<td></td>
<td>“We are pushing making accreditation as criteria on our accreditation. Yes, it is our preventive measures for the future client’s safety. If this project materializes, this will solve the problems even it occurs.”</td>
</tr>
<tr>
<td></td>
<td>“It is actually when they experience something they find satisfaction and more than you have to find a way to entertain them. To give them tips, where they want to go, what they wanted to do over the weekend.”</td>
</tr>
</tbody>
</table>
Sammanfattning
(Summary in Swedish)


Denna studie syftar till att undersöka hur tjänsteleverantörer i ett tillväxtland marknadsför hälsovårdstjänster internationellt. Denna avhandling består av fyra artiklar. Genom kvalitativ fallbaserad forskning koncentreras denna studie till sjukhus, kliniker och facilitatorer för medicinsk turism som spelar en central roll i leverans av tjänster inom den medicinska turistnäringen. Resultatet av denna avhandling illustrerar att tjänsteleverantörerna måste bygga förtroende för att effektivt marknadsföra hälso- och sjukvård, skapa tillförlitliga nätverk, skapa anpassade och kompletterade tjänster.

17. Renata Ingbrant, *From Her Point of View: Woman’s Anti-World in the Poetry of Anna Świrszczynska*, 2007
34. Tommy Larsson Segerlind, *Team Entrepreneurship: A process analysis of the venture team and the venture team roles in relation to the innovation process*, 2009
37. Karin Ellencrona, *Functional characterization of interactions between the flavivirus NS5 protein and PDZ proteins of the mammalian host*, 2009
43. René León Rosales, Vid framtidens hitersta gräns: Om pojkar och elevpositioner i en multietnisk skola, 2010
44. Simon Larsson, Intelligensaristokrater och arkivmartyrer: Normerna för vetenskaplig skicklighet i svensk historieforskning 1900–1945, 2010
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46. Alia Jaensson, Pheromonal mediated behaviour and endocrine response in salmonids: The impact of cypermethrin, copper, and glyphosate, 2010
47. Michael Wigerius, Roles of mammalian Scribble in polarity signaling, virus offense and cell-fate determination, 2010
48. Anna Hedytjärn Wester, Män i kostym: Prinsar, konstnärer och tegelbärare vid sekelskiftet 1900, 2010
49. Magnus Linnaarsson, Postgång på växlande villkor: Det svenska postväsendets organisation under stormaktstiden, 2010
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63. Wessam Melik, Molecular characterization of the Tick-borne encephalitis virus: Environments and replication, 2012
70. Maria Wolrath Söderberg, *Topos som meningsskapare: Retorikens topiska perspektiv på tänkande och lärande genom argumentation*, 2012
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105. Katharina Wesolowski, *Maybe baby? Reproductive behaviour, fertility intentions, and family policies in post-communist countries, with a special focus on Ukraine*, 2015
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141. Anh Mai, Organizing for Efficiency: Essay on merger policies, independence of authorities, and technology diffusion, 2017
142. Gustav Strandberg, Politikens omskakning: Negativitet, samexistens och frihet i Jan Patočkas tänkande, 2017
143. Lovisa Andén, Litteratur och erfarenhet i Merleau-Pontys läsning av Proust, Valéry och Stendhal, 2017
144. Fredrik Bertilsson, Frihetsstida polisckapande: Uppfostringskommissionen och de akademiska konstitutionerna 1738–1766, 2017
149. Roman Horbyk, Mediated Europes – Discourse and Power in Ukraine, Russia and Poland during Euromaidan, 2017
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151. Rahel Kuflu, Bröder emellan: Identitetsformerings i det koloniserade Eritrea, 2018
152. Karin Edberg, Energilandskap i förändring: Inramningar av kontroversiella lokaliserings på norra Gotland, 2018
153. Rebecka Thor, Beyond the Witness: Holocaust Representation and the Testimony of Images – Three films by Yael Hersonski, Harun Farocki, and Eyal Sivan, 2018
154. Maria Lönn, Bruten vithet: Om den ryska femininitetens sinnliga och temporala villkor, 2018
155. Tove Porseryd, Endocrine Disruption in Fish: Effects of 17α-ethinylestradiol exposure on non-reproductive behavior, fertility and brain and testis transcriptome, 2018
156. Marcel Mangold, Securing the working democracy: Inventive arrangements to guarantee circulation and the emergence of democracy policy, 2018
157. Matilda Tudor, Desire Lines: Towards a Queer Digital Media Phenomenology, 2018
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159. Johanna Pettersson, What’s in a Line? Making Sovereignty through Border Policy, 2018
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162. Mari Zetterqvist Blokhuis, Interaction Between Rider, Horse and Equestrian Trainer – A Challenging Puzzle, 2019
164. Ralph Tafon, Analyzing the “Dark Side” of Marine Spatial Planning – A study of domination, empowerment and freedom (or power in, of and on planning) through theories of discourse and power, 2019
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166. Mathilde Rehnlund, Getting the transport right – for what? What transport policy can tell us about the construction of sustainability, 2019
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169. Eva Karlberg, Organizing the Voice of Women: A study of the Polish and Swedish women’s movements’ adaptation to international structures, 2019
170. Maria Pröckl, Tyngd, sväng och empatisk timing – Förskollärares kroppliga kunskaper, 2020
172. Ingrid Forsler, Enabling media: Infrastructures, imaginaries and cultural techniques in Swedish and Estonian visual arts education, 2020
173. Johan Sehlberg, Of Affliction – The Experience of Thought in Gilles Deleuze by way of Marcel Proust, 2020
174. Renat Bekkin, People of reliable loyalty…: Muftiates and the State in Modern Russia, 2020
175. Olena Podolian, The Challenge of 'Stateness' in Estonia and Ukraine: The international dimension a quarter of a century into independence, 2020
176. Patrick Seniuk, Encountering Depression In-Depth: An existential-phenomenological approach to selfhood, depression, and psychiatric practice, 2020
177. Vasileios Petrogiannis, European Mobility and Spatial Belongings: Greek and Latvian migrants in Sweden, 2020
178. Lena Norbäck Ivarsson, Tracing environmental change and human impact as recorded in sediments from coastal areas of the northwestern Baltic Proper, 2020
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How do service providers in an emerging-market country market healthcare services internationally?

Medical tourism’s growing popularity offers a unique context to understand how providers with limited resources and constrained by environmental settings market themselves. Service providers must build trust, reliable networks and offer customized and supplementary services to healthcare consumers. This study has no prescriptive or predictive claim. It is an analytic account of how providers are managing the complexity of promoting healthcare services in an underdeveloped setting. The proposed framework presents the notions necessary for promoting the service but not the providers’ predictive requirement to succeed. This book is written primarily for marketing researchers and other scholars, regardless of discipline, and practitioners interested in the exciting field of healthcare.

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