Internationalization of health care services

Networking aspects

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Dedication

“If you build it, They will come”

Adapted from “Field of Dreams”
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Julius and Yonathan
Abstract
Principles of business management are increasingly being used to analyze health care systems. Conceptualizing health care as business networks offers the possibility to apply the ARA model of Actors, Resources and Activities to understand the functioning of the system. We have used this model to study the phenomenon of networking in cross-border care using Uppsala University Hospital as a research case.

The aim of the study was to understand actor’s perceptions of networking activities and how these related with international sales of health care services.

We collected primary data through five interviews with managers involved in internationalization and a survey study with 26 managers at the hospital. Secondary data on patient flows and research activity was collected from hospital and university records.

The main actors identified in the health care networks are doctors with professional identity being an important facilitating factor. Patient’s role as active participants in the system is increasing while researchers, innovators and key opinion leaders are also important. Networking activities consist of knowledge transfer via lecturing, meetings and external consulting activities. Resources in the form of supporting clinics, research centers and administrative services correlate positively with the level of internationalization.

The study identifies networking activities as important for internationalization and cross-border sales of health care services. We conclude that the ARA model is a valuable instrument for analyzing cross border activities and internationalization of health care.

Keywords
Networks, internationalization, health care, cross-border care, medical tourism
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1. Introduction

1.1 Internationalization of health care

Internationalization is changing the way healthcare is organized and conceptualized, by patients and practitioners alike. Internationalization, as the term is used here, includes patient mobility over country borders, which in later years has grown to such an extent, that the term “Medical Tourism” is now commonly used to describe these international patients flows (Carrera & Lunt, 2010). Patterns of patient movements have also changed in recent years. In the 1990s, this phenomenon mostly included patients from low-income countries who were seeking high quality care in well-endowed health care facilities. Now, a large proportion of cross-border patients come from high-income countries seeking to avoid long waiting lists and expensive health care in the home country (Lunt et al., 2013).

The increasing importance of cross-border care and rising numbers of patients seeking health care abroad necessarily affects how the health care system approaches several local issues in each country. As described by Carrera and Lunt (2010), there is for example an ongoing change in how the patient is conceptualized. In the European setting the patient traditionally has been considered to be a citizen with the rights this entails, but with increased focus on serving the international market, the patient is more and more being considered to be a consumer. This view has traditionally been dominant for example in health care in the US (Carrera and Lunt, 2010). This change effects for example approaches to patient decision making, continuity of care, quality and safety, economic planning and many other issues. The balance between public and private providers of care is also affected as private providers are in many ways more suitable to respond to the increased marketization of health care (Lunt et al., 2013).

In the United Kingdom, it is estimated that over 50 000 individuals travel abroad annually to seek health care in various medical specialties such as cosmetic surgery, dentistry, gastric bypass operations and assisted reproduction (Lunt et al., 2013). Similar developments can be observed in other European countries, probably at least partially because of the increasing cooperation between countries in the European Union (EU), but this phenomenon is clearly observed all over the world (Wismar et al., 2011). The US health care system is relatively expensive and globalization of healthcare is expected to have a large impact there. In the long run, globalization may have an even greater impact on the health care services industry in the US than it has
previously had on the production industry (Reeves, 2011). This same trend is observed in Canada and Australia and an increasing number of academics are starting to analyze these processes from varying aspects, including marketing and tourism as well as policy and legal aspects (Turner, 2012; Connell, 2013).

In Sweden, increasing patient flows can be seen both into and out of the country, although the total volumes are still relatively low compared to other European countries. Nevertheless, this aspect of internationalization and marketing of health care is considered an important area with possibilities for expansion by the health care industry (Symbiocare Marketing Analysis, 2012).

On an institutional level, medical tourism and international patient flows in general are facilitated by regulatory activities and establishment of administrative processes to increase transparency and financial security for patients regarding payments between public institutions in EU countries (Lunt et al., 2013). These changes are ongoing and will have an increasing effect on health care providers in years to come. They are also a sign of increasing cooperation and coordination between countries in the EU, intended to minimize differences and directly facilitate communication, transport and transfer of knowledge - and patients. Simultaneously, this will increase competitive pressure for university hospitals which more and more are being compared with international counterparts and also with private enterprises due to reduced discrimination between public and private providers of care (Iversen, 2011, p. 10).

1.2 Networks and health care

Using principles of business management to analyze health care systems is more relevant today than ever before, with health care becoming commodified and the patient increasingly seen as a consumer (Carrera & Lunt, 2010). For some time now, the analogy of retail has been used for health care marketing (Peyser, 1997) because of the increasing product orientation of health care services. The goals of the system increasingly resemble typical business outcomes including terms such as customer retention, trust towards the service provider, building reputation and positive word-of-mouth (Leisen and Hyman, 2004). Health care is becoming a business enterprise with demonstrated marketization where managers at both public and private providers of care are increasingly introducing business-like principles into its operations (Zolkiewski, 2004).
An interesting way of looking at the ongoing changes in health care is to try to understand who the relevant actors are in this context and why these changes are taking place. Who stands to benefit, who is affected and what are the connections between them? What are the characteristics of successful actors and what do they do, what are their relevant activities and what resources do they need? Taking a step back, looking at the complex network of interrelated actors and trying to understand how their activities are related to internationalization of health care services affords a unique perspective of these processes. This network perspective is not common in analyzing health care operations, although it has been used to some extent on the national level (Mascia & Di Vincenzo, 2011). Using this perspective for internationalization of health care services opens new possibilities for deeper understanding.

A successful way of analyzing business relationships is using network theory (Johansson and Mattsson, 1988) and it is therefore logical to apply this perspective on the business of health care. Previous work shows that network integration and knowledge transfer in networks are important factors when evaluating organizational competence in general and performance in health care in particular (Gupta and Govindarajan, 1991; Mascia and DiVincenzo, 2011; Hannemann-Weber et al, 2012). These parameters are previously known to be important when analyzing business networks of multinational Corporations (MNC´s; Forsgren et al., 2000) and using them as part of the network perspective for health care should provide new insights.

In this study, we wish to use network theory and its concepts as a framework to analyze the phenomenon of international patient flows and how care providers perceive the importance of networks in this context. We consider organizational competence and the role of resources from a network perspective also to be of value to study patient’s identification of foreign units in internationalization of health care whereupon we draw on the ARA model of networking (Actors, Resources, Activities; Håkansson and Johansson, 1992) which allows us to conceptualize the relevant aspects.
2. Aim of the study and structure of the thesis

The aim of the study is to gain a deeper understanding of cross-border patient choice in the health care service by analyze how health care professionals perceive networking and the importance of networks in the context of international sales of health care services. The focus is the interplay between networks of actors, activities and resources within the healthcare industry and the impact of this has on international patient flow.

We wish to elucidate the processes of internationalization of health care services and to further the understanding of how relevant actors perceive the importance of networking, bearing in mind the rationale behind a foreign patient’s choice of a specific hospital unit for a certain treatment.

The study is guided by network theory and specifically the ARA-model consisting of the perspectives of actors, resources and activities. The theoretical background is mostly dedicated to the ARA-model combined with an introduction of internationalization, knowledge transfer, embeddedness and the characteristics of centers of excellence as well as a shorter discussion on relevant aspects of B2B marketing and modernization processes termed New Public Management (NPM).

After the results have been presented and analyzed, the final section of the thesis is devoted to discussion and conclusion.

2.1 Research question

Our research question is twofold:

- How do professionals perceive the role of networking in internationalization of healthcare?
- What factors determine the ability of a hospital to attract international patients?
3. Literature review

3.1 Internationalization

Internationalization is the process of expanding the firm’s activities beyond the borders of the country of origin. Since the 1920’s this phenomenon has replaced imperialism as the dominant organization principle for cross-border interaction between market economies (Ruzzier et al., 2006). In recent years, the term globalization is used when a firm’s operations are managed globally, instead of only in a few selected countries.

To explain the process of internationalization of the individual firm, a number of theories have been proposed, many of which focus on large multinational enterprises (MNE’s) and which have their origins in different perspectives on the operations of these companies (Forsgren, 2008). Some of the most prominent of these theories are Internalization theory which postulates that firms try to develop their own internal markets when transactions can be made at lower costs within the firm. This may involve vertical integration of activities, especially under conditions of imperfect natural markets. The transaction cost approach is based on similar principles and the eclectic paradigm or the OLI paradigm also whereas the monopolistic advantage theory as proposed by Hymer in 1976 holds that the firm has unique sources of superiority over foreign firms in their own markets. The Uppsala Internationalization model on the other hand sees internationalization as a process of increasing a company’s international involvement through different types of learning. Internationalization is considered through gradual market expansion with increasing psychic distance of foreign markets (Ruzzier et al., 2006; Forsgren, 2008).

As a further development of the Uppsala Model, Johanson and Vahlne (1990) used a network perspective to analyze the process of internationalization whereas Johanson and Mattson (1993) emphasized gradual learning and the development of market knowledge through network interaction. In these latter theories, focus is on the management of international relationships and the development of these relationships within networks as well as the knowledge embedded in them (Ruzzier et al., 2006). Numerous other approaches to studying internationalization have been used and this subject is widely researched within the international business literature.

The context of firm’s actions has changed over the past decades with the emergence of the global economy, decreasing trade barriers and the increase of the service economy (Axinn & Matthysssens, 2002). These changes have been facilitated by improved communication, ease of travel and the explosion of internet communication. The service economy now accounts for over
30% of world trade whereas this particular area has not received much consideration in the international business literature (Axinn & Matthyssens, 2002). The focus of this thesis lies on the internationalization of health care services but instead of considering the expansion of the firm across borders or the globalization of the production of medical technology, the flows of patients to the service provider are considered.

The landscape of European health care is changing. The increasing cooperation and coordination between countries in the European Union (EU), evident in many aspects of society such as for example the common currency (Euro) adopted by a number of EU membership countries, is also starting to make its mark on health care. Directives regarding quality, safety and standardization in health care have been issued and the member states are obliged to incorporate these into legislation and implement them at the national level. Examples of these are the European blood directive, which sets standards of quality and safety for the collection and testing of blood and blood components; the tissues and cells directive which similarly applies to tissues and cells processed for treatment purposes; and recently a directive clarifying patient’s rights in cross-border health care was issued. This directive is foreseen to facilitate cross-border health care within the EU. These ongoing changes make internationalization and associated strategic issues more salient for hospitals – both university hospitals and private actors in health care. The university hospitals will be under competitive pressure from large hospitals in other European countries which may have lower prices for procedures or simply shorter waiting lists. At the same time, Swedish university hospitals may have an opportunity because of these changes since Swedish health care is considered to be of high quality and in many cases offers highly developed and specialized care, not readily available in many countries. Swedish health care is not number one in all measured parameters but quality and efficiency in health care are in general considered to be relatively good in Sweden (Swedish health care, report).

In the academic literature, it is acknowledged that the health care industry faces major changes in the coming years because of globalization pressures (Reeves, 2011). Both providers and users of health care are expected to increase cross-border activities and the first multinational health care

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2 Regeringens proposition: 2012/13:150. Patientrörlighet i EU – förslag till ny lagstiftning
services have already started operations. This activity is expected to increase in the coming years and the situation provides an excellent opportunity to apply the principles of firm internationalization to a new and poorly researched field. Already some few studies are starting to examine FDI (Foreign Direct Investment) in health care and the impact of MNE´s in this sector (Outreville, 2007). Completely new dimensions of marketing and internationalization strategies need to be explored and Swedish health care professionals need to study these issues carefully to make the most of the emerging opportunities and deal with possible threats.

3.1.2 Centers of Excellence
The importance of analyzing organizational activities from a network perspective is shown to be highly useful when analyzing MNC activities (Forsgren, 2008). One aspect of this approach is studying the development of Centers of Excellence (CoE´s). These are units (subsidiaries) which are specialized in certain skills, capabilities or fields of operation which are important for the whole organization (Forsgren et al., 2000). These units are important regarding knowledge transfer to other units in the organization and have a responsibility regarding competence development in the organization.

The CoE´s are not necessarily assigned this role by central management, but instead develop their competence and abilities as a consequence of their embeddedness in a dynamic and demanding environment and business relationships. The CoE is a center for knowledge creation and transfer in the organization and can be considered to play an important part in the internationalization process.

3.1.3 Knowledge flows
The importance of studying knowledge flows in an organization has been discussed by Gupta and Govindarajan (1991). They use the network perspective to further understanding of the strategic role and context of different units, focusing on the transactions between units. The strategic context of a unit may differ in terms of the magnitude of transactions and their directionality. This leads to the knowledge flows-based framework identifying four roles of units: Global Innovator (GI), Integrated Player (IP), Local Innovator (LI) and Implementer (I). GI and IP have high outflows of knowledge and IP has high in & outflow of knowledge. This
framework can then be used to predict variations in unit’s interdependence, communication, differences in responsibility and authority and other aspects. The concepts of GI and IP can be compared with Centers of Excellence (CoE’s) in line with the ideas expressed by Forsgren et al in terms of knowledge flows to sister units (Forsgren et al., 2000).

The resource based view of the firm/organization shows how important knowledge and knowledge management is for success in a competitive environment. Linking the study of internationalization with knowledge management and organizational competence is thus of high relevance in this context (Grant, 1996). Hospitals are organizations which rely on a high level of knowledge, formal competence and tacit knowledge, making this issue especially relevant for these organizations.

3.2 Networks and Business to business marketing in health care

Business-to-business (B2B) relationships and networks provide the infrastructure for the economic world in which we work. Organizations do not operate in isolation but rather the network view of relationships is generally applicable across all organizations (Zolkiewski, 2011). It is important for actors in a business network to develop network insight to understand the functioning of their relations and to improve their decision making (Mouzas et al., 2008). This insight extends managerial competence beyond task-oriented knowledge and cognition and allows for mobilization of other network actors to create competitive advantage for their organization, which is crucial for innovation and growth. Examples of the kind of relationships which are important in this respect are exchange relationships and interdependencies among actors. Managers need to understand that extant knowledge consisting of day-to-day routines and work forms may be a trap and that exchanges need to take place at all possible levels to ensure successful operations. This includes non-task oriented relationships. Fact-based understanding is of course also necessary and use of metrics and replication of best practice is consistent with value maximization (Mouzas et al., 2008).

When writing about marketing and strategy, it is common to view competition as the most important factor in business relationships (Ford & Håkansson, 2013). This is also a major driving force behind the logic of New Public Management (NPM; Simonet, 2008). However, although competition abounds both in literature and managerial thinking, cooperation, niching and networking may be more beneficial for organizations. Business has in fact by some authors,
notably members of the IMP group of researchers (Industrial Marketing and Purchasing), been
considered an overwhelmingly cooperative enterprise and not a competitive one (Ford & Håkansson, 2013). Networks may be analyzed by studying interdependence and specialization of
activities over time as well as co-evolution of actors in the network which can be a fruitful way
of studying business interactions (Ford & Mouzas, 2013).

The B2B perspective becomes highly relevant in health care with the implementation of NPM
principles because one of the important aspects in this respect is the establishment of purchasers
of health-care which are not the ultimate consumers, but are units within the system. This means
that the system operates on B2B relationships and the patients become units of value and the
management of patients a source of power for doctors and hospitals in contracts with buyers of
care (Zolkiewski, 2011). In this type of setting, intangible company features may help suppliers
to separate competitors and to create value to B2B customers. Examples of these are the
reputation of the supplier and his perceived innovativeness (Falkenreck & Wagner, 2011).

It is interesting to contrast the perspectives of NPM and networking with each other. The NPM
perspective focuses on efficiency by establishing anonymous markets for health care and by
promoting competition. The networking perspective on the other hand considers the actors
involved, their activities and the necessary resources. We consider the latter (network
perspective) to be more fruitful when trying to understand the actual functioning of the system
and its strengths and weaknesses. As this is our perspective of choice for the study, the
consequences are that we see the individuals and their relations and interactions, how contacts
are made and how new markets may open through the actions of individuals. Looking for value
optimization by considering only a faceless mass of exchangeable buyers or sellers of health care
regulated only by traditional market forces seems restrictive in a system which relies so heavily
on human interaction.

3.2.1 The ARA model
One of the most influential models to describe and conceptualize relationships in B2B networks
(Business-to-Business) is the ARA model (Actors, Resources, Activities), first described over 20
years ago (in Håkansson and Johansson, 1992). The model identifies these three concepts and
also suggests mechanisms by which they relate to one another. It proposes that the three entities,
actors, resources and activities, capture the key aspects of relationships between firms, as in B2B relationships, but also within firms in terms of relationships among individuals (Lenney & Easton, 2009). Actors are persons or groups who are goal oriented and who perform activities which may change resources which can be tangible or intangible as the case may be. Activities may take place on any level of the organization.

In addition to this, the ARA model introduces substance layers which bind together these three entities into actor bonds, resource ties and activity links. The resource ties connect various elements and may be material or completely virtual as in the case of organizational structures. Links of activities provide inter-organizational relationships or network pathways. Actor bonds are predominantly social in nature (Lenney & Easton, 2009).

The objective of this model is to explain the function of business relationships based on the stated layers. The very key function of the business relationship is to interlink the activities in a special way to assist the actors to transform resources for creating the maximum values (Håkansson and Johanson 1992).

### 3.2.2 Components and premises of the ARA model

As the ARA model in the business and management literature traditionally has been used to conceptualize B2B and industrial marketing, it can be useful to explain the model and relate it to how it is relevant for the health care services sector.

The “actors” dimension is in this case comprised of doctors and patients, local managers and officials, research institutions as well as government authority agencies. The ARA model emphasizes how the actors are connected with network bonds and how these bonds may simultaneously create opportunities and limitations for an actor (Håkansson & Ford, 2002) who may for example see new markets open up because of network contacts but at the same time be restricted in her actions in order not to damage the network relationships. This has given rise to what is called the first network paradox, i.e. the simultaneous increase and decrease of freedom to act (Håkansson & Ford, 2002). The model allows us to conceptualize how the various actors in different organizations may be bonded together. Examples of this are relationships, government policies, previous cooperation or learning processes such as study visits at each other’s clinics as well as professional contacts at international congresses and courses.
The “resources” dimension regards for example research facilities, research groups and organizational structures allowing and facilitating research. The resources can be tangible or intangible (Lenney & Easton, 2009). They may well consist of supporting units which surround and are tied to the focal unit supporting specialized care. Change in operational aspects of one tied resource would then lead to some effects in another regarding for example the number of incoming patients. The resources can also be intangible, such as participation in research activities, close ties between external physicians or even strong reputation.

Following the model to the “activities” dimension, here we can include patient flows between local units connected as above, where parts of treatment or analysis (X-ray examination for example) are performed in tied units. Further, we can include research activity with international collaborators, marketing activities or networking activities such as participation in congresses and presenting papers.

The network perspective shows how all components of the system are linked, for better or for worse. In addition to the first network paradox which elucidates opportunities and restrictions (Håkansson & Ford, 2002), the actors influence other actors and are influenced by them with the effect increasing with the importance of actors for each other (second network paradox). Additionally, the network affords some control over others while at the same time leads to lack of control, giving it away to other members of the network (third network paradox).

The mainstream view of strategy can be considered to be a zero-sum game with atomistic participants, where the winner’s advantages are annulled by the losses of the others. The ARA model and network view however sees the possibilities for win-win solutions where the output from the cooperative network is greater than the sum of the parts (Gadde et. al., 2003). Some support for this concept can be drawn from studies on specialization of hospitals where it has been shown that cooperation and not competition gives increased efficiency in operations (Mascia and Di Vincenzo, 2011). The ARA model and network perspective can thus be considered a valid concept for the analysis of hospital performance and patient flows. In fact, considering the current study, the ARA model coupled with a network analysis is much more likely to allow a meaningful analysis of international patient flows and afford a deeper understanding of the phenomenon of internationalization of health care services then the anonymous, competition oriented NPM perspective.
To summarize:
Working within business networks presents both opportunities and limitations for any given actor. One of the consequences of working in a network is that the actor is not free to do as she pleases but is restricted by relationships with the other network members. There is a balance between network opportunities and network restrictions. This is the first “network paradox”, the actors are not free to do as they please, but at the same time they draw benefits from the network.
The second paradox regards the influence each actor has in the network, which again is balanced against the influence from others which is exerted through the network. The third network paradox regards the control each actor exerts in the network, which is balanced by the control that others exert. (Håkansson & Ford, 2002).
Below, we would like to discuss some aspects of what the literature may teach us regarding relevant actors in the context of health care services.

3.2.3 Institutions
The institutional environment consists of macro-level dimensions of society, such as the societal, economic, political, and regulatory systems, which are exogenous to business arrangements (Carson et al., 1999). The institutional environment has a significant impact on a firm’s or organizations behavior; it can either act as a barrier or a facilitator for export behavior and accordingly performance (Gao et al., 2010).
Like schools and other public entities, generally hospitals can be categorized within the group of organizations that are robustly institutionalized and thereby embedded in strong long lasting values and norms. These norms do not differ much between hospitals and provide for solidifying the field through normative pressures for similarity. Additionally, the hospitals must adhere to health policies, regulations, and laws enforced by the government. Similar to the finance industry as banks for instance, the hospital market is highly regulated and customers do not usually switch from one hospital to another (Deephouse, 1999).
Governments play a vital role in crafting policies and laws that facilitate business operations contributing to boosting economic activities among firms. This has been well acknowledged in the literature, particularly in developing countries (Aulakh et al., 2000). Different governments design different policies and marketing strategies in their efforts to increase the international
patient flows. For instance some governments incentivize hospitals through tax benefits, visa policy and by certifying private health care to improve and ensure high quality service. In addition, cross-border patient rights for choice of treatment also produces incentives to attract as many patients as possible. The effect of these incentives is strengthened by obliging the regional healthcare agency to which the local hospital of the outgoing patient belongs, to accept treatment costs for additional expenses of the patient. Ultimately when patients are given the right to choose a preferred hospital, hospitals will be exposed to a more competitive environment.

Furthermore, there is an increasing imperative to implement principles of business management in hospitals both for strategy implementation and regarding aspects of quality (Nembhard et al, 2009). This is in line with the implementation of New Public Management in healthcare, a development which has both proponents and critics (Andrews 2013; Siltala 2013). Understanding management principles is crucial for managers working for public as well as private providers of health care to ensure continued success of their organizations. The main areas where NPM has effected a change in the practice of organizations include outsourcing of activities, introducing the concept of competition and using market forces to serve public purposes by creating markets for health care services, demanding organizational performance, increasing accountability and transparency, increasing patient financial responsibility, cost-cutting, increasing quality and bringing resources allocation closer to the point of delivery (Simonet, 2008). These reforms in organizational activities which followed the ascendancy of neo-liberal ideas in the early 1980’s in the U.S. and the U.K. have, at least in Europe and Canada, been seen as a panacea to solve fiscal and budget crises in these countries. Indeed, one of the main ideas behind these organizational reforms is the introduction of activity-based reimbursements in health-care (Jakobsen, 2010).

NPM reforms however, have not led to the expected improvements in for example productivity or cost reduction in public organizations as was originally anticipated and empirical results of outcomes following NPM reforms are far from clear (Meier and O’Toole 2009). The image that emerges is blurry and equally many studies show absence of improvement as those showing positive effects (Jakobsen, 2010). In fact, the issue of transfer of blame from political incumbents has been argued to be a more relevant argument for the implementation of these practices (Mortensen 2013). NPM-practices have been accused of channeling energy into “theatrical audit
performances”, killing creativity and hollowing out professional autonomy (Siltala, 2013). Some authors have shown that NPM did not necessarily lead to improvements (Simonet 2008, Jakobsen, 2010) with conflicting results regarding internal markets. The NPM principles, however have a greater effect on society then we realize at first glance. Re-organization and incorporation of management principles are making for example health care more and more organized at an international level, in fact business in general is increasingly organizing its activities across country borders. This, in addition to individual mobility has an effect on the internationalization of health care. Another interesting aspect which is facilitating these developments is increased patient influence in health care. This is a logical consequence of implementation of NPM principles where the patient increasingly is viewed as a consumer as is the case in the US, whereas in Europe, the patient traditionally has been considered a citizen with a set of rights (Carrera & Lunt, 2010). In the context of international sales of health care services, providers of health care need to simultaneously market themselves towards doctors and other health care institutions and towards patients.

Whether the implementation of NPM practices in the management of public organizations has lead to increased efficacy may be open to debate. The NPM perspective is however clearly quite different from the network perspective, which emphasizes the unique resources and differences of network constituents. The network perspective emphasizes cooperation and values different competencies and contributions whereas the NPM perspective presupposes similarity and anonymity. Therefore, for this study, the network perspective allows us to analyze individual competencies and their effect on the level of internationalization.

3.2.4 Professionals

The most important actors in the health care service organizations are doctors. By tradition, high levels of abstract and practical knowledge and by jurisdiction (Abbott, 1988, p 35-58 and 67-69) doctors have near exclusive rights for diagnosis, medication, planning and treatment of patients. This is coupled with a very strong professional identity and networking between colleagues. Contacts between doctors are one of the most important information channels in the health services sector and the right for independent decision making and self-control is a very important issue which is carefully guarded (Levay and Waks, 2009).
In recent years, the principles of NPM have to some extent challenged some of the traditional autonomy of doctors by demands of transparency, auditability and economic efficiency in health care (Levay and Waks, 2009). To some extent professional managers, controllers and project leaders have infiltrated the ranks of managers in health care amongst specialists such as doctors, nurses etc. This development is typically resisted by resident influential groups although professionalization of health care organizations can not very well be resisted (Levay and Waks, 2009). In spite of this, doctors remain the most influential group in hospitals and networking often revolves around them as individual commanding actors in this context. When actors are defined as ‘authoritative individuals’ the description of actor bonds is necessarily based upon psychological theory, which sets the trust and commitment variables of actor bonds (Håkansson and Snehota 1995) as individually held constructs, underwriting the resource and activity structures of the firms in time and space. Accordingly, trust occurs as a response to the uncertainty of future resource and activity commitments, made during adaptive interaction, simply because in the end there is no other way for the actors’ cognitive processes to deal with insecurity (Dwyer et al. 1987; Luhmann 1979). While it is evident that relationships and networks constrain and augment the ability of an actor to change resources and activities (Håkansson and Snehota 1995), it is also clear that actors have diverse capability to control the structure of their firm’s and other firm’s resources and activities in time and space.

3.2.5 Trust

According to Håkansson and Snehota (1995) actor bonds are composed of trust and identity, with identity affecting the character of the firm. Several scholars have repeatedly argued that trust is essentially important for successful cooperation and effectiveness in organizations (Zand 1972; Zand 1997; Lewis and Weigert 1985). In management research, numerous authors suggest that trust is an important element of relationships in business environment (Garbarino & Johnson 1999; Perry & Mankin, 2004).

Naturally trust comes from the concept of relationships. For the purpose of this study we define trust relationship as a bond between two actors where one is trusting and the other is trusted. In 1987, Dwyer et al. stated, “trust deserves priority attention”. Due to the fact that it has a significant function in the maturity of relationship marketing, which refers to all activities
intended to establishing, developing, and preserving positive exchange relationships among different actors (Morgan and Hunt 1994). Hence, it is an essential element in any positive and productive social process.

In addition, Morgan and Hunt (1994) argued that commitment and trust are vital to any discussion of business relationships because they encourage exchange partners to work at preserving the relationship and attain mutual benefits. Furthermore, there is an existence of cause–effect relationships between trust and cooperative behavior (Zalabak, et al., 2000). Over time professional develop skill and become experts on what they do and actually need an element that bonds them with other actors. Accordingly, Sonnenberg (1994) argued that trust augments when people are perceived as competent. Similarly Zand (1972) explained that trust as a gradual, self-reinforcing phenomenon. This in turns leads to enhancing reputation building, which also is an important factor in actor bonds.

3.2.6 Reputation

Reputation management is a recently institutionalized prescription with which modern organizations must cope (Power, 2007). It is based on the idea that all organizations have a reputation among customers and collaborators to keep and manage (Doorley and Garcia, 2007), in order to maintain their competitive ability (Fombrun and van Riel, 2004; van Riel and Fombrun, 2007). According to Fombrun (1996, p. 37) reputation is the ‘overall estimation to which a company is held by its constituents’. In the case of health care service provider’s reputation, trust and positive word-of-mouth becomes extremely important in combination with marketization of health care and patient empowerment (Leisen & Hyman, 2004; Chaniotakis & Lymperopoulos, 2009). Health care providers need to consider how patients view their organizations since this may affect their performance in the market and these aspects need to be considered also for example when recruiting new personnel (Chaniotakis & Lymperopoulos, 2009) since individual service providers may have a great effect on external views of the organization. Each individual becomes an ambassador for the organization.

In healthcare, a medical specialty must conform to the basic standards associated with the hospital category. Moreover, organizations embraced with shared values, routines and
organizational culture resulting in positive reputation need to safeguard the reputation commons through joint strategies (Barnett, 2006; Barnett and King, 2008; Winn, et al., 2008). Reputation inspires organizations to differentiate themselves amongst rivals with claims of exceptionality. Notably most recognized hospitals strive for the best qualified personnel. A recent study indicates that the hospitals are more concerned about losing qualified personnel than patients because the best doctors, nurses and therapists would prefer a hospital with a strong reputation (Waeras and Sataøen, 2013).

Hospitals are required to have a capacity for some types of treatment and services, such as urgent care, specialized surgery etc, given their need to respond to increased competitive pressures. For instance specializing in certain procedures or surgery areas and communicate these differences and specific competences as an advantage over other hospitals and as a way of building a unique reputation. This, in turn, would create a more attractive workplace for medical staff and prospective job applicants as well.

3.2.7 Embeddedness

Embeddedness of actors in business relationships is an important concept in network theory. It can be defined as the degree of closeness in a relationship and it reflects the intensity of information exchange and the extent to which the resources of the actors are adapted to each other (Andersson et al., 2001). The stronger the embeddedness, the more difficult it becomes to change to other partners and also the level of knowledge transfer and learning in the network is expected to increase with the strength of embeddedness. On the other hand, arm’s-length relationships can be considered the opposite of embedded relationships and these are mostly governed by market forces instead of interaction between actors.

The concept of embeddedness has been used to describe business relationships on three levels:
1. The level of the individual relationship, where it can be applied to analyze the capacity for knowledge transfer and learning in the relationship.
2. The level of the subsidiary in a multinational corporation, where it has been used to analyze market performance.
3. The corporate level, where it may give an indication of the competence development in the
multinational corporation as a whole (Andersson, et al., 2001).
As an important aspect of network theory, the concept of embeddedness is interesting to include when using the theory to analyze and study not only multinational corporations, but also other organizations.

3.2.8 Resources
The traditional RBV suggests that firms with unique resources can enjoy superiority with competitive advantage and economic success which can persist over longer time periods to the extent that the firm is able to protect itself against resource imitation, transfer, or substitution. In this study however, we further advance the focus from an internal-view of the firm’s resources and extend to firm’s external resources in the network and its capability to utilize those resources for competitive advantage. According to Conner (1991), a firm’s positive economic performance is a product of concurring interactions among the resources of the firm as well as its competitors and the public policy environment. Hence, a collaborative relationship or cooperative type of interaction in which the resources of either party can have a considerable impact to firm’s performance. The formation of an operational alliance governance structure and the development of inter-firm routines that facilitate the sharing of knowledge and information within the frontiers of alliance contributes to positive mutual benefits, hence enhanced firm performance. These resource alliances can be referred to as network resources that extend the opportunity set of the firm (Gulati, 1999). These aspects can be associated with inter-relationships among a health care providers units, other national health care institutes, collaboration with other research units as well as referral agreements with foreign hospitals.

The resources available to an organization figure into any marketing analysis as explained earlier in the ARA model where resources are an important component of the model. Combining the RBV and ARA models, Lavie presents a model of network resources as an important link between network theory and the RBV. He shows that network resources are important to the firm and that these resources may be an important contributor to a firm’s success (Lavie, 2006). The factors involved in the case of a health care provider could include attributes such as center of excellence, international competence, management commitment and institutional environment.
3.2.9 Activities

The move towards internationalization in health care, as mentioned in the introduction section, provides opportunities for providers of care as well as producers of products, pharmaceuticals and medical technology in this field. The marketing and other activities involved show the emphasis which must be placed on networking also in this field. A marketing analysis by the Swedish branch organization Swecare shows great potential for export of products and services within this field (Symbiocare, 2012). As showed by this marketing analysis, most companies in the field show great optimism and expect increasing market shares in years to come. Mature markets are generally considered easier to enter; this pertains to the Nordic countries and Western Europe. Of the countries with greatest potential in this respect, the Nordic countries are evaluated highly by the respondents in the study. Especially Norway and Denmark are considered interesting markets. The segments in the study which focus on export of healthcare services consider that the high quality of healthcare in Sweden is very important in this respect as well as facilitating local structural factors, such as societal stability and security, high competence and research activities, as well as a small and demanding local market which is known to be cooperative in development of products and services (Symbiocare, 2012).

It is interesting that none of the respondents in the marketing analysis (Symbiocare, 2012) considered competition to be a threat to future activities, but instead mentioned lack of international contacts, finding suitable partners and a need to enter foreign networks as the greatest hinder in their internationalization efforts. This clearly shows that a network perspective can be useful in analyzing internationalization activities in healthcare. Export Technical issues or language barriers were not considered to be a problem for internationalization in this field, but as mentioned above, most actors in Sweden are focusing on geographically close markets.

There are several identifiable activities in health care services networks which are of importance in the current context. Traditionally, activities incorporated in network analysis include for example collaboration on research/development projects, joined marketing efforts, collaboration on parts of the activity chain such as distribution or some parts of production (Bengtsson & Kock, 2000). In terms of health care, being a knowledge-intensive activity, research collaboration can be considered the most obvious. Nieching or specialization of activities is also to be considered a part of this picture where otherwise competing hospitals may choose to cooperate by specialization for certain types of rare diseases (Hannemann-Weber et al., 2012) or
through other variants of what has been termed co-opetition (Barretta, 2008). In health care, being a case of members with a strong professional identity and high individual profile (Abbott, 1988), personnel may well contribute to networking simply by working for more than one service provider simultaneously or periodically, moving between providers. In this way, individuals can create activity bonds between providers, facilitate inter-organizational contracts and initiate patient flows. Increased internationalization of the work force may in this way also facilitate international patient flows.

3.3 Summary of the literature review

To summarize, interactions between individual actors underline the structuring of resource ties and activities. Interaction is the necessary analytical concept (Ford 1990; Håkansson 1982; Håkansson and Snehota 1995) that links firms, relationships and networks (cf Håkansson and Snehota 1995). At the relationship level of analysis, Hallen et al. (1991) defined interaction as a process where “two participants carry out activities directed toward one and another and exchange valuable resources. Actors can be found at different levels; from individuals to groups of companies where their aim is to increase their control of the network. They perform activities and have certain knowledge of activities. In addition they control resources alone as well as jointly with others. On the other hand, activities include the transformation act, the transaction acts and activity cycles whereas resources are human and physical, and mutually dependent. Consequently activities link resources to each other. Activities change or exchange resources through the use of other resources.

The conceptual model which we have discussed in the literature review, the ARA-model is the basis for the study and the guiding concept for arranging the data and structuring the following analysis. When considering how the model may be applied to the study of international patient flows, it takes on the form shown in Figure 1 which represents the link between the theoretical background and how the present study was performed.
The Figure shows the theoretical model for the study. This is a Cause-Effect model or Fishbone model and illustrates how the ARA concept is used to analyze effects on cross-border patient flows to the operations unit in question.
4. Methods

4.1 Research approach
This study began with the interest in exploring and understanding the crucial factors involved in an ongoing phenomenon in the health care industry. More specifically we were interested in knowing how and why hospitals internationalize their services. In addition we wanted to know why foreign patients choose a particular hospital for treatment and also how a hospital can attract foreign patients. Moreover we wished to examine how professionals perceive this phenomenon. This area of research has not been studied extensively and more insight is needed to better understand this phenomenon. Hence, in order to get more clarification and indications of ‘how’ and ‘why’ this occurs, we found it necessary to choose an exploratory study. Additionally a descriptive approach was complemented as an extension our study. The reason for this is that results of exploratory research are not usually useful for generalization, but they can provide significant insight into a given situation with the aim to simply explore the research questions in depth having no final and conclusive solutions to existing problems. “Exploratory research tends to tackle new problems on which little or no previous research has been done” (Brown, 2006, p.43). However exploratory research must happen first for descriptive research to be effective. The latter organizes the data and hypotheses found during the exploratory process. Our approach then is both exploratory in the in-depth interviews and descriptive in the survey part of our study.

4.2 Research design
The use of both exploratory and descriptive approaches together, requires a source which provides us with rich data. As a result we decided to perform a mixed research study that entails a combination of qualitative and quantitative research aiming at data triangulation obtained from each source. Moreover it helps us complement one set of results with another or perhaps even uncover something that would have been missed out if only one of these approaches were to be chosen. Furthermore due to the selected combined approaches we found that a conducting case study will be most preferable. This strategy is advantageous since wish to gain a rich understanding of the context of the research and the processes being enacted (Morris and Wood 1991). In addition case studies are suitable for exploring new processes or behaviors or ones that are poorly
understood (Hartley 1994) but also exceptionally useful for responding to how and why questions about a contemporary set of events (Leonard-Barton 1990).

The case study is an appropriate form of scientific method when the following conditions are fulfilled (Yin, 2009 pp 8-14):

• We seek to understand a social phenomenon asking “how” and “why” questions
• The study does not require control over behavioral events
• The study analyses contemporary events

Finally out of the several options of conducting a case study we chose a single case study. A single case may be selected because it is typical or because it provides you with an opportunity to observe and analyze a phenomenon that few have considered before (Saunders et al., 2009).

Single cases are appropriate when a particular case is a critical case and we want to use it to explain or question an established theory. It is a critical case because it meets all the conditions necessary to confirm, challenge or extend the theory for instance; particular organisations may be of interest because they represent ‘outstanding successes’ or ‘notable failures’ (Patton 1990, p. 169). A single case design would also be appropriate in situations, such as an exploratory study that assists as the initial stage to a following more comprehensive study (Ghauri and Grønhaug 2002; Yin 1994).

4.3 Case firm selection

The present study takes the form of a single case study with the intent to gather data through multiple sources and analyze conceptual factors in relation to international patient flows to hospitals. Hence to seek answers to our research questions and to study the phenomenon as specified above, it is imperative that the object of study fulfills the criteria below:

a) Relatively large health-care organization with diversified operations so that units with varying conditions in the above parameters can be studied

b) The organization should consider the inflow of international patients to be an important addition to its activities since this will facilitate managerial focus on the subject and interest in the proposed study

c) There should be structures in place that allow registration of relevant parameters such as identification of patients from various countries
4.3.1 Uppsala University Hospital

Uppsala University Hospital (Akademiska Sjukhuset) is a useful model for this study because it relies heavily on external (national) and international revenues and patient flows. The city of Uppsala is itself relatively small in comparison to the size of the hospital. Uppsala is the fourth largest city in Sweden but it has only approximately 200 000 inhabitants whereas the county of Uppsala (Uppsala Län) has 300 000 inhabitants (Population statistics Dec 31.st 2012, Statistics Sweden). This constitutes the primary catchment area of the hospital, which on the other hand is the third largest hospital in Sweden. In 2011 more than 25 % of the hospital’s medical care episodes constituted patients who came from outside Uppsala or the immediate surroundings (www.akademiska.se). In 2012, the hospital reported revenues of 1.8 billion SEK from sources outside Uppsala, which is 15% of the total income of County of Uppsala (Årsredovisning för Uppsala Läns Landsting, 2012). The hospital has 1050 beds, 60 000 points of care per year and has 8000 employees. The above shows that the hospital is much larger then is motivated by the community of Uppsala and therefore is highly dependent on the sales of health care services, mostly on a national level, but also internationally.

The hospital has a long and proud history of research activities and incorporates units with varying degrees of specialization. The more advanced units in the hospital have been selected as nation-wide centers of care, which shows a high degree of specialization and competence (rikssjukvård, www.akademiska.se).

Uppsala Care is a unit which specializes in the administrative aspects of cross-border care at Uppsala University Hospital. The unit facilitates transport to and from the hospital, arranges accommodation for relatives or others who are travelling with the patients, orders interpreters when necessary and takes care of much of the necessary correspondence which is inevitable when planning cross-border care of patients. Also the unit takes care of billing for the hospitals services, either from the patients themselves, from foreign insurance companies or from other European states. This shows the importance attached by the organization to external sales of

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[^3]: http://www.akademiska.se/sv/Om-Akademiska/ accessed on February 19th 2014
health care services.

With the above information we consider that Uppsala University Hospital Akademiska hospital fulfills the requirement to pursue a single case study.

4.4 Data collection
This study consists of three main data sources:
1. Interviews with managers on the importance and perception of networks, based on the ARA-model.
2. Survey data among operations managers regarding networking and knowledge transfer.
3. Secondary data on patient flows and research activity.

As mentioned earlier we use multiple sources of evidence, collecting both primary data through structured interviews as well as secondary data from electronic records as specified below. This approach is consistent with the principle of data triangulation, which is an important principle in case study research (Yin, 2009 pp 114-118).

4.4.1 Primary data
The present study consists of both qualitative and quantitative aspects and comprises a combination of primary and secondary data.

The primary data consist firstly of in-depth, open answer and semi-structured interviews which enables the process to be explored in greater depth as it allows access to the respondents’ knowledge, perceptions and experiences (Bryman & Bell, 2007) and is thus an efficient way to gather rich, empirical data (Eisenhardt & Graebner, 2007). The use of open questions allows the interviewees to formulate their responses in more detail and without being affected by a predetermined direction (Yin, 2011). We interviewed four operations managers (verksamhetschefer) and one unit manager (sektionschef) who were selected because of their knowledge of and involvement in cross-border sales of health care. The operations managers were also included in the survey part of the study whereas the unit manager was selected especially because of a high degree of involvement in and knowledge of internationalization.

The second source of primary data was a survey study among operations managers
(verksamhetschefer) in the hospital. This level of management was chosen because it follows the primary division of operations units in the hospital allowing contact with varying parts of its operations and the managers involved have knowledge and control over the activity studied. Of the 40 operations managers eligible for the study, 26 agreed to participate. Managers of supporting units, such as purely administrative or technical supporting operations, were not considered eligible for the current study. The survey study was conducted by structured interviews using Likert scale questions, organized in a matrix structure to study embeddedness, internationalization and knowledge transfer on four levels: The level of the hospital or the local level; the national level; the international level; and the level of senior hospital management. The questions were repeated for each level as appropriate. We operationalized the concepts of knowledge transfer by questions of study visits and transfer of operational routines and we studied initiation of innovation as well as parameters of networking. The study items were graded on a scale of 1 (very seldom) – 6 (very frequently). Additional study items of interest, which were included in the study, are the operations managers’ evaluation of the effect of the new EU directive on patient’s rights in cross-border care as well as information status regarding internationalization. For the current thesis, we focused on the results on the international level of questioning. Details on the survey questions are given in Appendix 1 and 2.

This kind of evaluative questionnaire has previously been used for the study of for example embeddedness in business networks (Andersson, et al., 2001).

Background information on the managers was collected: Age, sex, level of education, profession and number of years working at the hospital. Certain control parameters, such as the number of employees at the different operations units were also included in the questionnaire. The reason for performing the survey part of the study as interviews was to facilitate participation and to aid in completeness of data collection.

4.4.2 Interview process

For the in-depth interviews, the questions where developed out of literature reviews from the ARA-model, feedback from our supervisors and previous studies regarding internationalization of health care. Open-end questions were assigned into pre-determined topics, focusing mainly on the firms internationalization processes and international patients flows, in order to ensure that the interviews included the most important aspects and were following the same themes.
Discussion questions evolved throughout the interview, in line with the open exploratory approach, and the informants were encouraged to share their insights and experiences, to provide the researcher with a deeper understanding of the themes. All informants approved the use of recording, further strengthening the reproducibility of reliable data. In order to minimize bias, open-ended questions were used in the semi-structured interviews to avoid influencing the respondents with any previous views of the researchers (Yin, 2009).

The interviewees were encouraged to explain with their own words in order to capture further insights and the questions were not rigorously followed, but the topics were covered in the interviewee’s own words in all interviews. The interviews were then transcribed and analyzed.

For the survey interviews, the questions were followed exactly although they were discussed during the interview as well.

4.4.3 Secondary data

Secondary data were collected for the time period of 2011-2013 with the aid of hospital administrators, regarding for example the number of patient referrals locally and nationally as well as the number of patients treated who originated from abroad and the distribution of patients to the various operations units. Data was compiled from the hospital records, Uppsala University and on-line scientific databases as well. The number of PhD graduates was registered from the University of Uppsala database (DIVA) and checked with the local administrators as necessary.

Some of the operations units had available information on the number of publications during the time period in question, but in most cases a list of active researchers associated with the operations units was obtained and the search performed through the ISI Web of Science database, available through the on-line service of the Library of the University of Uppsala. Citation counts were in all cases collected in this way. Citation counts are a way of studying the impact of publications (Hanneman-Weber et al., 2012; Bornman et al., 2008) as discussed below. The reason for collecting this data as well as the data on PhD graduates was to obtain measures of the research activity of the units in question.
4.5 Data presentation & Data analysis

4.5.1 Data presentation

In order to demonstrate the variety and richness of the studied phenomenon, a narrative data presentation approach has been used combined with traditional data presentation for both the survey part of the study and the in-depth interviews. The narrative approach is suitable when studying a case study in detail (Langley, 1999) by providing an accurately constructed and detailed description of the data, all of its robustness and complexity that exist in the situation can be captured. Narrative analysis can be used to record different viewpoints and interpret collected data to identify similarities and differences in experiences and actions. Stories are assumed to stipulate a holistic context that permits individuals to reflect and reconstruct their personal, work and historical experiences (Gill, 2001). The traditional approach is useful for presenting survey data.

4.5.2 Data Analysis

Data analysis has been conducted simultaneously throughout the process by adjusting our data collection between, and during, interviews to ensure the quality, in line with the iterative qualitative data analysis process (Merriam, 2010). Furthermore, the interviews were recorded to simplify the grouping and analysis of the pre-determined themes, which allows for a more comprehensive cross data analysis to be performed, by weighing the data sources against each other and identifying patterns of relationships and their underlying logical arguments (Langley, 1999; Bryman-&-Bell, 2007). Evidence that has been considered particularly important has been highlighted through quotes, which further enables within-case, analysis (Yin, 1981). The collected data was subsequently processed by comparing and analyzing it with the conceptual model, which enabled it to be further refined and developed.

In the survey part of the study, the results from the questionnaire and the secondary data were registered and analyzed in the SPSS statistical processor (IBM, version 21) in order to run correlation- and descriptive analyses. The results of the analysis were then presented in graphical forms as appropriate with further contextual interpretation. Once the results were obtained, a further cross analysis with findings from the in depth interview was performed in order to strengthen the study.
The following statistical methods were employed using SPSS:

a) Descriptive statistics.

b) Correlations between parameters of secondary data.

c) Kruskal-Wallis significance test for Likert scale questions, appropriate for non-parametric data

4.5.3 Limitations

From a case study perspective, it is essential to craft a plan for how one will ensure validity of the research (Yin, 2009). The present study was designed to place considerable emphasis on both internal and external validity. One of the ways we approached this was to use different data collection techniques within one study using in depth interviews for qualitative data in order to triangulate quantitative data collected by the survey questionnaire and other collected secondary data. Although the study comprises a case study of only a group of managers from a single university hospital, we try in this way to increase the validity and generalizability of the results. Access to managers at this level of operations is quite difficult and time consuming; this was addressed by continued correspondence and local support over a period of several months. This means that the number of respondents is not very high, even though considerable effort was invested in performing the study. Additionally, it would have been of value to extend the study to other institutions. Unfortunately however, this was not possible and it is important not to over-generalize from a single case.

Some of the managers had just started work, and did not give complete results, which makes it more difficult to draw overarching conclusions from the results. We tried to counter this problem by approaching as many managers as possible at the hospital.
5. Empirical results

The empirical results are presented in the following order. First we present the data from the in-depth interviews, which are structured according to the ARA model. This is followed by data from the survey study where we present results and a correlation analysis between primary and secondary data of relevance in terms of internationalization and where we also present data regarding the origin of international patients coming to Akademiska for treatment.

5.1 In-depth interviews

The interviewed managers all valued the importance of networking highly in the context of attracting patients in general and also specifically in the context of internationalization. Several actors, resources and activities were identified, these are specified below.

5.1.1 Actors

As could be expected, the most prominent and important actors identified by the respondents in the study are the doctors in the relevant fields. This is confirmed by all respondents. Doctors are a group with a high level of integrity and professional loyalty which in some cases transcends organizational boundaries. This is seen in the way they are able to move between organizations and work at other hospitals and health care institutions for longer or shorter periods. The fact that doctors work at other institutions and also in some cases work as researchers strengthens bonds with other local actors. The interviewed managers see this as an important facilitator of internationalization.

Researchers are important actors for several reasons. Researchers create networks and are important in establishing actors bonds. Perhaps more importantly, researchers are in many cases innovators and they are instrumental in creating or developing new treatment options or diagnostics which can be developed into “products”. As one of the interviewed managers pointed out, these “products” are then made available for the organization to attract cross-border patients. Here, the best interests of local patients through development of innovative and front-line care, coincide with organizational interests in terms of foreign sales of health care services. The researchers can in some ways be considered to be institutional entrepreneurs, just as they facilitate actor bonding and networking.
Uppsala Care is an important local actor which provides administrative support and greatly facilitates internationalization. Several interviewed managers pointed out the importance of being able to focus on the clinical treatment of the patient, having limited time even for that, while at the same time being able to rely on other practical issues being taken care of by a reliable partner.

Patients are actors who play a role of increasing importance in internationalization of health care services. This is making patients more proactive in choosing health care providers, while improved access to information is allowing for more critical assessment of local doctors competence and decisions. Our interviewees described how numerous patients seek second opinions and new treatment options at clinics at Akademiska, bypassing local doctors at home.

The study interviews revealed the importance attributed by the respondents to promotion of their units through word-of mouth by patients who received successful treatments. Examples of patients diagnosing themselves were mentioned by one respondent when doctors in the home country were unable to help. A socially prominent patient in another European country started a flow of patients from his home country after a successful treatment at Akademiska when he openly discussed this in local media. As our respondent described, it took some years for the local clinics in the patient’s home country to regain complete trust and legitimacy and several patients from this country followed suit because they perceived Akademiska as a trustworthy care provider and in fact the Swedish system as superior to the local one.

We find numerous examples of actor bonds, prominent ones being research collaboration and facilitation of administrative processes by working abroad. Local meetings at Akademiska can also been considered to create bonds between actors in local resource networks, we see participation of doctors in these local actor meetings to correlate positively with the level of internationalization.

Other important actors identified in the study are innovators and entrepreneurs which often are researchers. Key opinion leaders were also mentioned by one respondent in the context of networking and research connections. Finally, the owner of the hospital, Uppsala County, is
responsible for allocating economical resources to the units, along with the hospital board and thus has an important role to play, although the study data may indicate that it is distant and perhaps not ideal in terms of facilitating strategic investments for increased levels of internationalization. Some managers describe this important actor as distant and unable to focus sufficiently well on the details of individual units.

5.1.2 Resources

Several important resources were identified in the study. Of these, probably the most important are the local supporting units providing treatment (for example radiology, a new proton clinic) and diagnosis (laboratories). Local care facilities (vårdplatser) and access to specialists were also identified as important resources. We see support for this also in the survey part of the study where numbers of cross-border patients correlate with self-scored levels of doctor's participation in local meetings, indicating the importance of local resource ties. Also, the level of strategic information from local clinics/units positively correlates with numbers of cross-border patients as does the self-scored level of initiation of innovations by the hospital board. We interpret these survey items to support the importance attributed by managers to local resources and shows the relevance of resource ties for the level of internationalization. Also it is logical that the increased initiation of innovations by the hospital board should correlate with the level of internationalization as innovation per se is important as mentioned by interviewed managers and is likely to draw with it investments, although this was not evaluated by the study. This initiation of innovations will then as an indirect effect support increased levels of internationalization.

Other important resources identified by respondents in the study are Uppsala University and the proximity to local research centres such as life-sciences research clusters, which could be expected since researchers and innovators were previously identified as important actors in the network. One critical bottleneck identified is the availability of operative resources in the hospital where limited access to operation theatres appears in some cases to inhibit unit’s possibilities to attract international patients. Other important local resources are well established patient registers with available family information and biobanks, which are important for certain types of research such as genetic studies of inherited diseases.

Uppsala Care is mentioned as an important resource for units selling cross-border care because
the administrative work to facilitate practical aspects in this respect is considerable. Resources in the form of competent co-workers are also mentioned by managers. More technically competent personnel are required, especially specialist doctors but also competent nurses are important. Economic resources for strategic investments for example are considered lacking.

To cite one manager: “The hospital could do more proactive work to solve problems, not just to use cut-backs as a mechanism”.

Another manager: “Good local cooperation between related clinics in the field of neurology and neurosurgery is important. Close situation physically, good cooperation and positive environment in general. Builds a competence centre”.

Third manager: “I would focus on the closeness of clinics, good cooperation, not strong jurisdictional boundaries and clinics are close to each other, not as administratively complex as some other hospitals. Shorter paths of decisions here compared with many other hospitals. Closeness to a "complete" university although the university is a bit distant here. Uppsala university is more complete and complex but a bit distant”.

The resource ties we observe here are mostly administrative and organizational in nature. External resources in terms of patient hotels, availability for partner support are also mentioned and one manager pointed out the importance of organizing a sort of “Drive-Through” health care. Cross-border care needs to consist of well-defined treatments (hence the concept “Drive-Through”) since post-operative care and post-operative medication can be complicated to control and administer after the patient has gone back to her/his home country.

5.1.3 Activities

Knowledge transfer was identified as a highly important activity in the study. This takes on several forms, important ones including giving courses and organizing congresses. The most prominent unit in terms of internationalization at Akademiska reports having held courses and
educational activities for over 1000 doctors from all over the world through the years since its inception.

Lecturing at international congresses and meetings was also identified as an important activity in this respect which by many managers was directly linked to sales of cross-border care. Administrators at Uppsala Care maintained that they could see when the most prominent researchers had been lecturing at international congresses because this resulted in a marked increase in the numbers of patients requesting treatment.

These knowledge transfer activities are seen to contribute to creating a Centre of Excellence and by patients these knowledge transfer activities seem to be interpreted in a positive way. This attracts international patients which again supports this process. In this case the Swedish saying: “Shared knowledge grows” seems highly appropriate.

The other main activity identified is when doctors from the focal clinic work for shorter or longer periods at other clinics internationally. This may seem an unusual practice from a business perspective, but is in fact not uncommon and is facilitated by the strong professional identity of doctors (Levay and Waks, 2009) which supersedes organizational and national boundaries. Also, this illustrates the lack of competent specialists in many areas. This activity was considered more important by managers with lower intensity of knowledge transfer activities and was described as creating links to administrative and clinical processes at Akademiska. The doctors involved in this cross-border work simultaneously act as ambassadors for Akademiska, spreading the organizations prestige and increasing its legitimacy. Also, by familiarizing themselves with circumstances where they work, these doctors are able to facilitate administrative processes and establish contacts. From the in-depth interviews, it became clear that units with neither of these two kinds of activities had low numbers of cross-border patients.

One manager described this networking activity as a win-win solution because the system becomes greater than the sum of the parts. Cooperation and being relatively generous with allowing doctors to work for periods abroad brings benefits for the hospital in terms of facilitating sales of cross-border care. The smaller units abroad get assistance in solving local problems and support in identifying cases which need to be referred to Akademiska for highly specialized care and for the doctors this means some occupational variety and intra income. These same mechanisms were also seen to operate on a national level with doctors working at
various national hospitals, the interviewed managers themselves participating in some cases. We see these activities to be linked through the strong professional identity of doctors and they are also linked by the drive for knowledge transfer and professional development of the doctors themselves.

Research activity has at least three relevant aspects in the context of this study: Networking, innovation and marketing. Researching creates networks and facilitates contacts between groups internationally. This often creates positive side-effects and facilitates cross-border care. Innovation was mentioned by managers as a very important part in attracting cross-border patients. There are clear first mover advantages and it is important to be among the first clinics to implement new treatment forms and establish modern, top-of-the-line treatment facilities.

One manager said in this context: “If you build it, They will come”.

He was referring to the fact that new treatment facilities attract patients from around the world, if this can be seen to offer new and hopefully better treatment forms. Investing in innovative treatment facilities in itself of course shows a certain amount of reliance on the treatment in question.

Another manager mentioned new forms of treatment with stem cells as a result of high-level research activity. New treatment forms for Multiple Sclerosis had created international interest within a short time of publication and already patients were showing interest.

“Research as marketing” is a concept which is not well developed but which may be relevant to some extent. The hospital is not considered by managers to be performing any special marketing activities. It is not seen to have the capacity for this, instead it relies entirely on individual managers/researchers for this purpose. Some promotional activities are performed, such as business delegations to other countries, but this is not a prominent activity.

The results from the survey part of the study show the importance of local networks and resources as mentioned above and further specified below. This is corroborated by one manager who emphasized the importance of building internationalization from within. First it was necessary to work hard on building the local setting, then nationally and finally, towards
internationalization.
The interviewed managers in the study in many cases see the various units at Akademiska as centres of excellence, focusing on giving highly specialized care.

The important links between the activities now become clear as most of them can be seen to be interrelated. Lecturing and knowledge transfer is closely related to research and innovation and these activities support one another as well as does the high degree of specialization of units.

5.2 Survey study

5.2.1 Descriptive statistics.
First, we present specifications regarding the respondents and operations units participating in the study. The data are presented as mean +/- standard deviation and maximum and minimum values. Number of respondents was 26; data on number of citations was obtained from 25 respondents/units. Parameters 4-9 refer to the years 2011-2013.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Mean</th>
<th>SD</th>
<th>Min-Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age of interviewed managers (years)</td>
<td>53.7</td>
<td>6.9</td>
<td>39-65</td>
</tr>
<tr>
<td>2. Number of years employed at Akademiska</td>
<td>11.5</td>
<td>10.9</td>
<td>0.3-36</td>
</tr>
<tr>
<td>3. Number of employees in the operations unit</td>
<td>212</td>
<td>108</td>
<td>30-430</td>
</tr>
<tr>
<td>4. Number of cross-border patients at the units studied</td>
<td>47.2</td>
<td>172</td>
<td>0-885</td>
</tr>
<tr>
<td>5. Number of publications from researchers at the units</td>
<td>90</td>
<td>82</td>
<td>0-268</td>
</tr>
<tr>
<td>6. Number of publications per employee</td>
<td>0.52</td>
<td>0.65</td>
<td>0-3.3</td>
</tr>
<tr>
<td>7. Number of citations to papers from researchers at the units</td>
<td>340</td>
<td>355</td>
<td>0-1175</td>
</tr>
<tr>
<td>8. Number of citations per employee</td>
<td>2.0</td>
<td>2.63</td>
<td>0-12.4</td>
</tr>
<tr>
<td>9. Number of disputations (PhD)</td>
<td>4.9</td>
<td>4.4</td>
<td>0-17</td>
</tr>
</tbody>
</table>

Table 1. Characteristics of respondents and units.
5.2.2 Survey data

The results presented here regarding the survey data, emphasize the internationalization aspect of the results, not the local or national analysis although this was included in the data collection. This is because the focus of the thesis is on internationalization. Some relevant details regarding the local situation are mentioned however. The full study guide is presented in Appendix 1.

The empirical data shows that the operations managers do not rate the international networking questions highly. Local and national networks are much more important to their operations then international networks. International adaptations, innovation, knowledge transfer through study visits on average give a low score and additionally do not show any significant correlation with the observed number of international patients to the operations units. Adaptation and innovations in work routines on an international level on average score 1.7 and 1.8 respectively on a scale of 1 to 6, study visits from international clinics score 2.4 and study visits to international clinics 2.3. Doctors attendance of international congresses is rather high, scores at 4.0 whereas other employees at 1.9. Information from international clinics regarding strategic aspects scores at 2.3 and the managers evaluate possible effect of the recent EU directive on cross-border care on average at 2.0 on the scale from 1 to 6.

The self-scored questions on strategic information from the board and information regarding decisions on cross-border care gave the following results: Average score was 2.4 for strategic information from the board with one respondent who did not reply and 1.5 on information regarding cross-border care with 7 respondents not being able to provide an answer. These results would seem to indicate the board and owner of the hospital as being evaluated by managers as having a low degree of engagement regarding internationalization.

As examples, results from the evaluation of international adaptations are shown in Figure 2 and results from the evaluation of initiation of changes in work routines in Figure 3.
Figure 2. Respondents self-scored evaluation of unit’s international adaptations.

Figure 3. Respondents self-scored evaluation of unit’s international initiations of change.
5.2.3 Statistical analysis

When analyzing the survey data, two very interesting patterns of correlations emerge, one from the secondary data and one from the results of the Likert scale questions. The number of citations to research publications from the operations units shows a significant correlation with the number of cross-border patients received by the units, (Pearson's correlation, \( p=0.005 \)). This shows a potential effect of research activity as a marketing effort and supports the data from the in-depth interviews. This will be discussed further in the analysis and discussion.

When analyzing the Likert scale primary data and using the Kruskal-Wallis non-parametric test to test for correlations with the number of cross-border patients, three related areas show significant correlation (\( p<0.05 \)):

1. Level of doctor’s participation in local meetings
2. Level of strategic information obtained from local clinics
3. Level of initiation of innovations from the hospital board

It is interesting that local networking and knowledge transfer activities show significant correlation with the number of cross-border patients received at the operations units whereas these questions, when asked at the national or international levels, do not show significant correlation. This again gives strong support for the data from the in-depth interviews showing the importance of local resource ties.

5.2.4 Patient flows to Akademiska

The secondary data collected in the study allow us to analyze the number of patients treated at Akademiska based on their country of origin. The largest number of patients from a single country comes from Norway, which accounts for 32% of international patients at the hospital. In addition a rapid increase in Norwegian patients has been seen for the past three years. We could postulate that the Norwegian patients are to a large extent coming for specialized care since the Norwegian health care system can be considered to be of good quality. The Nordic countries
stand for 39% of international patients at Akademiska and other countries in Western Europe for 17%. Europe overall provides 80% of international patients which as above can be considered to be a sign of niching and specialization.
6. Analysis according to the ARA model

This study revolves around the concept of networking in sales of cross-border care and connects networking to important aspects of the functioning of the health care system.

Four forms of networking became clear from the interview data:

1 Networking in the form of intellectual activity such as giving courses and furthering education among professional colleagues.
2 Active participation in and development of professional societies, both national and international.
3 Presentations at international congresses and symposiums as well as research activity and scientific publications.
4 Direct establishment of network contacts by doctors who work at other hospitals and in this way mediate knowledge of the hospital's capacity and competence, obtain understanding of local requirements and assist in administrative issues.

These forms of networking seem to be operational both nationally and internationally and can be seen in the light of the strong professional identity of doctors (Levay and Waks, 2009). The interviewed managers showed varying networking activities and those who had the highest numbers of cross-border patients reported higher levels of these activities. Additionally, the managers seemed to have reached these higher levels of internationalization and networking through their own initiatives and enthusiasm rather than through support from hospital management.

6.1 Actors

An important aspect of the different roles of actors involved in the internationalization processes emerges when analyzing the data presented above. We see how doctors and patients have dual and partly conflicting roles. Doctors on the one hand are care providers who wish to win patients trust, to increase the legitimacy of their position and who are charged with the responsibility of offering the best possible care. We see from our data that this often includes staying in the forefront of research and promoting innovative treatments and that this is what attracts
international patients. At the same time, the health-care units in question are usually managed by doctors who then need to consider also the economical aspects and patient flows from a managerial point of view. We do not see from our data if this causes any conflicts in the work of the doctors, but perhaps there is less of an incentive for the doctors involved in managing the units to treat the operations as a business. There is no question as to their loyalty first to the local citizens to whom the hospital has responsibility to provide health care and secondly to offer care to external patients, if possible within budget limits and other potential local limitations such as facilities and personnel. This is in spite of the fact that the hospital as a whole might very well benefit from increased sales of health-care services internationally. This duality in the doctor’s duties, where loyalty to the patient always must come first, may in the long run pose a self-limiting situation for the whole organization. As a general concept, experience from the US health care system shows that increasing economic considerations in health care may have an alienating effect on doctors and may in fact decrease motivation in daily work (Hartzband & Groopman, 2009). These aspects are becoming more relevant as health care is becoming more commoditized and with the increasing influence of New Public Management in health care (Simonet, 2008).

In our study, we are also able to observe the changing role or conceptualization of the patient in the Swedish health care system. From traditionally being a citizen with a right to state-funded health care, the patient today is increasingly seen as a customer with greatly increased influence and initiative in the health-care system. This increasing effect of patient empowerment is one expression of the ongoing changes in patient's status (Carrera and Lunt, 2010) and we clearly see this effect when interviewing managers at Akademiska. The units with well developed cross-border sales of health care are used to patients themselves seeking second opinions, a phenomenon otherwise not common in the Swedish health care system, and even observe patients themselves diagnosing complex and life-threatening diseases as mentioned by one of our interviewees. The patient then approaches the clinic in question with a request for treatment to be performed with a method she has learned of through reading scientific publications, through online forums or the hospitals web pages. Additionally, the patient brings promise of payment from the home country if an EU citizen, from an insurance company or from her own pocket depending on the circumstances. Clearly the increasing importance of these processes for the individual clinic and for the organization as a whole, are a part of the changes occurring in the
health-care system. Through our discussions with the managers for the various hospital units, we can identify these ongoing changes and how the units with more advanced internationalization processes are more developed in this respect. These new developments relate back to the examples given previously regarding the commoditization of health care and we are able to identify these processes at work at Uppsala University Hospital today.

Issues of legitimacy and trust (Fombrun and van Riel, 2004; van Riel and Fombrun, 2007), always important in the patient-doctor bond, become especially important here. With increased patient empowerment and knowledge, finding a health care provider who can be trusted becomes an overriding factor. The actual location of the health care facility is secondary to finding a trustworthy health care provider with a good outcome reputation (Reeves, 2011). Positive word-of-mouth becomes not only a satisfying side-effect of doing excellent work in health care, today it is becoming as important to health care as to any business organization.

It is highly interesting when compared with other organizations that doctors are so easily able to move between organizations and country borders in a way that may even be beneficial for all involved, as shown above. This is partly because the work of the professional allows for a lifetime career in a shifting marketplace and also because traditionally it allows for independence from organizational employment (Abbott 1988, p. 7 and 324). In the case of internationalization, this professional loyalty may actually facilitate networking and actor bonds internationally between organizations. These bonds allow doctors to identify with each other across country and organizational borders and helps them to prioritize the patient’s best interests. As explained by one of the interviewed managers, doctor’s professional identity has in fact been the forum or medium for networking until now.

One further observation which receives support from the study data is how the hospital board is seen as a distant actor with limited possibility to focus on strategic aspects in some of the interviewed units. The involvement of the board is important, as we see that the level of cross-border sales of health care services positively correlates with the initiation of innovations by the board, as evaluated by managers in the survey data. However, the board is not able to afford the same level of focus to all units. This is probably not unexpected in an organization of this size but it may be useful for the board to consider this, as lack of support may reduce the individual
unit’s capacity for expansion or further increase in international sales of health care services. The general principle of boards of large organizations being distanced from daily operations of individual units, especially regarding innovation, is a concept well established in the management literature (Ciabushchi et al., 2011) and we see corroborations for this concept in the present study.

6.2 Resources

The importance of local networks and local resources in terms of the level of internationalization receives support in our study from both the in-depth interviews and the survey data. This is in line with the concept of building internationalization from the core competence and important resources in the organization. Resources are of course important for any firm and the interactions between internal resources, competitors and the environment influence the performance of the organization (Conner, 1991). We see clear support for this concept in the data from our study. Despite an extensive literature search in on-line databases, this concept of local resources seems poorly developed in terms on internationalization of health care services.

The main resources identified in the study are local supporting units, care facilities, specialists and professionals, university and research institutions as well as computerized registers and biobanks. The resource ties we identified are administrative and organizational ties. Resources are clearly highly important, both in terms of local supporting units to aid in diagnosis and treatment but also administrative and practical support such as provided by Uppsala Care in terms of finding accommodation etc. High local competence in the organization in terms of specialists in the various fields if of course crucial for success in this field. Local high competence in terms of innovation and high-profile research is also important as is the link to research facilities where basic research can be performed.

6.3 Activities

We see that giving courses and other educational activities, lecturing at congresses and publishing innovative scientific results is strongly associated with internationalization according
to the interviewed managers. Other authors have identified knowledge transfer activities as an important aspect of internationalization, using the concept of diffusion of scientific research results (Hannemann-Weber et al., 2012 pp 143). We also see strong support for this concept in the survey part of this study where number of citations to published articles is shown to positively correlate with numbers of cross-border patients. This parameter has been considered to be a measure of the spreading of practical information (Hannemann-Weber et al., 2012) and can also be seen as a measure of legitimacy and prestige. This phenomenon can also be interpreted as a way to promote the organization by using research publications as a form of marketing. Even though it is well known that any medical innovation today has to be supported by research, the concept “research as marketing” in the context of hospital management did not reveal any relevant publications after a literature search in the Business Source Premier and Web of Science databases.

When we see how the inflow of international patients is distributed, with the Nordic countries providing high numbers of patients, especially Norway, in spite of already having good quality health care in the home country, we interpret this as pointing to the importance of innovation and specialization of the units creating Centres of Excellence in the chosen speciality. Patients and doctors alike identify these centres internationally through knowledge transfer activities, making these units the most important focal centres for internationalization for the organization. We argue that this concept is clearly supported by the various data in the study showing that in the internationalization of health care services it is valid, just as in internationalization of business enterprises in general (Forsgren et al., 2000).

6.4 Organizational aspects

The difficulties mentioned by some interviewees regarding internationalization of health care services are the problems involved in treating diseases which require long periods of treatment, perhaps months or years as well as follow up at a time separate from treatment. One manager referred to “Drive Through” health care as optimal when treating cross-border patients. Not all diseases are suitable for this kind of care. Good accessibility is also considered important, including simple administrative routines.
Only one of the five respondents in the in-depth interviews mentioned competition, the other four did not even consider that concept in the context of internationalization. The hospital mentioned as a possible competitor was the University Hospital in Örebro, but more in general terms and not especially in terms of internationalization. Possibilities for cooperation were more highly regarded by respondents, for example regarding Karolinska in Stockholm. It is clear that the managers themselves see the advantages of cooperation which has previously been identified as an important efficiency factor for hospitals (Mascia and Di Vincenzo, 2011). In some cases the organizations in question have a relationship of simultaneous cooperation and competition and realizing the potential for cooperation in these situations can be of importance (Barretta, A. 2008). Cooperation between hospitals offers the possibility of creating Centers of Excellence. This can be expected to occur more frequently between organizations or countries which are geographically close.

The fact that geographical closeness in the case of Akademiska correlates with the number of international patients is not surprising. In our interviews however, we see how the managers of units focus on specialization and the creation of centers of excellence in terms of internationalization. The creation of centers of excellence is a well known concept from the management literature (Forsgren et al., 2000) but also in health care this is seen as important issue (Hannemann-Weber et al., 2012) and is associated with increased efficiency. In a relatively sparsely populated country as Sweden, it may be advantageous to extend the concept of national centers of excellence (rikssjukvård; Wenglén, 2009) to international centers, in cases of rare diseases or where great resources are required to establish such units. In these situations, cooperation in the EU can be considered useful.
6.5 Revised study model

The analysis of the empirical data above allows us to revise the theoretical model for the study showing the key components relevant for internationalization of health care services according to our results.

**Figure 4**

Revised study model showing the key actors and bonds (above left), activities and links (above right) and resources with ties (below).
7. Discussion

In this thesis, we show the relevance of using the ARA model of network analysis to understand significant aspects of health care. The phenomenon we have been studying is internationalization, to reveal if networking is an important factor with relevance for the level of sales of cross-border care, and if so which networking aspects would be important.

We find support for this concept in the empirical data collected, both from our primary and secondary sources. The primary data identifies four forms of networking to which our respondents clearly attach great importance in this context. The primary data also show the importance of local resources for internationalization. The secondary data support these concepts by showing a significant correlation between the number of citations to research publications, a form of knowledge transfer, to sales of cross-border care.

Citation counts are commonly considered a measure of research significance and impact and are often used to evaluate research performance (Bornmann et al., 2008). This parameter has been criticized because its utility varies between research fields, where for example narrow fields may by definition show low citation counts because of low numbers of researchers in the field, but when properly used its significance is valid (Bornmann et al., 2008). In this study, we are looking at the level of attention given to research activity by other researchers, a factor which previously has been shown to correlate positively with integration in local networks and operational experience (Hannemann-Weber et al., 2012). We find that this measure of research impact positively correlates with the number of cross-border patients treated at the units studied, which we interpret to show how impact of research activity increases prestige and interest among external actors and may be considered a form of knowledge transfer. An alternative interpretation is that high-impact research simply correlates with local resources and competence and in this way is linked to higher levels of sales of cross-border health care.

We have identified the importance of the networking and networks of doctors from the perspective of internationalization where professional identity is an important facilitator across organizational and country borders (Abbott, 1988; Levay and Waks, 2009) allowing doctors to establish international contact. Another way to conceptualize this phenomenon is to consider the constitution of networks (Mouzas and Ford, 2009). The term constitution here refers to a higher order of customary and expected conventions which often are self-enforcing and are based on a
shared system of values, norms and rules which transcend any single organization or relationship (Mouzas and Ford, 2009). From this perspective, networking has been shown to increase efficacy and stability while reducing costs for the actors involved. This requires a certain investment in the networks but the benefits are clear because this saves resources and increases stability in the long term. The constitution of the network provides a framework for interaction, facilitates common expectations and ease of interaction. This is another way of conceptualizing the networks involved and adds a new dimension to how the professional networks function and how this is related to internationalization in health care.

When considering networks and professionals cooperating between organizations which often are in competition for patients and sales of care, the concept of competition in networks becomes relevant (Ford and Håkansson, 2013). It is common to view competition as the most important factor in business relationships and this is also a major driving force behind the logic of New Public Management (Simonet, 2008). However, when studying business networks, such as the ones in this study, it becomes clear that cooperation is highly important and in fact research from the group of Industrial Marketing and Purchasing (IMP group) shows business to be an overwhelmingly cooperative venture (Ford and Håkansson, 2013). In health care, this concept has previously been observed and here the term “coopetition” has been used to describe the relationship between organizations which simultaneously compete and cooperate (Barretta, 2008). In the present study, this concept was not in itself an object of study, however several of the interviewed managers stressed the importance of cooperation between hospitals, both nationally and internationally, to increase efficiency and improve quality. Networking and collaboration has previously been shown to be beneficial for hospital networks (Mascia & Di Vincenzo, 2010).

A concept which emerges from the study is “Research as Marketing”. It is clear from our results that research activity creates international interest and we find support for the creation of patient flows this way. Both doctors and patients are active here since patient awareness is increasing simultaneously as internationalization. There are few references for the “Research as Marketing” concept in the published literature however, and we feel this motivates further research.
When using the network perspective for analyzing the operations of the health care organization which is the object of this study, we see how the concept of Centers of Excellence (CoE’s) is directly relevant as in other business organizations as explained above. We see in fact from our analysis of the study data how the networking perspective affords a more constructive and realistic way of analyzing internationalization than the faceless competitive orientation of New Public Management.

The interviewed managers frequently mentioned the importance of innovations and first-mover advantages. This aspect is linked to research activity and also has been seen to be related to network centrality, both locally and globally (Bunker Whittington et al., 2009). To stay ahead in a rapidly moving world, it is important to realize that collaboration and networking is the way forward. The survey part of the study shows that support for innovations by the hospital board correlates with international sales of health care services. This supports the reports from the in-depth interviews and correlates well with international studies in the field (Bunker Whittington et al., 2009).

Some limitations of the study should be mentioned. The number of respondents in the survey part and the in-depth interviews is unequal. Access to managers at this level of operations in general is not easy so compromises in the numbers of respondents had to be made because of the time-frame allocated for the study. Also, it would have been of value to study other institutions as well to see if these results could be corroborated. This was not possible and although it is important not to over-generalize from a single case, we do see confirmation for many of the observed networking effects from both forms of primary and also from the secondary data, which we see as providing a strength for our conclusions.

Some of the managers had just started work, and did not give complete results which makes it more difficult to draw overarching conclusions from the results.

The respondents were naturally only able to present a one-sided view of the networks they are part of. This needs to be taken into account because the present thesis only analyses the perceptions of managers and results from this single organization.
8. Conclusion

This thesis identifies four networking activities which were seen as highly important for internationalization in terms of cross-border sales of health care services:

Networking in the form of knowledge transfer such as giving courses and furthering educational activities among colleagues; Active participation in and development of professional societies, both national and international; Presentations at international congresses and symposiums as well as research activity and scientific publications; Direct establishment of network contacts by doctors who work at other hospitals. By using the ARA model, we were able to see how the actors, resources and activities were involved in the internationalization processes.

We find that the level of internationalization correlates positively with the level of knowledge transfer through the networking activities as described above, but also with the international impact of publications as seen by citations to scientific publications. Local resources are important as local networking and support correlate with the level of internationalization.

Innovation, specialization continuous development of new treatment modalities clearly is important to create interest and attention for the organization internationally. It is vital to stay in the front-line of development. This is not enough however; it has to be linked to knowledge transfer through networking and lecturing at congresses.

The managerial implications of these findings are potentially important, as we see that cooperation and networking are vital and must be taken into consideration when managers plan to increase the level of internationalization in health care organizations. Increased competition is not always the best way to ensure the prosperity of the organization – or the best options for patients. Building local resources is important but ensuring the right operational focus and specialization as well as ensuring good network contacts is crucial for success.

The present thesis is a single case study on a university hospital in a relatively small Swedish university town. Future research is needed to confirm our findings in a larger setting and to see whether these principles hold for other and larger university hospitals. Also, we were only able to study the managers at the selling node in the network and their perceptions and understanding of the situation. Further research might well analyze how patients themselves select the most trustworthy and interesting providers of health care and also how referring doctors choose
competent centers to which to send their patients for treatment. All these factors are highly relevant for better understanding of this system. Economic aspects of these phenomena would also be interesting to study and to see if networking and cooperation leads to increased profitability of the organizations involved.

One final concept has emerged from the study which simultaneously captures the importance of networking and cooperation and which also shows the most constructive way to proceed in knowledge-intensive operations such as modern health care. Knowledge transfer is a vital activity and increased knowledge means increased competence:

“Shared knowledge grows”
9. References:


Deephouse, D. L. 1999. To be different, or to be the same? It’s a question (and theory) of strategic balance. *Strategic Management Journal*, vol. 20, no. 2, pp. 147–166.


Eisenhardt, K. M & Graebner, M. E. (2007). Theory Building from Cases: Opportunities and


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Globalization and Health, vol. 8, pp. 8-16.


**Appendix 1**

Below is the full interview guide, used in the survey part of the study.

<table>
<thead>
<tr>
<th>1</th>
<th>Interviewguide Internationalisering - Bakgrundsfrågor</th>
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<tbody>
<tr>
<td><strong>Verksamhetschef</strong></td>
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<td><strong>Annat (vilket)</strong></td>
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<td><strong>Hur länge har du arbetat på sjukhuset</strong></td>
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<td><strong>Antal anställda i verksamheten</strong></td>
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<td><strong>Antal publikationer från verksamheten sedan 2011</strong></td>
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<td><strong>Antal disputerade doktorander sedan 2011</strong></td>
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<tr>
<td><strong>Vilka aktiva forskare inom verksamheten?</strong></td>
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<tr>
<td><strong>Vilken institution på Universitetet är knuten till verksamheten?</strong></td>
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**Intervjuguide Internationalisering - Nätverksfrågor**

De första frågorna försöker sätta finger på hur integrerad verksamheten är i sjukhusets övriga verksamhet samt på innovationskraften i verksamheten.

<table>
<thead>
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<th>n.a.</th>
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<td>c) internationellt?</td>
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<td>Hur ofta initierar din verksamhet förändringar i arbetsrutiner/patientprocesser hos andra kliniker?</td>
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<td>Hur ofta inför verksamheten sina nya/innovativa arbetsrutiner pga krav från sjukhusledningen?</td>
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<td>Hur ofta besöker anställda i verksamheten andra kliniker i syfte att lära sig nya arbetsrutiner för att utveckla verksamheten?</td>
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<td>Hur bra informationsunderlag får verksamheten för att kunna fatta strategiska beslut? Exempel kan vara nysatsningar, investeringar, nya behandlingsformer etc.</td>
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<td>Hur bra information har verksamheten fått angående EU-direktiv om patienters rättigheter vid internationalisering av sjukvård?</td>
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<td>Hur stort inflytande har verksamheten på sjukhusets policy angående krav på att ta emot patienter från regionen?</td>
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Appendix 2
The English translation of the list of questions for the survey part of the study

1. What is the frequency of adaptation of routines according to requirements from other local clinics/national clinics/international clinics?

2. What is the frequency of initiating changes in routines at other clinics/nationally/internationally?

3. What is the frequency of changing routines because of requirements from hospital management?

4. What is the frequency of initiating changes in routines at other clinics in the hospital through facilitation of hospital management?

5. What is the frequency of visits from other clinics at the hospital/nationally/international clinics?

6. What is the frequency of visits to other clinics at the hospital/nationally/international clinics?

7. What is the frequency of international referrals (number per month)?

8. How well are decisions regarding internationalization and strategy facilitated by information from other clinics at the hospital/national clinics/international clinics/hospital management?

9. How well have you/the clinic been informed regarding the EU directive on patient rights to cross-border health-care?

10. How much influence on the clinic's activities do you foresee that the EU directive on patient rights to cross-border health-care will have?

11. How much influence does the clinic exert on hospital policy with reference to requirements on facilitating acceptance of external patients?
Appendix 3
List of questions for the in-depth interviews:

1. What is the average number of incoming foreign patients. Is it increasing or decreasing?
2. In your opinion, what are the main reason for such a flow?
3. How do you describe the hospital’s effort in terms of attracting international patients? Are there any special activities mainly for this purpose?
4. What is your view on relationships with external actors in terms of knowledge sharing, research activities, special meetings or any sort of collaborations? Which are most effective so far?
5. In your opinion what attributes do you consider as the most unique resources to the hospital in influencing international patient flow? (both tangible and intangible)
6. What factors do you think play vital roles for external actors to send referrals here?
7. How do you relate the hospital’s reputation with international patient flow? Do you know of any promotional activities for this purpose?