INTERNATIONALISATION OF PRIVATE HEALTHCARE FIRMS FROM SINGAPORE

A thesis submitted to The University of Manchester for the degree of Doctor of Business Administration in the Faculty of Humanities

2011

CHOW TUAT WINSTON KHOO

Manchester Business School
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ABSTRACT

This research studies the phenomena of hospital groups expanding beyond their home country by setting up operations in less developed countries, and patients travelling out of their country for healthcare services, by looking at the internationalisation of private healthcare firms from Singapore. The research helps to address a gap in the literature as there is a lack of firm-level research on internationalisation of healthcare firms, and even more so for firms from Southeast Asia. For practitioners, the research offers a better understanding of the internationalisation strategies and choices adopted by healthcare firms, and more generally, service firms. With the region which Singapore is part of undergoing rapid integration, the study also offers useful insights on the impact of regional integration on internationalisation of healthcare firms.

Using a multiple-case study of four private healthcare firms from Singapore, the research examines the where (market selection), how (entry modes) and when (timing) of their internationalisation, as well as their response to regional integration, in the context of existing literature on internationalisation of firms.

The study shows that the internationalisation strategies of healthcare firms from Singapore, in relation to market selection, entry modes and timing of entry, were well-explained by existing theories on internationalisation of firms. Family ownership was identified as a reason for the deviation from theory for one of the cases.

Specifically on the internationalisation of healthcare firms, the study shows that healthcare services in Singapore is undergoing commodification, with increasing use of and emphasis on ‘marketing’ to procure patients-customers; increasing emphasis on quality; and the creation of customers and consumers. This has made healthcare services increasingly “exportable” in the sense that they can be “sold” overseas away from the point of “production”, via representative offices, instead of having to rely on higher commitment non-export entry modes as indicated in the literature. Another deviation from literature was the case firms’ stated preference to make market entry using management contract instead of joint venture. This can be attributed to their strategic need to internationalise quickly and the high cost of building new healthcare facilities.

Using the findings from the analysis, the thesis proposed a characterization of the internationalisation strategies of a healthcare firm from Singapore, in terms of market selection, entry modes and timing of entry. A conceptual model on the internationalisation of healthcare firms was also developed, identifying the factors which may influence the internationalisation of healthcare firms. Besides, the study identified that the healthcare firms went through four phases of internationalisation process, namely, learning, opportunistic, de-internationalisation and maturisation, with each presenting some unique patterns of internationalisation by the firms. Further analysis showed that the four phases tied in well with the “Link-Leverage-Learn” framework of Mathews (2006) for emerging/second wave multinational enterprises (MNEs), hence offering a new perspective for evaluating the internationalisation of such firms in future. On impact of regional integration, a possible “ideal” model for a healthcare MNE in an economically integrated region was proposed. Applying the model, it is proposed that internationalisation by healthcare MNEs will increase as the region integrates, and there will be further consolidation within the industry. Healthcare MNEs from small countries like Singapore are likely to compete particularly strongly, as they are under even greater pressure to secure the foreign markets given the constraint of their small domestic population.
THESIS DECLARATION

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ACKNOWLEDGEMENTS

The DBA process over the past five years has been a challenging but rewarding journey, and it would not have been possible without the support of a number of people.

First and foremost, words cannot express how appreciative I am of my wife, Fei Lin, and son, Kee Suen, for their encouragement, patience and sacrifices made during the journey. It was a long journey, and their support and encouragement were sometimes the only thing that stood between my continuing with it or giving up. My thanks also go to my parents and sister, who have supported and encouraged me in countless ways during the journey.

I am deeply indebted to my supervisor, Prof. Mo Yamin, for his astute intellectual guidance, hospitality and friendship throughout the last five years. I am most grateful for his guidance in scoping this research, from something that is quite nebulous and almost impossible, to one that is focused and more manageable, yet useful to both the academics and practitioners, and more importantly, absolutely relevant and useful for application at my own workplace. I am also grateful for his patience and support throughout the journey, notwithstanding the challenges posed by long-distance communications.

I would also like to thank my colleagues and fellow practitioners who have been so generous in sharing their knowledge and experience with me over the years. While it was not feasible to use an interview method to collect data for this research, “interviews” are in fact being done on an almost daily and ongoing basis for this research, as every bit of information and insights gained during my discussion, sharing and conversation with fellow practitioners contribute to the knowledge which I leveraged on to write up this thesis.

Last but not least, I would like to thank the present and former staff of the DBA Office, including Anne, Sian, Angela and Maria for their support during my candidature. Their facilitation and assistance have certainly played an important role in making this long ride a smoother one.
### ABBREVIATION

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<td>AEC</td>
<td>ASEAN Economic Community</td>
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<tr>
<td>AR</td>
<td>Annual Report</td>
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<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations, which consists of Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Singapore, the Philippines, Thailand and Vietnam.</td>
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<tr>
<td>CSA</td>
<td>Country-Specific Advantage</td>
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<tr>
<td>EBITDAR</td>
<td>Earnings Before Interest, Taxes, Depreciation, Amortization and Rent</td>
</tr>
<tr>
<td>FDI</td>
<td>Foreign Direct Investment</td>
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<tr>
<td>FSA</td>
<td>Firm-Specific Advantage</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HMI</td>
<td>Health Management International, one of the 4 case firms</td>
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<td>JCI</td>
<td>Joint Commission International</td>
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<td>JV</td>
<td>Joint Venture</td>
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<tr>
<td>MMC</td>
<td>Mahkota Medical Centre, the flagship hospital of HMI in Malacca, Malaysia</td>
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<td>MNE</td>
<td>Multinational Enterprise</td>
</tr>
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<td>Parkway</td>
<td>Parkway Holdings, one of the 4 case firms</td>
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<tr>
<td>PATMI</td>
<td>Profit after tax and minority interest</td>
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<tr>
<td>RMG</td>
<td>Raffles Medical Group, one of the 4 case firms</td>
</tr>
<tr>
<td>SESDAQ</td>
<td>Stock Exchange of Singapore Dealing and Automated Quotation. Established in 1987, SESDAQ’s purpose is to meet the fund raising needs of local small and medium enterprises (SMEs). It is the second board for Singapore stocks.</td>
</tr>
<tr>
<td>SGX</td>
<td>Singapore Exchange. This is the stock exchange of Singapore. Companies listed on SGX belong to one of two groups: the companies listed on the SGX Mainboard and the companies listed on SGX SESDAQ.</td>
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<tr>
<td>SMOPEC</td>
<td>Small and Open Economy.</td>
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<td>TMC</td>
<td>Thomson Medical Centre, one of the 4 case firms</td>
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<tr>
<td>UAE</td>
<td>United Arab Emirates</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>UN</td>
<td>United Nation</td>
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<td>USA</td>
<td>United States of America</td>
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# GLOSSARY OF TERMS

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<tr>
<td><strong>Acquisition</strong></td>
<td>Acquisitions are “purchase of stock in an already existing company in an amount sufficient to confer control” (Kogut and Singh, 1988: p412).</td>
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<tr>
<td><strong>Country-Specific Advantages or CSAs</strong></td>
<td>These are factors unique to each country that confer competitive advantages. They can be based on natural resource endowments (minerals, energy, forests) or on the labour force, and associated cultural factors (Rugman and Li, 2007).</td>
</tr>
<tr>
<td><strong>Export</strong></td>
<td>In International Business, “Exporting” is the sale of products or services to customers located abroad, from a base in the home country or a third country. Based on this definition, producers of soft services (namely, non-separable services) face difficulty in exporting their services given the close producer-consumer interaction required (Cavusgil et al, 2008: p5).</td>
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<tr>
<td><strong>Firm-Specific Advantages or FSAs</strong></td>
<td>These refer to a set of firm-specific factors that determine the competitive advantage of an organization. A FSA is defined as a unique capability proprietary to the organization. It may be built upon product or process technology, marketing, or distributional skills (Rugman and Li, 2007).</td>
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<td><strong>Foreign Direct Investment, or FDI</strong></td>
<td>Foreign Direct Investment is defined as an “investment involving a long-term relationship and reflecting a lasting interest of a resident entity in one economy (direct investor) in an entity resident in an economy other than that of the investor. The direct investor’s purpose is to exert a significant degree of influence on the management of the enterprise resident in the other economy” (IMF, 1993).</td>
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<td><strong>Globalisation</strong></td>
<td>The OECD (2010) defined globalisation from an economic perspective: “The term globalisation is generally used to describe an increasing internationalisation of markets for goods and services, the means of production, financial systems, competition, corporations, technology and industries”, while Clark and Knowles (2003: p368) defined it as “The process by which economic, political, cultural, social, and other relevant systems of nations are integrating into World Systems”. The latter definition is particularly suited for this study given the role that the political and cultural systems play in the internationalisation of services.</td>
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<td><strong>Greenfield Investment</strong></td>
<td>A Greenfield project entails building a subsidiary from bottom up to enable foreign sale and/or production. Real estate is purchased locally and employees are hired and trained using the investor’s management, technology, know-how and capital (Meyer and Estrin, 2004: p12).</td>
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<tr>
<td><strong>Internationalisation</strong></td>
<td>“Internationalisation” refers to the “the process of increasing involvement in international operations” by a firm (Welch and Luostarinen, 1988: p36).</td>
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Joint Commission International, or JCI

Joint Commission International is the international division of the U.S.-based Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), aimed at helping healthcare organizations outside US improve patient care safety through the provision of accreditation and certification services as well as through advisory and educational services implement practical and sustainable solutions. At present, there are over 200 healthcare institutions in 38 countries and regions with JCI accreditation.

Joint Venture, or JV

A joint venture involves the creation of a new organisation with resource contributions from two or more parent firms. The parents share strategic and operational control of the firm. A joint venture is created as a new legal entity like a Greenfield, but jointly by two or more firms that both contribute resources. Like an acquisition, a JV provides the foreign investor with access to resources of a local firm, whereas a Greenfield does not. Joint ventures are designed in a variety of different ways depending on the resource availability, concerns for control, and bargaining power (Meyer and Estrin, 2004: p13).

Management Contract

A management contract is an arrangement under which “the ‘know-how’ of the management of the contractor is transferred to the contractee, who then has the responsibility for undertaking the management services according to the terms of the contract.” (Dunning and Lundan, 2008: p279).

Multinational Enterprise, or MNE

A Multinational Enterprise is an enterprise that engages in foreign direct investment and owns or, in some way, controls value-added activities in more than one country (Dunning and Lundan, 2008).

Psychic distance

Psychic distance can be defined as “the factors preventing or disturbing firms learning about and understanding of a foreign environment” (Vahlne and Nordstrom, 1992: p3). It represents a transaction cost of doing business between countries, although psychic distance costs may also be expected to vary between any two countries according to the nature of the economic activity conducted in each (Dunning and Lundan, 2008).

Quaternary care

Quaternary care is considered an extension of “tertiary care” and includes advanced levels of medicine that are highly specialised, not widely used (for example, experimental medicine) and very costly. Quaternary care is typically provided by tertiary care centres (Green and Bowie, 2010: p12).

Regional strategy

Rugman (2000, 2001, 2005) argued that MNEs are regional, rather than global, in their focus. The choice of regional, as opposed to global, strategies is a direct outcome of the inherently regional character of MNEs. This means that the strategies they deploy, such as in marketing and management, address regional and local markets and not the global one per se.
Representative Office

A representative office is an office established by a company to conduct marketing and other non-transactional operations. In the context of healthcare, a good description of the function of a representative office can be found in the 2001 Annual Report of Parkway Holdings: the representative office “assists local and international patients with invaluable resource on specialists’ expertise, personalised patient care and cutting-edge services that are available at Parkway’s hospitals and related facilities in Asia. In addition to providing medical referrals, our friendly and trained customer service officers are always on hand to extend advice and assistance from travel and accommodation arrangements to emergency medical evacuations.”

Second wave or Emerging MNEs

The second wave or emerging MNEs refer to MNEs from developing countries which are engaged in a second wave of FDI activity since the early 1990s, which is distinct from the first wave in the 1970s and 1980s. The second wave MNEs tended to come from countries at a higher stage of industrial development that had evolved structurally towards industrial sectors which are capital- and knowledge-intensive. These firms engaged in simultaneously in outward FDI to locations with appropriate comparative advantages (often lesser developed countries) for their natural-asset intensive and labour-intensive activities, while, at the same time, they also engaged in both market-seeking and asset-augmenting FDI in the more developed countries. In comparison, the first wave MNEs showed a strong and marked trend to focus their investments in neighbouring and other countries which were at a similar or an earlier stage of development (due to their lack of international experience, hence they sought locations with resource endowments for markets which were broadly similar to those of their home countries (Narula, 2010).

Secondary care

Secondary care services are provided by medical specialists or hospital staff members to a patient who was referred by a general practitioner who first diagnosed or treated the patient (Green and Bowie, 2010: p12).

Services

Many scholars have offered various definitions of service, but for the purpose of this dissertation, the author adopts the definition proposed by Gronroos (1990: p27), namely: “A service is an activity or series of activities of more or less intangible nature that normally, but not necessarily, take place in interactions between the customer and service employees and/or systems of the service provider, which are provided as solutions to customer problems.”

Erramilli (1990) categorised services into “hard services” and “soft services”. The former refer to services which can be embodied in some tangible form, ie, separable, while the latter refer to services which need to be delivered in close physical proximity, enabling production and consumption to take place simultaneously, ie, non-separable.
Small and Open Economy, or SMOPECs include countries like Austria, Belgium, Denmark, Finland, Ireland, Israel, the Netherlands, New Zealand, Norway, Portugal, Singapore, Sweden and Switzerland, which have integrated themselves with the world economy by lowering or eliminating their trade barriers (Benito et al., 2002; Dick and Merret, 2007).

Strategic alliance Strategic alliances are voluntary arrangements between firms involving exchange, sharing, or co-development of products, technologies, or services (Gulati, 1998: p293).

Tertiary care Tertiary care services are provided by specialised hospitals equipped with diagnostic and treatment facilities not generally available at hospitals other than primary teaching hospitals. This level of service is also provided by doctors who are uniquely qualified to treat unusual disorder that do not respond to therapy that is generally available as secondary medical services. Examples include cardiothoracic and vascular surgery, neurosurgery, and radiation oncology (Green and Bowie, 2010: p12).

Timing of entry “Timing of entry” is one of the three dimensions that make up the internationalisation process (Melin, 1992). It has two aspects, namely, the age at which a firm initiates international activity, and the time of international development, which is the timing of the different activities undertaken by the firm along its path to internationalisation (Gallego et al, 2009).
CHAPTER 1 - INTRODUCTION

1.1 INTRODUCTION

This research looks at the phenomena of established hospital groups expanding beyond their home country by setting up operations in less developed countries, and patients travelling out of their country for healthcare services. Patients travelling overseas for healthcare services is not a new phenomenon, but with globalisation\(^1\), healthcare services have become increasingly “tradeable”, with patients having a wide range of treatment packages to choose from, not just from their local hospitals but also overseas, at different pricing levels to meet the requirements of different categories of patients. This has led to an increase in people travelling overseas for healthcare, which is sometimes referred to as “medical tourism”. Related to this phenomenon, hospital groups are expanding overseas, not just to serve the local patients but for other reasons as well, such as to set up a conduit to refer patients with more complicated conditions to their home base, or to tap the factor advantages of the location to offer lower cost alternatives for medical travellers. These are exciting developments which have been under-researched over the years, especially from a firm perspective.

This research will study the phenomena by looking at the internationalisation\(^2\), or international expansion, of healthcare firms from Singapore. It is a timely study especially given the increasing economic integration within the region which Singapore is part of – the Association of South East Asian Nations (ASEAN) – which has a firm roadmap to form the ASEAN Economic Community (AEC) by 2015.

Leveraging the in-depth primary knowledge of the Southeast Asian healthcare industry of the author and extensive analysis of data on four Singapore-based healthcare groups which have been active in growing their business overseas from Singapore, the research examines the strategies adopted by healthcare firms in their overseas expansion, the

\(^1\) The OECD (2010) defined globalisation from an economic perspective: “The term globalisation is generally used to describe an increasing internationalisation of markets for goods and services, the means of production, financial systems, competition, corporations, technology and industries”, while Clark and Knowles (2003: p368) defined it as “The process by which economic, political, cultural, social, and other relevant systems of nations are integrating into World Systems”. The latter definition is particularly suited for this study given the role that the political and cultural systems play in the internationalisation of services.

\(^2\) There are many ways of explaining and defining the internationalisation of firms; for the purpose of this research, “internationalisation” refers to the “the process of increasing involvement in international operations” by a firm (Welch and Luostarinen, 1988: p36).
reasons for their choices, and the factors influencing how they execute their respective strategies, in terms of market selection, entry modes and timing of entry\(^3\). The study also looks at the impact of regional integration on the strategies of these firms. These findings will be evaluated against existing literature relating to the internationalisation of firms, including those involving services firms, healthcare entities and Multinational Enterprises\(^4\) (MNEs) from Singapore.

This research will be relevant to both academics and practitioners. On the academic side, firm-level research on the internationalisation of service firms has historically been scarce, and this is even more so for healthcare service firms and service MNEs from Southeast Asia. The few firm-level research involving the services sector are typically focused on a narrow range of service sub-sectors, such as financial services and professional services. This research should yield valuable insights for literature relating to the internationalisation of service firms, MNEs from Asia, and specifically, healthcare firms.

From the practitioners’ perspective, this research provides a deeper understanding of the internationalisation strategies taken by healthcare firms, and more generally, service firms. The author had chosen this topic as he felt the research will provide useful insights for him, the firm he works for, and his fellow practitioners, as they develop and review their strategies for overseas expansion. In particular, with the increasing economic integration in the region, there will be new opportunities which firms can capitalise on, as well as threats they should prepare for. This study yields valuable insights for practitioners on this aspect.

### 1.2 RESEARCH BACKGROUND

#### 1.2.1 Globalisation of Healthcare

For healthcare, travelling overseas to seek medical advice or treatment is not a new phenomenon. For the elites of developing countries, the consumption of healthcare overseas is part of a general pattern of consumption of foreign goods and services, ...

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\(^3\) There are two aspects to the “timing of entry”, namely, the age at which a firm initiates international activity, and the time of international development, which is the timing of the different activities undertaken by the firm along its path to internationalisation (Gallego et al, 2009).

\(^4\) A Multinational Enterprise is an enterprise that engages in foreign direct investment and owns or, in some way, controls value-added activities in more than one country (Dunning and Lundan, 2008).
which either cannot be found, or are deemed of lower quality, in their home countries. Hospitals in the United States, such as the Mayo Clinic\(^5\) for example, are among the choice options of the developing world elite when they are in need of medical care. Over time, with rising standards of healthcare in other developed and even some developing nations, centres of excellence for healthcare have emerged in other parts of the world. Destination countries now include developing countries that have positioned themselves to take advantage of this new market by adopting the standards and processes of the developed countries (Segouin et al, 2005). These provided more options for medical travellers.

In recent times, the privilege of travelling to another country for healthcare has come within the reach of the Middle Class from the developing countries. In addition, there is a fairly new phenomenon of people from developed countries travelling to developing countries to seek medical care. Many reasons have been suggested for this, including the long waiting lists in the healthcare services of some developed countries, and the high costs of care in these countries coupled with a lack of medical insurance, or under-insurance (Garcia-Altes, 2005).

The growing affluence of the Middle Class in the developing countries, coupled with the increasing professional standards of healthcare professionals produced by these countries, also attracts established foreign operators to invest in setting up higher quality private healthcare services in the developing countries. This is especially evident in America and Europe, but is also starting to take place in Asia.

All these developments are set to grow further as the world becomes more globalised. With globalisation, transport links will become even better, information flow will become even faster and richer, healthcare delivery will become increasingly standardised, and standards of healthcare professionals will become more uniform (Segouin et al, 2005). These are further facilitated by the efforts of the World Trade Organization (WTO), which seeks to encourage trade, including for healthcare services, by reducing trade barriers and encouraging cross-border investments. This provides new opportunities for healthcare operators who are prepared to venture beyond their home base to invest in new facilities offshore or attract patients.

\(^5\) Mayo Clinic, together with its sister hospitals, Saint Marys Hospital and Rochester Methodist Hospital, in Rochester, USA, is the largest integrated medical centre in the world, providing comprehensive diagnosis and treatment in virtually all medical and surgical specialties.
1.2.2 Regional Integration in ASEAN

The other interesting development in the context of this research is the regional integration in ASEAN. Discussion on a framework to enhance integration within the region started in 1992 when the ASEAN Free Trade Area (AFTA) agreement was signed in Singapore. ASEAN countries also signed the ASEAN Framework Agreement on Services (AFAS) in 1995, which aimed to substantially eliminate restrictions on trade in services among ASEAN countries in order to improve the efficiency and competitiveness of the provision of services in the region. In 2007, ASEAN countries took the economic integration of the region one step further by pledging to form the ASEAN Economic Community (AEC) by 2015.

Since then, much progress has been made. The AFTA was fully implemented in 2010. In the area of services, ASEAN has concluded 7 packages of commitments, of which healthcare was included in the 6th Package concluded in November 2007. The Roadmap for Integration of Healthcare Sector in ASEAN covers a range of measures, including mutual recognition of healthcare professionals, measures to promote healthcare investments within ASEAN, facilitation of travel by harmonizing border procedures, facilitation of cross-border movement of patients and accompanying persons, and mutual recognition of laboratory results. Besides, as a first step towards AEC, four priority sectors had their foreign ownership limits raised to 70% in 2010 for ASEAN investors, including healthcare.

Besides these healthcare specific measures, developments in other areas have also strengthened the integration of healthcare services within ASEAN. For example, the implementation of visa exemption for intra-ASEAN travel by ASEAN nationals had reduced the hassle of cross-border travel. With liberalisation of air travel within the region, flights have become more frequent and affordable, hence making intra-region travel more convenient. The emergence of budget airlines in recent years had made air travel even more affordable. Besides, with low-cost telecommunications and

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6 Under AFTA, tariffs on goods traded within the ASEAN region, which meet a 40% ASEAN content requirement, have been reduced to 0-5% by 2010.
7 The ASEAN Framework Agreement on Visa Exemption was signed in July 2006 and implemented from January 2008.
widespread use of Internet, communication among people in the different countries has become easier and seamless.

1.3 OBJECTIVES OF THE RESEARCH

The last few decades have demonstrated significant changes in regard to the internationalisation of service industries. The importance of services to the world economy has increased rapidly, and most service industries have increased their international involvement significantly (Javalgi and Martin, 2007). However, most early theories on firm internationalisation were based on research on manufacturing companies. There are still uncertainties as to how well the traditional theories based on manufacturing companies apply to service companies (Bouquet et al, 2004).

Researchers have indicated many different service characteristics, such as intangibility, inseparability, and heterogeneity to be reasons for the deviations in the process of internationalisation between manufacturing and service companies that traditional process theories have not been able to explain (Erramilli, 1990; Knight, 1999; Javalgi et al, 2003). However, there seem to be significant differences in how different service sectors have internationalised (Lovelock and Yip, 1996), as services are heterogeneous in relation to their internationalisation strategies (Knight, 1999; Bouquet et al, 2004). Thus, there are calls by several researchers (e.g., Lovelock and Yip, 1996; Westhead et al, 2001; Knight, 1999; Bouquet et al, 2004), to extend the existing theories of internationalisation by studying industries and sectors that have not been the focus of earlier research, or which have recently faced significant changes in their business environment, or both. This research aims to answer these calls by studying a rather under-researched area of the service industry – healthcare.

This multiple-case study will analyse in depth four healthcare companies from Singapore which are active in internationalisation. While the healthcare sector is a relatively under-researched area within the service industry, firm-level research on this sector is even rarer, hence this research should yield some valuable insights on the behaviour of internationalising healthcare firms. By confining the research to Singaporean firms, it allows the host country conditions to be held constant and permits a better focus on other factors affecting the internationalisation strategy of the firms. Moreover, using Singapore as the country of focus allows internationalisation of firms
from a small and open economy\(^8\) (SMOPEC), of which Singapore is a classic example, to be studied. The choice of Singapore also allows the impact of regional integration on the internationalisation strategies of MNEs within the Asian region to be studied first hand.

### 1.4 SCOPE OF RESEARCH

The research will focus on the private healthcare firms. The restructured hospitals in Singapore, which are the de-facto public hospitals in Singapore and deliver healthcare services which are subsidized by the government, generally focus on the needs of the local population and are less involved in overseas expansion. They do receive some foreign patients given their reputation in the region in terms of clinical quality, but that generally constitutes only a small percentage of their patient load.

For greater comparability, and in line with the phenomena which this research seeks to investigate, the study will focus on healthcare groups with hospital operations, which is a subset of “healthcare firms”. The more generic definition of “healthcare firms” can include all types of firms dealing with healthcare services and products, for eg, General Practitioner chains, firms which deal with health supplements or even firms dealing with health spas, which would make the analysis complicated.

On the choice of the case firms, the author selected four private Singaporean healthcare firms which are active in expanding their overseas footprint. While it is possible to confine internationalisation of healthcare firms to investment in overseas hospital facilities, this study will take into account other forms of internationalisation which generally fit the definition of “increasing involvement in international operations”. Hence, it will cover the various types of overseas activities, including:

- Investment in overseas facilities, including wholly-owned subsidiaries and joint venture\(^9\) projects, as well as both Greenfield projects\(^10\) and acquisitions\(^11\);

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\(^8\) SMOPECs include countries like Austria, Belgium, Denmark, Finland, Ireland, Israel, the Netherlands, New Zealand, Norway, Portugal, Singapore, Sweden and Switzerland, which have integrated themselves with the world economy by lowering or eliminating their trade barriers (Benito et al., 2002; Dick and Merret, 2007).

\(^9\) A joint venture involves the creation of a new organisation with resource contributions from two or more parent firms. The parents share strategic and operational control of the firm (Meyer and Estrin, 2004: p13).
Non-equity involvement with overseas facilities, such as management contract\textsuperscript{12} and consultancy projects, as long as these had impact on patient flow to the home hospitals;

Non-hospital set-ups used to attract and refer foreign patients – clinics, medical centres and representative offices\textsuperscript{13}. Medical centres refer to larger clinics which may house several specialist outpatient clinics or even day surgery facilities. Representative offices are usually small offices manned by non-medical personnel which serve as a one-stop point for patients to make treatment enquiries, book appointments and settle their travel arrangements. In some cases, they also serve as exploratory base for the healthcare group to explore opportunities within the market and set up tie-ups with local partners, including hospitals, corporates and insurance companies.

Given the many types of patients involved in the study arising from the different modes of overseas expansion mentioned above, it will be useful to define the different categories which will be covered.

The first group are the local patients in the host country using the services of the overseas facilities set up by the Singapore healthcare firms. The scope of this group is fairly straightforward.

The other two groups are the “Medical travellers” and “Medical tourists”. These two terms are sometimes used interchangeably, but for the purpose of this study, it is necessary to make a distinction between the two.

\textsuperscript{10} A Greenfield project entails building a subsidiary from bottom up to enable foreign sale and/or production. Real estate is purchased locally and employees are hired and trained using the investor’s management, technology, know-how and capital (Meyer and Estrin, 2004: p12).

\textsuperscript{11} Acquisitions are “purchase of stock in an already existing company in an amount sufficient to confer control” (Kogut and Singh, 1988: p412).

\textsuperscript{12} A management contract is an arrangement under which “the ‘know-how’ of the management of the contractor is transferred to the contractee, who then has the responsibility for undertaking the management services according to the terms of the contract.” (Dunning and Lundan, 2008: p279).

\textsuperscript{13} A representative office is an office established by a company to conduct marketing and other non-transactional operations. In the context of healthcare, a good description of the function of a representative office can be found in the 2001 Annual Report of Parkway Holdings: the representative office “assists local and international patients with invaluable resource on specialists’ expertise, personalised patient care and cutting-edge services that are available at Parkway’s hospitals and related facilities in Asia. In addition to providing medical referrals, our friendly and trained customer service officers are always on hand to extend advice and assistance from travel and accommodation arrangements to emergency medical evacuations.”
Horowitz and Rosensweig (2008) referred “Medical travellers” to those based on the traditional pattern of international medical travel, where patients journey from less developed nations to major medical centres in highly developed countries for advanced medical treatment not available back home, or not at the level of care they desire.

For “Medical tourist”, they referred to those who travel to an assortment of countries at variable levels of development for their health care needs driven by forces outside of the organized health care system and traditional medical referral network. Such patients can include middle class patients from, say, United States, who requires elective surgical care but has inadequate or absent health insurance coverage. It also covers patients who desire elective procedures such as cosmetic surgery, dental reconstruction, fertility treatment and gender reassignment procedures, but do not have sufficient resources to comfortably buy care in their local market, but adequate for them to obtain care in a low cost offshore medical centre. For patients from Canada, Britain and other countries where a governmental health care system controls access to services, the primary motivation to abandon the local medical system is the desire to have timely treatment, circumventing delays associated with long waiting lists. Some patients choose to have medical care abroad because of the opportunity to travel to exotic locations and to vacation in luxurious surroundings. Finally, patients undergoing sex change procedures, cosmetic surgery, and alcohol or drug rehabilitation often have greater confidence that their privacy and confidentiality will be protected in a faraway health care facility. While Horowitz and Rosensweig (2008) acknowledged that the term “medical tourist” might not accurately reflect the true nature of a patient’s situation, they have chosen to stick with the term as it is in common usage, and provides an unambiguous way of differentiating it from the traditional model of international medical travel. They also noted that other terms suggested, such as “medical value travel” and “global health care”, have their own respective shortcomings.

1.5 KEY RESEARCH QUESTIONS

Based on the above objectives and scope, the main research question for this study will be – How do private healthcare firms from Singapore internationalise? In other words, what are their internationalisation strategies? This will involve studying not just the firms’ strategy in general, but also by looking more closely at the three dimensions that
make up the internationalisation process (Melin, 1992), namely, entry mode choice (how), choice of markets (where) and timing of entry (when). Besides, given the increasing integration in the Asian region, the study will also specifically consider the issue of how regional integration has influenced the internationalisation strategy of these healthcare firms.

The dissertation is organised as follows. In Chapter 2, the literature on the internationalisation of a firm, including a discussion of recent challenges to traditional theories, is reviewed. Literature on internationalisation of service firms, on MNEs from small countries and emerging economies, and on healthcare services will also be discussed. Chapter 3 will provide some background on the healthcare industry in Singapore and the region. Building on the discussions in the first 3 chapters, a conceptual framework for the study will be proposed in Chapter 4, followed by the development of propositions on the different aspects of internationalisation to guide the research. Chapter 5 discusses the research methodology, with the case studies being presented in Chapter 6, and the cross-case analysis in Chapter 7. The results from the analysis will be further discussed in Chapter 8, and finally, conclusions are drawn, and theoretical and managerial implications presented in Chapter 9.

1.6 CONTRIBUTIONS OF THE RESEARCH

This study aims to make significant contributions to both knowledge and management practice.

In terms of knowledge, firm-level research on the internationalisation of service firms has historically been scarce, and this is even more so for healthcare service firms and service MNEs from Southeast Asia. The few firm-level research involving the services sector are typically focused on a narrow range of service sub-sectors, such as financial services and professional services. This research should yield valuable insights for literature relating to the internationalisation of service firms, MNEs from Asia, and specifically, healthcare firms.

The research will also provide new insights on the applications of the various internationalisation theories that have emerged over the years, in particular, those that have emerged over the past decade for which firm-level applications are still limited,
especially in the context of healthcare services and a Southeast Asian country. The findings from this research should extend traditional theories by providing more understanding of the internationalisation of service MNEs from Singapore, specifically on healthcare MNEs. The findings can possibly be used also as reference for future studies involving other service industries and in other regions that are similarly undergoing regional integration.

The study hopes to use the empirical findings from the case studies to develop a conceptual model which will highlight the key factors which have influences on the internationalisation of healthcare firms. As far as the author is aware, this will be the first time that such a model has been specifically developed for healthcare firms, so hopefully it will create a breakthrough in terms of our understanding of the internationalisation of these firms. The model should make a useful contribution to extant literature in terms of highlighting additional factors which should be considered when studying the internationalisation of service firms, in particular, healthcare MNEs. It will be a good framework which researchers can use to conduct further research on internationalisation of healthcare firms, and possibly other services as well.

From the practitioners’ perspective, this research should provide a deeper understanding of the internationalisation strategies taken by healthcare firms, and more generally, service firms. The research should yield valuable insights for practitioners as they develop and review their strategies for overseas expansion. The study also aims to offer insights for practitioners on the impacts of the increasing economic integration in the region on the internationalisation of healthcare firms.

The conceptual model mentioned earlier will also be useful for practitioners, not just as a source of reference on the factors that influence the internationalisation of healthcare firms, but also for identifying measures or actions that managers can take to internationalise their firms effectively, some of which will be discussed at the end of this thesis in relation to the implications on managerial practice.

Beyond the academics and the practitioners, the findings of the study will also be relevant to governments in the region, as well as business owners and investors. For the governments, the findings will be useful in allowing them to identify the approach they should adopt in positioning their countries to facilitate their own healthcare firms in
their internationalisation efforts, as well as in attracting foreign investment in the healthcare arena. As for business owners and prospective investors for the healthcare sector in ASEAN, this study will provide them with a clearer understanding of the direction which the private healthcare sector in ASEAN is developing, and it will allow them to better evaluate their plans and expansion strategy in the region.

Besides parties within the region and within the healthcare sector, the study should yield useful knowledge for other service firms in Singapore and in the region whose nature of business has some similarities to the healthcare firms studied, for example, hospitality sector, other healthcare services, etc. It should also bear useful learning points for managers of service companies and policy makers from other SMOPECs with similar operating conditions as Singapore.

1.7 CHAPTER CONCLUSION

This chapter has set the context for the research by providing the background, the objectives and scope of the research. Essentially, the research aims to study the phenomena of healthcare firms expanding outside their home country and patients travelling overseas for healthcare, using a multiple-case study of four private healthcare firms from Singapore. In terms of internationalisation activities, the research will cover investment in overseas hospital facilities, non-equity involvement in overseas facilities, as well as non-hospital set-ups used to attract and refer foreign patients to the home base. The research will study how the private healthcare firms from Singapore internationalise, including their entry modes, choice of markets and timing of entry, as well as considering the impacts that regional integration will have on the firm’s internationalisation strategy.

Having introduced the key research question, the next chapter will review the various strands of literature that are relevant for this research.
CHAPTER 2 – LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents a critical evaluation of existing literature on internationalisation of multinational enterprises (MNEs). It provides a theoretical and conceptual foundation that is necessary for an understanding of the internationalisation of healthcare firms, the subject of this research. It also provides background information necessary for the interpretation of the case studies, taking into account certain special characteristics of MNEs from Singapore.

The theoretical underpinnings and empirical research spans a wide range of literature, including literature relating to firm internationalisation and internationalisation of service firms, together with relevant theories relating to the internationalisation of healthcare firms and firms from Southeast Asia and small and open economies (SMOPECs) (specifically, Singapore).

The chapter will first start with a discussion on some of the main theories relating to the 2 main strands of literature on firm internationalisation, namely, the determinants and process of internationalisation. For the former, some of the main theories that will be covered include the contributions of Hymer (1960), Vernon’s (1966) Product Life Cycle Theory, the internalisation paradigm proposed by Buckley and Casson (1976, 1998) and the Eclectic Paradigm of Dunning (1980, 1998, 1993). For the latter, Johanson and Vahlne (1977, 1990)’s Uppsala Internationalisation Process Model and the Network Theory (Johanson and Mattsson, 1988) will be covered.

This will be followed by discussion on some recent developments in this field, including an update on the Uppsala internationalisation process model by Johanson and Vahlne (2009), literature on regional focus of MNEs, especially by Rugman (2000, 2001, 2005); on the impact of regional integration on internationalisation strategy; on the concept of “Global factory” by Buckley and Ghauri (2004); and on timing of entry.

The next section will review literature relating to internationalisation of service firms, covering the applicability of prevailing internationalisation theories to service firms, the “industrialization” of services (Segal-Horn, 1998), factors that influence the
internationalisation of services, entry modes of services, regional focus of service firms, and application of the “Global factory” concept to services.

On the internationalisation of firms from Singapore, the literature reviewed includes those pertaining to the behaviours of emerging or second wave MNEs\textsuperscript{14}, MNEs from Asia, and MNEs from SMOPECs.

Finally, on the internationalisation of healthcare firms, some existing firm-level studies will be reviewed, as well as relevant research on trade in healthcare services in ASEAN. Literature relating to the increasing commodification of healthcare services will also be reviewed.

2.2 INTRODUCTION ON LITERATURE RELATING TO FIRM INTERNATIONALISATION

There are generally two main strands of literature that deal with firm internationalisation (Dunning and Lundan, 2008). One strand deals with the determinants of internationalisation, or the factors that drive firms to internationalise, including the reasons and motivations for MNEs to exist. Some of the main theories for this strand of discussion were the contributions of Hymer (1960), Vernon’s (1966) Product Life Cycle Theory, the internationalisation paradigm proposed by Buckley and Casson (1976, 1998) and the Eclectic Paradigm of Dunning (1980, 1998, 1993).

The other main strand of literature deals with the process of internationalisation. Some of the main theories on this aspect are the Uppsala Internationalisation Process Model of Johanson and Valhne (1977, 1990) and the Network Theory (Johanson and Mattsson, 1988).

\textsuperscript{14} The second wave or emerging MNEs refer to MNEs from developing countries which are engaged in a second wave of FDI activity since the early 1990s, which is distinct from the first wave in the 1970s and 1980s. The second wave MNEs tended to come from countries at a higher stage of industrial development that had evolved structurally towards industrial sectors which are capital- and knowledge-intensive. These firms engaged in simultaneously in outward FDI to locations with appropriate comparative advantages (often lesser developed countries) for their natural-asset intensive and labour-intensive activities, while, at the same time, they also engaged in both market-seeking and asset-augmenting FDI in the more developed countries. In comparison, the first wave MNEs showed a strong and marked trend to focus their investments in neighbouring and other countries which were at a similar or an earlier stage of development (due to their lack of international experience, hence they sought locations with resource endowments for markets which were broadly similar to those of their home countries (Narula, 2010).
These theories will be discussed in this section before moving on to more recent developments in the literature on firm internationalisation.

### 2.2.1 Hymer (1960)

Many international management theory sheds light on the question of what drives firms to go international and how they do so. Hymer (1960, published 1976) was the first author to focus on foreign direct investment as a tool used by MNEs to transfer and exploit proprietary resources abroad. Interestingly, his view was that they would face location disadvantages vis-à-vis indigenous firms in host countries such as language and cultural barriers, lack of knowledge on the local socio-economic and business system, expropriation risks, and so forth. which were synthesized under the heading of ‘liability of foreignness’. This implies that MNEs producing in host countries would not benefit to the same extent as indigenous firms from either localized network spillover effects or synergies from the combination of firm level and host country location advantages. Hymer suggested that firms went international to leverage “special advantages” including product market power, superior production techniques, imperfections in input markets, and first-mover advantages. Possessing such special advantages, a national firm could be profitable outside the home country despite the higher costs resulting from its relative ignorance of local conditions abroad.

### 2.2.2 Product Life Cycle Theory

Vernon’s (1966) Product Life Cycle theory explains the life cycle of an innovative product from its initial manufacturing in a developed country like the USA to being eventually produced in developing countries. According to this theory, product innovation typically takes place in developed countries in the early stages of the product life cycle. As the product matures, mass production techniques are employed and international demand for the product rises, leading to its export. Finally, as the product gets standardised, companies start to manufacture in low-cost locations and developing countries, bringing production closer to the point of consumption. Oftentimes, the product is then exported from these foreign locations back to the home country.
This dynamic approach, aimed at explaining market-seeking Foreign Direct Investment\(^{15}\) (FDI), neglected two key aspects of the linkages between MNEs and location advantages. First, it overlooked the fact that MNEs may use foreign markets to reduce risks, although this was taken into account in a later publication (Vernon, 1983). Second, it overlooked the contribution of host country location advantages to the MNE's rejuvenation or extension of its knowledge base. However, Vernon's dynamic approach went far beyond conventional models that attempted to explain FDI flows as an almost mechanistic reaction to exogenous macro-level location advantages such as favourable exchange rates or relative labour costs (Aliber 1970; Cushman 1985; Culem 1988).

2.2.3 Internalisation Paradigm

The internalisation paradigm has been in existence from the late 1970s with Buckley and Casson as its chief proponents (Buckley and Casson, 1976, 1998). Central to the paradigm is the avoidance of transaction costs by companies “internalising” the intermediate product market. Firms are likely to engage in FDI whenever they perceive that the net benefits of their common ownership of domestic and foreign activities, and the transactions arising from them, are likely to exceed those offered by external trading relationship. The core contention of the paradigm is that given a particular distribution of factor endowment, the extent and content of MNE activity will be positively related to the costs of organising cross-border markets in intermediate goods (Dunning and Lundan, 2008). The paradigm, like other industrial organization-based theories of the firm, assumes perfect competition, homogeneous firms and mobility of resources among firms, including perfect transferability of know-how between a parent company and its foreign subsidiary. Growth in companies continues until the benefits of further internalisation are outweighed by the costs.

Whilst the paradigm has remained one of the major schools of thought in internationalisation theory and has been tested in several different domains (Buckley and Casson, 1996, Oviatt and McDougall, 1994), it fails to recognize that strategic considerations, such as capability development or enhancement, may be the motivation for adopting a collaborative mode of entry (Kogut, 1988). While it explains why a firm

\(^{15}\) Foreign Direct Investment is defined as an “investment involving a long-term relationship and reflecting a lasting interest of a resident entity in one economy (direct investor) in an entity resident in an economy other than that of the investor. The direct investor’s purpose is to exert a significant degree of influence on the management of the enterprise resident in the other economy” (IMF, 1993).
may choose FDI as an entry mode, it does not explain the role of location advantages in entry mode choice.

2.2.4 Eclectic Paradigm

Dunning (1980; 1988; 1993) brought many of these earlier theories of internationalisation together in his eclectic paradigm, which identifies three major advantages that multinational companies possess: 1) Ownership specific advantages (O) including property rights and/or intangible asset advantages and advantages of common governance; 2) Location-specific advantages (L); 3) Internalisation-incentive advantages (I). Dunning argues that firms pursue foreign direct investment when they enjoy ownership, location and internalisation advantages. According to the OLI paradigm, the prerequisite for FDI is existence of some competitive advantages which the firm can exploit in foreign markets to compensate for the liability of foreignness. Whether and where it will actually engage in FDI will depend on finding a suitable location with sufficient country-specific advantages that match the particular FDI motivations of the MNE.

Firms’ intent in choosing a particular FDI location can be categorized into market-seeking, efficiency-seeking, and resource-seeking behaviour (Dunning, 1998). Market-seeking FDI will tend to go to large economies or to those economies that cannot be accessed other than via FDI (e.g., ones protected by trade barriers). Efficiency-seeking FDI will go to countries that can provide the best business environment for fully realizing the internalisation benefits of the firm’s assets. Resource-seeking FDI will go to those countries that are abundant in the resources sought (e.g., crude oil or low labour costs).

There has been wide empirical support for the eclectic paradigm both from studies in manufacturing and service (for example, Agarwal and Ramaswami, 1992; Brouters et al, 1999; Galan and Gonzalez-Benito, 2001; Javalgi et al, 2003). However, most studies researched firms in developed countries (Morck and Yeung, 1992). This paradigm has been criticised for not being able to explain the internationalisation of firms from developing countries which are often latecomers in global competition and that possession of ownership advantage at home may not be sufficient at the initial stages of foreign venturing (Mathews, 2002; Li, 2003). In addition, it was also overly focussed on
FDI at the expense of other operation modes such as exporting and alliances (Dunning, 1995; 2000). In response to these criticisms, Dunning (1995; 2000) provided an updated framework suggesting that some of the ownership advantages of firms follow rather than lead internationalisation as firms may pursue asset seeking strategies to fill resource gaps before they can embark on market seeking strategies where they will exploit certain types of proprietary resources.

2.2.5 Uppsala Internationalisation Process Model (also known as the Establishment Chain or Stages Model) and Related Variants

On the internationalisation process of firms, the Uppsala model (Johanson and Valhne, 1977; 1990) was one of the first major attempts to conceptualise the way in which firms internationalise. Drawing on the behavioural theory of the firm (Cyert and March, 1963), it argues that the process of internationalisation is an incremental interplay between knowledge and commitment. The firm starts exporting to neighbouring countries where psychic distance is short and as they accumulate more experiential knowledge, they take more risks by first establishing sales subsidiaries and then manufacturing facilities in more distant countries.

There is a Helsinki variant of the process model by Luostarinen (1979, 1994) which like the Uppsala model, emphasises the importance of international experience and organisational learning from a firm’s own activities as a source of that experience. However, instead of being limited to market specific knowledge, Luostarinen made a distinction between target market and firm patterns of internationalisation. He claimed that more important than target market knowledge is the knowledge of a firm’s internationalisation process itself. He argued that this experience accumulates, and thus the later phases of a firm’s internationalisation can be more rapid than, and not as deterministic, as the first market entries.

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16 In International Business, “Exporting” is the sale of products or services to customers located abroad, from a base in the home country or a third country. Based on this definition, producers of soft services (namely, non-separable services) face difficulty in exporting their services given the close producer-consumer interaction required (Cavusgil et al, 2008: p5).

17 Psychic distance can be defined as “the factors preventing or disturbing firms learning about and understanding of a foreign environment” (Vahlne and Nordstrom, 1992: p3). It represents a transaction cost of doing business between countries, although psychic distance costs may also be expected to vary between any two countries according to the nature of the economic activity conducted in each (Dunning and Lundan, 2008).
To add to these first internationalisation process theories, Welch and Luostarinen (Welch and Luostarinen, 1988, 1993; Luostarinen and Welch, 1990) introduced inward and co-operation modes in addition to traditional outward modes of internationalisation in their more holistic model of internationalisation. They argued that firms in many cases are able to gain valuable international experience from their inward operations prior to entering international markets themselves with outward operations, thus making it possible to internationalise more rapidly than the traditional models would suggest. In their model, cooperation modes often followed outward operations.

Although these process models have small differences, all of them place significant emphasis on the role of organisational learning to develop international experience needed in the internationalisation process. The ability of the Uppsala model to explain firm internationalisation has been validated by studies of both manufacturing and service MNEs (Engwall and Wallenstal, 1988; Chetty and Eriksson, 2002; Hohenthal et al., 2003). However, the model has been criticised for its deterministic nature as many studies have found that firm internationalisation is not always path dependent and that stages of the commitment process are often bypassed depending on the firm’s managerial behaviour (Cavusgil, 1980). The theory also ignored contractual entry modes and joint ventures (Root, 1987; Sharma and Erramilli, 2004).

Johanson and Vahlne (2006), in their response to the criticism of their theory, argued that rather than trying to develop originally a predictive model, the establishment chain was describing an empirical phenomenon, and the model was more about learning and commitment building in general. Their intention was not to define one generalisable pattern of internationalisation. Notwithstanding the limitations of the process models as general theory for use in predicting the internationalisation processes of most companies (Johanson and Vahlne, 2006), it is generally acknowledged that the models have an important role in contributing to the understanding of internationalisation (Luostarinen, 1994; Prasad, 1999; Tihanyi et al, 2005).
2.2.6 Network Theory

More recently, network\textsuperscript{18} theory has been proposed and appears to hold promise, especially for service industries. Developed from the late 80s, it makes use of social exchange and resource dependency theories (Coviello and McAuley, 1999). It states that firms engaged in distribution and production form systems of relationships developed mainly among customers, suppliers, competitors, and governments (Johansson and Mattsson, 1988). Networks may take many forms and include strategic alliances\textsuperscript{19}, joint ventures, licensing agreements, subcontracting, joint research and development, and joint marketing activities (Ireland et al, 2001). The networks that develop are the result of a cumulative process with relationships being made, extended, and terminated. As firms internationalise, the number and strength of the relationships among different parts of the network increase. As internationalisation is based upon the organization’s set of network relationships rather than company-specific advantages, externalization rather than internalisation takes place (Coviello and McAuley, 1999). An important point is that the long-term survival of the firm is dependent upon resources controlled by others. A firm’s success in entering new international markets may be more dependent on its relationships within current ones than it is on the cultural and other characteristics of the chosen one.

While the network theory is useful in overcoming some of the weaknesses of existing theories on internationalisation, it is not without limitations. The network approach has received criticism for having limited strength for understanding the pattern of internationalisation, not offering very precise conclusions, including too many variables (Björkman and Forsgren, 2000), having indistinctive criteria for differentiating between different firm types like the early and late starters (Chetty and Blankenburg Holm, 2000), not offering satisfactory models for predictions (Björkman and Forsgren, 2000) and concentrating on larger and/or manufacturing companies. Further, the model does not include exogenous variables that often result in internalisation, such as the level of domestic competition and government policies towards FDI (Chetty and Blankenburg Holm, 2000).

\textsuperscript{18} A network is defined as “a voluntary arrangement between two or more firms that involves durable exchange, sharing or co-development of new products and technologies” (Ireland et al, 2001: p7)

\textsuperscript{19} Strategic alliances are voluntary arrangements between firms involving exchange, sharing, or co-development of products, technologies, or services (Gulati, 1998: p293).
2.2.7 Recent Developments

While the two strands of firm internationalisation literature reviewed about have different focus, they are complementary rather than contradictory. The various theories covering determinants of internationalisation explain why companies internationalise, while the process theories focus on the dynamic process and patterns of internationalisation. As discussed above, these theories have faced some criticisms, due to recent changes in the international business environment which they were unable to address, and to issues not emphasised by these early internationalisation models. While these theories have remained important in explaining internationalisation phenomena, there are new theories that have been developed to extend some of them or to address new phenomena which were not addressed in the past. Some of these are discussed in this sub-section.

2.2.7.1 Uppsala 2009 Model

Johanson and Vahlne (2009) revisited the Uppsala internationalisation process model in the light of changes in business practices and theoretical advances that have been made since 1977. For example, the business environment is viewed as a web of relationships, a network, rather than as a neoclassical market with many independent suppliers and customers. Outsidership, in relation to the relevant network, more than psychic distance, is the root of uncertainty.

They posit that internationalisation is best seen as the outcome of firm actions to strengthen network positions by what is traditionally referred to as improving or protecting their position in the market. Drawing on a business network view (e.g., Coviello and Munro, 1995, 1997; Håkansson, 1982; Scott, 1995), Johanson and Vahlne (2009) argue that the challenges faced by firms involved in international ventures and also the possibilities that they may enjoy are less a matter of country specificity than of relationship specificity. As they see it: “markets are networks of relationships in which firms are linked to each other in various, complex and, to a considerable extent, invisible patterns. Hence insidership in relevant network(s) is necessary for successful internationalisation”. They point out further that relationships not only offer firms an opportunity to learn, but also to build trust and commitment, which they view as essential prerequisites for internationalisation.
According to Johanson and Vahlne (2009), networks have impacts on a firm's internationalisation and the internationalisation process depends on the network it belongs to. Obviously, the partner has a big influence on where the focal company will go. It is an easy option to follow the partner into a market where it has a strong position. But also the new market might be the one where both parties see opportunities. These opportunities could arise in the first step abroad, but as well in the later stages of internationalisation. If the focal firm sees opportunities in the markets where it does not have current partners or networks, it may start building new connections with a firm which is already operating in a network there. Finally, after establishing relationships with customers, it may bypass the middleman and set up its own subsidiary. Short psychic distance makes it easier to establish and develop relationships, which is a necessary but not sufficient condition for identification and exploitation of opportunities (Johanson and Vahlne, 2009).

2.2.7.2 Strategic Alliance

Related to the concept of network is the concept of strategic alliance. As discussed earlier, the emergence of strategic alliances challenged the traditional internationalisation theories that were based on studies of large internalised MNEs (Dunning, 1995). This development is most evident in rapidly growing industries, industries undergoing transition and environments with high uncertainties (Bartlett and Ghoshal, 1992; Contractor and Lorange, 2002). Strategic alliances can be divided into two main groups: relational contracting and equity joint ventures (JVs) (Gulati et al, 2000; Contractor and Lorange, 2002), the latter usually being more long-term arrangements. Contractual agreements include R&D cooperation and long established buyer-supplier relationships (Gulati et al, 2000; Contractor and Lorange, 2002). In many traditional internationalisation process theories, these operation modes were somewhat overlooked, as they often classified entry modes either as direct investments or as non-committed modes such as exporting, and focused less on the hybrid of entry modes and continuum in the share of ownership in different joint-venture structures and non-equity alliances. One exception was the research of Luostarinen and Welch (1990), who did include cooperation modes in their model of international market entry.
Many researchers saw strategic alliances as opposite to old internalised and mostly manufacturing-based MNEs (Contractor and Lorange, 2002). Companies now aim to become more flexible and rapid in their actions, and dis-internalise their value-chains (Lowell and Fraser, 1999, Contractor and Lorange, 2002). In most cases, when starting to compete globally, it was the best solution for a globalising company, sometimes even an essential solution, to join forces in a strategic alliance (Ohmae, 1989).

The motivations to enter into strategic alliances may be especially strong for internationalising companies with limited resources or for inexperienced firms (or both), as alliances help fill the gaps in their capabilities and share risks, thus enabling global expansion at a reasonable cost and risk level (Harrigan, 1984; Contractor and Lorange, 1988; Ohmae, 1989; Bartlett and Ghoshal, 1992; Gulati et al, 2000). For example, many smaller companies are able to challenge the dominant industry leaders by forming alliances with each other (Bartlett and Ghoshal, 1992). This allows these companies to achieve the necessary scale that may not be possible using internal resources alone (Dunning, 1995; Bartlett and Ghoshal, 1998; Dunning, 2000; Gulati et al, 2000).

2.2.7.3 Regional Focus of MNEs

Another recent strand of literature has focused on the argument that MNEs are largely regional-focussed rather than global-focussed, notwithstanding the macro forces of globalisation. Scholars such as Buckley et al. (2001), Malhotra et al. (2003) and Dicken (2011) have attested that MNEs are pursuing business strategies which are more consistent with regionalisation than they are with globalisation. In a series of articles which evaluated the globalisation versus regionalisation strategies of MNEs, Rugman (2000, 2001, 2005) argued that the choice of regional, as opposed to global\(^\text{20}\), strategies is a direct outcome of the inherently regional character of multinational firms. This means that the strategies they deploy, such as in marketing and management, address regional and local markets and not the global one per se. Stevens and Bird (2004) also argued that MNEs perceive the global market as a series of interconnected local and regional markets and, hence, pursue strategies which are consistent with this perspective.

\(^{20}\) Rugman and Verbeke (2004) define a global firm as a company with less than 50 percent of sales in its home Triad region and at least 20 percent in each of the two other Triad regions. The Triad regions refer to the regions of Europe, North America and Asia.
The pursuit of regional versus global strategies is partially determined by the imperatives of balancing between globalisation and localisation. There are intense, contradictory pressures on MNEs to integrate across borders as well as to respond to local pressures. As Rugman (2001) emphasises, the success of MNEs is partially predicated on market perceptions of them as belonging to and understanding the market in question, entailing the design of strategies which are consistent with the micro-environment. It is for this reason that MNEs adhere to regional, as opposed to global strategies. Nevertheless, it is important to note that corporations are embracing the basic principles of globalisation, as evidenced by increasing cross-border trade and the widening grip of MNEs on international business, except that they are doing so within the context of regionalisation, or so Rugman would argue.

The regionalisation theory has been criticized by numerous authors (Aharoni, 2006; Westney, 2006; Burr and Fischmann, 2008; Osegowitsch and Sammartino, 2008). The main opposition was to the methodology used to fuel the conclusions made by Rugman and coauthors and their high level of confidence. Aharoni (2006), for example, commented: “What is shocking may be the tendency to offer far reaching conclusions with less than sufficient substantiation, resulting in prescriptions for managers that are not very relevant”. This expressed criticism is also found in other critical reviews of Rugman’s work (Burr and Fischmann, 2008; Osegowitsch and Sammartino, 2008; Aharoni, 2006; Westney, 2006). Furthermore, a limitation of these regionalisation studies is their heavy bias towards the largest MNEs, many of them originating from the largest domestic markets such as the US and Japan. This means that firms from such countries may not have an urgent need to internationalise rapidly (Aharoni, 2006). There are firms that originate outside of these large markets and do not belong to the top 500 firms in the world that may be more “global”, and not including them in an analysis may underemphasise the overall importance of the globalisation phenomenon. Notwithstanding the criticisms, most acknowledged the theory as a useful contribution to MNE research and the “globalisation” versus “regionalisation” debate.

2.2.7.4 Impact of Regional Integration on Internationalisation Strategy

In a further study on regionalisation in 2003, Rugman demonstrated that the various regions are becoming increasingly integrated. He argued that a direct consequence of
this is that there is even less trade between the Triad blocs. With the blocs closing and becoming more inward looking and less global, MNE strategy has to be adapted accordingly. Rugman and Verbeke (2004) further articulated that the conventional framework therefore needs to be augmented since operating in the home Triad region may be associated with new needs for the development of region-bound firm-specific advantages\textsuperscript{21} (FSAs), imposed by regional integration. Hence, regional integration creates both a threat and an opportunity for MNEs as they need to complement the conventional bundles of non-location bound FSAs and location bound FSAs with a set of region bound FSAs. Rugman and Verbeke (2004) also showed empirically that many MNEs have FSAs that are region bound, i.e., they can be deployed across national borders, but only in a limited geographic region.

Using a Transaction Cost Economics approach, Rugman and Verbeke (2005) studied the observation of why large firms adopt regional, rather than global, strategies. They argued that in the case of market-driven geographic expansion, what is conventionally viewed as the MNE's proprietary knowledge (its FSAs), is not just deployed in geographic space in those locations where exogenously determined country-specific advantages\textsuperscript{22} (CSAs) are the greatest in an objective sense. Each foreign location requires location-specific linking investments to meld existing FSAs with CSAs. Such adaptation can take several forms, especially (a) investments in the development of location-bound FSAs in foreign markets (leading to benefits of national responsiveness) to complement non-location bound FSAs, and (b) investments in the development of new, non-location bound FSAs in foreign subsidiaries. It is, ceteris paribus, the extent of these adaptation costs, taking into account the redeployability of the resulting additional knowledge in the relevant locations, that explain why most MNEs expand first in their home region, and may face great difficulty expanding to other regions.

More specifically, many so-called non-location-bound FSAs can only be exploited profitably within the home region, without the need for substantial, location-specific adaptation investments. In addition, location-bound FSAs developed in the home country or in other countries in the home region can be “tuned up” to be fully

\textsuperscript{21} These refer to a set of firm-specific factors that determine the competitive advantage of an organization. An FSA is defined as a unique capability proprietary to the organization. It may be built upon product or process technology, marketing, or distributional skills (Rugman and Li, 2007).

\textsuperscript{22} These are factors unique to each country that confer competitive advantages. They can be based on natural resource endowments (minerals, energy, forests) or on the labour force, and associated cultural factors (Rugman and Li, 2007).
deployable in the entire region, with low-linking investments required, if the countries involved are subject to a low institutional and economic distance amongst themselves. Hence, these FSAs can easily be made “region-bound” (Rugman and Verbeke, 2005).

This process is further enhanced if governments in a region pursue policies that promote internal coherence via administrative and political harmonisation (as in the EU) or even merely via economic integration (as in NAFTA and ASEAN). Such public policies reduce the MNE's needs to engage in idiosyncratic, location-specific adaptation investments to meld existing FSAs and foreign-location advantages. In contrast, host regions may require large adaptation investments driven by home and host region differences in the institutional and economic sphere in order to meld the MNE's existing knowledge base and the host-region location advantages. This requirement for high, region-specific “linking” investments acts as an entry deterrent for many MNEs (Rugman and Verbeke, 2005).

A related point is that inter-Triad region business is likely to be restricted relative to intra-regional sales by government-imposed barriers to entry. The end result is the persistence of MNEs that will continue to earn 80% or more of their income in their home Triad region. There will only be a limited number of purely “global” MNEs in the top 500 according to Rugman and Verbeke (2005).

Lehrer and Asakawa (1999) also observed that the emergence of a regionalisation strategy is a response to external geopolitical pressures, such as the formation of regional trade blocs like the EU, NAFTA and ASEAN. They argued that the formation of regional trade blocs increases within-region homogeneity and between-region heterogeneity, which combine together to make regional strategies more effective. This was corroborated by Schutte (1997), who concluded that ‘the increasing integration of Asia enables MNEs to rationalize production activities in order to exploit cost advantages across countries, and to develop common marketing concepts adjusted to specific Asian needs and communications through increasingly regional media’.

Buckley et al (2001) noted that while the largest MNEs are already perfectly placed to exploit differences in the international integration of markets (Buckley, 1996), regional economic integration has offered both large and small firms the opportunity to enjoy the advantages of a large ‘home’ market, whether it is their native home or their adoptive
home. They added that regional integration that encompasses countries with differential labour markets is becoming increasingly beneficial. This regional integration enables costs to be reduced by locating the labour intensive stages of production in the cheaper labour economies within the integrated area. Firms that serve just one regional market, as well as those that serve several of the regional goods and services markets of the world through horizontally integrated foreign direct investment (FDI), are able to complement this with vertically integrated FDI in quality-differentiated labour markets. Vertical integration also reflects the spatial distribution of supplies of key inputs and raw materials. The MNE achieves advantages through both vertical and horizontal integration. Each strategy is promoted by the ‘size-of-country benefits’ of regional economic integration in goods and services markets, which reduce or eliminate artificial barriers to trade between the members. This maximises the ability of firms to exploit intra-regional differences in factor abundance, including differentiated human capital.

2.2.7.5 Concept of “Global Factory”

Further to the proposition in Buckley et al (2001) on ways to capitalize on regional economic integration, Buckley and Ghauri (2004) developed the idea of the ‘global factory’, which refers to an integrated MNE network that combines core functions, distributed manufacturing, service operations and marketing activities. It is seen as an “ideal” type of modern flexible MNE, and is contrasted with older vertically and horizontally integrated multinationals. This differentiated MNE network chooses location and ownership policies worldwide in order to maximise profits. This often involves outsourcing or offshoring rather than internalisation of activities. It follows that this MNE governance structure can benefit from a flexible network configuration in which subsidiaries are characterised by an entrepreneurial culture, learning effects and linkages with domestically owned firms (Buckley, 2007, 2009).

The move towards a “global factory” orientation has arisen from a combination of the emergence of global demand for products, which has reduced the need for national responsiveness (Mudambi, 2008), and the reality that host countries, rather than just being markets, also increasingly fit into the strategic calculation of MNEs as sites for accessing and exploiting key resources and capabilities (O’Brien et al, 2010). While the role of MNEs has always been to combine internationally mobile resources (such as knowledge) with locationally fixed ones (eg, labour, natural resources, markets), what
has changed within the global factory is the degree to which management has the ability to “fine slice” activities, to locate these in their optimal positions globally and to combine these dispersed activities through coordinating mechanisms that rely decreasingly on ownership. The global factory has perfected control, even at a huge distance, without ownership (Bartels et al, 2009).

In terms of components of the global factory, the global supply chain is divided into three parts. The Original Equipment Manufacturers (OEMs) control the brand and undertake design, engineering and R&D for the product, although these may be outsourced. They are customers for contract manufacturers (CMs) who perform manufacturing (and perhaps logistics) services for OEMs. For the CMs, flexibility is necessary to fulfil consumers’ product differentiation needs (local requirements) and low cost for global efficiency imperatives (Wilson and Guzman, 2005). The third part of the chain is warehousing, distribution and adaptation carried out on a ‘hub and spoke’ principle, in order to achieve local market adaptation through a mix of ownership and location policies. As Buckley (2009) puts it, “ownership strategies are used to involve local firms with marketing skills and local market intelligence in international joint ventures (IJVs), whilst location strategies are used to differentiate the wholly owned ‘hub’ (centrally located) from the jointly owned ‘spokes’”, as shown in Figure 2.1.

Figure 2.1 - ‘Hub and Spoke’ Strategies: An Example

The MNE, which is the focal firm of the global factory and the brand owner, is the information hub of the global factory (Buckley, 2009). The brand owner organises the market process itself. Production is outsourced to firms who specialize in maintaining and expanding production capacity, while the focal firm invests in intangible assets such as: (1) brand equity; (2) management skills; (3) innovative capacity (for example, R&D labs, design facilities); (4) distribution networks. (Buckley, 2009)
Depending on the types of industries, the OEM may take various forms, such as “contract assemblers” in a globally distributed operation for goods (see Fig 2.2), or “service hubs” in a globally distributed service operation (see Fig 2.3).

**Figure 2.2 - Global Factory - Globally Distributed Operations**

![Global Factory - Globally Distributed Operations](image1)

Source: Buckley (2009)

**Figure 2.3 – Global Factory - Globally distributed service operations**

![Global Factory - Globally distributed service operations](image2)

Source: Buckley (2003)

### 2.2.7.6 Timing of Entry

One of the gaps which Gallego et al (2009) have noticed in extant internationalisation literature is the little attention paid to timing of entry as one of the three dimensions of internationalisation process, compared to entry modes and market selection. They argued that time is a dimension that must be explicitly considered in order to develop a proper understanding of the internationalisation process of firms.
There are generally two approaches to analyse the timing of entry, namely, a sequential approach and an international entrepreneurship approach. For the sequential approach, a firm decides to internationalise by following a slow, gradual process that leads it to take decisions that entail less risk and little commitment, such as through exporting to geographically and psychologically nearby destinations (Johanson and Vahlne, 1977, 1990). As the internationalisation process continues and the firm’s knowledge of the process increases, it will choose more risk-entailing, that is, faster and more compromising options, aimed at destinations further afield. However, for the international entrepreneurship approach, access to alternative sources of knowledge accounts to a large extent for the fast internationalisation of born-global companies.

Gallego et al (2009) pointed out that there are two aspects of “timing of entry”, firstly, the age at which a firm initiates international activity, and secondly, the time of international development, which is the timing of the different activities undertaken by the firm along its path to internationalisation. The latter is linked to the observation that some firms target just one market while others target many simultaneously, even within a short period of time. Gallego et al (2009) made the proposition that a relationship exists between timing of entry, entry mode and market selection in a firm’s internationalisation process. Focusing on the timing of the first move overseas by a firm, they developed a model which linked the three dimensions, proposing that they act in one sense or another to minimise risk in the internationalisation process, so that as this risk increases, (a) the entry speed will slow down; (b) the entry mode will tend to be less compromising; (c) and the chosen market will tend to be nearer. For companies that do not respond to the logic of the model expounded, Gallego et al (2009) proposed that they did so as a result of the influence of certain mediating and moderating variables that affect the perceived risk and the risk that these companies are prepared to assume in their internationalisation process.

While the study and the model proposed offer an improved understanding of the relationship among the main decisions facing firms in their internationalisation process – timing of entry, entry mode, market selection – the model is still subject to further empirical study.
2.2.7.7 Institutional Theory

Institutional theory has emerged as a complementary approach to explain the ownership-based entry mode strategies of foreign investors in host country markets (Delios and Beamish, 1999; Davis et al, 2000; Meyer, 2001; Lu, 2002). Unlike the conventional perspectives that focus on economic and behavioural rationales for entry-mode choice decisions, the institutional theory posits that firms choose organizational practices and structures such as entry mode primarily to gain legitimacy from both internal and external claimants. The central premise of institutional theory is that organizations adopt structures and practices that are “isomorphic” to those of the other organizations as a result of their quest to attain legitimacy (DiMaggio and Powell, 1983; Scott, 2001). Researchers have identified several factors that give rise to isomorphic pressures. Scott (1995), for example, suggested that there are three pillars of the institutional environment. The regulative pillar refers to rules and laws that exist to ensure stability and order in societies; the normative pillar refers to the domain of social values, cultures, and norms, and the cognitive pillar refers to the established cognitive structures in society that are taken for granted.

For an organisation to survive, institutional theory emphasises the need to maintain a good relationship with the relevant social actors who participate in the organization’s environment, “who are not just competing firms, suppliers, employees or consumers, but also trade associations, professional boards, unions, government, politicians, families and environmental protection or consumer activist organizations” (Bianchi and Arnold, 2004: 152). Identifying the above social actors of an institutional will therefore put organisations in a better position to success in a foreign country, increasing firms’ likelihood of survival by successfully conforming to the host country institutional elements (DiMaggio and Powell, 1983).

Utilisation of institutional perspective to explain international organisations’ success and failure is becoming increasingly popular among international business academics (Scott, 2001). In particular, institutional theory is gathering increasing attention from academics in entry mode decision studies (Broutthers and Hennart, 2007; Yiu and Makino, 2002), as the institutional perspective offers a useful explanation of how institutional environments can affect a firm’s decision when entering a foreign country. This is especially so for emerging economy contexts where institutions have a firm hold
on society. However, it does not describe the decision process of internationalisation, which is needed to offer guidance in decision-making (Roersen et al, 2008).

2.3 LITERATURE RELATING TO INTERNATIONALISATION OF SERVICE FIRMS

Having discussed the various paradigms and new developments in the field of firm internationalisation, some studies on service internationalisation will be reviewed to provide a better understanding of the key factors that affect service companies in the internationalisation process. Many scholars have offered various definitions of service, but for the purpose of this dissertation, the author adopts the definition proposed by Gronroos (1990: p27), namely: “A service is an activity or series of activities of more or less intangible nature that normally, but not necessarily, take place in interactions between the customer and service employees and/or systems of the service provider, which are provided as solutions to customer problems.”

2.3.1 Applicability of Prevailing Internationalisation Theories to Service Firms

One of the main areas that have been extensively researched for service internationalisation is on the extent to which entry mode concepts, practices and theories developed for manufacturing firms are applicable to service firms. There have been two seemingly conflicting views about the applicability of determinants of entry mode choice to service firms, given the unique characteristics of services, namely, intangibility (ie, no transference of physical goods is usually involved), perishability (ie, services cannot usually be stored to respond to variations in demand), heterogeneity (ie, variability arising from client’s simultaneous involvement and the fact that services usually cannot be checked for quality before delivery), and inseparability (ie, their production usually cannot be separated from their delivery and consumption) (Zeithaml et al, 1985). One group of scholars takes the position that the determinants of entry mode choice for manufacturing firms are generalisable to service firms without much modification (see Agarwal and Ramaswami, 1992; Terpstra and Yu, 1988; Weinstein, 1977), while another group argues that those determinants need substantial modification when applied to services (see Erramilli, 1990; Erramilli and Rao, 1990, 1993).
Ekeledo and Sivakumar (1998, 2004) argued that the extent to which those determinants are generalisable to service firms depends on the category of service involved: hard service (which can be embodied in some tangible form, ie, separable) versus soft service (which need to be delivered in close physical proximity, enabling production and consumption to take place simultaneously, ie, non-separable), a service categorisation that was first introduced by Erramilli (1990). A soft service becomes a hard service once the production and consumption of the soft service can be decoupled. The delivery of healthcare services is typically classified as a “soft service” as it requires physical proximity between the healthcare worker and the patient (Erramilli and Rao 1990; Sampson and Snape 1985).

2.3.2 The “Industrialization” of Services

An interesting school of thought that has recently emerged is the “industrialization” of services propounded by Segal-Horn (1998). The theory adopts and applies Chandler’s (1990) framework of manufacturing MNE development to service industries, based on the idea that the growth in service MNEs is now mirroring or converging with those engaged in manufacturing (McCraw, 1988).

Chandler’s argument is that the main prospects for growth over the long term are either through geographic expansion into international markets or in related product markets. To an extent, this follows Levitt’s (1983) industrialisation of services theory. It is based upon the argument that:

a) fundamental, deep-seated changes have occurred in the concept of services, such as the ability to substitute capital for labour in services, and the possibility of changing the sophistication and characteristics of services through the integration of information technology;

b) additional changes (especially through the advances in information technology) have also increased the opportunities for service firms to exploit economies of scale (distributing cost reductions and expertise across national boundaries, expanding or exploiting scale in marketing, purchasing, technology, financing, etc); and scope (shared know-how, training, information networks, across brands and markets) which leads to more possibilities for expansion by service enterprises; and
c) extra national economies of scale have been created through more capital-intensive asset structures and higher fixed costs. As a result, there have been intensive mergers and acquisitions.

These developments have, therefore, led to increased concentration, with service industries moving away from highly fragmented markets to more concentration with clear market leaders. In many sectors they resemble oligopolies. Many services are seen to comprise “hard” tangible elements that may now be industrialized, and separated from the point of service delivery (McLaughlin and Fitzsimmons, 1996). In addition, it is possible to codify, and therefore transfer internationally, the all-important core competencies and information-specific assets of service enterprises. The end result is that the structure of service industries is increasingly converging with the development of manufacturing (Segal-Horn, 1998).

2.3.3 Factors that Influence the Internationalisation of Services

On factors that influence internationalisation of services, the United Nations identified nine major factors through a study of Service MNEs in 1993, namely:

a) Market size (market potential in terms of both size and growth) - The market size and rate of market growth of the host country are positively related to the location decision of new FDI by the service MNEs.

b) Home-country business presence - FDI by service MNEs is positively related to the home-country business presence, in the host-country.

c) Cultural distance (cf. psychic distance) - Cultural distance between home and host countries has a negative impact on foreign investment of the service MNEs.

d) Government regulations exercised by host country governments - Foreign investment by service MNEs is positively related to the openness of a host-country to the establishment of new foreign service affiliates.

e) Competitive advantages of service industries (ie, sustainable competitive advantage by both countries and companies) - FDI in services is positively related to the international competitiveness in services of a given home country.

f) Global oligopolistic reaction (ie, following actions of their domestic rivals) - FDI by service MNEs is positively related to the global oligopolistic reaction in the host-country.
g) Industry concentration of host country - FDI by service MNEs is positively related to the degree of industry concentration.

h) Tradability of service industries - FDI by service MNEs is negatively related to the tradability of service products.

i) Firm size and growth - FDI by service MNEs is positively related to the growth of the size of service firms.

(United Nations, 1993)

Since this study, there have been further developments on the literature with respect to internationalisation strategies of firms. In general, two types of factors influence the international strategy, market selection and the choice of entry mode, i.e. internal and external factors (see Agarwal and Ramaswami, 1992; Anderson and Gatignon, 1986; Ekeledo and Sivakumar, 1998, 2004; Javalgi and Martin, 2007; Koch, 2001; Lommelen and Matthyssens, 2005; Root, 1994). Internal factors include firm-specific resources and strategic considerations that can be managed by firms. External factors such as country factors and industry factors are usually beyond the firms’ control (Ekeledo and Sivakumar, 1998, 2004), but can have important influences on the strategies that can be adopted.

Koch (2001) suggested that market selection and entry mode choice are determined by several internal factors such as firm resources, the strategic concerns, foreign business experience and networking, and external factors including target market potential and risk, and similarity between home and host markets. More recently, Javalgi and Martin (2007) developed an internationalisation model that provides a useful insight into the internationalisation of services in general. This model dictates that for services firms’ internationalisation, the following should be analyzed: firm level resources, management characteristics, firm characteristics, competitive advantage, international advantage, the degree of involvement/risk and host country factors. This is similar to the framework proposed by Ekeledo and Sivakumar (2004), which also argues for the importance of firm-specific resources (such as the firm’s capabilities, organizational culture, specialized assets, large size, reputation, and business experience), strategic issues (such as its intention to develop new capabilities or protect an existing advantage), the nature of the product (eg, separable or nonseparable), and the level of control desired. All three are resource based theories stating that a services firm adopts a strategy that its resources can support and competes well in a setting with a fit between
external opportunities and the firm’s resources. The entry strategy model for services firms is therefore a function of the interplay between the services firm’s resources and characteristics, foreign country factors and the degree of control sought by the firm (Ekeledo and Sivakumar, 2004).

2.3.4 Entry Modes for Services

There are also some differences between the entry modes for services vis-à-vis manufactured goods. The three broad entry modes for services are exporting, contractual arrangement (joint venture, licensing/franchising, and management contract), and sole ownership (Vandermerwe and Chadwick 1989). Sole ownership, joint venture, franchising, and management contracts often require production in the host market, through either local partners or direct investment in production facilities in the local market. Exporting of services is somewhat different from that of goods because services are intangible. While exporting of goods involves exporting an object to the target market, exporting of a service requires embodying the service in a storage medium, such as transmitting an interior design plan via email or delivering television programmes via the satellite. This is not applicable to soft services, which must depend on non-export modes, such as sole ownership, joint venture, franchising, or management contract for foreign market entry (Ekeledo and Sivakumar, 1998).

For services where export in the traditional sense is not possible, such as in healthcare, the service provider can be transferred to the customer (outward foreign sales) or the customer can be transferred to the service territory (inward foreign sales) (Czinkota and Ronkainen 1995). Some services, such as education, transportation, and tourism involve mostly inward foreign sales, since they are mostly internationalised through bringing foreign customers to the premise of the service supplier. The consumption of a service on the local premise of the service provider is a foreign sale. Inward foreign sale involves international operations that are mostly similar to domestic operations. Increasingly, this is happening in healthcare as well, in the form of Medical tourism.

For capital-intensive services (which include hospitals), Sanchez-Peinado and Pla-Barber (2006) noted that high investments increase significantly the risks and uncertainties involved. Therefore, with increased psychic distance and country risk, capital-intensive firms tend to look for more flexible entry modes. It must be noted,
though, that capital-intensive services also try to maintain strict control of their most important commercial assets, such as brand and reservation systems in the hotel industry (Contractor et al., 2003). These findings can be linked with Erramilli and Rao’s (1993) study in which they classified services based on their asset-specificity\textsuperscript{23}, from low-specificity to high-specificity firms. They found that initially, both types of firms prefer high control modes, but if the capital intensity increases significantly, the low-specificity firms start looking for shared-control modes. They argued that the differences in entry-mode choice between low- and high-specificity firms become more pronounced with increasing capital intensity.

On the influence of the institutional factors discussed at section 2.2.7.7, Yiu and Makino (2002) found that MNEs tend to conform to the regulative settings of the host country environment, the normative pressures imposed by the local people, and the cognitive mindsets as bounded by counterparts and multinational enterprises own entry patterns when making foreign entry-mode choices.

Specifically, they found that regulative and normative institutions may account for the cross-national variations in the choice of entry mode, while cognitive institutions may account for the cross-firm variations in the choice of entry mode. They also found that institutional forces may influence the choice of foreign entry mode in different magnitudes, with the regulative forces and cognitive forces found to have a stronger influence on entry-mode choice decisions, compared to the normative forces. One possible explanation for this is that normative institutional pressures are less codifiable and take more time to be recognized. Unlike regulative institutional forces that are codified in formal legal restrictions and sanctions, and cognitive institutional forces that are reflected in observable industry or organizational historical patterns, normative institutional pressures might not be easily identified before local operations start. Also, when making the entry-mode decision, market legitimacy and cognitive legitimacy may be the most immediate legitimacy that multinational enterprises need to attain, while normative legitimacy takes a longer time to be established in the value systems of the host-country nationals.

\textsuperscript{23} Asset specificity is represented by the degree of idiosyncrasy that characterizes a service; in Erramilli and Rao (1993), this is measured by the extent to which the service is characterized by professional skills, specialized know-how, and customization. For example, hospital service would normally be considered high specificity while retail shops would be considered low specificity.
2.3.5 Additional Market Selection Considerations and Regional Focus of Service Firms

Various authors have shown that some service sectors, such as people-centred services or contact-based services, are especially sensitive to cultural factors in the early phase of their internationalisation (Erramilli, 1991; O'Farrell and Wood, 1994, 1999; Knight, 1999), in that cultural similarity plays a significant role in the market selection for internationalisation of such services. Also, researchers have found that psychic distance influences the internationalisation of many consumer-based services, such as retail, banking and financial services (Akehurst and Alexander, 1995; Hellman, 1996; Lovelock and Yip, 1996; Fuentelsaz et al, 2002). Thus, it could be argued that for many service sectors, the traditional process models are applicable for their market strategies, and that psychic distance might play an even greater role in their internationalisation than for manufacturing companies.

Nevertheless, there are other studies that have found contrasting results. For example, Evans and Mavondo’s (2002) study on retail companies found that many retailers from developed countries targeted especially less developed emerging markets in Eastern Europe and Asia, as these markets offered significant growth opportunities, thus overcoming possible cultural differences. In these target markets, competition was less fierce and growth prospects greater. Thus, economic differences, not similarities, were one of the most important factors of market selection for these companies. Interestingly, some studies on business services, such as that of Terpstra and Yu’s (1988) on the US-based advertising firms, reported that cultural or geographical distances were not very significant factors, as market size and other economic factors often overrode them. Other studies reported some irregularities in target market patterns due to opportunism (O'Farrell and Wood, 1994; Roberts, 1998; Sanchez-Peinado and Pla-Barber, 2006). In addition, although most business services operate between developed countries, there are others who focus on developing markets, based on comparative advantage in factor endowments (Roberts, 1998). That is, if a country is able to develop a national comparative advantage, then its service companies may be able to turn this to their competitive advantage, targeting countries with relatively lower development levels.

Through their analysis of the international expansion of services MNEs, Li and Guisinger (1992) showed that services FDI, as a partial measure of international
expansion, was negatively affected by distance, especially cultural distance from the home country. Such distance requires adaptation investments\textsuperscript{24} to reduce buyer uncertainty. FDI in services was found to be influenced positively by the openness of the host market to inward FDI in services and the presence of an oligopolistic market structure of the services sub-industry considered. Their analysis thus suggests a comparatively lower international market penetration in services, as the result of three factors - more stringent government regulation of foreign services firms, fewer options to divorce production from consumption, and more limited possibilities to engage in location choice optimisation from a supply side perspective.

The main weakness of Li and Guisinger’s (1992) work is their sole reliance, as a measure of the scope of international expansion, on growth in the number of affiliates abroad, thereby neglecting the actual value of the investments considered. (Rugman and Verbeke, 2008). To address this gap and the gap in their earlier theories where industry effects, especially the distinction between manufacturing and services, were not explicitly addressed, Rugman and Verbeke (2008) offered a refinement of regional strategy theory applicable to services MNEs.

Using the concept of the value chain as the central building block of the analysis, Rugman and Verbeke (2008) pointed out that manufacturing MNEs are generally able to decouple upstream and downstream activities, and to adapt those two activity types separately to host environment requirements. These firms can also make location choices subject to supply side optimisation criteria. In contrast, many services MNEs exhibit a relative lack of such flexibility in adapting upstream and downstream activities separately, or in selecting activity locations as a function of supply side considerations. This is because services MNEs are required to deliver their activities close to their consumers. Their FSAs are generally marketing and brand-name based. Upstream activities of services MNEs are intimately coupled with their downstream marketing and sales delivery, thereby making effective adaptation to high distance host environments much more complex. This further confines the number of services MNEs that can be regarded as truly global in terms of sales and asset dispersion. It is likely that only MNEs in narrow services sub-sectors such as information technology and media can operate across geographic space similar to manufacturing MNEs, in the sense of

\textsuperscript{24} Adaptation investments include investments in the development of location-bound FSAs in foreign markets (leading to benefits of national responsiveness) to complement non-location-bound FSAs, and in the development of new, non-location-bound FSAs in foreign subsidiaries.
exploiting flexibility in their value chains. The great majority of services MNEs lack such flexibility. This was borne out by empirical findings that few services MNEs operate globally (Rugman and Verbeke, 2008).

2.3.6 Application of the Concept of “Global Factory” to Services

Bartels et al (2009) considered the application of the concept of “Global Factory” to services. They argued that for services, it does not necessarily follow that lower host market production costs are a necessary condition for FDI and licensing options. In particular, for non-separable services, proximity to markets is a prerequisite for selling in foreign markets, and this factor supersedes cost considerations in foreign market-servicing decisions. There are also greater incentives for such service firms to internalise operations due to the non-codifiable25 nature of firms’ competitive advantages. Information and people-embodied knowledge are critical FSAs for many service firms and such competitive assets are non patentable, difficult to package into a saleable form, but easy to replicate or acquire through “poaching” of staff. There is thus a greater propensity to invest in foreign markets through equity joint ventures, rather than pursue contractual arrangements, compared to manufacturing, where contract manufacturing is a key feature of “Global factory”. Bartels et al (2009) added that the use of joint ventures was preferred over wholly-owned modes as it reduces capital risk and provides access to local specialized knowledge of the foreign partner which may be costly and take a long time for a foreign firm to establish.

2.4 LITERATURE RELATING TO INTERNATIONALISATION OF FIRMS FROM SINGAPORE

In many ways, the extant International Business literature predominantly reflects the behaviours of large firms from the large developed countries, given that firms from these countries were the first to start the trend of internationalisation and still make up the bulk of investments in overseas operations. As can be expected, internationalising firms from Singapore will have some characteristics that are different from these “traditional” internationalising firms, for example, Singapore’s status as a Newly

25 “Explicit” or codified knowledge refers to knowledge that is transmittable in formal, systematic language. On the other hand, “tacit” or non-codifiable knowledge has a personal quality, which makes it hard to formalize and communicate. (Nonaka, 1994: p16).
Industrialised Country\textsuperscript{26}, as an Asian country, and as a SMOPEC. This section will discuss the literature relating to some of the unique considerations that should be taken into account in this research.

2.4.1 Emerging/Second Wave MNEs

Studies of foreign direct investment of firms from developing countries identified two waves of internationalisation with distinctly different characteristics (Van Hoesel, 1999; Li, 2003). Studies of the first wave of internationalisation of Asian MNEs found a path dependent process of internationalisation with entries in developing countries and reliance on ethnic networks where they can exhibit some type of competitive advantage which is in line with extant theories (Lall, 1980; Giddy and Young, 1982; Lecrew, 1993; Van Hoesel, 1999). In addition, these multinationals entered developed countries in search for know-how which is often spatially determined than existing in a specific company (Kogut and Chang, 1991).

However, the second wave of MNEs\textsuperscript{27} from developing countries exhibit significant differences compared with the first wave of internationalisation as firms are prepared to take more risk in an effort to catch-up with competitors from developed countries (Li, 2003; Luo and Tung, 2007). This change in behaviour is attributed to globalization where an increasing number of MNEs from developing countries get exposed to international competition but also, to new skills acquired by collaborating with MNEs from developed countries by taking part in their global value chains or by simply operating in industries where presence of advanced MNEs creates spill-over effects.

\textsuperscript{26} Newly Industrialised Countries (NICs) or Newly Industrialised Economies (NIEs) are countries whose economies have not yet reached First World status but have, in a macroeconomic sense, outpaced their developing counterparts. One characterization of NICs is that of nations undergoing rapid economic growth (usually export-oriented) (Source: wikipedia).

\textsuperscript{27} The second wave or emerging MNEs refer to MNEs from developing countries which are engaged in a second wave of FDI activity since the early 1990s, which is distinct from the first wave in the 1970s and 1980s. The second wave MNEs tended to come from countries at a higher stage of industrial development that had evolved structurally towards industrial sectors which are capital- and knowledge-intensive. These firms engaged in simultaneously in outward FDI to locations with appropriate comparative advantages (often lesser developed countries) for their natural-asset intensive and labour-intensive activities, while, at the same time, they also engaged in both market-seeking and asset-augmenting FDI in the more developed countries. In comparison, the first wave MNEs showed a strong and marked trend to focus their investments in neighbouring and other countries which were at a similar or an earlier stage of development (due to their lack of international experience, hence they sought locations with resource endowments for markets which were broadly similar to those of their home countries (Narula, 2010).
Luo and Tung (2007) attempted to explain the international behaviour of the second wave of internationalisation of firms from emerging countries by proposing a springboarding perspective, where latecomer MNEs operating in a more global environment than the first wave of internationalisers are motivated to seek assets and markets simultaneously. To achieve this, MNEs integrate and mobilise newly acquired knowhow, in order to be able to compete in new foreign markets. Consequently, these multinationals disengage from path dependent trajectories by pursuing high commitment foreign entries in developed markets at the early stages of internationalisation.

Similarly, Mathews (2002; 2006) suggested that the international expansion of the second wave of firms from developing countries is driven by resource linkage, leverage and learning (LLL framework). Calling such firms from the Asia-Pacific region “dragon multinationals”, he noted that they have successfully internationalised and in some cases have become leading firms in certain sectors. Based on the framework, firms gain competitive advantage as latecomers by accessing resources through linkages with external firms, by choosing foreign locations where they can leverage their international network and by learning through linking and leveraging operations and relationships. These firms will find new ways to “complement” the strategies of the incumbents, such as through offering contract services, through licensing new technologies, to forming joint ventures and strategic alliances. Through these “complementary” strategies, both newcomers and latecomers have been able to win a place in the emergent global economy, not on the basis of their existing strengths, but on the basis of their capacity to leverage resources from the strengths of others, through making international connections (Melin, 1992).

One interesting facet of the internationalisation of the “dragon MNEs” is that they all have internationalised very rapidly (Mathews 2002; 2006), using and leveraging on various kinds of strategic and organizational innovations in order to establish a presence in industrial sectors already heavily populated with world-class competitors. They do so quickly because they are tapping into transient advantages; they are not concerned to establish solid international structures, but rather quickly develop flexible and “lattice-like” structures spanning diverse countries and markets (Mathews, 2006).
Both frameworks by Mathews (2006) and Luo and Tung (2007) recognise the importance of asset augmentation where firms learn, integrate and exploit markets in a dynamic process. However, to achieve this, a firm must have significant international experience and organisational capabilities to deal with operational complexity and change. It will also need significant amount of financial resources to do so. Therefore, it is expected that not all developing country MNEs are able to internationalise like the “dragon MNEs”.

The LLL framework proposed by Mathews (2006) has been debated in the literature. One main criticism is that it focussed almost exclusively on firms originating from the fast growing countries in the Asia Pacific region (Narula, 2006). While Narula agrees with Mathews’ proposition that the process of globalization requires available theoretical and conceptual frameworks covered in the international business literature to be modified and improved, he expressed concerns with Mathews’ attempt to generalise from the international success of a group of firms, some of which derive from a group of outlier countries, to firms from emerging countries (Narula, 2006). Besides, taking into account the growing empirical evidence available, Dunning (2006) shows that some latecomer firms might indeed possess certain unique competitive advantages explaining their internationalisation strategies, hence raising question about Mathews’ assertion about the lack of ownership advantages of such firms.

2.4.2 Asian MNEs

Sim (2006), in his study of Singaporean and Malaysian MNEs, argued that Asian MNEs exhibit characteristics, motivations and internationalisation paths which vary from those of western MNEs from developed countries and which are not fully explained by extant theories of MNEs. Li (2003) contends that extant theories of MNEs need to be modified and enhanced to explain all MNEs, including Asian MNEs. For example, western theories on internationalisation have overlooked the active role played by the state and have neglected the institutional or contextual perspective in the internationalisation of Asian firms (Zutshi and Gibbons, 1998; Yeung, 1999). In the Asian context the state often plays a direct and active role in the internationalisation of its MNEs. In the case of Singapore, Yeung (1998) indicated that this role was taken to overcome the underdevelopment of indigenous entrepreneurship in Singapore. The state assumed the role of entrepreneur by actively opening up overseas business opportunities and by
setting up institutional frameworks for Singaporean firms to tap, for example, collaborating with the Chinese government to develop the Suzhou Industrial Park in the 1990s, which provided a base for Singaporean companies to enter the Chinese market in an environment familiar to them. The government also provided generous incentives and other programmes (such as tax incentives, finance schemes, training and so forth) to foster the rapid development of local entrepreneurship in its regionalisation efforts. This was the same in Malaysia, where the government actively promotes the internationalisation of Malaysian firms, including organising investment promotion missions abroad, sometimes led by the prime minister. This is unlike the western context where the role of the state is benign and indirect. As a result, MNEs operating in the Asian context have to manage this institutional context successfully.

There is also a need to examine Asian MNEs within the context of their institutional as well as socio-cultural embeddedness. Asian internationalisation tends to be organised through social and ethnic networks. The ‘Spirit of Chinese capitalism’ (Redding, 1990), with its sets of values and beliefs, underlies the way Chinese business and cross-border operations are conducted (Yeung and Olds, 2000; Yeung, 2004). Personal relationships and networks (for example, Chen, 1995; Hamilton, 1996; Luo, 2000) often form the basis of the internationalisation of Chinese and Asian firms, especially smaller ones. Hence the internationalisation of Asian MNEs needs to be seen in its contextual embeddedness (both institutional and cultural).

2.4.3 MNEs from Small and Open Economies (SMOPECs)

It is often reported that MNEs from smaller countries seem to be relatively more internationalised when compared to MNEs from larger countries (Pedersen and Petersen, 2004; Hirsch, 2006), as there are stronger push forces for companies to internationalise due to small domestic markets (Larimo, 1995; Benito et al, 2002; Pedersen and Petersen, 2004). The concept of a distance premium describes this issue in that small country firms have a handicap due to their smaller domestic markets in benefiting from the higher efficiency achieved by the economies of scale advantages

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28 Distance premium refers to barriers - trade barriers, cultural barriers, legal barriers and economic barriers - faced by parties engaged in international transactions. DP consists of man-made or artificial trade barriers such as tariffs imposed on imports, and is augmented by the need faced by parties engaged in international transactions to employ more than a single language, to use different currencies, to comply with the dictates of multiple health and safety regulations, and to conform to the prescriptions of different legal systems (Hirsch, 2006).
Thus, it seems that to survive, MNEs from smaller countries need to internationalise rapidly, to benefit from scale economies and to access markets and human capital as well as material resources not available in their small home market. The gains from internationalisation are, however, limited by the distance premium, which constitute an economic burden not borne by large country firms (as they do not need to internationalise to gain these advantages).

Due to their narrow domestic resource pools, the large investments required for overseas expansion is often listed as a major problem for small country MNEs (Larimo, 1995; Carr and Garcia, 2003), as they may lack resources in areas such as financial and management resources (Hubbard et al, 2002; Gabrielsson and Gabrielsson, 2004). D’Aveni (2002), in his study on pressure maps, divided companies into orchestrators and targets, and considered that the targets, second-tier companies in globalising industries, often face huge challenges. As can be expected from the above analysis, even the largest MNEs from small countries are mostly second-tier companies when compared with the largest players in the industry. As a result, MNEs from smaller countries with their limited resources often need to find alternative evolutionary paths, and these patterns are often different from those suggested by the mainstream internationalisation theories (Carr and Garcia, 2003), or they need to avoid industries in which investments required are very large (Merkel and Osegowitsch, 1999).

Some means to overcome these challenges have been reported in research: For example, MNEs from smaller countries can enter into strategic alliances with each other to compete with the dominant MNEs in the industry (Cho, 1998; D’Aveni, 2002), or they can implement niche strategies29 (Benito et al, 2002; Hubbard et al, 2002; Dick and Merrett, 2007). Also, many researchers have emphasized the relatively significant role of governments in developing businesses and supporting MNEs internationalisation from smaller countries, when compared to MNEs from large countries (Lewis, 1999; Rugman and Hodgetts, 2001; Benito et al, 2002; Hubbard et al, 2002). Thus, it can be argued that for firms that originate from smaller countries, the role of governments is a significant factor influencing their internationalisation strategies. Some findings towards this direction have been reported, for example, in the airline industry (Goodovitch, 1997; Ramamurti and Sarathy, 1997; Antoniou, 2001) and in the banking industry.

29 A niche strategy refers to concentration on a small segment with the objective of achieving dominance of that segment.
(Boldt-Christmas et al, 2001; Benjamin and Merrett, 2007; Dick et al, 2007), where the competitiveness of these companies has been heavily influenced by government regulations and policies.

Hirsch (2006) also argued that a lower distance premium will benefit particularly small country firms since internationalisation is an efficient way to neutralise the negative effects of the small home market and small resource base. Developments in communication technology, reduction of barriers for doing business across borders, such as through harmonisation of regulations and regional trade and investments, are ways to reduce the distance premium. It can therefore be inferred that regional integration should benefit firms from small countries like Singapore.

Laanti et al (2009), in their study of telecommunication MNEs from SMOPECs, identified four different phases of internationalisation which the case companies, including one from Singapore, went through. The phases were described as: Learning phase, Opportunistic phase, De-internationalisation phase, and Maturisation phase. In each of these, some unique patterns of the internationalisation process were recognised. Laanti et al (2009) observed that these phases were different from the incremental and deterministic phases identified in some traditional internationalisation process models. They concluded that the implications for managers from MNEs in small countries lie in identifying the unique strategies required through the different internationalisation phases.

Besides the challenge of the small domestic market discussed earlier, another country specific factor, not directly linked to small countries, was that neighbouring countries often had political ambitions which prevented reciprocality of entry, or there were other interventionist government measures which shaped the industry structure. For example, in some cases, political pressures in a neighbour country against investments from a “competitor” country were identified. In many cases, this caused the barriers for companies to enter foreign market to be lower for more distant or developing countries, or both. These countries often welcomed financial, technological and managerial investments to further develop their service infrastructure (Laanti et al, 2009).

Laanti et al (2009) add that psychic distance still played an important role, as often it is time consuming to send managers and specialists to distant countries, and it is generally
less complex to do business in culturally close countries. However, some of the other considerations may override the psychic distance factor.

An interesting new finding by Laanti et al (2009) was that the case companies reported that coming from a small country can sometimes be seen as an advantage against competitors from large countries. Due to the strategic importance of the sector studied (ie, telecommunications), and the still relatively high role of governments in the industry in most countries, companies from smaller countries were often perceived to be less threatening than those from large developed countries, and this has won them opportunities to enter joint ventures with foreign governments or with other local partners. This finding may well be relevant for the healthcare sector as well, which in many countries are still relatively heavily regulated.

2.5 INTERNATIONALISATION OF HEALTHCARE FIRMS

As highlighted in the previous chapter, there have been very few researches specifically on the internationalisation of healthcare firms. Much of the research that has been done relates to globalisation/regionalisation of healthcare or generic discussions of foreign direct investments into the healthcare sector of specific countries. The few firm-level researches that were found were not specifically focused on hospital groups but on general medical services and healthcare firms. They are nevertheless covered here to provide a general feel for the current level of knowledge on this topic. There is also a discussion on an article by Chee (2007), which though not specifically about internationalisation of healthcare firms, covers the issue of commodification of healthcare, which bears important implications for this research.

2.5.1 Some Existing Firm-level Studies

Using a case study method, Orava (2002) identified three operational modes of internationalisation for medical service firms (including clinics and hospitals), namely:

- **person-based mode** - this mode is essentially based on the expertise of one renowned medical doctor, and is thus strongly person-dependent.
- **process-based mode** – this mode is based on expertise in the management of the treatment process. The expertise was embodied in the ‘brand’ of the hospital, rather than in individual experts.
- virtual-based mode – for this mode, the core competence is technological expertise. There is a question as to whether customers perceive technological competence as the core competence required in medical services. The virtual-based operational mode is also limited by its scope, being suited only for information exchange such as consultations, and not a large part of physical medical care.

Orava found that the modes have major differences in service type, marketing focus and customer base. However, they also had similarities - all were based on extensive networking. Most notably, they were all based on a strong sense of core competence - in personal specialised medical treatment, in organisational capability to manage the treatment process, or in technological edge.

In another study, Hall (2001) noted that the picture of multinational behaviour by private healthcare companies is not as coherent or as expansionist as MNEs in some other service sectors. For example, many of the USA groups, both hospital companies and health maintenance organization (HMO) insurers, have experienced financial and performance problems in their overseas ventures. Private hospital companies have also not been very successful at expanding internationally.

In a more recent study, Lethbridge (2007) observed that there are some common patterns of expansion among healthcare multinational companies throughout the world. There is a move towards diversifying away from just delivering healthcare to providing health insurance and other financial infrastructure, including in Asia. Lethbridge (2007) observed that in Asia, medical tourism is a growing expansion strategy but does not appear to be developing on the same scale in other regions. European healthcare companies appear to be the most active in expanding overseas, especially in comparison to American healthcare companies. The European healthcare companies see European and other global opportunities for expansion in different aspects of the healthcare sector, including insurance, clinical and diagnostic services, and facilities management services. They also see partnerships with the public sector as an essential step towards developing and delivering new services and facilities, and are stepping up such collaborations, including management contract and building of new hospitals. Lethbridge (2007) also observed that the ownership of European healthcare companies
is changing and becoming dominated by private equity investments, which see healthcare companies as investments with potentially good returns.

Outreville (2006) went further to identify some of the determinants of foreign investment of the largest MNEs operating in the healthcare industry (including hospital groups, pharmaceutical companies, medical equipment makers, and so forth). The results of the study, although limited by data constraints, have two important implications. First, the results indicate that location-specific advantages do provide an explication of the internationalisation of firms in the health care sector in developing countries. Second, they show that good governance, as measured by several different variables, has a significant impact on the choice of countries by these firms, and should be analyzed more carefully in further empirical work.

2.5.2 Relevant Research on Healthcare Services in ASEAN

In a comprehensive study on trade in health services in the ASEAN region, Arunanondchai and Fink (2007) reviewed the state of healthcare in the region, existing patterns of trade, and existing barriers to trade. They noted that technological progress has enabled the remote supply of services that were previously not tradable across borders. Thus, firms in richer countries have been able to realize cost savings by outsourcing health-related service activities to poorer countries with lower wages, such as the Philippines’ export of medical transcription services to the United States. Arunanondchai and Fink (2007) also noted that Malaysia, Singapore, and Thailand have become significant exporters of “health tourism” services, with the observation that for Singapore and Malaysia, the majority of foreign patients come from other ASEAN countries (mainly Indonesia), whereas in the case of Thailand only 7 percent of foreign patients are from the ASEAN region. Besides, Arunanondchai and Fink (2007) observed that health services in ASEAN countries are predominantly provided by domestic medical institutions. Foreign service providers typically account for small shares of the healthcare market, cater only to the middle and upper-income population segments, and are mostly found in urban areas.

Looking at the gains and pitfalls from trade in health services, Arunanondchai and Fink (2007) pointed out that differences across countries in endowments of capital, labour, and technology imply that some countries possess a comparative advantage in the
supply of certain health services, meaning they can provide them more cheaply than 
others. Allowing trade in healthcare services can thus generate efficiency gains for both 
the importing and the exporting economies. Patients who seek medical treatment abroad 
and hospitals which outsource medical transcription services to foreign service 
providers can realize significant cost savings, while countries that export health services 
realize gains from specialisation, allowing them to employ their capital and labour 
where they are most efficient and generating export revenues for the import of other 
goods and services. However, the paper also pointed out pitfalls that can arise from such 
trades, such as a “brain drain” from the public to private sector, and further widening of 
the standards of healthcare available to the higher income and lower income groups.

In a research on healthcare services in Malaysia, Chee (2008) explores the various 
ownership interests in healthcare provision in Malaysia: statist capital\textsuperscript{30}, rentier 
capital\textsuperscript{31}, and transnational capital, as well as the contending social and political forces 
that lie behind state interests in the privatisation of healthcare, the growing prominence 
of transnational activities in healthcare, and the regional integration of capital in the 
healthcare provider industry. This article has some relevance to the research as Malaysia 
is Singapore’s neighbour, and a prime target for market entry by Singapore MNEs. 
Chee (2008) concludes that given the complicit role of the state in the rise of corporate 
healthcare in Malaysia, the issues of ownership and control will continue to have 
important implications for governance in the healthcare system.

In the same article, Chee (2008) also studied transnational ownership of hospitals, and concluded that there are important synergies to be gained from being transnational. 
Operating hospitals in several countries, referrals and cross-referrals can be made 
through internationally-linked hospitals, increasing the likelihood of patients crossing 
borders and therefore leading to the expansion of the medical tourist market. 
Furthermore, the MNE makes use of the positioning of its range of facilities in the 
various countries to leverage on each of their comparative advantage. For instance, 
cross-country patient referrals, purportedly made to match the individual patient to the 
healthcare facility that can best attend to his or her needs, and ostensibly increases the

\textsuperscript{30} Statist capitalist refers to state institutions which function as a mechanism for capitalist accumulation in 
the interest of Malay capital within an ethnicised politics. Hospital groups owned by statist capital include 
KPJ Healthcare, the largest private healthcare group in Malaysia (Chee, 2008).

\textsuperscript{31} Rentier capitalist refers to politically well-connected private entities which gained control of state assets 
which were divested as part of the government’s privatisation efforts, or which were given preferential 
access to contracts and assets given out by the government (Chee, 2008).
range of choice for the patient, in effect also works to enlarge the patient-customer base for the corporation. It is in the clever utilisation of the relative advantages of its multinational facilities that the corporation becomes truly transnational.

On the medical tourist industry, Chee (2010) observed that a striking feature of the industry in Asia is the involvement of governments in supporting the private sector in marketing healthcare services to foreign patients. While both Malaysia and Singapore carried out reforms to enlarge private healthcare sector since the 1980s, she posited that the Singapore state, moving toward state corporatism, has advanced further in its healthcare reforms, and is therefore able to minimise the gap between government and private health services, in terms of standard of care. The Malaysian state, fragmented and facing greater opposition, has not been able to advance as far in its healthcare reforms, and faces a growing gap between public and private health services.

Gan and Frederick (2011) conducted a structure-conduct-performance analysis of the 17 Singaporean hospitals that are engaged in the medical tourism industry. Using data from hospital websites, Singapore’s Ministry of Health and the Singapore Department of Statistics, the authors argue that barriers to entry give the industry the structure of an oligopoly. However, because the industry is dominated by two publicly controlled hospital groups, the conduct and performance of the industry differ from those of the classical oligopoly model. The presence of two types of consumers, Western and Southeast Asian, also distinguishes this industry from the classical model. Gan and Frederick (2011) concluded that Singapore’s medical tourism hospitals appear to perform well in serving their international and domestic clients.

2.5.3 Commodification of Healthcare

While healthcare is usually considered as a “soft” service, there is increasing recognition that it is becoming more and more similar to a commodity that is amenable to being traded on the market. This has significant implications on the internationalisation strategy of healthcare firms. As healthcare services become more like “commodities”, it becomes more easy and feasible to consume healthcare services even if one has to cross national borders in order to do so.
In his classic work, *The Social Transformation of American Medicine*, Starr (1982) locates the commodification of healthcare as occurring when the market becomes the dominant institution for the care of the sick, characterising this process as involving increased specialisation of labour, greater emotional distance between the sick and their carers, and men increasingly taking on the dominant positions in the management of health and illness. Starr argues that the medical profession, in its rise to sovereignty, was able to establish its authority and control over the market by standardising its product, and this was accomplished by standardising the training and licensing of the producers, that is, the doctors.

Schaniel and Neale (1999), in attempting to clarify the concept of commodification, take as the point of departure their interpretation of Marx’s idea of commodities as things that are “produced, …in factory-like circumstances, …for sale, …on a commercial market.” According to these criteria, healthcare service does not qualify as a commodity, and even though it may be treated as a commodity, it does not portray the characteristic behaviour of other commodities in a free market. Nevertheless, in examining a few case studies, the authors concede that when things are treated as though they are commodities, processes of commodification may occur even though these processes may not lead to full commodification, but instead result in different degrees of commodification.

As healthcare is commodified, patients are recast as consumers (Pellegrino, 1999; Keaney, 1999). This follows from the logic that commodities are produced for consumption. Meanwhile, the changeover from patient to consumer is supported by the increasing availability of information on clinical conditions on the one hand, and by more standards being imposed on professionals (for example, clinical practice guidelines, best practice guidelines) on the other. Among the consequences of healthcare commodification, therefore, is the change in the nature of the relationship between patient and doctor. As consumers and providers respectively, the relationship will be primarily regulated by the rules of the market, in which profit-making is legitimately foregrounded.

In her study of the Malaysian healthcare sector, Chee (2007) argued that the process of commodification of healthcare is reflected in three features that are increasingly seen in the sector. First, the use of and emphasis on ‘marketing’ as an important activity by
which to procure patients-customers. In legitimising the ‘marketing’ of medical services, there is an implicit acceptance that healthcare is a commodity that has to be sold in a competitive environment. Second, the increasing emphasis on quality, and in order to achieve it, the use of benchmarking and standardisation in accordance with internationally recognised markers. The process of standardisation helps make the product for sale more uniform and more universally ‘understood’. Third, the creation of customers and consumers, through the emphasis on consumer choice, with healthcare users presented with a plethora of options – listings of clinics and hospitals, information on technology and treatment available, and the specialists who are in attendance.

Chee (2007) noted that in the Malaysian healthcare system, the general practice in the past is for a patient to consult a medical officer or general practitioner at the first point of contact, who then makes a referral to a specialist if necessary. This step is now either dispensed with, or it is assumed that the medical tourist already has a diagnosis. Thus, for example, in a marketing guide, the customer is given a list of ‘common medical conditions or diseases’ each with corresponding suggestions on which type of specialists to see. In the doctor-patient relationship, the doctor often makes the decisions for the patient, but in the customer-provider relationship, the customer has greater freedom of choice. The specialities may be marketed separately, and it is technically easy for customers to change doctors if dissatisfied. Further resembling a sales strategy of commodities, medical services are ‘packaged’, for example, with a specific price for six visits for lower back pain, or health screening packages such as the executive health screening package.

2.6 CHAPTER CONCLUSION

As can be seen from the review, there are many theories which are relevant to this research. In applying these theories to this research, the unique characteristics of healthcare services have to be taken into account, as well as the expected differences in the behaviours of firms from Singapore vis-à-vis the firms from more developed countries which many of these theories derived from.

32 Stoeckle (2000) suggests that the way in which healthcare is sold – as packaged medical services, surgical services, over-the-counter drugs, diagnostic and treatment technologies – illustrates its characteristic as a service commodity.
Interestingly, the subject matter itself, namely, internationalisation of healthcare firms from Singapore, has not been studied much in the past. In fact, from the literature search, healthcare firms covered in internationalisation studies thus far had covered firms dealing with different healthcare and medical services. This study should be one of the firsts, if not the first, to focus specifically on internationalisation of healthcare firms with hospital operations. Given that hospital services are one of the healthcare services most affected by globalisation, the research should yield valuable insights to help plug this existing knowledge gap.
CHAPTER 3 – BACKGROUND ON HEALTHCARE INDUSTRY IN SINGAPORE AND THE REGION

3.1 INTRODUCTION

Having reviewed the literature, this chapter will present a background of the business environment which the case firms operate within, both within the home market of Singapore, as well as the region. Understanding of the home market is important as it provides the context for the strategic choices made by the Singapore firms as they internationalise. Understanding the region is also crucial, both from the angle of the potential market which the firms are likely to internationalise to, given the prevailing expectation that service firms are likely to be regionally-focused (Rugman and Verbeke, 2008), and the competition which the firms are likely to face as they internationalise within the region. The regional context is also particularly important given the increasing integration within the region, which will eventually move the region towards becoming one large integrated market, hence, increasing the competition among firms from within the region, not just from the same country.

This chapter will first look at the state of the healthcare industry in Singapore, including the market structure, the quality of healthcare services, the competition among the providers, the development of the medical travel/tourism market, and the internationalisation of the private healthcare firms.

The next section will then cover the state of the healthcare industry in Southeast Asia, including the state of health and an overview of the other major healthcare MNEs in the region.

3.2 STATE OF HEALTHCARE INDUSTRY IN SINGAPORE

3.2.1 Market Structure

Singapore is an island state at the centre of the ASEAN region, with a population of about 5 million, and a per capita GDP of about US$43,000 in 2010\(^3\), the highest in ASEAN. Singapore spent about 3.9\% of its GDP, or S$10.2 billion, on healthcare

\(^3\) Source: Department of Statistics, Singapore
services in 2008, of which about S$2.7 billion (or 1.0% of its GDP) was spent by the
government\textsuperscript{34}. The Singaporean healthcare system is divided into a public sector and a
private sector. The public sector provides approximately 80% of the hospitalisation care
for the local residents, and the private sector offers the remaining 20% of care\textsuperscript{35}.
However, when it comes to medical tourism, the public–private split is reversed; the
public sector served around 20% and the private sector 80% of inpatient medical
tourism in the decade prior to 2002 (Khoo, 2003).

As of 2009, 30 hospitals served Singapore’s residents and visitors, with a total of more
than 10,000 hospital beds in 2007. Some of these were long-term care facilities that
would not interest medical tourists, such as the Institute of Mental Health. Focusing on
the hospitals which serve foreign patients and play active roles in contributing to
Singapore’s position as the regional medical hub, the list can be narrowed to about
seventeen healthcare establishments, including eleven public medical facilities and six
private hospitals.

The public medical facilities include five acute hospitals (Alexandra Hospital, Changi
General Hospital, National University Hospital, Singapore General Hospital, and Tan
Tock Seng Hospital), two specialist hospitals (KK Women and Children’s Hospital, and
Johns Hopkins Singapore International Medical Centre), and four specialty centres
(National Heart Centre, National Cancer Centre, National Eye Centre, and National
Dental Centre). The public hospitals provide inpatient and specialist outpatient services
and around-the-clock emergency departments.

Among the six acute private hospitals in Singapore, three belong to Parkway Holdings,
namely, Mount Elizabeth Hospital (505 beds), Gleneagles Hospital (380 beds), and
Parkway East Hospital (123 beds). Raffles Hospital is the largest of the three
unaffiliated private hospitals, with 380 beds. Thomson Medical Centre is a 190-bed
private hospital focusing on women and children care, while Mount Alvernia Hospital is
a not-for-profit Catholic hospital with 303 beds.

\textsuperscript{34} Source: Ministry of Health website: Singapore Healthcare System
\textsuperscript{35} Source: Ministry of Health website: Singapore Healthcare System
3.2.2 Market Share and Market Concentration

Using hospital admissions (measured by patient discharges) and the number of available beds, Gan and Frederick (2011) did a study of the market shares of the private and public hospitals in Singapore. Based on the study, the public and private sectors admitted 73.4% and 26.6% of hospital patients, respectively, in 2009. In terms of the number of beds, they had 76.1% and 23.9%, respectively. Singapore General Hospital had the largest market share, in terms of hospital admissions (16.2%) and the number of beds (19.2%).

3.2.3 Quality of Healthcare Services in Singapore

The quality of healthcare in Singapore is well-regarded in the region. In the World Health Organisation’s Ranking of Health Systems done in 2000, Singapore was ranked 6th in the world, and top among ASEAN countries.

To maintain the reputation of Singapore as a medical hub and provider of premium quality healthcare, Singapore’s hospitals compete among themselves and on the world markets in terms of quality. Most of the 17 hospitals highlighted earlier use accreditation by the Joint Commission International36 (JCI) to demonstrate their high quality, especially to medical tourists, and to differentiate themselves from other Asian hospitals. The JCI is an arm of the same organization that accredits most hospitals in the United States. The fact that most of Singapore’s hospitals have exceeded the government’s requirements by achieving JCI accreditation suggests that their quality improvements were due to competitive forces, rather than government mandates.

3.2.4 Competition Among Healthcare Providers

Given the small domestic population, the healthcare industry in Singapore is a highly competitive one. In particular, the private sector faces serious challenges in their competition against the public hospitals. The government provides subsidies to the public hospitals so that they can provide affordable health care to all Singaporeans.

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36 Joint Commission International is the international division of the U.S.-based Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), aimed at helping healthcare organizations outside US improve patient care safety through the provision of accreditation and certification services as well as through advisory and educational services implement practical and sustainable solutions. At present, there are over 200 healthcare institutions in 38 countries and regions with JCI accreditation.
through subsidised rates. About three-quarters of the hospital beds are subsidised by the government, though at different levels depending on the bed types. While medical tourists do not receive subsidies, subsidies provided to local patients who visit public hospitals may still give these hospitals an advantage over the private sector.

The other advantage the public hospitals have is group formation. By grouping the public hospitals into clusters, the public hospitals enjoy economies of scale and economies of scope. Among the private hospitals, only Parkway has the advantage of grouping. Even then, the scale is far from that of the public hospitals.

Hence, the public hospitals have a clear cost advantage over the private hospitals, which translate into price competitiveness. The private hospitals have to compete by differentiating themselves from the public hospitals using strategies other than price. They do so in a variety of ways. Some hospitals differentiate themselves by specializing in various niche services. For example, Thomson Medical Centre has built a very strong reputation in the area of obstetrics and gynaecology, Mount Elizabeth in heart and neurosurgery, and Gleneagles specializes in cosmetic surgery.

More importantly, the private hospitals are able to offer a less crowded atmosphere and much shorter waiting times, coupled with more personalised care. This attracts the segment of population who are prepared to pay a premium for a different level of service, than offered by the public sector.

3.2.5 Medical Tourism/Medical Travel

In Singapore, the government had increasingly encouraged private sector medicine since as early as 1965 (Purcal, 1989). Private consumption of health services at current market prices grew at an average of over 13% per year for a decade after 1969, and the private health sector expanded to meet the demands that increased with rapid economic growth in the 15 years between 1965 and 1980. Part of the private sector healthcare growth was in response to the growing demand from overseas customers in the region, and the government’s encouragement of specialist medical services for export so as to develop Singapore into a regional medical centre. By the end of the 1970s, a few specialists had a significant proportion of their patients coming from neighbouring
countries, and in 1984, some of them had 50% of their clients coming from surrounding countries (Chee, 2010).

Phua (1991) corroborates that as early as 1986, the Singaporean government had planned for the further development of private specialized medical services, and that this was with the overall objective of making the country into an international medical centre for patients from around the region. At this time, however, the linkage with tourism had not yet been made, and it was not called ‘medical tourism’.

Today, most of the 17 hospitals highlighted actively market themselves to foreign patients. All of them operate an international patient centre to arrange care and accommodations for medical tourists. Many of them also operate a network of international referral agencies outside of Singapore. These are foreign travel agencies or foreign medical tourism facilitators that can direct foreign patients to Singaporean hospitals. For the most part, these international referral agencies are in nearby Southeast Asian countries, such as Malaysia, Indonesia, Bangladesh, and Vietnam, but two of the groups have agencies in eastern Russia and one group (Parkway Health) has agencies in the United States and Canada.

The government of Singapore launched SingaporeMedicine in October 2003 as a multi-agency government initiative aimed at developing Singapore into one of Asia’s leading medical destinations for international patients. It targets drawing 1 million foreign patients to Singapore by 2012, while at the same time helps to generate S$3 billion in revenue for the medical travel industry. The agency includes representatives of the Ministry of Health, the Economic Development Board, the Singapore Tourism Board (STB), International Enterprise, and firms engaged in the medical travel industry. All of the 17 hospitals highlighted, including the private hospitals, participate in SingaporeMedicine. Some of the measures implemented include roadshows organised by STB in Malaysia, Indonesia, India, China, Russia and the Middle East to promote the capabilities of Singapore’s healthcare establishments. These roadshows help to showcase Singapore’s clinical expertise in areas such as coronary revascularisation, stem cell transplants, advances in brain tumour management, robotic surgery and advances in breast cancer management. In addition, the Government has also made it easier for patients from the Middle East to obtain medical visas for treatment in Singapore.
Besides the economic benefits that foreign patients can bring, the Singaporean government seeks to attract foreign patients also to create a critical mass in the medical community (Yap, 2006). Singapore has a population of only 4.2 million but has trained doctors in most specialties and sub-specialties. Among the foreign patients, many are the high-end difficult cases. Having them in Singapore helps to maintain a sustainable medical service. In a way, Singapore has to look after international patients so as to be able to look after her own (Yap, 2006).

In 2006, at least 410,000 medical travellers/tourists from 60 countries visited Singapore. Within that 410,000, more than 70 percent came from Indonesia, Malaysia, and the immediate surrounding regions. The rest of the patients come from a wide range of countries, including the Middle East, the United States, Canada, Europe, Russia, and Ukraine (Gan and Frederick, 2011). According to Yap (2006), international patients come to Singapore for four main types of healthcare services. These are:

a) essential healthcare, where the care is not available in their own country;
b) affordable healthcare, where the care is available but not affordable;
c) quality healthcare, where the care available locally is or is perceived to be of inferior quality; and
d) premium healthcare, where travelling for healthcare is seen as a luxury and adds prestige to the travelling person.

While foreigners generally make up only 5% of all patients at public hospitals, they account for 34% of total admission at Parkway’s hospitals, and a third of total hospital attendances at Raffles Hospital. For Parkway, more importantly, foreign patients contribute 55 - 60% of total revenue at its Singapore hospitals, given that revenue per foreign patient is almost twice that of a local patient\textsuperscript{37}.

\subsection*{3.2.6 Internationalisation of Private Healthcare Firms}

The public hospitals do not get involved in internationalisation beyond overseas marketing activities, given their primary responsibility to care for local patients.

\textsuperscript{37} “Singapore Healthcare Sector”, Su Tye Chua and Cher Ying Poh, Credit Suisse, 8 Jan 2008.
Among the private healthcare firms, Parkway Holdings was the earliest to expand overseas, and thus far, the one with the largest overseas network. Its internationalisation activities started some 20 years ago, when it first acquired a hospital in Penang, Malaysia. It subsequently added Mount Elizabeth Hospital and East Shore Hospital (renamed Parkway East Hospital in 2010) in Singapore to its Gleneagle Hospital in Singapore and in so doing became the largest private hospital operator in Southeast Asia. While initially focused on the Southeast Asian market, it has since gone beyond the region to set up hospitals and clinics in India, China and the Middle East, as well as setting up representative offices all over the world, including US, Russia and Middle East. As of 2010, it has a total of 15 hospitals around the region providing 3,277 beds, and operates 37 representative offices across the globe to facilitate medical travel.38

Raffles Medical Group which started as a primary care provider and has an extensive primary network in Singapore, opened a 380-bed hospital in Singapore in 2001 and has stepped up its efforts to attract foreign patients over the years. It is also involved in the primary healthcare sector in Hong Kong, and has medical centres in Indonesia and Shanghai, China, as well as representative offices in Indonesia, Bangladesh, Vietnam and Russia.

Thomson Medical Centre, a Singapore hospital focusing on women and children services, currently runs Vietnam’s first private purpose-designed women and children’s hospital, which it was involved from the design to operation on a management contract basis. It has an option to acquire a 25% equity stake in the project. It is also providing consultancy to develop a second women and children’s hospital in Vietnam.

Even not-for-profit Mount Alvernia Hospital, which traditionally focused predominantly on the local patients, has stepped up its international operations in recent years, with the opening of two representative offices, one in Jakarta, Indonesia and the other in Dhaka, Bangladesh.

Table 3.1 summarises the private healthcare firms with hospital operations in Singapore, and their overseas operations.

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38 Source: Parkway Holdings website.
Table 3.1 – Summary of private healthcare firms with hospital operation in Singapore

<table>
<thead>
<tr>
<th>Healthcare Firm</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkway Group</td>
<td>15 hospitals, 3277 beds in Singapore, Malaysia, China, India, Brunei; 37 representative offices in 17 countries.</td>
</tr>
<tr>
<td>Raffles Medical Group</td>
<td>One hospital, 380 beds in Singapore, network of 65 clinics in Singapore, four in Hong Kong and one in Shanghai; Representative offices in Indonesia, Bangladesh, Vietnam, Russia.</td>
</tr>
<tr>
<td>Thomson Medical Centre</td>
<td>One 190-bed hospital in Singapore. Managing a 260-bed women and children hospital in Vietnam, with option to purchase equity stake.</td>
</tr>
<tr>
<td>Mount Alvernia Hospital</td>
<td>One 303-bed hospital in Singapore. Two representative offices in Indonesia and Bangladesh.</td>
</tr>
</tbody>
</table>

3.3 STATE OF HEALTHCARE INDUSTRY IN SOUTHEAST ASIA

3.3.1 State of Health

The healthcare situation in ASEAN is a very diverse one. The standard of healthcare ranges from very high in countries such as Singapore, Brunei and Malaysia to those with poor healthcare standards such as Myanmar, Laos, Cambodia and Vietnam. The last time the World Health Organisation produced a ranking of the health systems across the world was in 2000, and the results for ASEAN countries are shown below in Table 3.2. As can be expected, there are controversies with the methodology used for the survey, hence its discontinuation, but it still gave a good reflection of the relative performance of the various healthcare systems.

Table 3.2 - Ranking for ASEAN Health Systems (in 2000)39

<table>
<thead>
<tr>
<th>Country</th>
<th>Ranking within ASEAN</th>
<th>World ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singapore</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Brunei</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td>Thailand</td>
<td>3</td>
<td>47</td>
</tr>
<tr>
<td>Malaysia</td>
<td>4</td>
<td>49</td>
</tr>
<tr>
<td>Philippines</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>Indonesia</td>
<td>6</td>
<td>92</td>
</tr>
<tr>
<td>Vietnam</td>
<td>7</td>
<td>160</td>
</tr>
<tr>
<td>Laos</td>
<td>8</td>
<td>165</td>
</tr>
<tr>
<td>Cambodia</td>
<td>9</td>
<td>174</td>
</tr>
<tr>
<td>Myanmar</td>
<td>10</td>
<td>190</td>
</tr>
</tbody>
</table>

Another indicator that can be used to reflect the healthcare standard is the number of physicians per 100,000 population. The GDP per capita also shows the amount of resources the country has for various public services, including healthcare. The relevant information for ASEAN countries is presented in Table 3.3 below. It reflects a similar picture as above.

Table 3.3 – Regional Comparison in terms of Physician to Population Ratio and GDP per Capita

<table>
<thead>
<tr>
<th>Country</th>
<th>Physician per 100,000 people in 2005 (ranking)</th>
<th>GDP per capita (US$) in 2005 (ranking)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei</td>
<td>101 (2)</td>
<td>17,121 (2)</td>
</tr>
<tr>
<td>Cambodia</td>
<td>16 (9)</td>
<td>440 (9)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>13 (10)</td>
<td>1,302 (5)</td>
</tr>
<tr>
<td>Laos</td>
<td>35 (8)</td>
<td>485 (8)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>70 (3)</td>
<td>5,142 (3)</td>
</tr>
<tr>
<td>Myanmar</td>
<td>36 (7)</td>
<td>249 (10)</td>
</tr>
<tr>
<td>Philippines</td>
<td>58 (4)</td>
<td>1,192 (6)</td>
</tr>
<tr>
<td>Singapore</td>
<td>140 (1)</td>
<td>26,893 (1)</td>
</tr>
<tr>
<td>Thailand</td>
<td>37 (6)</td>
<td>2,750 (4)</td>
</tr>
<tr>
<td>Vietnam</td>
<td>53 (5)</td>
<td>631 (7)</td>
</tr>
</tbody>
</table>

Most ASEAN countries spend between 2 and 5 percent of GDP on healthcare, which is low by developed countries standard. This partly reflects the relatively young population among ASEAN countries, though they are generally aging, especially in the more developed countries like Singapore.

Other than Singapore, where the public healthcare system is of a high standard with all the hospitals accredited by Joint Commission International (JCI), the healthcare infrastructure and delivery in most of the other ASEAN countries range from poor to uneven. Nevertheless, in the more developed economies like Brunei, Malaysia, Thailand and Philippines, there are isolated pockets of excellence that cater primarily to the elite and medical tourism, especially in the major cities.

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Some of the health trends that will drive healthcare demand in the region moving forward include (Deloitte, 2010):

- **Population growth** – The Southeast Asian population of about 580 million is expected to add a further 150 million people by 2050. Indonesia, the largest country in the region, is expected to grow from about 225 million to about 288 million by 2050.

- **Aging population** – As per United Nations’ estimates, the number of people aged 65 and above is expected to increase by 430% in Southeast Asia by the year 2050, to about 130 million.

- **Rising Middle-Class** – Economic development will increase the pool of Middle Class population in Southeast Asia, who are likely to demand higher quality healthcare. Two of the countries with the fastest growing middle class population in the region are Indonesia and Vietnam.

- **Rising Incidence of Lifestyle and Chronic Diseases** – Fast-paced economic growth, rising income levels, changing lifestyles and aging populations have led to an increase in diseases like hypertension, diabetes, cardiovascular diseases and cancer in ASEAN countries. Cancer and heart diseases are among the top five causes of morbidity and mortality in many of the ASEAN countries.

- **Growing Incidence of Infectious or Communicable Diseases** – For developing countries such as Vietnam and Indonesia, infectious or communicable diseases such as Avian Flu and dengue fever continue to be a major health concern. Additionally, malaria and tuberculosis are major causes of morbidity and mortality in these countries.

- **Increasing usage of private sector and medical travel** – Due to the poor state of public health system in many of the ASEAN countries, many among the emerging Middle Class families have turned to the private healthcare system. This has led to the number of hospitals in the private sector increasing significantly during the last few decades. In countries where the growth in the health sector is more than what the national economy can handle, the hospitals
have turned to attracting patients from neighbouring countries. This has increased medical travel within the region, as the more affluent groups from the less developed countries are attracted to the availability of high quality medical care at relatively low costs in other ASEAN countries.

The above trends point to a continued increase in demand for healthcare in the region. While this increasing demand will be good for healthcare operators in the region, serious challenges persist in the development and management of healthcare human resources in many countries. In addition to a continuing shortage of nurses, doctors and other allied health professionals, there are also imbalances in the mix of healthcare personnel. Disparities in the geographical distribution of healthcare personnel between urban and rural areas are stark, and this is further aggravated by the increasing competition between the public and private sectors.

3.3.2 Major Healthcare MNEs in the ASEAN Region (Outside Singapore)

Besides Singapore, the governments of Malaysia and Thailand also see the potential of healthcare sector as an economic engine for their countries, and have been actively positioning themselves as regional medical hubs as well. Private hospitals in Thailand and Malaysia tend to cite the 1997 Asian Financial Crisis as a key milestone for them. The saturation of private healthcare facilities in the two countries, coupled with the sharp drop in local patients during the crisis meant that the hospitals have to go out of their home country to fill the beds. This has led to the fast growth of groups like Bumrungrad and Bangkok Dusit from Thailand and KPJ from Malaysia.

Bumrungrad Hospital is one of the best known hospitals in the business of medical tourism. It is generally acknowledged as a pioneer in medical tourism, and currently sees over 400,000 international patients from over 200 countries each year. It is currently the largest private hospital in Southeast Asia, and is still being constantly upgraded and expanded. Besides having 18 representative offices in 15 countries, the hospital has since undertaken hospital management projects in the Philippines and Middle East\(^2\).

The other major Thai hospital group targeting foreign patient is Bangkok Dusit Medical Services, which runs the Bangkok Hospital Medical Centre in Bangkok, as well as 19 hospitals in Bangkok and other parts of Thailand, two affiliated hospitals in Cambodia and one in the UAE\textsuperscript{43}. Unlike Bumrungrad, which focuses on developing its flagship hospital in Bangkok, Bangkok Dusit has expanded its network of hospitals throughout Thailand, including in all the major tourist towns like Phuket, Samui and Pattaya.

The largest private healthcare group within Malaysia is KPJ Healthcare, which runs 20 hospitals in Malaysia and two in Indonesia\textsuperscript{44}. It also previously ran two hospitals in Saudi Arabia and one in Bangladesh, but had since withdrawn from these management contracts to focus on their regional business\textsuperscript{45}.

There is also Health Management International (HMI), which has its origin from Singapore and still has its headquarter and healthcare education operation based in Singapore, but operates two hospitals in Malaysia. HMI used to run a hospital in Singapore, but that was closed in 2002 following a restructuring. Its Malacca-based Mahkota Medical Centre is one of the main “medical tourism” hospitals in Malaysia, with strong support from Indonesian patients. Its other hospital in Johor, Malaysia, which opened in 2009, targets not just locals and Indonesians but also Singaporean patients looking for more affordable private healthcare.

An emerging new player in the region is Columbia Asia, which has its headquarters in Malaysia and has backing from a Seattle-based investment fund. It currently has 16 facilities in India, Malaysia, Vietnam and Indonesia, with 11 more hospitals under construction and it owns the property for another 12\textsuperscript{46}. By 2012, Columbia Asia will have 21 hospitals and an airport clinic in India, 11 hospitals in Malaysia, three in Vietnam and three in Indonesia. Unlike most other major hospital groups in the region, the company offers full-service hospitals built in neighbourhoods focusing on delivery of high quality primary and secondary\textsuperscript{47} care, rather than large hospitals in the central city.

\textsuperscript{43} Bangkok Dusit Medical Services Annual Report 2010
\textsuperscript{44} KPJ Healthcare Berhad Annual Report 2010
\textsuperscript{45} KPJ Healthcare Berhad Annual Report 2009
\textsuperscript{46} Source: \url{http://en.wikipedia.org/wiki/Columbia_Asia}
\textsuperscript{47} Secondary care services are provided by medical specialists or hospital staff members to a patient who was referred by a general practitioner who first diagnosed or treated the patient (Green and Bowie, 2010: p12).
A summary of the major private healthcare firms in ASEAN outside of Singapore, and their international operations is shown in Table 3.4.

Table 3.4 – Summary of Major Private Healthcare Firms in ASEAN Outside of Singapore

<table>
<thead>
<tr>
<th>Firm</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPJ Healthcare (Malaysia)</td>
<td>22 hospitals in Malaysia and Indonesia, with more than 2,600 beds</td>
</tr>
<tr>
<td>HMI (HQ in Singapore)</td>
<td>Two hospitals in Malaysia – Mahkota Medical Centre (288 beds) and Regency Specialist Hospital (218 beds), 20 representative offices overseas, mainly in Indonesia (^{48})</td>
</tr>
<tr>
<td>Columbia Asia (HQ in Malaysia)</td>
<td>16 facilities in India, Malaysia, Vietnam, Indonesia</td>
</tr>
<tr>
<td>Bangkok Dusit (Thailand)</td>
<td>22 hospitals, with more than 3500 beds in Thailand, Cambodia, UAE</td>
</tr>
<tr>
<td>Bumrungrad Hospital (Thailand)</td>
<td>Four hospitals, 1500 beds in Thailand, Philippines and Middle East; 18 overseas representative offices in 15 countries</td>
</tr>
</tbody>
</table>

3.4 CHAPTER CONCLUSION

This chapter has provided an overview of the healthcare industry in Singapore and the region. As can be seen, the Singaporean healthcare sector is a highly competitive one. The private hospitals face significant challenge in attracting local patients given that the public hospitals are subsidized by the government, are of a high quality and are equally active in attracting foreign patients. Nevertheless, the private hospitals have the advantage of being more able to offer more personalized care with short or no waiting times, which has made them attractive to the segment of population which is less price sensitive. The strong domestic competition, coupled with the small domestic population base, is an important point to remember when discussing the internationalisation strategies of the case firms in chapter 6.

At the regional level, the presence of large healthcare groups from Malaysia and Thailand which compete with the Singapore hospitals for foreign patients in the less

\(^{48}\) HMI’s Annual Report 2010.
developed parts of the region will have an impact on the way the healthcare industry will change as the region integrates. While the healthcare MNEs from Malaysia and Thailand have the advantages of a larger domestic base and lower cost, Singaporean healthcare firms still have an advantage in terms of quality, though the gap is expected to narrow over time\textsuperscript{49}.

With the research question presented in Chapter 1, literature review in Chapter 2 and the local and regional context provided in this chapter, the next Chapter will take all these into consideration in proposing the conceptual framework for this research.

\footnote{\textit{“Doctor is in but foreign patients dither”}, The Business Times, 13 Nov 2010.}
CHAPTER 4 – CONCEPTUAL FRAMEWORK AND PROPOSITION DEVELOPMENT

4.1 INTRODUCTION

As detailed in the literature review, there are many different strands of international business theories that need to be considered for this research. This chapter provides an overview of the conceptual base for this study and links the theories to the healthcare industry setting for the analysis of the case firms.

The chapter will first propose a conceptual framework for the analysis of the internationalisation of healthcare firms from Singapore, followed by a discussion on the various factors that may influence the internationalisation choices made by the healthcare firms, in relation to their market selections, timing of entry and choice of entry modes. Thereafter, applying the theories reviewed in Chapter 2 in the context of the conceptual framework proposed, nine research propositions were developed in relation to the different aspects of the internationalisation of healthcare firms from Singapore to guide the research.

4.2 CONCEPTUAL FRAMEWORK

The objective of a conceptual framework is to bring structure and focus to the study, without compromising the inductive nature of qualitative research (Parkhe, 1993; Miles and Huberman, 1994; Yin, 2003a). The framework increases the theoretical level of the study by including comparisons with similar and conflicting literature; that is, to apply analytic generalisation by using previous theories as a template (Eisenhardt, 1989; Yin, 2003a). Also, a conceptual framework helps to be selective in terms of identifying the most likely concepts and relationships to utilise for the study (Miles and Huberman, 1994; Dubois and Gadde, 2002; Yin, 2003a; Silverman, 2005), but being less defined than a theoretical framework with very specified variables (Cavana et al, 2001).

As introduced in Chapter 1, this research aims to study the internationalisation strategies of private healthcare firms from Singapore, including the market selection, entry modes, timing of entry, as well as their response to regional integration. Based partly on the models developed by Ekeledo and Sivakumar (1998, 2004), Koch (2001), Lommelen
...and Matthyssens (2005) and Javalgi and Martin (2007), as well as some of the extant theories which were reviewed earlier such as the Institutional Theory, a conceptual framework was developed to analyse the internationalisation of healthcare firms from Singapore. (see Fig. 4.1).

Figure 4.1 – Proposed Conceptual Framework

The framework identifies five groups of factors that potentially influence the internationalisation choices made by the healthcare firms, in relation to their market selection, timing of entry and choice of entry modes, namely:

a) Home country factors – These include factors such as market size, government support, and intensity of domestic competition. As discussed in the literature, a small home market is expected to push the firms to internationalise to overcome their handicap of a small domestic market. Government support helps to facilitate the internationalisation of firms, and where government provides funding support or an umbrella structure for smaller firms to expand overseas, such as through branding or facility (eg, setting up an industrial park), it helps the smaller firms to overcome their own size limitations. And when the competition in the home country is oligopolistic, the foreign investment behaviour of a firm often elicits similar behaviour to domestic rivals. For example, when foreign investment by a domestic rival threatens competitive balance at home, rival firms invest abroad to restore domestic competitive equilibrium (Watson, 1982).
b) Host country factors – These include factors such as market potential, country risk, rules and regulations, psychic/cultural distance, and availability of necessary resources, as well as the normative and cognitive forces operating in the host country. Market potential is obviously an important consideration since healthcare firms typically internationalise for market-seeking purpose. Country risk, in terms of political risk or other risks such as risk of natural disasters or poor economic infrastructure, may not deter market entry but may affect the choice of entry mode. Similarly, the host country’s rules and regulations, psychic/cultural distance and availability of necessary resources, especially manpower resources in sufficient quantity and quality, all have the potential to affect the internationalisation strategy of the firm.

Besides, there is a need to take into account the normative forces, which can take the form of nationalistic sentiments, unique customer preferences and the need to leverage on “Guanxi” (relationship) to facilitate business deals, as well as the cognitive forces, such as the business structure of the host country and the look and feel of the medical centre.

c) Firm-specific resources – These include factors such as firm size, network relationship, business experience, specialised assets and reputation. Firm size has a key influence on the internationalisation strategy as it determines the resources the firm has for overseas expansion, both in terms of financial and manpower resources. Larger firms are also often less afraid to undertake joint venture, as they are generally less concerned than smaller firms about the possibility of exploitation by local partners. As discussed in the literature, network relationship has an important influence on the location of entry, and in the case of MNEs from emerging economies, network relationship is critical in facilitating the internationalisation of the firm as it rely on these relationships to gain resources which it may lack. International business experience of the firm and the management, specialized assets such as a proprietary information technology system or a strong clinical team in particular medical sub-specialties, and a strong reputation are all factors that have an impact on the firm’s internationalisation strategy.
d) Nature of product – As discussed in the literature, “hard” (separable) and “soft” (non-separable) services have significant differences in terms of their options for internationalisation process and market entry modes. While healthcare has hitherto been generally considered a “soft” service, fundamental changes to the concept of healthcare service over time (eg, standardization of care and the greater feasibility to disaggregate care along the value chain), coupled with advancement in communication technology, there is increasing “hardening” of healthcare as a service. Moreover, the increasing commodification of healthcare as discussed in the literature review (Pellegrino, 1999; Keaney, 1999; Chee, 2007) may also have significant influence on the internationalisation strategy of healthcare firms, as it enables firms to internationalise simply by making information of their services available to foreign patients.

e) Strategic considerations – These include factors such as motives for expansion, business strategy and degree of control. As highlighted earlier, healthcare firms internationalise generally for market-seeking motives, though some are beginning to internationalise for efficiency-seeking reasons (for example, to operate in a lower cost location to attract more price-sensitive patients or to cope with rise in cost back home), or have efficiency-seeking as a secondary objective. The business strategy of the firm, for example, whether to be domestic-focused (consolidate the home operation and use representative offices to attract foreign patients) or overseas-focused (to serve local populations by setting up hospitals overseas), will also affect the internationalisation strategy. The degree of control desired by the firm will also dictate the types of entry modes that will be employed. Control is an important strategic consideration as it has been identified as the single most important determinant of risks and returns of the foreign venture (Anderson and Gatignon, 1986).

In the conceptual framework, regional integration is posited as a factor that affects the “host country factors” and “strategic considerations”, which in turn will affect the internationalisation strategy of the firm. From the various literature reviewed, it has been highlighted that regional integration affects host country factors by reducing distance premium (Hirsch, 2006), and reducing barriers for doing business across borders, such as through the harmonization of regulations and regional trade and
investment regimes (Hirsch, 2006; Li and Guisinger, 1992; Rugman and Verbeke, 2004 and 2005; Lehrer and Asakawa, 1999; Schutte, 1997; Arunanondchai and Fink, 2007). It also potentially expands the “market potential” as investment in new facilities in one of the countries can effectively serve not just the population there but also the surrounding countries. Besides, regional integration affects the strategic considerations discussed above, as well as providing other strategic impetus for firms when deciding their internationalisation strategies. For example, regional integration levels the playing field for all the key healthcare firms within the region, through benefits like reducing regulatory barriers and transaction costs for cross-border activities, offering a larger market to firms, and availing the firms of human resources within the region. While this means the firms will have increased opportunities to access previously protected markets as well as enter into other countries with specific country-specific advantages which they can tap on, it also opens their home country to entry by firms from other countries. This opens up new strategic considerations for the firms in their internationalisation strategy.

4.3 PROPOSITION DEVELOPMENT

Shanks and Parr (2003) stated that propositions are predictions about the world that may be deduced logically from theory. According to Yin (2003b), a proposition “directs attention to something that should be examined within the scope of the study”. Research propositions are less precise than hypotheses used in a quantitative study, but are also more specific than broad research questions used to guide the research in more inductive qualitative studies (Miles and Huberman, 1994; Ghauri et al, 1995; Carson et al, 2001; Cavana et al., 2001; Silverman, 2005). In case study methodologies, more specific research propositions based on theory can give direction to data collection and analysis in the search for relevant findings (Miles and Huberman, 1994; Yin, 2003a). Research propositions can be used in a systematic way to explain emergent theory, but also allow space to identify variations in the patterns and previously unidentified factors influencing the process (Strauss and Corbin, 1998; Yin, 2003a; Ghauri, 2004). Also, the use of specific research propositions allows better comparability across multiple-cases and with different theories, especially when the data from the case studies are then related back to the propositions (Ghauri et al, 1995).
Therefore, to guide the research, the various theories reviewed earlier will be applied to the context of the healthcare firms from Singapore, and nine research propositions were developed with respect to the internationalisation strategy of healthcare firms from Singapore. The propositions will relate to the various aspects of internationalisation to be studied, namely, market selection, entry modes, timing of entry, as well as on the firms’ overall strategy and responses to regional integration.

4.3.1 Market Selection

4.3.1.1 Proposition 1

According to Johanson and Valhne (1977; 1990), MNEs are expected to internationalise incrementally, starting with neighbouring countries where ‘psychic’ distance is short, and move towards more distant countries as they accumulate more experiential knowledge. In terms of entry modes, they tend to start with less committed modes like exporting, then gradually adopt more committed modes such as foreign country-based subsidiaries. However, due to the specific characteristics of services such as intangibility and inseparability, service companies may have to start their internationalisation with more committed operation modes. On the other hand, according to the Uppsala model (Johanson and Vahlne, 2009), the firms will tap into their network for their internationalisation. Hence the choice of market might not follow the traditional sequential process but may be more dependent on the network it belongs to. If the focal firm sees opportunities in markets where it does not have current partners or networks, it may start building new connections with a firm which is already operating in a network there.

This proposition about the firm tapping on its existing network is further reinforced in the case of the healthcare groups from Singapore, given the findings from some literature that Chinese and Asian firms rely especially more on personal relationships and networks for their internationalisation (Chen, 1995; Hamilton, 1996; Luo, 2000).

Thus, the first proposition is that: *the healthcare firm will tap into its network when selecting markets to enter; if it sees opportunities in markets where it does not have current partners or networks, it may start building new connections with a firm which is operating in a network there.*
4.3.1.2 Proposition 2

In addition, according to Rugman and Verbeke (2008), services MNEs are expected to be regional in focus, notwithstanding that they are increasingly expanding internationally, leveraging on globalisation trends. Given the increasing regional integration within the ASEAN region, the Singaporean healthcare firms can be expected to adopt a regional strategy rather than a global strategy, and they are expected to be able to exploit their non-location-bound FSAs profitably within the home region. On the other hand, they may also face greater difficulties in attempting to exploit their FSAs outside the region.

One issue that needs to be addressed here is the definition of “regional” in the context of Singapore-based MNEs. Rugman and Verbeke (2004) define a global firm as a company with less than 50 percent of sales in its home Triad region and at least 20 percent in each of the two other Triad regions. In their definition, the Triad regions refer to the regions of Europe, North America and Asia. In the context of Singapore-based MNEs, it is possible to equate “region” to “Asia”, but the author prefers to adopt a more restrictive but meaningful way of defining “region” as the ASEAN region, since this is the immediate “region” which the firms operate in, and which they are more likely to have advantage exploiting their FSAs given their “insider” status. Nevertheless, ASEAN has since entered into free trade agreements with key trading partners within Asia like Japan, South Korea, China and India, which should facilitate the regional integration within the wider Asia region over time, though this is unlikely to reach the same extent as the integration within ASEAN in the short run, especially with the move towards AEC by 2015.

Thus, my Proposition 2 is that: as the healthcare firm expands internationally, it adopts a regional strategy rather than a global strategy. Based on the above definition, it can be expected that the majority of the firm’s business activities are within the ASEAN region.
4.3.2 Entry Modes

4.3.2.1 Proposition 3

Moving on to firms’ choices of entry modes, according to the traditional Eclectic Paradigm (Dunning, 1980; 1988; 1993), firms pursue foreign direct investment when they perceive ownership, location and internalisation advantages. Whether and where the firm will actually engage in FDI will depend on finding a suitable location with sufficient country-specific advantages that match the particular FDI motivations of the MNE. However, firms from Singapore, being latecomer MNEs, may not have the types of resource advantages as highlighted by Dunning. As discussed in the literature review, both frameworks by Mathews (2006) and Luo & Tung (2007) recognise the importance of asset augmentation for such latecomer MNEs to learn, integrate and exploit markets in a dynamic process. Applying the LLL framework of Mathews (2006), the healthcare firms from Singapore can be expected to have their internationalisation driven by resource linkage, leverage and learning. They internationalise in order to build their advantages - a reversal of the traditional perspective. To do so, they are expected to use collaborative entry modes such as joint ventures or service contracts to gain leverage on incumbent firms (Mathews, 2006). The use of collaborative entry modes is also expected of the MNEs from Singapore due their relative lack of resources, given their smaller domestic market (Cho, 1998; D’Aveni, 2002).

Adding to the above, Bartels et al (2009) argued that for services, there is a greater propensity to invest in foreign markets through equity joint ventures, rather than pursue contractual arrangements.

Therefore, the third proposition is that: *the healthcare firm will find ways to link up with sources of resources which it can tap, and use collaborative entry modes such as joint ventures or service contracts for market entry, with joint venture preferred over contractual modes.*

4.3.2.2 Proposition 4

The nature of the product was highlighted in the conceptual framework as a factor that has significant influence on the internationalisation of firms. As discussed in the
literature review, Chee (2007) argued that healthcare in Malaysia is undergoing a process of commodification, as reflected in three features that are increasingly seen in the sector, namely, the use of and emphasis on ‘marketing’ as an important activity by which to procure patients-customers; the increasing emphasis on quality, and in order to achieve it, the use of benchmarking and standardisation in accordance with internationally recognised markers; and the creation of customers and consumers. While there has been no similar study done on the Singapore healthcare sector, similar observations can be expected for Singapore, since the same three features mentioned by Chee (2007) can also be observed in Singapore, as highlighted in Chapter 3. As a “service commodity”, healthcare services can be expected to be tradable in almost the same way as a commodity and it is possible for healthcare service to be “exported” to a foreign country (or for it to be sold in a foreign country away from the point of production), though actual consumption will have to be done at the premises of the “exporting” hospital. This will be a move away from the traditional view of healthcare services as a non-separable “soft” service that can be internationalised only via non-export modes such as sole ownership, joint venture, franchising, or management contract.

Therefore, my proposition 4 is that: the provision of healthcare service in Singapore is undergoing the process of commodification, and healthcare firms can enter foreign markets via “exporting” (ie, sold in a foreign country away from the point of production and consumption).

4.3.3 Timing of Entry

4.3.3.1 Proposition 5

Moving on to the timing of entry, Mathews (2006) observed that the “dragon MNEs” all internationalise very rapidly. They do so to capitalize on the transient advantages they had at the point in time; they are not concerned with establishing solid international structures, but rather quickly develop flexible and “lattice-like” structures spanning diverse countries and markets. This internationalisation behaviour can be expected to be exhibited by internationalising healthcare firms from Singapore. In addition, based on the literature on MNEs from SMOPECs, the healthcare firms from Singapore can be expected to be more outwardly oriented compared to those from larger countries and to
internationalise quickly (Hirsch, 2006), as there are stronger push forces for them to expand overseas due to constraints imposed by their small domestic markets.

This leads to the fifth proposition, which is that: the healthcare firm will internationalise very rapidly.

4.3.4 Overall Strategy

In addition to propositions about the three specific aspects of internationalisation, there are other theories from existing literature that can help in the understanding of the overall internationalisation strategy of private healthcare firms from Singapore.

4.3.4.1 Proposition 6

In terms of how MNEs organise their internationalisation activities, a useful concept that was discussed in the literature review is the “Global Factory” (Buckley and Ghauri, 2004). While Bartels et al (2009) discussed its application to services sector, the concept has yet to be specifically applied to a service, and certainly not to healthcare services. On the other hand, this appears to be a powerful concept for studying the impact of regional integration on internationalisation strategy of service firms, in the same way it has been applied to study the strategies of manufacturing MNE, for example, with respect to the rise of China (Buckley, 2007). Furthermore, based on the background discussion in Chapter 3 and the study by Arunanondchai and Fink (2007), there are certain aspects in the development of healthcare services in the ASEAN region that suggest that this is a relevant model for MNEs in the region – the emergence of regional transnational demand for healthcare, and the availability of locations within the region which can serve not just as markets but also as sites with differentiated resources and capabilities which the healthcare MNEs can tap into.

To recap, the global factory is made up of three components – the Original Equipment Manufacturers (OEMs), the contract manufacturers (CMs), and warehousing, distribution and adaptation “spokes” organised in a “hub and spoke” manner. For application to a healthcare MNE, the components need to be adjusted. The OEM can be correlated to the hub hospitals of the firm; the CM can be correlated to secondary hospitals overseas which the hub hospitals can offshore some of its services to, to better
cater to local requirements and to leverage on the lower production cost; and the “warehousing, distribution and adaptation” can be correlated to the medical centres, clinics and representative offices which do not perform hospital services but focus on the primary care or “sales” functions, with the objective of “selling” healthcare services to the patients (who would then have to consume the service at the firm’s hospitals).

Two other points need to be clarified here. Firstly, the offshoring to the CMs in this case involves hospital services, rather than a specific process within the hospital service at the hub. This is a point of deviation from the manufacturing “global factory”, where the offshored function is typically a part of the manufacturing process of the product. While it is possible to offshore or outsource certain parts of the healthcare service, eg, radiology or medical transcription services, these are too small in the entire value chain of healthcare services to be included for discussion here, since the bulk of the value added activity will have to be done at the hospital itself, where the care by the doctors, nurses and other healthcare professionals takes place. Secondly, the CMs in this case are likely to be healthcare institutions which can also perform the role of “warehousing, distribution and adaptation” as well (ie, to refer patients to the hub hospitals).

Summarising the above, it can be argued that if the “Global factory” model is applicable to healthcare service providers, the firm is expected to organise its operations in a hub-and-spoke network, with the hub hospitals supported by a “spoke” network of clinics/medical centres/ hospitals/ representative offices which help to “sell” the services of the hub hospitals. Some of the spoke-hospitals can also be expected to perform the role of the CMs, performing some hospital services “offshored” by the hub hospitals.

Thus, my Proposition 6 is that the healthcare firm will move towards a hub and spoke configuration as they expand overseas, including having some spoke-hospitals which the firm offshores some of its services to.

4.3.4.2 Proposition 7

Another relevant issue is whether there are different phases in the internationalisation process of the private healthcare firms, and if so, whether the internationalisation strategies and choices of the firms vary during the different phases. Laanti et al (2009), in their paper on internationalisation of telecommunication MNEs from SMOPECs,
discussed four phases of internationalisation process which the firms went through, namely, learning phase, opportunistic phase, de-internationalisation phase, and maturisation phase, which were different from the incremental and deterministic phases identified in some traditional internationalisation process models, such as the Uppsala Internationalisation Process Model (Johanson and Valhne, 1997, 1990). While the subject of this study is different, it will be interesting to see if the healthcare firms from Singapore went through these phases of internationalisation process as well, and possibly extend the concept to other services beyond telecommunication.

To elaborate, Laanti et al (2009) observed that in the first phase of outward internationalisation (ie, the learning phase), the companies focussed on learning and gaining international experience through undertaking consultancy projects and via international inward operations\(^{50}\). Although the consulting operations were not important for the case companies in regard to revenues or profits, it helped them to overcome some of the early challenges in internationalisation linked to uncertainty and risk.

In the second phase (ie, the opportunistic phase), the case companies started to invest in companies and networks in several different foreign markets. Most of these investments were joint ventures with local partners.

In both phases one and two, market selection was very opportunistic and diversified geographically. Any pattern appeared to be based on the exploitation of core competencies such as technical and marketing knowledge in this industry.

In the third phase (ie, the de-internationalisation phase), the case study companies started to retreat from several target markets. This was partly prompted by the change in general market sentiment around 2000/2001, though one of the case firms started de-internationalising from distant markets earlier in the 1990s to focus on expanding in its immediate region. Little if any investments were made in distant markets during that phase.

\(^{50}\) An example of “international inward operations” in Laanti et al (2009) was the building of international connections by the telecommunication companies, such as submarine cables and satellite systems, in order to serve their domestic customers’ needs to be connected internationally.
In the fourth phase (ie, the maturisation phase), the case companies started to grow their businesses again but instead of global strategies, they focussed on neighbouring markets and their own region. Companies became more focused both in their market strategies and product strategies.

The seventh proposition is, therefore, that: *the healthcare firms from Singapore follow the four phases of internationalisation process, namely, learning phase, opportunistic phase, de-internationalisation phase, and maturisation phase.*

4.3.4.3 *Proposition 8*

One challenge faced by MNEs from smaller countries highlighted in the literature review is their lack of resources needed for internationalisation, due to their narrower domestic resource pools (Hubbard et al, 2002; Gabrielsson and Gabrielsson, 2004). Therefore, the governments of these countries tend to play a greater role in supporting their MNEs in their internationalisation, when compared to MNEs from large countries (Lewis, 1999; Rugman and Hodgetts, 2001; Benito et al, 2002; Hubbard et al, 2002).

Besides this being a characteristic of MNEs from SMOPECs, literature on internationalisation of Asian firms have also found that the state tends to play a significant role in the overseas expansion of firms (Zutshi and Gibbons, 1998; Yeung, 1999). Hence, the same can be expected to be applicable to the internationalising healthcare firms from Singapore.

Given the above, it can be expected that the government plays a role in the internationalisation of private healthcare firms from Singapore. This in turn may affect the internationalisation strategies they adopt. Therefore, the eighth proposition is that *the government plays a relatively significant role in developing the business and supporting the internationalisation of healthcare firms from Singapore.*
4.3.5 Responses to Regional Integration

4.3.5.1 Proposition 9

Moving on to the issue of impact of regional integration, this was discussed in several of the articles in the literature review. The main impact of regional integration with respect to the internationalisation of firms is to reduce the cross-border barriers and facilitate firms’ expansion within the region. This will lead to MNEs placing an even greater emphasis on regional strategy (Rugman and Verbeke, 2004; 2005), making it easier and more profitable to tap into the differentiated manpower resources in locations within the region (Buckley et al, 2001), as well as it becoming easier for firms to move towards the “global factory” configuration since regional integration reduces the cost of coordination across borders. Hirsch (2006) also argue that firms from SMOPEC would benefit even more from regional integration as it reduces the distance premium, which allows them to be more internationalised, and to achieve greater economies of scale.

Furthermore, taking the concept of “industrialization” of services (Segal-Horn, 1998), regional integration can be expected to spur the healthcare industry to move towards greater concentration with clear market leaders, through mergers and acquisitions, to exploit the economies of scale and scope.

Therefore, my Proposition 9 is that: with regional integration, healthcare firms from Singapore are expected to emphasise even more on regional strategy, step up their overseas expansion, actively seek opportunities for mergers and acquisitions, and deploy location strategy which taps even more on differentiated manpower resources in locations within the region.

4.4 CHAPTER CONCLUSION

This Chapter started with a proposal of the conceptual framework for the analysis of the internationalisation of healthcare firms from Singapore. The framework identified five groups of factors that potentially influence the internationalisation choices made by the healthcare firms, namely, home country factors, host country factors, firm-specific resources, nature of product and strategic considerations. The impact of regional
integration is also considered through the “host country factors” and “strategic considerations”.

To guide the research, nine research propositions were also developed by applying the various theories reviewed earlier to the context of the healthcare firms from Singapore. The propositions relate to the various aspects of internationalisation, including market selection, entry modes, timing of entry, as well as on the firms’ overall strategy and responses to regional integration. These propositions should be useful in directing the attention to some of the specific behaviours to be expected of the case firms based on the extant theories. These propositions will be examined in the cross-case analysis in Chapter 7, after discussion of the case firms in Chapter 6.
CHAPTER 5 – RESEARCH METHODOLOGY

5.1 INTRODUCTION

This chapter discusses the research methodology and the research process from design to selection of case firms, and explains the choice of case study approach for the research.

The first section deals with the research approach, where the use of a qualitative approach for this research is discussed. This is followed by discussion on the research strategy, which explains the appropriateness of case study method for this research, and specifically, a multiple-case study. The research design and case study protocol are then discussed, including the selection of the case firms, data collection and data analysis. Finally, the steps taken to ensure the validity and reliability of the research are covered.

5.2 RESEARCH APPROACH

This research uses a qualitative approach to study the internationalisation strategy of private healthcare firms from Singapore, in relation to their market selection, entry modes, timing of entry and response to increasing integration in the region.

Qualitative research is one of the many structures and orientations used for investigating social phenomena. It provides a framework within which data are collected and analysed (Bryman, 1988; Hancock, 1998) and is concerned with finding the answers to questions which begin with “why”, “how”, and “in what way” (Hancock, 1998). As discussed in Chapter 1, the focus of the study is to investigate and analyse the internationalisation decisions of the case companies, seeking answers to the “where” (market selection), “when” (timing of entry) and “how” (entry mode) of their expansion outside Singapore. As such strategy-related decisions relating to internationalisation is an evolving process and not static, a qualitative approach is considered appropriate. (Blaikie, 2000)

Additionally, finding the answers to the research questions of this study, concerning for example the reasons for choices of entry modes and market selection by the case firms, requires a rich description and explanation of sequential events. As Miles and
Huberman described: “With qualitative data, one can preserve chronological flow, see precisely which events led to which consequences, and derive fruitful explanations.” (Miles and Huberman, 1994: p1)

Miles and Huberman (1994) posit that although qualitative research has always been a primary method of research in the social sciences, notably in anthropology, political science and history, it has been widely applied into other fields of research including organisational and business studies. The relevance of using qualitative methods in international business research is also a reflection of arguing the relevancy of linking business behaviour with sociological and anthropological perspectives (Chapman, 1997). The qualitative research approach is also appropriate in many different situations. Yin (2003a), for instance, argues that the first and most important condition for differentiating among the various research strategies is to identify the type of research questions being asked. He proposed that a qualitative approach is appropriate to answer “what and why” questions.

Despite the growing popularity of qualitative research, there is no consensus on its definition. As Mason (1996) qualifies, qualitative research does not represent a unified set of techniques or philosophies; it has grown out of a wide range of intellectual and disciplinary traditions. Taking into consideration its common elements, she defines qualitative research as grounded in a philosophical position which is broadly “interpretivist” in the sense that it is concerned with how the social world is interpreted, understood, experienced or produced. It is therefore based on methods of data generation which are flexible and sensitive to the social context in which the data are produced, and is also based on methods of analysis and explanation building that involve understandings of complexity, detail and context (Mason, 1996). Merriam (1998) also argues that an important element of qualitative research is that it covers several forms of enquiry that help in the understanding and explanation of social phenomena with as little disruption to the natural setting as possible.

A qualitative research approach is appropriate for this study because of the following reasons:

a) The approach of this research is “interpretivist” and not “positivist”. The main objective is not to establish cause-and-effect relationships but the understanding
of a social world through an examination of the interpretation of that world by its participants (Bryman, 2001);

b) Qualitative research is able to examine the process of events, and to be able to create a link between events and to explore possible interpretations of the factors that produce such connections;

c) The internationalisation strategies of private healthcare firms from Singapore are not static accounts of events but are interconnected to each other. The complexity of these issues did not favour quantitative investigation;

d) The small number of private healthcare firms from Singapore which are actively pursuing internationalisation limits the ability of producing meaningful results in statistical analysis of quantitative data; and

e) Quantitative data are unable to generate the intricate details which are necessary to explain the internationalisation-related decisions made by the companies.

5.3 RESEARCH STRATEGY

In determining the research strategy, Saunders et al (2003) suggest choosing between experiment, survey, case studies, grounded theory, ethnography and action research. For this research, the case study method is preferred as the phenomena being studied are contemporary observations that occurred as a result of the behaviour or decisions that were taken in the past. This is in line with the argument that a case study is particularly appropriate when there is a need to unfold the history of particular companies (Yeung, 1995).

Yeung (1995) defines a case study as being a detailed investigation, often with data that are collected over a period of time, of one or more organisations or groups within organisations with a view to provide an analysis of context and processes involved in the phenomenon under study. On the other hand, Yin (2003a) defines it as an empirical enquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and the context are not clearly evident. Yin further argues that a case study is preferred when a “how” or “why”
question is being asked about a contemporary set of events over which the investigator has little or no control. Although there is an overlap between case study and history, as Yin argues, “The case study's unique strength is its ability to deal with a full variety of evidence - documents, artefacts, interviews, and observation - beyond what might be available in the conventional historical study” (Yin, 2003a: p8).

The rationale for using a case study approach in researching internationalisation choices and decisions made by private healthcare firms from Singapore is:

a) The type of research question to know “how”, “when” and “where” the healthcare firms from Singapore undertake their overseas ventures are in line with the suggestion by Yin (2003a) in which he noted that “these questions deal with operational links needing to be traced overtime, rather than mere frequencies and incidence”. The unique strength of the case study is its ability to deal with a full variety of evidence such as documents and interviews;

b) Since internationalisation can be viewed as a development process through time, Melin (1992) had argued that there is a substantial need for internationalisation research using a longitudinal case study approach such as biographic history where ‘the biography of a firm captures the whole development from the time of its founding to the present time’ (Melin, 1992: p102). This is particularly important because, as argued by Bell and Young (1996), internationalisation strategies are not developed in isolation but are components of the overall operations of the firm. Therefore, the internationalisation process of the firm needs to be examined in the context of its lifecycle, current operations and critical events in the life of the firm (Andersen, 1993).

c) Case study methodology enables particular contexts to be studied in depth, promoting the emergence of new ideas or new interpretations of existing ideas (Christie et al, 2000). The current study is concerned with understanding internationalisation of healthcare firms from Singapore with one of the key objectives to find out if current internationalisation theories cater to the explanation of the internationalisation choices of these firms; hence, the case study method is appropriate.
d) Case study method is highly suited for inductively building a rich, deep understanding of phenomena that are not well understood or researched. As stated in Chapter 1, despite the fact that research on the internationalisation of services sector in general is increasing, research on the internationalisation of firms for specific sectors or industries within the realm of services is still lacking, including healthcare. Thus, the internationalisation behaviours and strategies of healthcare firms are currently not well understood. Accordingly, the current study lent itself to using a case study approach where rich detail can be gathered in order to make contributions to, or reinterpretations of, existing internationalisation theory. (Christie et al, 2000)

With the above justifications, this study will utilize a case study method, specifically a multiple-case study. A multiple-case study was preferred to a pure single-case study as it improves generalisability (Miles and Huberman, 1994). The study utilizes the literal replication method, building on earlier theories, improves robustness and allows generalisation from the sample, although this generalisation does not have statistical grounds (Saunders et al, 2003; Yin, 2003a; Silverman, 2005). Thus, the conceptual framework used in this study, as detailed in the previous chapter, was developed using previous theories on internationalisation. This “analytic generalisation” tactic follows the recommendations of Eisenhardt (1989) and Yin (2003a).

5.4 RESEARCH DESIGN AND CASE STUDY PROTOCOL

A good scientific research needs to be based on a theoretical foundation with methodological sophistication ensuring rigour, accuracy, objectivity, generalisability, testability, and replicability (Cavana et al, 2001). This can be achieved with systematic procedures and by providing information about the research design, for example, on sampling logic, data collection process, and analysis and composition (Parkhe, 1993; Miles and Huberman, 1994; Yin, 2003a; Paré, 2004). It could be argued that this is especially important in qualitative studies. For example, there are arguments that lack of rigour in qualitative studies in international business has contributed to their relatively low number in high-level international journal publications so far (Pauwels and Matthysssens, 2004). In this section, these issues will be addressed.
A case study protocol was developed for this study following Yin’s (2003a) recommendations for multiple-case studies. This is essential given the importance of a clear structure and codification of methods in a multiple-case study (Parkhe, 1993; Miles and Huberman, 1994; Paré, 2004; Pauwels and Matthyssens, 2004). A case study protocol brings consistency, objectivity, rigour, and comparability to a research project and improves its generalisability (Sekaran, 1992; Yin, 2003a; Cavana et al, 2001; Paré, 2004). A rigorous research design and standardisation at some level is even more important in multiple-case studies to maintain consistency and to ensure comparability across individual cases (Miles and Huberman, 1994).

The case study protocol of this study consists of different phases:

a) Definition of the research problem
b) Comprehensive literature review
c) Development of a conceptual framework and specific research propositions
d) Selection of case companies
e) Data collection
f) Conduct of a pilot case study
g) Within-case analyses
h) Cross-case analysis
i) Summary of the emerging patterns
j) Extension and development of the theory

The protocol follows sequential steps, but includes iterative feedback loops as recommended in qualitative studies. The conceptual framework and the emerging theory will continue to develop based on the analysis of the data from the pilot case study but also during the rest of the data collection and analyses. Each of the phases will be discussed in more depth in the next sections.

5.4.1 Definition of Research Problem

The first phase of the research is to define a research problem. This step of the process was already discussed and research problem defined in section 1.5. Also, the broad research questions were defined at this phase to guide the research process further. A
qualitative researcher should always have a research objective as ‘a pole star’ to guide the process (Cavana et al, 2001).

5.4.2 Comprehensive Literature Review

A good and comprehensive literature review on existing theories is a foundation for the development of the conceptual framework and specific research propositions (Miles and Huberman, 1994; Yin, 2003a; Cavana et al, 2001). In this multidisciplinary study, an extensive review of literature on firm internationalisation, and on specific research areas such as service internationalisation, internationalisation of firms from SMOPECs, firms from Southeast Asia and healthcare was carried out.

5.4.3 Development of Conceptual Framework and Research Propositions

As Siggelkow (2007: p21) claimed: “a paper cannot just stand on its descriptive feet”. Thus, an explanatory/illustrative case study needs to provide theoretical ground for the cases to strengthen its explanatory power (Yin, 2003a; Ghauri et al, 1995; Siggelkow, 2007). In this study, the conceptual framework is recommended to provide this theoretical ground. As already discussed in section 4.2, the conceptual framework – a graphical description of key ideas, constructs and factors – includes comparisons with similar and conflicting literature, and increases the theoretical level of the study by applying analytic generalisation. In summary, the conceptual framework brings more generalisability to the findings (Yin, 2003a; Silverman, 2005).

As also discussed in section 4.3, the conceptual framework was then used to develop specific research propositions; that is, to operationalise the conceptual framework. These propositions will then be compared across the multiple cases and with different theories during the cross-case analysis in Chapter 7.

The inductive part of the study is to identify possible idiosyncrasies in the internationalisation of healthcare firms from Singapore and factors influencing them that did not emerge during the literature review, or situations where the previous findings have been inconsistent. That is, the framework may be modified as a result of any unanticipated findings from the case studies (Dubois and Gadde, 2002).
5.4.4 Selecting Case Study Firms

The unit of analysis in this study will be a firm, a private healthcare firm with hospital operations. Theoretical sampling, namely, replication logic instead of sampling logic, was used to select the case study companies. This type of purposive sampling is in-line with recommendations by several researchers on case studies when the aim is to extend existing theories (Eisenhardt, 1989; Miles and Huberman, 1994; Yin, 2003a; Cavana et al, 2001; Dubois and Gadde, 2002; Saunders et al, 2003; Ghauri, 2004; Paré, 2004; Silverman, 2005). This means that the case companies are not chosen on statistical grounds, but on conceptual grounds to fill theoretical categories and increase confidence in the findings (Eisenhardt, 1989; Miles and Huberman, 1994; Ghauri, 2004). They need to be typical and informative cases that most likely will confirm and sharpen the emerging theory being evaluated (Eisenhardt, 1989; Stake, 2000; Dubois and Gadde, 2002; Paré, 2004). That is, they illustrate particular organisations or processes that the researcher is interested in and situations in which the process most probably takes place (Saunders et al, 2003; Silverman, 2005; Siggelkow, 2007). The cases need to be consistent with the conceptual framework and research propositions of the study (Ghauri et al, 1995; Silverman, 2005).

In a multiple-case study, the objective is to replicate the process or phenomenon in a predictable manner (Yin, 2003a; Ghauri, 2004). That is, each case needs to serve a purpose (Yin, 2003a; Ghauri, 2004). In literal replication, cases that predict similar results are chosen, while in theoretical replication, cases that predict contrary results are chosen (Parkhe, 1993; Miles and Huberman, 1994; Yin, 2003a; Ghauri, 2004; Pauwels and MatthysSENS, 2004; Silverman, 2005). Literal replication, based on theory, improves the rigour and generalisability of the study (Yin, 2003a; Silverman, 2005) (although not on a statistical, but on theoretical grounds, as already mentioned). Also, multiple-cases, if their patterns are predictable, add confidence to the results and to the emerging theory (Miles and Huberman, 1994). This method enables comparisons with generic theories of internationalisation and of the service industry, as well as allows new interpretations (Strauss and Corbin, 1998). In this study, literal replication is used.

The number of cases required in a multiple-case study is an issue that is not decided on statistical grounds (Miles and Huberman, 1994). The adequate number depends on the
complexity of the research, and the decision should be made conceptually and when the confidence to analytic generalisation has been achieved (Miles and Huberman, 1994).

Based on the scope of research defined earlier in Chapter 1, and to ensure there are sufficient data for meaningful analysis of the case firms, the following are the criteria used for the selection of cases for this study:

a) Singapore-based private healthcare firm with hospital operations  
b) Have internationalisation experience  
c) Listed on the Singapore Exchange – this is to ensure sufficient information can be obtained publicly for analysis

Based on these criteria, four firms were identified for the study, namely, Parkway Holdings (Parkway), Raffles Medical Group (RMG), Thomson Medical Centre (TMC) and Health Management International (HMI). The four firms are in fact the only ones that met the criteria and are suitable for the purpose of this study. There is one other major private hospital in Singapore with some overseas operations but it is not suitable for this study as it is a not-for-profit institution which does not have as much information on its business, activities, strategies and plans in the public domain. Of the four selected firms, Parkway and TMC have since been de-listed, following their acquisition in 2010\(^{51}\), but as the de-listing happened only in November 2010 and January 2011 respectively, there are adequate data for their analysis.

As all the case firms have been involved in internationalisation for many years, there were sufficient data for longitudinal analysis, a recommended method when analysing the process of internationalisation.

A summary of the case firms is attached at Table 5.1.

\(^{51}\) Parkway was acquired by Khazanah Nasional Berhad from Malaysia while TMC was acquired by Singaporean investor Mr Peter Lim. These are further elaborated in their respective cases in Chapter 6.
Table 5.1 – Summary Information of Firms Selected for the Research

<table>
<thead>
<tr>
<th></th>
<th>Parkway</th>
<th>RMG</th>
<th>TMC</th>
<th>HMI</th>
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<tbody>
<tr>
<td>Local facilities</td>
<td>Three hospitals, 54 GP</td>
<td>One flagship hospital</td>
<td>One flagship hospital</td>
<td>Headquarter and its healthcare</td>
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<tr>
<td></td>
<td>clinics, eight imaging</td>
<td>and 74 clinics</td>
<td>and seven women’s</td>
<td>education and training services</td>
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<tr>
<td></td>
<td>labs and four labs</td>
<td></td>
<td>clinics</td>
<td></td>
</tr>
<tr>
<td>Overseas ventures</td>
<td>Significant presence in</td>
<td>Four clinics in Hong</td>
<td>Manage a women and</td>
<td>Two hospitals in Malaysia. 20</td>
</tr>
<tr>
<td></td>
<td>Malaysia (11 hospitals),</td>
<td>Kong and one in</td>
<td>children hospital</td>
<td>representative offices overseas,</td>
</tr>
<tr>
<td></td>
<td>China, India and Brunei.</td>
<td>Shanghai (China).</td>
<td>and provide consultancy</td>
<td>mainly in Indonesia.</td>
</tr>
<tr>
<td></td>
<td>Runs 37 Parkway Patient</td>
<td>Five representative</td>
<td>to develop a second</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assistance Centres in 17</td>
<td>offices overseas.</td>
<td>one, both in Vietnam</td>
<td></td>
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<td></td>
<td>countries</td>
<td></td>
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<td></td>
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<tr>
<td>Market Capitalisation</td>
<td>4,243.2</td>
<td>930.3</td>
<td>205.6</td>
<td>57.7</td>
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<tr>
<td>as at 7 Jun 2010 (S$ m)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>FY2010 Revenue (S$ m)</td>
<td>1,113.9</td>
<td>239.1</td>
<td>81.7</td>
<td>58.6</td>
</tr>
<tr>
<td>Foreign patient mix</td>
<td>1/3 of volume. Main</td>
<td>1/3 of volume: more</td>
<td>Foreign patients</td>
<td>About 25% of the patients at its</td>
</tr>
<tr>
<td></td>
<td>source countries are</td>
<td>than 100 countries,</td>
<td>make up about 25%</td>
<td>flagship at Malacca are foreign,</td>
</tr>
<tr>
<td></td>
<td>Indonesia, Malaysia,</td>
<td>including Indonesia,</td>
<td>of its volume, mainly</td>
<td>mainly from Indonesia</td>
</tr>
<tr>
<td></td>
<td>Vietnam, Bangladesh and</td>
<td>Malaysia, Australia,</td>
<td>from Indonesians, China,</td>
<td></td>
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<tr>
<td></td>
<td>the Middle East</td>
<td>Japan – a large</td>
<td>Philippines, India and</td>
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<td></td>
<td></td>
<td>proportion are</td>
<td>Korea</td>
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<td></td>
<td></td>
<td>expatriates working</td>
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<td></td>
<td></td>
<td>in the region</td>
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<td></td>
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</tbody>
</table>

5.4.5 Data Collection

While primary data are typically collected by interviewing relevant personnel from the case companies, such a method of data collection was inappropriate for this particular study, as the author himself is a member of the management team in one of the private hospitals in Singapore which also has international operations. Hence, it will not be appropriate to conduct interviews with the other private hospitals, given the potential conflicts of interest and confidentiality issues, and for competitive reasons.

52 The respective firms’ annual reports for 2010.
53 The respective firms’ annual reports for 2010.
54 Share price information from the Singapore Stock Exchange
55 The respective firms’ annual reports for 2010.
Nevertheless, the author believes that his in-depth knowledge of the Singapore and regional healthcare industry provide a strong primary basis for the study. While it was not feasible to conduct specific interviews with executives of the case firms, “interviews” are in fact being done on an ongoing basis for this research, as every bit of information and insights gained during the author’s discussion, sharing and conversation with fellow practitioners contribute to the knowledge which he has leveraged for preparing this thesis.

Besides the author’s four years of experience in running the hospital and hands-on experience in expanding the hospital’s overseas operation, the author was also formerly a policy administrator and head of the research and information unit at the Singapore Ministry of Health for about three years, hence he has a strong knowledge of the sector and the different institutions in the industry, both public and private. The author was instrumental in leading his firm’s overseas ventures, setting up representative offices in two countries between 2008 and 2011, and almost doubling foreign patient admissions to the hospital between 2008 and 2010. Research published by the Ministry’s research unit while under his watch include one on foreign patient admission trends in Singapore (Khoo, 2003), which remained a highly referenced paper for academic researches involving health tourism in Singapore and the region.

Having been in the industry for many years, the author has a strong understanding of the case companies, in terms of their history, strategies, senior management and plans. This was accumulated through regular interactions with senior executives of these firms, doctors, healthcare administrators, as well as participation at industry networking sessions and industry conferences.

Given that the focus of the Doctor in Business Administration program is for practitioners to apply theoretical knowledge to the advancement of business practice, the proposed approach in deriving the primary basis for this research is not inappropriate. The strong industry background of the author also enables him to extract greater insights from publicly available data on the case firms, compared to people without the industry experience.

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60 In the 2011 brochure on the Doctoral Programmes by Manchester Business School, Professor Jikyeong Kang, the DBA Programme Director, stated: “Our DBA candidates utilise their global career experience and industry knowledge in developing a research project which not only tackles an important unresolved problem in the real world, but also makes a critical contribution to their subject field.”
Besides the author's strong primary knowledge of the healthcare sector, the case firms, and the issues and considerations involved in internationalisation from Singapore, the study will utilise a large amount of information available on the case companies. The sources of information relating to each of the case companies include (please refer to Appendix for a listing):

a) Past published interviews with key company executives
b) Annual reports, company web-pages, company presentations, news releases by the company
c) Company reports prepared by financial analysts
d) Published materials in business periodicals and trade magazines
e) Newspaper articles and other media reports
f) Public statistics
g) Relevant journal articles

The use of multiple sources of data for the study was as recommended by Eisenhardt (1989), Parkhe (1993) and Ghauri (2004). A database was created for each case company.

Besides information on the case companies, the study also used for reference industry reports by analysts and healthcare consultancy firms, media and magazine articles on the sector, and official reports such as UNCTAD’s World Investment Reports. These are also listed in the Appendix.

While these information are publicly available, the author’s strong knowledge of the sector and the case companies ensure that all the potential sources of information are taken into account and the different perspectives are all covered.

5.4.6 Conduct of a Pilot Case Study

Although the nature of all qualitative research is inductive at some level, as already discussed, this is even more so with regards to a pilot case study. A pilot case study can provide input for additional literature review and for the refinement of the conceptual framework and research propositions (Eisenhardt, 1989). In this study, Parkway Holdings was chosen as a pilot case study. Since it is the most “internationalised” and
has the highest public profile among the case firms, it was the easiest to gather enough data to put together a first-cut case study, though subsequent iterations and intelligence gathering on the firm enable the case to be further strengthened.

With the experience gained from conducting the pilot case study, the other case studies were conducted, each using a comprehensive and exhaustive range of data as highlighted in the previous section.

5.4.7 Within-case Analyses

The multiple-case study analysis started with a within-case analysis of each individual case study, as recommended by Eisenhardt (1989), Parkhe (1993) and Yin (2003a). That is, evidence, facts and conclusions are sought for each individual case study first (Yin, 2003a).

The individual case reports include chronological case descriptions, which are important, especially in longitudinal studies, and a more structured analysis based on the conceptual framework model (Ghauri, 2004; Silverman, 2005). At the pattern matching phase, the data were divided into categories based on the conceptual framework, and compared systematically with similar and conflicting literature (Yin, 2003a; Ghauri, 2004; Pauwels and Matthyssens, 2004). The emerging within-case patterns were identified and evaluated based on how well they fit the propositions (Eisenhardt, 1989; Yin, 2003a; Ghauri, 2004; Pauwels and Matthyssens, 2004; Silverman, 2005). The purpose was to search for and display evidence, search for common themes, understand the causal relationships, rule out rival theories, and identify any gaps in the data (Eisenhardt, 1989; Ghauri, 2004; Pauwels and Matthyssens, 2004).

For analytical purposes, the data were coded based on the concepts and themes of the study (Eisenhardt, 1989; Ghauri et al, 1995; Ghauri, 2004; Pauwels and Matthyssens, 2004). Tables and matrices were used to organise, analyse and present both chronological and conceptual data, based on the recommendations of Eisenhardt (1989), Miles and Huberman (1994), and Ghauri (2004).
5.4.8 Cross-case Analysis

Following the within-case analyses, a cross-case analysis was drawn. Cross-case analysis is useful in finding similarity in terms of patterns and behaviours for all case studies, as well as explanations for divergent cases before final inferences can be made (Eisenhardt, 1989; Miles and Huberman, 1994). This is also a useful process in terms of enhancing generalisability and deepening the understanding and explanation of a phenomenon (Miles and Huberman, 1994). Cross-case analysis involved describing and rationalising all the events and the internationalisation choices made by each company into a holistic account according to categories and themes.

The conceptual framework structure was used to bring together the data from each individual case study. That is, a pattern matching logic was followed with a systematic comparison in a cross-case analysis (Yin, 2003a). Patterns that emerged from the within-case analyses were compared with each other, with the research propositions and the emerging theory, and with alternative theories (Parkhe, 1993; Ghauri et al, 1995; Yin, 2003a; Pauwels and Matthyssens, 2004). Similarities and variations were analysed and causal meta-patterns developed (Eisenhardt, 1989; Pauwels and Matthyssens, 2004). Tables and meta-matrices were used, including direct quotes from key executives of the case firms (extracted from interviews, newspaper articles or annual reports), to compare the data and to present them (Miles and Huberman, 1994; Ghauri, 2004).

A deduction was then made from the thematically presented data for all the case firms. Evidence supporting the categories and themes was displayed, and any counterevidence and subsidiary or branching paths were laid out, either to support the existing patterns or otherwise. Themes were also analysed within individual cases and findings on each theme aggregated across cases. The results of data analysis are presented topically in narrative form, based on the research questions or the propositions, before conceptual and theoretical coherence of the findings is made. This will be discussed in Chapter 7.

5.4.9 Summary of the Emerging Patterns

The emerging patterns from the case analyses were identified and summarised. When the process has included systematic pattern matching with the empirical data, with the emerging theory, and with the alternative theories, analytical generalisation has been
ensured (Miles and Huberman, 1994; Dubois and Gadde, 2002; Yin, 2003a; Pauwels and MatthysSENS, 2004). If systematic patterns are found, then the propositions can be accepted (Ghauri et al, 1995). Generally, if the patterns from two or more cases provide support to a theory, replication can be confirmed (Yin, 2003a). In some categories, similar patterns may emerge, whereas in others they may not (Eisenhardt, 1989). Confidence in the findings increases significantly if alternative explanations have also been considered and reasons given as to why they do not hold (Siggelkow, 2007); that is, to demonstrate that the data support the emerging theory, but not an alternative theory (Yin, 2003a). It needs to be noted, though, that the findings are not statistically generalisable outside the sample (Ghauri et al, 1995; Pauwels and MatthysSENS, 2004). Only the validity of the theory directly linked to phenomena and research propositions were evaluated (Yin, 2003a; Pauwels and MatthysSENS, 2004).

5.4.10 Extend/Develop Theory

Llewellyn (2003) argued that there are five different levels of theorisation: metaphors, dualities, conceptual development, context-dependent theories, and context-free ‘grand-theories’. As discussed earlier, the term conceptual framework has been used in this research, rather than a theoretical framework, even though the objective is that the final framework would fulfil the requirements of at least the context-dependent theory, ie, “middle-range theory”.

As discussed earlier, in an explanatory/illustrative case study, the contributions to theory will extend and refine the existing theories rather than generate a new one. Also, the objective for these types of studies is to develop sub-models to contribute to a more comprehensive grand theory, rather than a grand theory itself (Benito and Welch, 1994; Liesch et al, 2002). In other words, an objective and a result in an explanatory/illustrative study is in most cases a middle-range theory in which the phenomena and context were analysed in categories, and which, together with in-depth analyses, were linked back to the grand theory (Pauwels and MatthysSENS, 2004). However, to be relevant, the middle-range theory needs to be different from the existing theories at least in one of its parameters in its explanation of the specific event under analysis (Pauwels and MatthysSENS, 2004).
5.5 VALIDITY AND RELIABILITY OF THE RESEARCH

The methods used to test the quality of the multiple-case study process (ie, its rigour and accuracy), include tests on construct validity, internal validity, external validity and reliability, as recommended by several researchers (Parkhe, 1993; Miles and Huberman, 1994; Cavana et al, 2001; Yin, 2003a; Andersen and Skaates, 2004; Pauwels and Matthyssens, 2004) (see Table 5.2).

Table 5.2 – Testing Validity and Reliability

<table>
<thead>
<tr>
<th>Tests</th>
<th>Tactics</th>
</tr>
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</table>
| Construct validity | • Multiple sources of evidence used – public reports (eg, media reports, articles in business periodicals and trade magazines, past interviews of key company executives), archival records (eg, annual reports and company newsletters published over a period of time), third party analyst reports, and knowledge/business intelligence on the industry and case firms gathered directly by the author over the years – which provided the necessary triangulation.  
  • Chain of evidence established (between case study report, database, citations, protocol, and questions) |
| Internal validity | • Conceptual thinking and keeping research questions/propositions in mind  
  • Pattern matching between patterns defined in the conceptual framework and patterns found from the empirical data  
  • Explanation building addressing rival explanations (analytic generalisation)  
  • Data displays and matrix techniques suitable for qualitative research were used |
| External validity | • Literal replication logic used, as recommended for multiple-case studies |
| Reliability      | • Case study protocol developed and used  
  • Case study database developed  
  • Systematic documentation used  
  • Possible researcher’s subjectivity acknowledged |

Source: Adapted from Yin (2003a, p34)

To test construct validity, multiple sources of evidence and different data collection methods were used, combining both primary and secondary data sources (Eisenhardt, 1989; Parkhe, 1993; Miles and Huberman, 1994; Ghauri et al, 1995; Cavana et al, 2001; Yin, 2003a; Andersen and Skaates, 2004; Pauwels and Matthyssens, 2004). A chain of evidence was also established between the case study reports, the case study databases, citations, the case study protocol, and the case study questions (Yin, 2003a).
Internal validity was ensured by maintaining conceptual thinking throughout the research process and keeping broad research questions in mind (Miles and Huberman, 1994; Yin, 2003a). This included pattern matching between the patterns defined in the conceptual framework and the ones identified in the data collection phase of this study (Miles and Huberman, 1994; Yin, 2003a). That is, analytical generalisation was used in explanation building by linking the findings to the propositions, extant literature, and the emergent theory, while at the same time excluding any alternative theories (Parkhe, 1993; Miles and Huberman, 1994; Yin, 2003a; Pauwels and Matthyssens, 2004), as already discussed earlier. This was conducted systematically starting with individual within-case analysis and later with the cross-case pattern matching. Codes and pattern codes were created for the data analysis (Miles and Huberman, 1994). In addition, data displays, such as conceptually-ordered displays, charts, figures, and matrices, such as time-ordered matrices, and conceptually-clustered matrices and meta-matrices, were used based on the recommendations of Miles and Huberman (1994) for qualitative research. Supportive tables to present the events chronologically were used to help identify causalities (Miles and Huberman, 1994). As Cavana et al (2001) argued, the analysis of the sequence of time is essential in qualitative research on processes.

External validity was achieved with literal replication (Parkhe, 1993; Yin, 2003a), by selecting four typical cases. This method, used broadly in multiple-cases by many researchers, can be scientifically as valid as other sampling logics (Parkhe, 1993). Also, the findings were connected to the prior theory, and suggestions for further tests were made (Miles and Huberman, 1994).

Reliability was ensured with the development of a case study protocol (see Section 5.4) (Miles and Huberman, 1994; Yin, 2003a; Paré, 2004). It is not feasible to replicate the whole qualitative study due to its complexity, but as detailed a description as possible of the research process will improve the transparency, comparability, testability, replicability and confidence in the study (Sekaran, 1992; Miles and Huberman, 1994; Cavana et al, 2001). This was further enhanced by systematic documentation, for example, case study databases were created, key words for data searches listed, and sources of the empirical data identified (Parkhe, 1993; Miles and Huberman, 1994; Yin, 2003a; Paré, 2004). Also, the ‘voice of the source’ was reported using the actual words of the interviewees, where relevant past interviews with key executives of the case firms were available (Cavana et al, 2001; Ghauri, 2004).
Finally, Cavanaugh et al’s (2001) recommendations for reliability were followed by acknowledging any possible subjectivity and to prevent any unacceptable personal effect or contamination by the researcher. They argued that as it is nearly impossible to avoid this type of influence in a study, a researcher needs to be aware of their ‘frame of reference’, and try to benefit from their insight. This is in line with Miles and Huberman’s (1994) argument on objectivity, that a good qualitative researcher needs to be familiar with the phenomenon and the environmental setting, and his/her own personal assumptions and biases. For the author, potential biases may arise from his personal experience in leading his firm in its internationalisation efforts, including the interactions he had over the years with collaboration partners and potential partners in the various regional countries. There are also potential biases arising from his views and perceptions of the case firms, as well as key executives working in them. Naturally, the objective of the researcher has been to report and interpret the empirical data as authentically and precisely as possible (Cavanaugh et al, 2001), which is what the author seeks to achieve.

5.6 CHAPTER CONCLUSION

The purpose of this chapter was to outline the research methodology and research process employed in the study. Justification was given for the use of a multiple-case study approach for the research, and the research design and case study protocols were outlined.

Based on the criteria set out in line with the scope and objectives of this study, four private healthcare firms from Singapore were found suitable for the purpose of this study, and they were all included.

Explanation was also given on why interview with the case firms was not appropriate as a source of primary data for this research, given the author’s position in one of the private hospitals in Singapore which is itself involved in internationalisation. Nevertheless, the author’s in-depth knowledge of the healthcare industry and the case firms provides a strong primary basis for the study. The author’s experience in running hospital operations and in leading the internationalisation of his firm from Singapore also enables him to extract greater insights from the secondary data on the case firms. In
addition, the study will utilize a large amount of information that is publicly available on the case firms.

The strategy for analysing the data was also discussed, including within-case and cross-case analyses which the study involved, as well as the approaches for identifying emerging patterns from the case analyses and using the findings to extend existing theories. Finally, the tests for research quality, that is, validity and reliability, were discussed. The outcomes of the qualitative analysis of the internationalisation of the four cases are presented in Chapter 6, and the cross-case analysis in Chapter 7.
CHAPTER 6 – CASE STUDIES

### 6.1 INTRODUCTION

This chapter will discuss the four case firms in the following sequence:

- Case 1 - Parkway Holdings
- Case 2 - Raffles Medical Group
- Case 3 - Thomson Medical Centre
- Case 4 - Health Management International

Each case will begin with a brief background on the company, starting from its founding, key milestones in its history, brief overview of its state of internationalisation and its current situation. The background will also cover the ownership of the firm.

In terms of the internationalisation activities of the firms, the information will be presented in two ways. First, there will be a discussion of the firm’s internationalisation activities by country. This will allow a more in-depth look at each of the market entries as well as how the company has expanded within the market over time, taking into account the timing of entry and entry mode. Company statements or comments by key executives relating to the respective markets will also be highlighted. The second section will present a summary of the key internationalisation events in chronological order to give a better perspective in terms of the timing and sequence of market entries.

In the third section, the internationalisation strategy of the firm will be discussed, first on the overall strategy, followed by the market selection, entry mode and timing of entry. This will involve an in-depth analysis of the choices made by the firm in its internationalisation. Where relevant, cases of failed entries by the firm will also be highlighted, which will yield further insights on what went wrong in some of the market entries.
6.2 CASE 1 – PARKWAY HOLDINGS

6.2.1 Background

Parkway Holdings Ltd was founded back in the 1970s by individuals from two prominent business families from Malaysia, the Tan family of IGB Corp and the Ang family of Petaling Garden. The main businesses of both families are in property development and investment holdings, with interests in areas like shopping malls, hotels and plantations. Then, they won the bid for a piece of land offered for sale by the Singapore government and built Parkway Parade, Singapore’s first shopping complex. The company has been listed on the Singapore Stock Exchange since 1975. From there, Parkway sought to get into the private hospital business by acquiring Singapore’s Gleneagles Hospital in 1987. After the acquisition, the Group embarked on an S$150 million three-year expansion and upgrading programme for the hospital, which consisted of a 10-storey building, 14 operating theatres and 150 consulting rooms.

In 1995, Parkway Holdings bought Mount Elizabeth and East Shore Hospitals and became the largest private healthcare provider in Southeast Asia. Prior to the purchase, the two hospitals belonged to Tenet Healthcare, the largest US healthcare group at that time.

In 1999, as part of the group’s restructuring and business rationalization, it sold its property and other non-healthcare assets to focus its resources on healthcare business.

Today, Parkway Holdings is one of the region’s leading providers of healthcare services, with a network of 16 hospitals with more than 3,000 beds throughout Asia, including 3 hospitals in Singapore (excluding 1 under construction), 11 in Malaysia (2 under construction), 1 in Brunei, 1 in India (1 under construction) and 1 under construction in the United Arab Emirates, as well as 8 clinics and medical centres in China and 1 clinic in Vietnam.

61 “Parkway’s long history with Malaysia”, The Star Online, 31 July 2010.
62 Prior to 1995, Tenet Healthcare was named National Medical Enterprises (NME). NME acquired Mount Elizabeth Hospital in 1985 and East Shore Hospital in 1989. It drew upon the management expertise from the US and strived to provide the best tertiary hospital services in Southeast Asia.
In Singapore, the group operates three of Singapore’s premier healthcare providers: Gleneagles, Mount Elizabeth and Parkway East Hospitals. It also owns Parkway Shenton Pte Ltd, a major provider of primary healthcare services; Medi-Rad Associates Ltd, a leading radiology services provider; and Parkway Laboratory Services Ltd, a major provider of laboratory services. In addition, Parkway Trust Management Limited provides management services to Parkway Life REIT, while Parkway Education Pte Ltd offers healthcare education through the Parkway College of Nursing and Allied Health.

Parkway has an extensive network across Asia, Europe and the Middle East with 37 representative offices (called Parkway Patient Assistance Centres or PPACs) in Bangladesh, Brunei, Cambodia, China, India, Indonesia, Malaysia, Mongolia, Myanmar, Pakistan, the Philippines, Russia, Saudi Arabia, Sri Lanka, Ukraine, the United Arab Emirates and Vietnam.

The founding Tan and Ang families gave up control of the group in 1999 when they sold a 19.6% stake to Schroder Capital Partners, leaving themselves with just a 12% stake. However, they bought back a stake of 16.7% two years later from another large shareholder\(^63\), and a member of the Tan family was appointed Deputy Chairman of the group\(^64\). The founding families finally ended their involvement in 2005 when they sold a 26% stake to Newbridge Capital, which then took over control of the Group. In 2010, Parkway Holdings was acquired by Khazanah Nasional Berhad\(^65\), after an intense takeover battle with Fortis, India’s second largest healthcare group.

Parkway has since been de-listed from the Singapore Exchange on 24 Nov 2010, and is now part of Khazanah’s Integrated Healthcare Holdings (IHH), which also holds 100% of Malaysian Pantai, 100% of International Medical University (IMU) and 12.2% of India’s largest healthcare group Apollo. Khazanah planned to re-list the group within 3 years (Ali, 2011). In the meantime, Khazanah planned to leverage on Parkway’s network and branding to grow its regional healthcare platform. It will also be looking at ways to garner more synergies from all its healthcare assets. One clear move towards that was the appointment of Dr Lim Cheok Peng, former CEO of Parkway, as Executive Director of IHH, with focus on developing strategic opportunities at IHH, working with

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\(^64\) Parkway’s annual report 2001.
\(^65\) Khazanah Nasional Berhad is the investment holding arm of the Government of Malaysia, entrusted to hold and manage the commercial assets of the government and to undertake strategic investments. Khazanah has stakes in more than 50 companies globally across different sectors.
CEOs of Parkway, IMU and Apollo. Other synergies for the group should flow from global procurement and developing a team specialising in putting up new hospitals\textsuperscript{66}.

In 2010, Singapore continued to be the largest contributor to Parkway’s revenue at 69%. Southeast Asia, North Asia and South Asia contributed 24%, 5% and 2% respectively (see Fig 6.1). Similarly, for profit after tax and minority interest (PATMI), Singapore is the largest contributor at 65%, with Southeast Asia, North Asia and South Asia contributing 27%, 5% and 3% respectively (see Fig 6.2).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure61.png}
\caption{Figure 6.1}
\end{figure}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{Figure62.png}
\caption{Figure 6.2}
\end{figure}

\textsuperscript{66} “Parkway announces Mitsui as a strategic shareholder via Integrated Healthcare”, Parkway’s press release, 7 April 2011.

\subsection{Internationalisation Activities by Country}

\subsubsection{In Malaysia}

Parkway’s first overseas venture was in Malaysia. In 1989, the Group bought Penang Medical Centre, which was then renamed Gleneagles Medical Centre, Penang. Parkway has a 70% stake in the 212-bed hospital.

Parkway’s second venture in Malaysia was Gleneagles Intan Medical Centre (330 beds), a joint venture which commenced operation in 1996. Before Parkway’s acquisition by Khazanah, it held a 30% direct stake in the hospital, with the balance 70% held by Pantai Irama Ventures, a 40%:60% JV between Parkway Group and Khazanah Nasional Berhad. This gave Parkway effectively a 58% share of the hospital.
Parkway’s main presence in Malaysia was through Pantai Holdings, the second largest private hospital chain in Malaysia, with 9 hospitals and more than 1,800 beds. It first gained control of Pantai in September 2005 when it bought a 31% stake in the group and emerged as the largest shareholder. This turned out to be a politically sensitive deal because Pantai holds lucrative government concessions to conduct the medical examination of foreign workers and also for government healthcare support services (Chee, 2008).

There were political demands to reverse this transaction. The problem was only resolved when Khazanah stepped in to form a JV with Parkway called Pantai Irama in Aug 2006 which bought out Parkway’s stake and acquired the rest of the Pantai share to take it private. Parkway’s eventual share of the JV was 40%. Nevertheless, Parkway was given management control of the Pantai hospitals.

With Parkway’s branding, network and experience in attracting foreign patients, one key area of development for the Pantai group of hospitals after Parkway’s acquisition was to develop the medical tourism segment. In fact, immediately after the acquisition in 2005, it was announced that Pantai would invest in facilities to attract foreign patients, with the aim of tripling its foreign patients to 15% of the total within three years.

Pantai has since become Parkway’s main channel for expansion in Malaysia. In its 2009 Annual Report, Parkway stated:

“During the year, we reviewed our presence in Malaysia and are now aggressively expanding our network there. Our expansion into Malaysia is based on a hub and spoke model where we plan to set up community hospitals in smaller towns across Malaysia. There is a lot of demand for private healthcare in Malaysia; this demand is not only from medical tourists in the region, but more importantly, there is a strong demand from the local population who are seeking premier healthcare services and do not want to travel long distances to main cities in Malaysia where most private hospitals are currently located.

This demand for healthcare can be seen in our existing Malaysian hospitals, which are experiencing high occupancy levels. To that end, we are looking at new hospital developments throughout the Peninsula...”

As background, Malaysia has allowed 100% foreign equity ownership for healthcare investments since 2009. Previously, foreign investment in healthcare, among other sectors, was subject to 30% equity requirement for Bumiputra (ie, ethnic Malays and other indigenous people).

6.2.2.2 In Indonesia

Parkway entered the Indonesian healthcare market early. RS Siloam Gleneagles was the first foreign investment hospital in Indonesia, starting operation in 1997. It opened following the Indonesian government’s deregulation policy in 1992 allowing foreign investment to operate in the hospital service sector. Parkway obtained the license to operate the hospital in 1994.

The US$70 million investment was a joint venture between the Lippo Group (30%), some Indonesian partners and Parkway Holdings (30%). At that time, the plan was for the joint venture to establish a network of international-standard primary, secondary and tertiary healthcare facilities in metropolitan Jakarta and other major cities in Indonesia.68

At the same time, another Gleneagles hospital was also being built in Medan, North Sumatra, via a JV by Parkway (25%) with some Indonesian businessmen. RS Gleneagles Medan also opened in 199769.

By 1999, Parkway has four hospitals in Indonesia. Please refer to their respective ownership structures in Table 6.1.

Table 6.1 – Ownership Structures of Parkway’s Indonesian Hospitals, 1999

<table>
<thead>
<tr>
<th>City</th>
<th>Hospital</th>
<th>No. of beds</th>
<th>Ownership Share by Parkway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jakarta</td>
<td>RS Siloam Gleneagles</td>
<td>328</td>
<td>30% JV</td>
</tr>
<tr>
<td>Jakarta</td>
<td>RS Graha Medika</td>
<td>209</td>
<td>54% through PT Siloam Gleneagles Healthcare TBK, a JV Co</td>
</tr>
<tr>
<td>Surabaya</td>
<td>RS Budi Mulia Gleneagles</td>
<td>148</td>
<td>100% through JV Co</td>
</tr>
<tr>
<td>Medan</td>
<td>RS Gleneagles</td>
<td>243</td>
<td>25% JV</td>
</tr>
</tbody>
</table>

69 Parkway’s Annual Report 1999.
Parkway’s entry into the Indonesian healthcare market seemed a logical move, since Indonesians have traditionally come to Singapore for medical services, where Parkway was the dominant player.

By 2000, the ownership structures of the hospitals have changed as shown in Table 6.2.

**Table 6.2 – Ownership Structures of Parkway’s Indonesian Hospitals, 2000**

<table>
<thead>
<tr>
<th>City</th>
<th>Hospital</th>
<th>No. of beds</th>
<th>Ownership Share by Parkway</th>
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</tr>
<tr>
<td>Surabaya</td>
<td>RS Budi Mulia Gleneagles</td>
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</tr>
<tr>
<td>Medan</td>
<td>RS Gleneagles</td>
<td>243</td>
<td>25% JV</td>
</tr>
</tbody>
</table>

The two hospitals in Jakarta and one in Surabaya were consolidated under the Siloam Group.

In Parkway’s Annual Report in 2000, it was stated: “RS Gleneagles in Medan continued to perform poorly and a decision has been made to divest the Group’s interest in the hospital at the appropriate time.”. The report also stated: “We will continue to review and improve the operations and to enhance returns from the hospitals. In the first quarter of 2001, Parkway Holdings’ stake in the Siloam Group was reduced to 9.3% from 25.6% following a decision not to participate in the rights issue exercise of Siloam.”

In Parkway’s Annual Report in 2001, it was stated: “Reduced our exposure to non-performing Indonesian hospitals and the capital intensive business of building or owning hospitals.”

Given the importance of Indonesia as a source of patients for Parkway, the decision to reduce its physical presence in Indonesia, a market which has great potential and high familiarity for Parkway, certainly appeared counter to the expected behaviour according to the literature in relation to market selection and entry modes. However, it is important to take into consideration some local factors that could have affected profitability and hence led to Parkway’s decision, especially the following:
a) Indonesia only allows locally trained doctors to see patients at their hospitals\(^70\) (also, Marzolf, 2002). Given that the standard of medical education is still significantly lower in Indonesia compared to Singapore, Indonesians who can afford medical care will likely still fly to Singapore for their treatment. The close proximity between Singapore and main cities of Indonesia also meant that the journey could be made easily, hence the benefit of having hospital facilities in Indonesia could be just marginal;

b) The requirements for private hospitals in Indonesia to provide a certain percentage of subsidised beds (typically 10 – 15\%) would have affected the profitability of the hospitals (Marzolf, 2002).

Since Parkway’s previous hospital venture in Indonesia, the country has raised the foreign ownership limit for health care, among other sectors, in a bid to attract more investments in the sector. Under a presidential decree issued in June 2010, the ceiling for foreign ownership in hospitals was raised to 67\%, with access to facilities across the country. Previously, foreigners could hold up to 65\% equity share of hospitals in certain major provinces only\(^71\).

6.2.2.3 In India

Parkway’s first venture in India was a 50-50 JV with the GP Goenka-owned Duncan Group to launch a 270-bed Duncan Gleneagles Hospital in 1997. The project fell through when differences between the two groups’ vision surfaced. The Duncan Group moved away by selling its stake in the JV to the Apollo Group in 2002, which subsequently built Apollo Gleneagles Hospital in collaboration with the Parkway Group (Dutta, 2006). The hospital, which was opened in 2003 with 325 beds, has since expanded to 405 beds. In Parkway’s Annual report for 2003, it stated its intention for Apollo Gleneagles to develop into the healthcare hub of the eastern region of India, covering the North Eastern states of India, Bangladesh, Nepal, Bhutan and Myanmar.

Parkway has always been actively pursuing India as a market. In an interview in October 2006, Mrs Tan-Hoong Chu Eng, then Parkway’s Executive Vice President,

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\(^71\) “Government raises foreign ownership limits”, The Jakarta Post, 10 Jun 2010.
said, “We are looking at acquiring hospital projects in India. The mere Indian population of 1.3 billion is reason enough for us to look at India” (Dutta, 2006). Mr Richard Seow, then Chairman of Parkway Group Healthcare added, “The excellent clinical acumen of Indian doctors is also a reason that we are looking at having facilities in India.” Additionally, the fact that there is no ceiling in Foreign Direct Investment (FDI) in healthcare prompted the Group to look at owning facilities in India (Dutta, 2006).

When asked why acquisition and not Greenfield projects, Tan said, “Greenfield projects involve a lot of money, which is blocked for years. For acquisition, the profits are faster.” The group is not interested in dabbling with franchising or JVs. “There is no fun in franchising. We would rather like to have our own facilities,” Tan explained. Asked why not JVs, given that Parkway first entered India through a JV with the Apollo group in Kolkata to set up the Apollo Gleneagles Hospital, Tan added “We have already tested the water in JV and now we want to have our fully-owned facility” Tan informed. She was also quoted as saying that the Group was looking at a facility of no less than 300 beds, with focus on oncology, orthopaedics, plastic and cosmetic surgery and liver transplant. (Dutta, 2006)

However, its venture into India has been anything but smooth sailing. For example, its plans of acquiring the New Delhi-based Escorts Heart Institute in 2005 did not materialise as an astronomical sum was quoted for the acquisition (Dutta, 2006).

The other venture which did not materialize was Parkway’s deal with Asian Heart Institute (AHI). In 2005, the two groups inked a JV for a long-term partnership. According to the Memorandum of Understanding, Parkway was supposed to do management control for AHI, utilise the extra space of AHI to run a multi-specialty hospital and eventually come up with a new multi-specialty hospital together. However, sources claimed that lack of common vision on management control created some frictions between the groups (Dutta, 2006).

Parkway finally got its second breakthrough in 2007, when it signed a Greenfield 50-50 joint-venture with Mauritius-based Koncentric Investments Ltd to build Khubchandani
Hospital, a 500-bed international-standard tertiary hospital with world-class facilities in Mumbai. The official technical agreement to establish, implement, and operate the hospital project was signed on 29 July 2008. Construction started in April 2010 and is expected to complete by 2012.

In January 2010, Parkway entered into a Memorandum of Understanding with New Delhi-based GM Modi Hospital & Research Centre for Medical Sciences (GMHRC). This was meant to facilitate the further negotiations and finalisation of the appointment of Parkway Group Healthcare and/or its subsidiaries to provide project management and consultancy services for the proposed renovation and expansion of the 100-bed GM Modi Hospital. This latest development will expand Parkway's presence in India, adding to its hospitals in Kolkata and Mumbai. On the deal, Dr Lim Cheok Peng, then Executive Vice Chairman and Chief Executive Officer of Parkway Holdings Limited said “…With this latest development, we look forward to further expanding our regional footprint by securing more hospital management contracts and partnerships with hospitals in the region”.

As background, India has a liberal foreign investment policy for hospitals, with FDI permitted up to 100% under the automatic route for hospitals in India since January 2000. Prior to that, FDI in hospitals was permitted under “Government-administered route”, which meant that the investment proposals have to be considered by the Foreign Investment Promotion Board and the maximum foreign equity ownership is 51%.

Nevertheless, Chanda (2007) found that there are many constraints, especially domestic ones, which explain the limited presence of foreign investment in India’s hospital segment. These include high initial establishment costs, the prohibitive cost of procuring land, low health insurance penetration in the country (which reduces the consumer base for corporate hospitals), restrictions on medical education and training providers (which created a supply bottleneck and adversely affects the quality of medical personnel at all levels), and the high cost of importing medical devices and the

72 Tertiary care services are provided by specialised hospitals equipped with diagnostic and treatment facilities not generally available at hospitals other than primary teaching hospitals. This level of service is also provided by doctors who are uniquely qualified to treat unusual disorder that do not respond to therapy that is generally available as secondary medical services. Examples include cardiothoracic and vascular surgery, neurosurgery, and radiation oncology (Green and Bowie, 2010: p12).
73 “Parkway and GM Modi Hospital Sign MoU for Strategic Partnership”, Express Healthcare, 22 Jan 2010.
limited domestic manufacturing capacity in this area. There are also other regulatory
deficiencies which result in lack of standardization, proper governance, and quality
assurance in the healthcare sector, and lack of policy clarity and priority to the
healthcare sector. All these factors adversely affect the returns on investment in
hospitals in India, and make it difficult for foreign operators to penetrate the market
relative to domestic ones. Chanda (2007) noted that while some of these factors could
be moderated through joint venture with a local partner, it is common for problems to
arise in maintaining the partnerships, as there are issues of financial control and
differences in expectations and management styles, given the cultural differences.

6.2.2.4 In Brunei

Parkway entered into Brunei with Gleneagles Jerudong Park Medical Centre (JPMC), a
20-bedded hospital which focused on cardiac treatments. It was a 75:25 joint venture
with the Brunei Investment Agency, and was the first hospital in Brunei Darussalam to
set up a world-class tertiary Cardiac Centre for patients with cardiac problems. In
Parkway’s annual report in 2002, it was stated: “In addition to expanding Parkway’s
footprint in the region, this venture has also provided our Singapore hospitals with a
steady stream of patients from Brunei.”

For Brunei, its foreign equity policy states that “Full and majority foreign ownership
and minority foreign ownership are allowed depending on the type of industry and
activity. 100% foreign equity ownership may be permitted in certain industries and
activities which the Government promotes. Activities relating to national food security
and those activities requiring the use of local resources, including government sites (i.e.
agriculture, fisheries, and food processing) must have at least 30% local equity
participation.”74 Therefore, full foreign ownership in healthcare investment is
technically allowed, though it will be subject to review by the Brunei Economic
Development Board.

6.2.2.5 In Vietnam

As Southeast Asia’s second most populous country (population of 88 million in 2009),
Vietnam has always been a key target of Parkway’s regionalization plan. In its annual

74 ASEAN Investment Guidebook 2009.
report in 2000, it was stated “…we leveraged on our organisation’s skills and expertise to generate consulting services for third parties through our two consulting subsidiaries. This resulted in a consulting contract for a 200-bed hospital in Ho Chi Minh City.”

In its annual report for 2001, it was stated “…Adding to our existing contracts in Malaysia, we managed to clinch a consultancy agreement to help set up the first 200-bed foreign owned hospital in Ho Chi Minh City, Vietnam (currently Franco-Vietnam Hospital). Tapping on our existing brand reputation and expertise, we see the management and consultancy businesses as our key growth drivers for 2002 and it is an area where we can be free from capital-intensive investments.” However, Parkway’s involvement with the hospital ceased after its completion in 2003.

While Parkway has yet to own a hospital in Vietnam, Parkway Shenton opened a Plastic Surgery and Aesthetics Centre in Ho Chi Minh City in 2005.

Under Vietnam’s WTO commitments, foreign investors can establish 100% foreign-invested hospitals or set up business cooperation contracts with Vietnamese partners, since January 2009. The minimum required capital for hospital construction is US$20 million. Prior to that, the total equity held by a foreign investor was capped at 30%, except for firms listed on the Vietnamese Stock Exchange, for which the cap was 49%.

In an interview in May 2010, Parkway CEO Tan See Leng identified Vietnam, along with China, as priority countries for their overseas growth, due to their strong economic growth and that the patients there were familiar with the Parkway brand (Quek, 2010).

6.2.2.6 In China

Parkway started exploring the China market in the late 1990s. At that time, it was looking at setting up day-surgery centres and smaller clinics there. Then, it invested $500,000 to set up a small laboratory servicing public hospitals and private medical centres in the coastal city of Xiamen, with plans to expand it (Berfield, 1996).

In 2000, it entered into talks to lease a wing from the Sixth People's Hospital in Suzhou. In that deal, however, the costs proved prohibitive and Parkway walked away. It would have cost the group about $1 million just to equip and upgrade the ward into a private
clinic and the cost of the lease was too high, Lim explains (Saywell, 2001).

Nevertheless, the group continued to look into similar tie-ups with other public hospitals in China. It also eyed management contracts with a few established clinics there that are co-owned by foreign doctors through joint ventures with local hospitals (Saywell, 2001).

Parkway finally made its breakthrough in 2005. It established a 70:30 joint venture with Shanghai Huashan Hospital, with plans to own and manage medical and surgical centres, clinics and hospitals. The result was a 32,000 sqf ambulatory surgical centre in Shanghai which opened in 2006. The Shanghai Gleneagles International Medical and Surgical Centre specializes in healthcare services such as health screenings, aesthetics, dental work, and obstetrics and gynaecology.

Parkway then made a US$42 million acquisition of 60% stake in World Link Group, a leading expatriate-focused outpatient network of clinics in Shanghai, in May 2007. Its other partners are Shanghai Alliance Investment Limited (“SAIL”) and Ruijin Hospital, with each owning 20% of the Group. SAIL is an investment holding company of the Shanghai Government and Ruijin Hospital is the largest teaching hospital in Shanghai founded in 1907. Parkway has since raised its stake to 70%, with option to acquire the remaining 30% upon regulatory approval. It has continued to expand its network in Shanghai and also opened an international expatriate clinic in the First People’s Hospital in Chengdu in 2008.

In 2009, it entered into a cooperation agreement with Shanghai Fosun Ping Yao Investment Management Co. and Shanghai Hui Xing Hospital Investment Management Co. to jointly establish medical centres in Shanghai. This resulted in the opening of two more medical centres in 2010.

While China’s 1.3 billion population and fast growing middle class make it an attractive market for major healthcare operators, there are many hurdles for would-be entrants. Wholly foreign-owned investments are prohibited, and in joint venture healthcare facilities, foreign investors are limited to a maximum stake of 70 percent. Regulations

also call for a minimum investment of RMB20 million (about US$3 million) and require all services and activities to be domiciled at the same licensed facilities. Branch hospitals or clinics are thus prohibited. In addition, foreign-invested healthcare facilities are excluded from some preferential tax treatment plans aimed at encouraging foreign investment. And foreign medical professionals are officially limited to being the minority employees at any foreign-invested enterprise, with 6 to 12-month limits on how long they may work in China, though in practice, contracts are often renewed for longer periods (Lipson, 2004).

Given these hurdles, it is not surprising that of the 29,000 medical facilities of all types registered in China in 2003, only 45 have foreign investment and another 15 have investment from Hong Kong, Taiwan, and Macao. The vast majority of these are classified as primary care and dental clinics, emergency evacuation centres, and research facilities. Only several would qualify as hospitals (Lipson, 2004). Nevertheless, China announced some measures to liberalise the hospital sector by the end of 2010, which allowed foreign investors to hold stakes beyond 70% and delegated the licensing process to the provincial government rather than the Central government. While this should enable more foreign investment in the healthcare sector, the detailed operation of the new regulations would take some time to evolve before they can be fully implemented, which is typical for new regulations in China.

The person who led Parkway’s breakthrough into China was Dr Jonathan Seah, a general practitioner who did investment banking at Merrill Lynch and Goldman Sachs after getting an MBA at Harvard. He was appointed to lead Parkway’s entry into China in 2004. In an interview in 2008, he shared: “It took us about six months to get a good understanding of what we didn't know.” He added “I think it’s important to realize that one cannot ever know everything that is going on throughout the country - it’s a very large country - and the rules are different from city to city, especially for health care. Some of it is centrally governed, but a lot of it is on a city-by-city or district basis.” (Tan, 2008)

On the purchase of World Link Group, he explained: “The reason why we purchased the World Link Group is to give us a base of people that we can use to help us grow very quickly.” Dr Seah also noted that the Chinese regulatory process was “difficult”,

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with layers and layers of approvals needed lest a project be derailed. The ParkwayHealth Shanghai Gleneagles project took about a year to get a license. “But we were very fortunate; we were one of only two companies in all of China to get this international medical license [that year],” Seah added (Tan, 2008).

6.2.2.7 In the United Arab Emirates (UAE)

Parkway’s first foray into the Middle East was a contract to manage a hospital in Abu Dhabi, United Arab Emirates. Parkway was selected by the owner of the Danat Al Emarat Women and Children’s Hospital, healthcare investment and development company United Eastern Medical Services (UEM), to manage the hospital, due to complete in 2011. ParkwayHealth will provide clinical development and management services. Danat Al Emarat will be the first private hospital in the UAE to be run by an international operator. The hospital is due to open with 170 beds, a figure that will later rise to 260.

In Parkway’s Annual Report in 2009, it stated, “Entering into management contracts is an effective means for Parkway to share its expertise and expand our presence to new markets.” It added “We will continue to look to secure more of such management contracts in the Middle East and other regions, in order to diversify our revenue streams. We anticipate that with Parkway’s strong brand equity, we will be able to successfully export our healthcare services and decades of knowledge overseas.”

In the UAE, full foreign ownership of companies is allowed in designated areas, known as free zones, designed to encourage foreign investment in designated industries, namely, Healthcare City, Media City, and Dubai Airport Free Zone. The free zone companies cannot however directly trade with the ‘mainland UAE’ and outside these designated areas, all locally formed limited liability companies must by law be at least 51 per cent owned by a UAE national or locally-owned company.

6.2.2.8 In the United Kingdom

In the United Kingdom, Parkway bought a cardiac facility from the NHS in 1991, when the cardiac services at the site were moved to the Brompton Hospital. The facility was in the medical district centred on Harley Street in central London. After investing
further funds between 1996 and 1998 to refurbish the hospital and purchase new medical equipment, the hospital was opened in 1999 (the medical centre was opened in July 1997).

The hospital, which was a 65% JV with a group of doctors, did not do well and posted yearly losses since opening, despite a gradual increase in patient volume, as well as efforts to improve the operations and cut costs. One possible reason was the strong competition within the London private healthcare market, partly due to the competitive role played by the Private Patient Units (PPUs) of NHS hospitals\(^78\) (Lethbridge, 2004). A decision was taken in 2000 to divest or restructure the hospital as the group decided that it did not fit in its core business strategy. In 2001, the hospital was sold to the UK Government, with Parkway having to write off a substantial loss.

6.2.2.9 Network of Representative Offices (Representative offices)

In 2001, Parkway launched its 24-hour Medical Referral Centre hotline and 5 representative offices\(^79\), in Singapore, Indonesia, Hong Kong, Myanmar and Bangladesh. These were meant to “complement the Group’s extensive healthcare network”. As stated in Parkway’s 2001 Annual Report, the purpose of the representative offices was to assist local and international patients with information on specialists’ expertise and services available at Parkway’s hospitals and related facilities in Asia. In addition to providing medical referrals, the staff at the centres also offer assistance ranging from travel and accommodation arrangements to emergency medical evacuations.

Since then, Parkway has expanded the network of its representative offices. The roll-out sequence of the representative offices is as stated in Table 6.3 below.

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\(^{78}\) The London private health care market is highly competitive as many of the main NHS teaching hospitals are located there and enjoy the services of eminent consultants, who also undertake private work at well-known central London private acute hospitals, such as The Harley Street Clinic and The Wellington Hospital (Source: “British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger”, Competition Commission UK, 2000).

\(^{79}\) The representative offices were called Medical Referral Centres (MRCs) when they were first launched in 2001; they were rebranded International Patient Assistance Centre (IPAC) in 2006 and Parkway Patient Assistance Centres (PPACs) in 2008.
Table 6.3 - Roll-out sequence of Representative Offices set up by Parkway

<table>
<thead>
<tr>
<th>Year</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>5 centres in 5 countries - Singapore, Bangladesh, Hong Kong, Indonesia, Myanmar</td>
</tr>
<tr>
<td>2002</td>
<td>11 centres in 8 countries - Singapore, Bangladesh, Hong Kong, Indonesia (4), Myanmar, Russia, Sri Lanka, Vietnam</td>
</tr>
<tr>
<td>2003</td>
<td>18 centres in 11 countries – Singapore, Bangladesh, Brunei, China, Hong Kong, India (3), Indonesia (6), Myanmar, Russia, Sri Lanka, Vietnam</td>
</tr>
<tr>
<td>2004</td>
<td>34 centres in 16 countries – Singapore, Bangladesh, Brunei, China, Hong Kong, India (2), Indonesia (13), Malaysia (3), Myanmar, Pakistan (3), Philippines, Russia, Sri Lanka, the UAE, UK, Vietnam (2)</td>
</tr>
<tr>
<td>2005</td>
<td>45 centres in 19 countries - Singapore, Bangladesh (2), Brunei, Canada, China, Hong Kong, India (4), Indonesia (17), Malaysia (4), Myanmar, Nigeria, Pakistan (3), Philippines, Russia, Sri Lanka, Thailand, the UAE, UK, Vietnam (2)</td>
</tr>
<tr>
<td>2006</td>
<td>49 centres in 20 countries - Singapore, Bangladesh (3), Brunei (2), Cambodia, Canada, China, Egypt, India (4), Indonesia (17), Malaysia (4), Myanmar, Nigeria, Pakistan (3), Philippines, Russia, Sri Lanka, Thailand, the UAE, USA, Vietnam (3)</td>
</tr>
<tr>
<td>2007</td>
<td>53 centres in 23 countries - Singapore, Bangladesh (3), Brunei, Cambodia, Canada, China (2 – Hong Kong counted under China), Egypt, India (4), Indonesia (18), Korea, Malaysia (4), Myanmar, Nigeria, Pakistan, Philippines, Russia, Saudi Arabia, Sri Lanka, Ukraine, the UAE, the UAE, Uzbekistan and Vietnam</td>
</tr>
<tr>
<td>2008</td>
<td>48 centres across the world (specific locations not reflected in the Annual Report)</td>
</tr>
<tr>
<td>2009</td>
<td>48 centres in 18 countries (exclude Singapore; specific offices not stated): Bangladesh, Brunei, Cambodia, China, India, Indonesia, Malaysia, Mongolia, Myanmar, Pakistan, the Philippines, Russia, Saudi Arabia, Sri Lanka, Ukraine, the UAE, Uzbekistan and Vietnam.</td>
</tr>
<tr>
<td>2010 (as at Sep 2010)</td>
<td>37 centres in 17 countries (exclude Singapore): Bangladesh (2), Brunei, Cambodia, China, India, Indonesia (14), Malaysia (4), Mongolia, Myanmar (2), Pakistan, the Philippines, Russia (2), Saudi Arabia, Sri Lanka, Ukraine, the UAE and Vietnam (2).</td>
</tr>
</tbody>
</table>

As can be expected, Indonesia, which is the largest supplier of foreign patients to Parkway hospitals, has the largest network of representative offices. More than two-thirds of the centres (25 out of 37) are in Southeast Asia, showing Parkway’s focus on the immediate region. If the definition of region is expanded to cover the entire of “Asia”, only 3 of the centres are outside (Russia and Ukraine). It is also clear that representative offices are a good way to reach distant countries with good potential, for example, Russia and Ukraine.
6.2.3 Chronology of Internationalisation Activities

Please refer to Table 6.4 for the chronology of internationalisation activities of Parkway.

Table 6.4 - Chronology of Internationalisation Activities of Parkway

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
</table>
| 1987 | Major events:  
• Parkway Holdings acquired Gleneagles Hospital in Singapore and started its healthcare business (Thulaja, 2003a). |
| 1989 | Major events:  
• First acquisition in Malaysia 1989 – bought Penang Medical Centre, which was renamed Gleneagles Medical Centre, Penang.\(^{80}\) |
| 1991 | Major events:  
• Bought a cardiac facility in UK in London NHS when cardiac services at the site was moved to the Brompton Hospital\(^{81}\). |
| 1995 | Major events:  
• Acquired Mount Elizabeth and East Shore Hospitals in Singapore (Thulaja, 2003b). |
| 1996 | Major events:  
• Opened Gleneagles Intan Medical Centre in Kuala Lumpur, Malaysia, a Joint Venture\(^{82}\).  
• Acquired RS Budi Mulia in Surabaya, Indonesia\(^{83}\). |
| 1997 | Major events:  
• JV hospitals at Jakarta and Medan in Indonesia started operation (Annual Report 1999; henceforth put as AR1999).  
• Parkway’s first venture in India – a 50-50 JV with the GP Goenka-owned Duncan Group to launch a 270-bed Duncan Gleneagles Hospital in Kolkata\(^{84}\). |
| 1998 | Major events:  
• Acquired RS Graha Medika in Jakarta, Indonesia\(^{85}\). |

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\(^{82}\) Source: Website of Gleneagles Intan Medical Centre, at http://www.gimc.com.my

\(^{83}\) Source: Information on RS Budi Mulia on the website of the Indonesian Hospital Association, at http://www.pdpersi.co.id/?show=detailnews&kode=1113&tbl=klasrs.

\(^{84}\) “INDIA - Duncan Gleneagles Hospitals Limited”, Summary of Project Information, IFC, 9 Jun 1997.

<table>
<thead>
<tr>
<th>Year</th>
<th>Major events</th>
</tr>
</thead>
</table>
| 1999 | | - Parkway’s founding Tan and Ang families sold a 19.6 per cent stake to Schroder Capital Partners, which then became the biggest shareholding in Parkway (Lethbridge, 2004).  
- Restructuring and business rationalisation – Sold Parkway Parade (a key asset of the property arm of Parkway in Singapore) and focused resources on healthcare business (AR1999).  
- London Heart Hospital in UK opened (AR1999). |
| 2000 | | - Reduced stakes in their Indonesian hospitals (AR2000).  
- Secured a consulting contract to develop a 200-bed hospital in Ho Chi Minh City, Vietnam (AR2000).  
| 2001 | | - Exit the UK by selling the London Heart Hospital at a loss (AR2001).  
- Large exited the Indonesian hospitals in 2001 by further reducing its stake in the holding company (AR2001).  
- Launched its 24-hour Medical Referral Centre hotline and 5 Medical Referral Centres, in Singapore, Indonesia, Hong Kong, Myanmar and Bangladesh (AR2001).  
| 2002 | | - Entered into a joint venture with Brunei’s Jerudong Park Medical Centre to establish the Gleneagles Jerudong Park Medical Centre in Bandar Seri Begawan (AR2002).  
- Restructured the Group’s investment in a new hospital in Kolkata, India by bringing in the Apollo Hospitals group as the partner (AR2002).  

Announcements/Comments relating to its Internationalisation Strategy:
- “…we will grow and expand our healthcare reach to more countries in Asia like China and India where there is a major demand for basic healthcare facilities…” (AR1999)
- “…we will study opportunities to enter new geographic markets… This will be done either by acquisitions, by strategic alliances with selected partners…” (AR2000)
- “…Our initiatives have included exploring new markets in the Middle East and Eastern Europe as potential new sources of patients for the Singapore hospitals.” (AR2000)
- “We plan to explore growth opportunities such as potential acquisitions and by taking on more consultancy and management projects for international hospitals.” (AR2000)
- “Consultancy opportunities are being studied in Asia and the Middle East by the Group’s Consultancy Services unit.” (AR2000)
- “Establish small, non-capital intensive facilities like clinics and diagnostic centres in markets that have potential to provide foreign patients to our hospitals in Malaysia and Singapore.” (AR 2001).
- “To grow the business by developing strategic and synergistic alliances and partnerships with other specialized medical entities across Asia.” (AR2001)
- “Tapping on our existing brand reputation and expertise, we see the management and consultancy businesses as our key growth drivers for 2002 and it is an area where we can be free from capital-intensive investments.” (AR2001)
<table>
<thead>
<tr>
<th>Year</th>
<th>Major Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td><strong>Opening of JV Apollo Gleneagles Hospital in Kolkata, India in 2003 (AR2003).</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Announcements/Comments relating to its Internationalisation Strategy:</strong></td>
</tr>
<tr>
<td></td>
<td>- “…the Group partnered with Singapore government agencies in the SingaporeMedicine initiative, to actively market Singapore as an international healthcare hub…” (AR2003)</td>
</tr>
<tr>
<td></td>
<td>- “On the international front, the Group is developing strategic partnerships with established healthcare players in the region, with a focus on China, India, Malaysia, Indonesia and Vietnam.” (AR2003)</td>
</tr>
<tr>
<td>2004</td>
<td><strong>Announcements/Comments relating to its Internationalisation Strategy:</strong></td>
</tr>
<tr>
<td></td>
<td>- “Regionally, we plan to review expansion plans for our existing international hospitals and at the same time seek opportunities to enter new markets such as China and Vietnam. We also plan to expand the number of medical referral centres around the region.” (AR2004).</td>
</tr>
<tr>
<td></td>
<td>- “…we have actively participated in the Singapore government’s initiatives to attract more foreign patients through fairs, exhibitions and marketing trips overseas.” (AR2004)</td>
</tr>
<tr>
<td></td>
<td>- “…we also took advantage of the liberalisation in medical advertising rules to advertise and promote Parkway in a more extensive manner through various media.” (AR2004).</td>
</tr>
<tr>
<td>2005</td>
<td><strong>Major Events:</strong></td>
</tr>
<tr>
<td></td>
<td>- Newbridge Capital and Associates acquired a 26% stake in Parkway Holdings, making it the largest shareholder86 (AR2005).</td>
</tr>
<tr>
<td></td>
<td>- Expanded presence in Malaysia through the acquisition of a 31% stake in Pantai Holdings, Malaysia’s second largest private healthcare service provider. Became the largest shareholder of Pantai. Number of hospitals in Malaysia increased from 2 to 9 (AR2005).</td>
</tr>
<tr>
<td></td>
<td>- Entered into a joint venture with Apollo Hospitals Enterprise to establish a radio imaging centre in Hyderabad, India (AR2005).</td>
</tr>
<tr>
<td></td>
<td>- Sealed a management contract with the Asian Heart Institute and Research Centre in Mumbai, India (AR2005).</td>
</tr>
<tr>
<td></td>
<td>- Established a joint venture with Shanghai Huashan Health Development (Huashan), with plans to own and manage medical and surgical centres, clinics and hospitals in China (AR2005).</td>
</tr>
<tr>
<td></td>
<td>- Obtained operating licence for a Plastic Surgery and Aesthetics Centre in Ho Chi Minh City, Vietnam (AR2005).</td>
</tr>
<tr>
<td>2006</td>
<td><strong>Major Events:</strong></td>
</tr>
<tr>
<td></td>
<td>- Opened the Shanghai Gleneagles International Medical and Surgical Centre in China (via the JV with Huashan) (AR2006).</td>
</tr>
<tr>
<td></td>
<td>- Management contract with the Asian Heart Institute and Research Centre in India fell through (Dutta, 2006).</td>
</tr>
<tr>
<td></td>
<td>- Partnered Khazanah Nasional in Malaysia to privatize Pantai Holdings, owning Pantai through a JV which Parkway held 40% stake87 (AR2006).</td>
</tr>
<tr>
<td></td>
<td>- Gleneagles Hospital and Mount Elizabeth Hospital in Singapore received accreditation from the Joint Commission International (JCI) (AR2006).</td>
</tr>
</tbody>
</table>

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86 “Newbridge Capital leads acquisition of 26% of Parkway”, Parkway’s press release, 26 May 2005.
### 2007

**Major events:**
- Acquired World Link Group, a leading expatriate-focussed network of medical facilities in Shanghai, China (AR2007).
- Won the bidding for a new hospital site in Singapore, which it will build a new “Hospital of the Future”, scheduled to open by 2011 (AR2007).
- Disposed its interest in hospitals and medical units in East Shore Hospital, Gleneagles Hospital and Mount Elizabeth Hospital in Singapore, into Parkway Life REIT (AR2007).
- Signed a Greenfield 50-50 joint-venture with Mauritius-based Koncentric Investments Ltd to build Khubchandani Hospital, a 500-bed tertiary hospital in Mumbai, India (AR2007, AR2008).
- Launched a new global brand (AR2007).
- East Shore Hospital in Singapore achieved JCI accreditation (AR2007).

### 2008

**Major events:**
- Parkway’s first foray into Middle East; signed management contract for Danat Al Emarat Women & Children’s Hospital in Abu Dhabi, the UAE, scheduled to open in 2012 (AR2008).
- Added a clinic in Chengdu in Western China.

Announcements/Comments relating to its Internationalisation Strategy:
- “Parkway’s ongoing focus on achieving success with complex medical procedures and delivering consistent standards in patient care, coupled with Singapore’s leading reputation as a centre for medical services, as well as our proven ‘hub and spoke’ business strategy to bring in more foreign patients from overseas growth markets, should strengthen our position in the face of challenging economic conditions.” (AR2008)

### 2009

**Major events:**
- Completed the acquisition of Pantai Hospital Sungai Petani and Pantai Hospital Batu Pahat in Malaysia (AR2009).
- JCI accreditation for Pantai Hospital Kuala Lumpur in Malaysia (AR2009).
- Entered into a cooperation agreement with Shanghai Fosun Ping Yao Investment Management Co. and Shanghai Hui Xing Hospital Investment Management Co. to jointly establish medical centres in Shanghai, China.
- Launched 40 fixed-fee surgical packages to help patients lower their healthcare costs during the recessionary period. There was a strong demand for these packages and by the end of the year, over 4,000 packages had been sold (AR2009).

Announcements/Comments relating to its Internationalisation Strategy:
- “The Group will continue to assess suitable opportunities to achieve further growth in its existing and new markets through joint ventures, collaborations, and new acquisitions.” (AR2009)
- “…we reviewed our presence in Malaysia and are now aggressively expanding our network there. Our expansion into Malaysia is based on a hub and spoke model where we plan to set up community hospitals in smaller towns across Malaysia. There is a lot of demand for private healthcare in Malaysia; this demand is not only from medical tourists in the region, but more importantly, there is a strong demand from the local population who are seeking premier healthcare services…” (AR2009)

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90 “Parkway Holdings’ unit to jointly establish medical centre in Shanghai”, The Edge, 2 Nov 2009.
- “We will continue to look to secure more of such management contracts in the Middle East and other regions, in order to diversify our revenue streams.” (AR2009)
- “Entering into management contracts is an effective means for Parkway to share its expertise and expand our presence to new markets.” (AR2009)

2010 Major events:
- Parkway Holdings first went under the control of Fortis, India’s second largest healthcare group, who acquired a 23.9% stake from TPG (formerly Newbridge) and became the largest shareholder\(^91\); Khazanah subsequently made a partial offer, with the intention to take its stake from 23.86 to 51.5%\(^92\); Fortis countered with a General Offer for all Parkway shares\(^93\); Khazanah eventually won the battle with a General Offer higher than Fortis’ and took Parkway private\(^94\). De-listed from the Singapore Exchange since 24 Nov 2010\(^95\).
- Became part of Khazanah’s Integrated Healthcare Holdings (IHH)\(^96\).
- Entered into a Memorandum of Understanding with New Delhi-based GM Modi Hospital & Research Centre for Medical Sciences (GMHRC) to explore a consultancy project for the proposed renovation and expansion of the 100-bed GM Modi Hospital in India\(^97\).
- Added 2 new clinics in Shanghai, China\(^98\).
- Signed an agreement with Jesselton Wellness to set up a 200-bed Gleneagles Medical Centre Kota Kinabalu in Sabah, Malaysia (AR2010).
- The Pantai Group purchased 15 acres of land in Medini, Malaysia to develop the 300-bed Gleneagles Medini Hospital (AR2010).

Announcements/Comments relating to its Internationalisation Strategy:
- “We continue to look at ways to streamline the various components of the group, with the objective to boost productivity and spur faster regional growth, especially in Singapore and Malaysia. Areas we see synergistic opportunities include procurement, integrated support services and centralization of it systems, as well as collaboration and partnership in marketing our services and leveraging patient referrals. We are also looking at potential areas for sharing of best practices, such as clinical pathways and talent management.” (AR2010)
- Parkway aims to build hospitals in China and Vietnam to diversify from its home market which is close to saturation. Aim was for the international segment to grow to 45 percent of revenue, up from the current 31% (Quek, 2010).

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\(^91\)“Indian firm to buy S1b stake in Parkway”, The Straits Times, 12 Mar 2010.
\(^92\)”Khazanah tries to grab Parkway via window”, Business Times, 28 May 2010.
\(^93\)”Fortis goes surgical with Parkway general offer”, Business Times, 2 Jul 2010.
\(^94\)”Khazanah wins bidding war for Parkway”, The Straits Times, 27 July 2010.
\(^95\)”Approval for the delisting of the company”, Parkway’s Company Announcement, 2 Nov 2010.
\(^96\)”Khazanah wins bidding war for Parkway”, The Straits Times, 27 July 2010.
\(^97\)”Parkway and GM Modi Hospital Sign MoU for Strategic Partnership”, Express Healthcare, 22 Jan 2010.
6.2.4 Internationalisation Strategy - Overall strategy

Parkway’s overseas growth strategy aims to rationalise current businesses to drive operational efficiencies and profitability, leverage expertise in specialist services via consultancy contracts, and aggressively seek strategic acquisition opportunities to broaden the patient pool for its medical centres (Chua and Poh, 2008a).

This is done through two main sub-strategies:

a) Operate a hub and spoke network

It operates hub hospitals in Singapore, Malaysia and India, with satellite hospitals or specialist clinics and medical centres that provide intermediate health services. These satellite centres potentially refer patients that need more intensive care or specialist attention back to the hub hospitals, where specialists are based in clusters. The representative offices can also be considered to be part of the “spoke” network. While these do not provide medical care for the patients, they can be viewed as “sales office” for the hub hospitals, and facilitate the “export” of medical services to the host countries.

Besides acting as a source of patient referrals, having a network of hospitals allows economies of scale, for instance, the bulk purchase of pharmaceuticals and medical equipment, more efficient utilisation of expensive medical equipment, back room consolidation, sharing of staff and so forth. It also provides economies of scale in terms of providing enough volume for specialized teams performing highly complex but rare surgeries; for example, neurosurgery, liver transplant, and so forth. In addition, with a bigger pool of hospitals, selected hospitals can be structured to cater to specific groups of patients, thereby allowing some measure of price differentiation. For example, for Indonesian patients seeking quality healthcare overseas, Parkway will be able to offer them the choice of premium quality healthcare at higher cost in Singapore, or good quality healthcare at lower prices at its Malaysian hospitals.

This approach of setting up a hub and spoke network leveraging on the relative strengths of the different locations within the region is in line with the views
articulated in Buckley (2001) and Buckley and Ghauri (2004) concerning the “global factory”.

The hub and spoke strategy particularly leverages on the Country Specific Advantages (CSAs) of Parkway’s home base, namely, Singapore. With Singapore’s strengths within the region in terms of quality of healthcare manpower, high quality healthcare system, strong reputation and long history as the region’s medical hub, as well as strong infrastructure, including being a transport hub of the region and a major tourist hub, it is an ideal base for the execution of such a strategy.

The hub and spoke strategy has always been articulated clearly by Parkway in its overall internationalisation strategy. For example, in its annual report for 2008, it stated “…Parkway’s ongoing focus on achieving success with complex medical procedures and delivering consistent standards in patient care, coupled with Singapore’s leading reputation as a centre for medical services, as well as our proven ‘hub and spoke’ business strategy to bring in more foreign patients from overseas growth markets, should strengthen our position in the face of challenging economic conditions”.

b) Asset-light strategy

The other key element of Parkway’s strategy is to adopt an asset-light strategy as it expands its network. This is done via three measures. Firstly, it set up a Real Estate Investment Trust (REIT) into which it disposes its hospital assets in Singapore, which it then leases back on a long-term basis. This frees up capital for the group to explore new opportunities while still giving the group control of the assets through the manager of REIT. It may gradually divest the physical assets in its other overseas hospitals into this fund (eg, the Pantai Hospitals) and further free up capital. Secondly, it has started to use management contracts with

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99 Asset-light strategy refers to strategy to expand the firm’s operation with no or minimal fixed assets. The strategy was popularized by Enron in the 1990s (Foss, 2003), when they determined that heavy assets like pipelines, which were expensive to build, buy and maintain, were no longer a competitive advantage. What mattered was information, ability and capital. In healthcare, the asset-light approach provides a meaningful way for a firm to expand its brand overseas without the need for much capital expenditure.

embedded option\textsuperscript{101} as the approach for future expansion, and had indicated an intention to use this as the main mode moving forward. Again, this entry mode enables Parkway to enter new market without having to put in capital investment upfront, while giving it the option to share the gain of the venture in future, if it turns out successful. Thirdly, its extensive use of representative offices as a low cost low risk way of establishing a wide network. This is especially useful in distant unfamiliar markets like Russia, as well as important but sprawling markets like Indonesia.

The use of an asset-light strategy to internationalise is in line with the strategy expected of Dragon MNEs (Mathews 2002, 2006). In Parkway’s case, its key assets are its branding and its operational expertise. These are transient advantages which it will want to leverage on to internationalise quickly, as others will catch up in terms of such knowledge. On the other hand, what it lacked is the financial resources to use high commitment entry modes for all of its overseas expansion.

It is important to bear in mind that Parkway was able to execute the above strategy because of its strong FSAs in the form of a globally-oriented management team and a strong reputation for high clinical standards. These are the resources which it leverages on, and much of these were gained from the purchase of Mt Elizabeth and East Shore Hospitals, which were owned by Tenet Healthcare. As a large global healthcare MNE, Tenet Healthcare was able to introduce advanced healthcare management practices at the hospitals and put in place a team of strong globally-exposed healthcare administrators with internationalisation in and around the region (Tenet’s regional network includes hospitals in Singapore, Thailand and Australia). In line with the LLL framework of Mathews (2006), this can be considered as the start of the LLL chain for Parkway, ie, by linking up Mt Elizabeth Hospital, it was able to leverage on the expertise there, and through learning, it was equipped with the people and knowledge, which it then leverages on for its expansion beyond Singapore.

To emphasise its high clinical quality, Parkway also leverages on the Joint Commission International (JCI) accreditation. This is generally not necessary for patients from the

\textsuperscript{101} This means that the option is included as part of the management contract; the option entitles its holder the right to acquire a predetermined stake in the asset being managed at a predetermined price within a certain period of time.
region as the quality of Singapore healthcare is well-recognised within the region over the years, and regional patients generally have confidence in the stringent licensing standards of the Singaporean government. Nevertheless, such accreditation may be useful for patients from more distant countries who may not be as familiar with the Singapore healthcare standards and may need the extra assurance. For Parkway, besides its three hospitals in Singapore, two of its hospitals in Malaysia are also JCI-accredited.

6.2.4.1 Further Evaluation of Parkway’s Hub and Spoke Strategy

While much have been publicly stated about Parkway’s use of a hub and spoke strategy to create feeders for its home base, it has increasingly become a necessity for healthcare groups internationalising from Singapore to adopt this strategy in the face of strong competition from other up-and-coming medical hubs in the region, especially in Thailand and Malaysia. While in the past, affluent regional patients come to Singapore for all kinds of healthcare services, from health screening to routine procedures (like Colonoscopy) to complex procedures (like Open Heart Surgeries), the more price-sensitive group among them now have more options within the region. Over the years, hospitals in Thailand and Malaysia have become equally competent as their Singapore counterparts for the more routine procedures and can do so at a significantly lower fee, typically about 40 – 60% lower than that in Singapore depending on the types of treatment.

This trend is generally backed by the data on medical travel to Singapore. According to the exit survey done by the Singapore Tourism Board, medical traveller arrival numbers declined by 15% in 2007, but total medical tourist expenditure increased by 30% to S$1.7 billion (see Fig 6.3).

Figure 6.3 - Medical Tourist Arrivals in Singapore

Source: Singapore Tourism Board
While the decline may be due to statistical errors, it is more likely that it was due to increasing competition from neighbouring countries, such as Thailand, Malaysia and India. Price-sensitive patients may have turned to these countries for low-risk elective procedures, while Singapore is receiving more patients seeking high-end care, as shown by the increase in revenue intensity of Parkway, which is reflected in revenue per patient day increasing by a CAGR of 9.8% between 2005 and 2007 (see Fig 6.4). During the same period, the number of admissions stayed relatively unchanged (Fig 6.5), though inpatient occupancy increased from about 61% to 65% (Fig 6.6), showing that patients were being admitted for more complex procedures requiring longer inpatient stay. This trend is also reflected in the increase in revenue and profitability of Parkway’s Singapore hospitals (see Figs 6.7 and 6.8). (Lim and Tsai, 2009)

Among the three countries, Malaysia poses the strongest competition for Singapore in terms of attracting foreign patients, since both focus heavily on the Indonesian market. Between 2006 and 2007, foreign patients visiting Malaysia increased from 296,687 to 341,288 (Source: Association of Private Hospitals of Malaysia), compared to a drop for Singapore.

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102 Among the three countries, Malaysia poses the strongest competition for Singapore in terms of attracting foreign patients, since both focus heavily on the Indonesian market. Between 2006 and 2007, foreign patients visiting Malaysia increased from 296,687 to 341,288 (Source: Association of Private Hospitals of Malaysia), compared to a drop for Singapore.
Nevertheless, to ensure optimum utilisation of the facilities in Singapore, Parkway’s challenge is to ensure that the increase in the load of foreign complex cases done in Singapore is enough to make up for the decline in the load of routine cases from their traditional markets, like Indonesia. In this context, the hub and spoke model works, as the complex cases from the region are fed to their hub in Singapore. The hub and spoke model also allows Parkway to continue to serve some of the more price-sensitive patient-customers who have moved from their Singapore facility to their other regional facilities, for example, in Malaysia.

To ensure the group’s Singapore facilities remains optimally utilised, it is essential for Parkway to broaden the reach of its spokes as wide as possible. Parkway has addressed this through two ways. Firstly, it has increased its internationalisation efforts, through overseas acquisitions and expansion of its existing facilities overseas. Secondly, it has to widen its network of spokes rapidly, eg, via the representative offices, to have a wider base to refer patients to its hospitals in Singapore.

The above explanation is supported by a recent study by Frost and Sullivan. According to the study\textsuperscript{103}, the number of Malaysian patients coming to Singapore and their total expenditure have grown sharply between 2005 and 2009, with their numbers increased from 33,750 to 60,000, and revenue contribution increased from $13.3 million to $89.5 million. Frost & Sullivan said the trend might be a result of greater awareness of Singapore healthcare facilities given the increase in hospital partnerships between the two countries. It was added that a high proportion of patients coming from Malaysia are “quality-hunters” who are seeking the type and the quality of medical care that is

\textsuperscript{103} “Malaysian ‘quality hunters’ take bigger slice of medical tourist pie”, The Business Times, 23 May 2011.
deemed unavailable in Malaysia. In the same article, Parkway also confirmed that the number of Malaysian patients using its facilities in Singapore has been growing. On the other hand, the flow of Indonesian patients shows a slowly declining trend, falling 3% to 184,600 between 2005 and 2009. This was attributed to the more price-sensitive Indonesian patients using hospital services back home as the quality of facilities there had improved.

6.2.5 Internationalisation Strategy – Market Selection

6.2.5.1 Countries with Hospital Presence

In terms of market selection, the chronology of events shows that Parkway’s initial entries were mainly in Malaysia and Indonesia. This was largely in alignment with the Uppsala 1977 Model (Johanson and Vahlne, 1977; 1990) where the firm is expected to start from neighbouring countries where ‘psychic’ distance is short. In a way, the Uppsala 2009 Model (Johanson and Vahlne, 2009) would have predicted the same path of internationalisation. The Tan and Ang families which owned Parkway then were prominent business families in Malaysia, hence their network there would have made Malaysia a natural first entry point for Singapore-based Parkway. As for the collaboration with Indonesian Lippo Group on the Siloam hospitals, and with a group of Indonesian businessmen on the Medan hospital, this would have been expected based on the dealings the different groups have in their other business areas.

The only exception during the initial period was the purchase of the cardiac facility in London, UK, which as is now known, turned out to be a mismatch of the firm’s FSA and the FSA required to make the venture successful. Parkway exited the project in 2001 with a significant write-off.

The group then went on to spread their net much wider, exploring opportunities in countries like China, India, Vietnam and Middle East, even Russia and Eastern Europe. This was clearly an attempt by the group to diversify its revenue stream and to diversify its foreign patient sources. This arose from a particularly painful lesson which Parkway learnt during the 1997/8 Asian Financial Crisis, where the sharp drop in Indonesian patients, and an over-reliance on its Singapore operations landed the company in significant hardship. This meant that while Indonesia remained an important market,
Parkway had to explore other new markets as well. It also meant that Parkway had to accelerate its internationalisation to increase its overseas operations, so as to reduce its dependence on the over-saturated Singapore market where it had to rely significantly on the volatile foreign patient business.

The need to accelerate its internationalisation meant that Parkway had to explore opportunities not just within the immediate region (that is, ASEAN), but also outside the region. This is the start of a deviation from the Uppsala 1977 Model and follows more closely to the behaviour predicted by Mathews (2002, 2006) and the Uppsala 2009 Model.

For China, India and Vietnam, all three are attractive markets with huge population and a rapidly growing middle class. As highlighted in the Uppsala 2009 Model, where the firm sees opportunities in the markets where it does not have current partners or network, it may start building new connections with a firm which is operating in a network there. From the market entry experience for China, India and Vietnam discussed in the previous section, it does appear that Parkway did not have firm partners to work with in those markets from the start, and hence, had to struggle a bit before they gained a foothold there. In the interview with Forbes in 2008, then Parkway’s CEO for China Jonathan Seah even shared how he tapped on his Business School alumni network to assemble a small team of employees to kick start Parkway’s exploration process in China in 2004 (Tan, 2008). Among the three, Parkway has yet to establish a significant presence in Vietnam, with only a Plastic Surgery and Aesthetics Centre there since 2005.

The other two countries where Parkway has a hospital presence are Abu Dhabi and Brunei. In both cases, it was able to find good government-linked partners which value the Parkway brand for collaboration.

An interesting observation is the difficulty which Parkway encountered in Malaysia when it acquired a healthcare group (namely, Pantai) owned by rentier capital. This highlights the potential complications within the Malaysian private healthcare sector raised by Chee (2008), in view of the strong state involvement in the sector (see Section 2.5.2). The example demonstrated the impact of political considerations as a host country factor during market and target selection. The case also showed how such
complications can be best resolved – by joining hand with an appropriate local partner. This again demonstrates the importance of networks as emphasised in the Uppsala 2009 Model (Johanson and Vahlne, 2009). Furthermore, it shows that notwithstanding the close psychic distance between Singapore and Malaysia and the experience a firm has in a market, each new expansion move will still come with its own set of considerations which have to be addressed for the move to be successful; there are times when new additional ties had to be forged to facilitate further penetration within the market, especially when it involves a sector which the government has a strong interest in.

6.2.5.2 Countries with Representative Offices

As part of the strategy to diversify its sources of patients, Parkway also expanded its representative office network to many countries which are attractive potential sources for foreign patients but which Parkway was still not familiar with or which the market uncertainties remained high. These include countries like Russia, Ukraine, Myanmar, Bangladesh, and so forth. This mirrors the literature where MNEs will enter attractive markets with high uncertainties using “export” (Erramilli and Rao 1990; Ekeledo and Sivakumar 2004; Lommelen and Matthyssens 2005). Since healthcare services cannot be exported in the traditional sense, having a representative office is the closest alternative as it serves as a “sales office” for the firm.

Notwithstanding the objective of these representative offices as low-cost, low-risk channels to explore the market, Parkway has also rolled back some of these representative offices over the years, when it became clear over time that the market is not worth focusing on. These include markets like Korea, Thailand, Nigeria, Egypt, UK, USA and Canada. This illustrates the role of the representative offices as a tool for “testing the market”.

On the other hand, other markets which showed promise might see more representative offices spread to other parts of the country or attract Parkway to make investment with a physical presence, as Parkway learns more about the market and the consumers there. The former group includes countries like Indonesia, Vietnam, Myanmar, Bangladesh and Pakistan, while the latter group includes Vietnam, China and the UAE, where Parkway established a higher commitment presence after assessing the markets and deemed these as attractive for a stronger presence.
Nevertheless, the process is a dynamic one. As the different cities develop and as other competitors enter the market, the location of the representative offices changes even within the same country (for example, in Indonesia), where some representative offices were closed in recent years, while new ones were added.

6.2.5.3 Impact from the Market Selection

The active internationalisation by Parkway has enabled it to increase overseas contribution from 6% of total revenue in 1997 to 32% in 2008. On the diversification of patient sources, it has managed to reduce the proportion of Indonesian patients from 74% in 2000 to 58% in 2008, while almost doubling patients from other non-traditional sources like Bangladesh, the Philippines, Vietnam, Cambodia, Pakistan, Russia and Middle East from 16% to about 31%. The proportion of patients from Malaysia stayed relatively stable at about 10 – 11%.

While Parkway had over the years created a network across Asia and beyond, its main operations remain in Singapore, Malaysia and Indonesia (covered via representative offices). It can therefore be concluded that Parkway remained largely regional in its strategy.

6.2.6 Internationalisation Strategy – Entry Modes

In terms of entry modes, there are various modes which have been adopted by Parkway over the years.

6.2.6.1 Acquisitions and Joint Ventures (JV)

In the initial years, Parkway expanded its network mainly by way of acquisitions and Joint Ventures. Generally, acquisitions are desired if a suitable asset is available at a reasonable price, and the firm is familiar with the operating environment of the asset. In general, the reasons for healthcare firms to use acquisition are: (1) expectations of a relatively shorter payback period (a Greenfield hospital typically has a 3-5 year gestation period); (2) a lack of suitable land sites; and (3) the convenience of leveraging an existing staff and patient base (Hee, 2007). Acquisitions by Parkway in the earlier
A Joint Venture is needed when there are no suitable assets, or at least, not at a right price. This is especially so for developing countries which the firm enters, where most of the facilities might not be of the standard expected by the firm. In addition, for countries where the firm is not familiar with, the Joint Venture mode serves as a good way for it to leverage on another party with the ground experience (Mathews 2002; 2006). For example, in an interview in 2010, Parkway’s Managing Director and CEO, Dr Tan See Leng, mentioned that markets which are less easy to canvas may also require working hand-in-hand with partners. In India, for instance, Parkway has a joint venture with Apollo Hospitals. Leveraging on Apollo’s expertise, outreach and network could be a better way to maximise Parkway’s presence in India, rather than going it alone, he pointed out."!

Projects which were structured as JV include Gleneagles Intan Medical Centre (Malaysia), Gleneagles Jerudong Park Medical Centre (Brunei), Apollo Gleneagles Hospital and Khubchandani Hospital (both India), RS Siloam Gleneagles and RS Gleneagles (both Indonesia).

The Pantai deal was again interesting. It was initially done as an acquisition. It was a very attractive piece of asset, with a good market position, clearly ranked second in the Malaysian market, with a strong brand, and holding a few lucrative government concessions. However, given the political concerns arising from the acquisition, Khazanah stepped in to form a 60:40 JV with Parkway which bought out Parkway’s stake and acquired the rest of the Pantai share to take it private. Parkway retained management control of Pantai. The eventual deal was an innovative win-win solution for both parties – the Malaysian government retained ownership of Pantai, while Parkway got what it sought in the first place – management control of Pantai.

6.2.6.2 Management Consultancy and Management Contract

Another entry mode that was used for internationalisation was management consultancy and management contract. Management consultancy involves advising the client

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104 “Moving up the value chain”, The Business Times, 9 Nov 2010.
organisation on the setting up of a new hospital or redevelopment of an existing facility, while a management contract involves a contract to run a hospital or a group of hospitals. The two activities can be done independent of one another, but they can also be undertaken together, especially for new hospitals. For firms like Parkway, where the focus is to set up a hub and spoke network for referral of patients, the main aim is to secure a management contract, while management consultancy is largely a means to that end.

In the initial period of Parkway’s internationalisation, they were active in exploring the use of management consultancy as a channel. In 2000, Parkway secured a consulting contract for a 200-bed hospital in Vietnam. Between 2000 and 2001, Parkway highlighted in its annual reports that it saw the management and consultancy businesses as its key growth drivers and it is “an area where we can be free from capital-intensive investments.” In an interview in 2001, commenting on the consultancy strategy, Dr Lim Cheok Peng said “All we have to do is mobilise the people and expertise and bring out a blueprint of all the hospitals we've done and we come out with a standard package. This is the cheapest means of doing business without any investment.” (Saywell, 2001)

At that time, Parkway was also looking at a similar consulting and management contract for a hospital that was being planned by a group of private investors in Bahrain, besides the Vietnam deal. Dr Lim even highlighted his goal to sign four new management contracts a year over the next five years (Saywell, 2001).

Nevertheless, Parkway’s involvement with the Vietnam hospital ceased after its completion in 2003. Use of project consultancy for internationalisation was also no longer mentioned by Parkway after 2001.

In recent years, Parkway has stated management contract as its preferred mode for entry into new markets, after using it for a first time for the Danat Al Emarat Women & Children’s Hospital in UAE. In fact, that project was Parkway’s first foreign venture without an equity stake.
Elaborating on this new strategy for entry, Dr Tan See Leng, in an interview in 2010\textsuperscript{105}, said that he hoped to expand Parkway’s footprint through hospital management agreements and management projects in markets and regions such as the Middle East, China and Indo-China. “It allows us a very nimble, low risk approach to different markets where we do not have at this point in time a significant presence,” he said in the interview, adding that the group will typically embed a call option, enabling it to buy equity in the project further down the line. “We’re looking at a couple in Saudi Arabia, China and India. We’re also looking at some in Malaysia.” He added that “Management contracts can also drive business for its hospital operations in Singapore and Malaysia, as more complex procedures may be fed to these hospitals.” And he concluded that “The healthcare needs in each country will be different. And if you try to build a profitable hospital to cater to the entire spectrum of diseases, it would be foolhardy.”

The use of management contracts is in line with the expected behaviour of “Dragon MNEs”, as they access resources through linkage with external firms, and use collaborative entry modes like service contracts (Mathews, 2006). In the case of Parkway’s deal in the UAE, it leverages on the local government-linked company’s familiarity with the country, and offer its “resource” in return, in the form of hospital management expertise. Management contracts are the ultimate asset-light strategy, which as highlighted earlier, is a key aspect of Parkway’s internationalisation strategy. A management contract gives control of the business but not the ownership, which works well for Parkway, given its priority for accelerated internationalisation. The embedded options in such contracts would allow it the opportunity to share the gains of the project more tangibly some time later, should the project prove to be successful.

6.2.6.3 Clinics and Representative Offices

For locations which are attractive potential sources for foreign patients but which Parkway did not want to make a high commitment entry, either because it did not have the relevant network to tap on or the local conditions did not permit a meaningful hospital presence to be set up, Parkway has effectively used representative offices or clinics as their local presence.

\textsuperscript{105} “Moving up the value chain”, The Business Times, 9 Nov 2010.
A representative office is a particularly cheap option as it requires only a small staff - a representative and a secretary - and a rented office. It serves as outreach and “sales office”, to facilitate the “export” of hospital services by facilitating the referral of patients to Parkway’s network of hospitals. They are also a good first channel into a new market, as a low cost low risk approach to understanding the market, especially one which the company is not familiar or where risk is high. As the firm learns more about the particular group of patients and gains a better understanding of the market, it is then opportune to look at some other higher commitment entry modes, eg, opening medical clinics (like in Vietnam and China) or managing hospitals (eg, in the UAE).

The setting up of a Plastic Surgery and Aesthetics Centre in Vietnam and the establishment of a large clinic and medical centre chain in China (largely in Shanghai) are a good way to incrementally progress Parkway’s presence in the two countries while foreign investment rules on healthcare services in these two countries are still evolving. These centres provided Parkway with the opportunities to test the market before embarking upon even more substantial capital investment, while at the same time, continue to act as a source of patient referrals to Parkway’s network of hospitals. It also allowed Parkway to build up a brand name locally, as well as seek potential partners whom it can work with when it decides to expand further.

The extensive use of representative offices by Parkway for its internationalisation is interesting and deserves further study. The use of representative office is aligned with the work of Johanson and Vahlne (1977), which advocates using small, sequential steps both in the scale of operations in a particular country and of the geographic scope of the firm’s operations. The model is one of rational search in a world in which information acquisition is costly. This model of local search is also consistent with the view of the process as one of acquisition and utilisation or abandonment of options to expand (Kogut, 1983).

Secondly, it is a useful entry mode to achieve the accelerated internationalisation desired by a “Dragon MNE” like Parkway. The use of representative offices is the fastest way of spreading the net very wide. As highlighted by Mathews (2006), such an outward orientation carries a high risk given the lack of full market intelligence and uncertainties, hence a representative office is a good way to establish a quick presence.
Thirdly, the effectiveness of the representative offices as a channel to facilitate referral of patients is a clear illustration of the commodification of healthcare. It demonstrates that healthcare service is becoming “exportable”, not in the traditional sense of having the goods exported since the service still have to be consumed at the “home” hospital, but it is now possible to “sell” the healthcare service overseas without the “production base”. This marks the evolution of healthcare service from a doctor-patient relationship to a customer-provider one, with a greater freedom of choice for the customer.

6.2.7 Internationalisation Strategy – Timing of Entry

In terms of timing of internationalisation, this has been indirectly discussed in the previous two sections. Generally, as can be expected from a typical “Dragon MNE”, Parkway has internationalised quickly, both in terms of starting its internationalisation activities, as well as the speed with which it expands internationally.

In fact, it made its first overseas acquisition within two years of entering into the healthcare market, and within ten years (ie, 1997), it expanded from one hospital to ten hospitals, including seven overseas in three countries.

The rapid internationalisation is also a necessity as a result of Singapore’s small domestic demand (Hirsch, 2006). As former Parkway CEO, Dr Lim Cheok Peng said at an interview in 2001, “Growth won’t be as dramatic in Singapore as it is in the region. If the patients aren’t coming to us, we have to go to the patients” (Saywell, 2001).

6.2.8 Lessons from Failed Entries

Parkway’s extensive internationalisation activities included both successes and failures. Besides looking at the factors and considerations in the successful entries, it will also be interesting to look at the not-so-successful cases.

Firstly, looking at Indonesia, Parkway entered the market with two joint venture Greenfield hospitals in the mid-1990s, as well as acquiring two existing hospitals via a JV company. It reduced its involvement in these hospitals in 2001 as they were not profitable. In this case, it could be considered a case of wrong choice of entry mode. Given the various restrictions placed on private hospitals in Indonesia at that time, eg,
recruitment of doctors and requirement to provide low-cost beds (which were discussed earlier), it is difficult to make a profit, especially for foreign operators. For Parkway, in particular, its objective in Indonesia was to refer patients to Singapore, which is just a short flight away from most of the affluent areas in Indonesia. Hence, a lower cost mode which provided wider coverage, like a network of representative offices, would perform that function well. Hence, it was a good decision then by Parkway to withdraw from physically owning hospitals in Indonesia. Nevertheless, with changes to the regulations for private hospitals in Indonesia over the years, owning hospital there might be commercially viable for Parkway at some point.

Secondly, looking at the difficulties that Parkway faced in India, it highlighted the importance of having the right partner, especially in countries which the firm is unfamiliar and which the operating environment is challenging. Eventually, a project that was stalling with one group (Duncan group) went on to be a successful model of partnership with another (Apollo).

Finally, Parkway’s failed venture in the UK was a case of wrong choice of market. Parkway’s FSA is confined to the region, where it has served regional patients for many years and where it enjoys a strong reputation as a provider of clinical care of the highest quality in the region. When it went to the UK, which has its own centres of excellence, in this case, in cardiac services, Parkway’s Heart Hospital was just one of the good centres and did not enjoy the FSA that it enjoys within ASEAN or in Asia. Besides, with universal health coverage in UK under NHS, it would have been challenging for a private health facility to succeed without a clear distinct value proposition.

6.2.9 Case Summary

As the most established and largest healthcare group in Singapore and the region (by market capitalisation until its delisting in November 2010), Parkway has a wide network of healthcare institutions in Singapore, Malaysia, Brunei, India, China, Vietnam and United Arab Emirates, as well as 37 representative offices across Asia, Europe and the Middle East.

Parkway has adopted a hub and spoke strategy for its overseas operation, with hub hospitals in Singapore, Malaysia and India, and spokes in the form of smaller hospitals,
specialist clinics, medical centres and representative offices. Its internationalisation strategy is to expand this hub and spoke network, so as to increase referrals of more complex cases to its hub hospitals. It also adopts an asset-light strategy, which includes divesting some of its hospital assets to a REIT to free up funds for overseas expansion, the use of management contract for market entries, and use of representative offices to widen its network. It leveraged on the expertise of acquired hospitals to accelerate its “learning” in internationalisation in the early days, and continued to leverage on international accreditation like JCI to attract foreign patients to its hub hospitals. Analysis of company data and foreign patient trends showed that Parkway’s hub and spoke strategy had been effective in attracting more patients with more acute conditions to its main hub in Singapore.

In terms of market selection, while Parkway started its overseas expansion in Malaysia and Indonesia in alignment with the Uppsala 1977 Model (Johanson and Valhne, 1977; 1990), it subsequently expanded to more distant markets, including the UK, as it accelerated its internationalisation activities. It has since rationalized some of its overseas operations, but it was clear that its later market entries did not always follow the incremental approach of the Uppsala 1977 Model. Parkway also uses representative offices extensively to enter countries which are attractive potential sources for foreign patients but which it is less familiar with.

Parkway deployed a wide range of entry modes, including acquisitions, joint ventures, management consultancy/management contract, clinics and representative offices. Its present stated preference is to enter markets using management contracts with embedded options, which allow accelerated entry with low capital investment, yet provide the opportunity to co-own the facility in future if it turned out successful. Some observations relating to the use of representative offices are that they facilitate accelerated market entries, and are useful as the first small step for entering new markets, in line with the work of Johanson and Vahlne (1977).

In terms of timing, Parkway started its internationalisation shortly after it entered the healthcare industry, and had since internationalised quickly to other countries.

Studying the various cases of failed entries by Parkway, the importance of choosing the right entry mode, the right partner and the right market to enter were highlighted.
6.3 CASE 2 – RAFFLES MEDICAL GROUP (RMG)

6.3.1 Background

Raffles Medical Group (RMG) is a leading medical group and the largest private group practice in Singapore. The Group was founded in 1976, when Dr Loo Choon Yong and Dr Alfred Loh Wee Tiong acquired an existing medical practice with two clinics. Its medical services and clinic network then expanded rapidly. The Group opened Raffles SurgiCentre in September 1993, the first free-standing day surgery centre in Southeast Asia. In 1997, it entered into a joint venture with Pidemco Land to retrofit an existing mixed-use building downtown into a hospital and medical centre. Named Raffles Hospital, it was opened in March 2001.

Today, the Group owns and operates a network of family medicine clinics, a tertiary care private hospital, insurance services and a consumer healthcare division. It operates a network of 65 multi-disciplinary clinics across Singapore, three clinics in Hong Kong and one each in Indonesia and China. The Group also manages the airport clinics in Singapore’s Changi International Airport and Hong Kong’s Chek Lap Kok International Airport.

RMG’s presence in Hong Kong started in 1995, when it opened its first clinic there. In 1997, RMG acquired a medical group there, which added more clinics to its Hong Kong practice. However, as the focus of this study is on internationalisation of hospital groups, RMG’s Hong Kong practice will not be a focus in this case study. Unlike clinics or representative offices in the developing countries, there are minimal referrals from RMG’s Hong Kong practice to its hospital in Singapore, given that the healthcare standard in Hong Kong is on par with Singapore’s.

The Group’s flagship, Raffles Hospital, is a 380-bed tertiary hospital which offers a full complement of specialist services combined with advanced medical technology. Its 16 specialist centres meet a wide variety of medical needs such as obstetrics and gynaecology, cardiology, oncology and orthopaedics. The Group also has representative offices in Indonesia, Vietnam, Cambodia, Bangladesh and the Russian Far East, as well as associates throughout the Asia-Pacific region. In 2010, foreign patients account for
about a third of its patients, with about 20 – 25% from Indonesia, and 5 – 7% each from Malaysia and Russia.

Dr Loo Choon Yong, the founder and Executive Chairman of the Group, remains the largest shareholder of the group, with about 50% stake.

6.3.2 Internationalisation Activities by Country

6.3.2.1 In Malaysia

In 2004, RMG tried to buy a hospital in Malaysia but failed. It announced on 24 Oct 2004 that it would purchase up to 100% of Penang-based Island Hospital for a cash consideration of RM110 million. The 240-bed private tertiary hospital offers a wide and comprehensive range of medical, surgical and emergency services, and is a leading private hospital in Northern Malaysia, serving a wide geographical region which includes Southern Thailand and the Indonesian state of Sumatra, with a large number of patients from Medan. Dr Loo Choon Yong, Executive Chairman of RMG, said then: “This is an acquisition that will enable us to build a strong clinical relationship between our respective physician groups. There is also tremendous potential for marketing and promotional synergies, as well as cross referrals of clients and patients. The acquisition is a step towards transforming RMG into a regional powerhouse in healthcare services. As we expand, we want to bring the Raffles brand of quality healthcare to the region and beyond.”106 However, the acquisition fell through in December 2004. The public reason given was that the “two firms could not resolve some issues relating to due diligence” (Wee, 2007).

6.3.2.2 In China

RMG has always been keen on China as the next market it expands into. In 2006, it mentioned in its annual report: “Business development activities are in full swing as the Group explores investment co-ownership opportunities in regional hospitals and medical centres in key cities of China. It also plans to set up consultancy services in the Middle East.”

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In an interview with Dr Prem Kumar Nair, RMG’s General Manager of Business Development, in 2007, it was mentioned that “Raffles Medical Group plans to set up two medical centres in the Chinese cities of Beijing and Shanghai within a year, and hopes to open a hospital in China after that.” (Lee, 2007)

Nair added that Raffles was also looking at expansion opportunities in Malaysia, India and the Middle East. “We’re still interested to look at a hospital in Malaysia. Malaysia, unlike China, would be an acquisition because there are good, well-run hospitals there,” Nair said, adding that the firm's target would be a mid-sized to large hospital.

However, the much-talked about overseas venture did not happen. It was only on 6 July 2010 that RMG finally announced that it has opened a new medical centre in Shanghai. Designed to offer world class medical care to expatriates, corporate customers and high net worth mainland Chinese, Raffles Medical – Shanghai is equipped to provide comprehensive medical services, including, health screening, general medical and dental treatments.

In an interview with Reuters, Dr Loo revealed that RMG is prepared to invest S$200m to S$300 million to build a hospital with at least 300 beds in China, in a “gateway city” like Shanghai, Beijing, Shenzhen or Guangzhou (Reuters, 2010).

6.3.2.3 Network of Representative Offices (Representative offices)

The following is the opening sequence of RMG’s representative offices:

2000 - Indonesia
2004 - Bangladesh
2006 - Vietnam
2008 - Cambodia and Russia
6.3.3 Chronology of Internationalisation Activities

Please refer to Table 6.5 for the chronology of internationalisation activities of RMG.

Table 6.5 - Chronology of Internationalisation Activities of RMG

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>1993</td>
<td>Major events:</td>
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<tr>
<td></td>
<td>• Opened Raffles SurgiCentre in Singapore as the first standalone day surgery centre in Southeast Asia.(^{107}).</td>
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<tr>
<td>1997</td>
<td>Major events:</td>
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<td></td>
<td>• Listed on SESDAQ, the second board of the Singapore Exchange(^{108}).</td>
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<td></td>
<td>• Entered into a joint venture with Pidemco Land to retrofit an existing mixed-use building in Singapore into a hospital and medical centre (Thulaja, 2003c).</td>
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<tr>
<td>2000</td>
<td>Major events:</td>
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<td></td>
<td>• Set up a liaison centre in Jakarta, Indonesia (AR2000).</td>
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<tr>
<td>2001</td>
<td>Major events:</td>
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<td></td>
<td>• Raffles Hospital commences operations in Singapore (AR2001).</td>
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<tr>
<td>2004</td>
<td>Major events:</td>
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<tr>
<td></td>
<td>• Announced that it would acquire Island Hospital in Penang, Malaysia; however, the deal subsequently fell through.(^{109}).</td>
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<tr>
<td></td>
<td>• Representative Office opened in Dhaka, Bangladesh (AR2004).</td>
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<td></td>
<td>Announcements/Comments on Internationalisation Strategy:</td>
</tr>
<tr>
<td></td>
<td>• “The Group will continue to seek regional opportunities in Indonesia, Malaysia and China.” (AR2004)</td>
</tr>
<tr>
<td>2005</td>
<td>Major events:</td>
</tr>
<tr>
<td></td>
<td>• Upgraded its Jakarta office in Indonesia into a medical centre (AR2005).</td>
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<tr>
<td></td>
<td>Announcements/Comments on Internationalisation Strategy:</td>
</tr>
<tr>
<td></td>
<td>• “The group is actively seeking opportunities in the region and will consider growth through acquisition or Greenfield projects.” (AR2005)</td>
</tr>
<tr>
<td>2006</td>
<td>Major events:</td>
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<tr>
<td></td>
<td>• Patient Liaison Office opened in Ho Chih Minh City in Vietnam (AR2006).</td>
</tr>
<tr>
<td></td>
<td>• Raffles Hospital International (RHI), the international arm of RMG was started to provide healthcare consultancy services.(^{111}).</td>
</tr>
<tr>
<td></td>
<td>Announcements/Comments on Internationalisation Strategy:</td>
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<tr>
<td></td>
<td>• “Business development activities are in full swing as the Group explores investment co-ownership opportunities in regional hospitals and medical centres in key cities of China. It also plans to set up consultancy services in the Middle East.” (AR2006)</td>
</tr>
</tbody>
</table>


\(^{110}\) “Raffles Medical aborts Island Hospital buy”, The Edge Daily, 14 Dec 2004.

<table>
<thead>
<tr>
<th>Year</th>
<th>Major events</th>
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</table>
| 2007 | - Acquires the remaining 50 per cent of the Raffles Hospital building in Singapore to give it greater flexibility on future development for the building (AR2007).  
- Placed shares to strategic investors Temasek Holdings (Singapore) and Qatar Investment Authority, the investment arm of the Government of Qatar, with each owning 4.87% of RMG after the placement\(^{112}\) (AR2007).  
Announcements/Comments on Internationalisation Strategy:  
  - “Raffles Medical Group plans to set up two medical centres in the Chinese cities of Beijing and Shanghai within a year, and hopes to open a hospital in China after that.” (Lee, 2007) |
| 2008 | - Associates appointed in Russia\(^{113}\) and Cambodia to perform patient liaison function (AR2008). |
| 2009 | - Raffles Hospital in Singapore received the Joint Commission International accreditation (AR2009). |
| 2010 | - Raffles Medical opens its first medical centre in Shanghai, China (AR2010).  
- Announced that it will be spending between S$80 to 100 million to expand its flagship Raffles Hospital in Singapore\(^{114}\) (AR2010).  
- Submitted a proposal to the Hong Kong authorities which has called for an Expression of Interest on new hospitals to be built on new sites\(^{115}\).  
Announcements/Comments on Internationalisation Strategy:  
  - “Revealed that it is prepared to invest S$200m to S$300 million to build a hospital with at least 300 beds in China, in a “gateway city” like Shanghai, Beijing, Shenzhen or Guangzhou.” (Reuters, 2010) |
| 2011 | - Purchased a building within the tourist belt in Singapore (Orchard Road) to convert to a medical centre to serve its patients from that area and to target medical tourists\(^{116}\). |

\(^{112}\) “Placement of 50 Million New Raffles Medical Group Shares to Temesek Holdings and Qatar Investment Authority”, News Release, 18 June 2007.  
\(^{113}\) The RMG website mentioned “Raffles Hospital has appointed R-Group as Raffles Patient Liaison Office in Vladivostok and Mandarin Travel as Raffles Patient Liaison Office in Khabarovsk starting November 2008.”  
\(^{114}\) “Raffles Hospital Expansion”, RMG’s company announcement, 26 July 2010.  
\(^{115}\) Analyst Report on Raffles Medical, Gary Ng, CIMB, 26 Apr 2010.  
\(^{116}\) “RafflesMedicalGroup Enters 35th Year of Healthcare Delivery on a High Note”, RMG’s media release, 21 Feb 2011.
6.3.4 Internationalisation Strategy – Overall strategy

RMG’s internationalisation strategy can be summarized as follow:

a) Hub-and-spoke with representative offices and clinics overseas as referral channels\textsuperscript{117};

b) Continuous expansion of its home base to increase its capabilities and hence attraction\textsuperscript{118}.

On (a), it has been active in marketing its services overseas as well as opening representative offices\textsuperscript{119}. It first opened a representative office in Jakarta in 2000, which was upgraded to a medical centre in 2005. It then opened a representative office in Vietnam in 2006, followed by Russia in 2008 and Bangladesh and Cambodia in 2009. This has helped it bring in foreign patients from all over the world (see Fig 6.9).

![Figure 6.9 – Raffles Medical’s Foreign Patient Mix](source: Nomura Singapore Limited (Lim and Tsai, 2009))

On (b), since its opening in 2001, RMG has constantly upgraded and expanded its facilities and range of offerings at its flagship Raffles Hospital. In line with that, it bought over the share of the hospital building belonging to a property group in 2007, to give it greater flexibility to develop the building. In 2010, RMG announced that it will be spending between S$80 to $100 million to expand its flagship Raffles Hospital. In 2011, it acquired a building within the tourist belt to be converted to a large medical centre. The new medical centre within the tourist belt should help further strengthen its ability to attract more medical tourists.

\textsuperscript{118} Analyst Report on Raffles Medical, Research Team, OCBC Investment Research, 6 Oct 2010.
\textsuperscript{119} Analyst Report on Raffles Medical, Lynette Tan, DMG & Partners, 10 June 2008.
One additional strategy that RMG had attempted to use is to cultivate strong partners which can help it in its overseas expansion. In 2007, when it wanted to buy the 50% share of the hospital building which it did not own, it placed out a small amount of shares to Temasek Holdings (Singapore) and Qatar Investment Authority, the investment arm of the Government of Qatar. Analysts noted that RMG could have easily funded the purchase using internal cash or debt, given its strong cash flow generation and low gearing. The reading was that RMG took the opportunity to cement a relationship with Temasek and the Qatar government, which it can then leverage on for growth opportunities in China and the Middle East (Chua and Poh, 2008b). This is aligned with the concept of using network for market entry in Uppsala 2009 Model, and the LLL framework of Mathews (2006). However, the tangible impact of these strategic partners has yet to be seen.

Like Parkway, RMG also leverages on JCI-accreditation for its Raffles Hospital to attract foreign patients.

6.3.5 Internationalisation Strategy – Market Selection

6.3.5.1 Malaysia, Indonesia and Hong Kong

Given the strong historic ties between Singapore and Malaysia, it is not unexpected that Malaysia was an early choice for RMG in terms of market entry, and with a high commitment entry too, via a 100% acquisition. Unfortunately, they did not manage to pull the acquisition off.

RMG also entered Indonesia early, starting with a representative office, and subsequently upgrading it to a medical centre. Given that the Indonesians are the largest source of foreign patients for Singapore hospitals, this market selection is as expected.

In 2010, RMG also announced that it has submitted a proposal to the Hong Kong authorities which has called for an Expression of Interest on new hospitals to be built on new sites. Like Malaysia, Hong Kong is a familiar target for RMG to enter, firstly because of its similarities to Singapore due to the common heritage as British colony; secondly, the ease of doing business there with transparent rules and systems; thirdly,
RMG’s many years of operating in the market through its general practitioner (GP) chain there.

6.3.5.2 China

Like for Parkway, the China market is just too huge and too attractive to be ignored, especially for Singapore firms which can leverage on the strong ties between the Singapore government and the Chinese government to enter the market. RMG started to talk about its interest to enter China in 2004, and had emphasized it as one of its key targets every year in its annual report since. However, as opposed to Parkway, RMG have been more cautious in its approach to venturing into emerging markets. In an interview in 2008, Dr Loo Choon Yong, the Executive Chairman, commented: “The Chinese health care market is what I call a treacherous one. There are many barriers and even more invisible barriers.” He added, “We’ll start with one and see if we lose our pants. If we do well, if we truly know how to deliver the kind of health care that we think we should deliver associated with our brand, then we’ll do more. If we can’t, then we’ll know that it isn’t the place for us” (Tan, 2008). RMG eventually set up its medical centre in Shanghai, China in 2010.

6.3.5.3 Representative Offices

Like for Parkway, RMG established representative offices in countries which are good potential sources of foreign patients but which might not be suitable for direct entry at this juncture. Nevertheless, it is more selective in its choices of countries, with only five countries entered so far, all of which Parkway had opened its offices earlier.

In a way, Singapore-based firms setting up representative offices after Parkway has the benefit of leveraging on Parkway’s and more generally, the Singapore healthcare branding, to enter these markets, making the barrier of entry significantly lower.
6.3.6 Internationalisation Strategy – Entry Modes

As highlighted in the previous section, RMG’s main entry modes overseas have been via representative offices and medical centres. It has attempted one unsuccessful acquisition, and had over the years indicated its willingness to acquire or invest in Greenfield projects in countries like China and Malaysia.

In Indonesia, it has progressed its representative office into a medical centre when the market shows promise for a more committed entry.

In China, it has made its first entry with a medical centre, instead of the incremental approach of having a representative office first. This could be due to its familiarity with the market after exploring opportunities there for almost six years prior to the opening of the centre. It could also be the confidence it drew from the success of Parkway in running medical centres in China.

RMG’s current medical centre in Shanghai should allow it to better understand the operating landscape of the Chinese healthcare market as well as the regulatory conditions present. This would be useful for its future plans in China, such as the plan to build a hospital with at least 300 beds in a tier-one city120.

6.3.7 Internationalisation Strategy – Timing of Entry

Considering that the Raffles Hospital was only opened in 2001, RMG has made good progress in attracting foreign patients, with a high proportion of foreign patients among its patient base. While RMG has not internationalised to the same extent as Parkway, its internationalisation using clinics/medical centres and representative offices overseas had been rapid.

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120 “Raffles Medical Group: China hospital as potential next phase of growth”, OCBC Investment Research, 3 Jan 2011.
6.3.8 Case Summary

RMG has one 380-bed hospital and 65 clinics in Singapore, 3 clinics in Hong Kong, 1 clinic each in Indonesia and China, and 5 representative offices in 5 countries.

RMG adopts a hub-and-spoke strategy with representative offices and clinics overseas as referral channels. It also puts a lot of attention and resources to expanding its home base to increase its capabilities and attraction. Besides, it leverages on JCI-accreditation to attract medical tourists.

In terms of market selection, RMG’s first attempt at acquiring a hospital overseas was in Malaysia, though that did not succeed. It also tried to enter the China market for some years, and finally set up a clinic there in 2010. It was observed that RMG’s network of representative offices are in countries which Parkway had entered, possibly to ride on the awareness of Singapore healthcare in these markets to lower entry barriers.

Unlike Parkway, RMG had so far only used medical centres and representative offices in its market entry. It has attempted one unsuccessful acquisition, and had over the years indicated its willingness to acquire or invest in Greenfield projects though without much progress thus far.

In terms of timing, RMG has been quick in establishing a network of clinics/medical centres and representative offices to help attract patients to its home base.
6.4  CASE 3 – THOMSON MEDICAL CENTRE (TMC)

6.4.1  Background

Thomson Medical Centre (TMC) is a leading private women and children’s hospital in Singapore. It provides a comprehensive range of facilities and services for primary, secondary and tertiary healthcare, with focus in the areas of Obstetrics and Gynaecology (O&G) and paediatric services.

The 190-bed hospital has been in operation since 1979. It also operates Thomson Fertility Centre, which offers In-Vitro Fertilisation (IVF) programmes to aspiring parents, as well as a chain of seven Thomson Women’s Clinics island-wide. Other subsidiary companies include Thomson Pre-Natal Diagnostic Laboratory, Thomson Aesthetics Centre and Thomson International Health Services. The vast majority of newborns at TMC are Singaporeans. About a quarter of the patients who use the hospital’s facilities are foreign, with the majority of them coming for gynaecological and fertility treatment.

TMC was listed on SESDAQ, the second board of the Singapore Exchange, in 2005. In 2006, TMC divested its stake in West Point Family Hospital, a hospital with a focus on step down care services, to free up resources for the Group to pursue healthcare opportunities locally and in the region in line with its core competencies in Obstetrics & Gynaecology and Paediatrics.

TMC has made significant strides with its regional aspirations in recent years. In Nov 2006, Thomson International signed a 5-year hospital management agreement with Hanh Phuc International Women and Children Hospital Joint Stock Company (Hanh Phuc JSC) – the first purpose-designed women and children’s hospital to be built in Binh Duong Province, Vietnam. It also has an option agreement with Hanh Phuc JSC to acquire a 25% equity interest in Hanh Phuc JSC.

The 260-bed, 35 medical suites Hanh Phuc Hospital has since opened in November 2010. In September 2008, the Group secured a second hospital consultancy project in Vietnam - a proposed private women and children hospital to be sited in Hanoi.
In November 2010, the founder, Dr Cheng Wei Chen, and his family sold their 39% stake to billionaire investor Mr Peter Lim, who subsequently took the company private via a general offer.

It was reported that the Cheng family decided to sell the business because they found it increasingly challenging to juggle its medical practice and the running of the business (Chan, 2010). There was also a growing feeling among the Chens that they had taken TMC as far as they could, and that they did not have the capital and resources to match the bigger companies in this sector. More importantly, the doctors wanted to focus on their true passion – their medical practice and patients. With the high valuation for healthcare firms in Singapore in the immediate aftermath of Parkway’s takeover, they decided that it was a good time to let another owner take TMC further (Chan, 2010; Cheong, 2010).

6.4.2 Internationalisation Activities by Country

6.4.2.1 In Vietnam

The main external market TMC has ventured into is Vietnam. While the revenues and profits at the Vietnam hospital will be a lot lower than in Singapore at first, by establishing itself at this early stage, TMC hopes to be well-placed to benefit as Vietnam’s middle class expands and becomes richer over the next couple of decades.

In an interview in Dec 2008, Mr Allan Yeo, TMC’s then Group CEO, revealed that he was introduced to Mr Nguyen Van Minh, Chairman of Protrade Corporation (a Vietnamese state-owned enterprise) by a contact from his days as CEO of Bangalore IT Park. Mr Minh subsequently visited TMC, and was impressed enough to engage it as a consultant for a new hospital in Vietnam (Pulses, 2008).

Mr Yeo noted that the opportunity was exciting as one hospital in Ho Chi Minh City alone was doing 55,000 deliveries a year, and the whole of Vietnam sees more than 1.6 million births a year. In comparison, Singapore’s deliveries totaled about 36,000 – 37,000 a year (Pulses, 2008).
In Ho Chi Minh City, there was no custom-designed and custom-built private women and children’s hospital, and Mr Minh wanted to set one up, knowing that there is huge demand for it. Protrade Corporation and two other business entities formed a joint venture which engaged TMC to provide project consultancy services. “Mr Minh wanted us to work exclusively with them. We were not quite receptive at first but he assured us that as a show of confidence, he would give us not one but three hospital projects,” recalled Mr Yeo (Pulses, 2008).

This gave birth to the plan for the Hanh Phuc Hospital sited in Binh Duong Province, which is the fastest growing province in Vietnam and only some 30km from Ho Chi Minh City, the largest Vietnam city with more than 7 million population.

The hospital was built not just with locals and expatriates in mind but also regional patients. For example, it has a helicopter landing pad to cater to rich Laotians and Cambodians. The hospital is located next to a river, and will be accessible by water taxis in addition to roads and helicopters.

TMC served as project consultant during the construction phase, and after the hospital began operations, it is providing management services which include operation management, financial management, marketing and business strategies. The work is for an initial 5-year period with an option for a 5-year extension. The benefit of the project is that TMC does not have to bear the investment risk for the project. It has been booking consultancy fees since the start of the project. With the hospital going into operations, it will be booking a retainer plus a percentage of gross profit before tax in the first year. The second and third year will be based on top line and bottom line, because patient load would have stabilised by then (Sim, 2010a).

TMC also have an option to buy up to 25% in the Hanh Phuc hospital within the first three years of its operations at founders’ price. This gives it the incentive to ensure the hospital is a success, besides getting a share of the profits. It expects the new hospital to breakeven within two to three years. (Sim, 2010b)

Besides revenue from the new hospital, the new hospital should also benefit TMC’s flagship hospital in Singapore, through more patient flow given the wider awareness of its brand there.
Besides the hospitals, Yeo said that the company would consider adopting the strategy of having satellite Obstetrics & Gynaecology and paediatrics clinics, which the company is well-known for in Singapore, in Vietnam when the base there is more established. It has commenced operations for a satellite clinic at Saigon Trade Centre on 1 Nov 2010, partly as a source of referral to the Hanh Phuc hospital (Sim, 2010b).

Other than Hanh Phuc Hospital, TMC is also evaluating potential sites for a second hospital in Hanoi and also the opening of a paediatric eye centre and childcare centre in Vietnam.

6.4.2.2 Other Countries

In an interview in October 2010, Mr Allan Yeo, then Group CEO, indicated that the company is considering opportunities in Indonesia, India and Malaysia. In particular, he highlighted India as a good target; he said “India has good potential; people have approached us. We want to ensure the consultancy agreement mirrors our Vietnam deal.” (Sim, 2010b)

With the new owner, TMC looked set to expand in Malaysia. Mr Peter Lim is also the largest stakeholder of TMC Life Sciences, which owns the 180-bed Tropicana Medical Centre, a fertility treatment facility in Petaling Jaya, Malaysia. After his takeover of TMC, he brought in two senior executives with previous experience in running Pantai Hospitals in Malaysia to take over the running of the group. Besides, it was reported that Mr Peter Lim had bought a 14ha piece of land in Johor, 2km from Singapore border, to build a new healthcare facility121.

Dr Chan Boon Kheng, the new Group President, acknowledged that TMC would need to venture outside Singapore for growth, given that the local health-care market is close to being over-saturated (Chan and Chan, 2011). He shared that the group is “looking at Vietnam, China and the Middle East and also not ruling out other South-east Asian countries, but our focus will clearly be Asia.”

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121 “S’pore billionaire plans Johor medical centre”, Asiaone, 17 Apr 2011.
6.4.2.3 Network of Overseas Representatives

To attract foreign patients for its flagship hospital in Singapore, TMC appoints marketing representatives in Indonesia and Vietnam, two of the largest markets besides Malaysia.

6.4.3 Chronology of Internationalisation Activities

Please refer to Table 6.6 for the chronology of internationalisation activities of TMC.

Table 6.6 - Chronology of Internationalisation Activities of TMC

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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</table>
| 1979 | Major events:  
|      | • TMC founded by Dr Cheng Wei Cheng and his wife. |
| 2005 | Major events:  
|      | • Listed on SESDAQ, the second board of the Singapore Exchange (AR2006). |
| 2006 | Major events:  
|      | • Divested its stake in West Point Family Hospital in Singapore (AR2006).  
|      | • Set up Thomson International as the Group’s regional arm for the provision of hospital consultancy and management services (AR2006).  
|      | • Signed a hospital management agreement with Hanh Phuc Joint Stock Company (JSC) to develop the first purpose-designed women & children’s hospital in Vietnam (AR2006).  
|      | Announcements/Comments on Internationalisation Strategy:  
|      | • “Encouraged by the progress of its hospital consultancy work and the securing of the hospital management agreement for Hanh Phuc Hospital in Vietnam, the Group intends to pursue more hospital consultancy and management projects and expand its reach in the region.” (AR2006)  
|      | • “The Group will capitalize on its brand recognition and will market aggressively to our local market and also in the region, in particular, Indonesia.” (AR2006) |
| 2007 | Announcements/Comments on Internationalisation Strategy:  
|      | • “The Group is also exploring opportunities to establish a fertility centre in Vietnam to capitalise on the high demand for fertility treatment. Apart from Vietnam, the Group will continue to explore opportunities in countries such as Malaysia and Indonesia where there is a growing demand for quality healthcare services.” (AR2007) |
| 2008 | Major events:  
|      | • Entered into an option agreement with Hanh Phuc JSC to acquire a 25% equity interest in Hanh Phuc JSC (AR2008).  
|      | • Awarded a second hospital consultancy project for a proposed private women and children’s hospital in Hanoi, Vietnam (AR2008).  

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2009

Major events:
- Appointed new marketing representatives in Indonesia and Vietnam (AR2009).

2010

Major events:
- Opened the 260-bed Hanh Phuc International Women and Children Hospital in Vietnam (AR2010).
- Change of ownership as investor Mr Peter Lim took TMC private\textsuperscript{123}.

6.4.4 Internationalisation Strategy – Overall Strategy

In 2005, TMC articulated its overseas expansion plan as follow (Ong, 2005):

a) **Intensify marketing efforts** - increase its presence in the region, particularly in Indonesia, with aggressive marketing efforts at key catchment areas for foreign patients. Marketing efforts include participation in regional road shows organised by the Singapore Tourism Board.

b) **Provide healthcare consultancy services** - explore opportunities for fee-based projects with management consultancy potential. It believes that healthcare consultancy services offer significant follow-on prospects after the completion of the project. This was the basis for its Vietnam project.

c) **Provide hospital management services** – explore hospital management contracts, including acquiring equity interests in other hospitals in the region.

d) **Seek strategic alliances** - establish strategic alliances with its partners in the region with complementary strengths to assist the Group’s attempt to enter into new regional markets to offer its services.

Unlike for Parkway and RMG, TMC’s focus on women and children health is less tertiary in nature, hence there is less need for a wide hub and spoke network to channel especially the complicated cases to Singapore to build up critical mass. However, there are specialised services which TMC clearly had strengths in, such as its fertility centre and woman oncology centre, which will benefit from foreign patients. Hence, the referral potential is there but less critical.

6.4.4.1 Impact of Overseas Experience of Senior Management

It was interesting that despite TMC’s long history of more than 30 years, it only started its internationalisation activities about 6 years ago. The main person driving the internationalisation was Mr Allan Yeo, who was appointed the Group CEO in 2002. Unlike previous CEOs of TMC, Yeo had a lot of experience working overseas, including stints in New Zealand, India and Malaysia. Prior to joining TMC, he was with HMI, where he was the Group CEO since joining in 1996. He helped to lead HMI to its listing, was involved in the turnaround of Mahkota Medical Centre in Malaysia, as well as the various consultancy projects undertaken by HMI. With his joining of TMC, he led TMC to its listing on SESDAQ in 2005, and started to make TMC more outward oriented. The project in Vietnam was in fact started from a connection made by a contact of his from his time as CEO of Bangalore IT Park.

The impact of Yeo points to two observations. Firstly, the experience of the Senior Management is important in the internationalisation of the firm. This is highlighted in many of the literature on foreign entry by services firms (eg, Ekeledo and Sivakumar 2004; Lommelen and MatthysSENS 2005). Secondly, it shows the importance of networks in internationalisation (Johanson and Vahlne, 2009). Yeo is a strong believer of the importance of having a strong partnership before commencing a market entry. For example, in an interview in 2009, when asked whether TMC has any plans to expand to other countries, he said “Partnership is crucial; China is a big market but we are not familiar with it. I don’t want to jump in just because the project looks good. Vietnam is a good start for us.”

6.4.4.2 New direction Post-Acquisition

With the change in ownership at TMC, it is still not clear the direction which the new owner is taking. However, the company has since appointed a new Group President and President (International), while re-designating Mr Allan Yeo as President (Singapore and Vietnam). Both new appointees were healthcare veterans who have run Pantai Group in Malaysia previously, and this could signal the intention of the new owner to increase TMC’s internationalisation efforts, particularly in Malaysia.

124 “THOMSON MEDICAL: Delivering Good Results!”", Lee Shu-En, NextInsight, 10 Oct 2009.
In an interview in 2011, Dr Chan Boon Kheng, the Group President, said that acquiring Thomson Medical was part of a broad strategy to consolidate Mr Peter Lim’s healthcare assets (Chan and Chan, 2011). Mr Lim already had a large stake in TMC Life Sciences in Malaysia. Together with TMC in Singapore, and TMC’s maternity hospital projects in Vietnam, he would have maternity facilities in three ASEAN countries, and become the market leader in this niche category. Whether TMC keeps its focus on this niche or expand into other specialties remains to be seen.

6.4.5 Internationalisation Strategy – Market Selection

The main country of entry for TMC is Vietnam. Starting with a hospital project, TMC is planning to move into setting up a network of satellite clinics, and then possibly diversifying into other areas, like setting up a paediatric eye centre.

It is also considering opportunities in Indonesia, India and Malaysia. In particular, as discussed in the earlier sections, TMC appeared likely to step up its presence in Malaysia and possibly consolidate its new owner, Mr Peter Lim’s interest in Malaysia as well.

TMC also has marketing representatives appointed in Indonesia and Vietnam, two of its largest markets besides Malaysia.

6.4.6 Internationalisation Strategy – Entry Modes

TMC’s main mode of entry is management contract. As articulated in its overseas expansion plan in 2005, healthcare consultancy and hospital management are two of the modes which it planned to use for overseas expansion, and the purpose of consultancy was with the hope of securing the management contract subsequently. Its main project was the Hanh Phuc Hospital project in Vietnam which it secured in 2005, and had progressed from consultancy to management. It subsequently secured a second consultancy project for a similar hospital in Hanoi, Vietnam.

Like in the case of Parkway, the use of consultancy and management contract for entry is a low risk approach for entry while leveraging on the local expertise of the partner in
the host country. This is in line with the behaviour of “Dragon MNEs” (Mathews 2002, 2006). The fact that TMC bypassed Singapore’s immediate neighbour and made its first overseas foray in more culturally distant Vietnam made it a good case to illustrate the weakness of Uppsala 1977 Model and the strength of Uppsala 2009 Model in explaining the behaviour of second wave MNEs like TMCs.

6.4.7 Internationalisation Strategy – Timing of Entry

As explained earlier, TMC has not been as active in internationalisation compared to Parkway and RMG. Besides the reason highlighted earlier about the less tertiary nature of TMC’s business, TMC has also been operating at near capacity in recent years, hence it has less urgency in expanding overseas to fill excess capacity in its Singapore hospital, unlike Parkway and RMG. Yet another reason could be the attitude of the former owner towards internationalisation. As reported in the media, the Cheng family sold out possibly due to their preference to focus on their true passion, which is their medical practice and patients (Chan, 2010). Therefore, it is understandable that internationalisation might never have been a top priority in their overall strategy for the business but that they viewed it more as a bonus.

With the new owner putting senior management with international experience in charge of the business, as well as the vast financial asset the owner had at his disposal, it is expected that TMC will adopt a stronger external focus moving forward.

6.4.8 Case Summary

TMC has a 190-bed hospital in Singapore and manages a 260-bed hospital in Vietnam, both specialising in women and children care.

TMC’s overseas expansion plan comprises intensification of marketing efforts, provision of healthcare consultancy services, provision of hospital management services and establishing strategic alliances. Despite its long history, TMC only started its internationalisation after 2002, when a new Group CEO with internationalisation experience at another healthcare firm took over.
TMC’s main country of entry is Vietnam, where it is managing a hospital and provides consultancy for another. In terms of timing of entry, TMC is not as active in internationalisation as the other private healthcare firms from Singapore. One possible reason highlighted was the attitude of its owner towards internationalisation, though this is expected to change under its new owner, who acquired the firm at the end of 2010.
6.5 CASE 4 – HEALTH MANAGEMENT INTERNATIONAL (HMI)

6.5.1 Background

Health Management International Ltd (“HMI”) is a regional healthcare and education services provider with presence in Singapore, Malaysia, Indonesia and China. The Group has two core businesses, Healthcare and Education. Its healthcare division comprises two hospitals in Malaysia, the 288-bed Mahkota Medical Centre in Malacca and the 218-bed Regency Specialist Hospital in Johor, and a network of 20 patient referral centres in Indonesia, Malaysia, Cambodia and Singapore. The education function is undertaken by HMI Institute of Health Sciences (HMI-IHS) in Singapore, which provides healthcare education and training for nurses and other allied health professionals. HMI-IHS has collaborations with a few universities and hospitals in China on nursing training.

Unlike the other Singapore-based hospital groups, HMI is the only Singapore-based hospital group without hospital operations in Singapore.

It began with a hospital in Singapore called Balestier Medical Centre in 1991, which was a 62-bed secondary care hospital providing a range of medical, surgical, therapeutic, diagnostic and preventive healthcare services. Its name was changed to HMI Balestier Hospital (BH) in 1995, and the group was listed on SESDAQ in 1999.

However, the Singapore economic slowdown since 1997 and a decline in arrivals of Indonesian patients took their toll on BH. In 2001, HMI tried to re-position BH as a niche healthcare player by emphasising wellness, health screening programs, diagnostic services and sports medicine. BH’s services were reduced to ambulatory and day surgery services, health screening and diagnostic services in 2002, and the hospital was eventually closed in 2003, following a corporate restructuring and strategic repositioning exercise.

Since 2003, the company has been focusing on its two core business activities, namely, healthcare and education. On the healthcare service front, HMI has focused on strengthening and expanding its Malaysian operations, which delivers more than 95% of the group’s revenue. Dr Chin Koy Nam, one of the founders, and his wife Dr Gan See
Khem, the Group’s Executive Chairman, remained the largest shareholders of the group, with a total stake of about 40%.

6.5.2 Internationalisation Activities by Country

6.5.2.1 In Malaysia

Between 1995 and 2001, HMI secured 4 hospital consultancy and management projects in Malaysia. It secured its first project in 1995 to develop a private hospital in the Larkin district of Johor Bahru, Malaysia. It has a 30% stake in the project.

In November 1998, HMI purchased a 20% equity stake in Excellent Strategy Sdn Bhd (ESSB). Excellent Strategy is the owner of 235-bed Mahkota Medical Centre (MMC), located in Malacca, Malaysia. HMI was given a 5-year management contract to manage MMC, the first hospital to be managed by HMI outside Singapore.

In 1998, HMI was also appointed by another subsidiary of Amsteel Corporation (which owned ESSB) to develop a business plan to start up a medical centre in Ipoh, Malaysia, which physical construction was near completion then.

In 2001, HMI was awarded a contract to provide consultancy and management services to develop a new Hospital Bukhary in Kedah, Malaysia. When completed, HMI would be responsible for the management of the Medical Centre.

Among the 4 projects, the Larkin project was put on hold during the economic crisis in 1998 and the Ipoh medical centre project was aborted when Amsteel got into financial difficulties. The consultancy for the Hospital Bukhary project was completed but HMI did not continue with the management of the hospital.

For MMC, HMI helped turned around the hospital by restructuring the facility, developing areas of specialty in acute care for cancer and cardiovascular diseases, and bringing in a new top management team. It also embarked on a marketing campaign to attract well-heeled patients from Indonesia and Brunei. By 2000, the number of patients

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125 Dr Gan is not a medical doctor, but holds a PhD in Business Administration. She specialized in strategic planning and management during her 15-year tenure with the National University of Singapore.
from Indonesia jumped to more than 1,000 per month, up from 200-300 in 1997. MMC had since become the Group’s flagship. It is a major medical tourism player in Malaysia, with 80 per cent share of the foreign-patient market in Malacca and treats more than 50,000 Indonesians each year (Ganesan 2008).

HMI’s second hospital in Malaysia took a longer time to materialize. HMI entered into an agreement to acquire a 65% equity interest in Premier Health Corporation (M) Sdn Bhd (PHCM), which owns a completed but yet-to-be-equipped medical centre in Seri Alam, Johor which has approval from the authorities to be developed as a 218-bed medical centre. The medical centre, which was to be called Regency Specialist Hospital, was supposed to commence operations in 2003. However, for various reasons, the acquisition was only finally completed in 2007, and the hospital finally commenced operations in November 2008.

In an interview in 2008, Mr Francis Lim, then CEO of MMC, mentioned that HMI was looking for other sites to set up hospitals in Malaysia, especially in Sabah and Sarawak, where there is no heavy concentration of private hospitals. The group was prepared to consider accepting management contracts without an equity stake. Mr Lim added that MMC and Regency Specialist Hospital were preparing for the Joint Commission International (JCI) accreditation in two years, and with the accreditations, the group hoped to penetrate new markets, including Bangladesh and Europe (Ganesan, 2008). As at end 2010, the two hospitals have yet to attain JCI accreditation.

6.5.2.2 In Indonesia

In Indonesia, HMI’s subsidiary MMC signed a 2-year contract in 2003 to provide hospital management consultancy services to the 150-bed Grand Hospital Bengkalis in Riau. The project was completed in 2005.

6.5.2.3 In China

In 1996, it signed an agreement with Beijing to build and run China’s first private medical centre. Although all the necessary approvals for the hospital was obtained, the project was delayed “due to the bureaucracy in China and the cautious attitude which
was adopted by the consortium towards developments in China, as well as an extensive redesign of the project due to the economic crisis in 1997/8.\textsuperscript{126}

In 1998, HMI wrote off the initial investment of S$1.5 million on the project. HMI’s Executive Chairman, Dr Gan explained in 2001 that: “When we studied the project more closely, we weren’t convinced that the Chinese legal system and working environment was really ready for our consortium to put in $30 million.” She added: “It was our tuition fee. China is a very tough market.” (Saywell, 2001)

However, with China’s gradual liberalisation of regulations on private health care, HMI had continued to explore opportunities in the market, including a joint venture with a public hospital to set up a specialist outpatient clinic in Guangzhou and a tie-up with a private clinic in Beijing, though without much success. In 2007, the Group indicated that it will initiate developments in China, with respect to the area of healthcare and consultancy services (AR2007).

\textbf{6.5.2.4 Singapore – Medical Tourism}

Since 1 March 2010, the Singapore Ministry of Health allowed Singapore residents to use their Medisave overseas for approved hospitalisation and day surgeries at MMC and Regency Specialist Hospital. Since the liberalisation of Medisave usage, MMC and Regency have received growing number of Singapore patients who have come to HMI hospitals in Malaysia for a wide range of medical treatments. In response to customer demand, Regency has organized busloads of Singaporeans for its popular “Regency Health Screening & Leisure Day Trip” packages.

\textbf{6.5.2.5 Network of Representative Offices}

HMI has been focused on local and regional marketing activities to attract more patients to their 2 hospitals in Malaysia. To date, the Group has set up a strong regional network of 20 representative offices in Indonesia, Cambodia, Malaysia and Singapore, to provide up-to-date healthcare service information and logistic assistance to patients from these countries. The following is the sequence:


\textsuperscript{126} Prospectus for SESDAQ listing on 15 Oct 1999.
- 2004 – 4 representative offices in Indonesia (AR2006).
- 2009 – 3 new representative offices in Indonesia and the first representative offices in Malaysia and Cambodia were set up (14 in total) (AR2009).
- 2010 – 4 new representative offices in Indonesia, a second representative office in Malaysia and the first Medisave-accredited HMI Referral Centre in Singapore were launched, bringing the total number of representative offices to 20 (AR2010).

6.5.3 Chronology of Internationalisation Activities

Please refer to Table 6.7 for the chronology of internationalisation activities of HMI.

Table 6.7 - Chronology of Internationalisation Activities of HMI

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
</table>
| 1991 | Major events:  
| | • Balestier Medical Centre (name changed to HMI Balestier Hospital in 1995) began operation in Singapore\textsuperscript{127}. |
| 1995 | Major events:  
| | • Secured its first hospital project management and technical services consultancy contract in 1995 for the development of a private hospital project in the Larkin district of Johor Bahru, Malaysia\textsuperscript{128}. |
| 1996 | Major events:  
| | • Signed an agreement with Beijing Medical (a consortium) to build and run China’s first private medical centre\textsuperscript{129}. |
| 1998 | Major events:  
| | • Purchased a 20% equity stake in the holding company of Mahkota Medical Centre (MMC) in Malacca, Malaysia. HMI was also given a 5-year management contract to manage MMC, the first hospital to be managed by HMI outside Singapore\textsuperscript{130}.  
| | • Appointed to develop a business plan to start up a medical centre in Ipoh, Malaysia\textsuperscript{131}.  
| | • Beijing project in China aborted and initial investment was written down\textsuperscript{132}. |
| 1999 | Major events:  
| | • Listed on SESDAQ in Singapore\textsuperscript{133}. |

\textsuperscript{127} Website of Balestier Clinic and Health Screening Centre, at http://www.balestiermedical.com/balestier/.
\textsuperscript{128} Prospectus for SESDAQ listing on 15 Oct 1999.
\textsuperscript{129} Prospectus for SESDAQ listing on 15 Oct 1999.
\textsuperscript{130} Prospectus for SESDAQ listing on 15 Oct 1999.
\textsuperscript{131} Prospectus for SESDAQ listing on 15 Oct 1999.
\textsuperscript{132} Prospectus for SESDAQ listing on 15 Oct 1999.
<table>
<thead>
<tr>
<th>Year</th>
<th>Major events</th>
</tr>
</thead>
</table>
| 2001 | **Tried to re-position Balestier Hospital in Singapore as a niche healthcare player by emphasising wellness, health screening programs, diagnostic services and sports medicine (AR2001).**  
- Awarded a contract to provide a comprehensive range of consulting, project and hospital management services to Hospital Bukhary, Kedah, Malaysia (AR2001).  
- Raised stake in MMC to 40% (AR2001).  
- **Announcements/Comments on Internationalisation Strategy:**  
  - “Subject to the completion of the sale and purchase agreement, RSH is expected to commence operations in the second half of year 2003.” (AR2002) |
| 2002 | **Entered into a sale and purchase agreement for the acquisition of a 65% share of Premier Health Corporation, which owns Regency Specialist Hospital (RSH) in Johor, Malaysia. Building work for the 218-bed hospital has been completed (AR2002).**  
- Wrote down the initial investment for the project to develop and operate the proposed Hospital Pakar Larkin in Malaysia (AR2002).  
- Completed restructuring exercise for the group, with decision to focus on two core activities - healthcare and education (AR2002).  
- **Announcements/Comments on Internationalisation Strategy:**  
  - “The Group will continue to grow its hospital management consultancy business.” (AR2003) |
| 2003 | **Discontinued hospital operation in Singapore (AR2003).**  
- Secured a 2-year contract to provide hospital management consultancy services to the 150-bed Grand Hospital Bengkalis in Riau, Indonesia (AR2003).  
- **Announcements/Comments on Internationalisation Strategy:**  
  - “The Group will continue to grow its hospital management consultancy business.” (AR2003) |
| 2004 | **Announcements/Comments on Internationalisation Strategy:**  
  - “We expect MMC to continue contributing to the Group’s revenues and secure more hospital management and consultancy contracts in the region.” (AR2004) |
| 2005 | **Announcements/Comments on Internationalisation Strategy:**  
  - “The group is also working towards securing additional hospital management consultancy contracts in the region.” (AR2005) |
| 2007 | **Completed acquisition of additional 8.95% equity stake in Mahkota Medical Centre Sdn Bhd in Malaysia, bringing HMI’s total stake to 48.95% (AR2007).**  
- Completed the acquisition of Regency Specialist Hospital in Malaysia (AR2007).  
- **Announcements/Comments on Internationalisation Strategy:**  
  - “With the Group’s focus on expanding its healthcare and consultancy services in Asia, the Group will also initiate developments in the China.” (AR2007) |

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<table>
<thead>
<tr>
<th>Year</th>
<th>Major events:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>- Regency Specialist Hospital in Malaysia commenced operation (AR2009).</td>
</tr>
<tr>
<td></td>
<td>Announcements/Comments on Internationalisation Strategy:</td>
</tr>
<tr>
<td></td>
<td>- Preparing to get JCI accreditation for both the Malacca and Johor hospitals within 2 years; with the accreditations, the group hopes to penetrate new markets, including Bangladesh and Europe. (Ganesan, 2008)</td>
</tr>
<tr>
<td>2010</td>
<td>- Singapore Ministry of Health allowed Singapore residents to use their Medisave overseas for approved hospitalisation and day surgeries at Mahkota Medical Centre and Regency Specialist Hospital in Malaysia (AR2010).</td>
</tr>
<tr>
<td></td>
<td>- Mahkota Medical Centre in Malaysia increased its capacity by 23% to 288 beds (AR2010).</td>
</tr>
<tr>
<td></td>
<td>Announcements/Comments on Internationalisation Strategy:</td>
</tr>
<tr>
<td></td>
<td>- “Furthermore, with increasing healthcare costs in Singapore and political instability in Thailand, the Group’s hospitals are well-positioned to benefit from the fast growing medical tourism industry in Malaysia.” (AR2010)</td>
</tr>
</tbody>
</table>

### 6.5.4 Internationalisation Strategy – Overall Strategy

HMI’s overseas strategy in the 1990s was to build upon its foundations in hospital management services and provide its expertise to hospitals in the region. In particular, its management and consultancy business aimed to provide hospital management and consultancy primarily in the healthcare industry, project management for hospital development and hospital management services. Its strategies were to:

- Target fee-based projects with “follow-on” potential
- Secure hospital management contracts which give the opportunity to secure strategic stakes in hospital projects
- Leverage on experience and expertise of its Directors and shareholders
- Focus on niche markets
- Develop strategic alliances with credible partners

Between 1999 and 2001, HMI actively looked for opportunities to manage hospitals in Malaysia, Thailand, the Philippines, Indonesia and India. HMI wanted to focus on management and consultancy work as this gives good profit margins. In an interview in 2001, Dr Gan shared that such management contract overseas gave margins as high as 60%, while its hospital in Singapore had margin of below 10%. Dr Gan also noted that

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Singapore healthcare companies are attractive as hospital managers as many of the region’s hospital owners are conglomerates whose core competencies are not in health care. Citing the example of MMC, she noted that the owner was in “chemicals, properties, and they didn't have the domain knowledge to manage a tertiary hospital”. (Saywell, 2001)

Unfortunately for HMI, the basis for its strategy turned out to be its problem as well. Many of these conglomerates over-diversified themselves during the 1990s, financed by borrowings, and hence, were caught in financial difficulties when the Asian Financial Crisis struck in 1997/8. Many of the projects that HMI had planned, especially in Malaysia, were aborted as a result. The only one which survived was the MMC, which was eventually sold off by its owner, with HMI taking the opportunity to double its stake and became the largest shareholder. The hospital had since become HMI’s flagship, after it took the decision to close its hospital operation in Singapore.

Explaining the change of HMI’s flagship to MMC, Dr Gan commented in 2001 that “the lower cost of manpower, construction and land in Malaysia allowed Singapore’s health-care providers to offer less expensive services than they do in Singapore, but of equal quality. And that means they can attract more patients. What’s more, the patients can receive treatment in their own countries.” She added “Traditionally you have seen a lot of Indonesians, Malaysians, Bangladeshis and even Thai patients coming to Singapore for health-care services. Now Singapore is seen to be too expensive and demand is growing in their home countries. Rather than waiting for patients to come to Singapore, we should go out to these countries.” (Saywell, 2001)

In a way, HMI’s strategy of moving its hospital services out to a lower cost location is in line with the offshoring discussed in Bartels et al (2009), except that it has taken the unusual step of offshoring the entire hospital instead of just parts of the hospital functions or services.

Nevertheless, its success in turning around MMC and in positioning it as a reputable tertiary hospital within the region had given it a strong base to attract foreign patients, which it is doing through a hub and spoke strategy, using representative offices as spokes. Besides this, HMI had continued to indicate its interest to provide hospital management and project consultancy service in the region.
6.5.5 Internationalisation Strategy – Market Selection

6.5.5.1 Malaysia

HMI’s choice of Malaysia as its preferred market of foreign expansion follows the classical incremental internationalisation, since Malaysia is the immediate neighbour of Singapore, and they share a common heritage. The target customers there are also familiar to HMI as it was already serving a substantial number of Malaysians and Indonesians back at its Balestier Hospital in Singapore. Besides, as articulated by Dr Gan, the cost of operation in Singapore was too high, and hence, HMI was looking for a lower cost location to continue serving its target customers profitably, and Malaysia fitted the bill.

6.5.5.2 Countries with Representative Offices

HMI is highly focused in attracting Indonesian patients to its hospitals in Malaysia. MMC is particularly attractive to Indonesians given the cultural similarities between Indonesia and Malaysia and the close proximity (especially from Sumatra of Indonesia). MMC’s lower charges compared to hospitals in Singapore also make it an attractive choice for price-conscious Indonesians. Of its 20 representative offices, 16 are in Indonesia, even more than Parkway (14).

The setting up of a representative office in Cambodia follows the pattern of Parkway and RMG, both of which see Cambodia as a good source of foreign patients.

The interesting aspect of HMI’s internationalisation is its use of its “offshored” Malaysian hospitals to attract patients from its home base, Singapore. This is an interesting concept, which may get increasingly attractive as the gap between private healthcare cost in Singapore and Malaysia widens, the gap in standard and quality of care narrows, and transport link between the two countries improves.
6.5.3 China

Similar to Parkway and Raffles, China is too attractive a market to be ignored for HMI. Unfortunately, HMI did not succeed in its first attempt to enter China in 1996. Notwithstanding that experience, HMI remained interested in the market and had continued to explore opportunities there. On the education side, it has over the years established tie-ups with a few hospitals and universities in China on nursing training and placement. While these have no direct impact on its hospital business, it allows HMI to stay engaged in the market while exploring opportunities and identifying suitable partners.

6.5.6 Internationalisation Strategy – Entry Modes

Since 1990s, HMI had articulated its preference to use management contracts for its overseas expansion, with consultancy used as a means to the end of securing the management contract for new hospital. As have been articulated in the cases for Parkway and TMC, such an entry mode is a good way to leverage on its most valuable resource; that is, its expertise in setting up and running hospitals. It is a low risk low cost way of entering into new markets, which fit the strategy expected of “Dragon MNEs” (Mathews 2002, 2006).

Unfortunately for HMI, a number of the consultancy projects it went into were aborted due to the partner firms getting into financial difficulties during the 1997/8 crisis. For the other projects which it did carry out (ie, Hospital Bukhary in Malaysia and Grand Hospital Bengkalis in Indonesia), these did not eventually translate into management contracts.

The case of MMC was interesting, as HMI started off with a management contract with a small 20% stake, but as it gained familiarity with the hospital and the operating environment in Malaysia, it acquired the hospital by buying a larger stake and becoming its largest shareholder. This is in line with the classical incremental involvement under the Uppsala 1977 Model.

HMI also used JV in the case of Regency Specialist Hospital. Its JV partners are a group of doctors, which was useful as they formed the base of doctors which the hospital can
depend on to start with at the new hospital. Its willingness to take a large 65% versus its
previous preference of taking only a small stake in the hospitals showed its comfort with
the operating environment in Malaysia and confidence in the business prospect,
following its success at MMC.

In addition, HMI used an extensive network of representative offices to form the spokes
for its hub in MMC, particularly in Indonesia.

6.5.7 Internationalisation Strategy – Timing of Entry

HMI’s internationalisation can be considered as quick. Within a few years of its
formation, it was already signing deals to manage hospitals overseas as well as
undertaking a consultancy project in China. However, both their projects in Johor,
Malaysia and Beijing, China did not materialize and HMI had to write-off a substantial
initial investment for both projects.

Beyond these two projects, HMI had attempted to go on an accelerated
internationalisation by taking on many projects, but unfortunately, many of these did not
work out well or had no follow-on potential after the projects were completed. HMI’s
second hospital also took much longer to come through than originally
planned. These
meant that despite their ambitions, HMI had not been able to internationalise as much
and as quickly as it would have wished.

6.5.8 Lessons from Failed Entries

Like Parkway, HMI had been very aggressive in its internationalisation, and hence, it is
only natural that there were some market entry attempts which were less successful. In
the case of HMI, the main issue was the choice of partners. Given HMI’s constraints in
terms of resources, it is natural for it to enter markets in partnership with other
companies. In particular, it will find local partners who have the advantage of local
knowledge and resources which it can leverage on (Mathews 2002, 2006).

The following are three partners which HMI had partnered with in its attempts to
develop hospitals in Malaysia and China, and a summary of the outcomes:
Amsteel (part of the Lions Group in Malaysia, with diversified interests in manufacturing, services and property development)

- Projects: Management contract for MMC in Malacca and Consultancy project for the proposed Mahkota Medical Centre in Ipoh
- Amsteel’s parent Lion Group got into financial difficulties during the 1998 financial crisis. Its problems stemmed from a buying binge that began in the mid-1980s. The expansion, financed largely by borrowings, turned the group into a regional conglomerate with businesses ranging from steel and chocolates to beer and shopping malls. When the financial crisis struck, Lion Group was caught by the twin troubles of rising interest rates and slowing sales.
- Lion Group underwent a restructuring in 2000
- Lion Group disposed its stakes in MMC, partly to HMI
- Lion Group aborted the Ipoh project

Ocean Capital Berhad

- Project: Proposed HMI Hospital Pakar Larkin in Johor Bahru, Malaysia
- Ocean Capital Berhad was a listed investment holding and trading company, with focus on the retail industry
- The project was initiated in 1995; construction was to start in 2000, with completion in 2003
- Project put on hold in 1998 during the financial crisis as Ocean Capital was badly affected by the crisis
- Investment finally wrote down in 2002
- Project dormant since

Beijing Medical (the consortium)

- Project: Proposed Beijing Weikang International Hospital
- Explored the project as part of a consortium
- Project commenced in 1996
- In 1998, the consortium decided to withdraw from the project after evaluating the risks involved
- HMI billed consultancy worth S$1.5m, which had to be written off in 1998 as it was deemed unrecoverable
Similar to the lesson from the Parkway case, HMI’s experience emphasizes the importance of having the right partner for collaboration projects.

6.5.9 Case Summary

HMI is the only Singapore-based healthcare firm without hospital operations in Singapore. With its hospital in Singapore suffering from sharp drop in foreign patients following the financial crisis in 1997/8, it decided to close the hospital in 2003 and moved its flagship to a hospital in Malaysia. It now has two hospitals in Malaysia, and a network of 20 representative offices, mostly in Indonesia.

Right from the start, HMI had stated the provision of hospital management and project consultancy service as its main strategy of growth, though this strategy was badly affected by the 1997/8 financial crisis, when a few of the projects were aborted. Since moving its flagship to MMC in Malaysia, HMI has successfully turned around the hospital, which it uses as a base to attract foreign patients via a hub and spoke strategy, with representative offices as spokes.

In terms of market selection, Malaysia is HMI’s main base for its hospital operation. While it has representative offices in Cambodia and Singapore, the fact that it has 16 of its 20 representative offices in Indonesia showed its sharp focus on that market.

HMI has deployed a number of entry modes over the years, including hospital management contract, management consultancy for new hospitals, acquisition, joint venture, and representative offices.

HMI’s internationalisation can be considered quick. It started exploring overseas market shortly after its hospital in Singapore was set up, and secured its first consultancy project within four years of founding. It went on to sign a number of consultancy and management projects in the 1990s, though a few were aborted due to troubles at its partners. Since its acquisition of MMC, it has been quick in rolling out the representative offices to boost foreign patients to its hub hospital.
A study of the various cases of failed entry by HMI highlights the importance of having the right partner, especially given HMI’s preference for market entries via collaborative modes.

## 6.6 CHAPTER CONCLUSION

This chapter presented the detailed analyses of the four case firms. Besides detailing the internationalisation activities of each of the firms, their internationalisation strategies, in relation to the overall strategy, market selection, entry mode and timing of entry, were discussed.

As can be seen from the case studies, while the firms were started at different times, have different ownership structures, and have their own business directions, there are some similarities in the way they have internationalised over the years. These will be discussed further in the cross-case analysis in the next chapter.
CHAPTER 7 – CROSS-CASE ANALYSIS

7.1 INTRODUCTION

This chapter will perform a cross-case analysis of the internationalisation strategies of the four case firms as discussed in the previous chapter, using the data analysis methods articulated in chapter 5 and taking into account the conceptual framework presented in chapter 4.

Based on the cross-case analysis, the chapter will summarise the patterns that have emerged from among the internationalisation strategies of the case firms, in terms of their overall strategy, market selection, entry modes, and timing of entry. This will be followed by an examination of the propositions articulated in Chapter 4.

7.2 EMPIRICAL CROSS-CASE ANALYSIS

This section shall analyse the internationalisation strategy across the four case firms, looking at the areas of overall strategy, market selection, entry mode and timing of entry. The summary analysis is consolidated in Table 7.1 below.

Table 7.1 - Summary of Cross-case Analysis

<table>
<thead>
<tr>
<th>Overall Strategy</th>
<th>Parkway</th>
<th>RMG</th>
<th>TMC</th>
<th>HMI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Hub and spoke strategy</td>
<td>• Hub and spoke strategy</td>
<td>• Hub and spoke strategy</td>
<td>• Hub and spoke strategy</td>
</tr>
<tr>
<td></td>
<td>• Asset-light model, including use of management contract as preferred mode of entry</td>
<td>• Strengthening of home base</td>
<td>• Provision of consultancy or hospital management contract as a key entry strategy</td>
<td>• Provision of consultancy or hospital management contract as a key entry strategy</td>
</tr>
<tr>
<td></td>
<td>• JCI accreditation</td>
<td>• JCI accreditation</td>
<td>• JCI accreditation</td>
<td>• JCI accreditation</td>
</tr>
</tbody>
</table>

Similarities:
• Hub and spoke strategy (all)
• Provision of consultancy or hospital management contract as a key entry strategy (Parkway, TMC, HMI)
• JCI accreditation (Parkway, RMG, HMI)
### Market selection

<table>
<thead>
<tr>
<th>Malaysia</th>
<th>Indonesia</th>
<th>India</th>
<th>China</th>
<th>Brunei</th>
<th>Vietnam</th>
<th>UAE</th>
<th>UK</th>
<th>10 other countries via representative offices, including Bangladesh, Cambodia and Russia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia</td>
<td>China</td>
<td>Bangladesh, Vietnam, Cambodia and Russia via representative offices</td>
<td>Malaysia (attempted acquisition)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vietnam via marketing representatives</td>
<td>Malaysia – extensive network of representative offices</td>
<td>Cambodia via representative office</td>
<td>China (attempted entry)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Similarities:

- Targeting Malaysia and China to set up operations (Parkway, RMG, HMI)
- Entering Indonesia with low commitment modes (all)
- Regional focus (all)

### Key differences:

- Parkway’s short venture outside the region in UK
- Parkway’s high commitment presence in more distant markets
- TMC’s choice of Vietnam for its first major foreign operation

### Entry Mode

<table>
<thead>
<tr>
<th>Acquisitions</th>
<th>Joint Ventures (JVs)</th>
<th>Management consultancy and contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics/medical centres</td>
<td>Representative offices</td>
<td></td>
</tr>
</tbody>
</table>

- Acquisition (attempted but unsuccessful) Clinics/medical centres Representative offices
- Management consultancy and contract Appointing marketing representative
- Acquisition JV Management consultancy and contract Representative offices

### Similarities:

- Stated preference to use management consultancy and contract for entry (Parkway, TMC, HMI)
- Use of collaborative modes like JV, management contract, etc (Parkway, HMI, TMC)
- Extensive use of representative offices/clinics/medical centres for entry (Parkway, HMI, RMG)

### Timing of entry

- Started its first overseas venture quickly
- Internationalised quickly
- Started its first overseas venture quickly
- Internationalised quickly, though no hospital overseas yet
- Slow in venturing overseas
- Cautious internationalisation
- Started its first overseas venture quickly
- Internationalised quickly, including a number of aborted attempts

### Similarities:

- Started venturing overseas quickly (Parkway, RMG, HMI)
- Internationalised quickly (Parkway, RMG, HMI)

### Key differences:

- TMC’s relatively slower internationalisation

### 7.2.1 Overall Strategy

Although only Parkway stated clearly its “hub and spoke” strategy, each of the healthcare firms is adopting a hub-and-spoke strategy, to varying degrees, leveraging on their network of clinics/medical centres/hospitals/representative offices to bring in
patients from overseas. Among the firms, Parkway has the most extensive network, with 13 hospitals, 9 clinics/medical centres and 37 representative offices across 17 countries outside Singapore. RMG has the second largest network covering 7 countries (including Hong Kong). HMI is third with 18 representative offices in 3 countries outside its hub in Malaysia, while TMC has a hospital under its management in Vietnam.

Parkway has also articulated its strategy to expand overseas using an asset-light model; that is, through management contract, with embedded option where possible. While not put in the same way, it is also an approach which both TMC and HMI adopt. As discussed in the cases, this strategy is preferred by the Singapore-based MNEs because it allows them to enter new market without having to put in capital investment upfront, while giving them the option to share the gain of the ventures in future, if they turned out successful. This consideration is particularly valid in healthcare as hospital facilities are very expensive to build. In the mean time, they can earn management fees from the project without bearing much of the risk of the project. The partner is usually a prominent local company, sometimes government-linked, which it can leverage on as per the LLL framework proposed by Mathews (2006).

One reason why private healthcare operators in Singapore are in demand as partners for such collaborative entry mode is because as a result of the demanding competitive environment in the country, the existing operators have amassed valuable knowledge, experience and capability in delivering high-quality healthcare services efficiently. Over the years, Singapore healthcare providers have also built up a “premium” reputation, underpinned by their ability to deliver consistently high quality healthcare, high success rates, strong focus on complex specialisations and Singapore’s superior transportation cum medical infrastructure.

Both Parkway and RMG also leveraged on the Joint Commission International (JCI) accreditation to attract foreign patients. HMI has also stated that it intends to seek JCI accreditation for its two hospitals in Malaysia, and thereafter, to penetrate new markets, including Bangladesh and Europe.

It is also useful to note that when the hospital groups set up a spoke, it is sometimes not just for serving of local patients and referral of patients to the hub, but also to create a new regional “sub-hub”, which may establish its own sub-regional hub-and-spoke
network, as well as tap on the group’s wider network, to get its supply of foreign patients. For the firm as a whole, this offers the patients choice. For example, a patient from Cambodia can choose to fly to the firm’s hospital in Malaysia or Singapore, depending on his price-sensitivity and the specific medical condition.

Examples of sub-hubs include Parkway’s Gleneagle-Apollo Hospital in Kolkata, which stated intention was to be the healthcare hub of the Eastern Indian region, covering the North Eastern states of India, Bangladesh, Nepal, Bhutan and Myanmar (Parkway’s Annual Report 2003); Parkway’s Pantai Group, which Parkway stated its intention to triple the group’s foreign patients level to 15% within three years, immediately after its acquisition of the group in 2005; and TMC’s Hanh Phuc Hospital in Vietnam, which was targeted not just at locals but also patients from neighbouring Cambodia and Laos.

7.2.2 Market Selection

Parkway, RMG and HMI all target Malaysia and China to set up healthcare operations, though not all attempts were successful. The preference for these two markets was discussed in the cases. The choice of Malaysia was expected, given its proximity and familiarity to firms from Singapore. The choice of China, despite the challenges faced in the market, was linked to its huge potential. Singapore firms also have some advantages in China because Singapore products typically has a strong reputation in China for their quality and trustworthiness, and the large amount of business and social interactions between the two countries narrowed the “cultural distance” between them.

In terms of representative offices, all four groups have presence in Indonesia (TMC via an appointed agent), which is within expectation given that Indonesia is the largest supplier of foreign patients to Singapore. Beyond that, the other four countries which RMG had offices and two countries which HMI had presence are both subsets of Parkway’s network.

RMG appears to be “following” some of Parkway’s internationalisation path in terms of market selection. There could be some element of oligopolistic reaction (Hymer 1976, Knickerbocker 1973) where a firm will go wherever its competitor goes to when the competition in the home country is oligopolistic. However, a more likely explanation is that RMG and other Singapore-based healthcare operators internationalise to countries
which Parkway had built up brand recognition, as this helps to lower the barriers of entry for subsequent entrants from Singapore, given that the locals would already be familiar with Singapore healthcare.

The fact that Parkway had the confidence to expand to more distant markets which the other companies were not ready to enter illustrates the Uppsala 1977 Model (Johanson and Vahlne, 1977; 1990), which indicated that firms would internationalise to more culturally distant countries as they accumulate more experiential knowledge.

One interesting observation from the cross-case analysis was TMC’s entry into Vietnam with the management contract of a hospital. This is a higher commitment mode which Parkway had not been able to achieve despite it having worked the Vietnam market for a longer time. This demonstrates the importance of business networks as emphasised in Uppsala 2009 Model (Johanson and Vahlne, 2009), which TMC had in this instance, but which Parkway was still working on.

7.2.3 Entry Modes

As highlighted under the internationalisation strategy, Parkway, TMC and HMI all had a preference for the use of management contract, with option embedded where possible, in terms of entry mode.

There were some cases of acquisitions, though this mainly applies to Parkway, which is the largest and best-resourced among the case firms. The other entries were mainly made using Joint Venture, which was desirable as it allows sharing of the risk of the market entry, as well as enable the firm to tap on the resources and local expertise of the local partner. In some cases, the use of joint venture was necessary due to regulations in the country, for example, the 70% cap on foreign holdings in healthcare companies in China and Indonesia.

Other than TMC, the other three groups all used representative offices extensively for their internationalisation. As discussed in the Parkway case, the use of representative office is aligned with the work of Johanson and Vahlne (1977), which advocate using small, sequential steps both in the scale of operations in a particular country and of the geographic scope of the firm’s operations. It also permits accelerated
internationalisation (Mathews, 2006), given that the representative offices are relatively low cost and fast to set up. Besides, it highlights the increasing commodification of healthcare services, which has turned healthcare services to become increasingly “exportable”.

The role of the representative offices as the first small step entry into a new market to understand the market is demonstrated by the fact that the operations in some countries were upgraded to a higher commitment mode when the potential becomes clearer, for example, Parkway in Vietnam, China and the UAE, and RMG in Indonesia. In Parkway’s case, some of the offices were also reviewed and discontinued after a while, when it was established that the market potential in those countries was weaker than expected, at least in the short to medium term.

### 7.2.4 Timing of Entry

As MNEs from a SMOPEC (in this case, Singapore), the healthcare groups are expected to internationalise quickly (Hirsch 2006). This is to overcome the constraint caused by the small domestic base. Mathews (2006) also explained that second wave MNEs, like those from newly industrialized economies (which includes Singapore), tend to accelerate their internationalisation to quickly leverage on their relatively transient advantages. This pattern of an accelerated internationalisation is clearly shown in Parkway’s case.

In the case of the other three case firms, RMG and HMI showed some attempts to internationalise quickly, despite the fact that they had not been able to expand as far and as fast as Parkway. For example, RMG had attempted to buy a Malaysian hospital in 2004 and had been working on the China market for some time before finally making its breakthrough in 2010. As for HMI, it had many deals sealed in the 1990s, and if not for the financial crisis and the difficulties that a few of its partners went into, it could potentially be engaged in more overseas ventures than the two Malaysian hospitals it currently operates.

For TMC, it was relatively less active in internationalisation. In the case study, this was partly attributed to the nature of TMC’s business, the fact that TMC was operating near capacity, and the attitude of its owner towards internationalisation.
Riding on this aspect of owners’ attitude towards internationalisation, literature on family businesses has shown that owner-managed firms have different governance issues from those of publicly owned firms. In particular, in the area of investing in the business, James (1999) and Stein (1989) indicated that the family-owner tends to maintain longer investment horizons than other shareholders, who may make myopic investment decisions that boost current or short-term earnings. Family firms may also attempt to invest more efficiently because they may view their firms as an asset to pass on to succeeding generations.

However, there are also observations that the family-owner may forego maximum profits when they are unable to separate their own financial preferences from those of other owners outside the family (Shleifer and Summers, 1988; Shleifer and Vishny, 1997). Founding families may also have interests of their own, such as stability and capital preservation, which may not be consistent with the interests of other investors (Lee, 2006).

Using the above literature as basis, the case firms will be analysed with respect to their ownership to see if this provides an explanation on some of the observed deviations in terms of timing of entry for the firms.

Of the 4 firms, RMG, HMI and TMC (prior to its takeover in November 2010) all have their founders as the majority shareholders. All the founders were actively involved in the running of the firm.

As highlighted earlier, TMC was relatively less active in internationalisation, despite its very strong cash position which could have allowed it to expand overseas more aggressively. Hence, the founder-ownership could possibly explain its internationalisation stance, as they might have preferred stability and capital preservation to the risks involved in overseas expansion.

Similarly, RMG has a strong cash position which could have allowed it to expand overseas more aggressively. Again, the owner’s more conservative attitude towards business investment could have made it less willing to pay over the board to acquire overseas assets and in the process, it might have foregone some opportunities or took
longer than expected. For example, in the bidding for a piece of land set aside for private hospital development in Singapore in 2008, Parkway won the bid with a very high bid of S$1.25 billion. This worked out to about S$1,600 per square foot per plot ratio (psf ppr), more than double the second highest bid of S$695 psf ppr. RMG’s bid was third, at $344 psf ppr, less than a quarter of Parkway’s.\footnote{“Parkway’s Novena Bid Poised To Set Govt Land Sales Record”, The Business Times, 16 Feb 2008.}

The above observations for RMG and TMC raised question about the more active internationalisation by HMI, which is also majority owned by the founders. One reason why HMI was less risk-averse and had been more active in internationalisation could be linked to the active involvement of Dr Gan See Khem, who is the Executive Chairman of the group, and who was a business professor from the National University of Singapore and not a medical doctor. On the other hand, the founders of TMC and RMG are both doctors, who may be more risk-averse.

Turning to Parkway, its controlling shareholders have been investment funds since 1999, first Schroder Capital, then Newbridge, and now Khazanah Nasional. As private equity funds or sovereign funds, these funds have the resources and risk appetite to take on larger risks in return for faster growth for Parkway, as illustrated by the 2008 example on the bidding of land above. Even Parkway’s founders were business families which were involved in a wide range of businesses, with strong focus on the property sector.

Notwithstanding the above, all the healthcare groups were clear of the need for them to venture out of Singapore given the constraints of the small domestic demand in Singapore (Hirsch 2006). In fact, HMI had already closed its hospital operation in Singapore and moved its flagship to Malaysia, which has a much larger domestic catchment. Parkway’s Dr Tan See Leng, in an interview in 2010 (Quek, 2010) commented that “Parkway aims to build hospitals in China and Vietnam to diversify from its home market which is close to saturation.” Similarly, Dr Prem Kumar Nair, RMG’s general manager of business development, said in an earlier interview (Lee, 2007): “Can we continue to grow in Singapore? I would say yes, but it’ll probably level off at some stage, so we have to look for new opportunities overseas.” More recently, Dr Chan, the new Group President of TMC, admitted that TMC would need to venture outside Singapore for growth (Chan and Chan, 2011). He said: “We are looking at
Vietnam, China and the Middle East and also not ruling out other South-east Asian countries, but our focus will clearly be Asia.”

### 7.3 EXAMINATION OF PROPOSITIONS

Having completed the cross-case analysis, this section will relate the case findings and analysis to the propositions that were made in Chapter 4. The summary analysis of the provisions in relation to the 4 firms is consolidated in Table 7.2.
Table 7.2 - Summary Analysis of the Propositions in Relation to the Case Firms

<table>
<thead>
<tr>
<th>Proposition</th>
<th>Parkway</th>
<th>RMG</th>
<th>TMC</th>
<th>HMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposition 1: The healthcare firm will tap into its network when selecting markets to enter; if it sees opportunities in markets where it does not have current partners or networks, it may start building new connections with a firm which is operating in a network there.</td>
<td>Supported. Parkway’s JV in Brunei and management contract in UAE were made possible through links with the government-linked partners there; Parkway’s experience in India and China demonstrated the point about having to build new connections in high potential new markets where a firm does not have current partners or network. Parkway’s arrangement with Khazanah to own Pantai in Malaysia via a Joint Venture also demonstrated the importance of network in facilitating further penetration within a market, even one with low psychic distance.</td>
<td>Untested.</td>
<td>Supported. TMC’s entry into Vietnam was made possible through a contact of its former Group CEO.</td>
<td>Supported. HMI signed a few hospital management and/or consultancy projects in Malaysia in the 1990s, tapping on its working relationship with a firm there.</td>
</tr>
<tr>
<td>Proposition 2: As the healthcare firm expands internationally, it adopts a regional strategy rather than a global strategy.</td>
<td>Supported.</td>
<td>Supported.</td>
<td>Supported.</td>
<td>Supported.</td>
</tr>
<tr>
<td>Proposition 3: The healthcare firm will find ways to link up with sources of resources which it can tap, and use collaborative entry modes such as joint ventures or service contracts for market entry, with joint venture preferred over contractual modes.</td>
<td>Partially supported. Used collaborative modes extensively for market entry. But stated preference for contractual mode over JV.</td>
<td>Untested.</td>
<td>Partially supported. Used collaborative mode for market entry. But stated preference for contractual mode over JV.</td>
<td>Partially supported. Used collaborative mode for market entry. But stated preference for contractual mode over JV.</td>
</tr>
<tr>
<td>Proposition 4: The provision of healthcare service in Singapore is undergoing the process of commodification, and healthcare firms can enter foreign markets via “exporting” (ie, sold in a foreign country away from the point of production and consumption).</td>
<td>Supported.</td>
<td>Supported.</td>
<td>Supported.</td>
<td>Supported.</td>
</tr>
<tr>
<td>Proposition 5: The healthcare firm will internationalise very rapidly.</td>
<td>Supported.</td>
<td>Supported.</td>
<td>Not supported.</td>
<td>Supported.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Proposition 6: The healthcare firm will move towards a hub and spoke configuration as they expand overseas, including having some spoke-hospitals which the firm offshores some of its services to.</td>
<td>Supported.</td>
<td>Partially supported. Uses a hub-and-spoke strategy to bring patients to its hub in Singapore, but yet to set up spoke-hospitals.</td>
<td>Supported. Uses a hub-and-spoke strategy to bring patients to its hub in Singapore. Provided consultancy for the setting up of a spoke-hospital in Vietnam, which it now manages.</td>
<td>Supported. Uses a hub-and-spoke strategy to bring patients to its hub in Malaysia, but yet to set up spoke-hospitals elsewhere. The choice of Malaysia to place its flagship is in itself an offshoring (from its original home base).</td>
</tr>
<tr>
<td>Proposition 7: The healthcare firms from Singapore follow the four phases of internationalisation process, namely, learning phase, opportunistic phase, de-internationalisation phase, and maturisation phase.</td>
<td>Supported.</td>
<td>Not conclusive due to short history of the hospital.</td>
<td>Not conclusive due to late start in overseas expansion.</td>
<td>Supported.</td>
</tr>
<tr>
<td>Proposition 8: The government plays a relatively significant role in developing the business and supporting the internationalisation of healthcare firms from Singapore.</td>
<td>Supported. Singapore Government set up SingaporeMedicine initiative to support the hospitals in their internationalisation efforts. Various initiatives had since been carried out, which healthcare firms from Singapore acknowledged were useful in supporting their overseas venture.</td>
<td>Supported. Had exhibited the various behaviours stated, and had since been acquired itself; the new owner is expected to consolidate Parkway together with its other healthcare holdings.</td>
<td>Supported. Had been acquired, and should see the new owner consolidating his healthcare holdings in the region with the company.</td>
<td>Not applicable, since its hospital operations are based in Malaysia.</td>
</tr>
<tr>
<td>Proposition 9: With regional integration, the healthcare firms from Singapore can be expected to emphasise even more on regional strategy, step up their overseas expansion, actively seek opportunities for mergers and acquisitions, and deploy location strategy which taps even more on differentiated manpower resources in locations within the region.</td>
<td>Supported. Had exhibited the various behaviours stated, and had since been acquired itself; the new owner is expected to consolidate Parkway together with its other healthcare holdings.</td>
<td>Partially supported. Has stated its intent to step up acquisitions as well as carry out Greenfield projects in the region, but no firm projects yet.</td>
<td>Supported. Had been acquired, and should see the new owner consolidating his healthcare holdings in the region with the company.</td>
<td>Partially supported. Has stated that it is exploring management contract and JV opportunities in the region, but no firm projects yet.</td>
</tr>
</tbody>
</table>
7.3.1 Proposition 1

The first proposition stated that the healthcare firm will tap on its network when selecting markets to enter; if it sees opportunities in markets where it does not have current partners or network, it may start building new connections with a firm which is operating in a network there. This was clearly supported by the cases studied. The few market entries that clearly illustrate this were TMC’s entry into Vietnam and Parkway’s JV in Brunei and management contract in the UAE. Parkway’s internationalisation experience in India and China also demonstrated the related point about having to build new connections in high potential new markets where a firm does not have current partners or network.

Parkway’s arrangement with Khazanah to own Pantai in Malaysia via a Joint Venture also demonstrated the importance of networks in facilitating further penetration within a market, even one with low psychic distance and one which the firm is already familiar with. This demonstrated the importance of not just having network in the market, but different networks are sometimes needed for different purposes. In this case, Parkway’s private sector network helped it net Pantai, but given the state’s interest in the sector, the link-up with a state-related partner was essential for the deal to gain acceptance, and with that, access to opportunities to further expand its network within the country. Such need to link up to state-related network to not just enter the market but also gain access to opportunities is expected in countries where the state has significant interest in the private healthcare sector, which is predominantly the case in developing economies in Southeast Asia.

However, it should also be noted that the Uppsala 2009 Model (Johanson and Vahlne, 2009) does not necessarily displace the earlier Uppsala Model (Johanson and Vahlne, 1977), which still has its value, as the healthcare groups generally start their internationalisation in neighbouring countries where ‘psychic’ distance is short. This could also have been contributed by healthcare being a high-touch service industry, where cultural familiarity is important in ensuring a high quality of service. The Uppsala 2009 Model was particularly useful in explaining entries to more distant markets at an early stage leveraging on appropriate networks.
The importance of the network is also emphasized in HMI’s case, where the choice of partners who tried to enter the healthcare business as a diversification without knowing the business affected the success rate of the collaboration. This is because being a non-core segment for the partner, the healthcare projects tend to be easy targets for dropping whenever the partner firms are under financial pressure.

7.3.2 Proposition 2

Proposition 2 states that as the healthcare firm expands internationally, it adopts a regional strategy rather than global strategy. This is clearly supported. For all the 4 case firms, they have a vast majority of their businesses and revenues from within the ASEAN region. In fact, none of them have ventured beyond Asia, other than representative offices for the purpose of attracting medical tourists. Parkway’s failed entry into UK also illustrates the challenges a firm will face when it tries to bring its region-bound FSAs beyond the region.

A related observation is that healthcare services in ASEAN had been dominated by regional providers. Since Tenet sold off its hospitals in the Singapore and Thailand in the 1990s, there had not been another major foreign healthcare MNEs servicing the market. There are small presences like Ramsay Health from Australia with three hospitals in Indonesia and Johns Hopkins with a medical centre in Singapore but not at the same level as Tenet in the past. It can therefore be concluded that healthcare groups tend to be regionally-focused, and hence, foreign groups might be cautious as to whether they have the necessary region-bound FSA to enter the region profitably.

7.3.3 Proposition 3

Proposition 3 states that the healthcare firm will find ways to link up with sources of resources which it can tap, and use collaborative entry modes such as joint ventures or service contracts for market entry, with joint venture preferred over contractual modes.

There are three points in this proposition: (i) finding ways to link up with resources; (ii) using collaborative entry modes; and (iii) a preference for joint venture. The first two points are generally supported by the cases studied. While the acquisition mode is used occasionally when the firm is familiar with the market, comfortable with the risk level
involved, and there is a suitable target at a reasonable valuation (eg, Parkway’s acquisition of Pantai in 2005), the case firms use collaborative entry modes more extensively for market entry. For many of these instances, the collaborative entry modes were used to leverage on the resources of the partner firms, especially to tap on their knowledge, outreach and networks within the host country.

However, a deviation from the view of Bartels et al (2009) was the stated preference of the case firms for management contract instead of joint venture. Bartels et al (2009)’s main argument was that for service firms, information and people-embodied knowledge are critical FSAs, and since they are non-patentable and are easy to replicate or acquire through “poaching” of staff, a higher commitment entry is more desirable. For the case of the healthcare firms from Singapore, the threats highlighted by Bartels et al (2009) are important considerations, though there are possibly more important considerations which make management contracts attractive. Firstly, the cost of building a new hospital is very high. This includes not just the land and building, but also the many expensive equipment needed within the hospital. Secondly, there is a strategic need for these firms to internationalise quickly (to be further discussed in proposition 5). The use of management contract will allow the firms to address both considerations, as it allows them to internationalise quickly without having to commit too much capital investment. This is especially important for firms from SMOPEC, which are short on resources to start with. Besides, quick internationalisation meant that they might not have full understanding and knowledge about the entry target at the point of decision, hence, a lower commitment mode will prevent the firm from having to suffer significant financial loss should it not work out (Mathews, 2006). Referring more specifically to the strategy of the case firms, one of their main objectives for internationalisation was to establish channels to refer more complex cases to their home base. This is where attractive margins are going to be made, while profitability of the overseas hospitals is an unknown at that juncture. In any case, as mentioned in the cross-case analysis, the firms usually negotiate for an option to acquire stakes in the venture to be embedded in the contract. This allows the firm to take a stake in the project (and turn it into a joint venture) later.
Proposition 4 states that healthcare service in Singapore is undergoing the process of commodification, and healthcare firms can enter foreign market via “exporting” (ie, sold in a foreign country away from the point of production). This is clearly supported, judging from the extensive use of representative offices by the case firms to “sell” their services in potential markets and attract foreign patients to their hospitals.

This is an interesting observation as healthcare is still a soft service; that is, it is still not possible to separate the production and consumption of healthcare service, and according to the literature, soft services need to adopt non-export modes such as sole ownership, joint venture, franchising, or management contract for foreign market entry. While healthcare services still cannot be exported in the traditional sense like goods or hard services, the increasing commodification of healthcare made it possible for market entry just by having marketing and sales channels in the form of representative offices. This has made low cost, low risk market entry possible.

Proposition 5 states that the healthcare firm will internationalise very rapidly. This has been discussed in much detail in section 7.2.4 in relation to the timing of entry. As highlighted there, all the case firms internationalise very rapidly, except TMC. Family ownership was highlighted as a possible reason for the slow internationalisation by TMC and the slower-than-expected internationalisation by RMG, despite both of them having strong cash positions which would have allowed them to internationalise more aggressively. It was explained that where the firm is family-managed, the decision-making may be subject to the interests of the founding family and may not be consistent with the interests of other investors.

Therefore, it can be argued that the proposition is generally supported, though it may be affected by the circumstances within each firm.
7.3.6 Proposition 6

Proposition 6 states that the healthcare firm will move towards a hub and spoke configuration as they expand overseas, including having some spoke-hospitals which the firm offshores some of its services to. This is generally supported. To varying degrees, each of the hospital operators is adopting a hub-and-spoke strategy, leveraging on its network of clinics/medical centres/hospitals/representative offices to bring in patients from overseas. For each spoke-hospital, besides bringing the firm’s healthcare service to a new pool of patients at the new location, it also offers a cheaper alternative for other patients who may have been using the firm’s services at the hub hospitals.

However, at this moment, only Parkway had been actively setting up spoke-hospitals overseas which leverages on the relative strengths of the different locations within the region. TMC is seen trying to do it via the hospital it manages in Vietnam, while RMG had so far indicated its plan to open hospitals in Malaysia, China and Hong Kong but without much progress to date. For HMI, the choice of Malaysia to place its flagship is in itself an offshoring from its original home base in Singapore, leveraging on the lower cost and yet good quality healthcare standard there.

With the region moving towards the ASEAN Economic Community by 2015, more of the healthcare MNEs from Singapore can be expected to set up hospitals overseas to create a hub and spoke network that not just refers patients to the hub hospitals but also leverages on the relative strengths of the different locations to provide more choices for the patients.

7.3.7 Proposition 7

Proposition 7 states that the healthcare firms from Singapore follow the four phases of internationalisation process, namely, learning phase, opportunistic phase, de-internationalisation phase, and maturisation phase.

Unlike the case of the telecommunications companies discussed in Laanti et al (2009) where the internationalisation is shaped by industry developments and have comparable timeframe, the healthcare firms from Singapore started their internationalisation at
different times and hence might not be at the same stage. Hence, the discussion on the phases of internationalisation will have to be done on each of the case firms separately.

Studying the internationalisation experience of the four cases, Parkway and HMI are observed to have both gone through all the four phases, while RMG and TMC are still at Phase 2. This is plausible as both Parkway and HMI started their internationalisation activities in 1989 and 1991 respectively, while RMG only opened its hospital in 2001 and TMC began actively exploring internationalisation when Mr Allan Yeo joined as Group CEO in 2002. The detailed phasing for each of the case firms is as follow:

**Parkway**

For Parkway, learning phase was between 1989 to about 1995, when it bought a hospital in Penang, Malaysia and acquired Mount Elizabeth and East Shore Hospitals from Tenet. As discussed in the case study, the purchase of Mount Elizabeth Hospital, in particular, was significant from a learning perspective as Tenet had put in much resources in the hospital to make it the top private tertiary hospital in the region, hence the acquisition provided Parkway with a team of hospital administrators with the expertise and international outlook, as they were exposed to Tenet’s global operation (which included significant operations in Southeast Asia and Australia at that time).

It then went on to its opportunistic phase, which lasted till about 1999, when it expanded quickly not just in the region but also opened a hospital in London, UK. The Asian financial crisis in 1997/8 affected Parkway as foreign patients, especially from Indonesia, dropped significantly. The founding families sold a significant portion of their shares in 1999, and Schroder Capital took over ownership of the group.

From 1999 to 2001, the de-internationalisation phase took place. Parkway rationalized its business by selling off its non-healthcare assets to focus solely on healthcare. It rolled back its involvement in the hospitals in Indonesia and launched a network of representative offices to continue to bring patients to its hub in Singapore. It also sold its loss-making hospital in UK to focus on Asia.

From 2002 onwards, Parkway has reached the maturisation phase. It became a pure healthcare player and has successfully become the top regional healthcare group. It
expanded its footprint in Malaysia significantly with the tie-up with Pantai, successfully entered into new markets like Brunei, India, China and UAE, and strengthened its hub in Singapore by building an additional “hospital of the future”. Strategy-wise, it has also matured, with a clear strategy of combining a hub-and-spoke strategy with an asset-light expansion model.

**HMI**

For HMI, the learning phase was between 1991 to 1995, when it started operating the Balestier Hospital in Singapore, got exposed to servicing foreign patients and subsequently explored management consultancy and hospital management opportunities in Malaysia. It secured its first such project in 1995.

It then went on to the opportunistic phase till about 1999, where it secured another two more projects in Malaysia, was involved in a project in China as part of a consortium, and got listed in Singapore.

It underwent the de-internationalisation phase from about 1999 to 2002, during which two of its projects in Malaysia got aborted due to financial problems over at their partners’ side, and it has to write off its initial investment in the China project. It then did a restructuring which eventually led to closure of its Singapore hospital operation and moving of its flagship to MMC in Malaysia. It also set its focus on two core businesses – healthcare and education.

Since 2002, HMI has been in maturisation phase, having turned around MMC, completed a few consultancy projects in Malaysia and Indonesia, and opened its second hospital in Malaysia.

**RMG**

Given RMG’s short history in running a hospital, it is probably only at Phase 2. As medical travel to Singapore was already well established in Singapore when Raffles Hospital was set up, RMG did not need to take long to get over the learning phase. With former CEO of the largest public hospital in Singapore as the general manager of the hospital when it first started, RMG was able to get past the learning phase very quickly.
In the opportunistic phase, RMG has been able to tap on the national initiative under SingaporeMedicine, and more generally, the reputation of the Singapore healthcare services, to internationalise. It attempted to acquire a Malaysian hospital but failed, though it recently managed to successfully enter the China market with a medical centre in Shanghai.

Given that RMG had been adopting a relatively cautious and steady approach in its internationalisation strategy, it may never have to undergo Phase 3 (de-internationalisation) before reaching Phase 4 (maturisation).

**TMC**

Unlike RMG, TMC has a long history but has historically focused on the local market. Foreign patients came largely through word-of-mouth publicity. Its commencement in internationalisation can possibly be traced to the appointment of Mr Allan Yeo as the Group CEO in 2002, who as Group CEO of HMI, had much internationalisation experience. This possibly helped to kickstart the process without much learning needed.

In the opportunistic phase, TMC entered Vietnam with a management consultancy project, which has since completed and it is now running the hospital. It has also secured another consultancy project from the same partner. With the change in ownership and a new management team with internationalisation experience in place following TMC’s acquisition by investor Peter Lim in November 2010, it appears likely that TMC will step up its overseas expansion.

**Implication**

Based on the above analyses, it is possible to conclude that the proposition that the firms go through the 4 phases of internationalisation process is generally supported, at least for the two firms which have been internationalising for longer. For the other two firms which have a shorter history of internationalisation, it can be assumed that they have yet to complete the full cycle.
Focussing on the two firms that started internationalisation about the same time and have gone through the four phases, some common patterns in their internationalisation process can be observed in each of the phases. During the learning phase, the firms find ways to learn about internationalisation, including by serving foreign patients in their existing hospitals and acquiring hospitals with experience in internationalisation. In the opportunistic phase, the firms began to actively expand their operations overseas. These include countries from where the patients they had been serving come from, for eg, Parkway’s joint venture projects in Indonesia and Malaysia, and HMI’s consultancy and management projects in Malaysia. However, they also went beyond these familiar markets and make opportunistic moves into more culturally and physically distant markets, such as HMI’s venture into China, and Parkway’s venture into the UK, India and China. For both Parkway and HMI, the de-internationalisation phase was a result of the 1998 regional financial crisis. Given the small domestic market in Singapore, both had relied significantly on foreign patients for their local operation, hence the drop in foreign patients affected them badly. Operations that were not viable were closed down, and their internationalisation strategies became more focussed – HMI focussing on its operation in Malaysia and Parkway on its operation in Asia. In the maturisation phase, both started to grow their businesses again, focussing on the neighbouring markets and the region. They also became more focused in their internationalisation strategies, concentrating on growing their respective hub-and-spoke networks, both as feeders to their hub hospitals as well as to offer more choices to their target population.

The discussion above highlights some interesting insights with regard to market selection and entry modes used by the firms in the different phases of their internationalisation process. In the opportunistic phase, the role of psychic distance was relatively smaller, while other factors, especially market potential of the host market, played a bigger role in influencing the market selection. However, psychic distance becomes more important as a factor in the later phases, as the firms adopted a more focussed approach to internationalisation. This is especially where it concerned internationalisation involving higher commitment modes. Taking Parkway as an example, its businesses in North Asia and South Asia only made up 5% and 2% respectively of its revenue in 2010 (see Figure 6.1), compared to 24% for Southeast Asia (excluding Singapore), despite their far larger market sizes. HMI also derives more than 95% of its revenue from its Malaysian operations.
In terms of entry mode, the firms adopted more collaborative and lower commitment modes during the opportunistic phase. In the maturisation phase, while they still expressed a preference for collaborative entry modes for entering new markets, their main internationalisation activities (in terms of investment and revenue contribution) were in expanding their operations in more culturally familiar markets using higher commitment mode, such as acquisitions and Greenfield developments.

7.3.8 Proposition 8

Proposition 8 states that the government plays a relatively significant role in developing the business and supporting the internationalisation of healthcare firms from Singapore. This is generally supported. In particular, the government set up the SingaporeMedicine initiative in October 2003 to support the hospitals in attracting foreign patients. This has been well received by the hospitals. For example, Parkway stated in its 2003 Annual Report that it partnered with Singapore government agencies in the SingaporeMedicine initiative to actively market Singapore as an international healthcare hub. Besides, one of the agencies involved in the SingaporeMedicine initiative, the International Enterprise (IE) Singapore, had also led local firms on healthcare missions to China, Vietnam and Middle East to explore business opportunities. It also has local offices in these prospective countries to facilitate market entries by Singapore companies.

In an interview in 2007, Dr Prem Kumar Nair, RMG’s General Manager, Business Development, said: “The SingaporeMedicine initiative has been crucial to the growth of the foreign patient market here. It has paved the way for hospitals to move into new markets regionally.” He added: “Ever since the launch of SingaporeMedicine in October 2003, the number of foreign patients coming to Singapore has grown steadily. And Raffles Hospital mirrors this growth. Today, 35 per cent of all patients at the hospital are foreign, from more than 120 countries.” (Ramesh, 2007)

Other than the publicity efforts, the Singapore Government have also made other changes and introduced certain measures to support the internationalisation of the Singapore hospitals. For example, it embarked on a massive effort to develop Singapore as a biomedical hub, which gave Singapore an even greater edge in terms of high-end medicine. Singapore’s competitive positioning as a premium medical services hub is enhanced by government bringing in world-renowned institutions like John Hopkins
University and Duke Medical School for tie-ups with local institutions. Besides, it has sharply increased supply of healthcare manpower, in medical, nursing and allied health. For medical talent, the government has liberalised the entry requirements for foreign talent compared to Malaysia and Thailand. It also liberalised the medical advertising rules, which gave greater leeway to the healthcare firms in advertising and promoting their services via the media.

Going a little further back in history, the Singapore government was the first in the region to open up the healthcare sector for private sector participation earlier. This allowed Singapore private healthcare firms to have a head start compared to firms from other regional countries.

7.3.9 Proposition 9

Proposition 9 states that with regional integration, healthcare firms from Singapore can be expected to emphasise even more on regional strategy, step up their overseas expansion, actively seek opportunities for mergers and acquisitions, and deploy location strategy which tap even more on differentiated manpower resources in locations within the region.

This is supported, but as highlighted under proposition 6, only Parkway’s internationalisation has reached the level of maturity to actively deploy location strategy which taps on differentiated manpower resources in locations within the region. The increase in mergers and acquisitions have taken place in Singapore, with Khazanah Nasional buying out Parkway and billionaire investor Peter Lim buying out TMC. Both Khazanah and Peter Lim also separately own other healthcare assets in the region, which they can be expected to consolidate with their Singapore assets as they rationalize their holdings and derive greater synergies from the assets.

Beyond Singapore, there have also been active mergers and acquisitions taking place among the major Thai healthcare operators. These include Bangkok Dusit’s acquisition of the Phyaathai Hospital and Paolo Memorial Hospital chains in December 2010, adding 8 medical facilities and expanding its network to 27 facilities in total. It also purchased an 11% stake in Bumrungrad Hospital in February 2011. Bumrungrad, in turn, purchased a 24.99% stake in Bangkok Chain Hospital Plc, the chief operator of
Kasemrad Hospital Group with a network of six hospitals. Both cited that they were doing so to strengthen their respective domestic positions in preparation for the impending liberalization of the healthcare market come 2015, when AEC is fully implemented. This demonstrates that regional integration leads to increasing consolidation across the region among healthcare firms.

7.4 CHAPTER CONCLUSION

Through the cross-case analysis of the four case firms, this chapter has identified those internationalisation behaviours or choices which were similar among the firms, as well as those where there were deviations. The few instances of significant deviation by specific case firms were investigated and analysis presented.

The propositions articulated in Chapter 4 were also examined in relation to the case firms. The process allowed an evaluation of the applicability of the various theories to the internationalisation of healthcare firms from Singapore. The analysis showed that all the propositions were generally supported, though there were some deviations such as the influence of family-ownership on the internationalisation stance of the company; the preference of firms to use management contract with embedded option for market entry; as well as Parkway being the only case firm that have gone some way towards leveraging on the differentiated manpower resources in locations within the region for its hub and spoke network.

Overall, the cross-case analysis has enabled a characterisation of the internationalisation strategies of healthcare firms from Singapore, in terms of their overall strategy, market selection, entry mode and timing of entry. The examination of the propositions further added to this analysis by relating the behaviours of the firms in specific areas to the various extant theories. Taking all the findings together, it has provided a deeper understanding of the internationalisation strategies of healthcare firms from Singapore. These results will be discussed further in the next chapter.
CHAPTER 8 – DISCUSSION OF THE RESULTS

8.1 INTRODUCTION

Following on from the cross-case analysis in the previous chapter, this chapter aims to derive further insights with regards to the internationalisation of healthcare firms from Singapore by discussing the results from the analysis in relation to four issues that have emerged from this research. The discussion in this chapter enables this thesis to move beyond just trying to understand and explain the firms’ behaviours to creating new perspectives which will be useful both for the academic circle as well as the practitioners.

The first issue that will be addressed is – How does a private healthcare firm from Singapore internationalise, in terms of their overall strategy, market selection, entry mode and timing of entry? This refers not to any particular firm but a “typical” firm. It is important to address this so that the findings from this study can then be considered for application to other relevant contexts, such as internationalisation of other service firms from Singapore, healthcare firms from other SMOPECs, other service firms from other SMOPECs, or even healthcare firms in general.

The second issue that will be addressed is – What are the factors that influence the internationalisation of healthcare firms? In the conceptual framework proposed at Figure 4.1, five groups of factors were posited to influence the internationalisation of healthcare firms. With the findings from the case studies and the cross-case analysis, it will be useful to revisit these factors to ascertain their influence on the internationalisation of the case firms, and to identify additional factors that are not already covered. With the set of factors identified, the conceptual framework proposed in Chapter 4 will be updated to develop a conceptual model on the factors that influence the internationalisation of healthcare firms. Given that no conceptual model on internationalisation of healthcare firms had been developed in the past, the proposed conceptual model will be a first attempt at developing such a model. It will be a useful contribution to extant literature in terms of highlighting additional factors which should be considered when studying the internationalisation of service firms, especially healthcare MNEs.

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The third issue is – Are there different phases in the internationalisation process of the healthcare firms from Singapore? As have been discussed in the literature and in Chapter 7, the internationalisation of the healthcare firms is not expected to be an incremental straight-line progression over time like that discussed in Uppsala 1977 Model, but is the internationalisation process then completely random or are firms expected to follow a certain pattern in their internationalisation process over time? This is a relevant issue, as if it is the latter, it is important for managers to recognize the phase that the firm is in and take the necessary measures to capitalize on the opportunities while avoiding the pitfalls.

The fourth issue is – How does regional integration influence the internationalisation strategy of healthcare firms from Singapore? This is an important issue for healthcare firms from Singapore, as well as internationalising healthcare firms from other countries in the region, as regional integration will affect the way they operate within the region. Like for the first issue, the findings from the discussion of this issue can be applied to many other relevant contexts, including to service firms in other regions undergoing economic integration similar to ASEAN.

8.2 CHARACTERIZATION OF THE INTERNATIONALISATION STRATEGY

As highlighted in the introduction above, it will be useful to be able to characterize the internationalisation strategy of a healthcare firm from Singapore, as this can then be applied to other relevant contexts, such as internationalisation of other service firms from Singapore, healthcare firms from other SMOPECs, other service firms from other SMOPECs, or even internationalising healthcare firms in general. This will be done by combining the findings from the first section of the cross-case analysis and the further understanding of the case firms’ behaviours gained through examining the propositions.

In terms of the overall strategy, the firm is expected to adopt a hub-and-spoke strategy, leveraging on its network of clinics/medical centres/hospitals/ representative offices at different locations within the region to bring patients to its hub hospital(s) (Buckley and Ghauri, 2004; Bartels et al, 2009). Notwithstanding its inherent disadvantage of a small domestic home base, it is able to leverage on the facilitation and support provided by the Singapore government for its internationalisation (Hirsch 2006). It may also seek a
suitable international accreditation, such as JCI, to attract patients from more distant countries who needed the extra assurance.

In terms of market selection, the firm will still generally start with neighbouring countries where psychic distance is short (Johanson and Vahlne, 1977; 1990), but that does not preclude it from internationalising to more distant markets at an early stage should there be an appropriate network or link which it can access and exploit (Johanson and Vahlne, 2009). Where it sees opportunities in markets where it does not have current partners or network, it may start building new connections with a firm which is operating in a network there. However, its strategy will remain regional, rather than global, to fully exploit its non-location-bound FSAs within the home region (Rugman and Verbeke, 2008).

In terms of entry modes, the firm will find ways to link up with sources of resources which it can tap, and use collaborative entry modes such as joint ventures or service contracts for market entry (Mathews, 2006; Luo and Tung, 2007). In particular, it has a preference for a more asset-light strategy of using management contract with embedded option, to avoid the high upfront capital investment for the market entry, earn a risk-free management fee, and still able to share gains from the project by exercising the option later, if it turns out profitable. With the increasing commodification of healthcare services in Singapore and the region (Chee, 2007), the firm will also enter markets which are attractive but is not yet suitable for use of high commitment modes of entry using representative offices, to refer patients to its hub hospital(s) while learning more about the market and explore possible opportunities.

In terms of timing of entry, it will internationalise rapidly, to tap into the transient advantages it enjoys at that moment (Mathews, 2006). It is not concerned to establish solid international structures, but rather quickly develop flexible and “lattice-like” structures spanning diverse countries and markets.

As the region integrates further, the firm emphasises even more on regional strategy (Rugman and Verbeke, 2004/2005), steps up its overseas expansion (Hirsch, 2006), looks for mergers and acquisitions opportunities (Segal-Horn, 1998) and works towards deploying location strategy which taps even more on differentiated manpower resources in locations within the region (Buckley et al 2001).
While the above characterization may not be seen in all the healthcare firms from Singapore at this moment, a typical healthcare firm from Singapore can be expected to exhibit these characteristics in its internationalisation journey over time. As explained in Chapter 7, there may be circumstances that cause the internationalisation of certain firms to deviate from the “typical” behaviours expected of them, such as the attitude of the controlling shareholder towards internationalisation. This needs to be kept in mind when applying the characterizations on a healthcare or service firm.

8.3 CONCEPTUAL MODEL ON THE INTERNATIONALISATION OF HEALTHCARE FIRMS

The findings from the case studies and the cross-case analysis have highlighted various considerations which influenced the internationalisation choices made by the case firms, in relation to their market selection, timing of entry and choice of entry modes. It will therefore be useful to revisit the various factors proposed in the conceptual framework at Figure 4.1 to ascertain their influence on the internationalisation of healthcare firms from Singapore, as well as to identify additional factors that might not have been captured earlier. With the set of factors identified, the conceptual framework proposed in Chapter 4 can then be updated to develop a conceptual model on the factors that influence the internationalisation of healthcare firms.

To recap, the conceptual framework proposed earlier identifies five groups of factors that potentially influence the internationalisation choices made by the healthcare firms, namely, home country factors, host country factors, firm-specific resources, nature of product, and strategic considerations, with regional integration conceptualised to influence internationalisation choices of firms via “host country factors” and “strategic considerations”. These different groups of factors will be examined in turn, including additional factors that have surfaced from the discussions in Chapters 6 and 7.
8.3.1 Home Country Factors

Since the home country in this thesis is a constant, the study is unable to contrast between the internationalisation behaviours of healthcare firms from different types of home countries. Nevertheless, the study has affirmed some of the behaviours expected of firms from a small, Asian and Newly Industrialised Country like Singapore.

8.3.1.1 Market Size

On market size, the internationalisation behaviours of firms from a SMOPEC like Singapore were discussed extensively in the literature review (section 2.4.3). Such firms are expected to internationalise rapidly and have a preference for collaborative modes of entry. These behaviours are observed in empirical evidence from the case studies (sections 7.2.4, 7.3.3 and 7.3.5).

8.3.1.2 Government Support

On government support, the study has shown that government plays a relatively significant role in developing the business and supporting the internationalisation of healthcare firms from Singapore (section 7.3.8). With the government supporting the firms’ internationalisation through publicity and other measures, the case firms have leveraged on the government support to enter the countries targeted, mainly in the form of setting up channels to refer patients back to their hub in Singapore. The facilitation efforts by the government also helped to lower the barriers of entry for the firms, hence, expediting their market entry. For example, with the government’s efforts in promoting the “SingaporeMedicine” brand overseas, healthcare providers from Singapore do not need to individually spend time and effort to convince overseas patients about the quality of healthcare they can expect in Singapore.

8.3.1.3 Intensity of Domestic Competition

The impact of “intensity of domestic competition” is similar to that of “market size” in the case of Singapore, as the small domestic market leads to intense domestic competition which causes the healthcare firms to be more active in exploring overseas opportunities, and hence, internationalise more rapidly (sections 7.2.4 and 7.3.5).
However, oligopolistic reaction (where foreign investment behaviour of a firm elicits similar behaviour to domestic rivals), which was indicated in extant literature as a possible behaviour of firms in markets with intense domestic competition, was not evident among the case firms. This could be because the case firms were of different sizes and at different levels of internationalisation.

**8.3.1.4 Status of Economic Development**

The status of economic development of the home country has an influence on the internationalisation of the healthcare firms largely because “second wave” MNEs from Newly Industrialised or emerging economies have been found to exhibit certain unique behaviours, which were discussed earlier in the literature review (section 2.4.1). These include a preference to use collaborative modes for market entry and internationalising rapidly, which were evident from the study (sections 7.3.3 and 7.3.5). The study also shows that some of the private healthcare firms from Singapore, in relation to their status as second wave MNEs, went through four phases of internationalisation process (section 7.3.7). Some unique patterns of internationalisation were observed in each of the phases of the internationalisation process, including market selection. For example, in the opportunistic phase, market potential of the host market appeared to play a greater role in market selection while psychic distance becomes more important as a factor in the later phases. Hence, we can expect the status of development of the home country to influence the market selection of the firms, besides entry mode choice and timing of entry.

**8.3.1.5 Region the Country is in**

The region that the country is in has to be considered, as the case firms have been shown to be regionally-focussed in their internationalisation (section 7.3.2), in line with extant literature (section 2.3.5). Being regionally-focussed meant that the firms’ market selection would largely focus on markets within the region. Besides, literature on Asian MNEs suggests that Asian internationalisation tends to be organised through social and ethnic networks (section 2.4.2). There were some evidences of this among the case studies (section 7.3.1)
8.3.2 Host Country Factors

8.3.2.1 Market Potential

Among the host country factors, market potential is one of the most important factors influencing market selection, given that most of the overseas ventures by the case firms are market-seeking. For example, as highlighted in section 7.2.2, Parkway, RMG and HMI all targeted China as a priority for setting up healthcare operations, despite the challenges they faced in the market. This was due to the huge potential of the Chinese market. The market potential also influences market entry mode in the sense that firms will want to progress towards higher commitment mode in markets with high potential, subject to risks and other factors, so as to reap the greatest possible returns from the market. For example, in China, Parkway raised its stake in World Link group from 60% to 70% shortly after acquiring the chain, with an option to acquire the remaining 30% upon regulatory approval (section 6.2.2.6). RMG is also planning to invest S$200 million to S$300 million to build a hospital with at least 300 beds in China (section 6.3.2.2). In terms of timing, firms will want to enter a high potential market early, though further expansion will be subject to other factors. This can be seen from the rapid pace with which Parkway rolled out its representative offices to cover many of the high potential emerging markets (Table 6.3).

8.3.2.2 Country Risk

While market potential is an important factor influencing market selection, it has to be considered along with the country risks, such as political and other risks. In general, high country risk makes a market less attractive. However, if a low cost low risk entry mode is available to the firm to enter the market and “test” the market, firms may still enter the market if they assess that the potential justifies the effort, especially for firms with larger resources and whose strategy is to establish a large hub-and-spoke network. For example, Parkway set up representative offices in countries with high market potential like Bangladesh, Myanmar, Russia, Sri Lanka and Vietnam very early on in its
internationalisation efforts, notwithstanding the higher risks posed by these unfamiliar markets\textsuperscript{136}.

On the other hand, country risk will have a significant influence on entry mode choices, as firms will tend to adopt a lower commitment mode for market entry if the country risk is high, moving up to higher commitment only when they are more familiar with the market, if it is deemed appropriate. Given that “exporting” is not available to soft services like healthcare, the most common mode adopted is to set up a representative office in such markets. In terms of timing, high country risks will influence firms to take more time to consider before making an entry or expanding its operation. A particularly insightful comment on this was that made by Mr Allan Yeo, President (Singapore & Vietnam) of TMC: “Partnership is crucial; China is a big market but we are not familiar with it. I don’t want to jump in just because the project looks good….” (section 6.4.4.1)

8.3.2.3 Rules and Regulations

Rules and regulations of the host country is another factor that needs to be considered along with the market potential in making market selection decisions. If a market is attractive but have rules and regulations that make it difficult or unprofitable to enter the market, it may deter market entries. However, like for the case of country risk, where the country’s market potential is high but has rules and regulations that make it not attractive for a high commitment entry, firms may enter the market with a lower commitment mode focusing on referring patients back to their home base. One example that arose from the case studies was Indonesia, which is an attractive market familiar to the case firms, but existing rules and regulations make it challenging to own and run private hospitals profitably there, or at least not at the level of returns expected by the firms. Hence, the healthcare firms from Singapore actively use representative offices to service the market (section 6.2.2.2). Besides the above scenario where rules and regulations make it unattractive for the use of high commitment entry modes, there are also situations where regulations such as cap on foreign equity may rule out certain modes. For example, the UAE requires healthcare investments to be at least 51 per cent owned by a UAE national or locally-owned company outside the free zones (section 6.4.4.2).

\textsuperscript{136} In 2002, none of these countries were among the top 11 sources of foreign patients for private hospitals in Singapore, except Sri Lanka, which is ranked fifth when combined with India and Pakistan (Khoo, 2003).
6.2.2.7), making it not possible for foreign investors to set up wholly-owned subsidiaries there (outside the free zones).

8.3.2.4 Psychic Distance

The roles played by psychic distance in the internationalisation of firms have been discussed extensively in earlier parts of the thesis, namely, on the influence of network vis-à-vis psychic distance on market selection (section 7.3.1), on the role played by psychic distance in the different phases of the firm’s internationalisation process (section 7.3.7), psychic distance as a characteristic of internationalising healthcare firm from Singapore (section 8.2.1), and the use of lower commitment mode to explore new and unfamiliar markets (sections 6.2.5.2 and 7.2.3). In summary, psychic distance influences market selection and entry mode choice in that healthcare firms from Singapore tend to enter a market with low psychic distance when they first start their internationalisation, and where the psychic distance is high, lower commitment mode is usually used for initial market entry.

8.3.2.5 Availability of Necessary Resources

Availability of resources of the right quality, especially manpower, is critical for running a high quality hospital, since high quality healthcare service has to be delivered by skilled healthcare professionals and managed by good healthcare executives. More specifically, the lack of suitable resources will rule out certain entry modes, for example, the firm will not want to own and operate a healthcare facility in a country if it is not comfortable with the standard of the healthcare manpower there. The situation becomes even more difficult if the country has regulations that forbid the use of foreign healthcare professionals in the country. This was one of the challenges faced by Parkway when it was operating hospitals in Indonesia in the late 1990s, leading to its subsequent pull-out and its use of representative offices to service the market instead (section 6.2.2.2).

8.3.2.6 Normative Forces

As discussed in the literature review, normative institutional forces relate to the social values, cultures, and norms of the host country (section 2.2.7.7). Where the social
values, culture, and norms are vastly different from that of the home country, the firm tends to prefer lower commitment mode for initial market entry. Empirical evidence from the case studies showed that representative offices are used extensively to enter such markets; in cases where there are suitable partners, firms also used collaborative modes, such as Parkway in India and the UAE, and TMC in Vietnam.

Nevertheless, where normative forces pose a challenge in the host country, the firm will have to spend more time to learn about the market or find a right partner; hence, timing of entry will be affected, be it for market entry or for further expansion within the market. This was evident in the long delay in Parkway and RMG gaining a foothold in China despite them expressing their interests to enter the market many years prior to that. The following was a comment by Dr Loo Choon Yong, Executive Chairman of RMG on entry into the Chinese market: “The Chinese health care market is what I call a treacherous one. There are many barriers and even more invisible barriers. We’ll start with one and see if we lose our pants. If we do well, if we truly know how to deliver the kind of health care that we think we should deliver associated with our brand, then we’ll do more. If we can’t, then we’ll know that it isn’t the place for us” (section 6.3.5.2). The comment was particularly insightful as he highlighted the role played by “invisible barriers”, which are probably the normative forces referred to here.

Besides the delay due to the time needed to learn about the market or find a right partner, normative forces in some emerging markets may cause the investment proposal to go through more complicated clearance process than stated in the regulations and require a long time to process, as shown in the long delay before Parkway got its operating license in China (section 6.2.2.6).

8.3.2.7 Cognitive Forces

Cognitive forces relate to the established cognitive structures in society that are taken for granted. As discussed in section 2.3.4, cognitive forces are reflected in observable industry or organizational historical patterns, and may influence firms to follow the entry modes of other MNEs. This was observed in the entry mode behaviours of the case firms, for example, RMG adopting the same entry mode in China as Parkway, and RMG and HMI adopting the same mode as Parkway in Indonesia.
8.3.3 Firm-Specific Resources

8.3.3.1 Firm Size

Moving on to firm-specific resources, firm size may influence market selection in that larger firms have greater resources and hence, more capacity to “experiment” with new markets and invest in overseas ventures, and can take a longer term view to overseas investment (ie, holding on to the investment for a longer time horizon before it reaps the expected returns). Therefore, in terms of market selection, larger firms may be more prepared to enter markets where there are greater uncertainties, as evident in Parkway’s more extensive internationalisation vis-à-vis the other case firms. In terms of entry modes, larger firms may be prepared to adopt higher commitment modes even in fairly unfamiliar markets at an early stage of market entry, for example, Parkway’s entry into India with a JV project in 1997 and its entry into China with a US$42 million purchase of the World Link Group in Shanghai in 2007.

8.3.3.2 Network

A firm’s network is another important resource which will influence its internationalisation. One of the findings from the cross-case analysis is the affirmation of networks as a useful facilitator for market entry (see section 7.3.1). It can be argued that a firm’s networks influence market selection, in that it may enter countries where it has good links to tap on; choice of entry mode, in that it will likely use collaborative modes for market entry when leveraging on an existing linkage; and timing of entry, in that market entry can be accelerated when there is a strong network to leverage on. Besides, a strong network enables the firm to expand its operation in a country quickly, if so desired, such as Parkway leveraging on Khazanah to grow in Malaysia and TMC leveraging on Protrade Corporation to grow in Vietnam.

8.3.3.3 International Business Experience

The internationalisation processes of the case firms were discussed in section 7.3.7, and it was evident that RMG and TMC both tapped on the international business experience of key executives whom they hired to shorten their respective learning curves for internationalisation. The study also showed that Parkway had the confidence to expand
to more distant markets given their greater experience in internationalisation (section 7.2.2). Therefore, it can be concluded that the international business experience of the firm (which can be boosted by bringing in key executives with healthcare internationalisation experience) influences the internationalisation of the firm in that greater international business experience made the firm more prepared to enter more distant market, adopt higher commitment mode and internationalise more quickly.

8.3.3.4 Specialised Assets, Reputation and Quality Assurance

Specialised assets, such as having a strong clinical team capable of performing certain highly complex procedures; a strong reputation; and quality assurance, such as being JCI accredited, are intangible assets which can help accelerate a healthcare firm’s market entry, as they enable the firm to gain acceptance in the new market more quickly. However, given the prevalence of collaborative entries by the healthcare firms from Singapore, a more important role played by these assets is that they provide leverage for the firms to attract local partners for market entry. In other words, they facilitate the creation of linkages and formation of networks, which then helps the firm in its internationalisation (see the discussion on “network” above). For example, TMC’s strong reputation in the areas of Obstetrics & Gynaecology and Paediatrics was the main reason why it was invited by a local partner to develop a new women and children’s hospital in Vietnam (section 6.4.2.1).

8.3.4 Nature of Product

8.3.4.1 Inseparability

On the nature of the product, inseparability was highlighted in extant literature as one of the characteristics of services (section 2.3.1). This factor has implications on the entry mode choice for firms, as non-separable or soft services cannot be exported in the same way as separable (or hard) services and manufactured goods. At present, healthcare service is still non-separable, hence healthcare firms are unable to use exporting as a mode to enter a foreign market.
8.3.4.2 Extent of Commodification

While healthcare services still cannot be exported in the traditional sense like goods or hard services, the increasing commodification of healthcare made it possible for healthcare firms to make market entry just by having marketing and sales channels in the form of representative offices (sections 7.2.3 and 7.3.1). The implication of this is that it enables the use of representative office as a low cost low risk, yet effective mode for market entry, especially for host countries with high risk or psychic distance. The possibility to use representative offices to enter markets effectively also enables faster market entry, as well as accelerated expansion within a market.

8.3.4.3 Capital Intensity

Capital intensity has also surfaced as one of the product-related factors that may influence a firm’s internationalisation. When discussing the case firms’ stated preference for management contract instead of joint venture as suggested by extant literature (section 7.3.3), one of the reasons suggested was the high cost involved in building and equipping a new hospital. Weighing against the case firms’ interest to internationalise quickly, the high capital intensity of the hospital business made market entry by management contract an attractive option. This suggests that capital intensity of the business needs to be considered when considering the entry mode to deploy.

8.3.5 Strategic Considerations

8.3.5.1 Motives for Expansion

In terms of strategic considerations, one of the key factors influencing the firm’s internationalisation is its motives for overseas expansion. As highlighted earlier, healthcare firms internationalise generally for market-seeking motives, though some are beginning to internationalise for efficiency-seeking reasons (sections 7.2.1 and 7.3.6). The motive for internationalisation has significant impact on market selection and entry mode. Where the motive is market-seeking, market potential will be the main consideration in selecting the host country; where it is efficiency-seeking, the availability of the right resources (for example, healthcare manpower of the right qualities, at lower cost and in adequate supply) will be a key consideration. Besides,
efficiency-seeking market entry would require setting up or acquiring a hospital or medical facility in the market. For market-seeking market entry, it is possible for a firm to enter with a lower-commitment representative office.

8.3.5.2 Business Strategy

The business strategy of the firm will influence the market selection, entry mode and timing. It is impossible to discuss all the different business strategies here but examples from the case studies include the deployment of hub-and-spoke strategy and the setting up of overseas hospitals to tap on lower cost resources there to cater to different segments of foreign patients. Using the example of the hub-and-spoke strategy, which is used by all the case firms in one way or another to attract patients to their hub hospitals, the strategy has implications on the firm’s choices in terms of market selection, entry mode and timing of entry. For example, Parkway expanded its hub-and-spoke network to many countries quickly, including some using representative offices to enable it to increase referrals to its hub hospitals in Singapore.

8.3.5.3 Degree of Control

While extant literature points to degree of control desired by the firm as a key influence on the entry mode choice (for example, Ekeledo and Sivakumar, 2004) and tends to equate control with ownership, these are becoming less so with the advent of the “global factory” form of MNEs, which are able to exercise control, even at great distance, without ownership (section 2.2.7.5). While degree of control remains a key consideration in the choice of entry mode, it is no longer necessary for firms to set up wholly-owned or at least majority-owned entities overseas for control to be exercised. Control can be equally imposed through a management contract arrangement, with or without the company having an equity stake. Examples of such market entries by the case firms include TMC in Vietnam and Parkway in the UAE. However, the limitation of management contract is that it will expire at some point, so where absolute and long-term control of an overseas entity is desired, ownership of the entity would have to be considered.
8.3.5.4 Owner’s Preferences

Family ownership was highlighted in Chapter 7 as a possible reason for the slow internationalisation by TMC and the slower-than-expected internationalisation by RMG (sections 7.2.4 and 7.3.5). The family-owner may have interests of their own, such as stability and capital preservation, which may not be consistent with the interests of other investors. Hence, we can expect the owner’s preferences to have an influence on the internationalisation choices made by the firm, especially timing of entry.

8.3.6 Influence of Regional Integration

In the conceptual framework, regional integration was posited as a factor that affects the “host country factors” and “strategic considerations”, which in turn will affect the internationalisation strategy of the firm. It was proposed that regional integration affects “host country factors” by expanding the “market potential”, as investment in new facilities in one country can effectively serve not just the population there but also the surrounding countries. It also affects “rules and regulations” with the streamlining of certain rules and regulations across the regional countries, and improves “availability of necessary resources” by reducing restrictions on cross-border movement of healthcare professionals. The full impacts of these influences have yet to be felt in ASEAN as the ASEAN Economic Community is only scheduled to be fully implemented in 2015. Their impacts should be felt more as the region integrates further.

On “strategic considerations”, regional integration is expected to affect “motives for expansion” by encouraging more efficiency-seeking investment as the barrier is lowered for firms to invest in other regional countries to leverage on their differentiated manpower resources, as well as “business strategy” by encouraging firms to step up their overseas expansion. These are generally supported by empirical evidence from the cross-case analyses (sections 7.3.6 and 7.3.9), though we should see more of such trends as regional integration deepens moving forward.
8.3.7 Conceptual Model for Internationalisation of Healthcare Firms

Taking into consideration the discussion above, the factors that are found to influence the internationalisation of healthcare firms, and their impact on market selection, entry mode choice and timing of entry, are summarised in Table 8.1.
Table 8.1 – Summary of the Influence by the Different Factors on the Internationalisation Strategies of Healthcare Firms

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<th>Factor Group</th>
<th>Factor</th>
<th>Influence on Internationalisation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Country factors</td>
<td>Market Size</td>
<td>Entry Mode – Firms from SMOPEC have a preference for collaborative modes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Timing – Firms from SMOPEC tend to internationalise rapidly</td>
</tr>
<tr>
<td>Government Support</td>
<td></td>
<td>Market Selection – Government support may influence firms to enter the countries targeted by the government’s facilitation efforts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Timing – Government facilitation may expedite market entry</td>
</tr>
<tr>
<td>Intensity of Domestic Competition</td>
<td></td>
<td>Timing – Intense domestic competition causes firms to more actively explore overseas opportunities</td>
</tr>
<tr>
<td>Status of Economic Development</td>
<td></td>
<td>Market Selection – “Second wave” MNEs from Newly Industrialised and emerging economies may have different focus in terms of market selection depending on the phase of internationalisation process they are in</td>
</tr>
<tr>
<td></td>
<td>Entry Mode – “Second wave” MNEs may prefer using collaborative modes for market entry</td>
<td></td>
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<tr>
<td></td>
<td>Timing – “Second wave” MNEs tend to internationalise rapidly</td>
<td></td>
</tr>
<tr>
<td>Region the Country is in</td>
<td>Market Selection – Focus will be on markets within the region; Firms from Asia tend to rely on networks in their market selection</td>
<td></td>
</tr>
<tr>
<td>Host Country factors</td>
<td>Market Potential*</td>
<td>Market Selection – One of the main considerations for market selection, since most of the overseas expansion are market-seeking</td>
</tr>
<tr>
<td></td>
<td>[Regional integration expands the market potential]</td>
<td>Timing – Firms will want to enter the market early where the potential is high</td>
</tr>
<tr>
<td></td>
<td>Entry Mode – Firms will want to progress towards higher commitment mode in markets with high potential, subject to risks and other factors</td>
<td></td>
</tr>
<tr>
<td>Country Risk</td>
<td></td>
<td>Market selection – High country risk makes a market less attractive, though it may not deter entry if potential is high</td>
</tr>
<tr>
<td></td>
<td>Entry Mode – Lower commitment mode preferred if country risk is high</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Timing – Slower entry or market expansion, if country risk is high</td>
<td></td>
</tr>
<tr>
<td>Rules and Regulations*</td>
<td></td>
<td>Market Selection – Unhelpful rules and regulations make a market less attractive, though it may not deter entry if market potential is high</td>
</tr>
<tr>
<td></td>
<td>[Regional integration streamlines rules and regulations]</td>
<td>Entry Mode – Certain regulations may rule out certain modes, for example, cap on foreign equity.</td>
</tr>
<tr>
<td>Psychic Distance</td>
<td></td>
<td>Market Selection – Firms tend to internationalise to a country with low psychic distance when they first start</td>
</tr>
<tr>
<td></td>
<td>Entry Mode – Use of lower commitment mode for a start if psychic distance is high</td>
<td></td>
</tr>
<tr>
<td>Availability of Necessary Resources*</td>
<td></td>
<td>Entry Mode – Lack of suitable resources may rule out certain entry modes</td>
</tr>
<tr>
<td></td>
<td>[Regional integration improves resource availability]</td>
<td></td>
</tr>
<tr>
<td>Normative Forces</td>
<td>Entry Mode – Where the culture, norms are vastly different, firm may need to enter with lower commitment mode first to understand the market; May also require the use of collaborative entry modes.</td>
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<tr>
<td></td>
<td>Timing – Normative forces may slow down entry; Besides, for many emerging markets, the investment proposal can take a long time to process.</td>
<td></td>
</tr>
<tr>
<td>Cognitive Forces</td>
<td>Entry Mode – Cognitive forces may influence firms to follow the entry modes of other MNEs.</td>
<td></td>
</tr>
<tr>
<td>Firm-Specific Resources</td>
<td>Firm Size</td>
<td>Market Selection – Larger firms may be more prepared to enter markets where there are greater uncertainty. Entry Mode – Larger firms may be more prepared to adopt higher commitment modes.</td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>Market Selection – The firm’s networks offer market entry opportunities. Entry Mode – Collaborative modes usually used by firms when leveraging on their network for market entry. Timing – Accelerated entry where there is a network to leverage on.</td>
</tr>
<tr>
<td></td>
<td>International Business Experience</td>
<td>Market Selection – Firms with greater international experience are more prepared to enter more distant markets. Entry Mode – Firms with greater international experience are more likely to adopt higher commitment mode. Timing – Faster internationalisation with greater international experience.</td>
</tr>
<tr>
<td></td>
<td>Specialised Assets</td>
<td>These assets help to accelerate market entry (ie, Timing), but more importantly, they provide leverage for the firm to establish network for market entry.</td>
</tr>
<tr>
<td></td>
<td>Reputation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality Assurance</td>
<td></td>
</tr>
<tr>
<td>Nature of Product</td>
<td>Inseparability</td>
<td>Entry Mode – Exporting is not possible for soft (non-separable) services.</td>
</tr>
<tr>
<td></td>
<td>Extent of Commodification</td>
<td>Entry Mode – Commodification enables the effective use of representative office as a low cost low risk entry mode. Timing – Use of representative offices enables market entry and expansion within a market to be done quickly.</td>
</tr>
<tr>
<td></td>
<td>Capital Intensity</td>
<td>Entry Mode – High capital intensity of hospital business leads to a preference to use management contract for market entry if quick internationalisation is desired.</td>
</tr>
<tr>
<td>Strategic Considerations</td>
<td>Motives for expansion* [Regional integration encourages more efficiency-seeking investments]</td>
<td>Market Selection – Different considerations when selecting markets for market-seeking vis-à-vis efficiency-seeking market entry. Entry Mode – Efficiency-seeking market entry would require setting up or acquiring a hospital or medical facility.</td>
</tr>
<tr>
<td></td>
<td>Business strategy* [Regional integration encourages firms to step up overseas expansion]</td>
<td>The firm’s business strategy influences its market selection, entry mode and timing; specific impact depends on the strategy adopted.</td>
</tr>
<tr>
<td></td>
<td>Degree of Control</td>
<td>Entry Mode – Control can be exercised using management contract arrangement, with or without the company having an equity stake.</td>
</tr>
<tr>
<td></td>
<td>Owner’s Preferences</td>
<td>Timing – Owner’s preferences have an influence on the firm’s internationalisation choices, especially timing of entry.</td>
</tr>
</tbody>
</table>

* Factors which are influenced by regional integration.
Based on the factors summarized above, the conceptual framework at Figure 4.1 is updated below in Figure 8.1. The updated diagram can be viewed as a conceptual model on the internationalisation of healthcare firms. It provides an overview of the key factors which this thesis has found to influence the internationalisation of healthcare firms, in terms of their market selection, entry modes and timing of entry.

Figure 8.1 – Proposed Conceptual Model on the Internationalisation of Healthcare Firms

As far as the author is aware, this is the first time a conceptual model has been developed specifically on the internationalisation of healthcare firms. The significance of this is that the model provides a framework for researchers to conduct future research on internationalisation of healthcare firms. Compared to prevailing models on internationalisation of service firms, the new model includes additional factors which have been found to have influence on the internationalisation behaviours of healthcare firms. The new model can also potentially be used for studying the internationalisation behaviours of other service firms as well, especially those with similar characteristics as healthcare service.

For the practitioners, the model presents a comprehensive set of factors that they should take into account when planning or reviewing their firms’ internationalisation efforts. It should be a useful reference for managers working in healthcare firms.
8.4 PHASES OF INTERNATIONALISATION PROCESS

Moving on to the third issue, this section shall examine if there are different phases that can be identified in the internationalisation process of the healthcare firms from Singapore.

Looking at the discussion for proposition 7 in the previous chapter, it is clear that the two healthcare firms from Singapore with longer history of overseas ventures went through four distinct phases during their internationalisation process, similar to those observed for the telecommunication firms from SMOPECs in the research by Laanti et al (2009). While they remained just an observation in the paper by Laanti et al (2009), it will be useful to better understand how these different phases could have come about, so that there can be a better appreciation of its application, not just to healthcare or telecom MNEs, but to other internationalising firms as well.

The four firms studied by Laanti et al (2009) were SingTel from Singapore, Telstra from Australia, Telia from Sweden and Sonera from Finland. In the realm of the telecommunication industry, these are smaller MNEs compared to the large telecom MNEs from the large developed countries and since they generally internationalise later than the large telecom MNEs, can be considered as second wave MNEs. Their circumstances are therefore similar to the healthcare firms studied in this research. Given that these are all second wave MNEs, the LLL framework proposed by Mathews (2006) can be applied to see if it explains the 4 phases.

As highlighted by Mathews (2006), second wave MNEs typically lacked the resources needed for internationalisation when they first considered expanding overseas. To overcome this handicap, they needed to start linking, leveraging and learning (Mathews, 2006). Hence, learning marked the start of their internationalisation process.

After they have gathered some experience in internationalisation, they had to internationalise rapidly, making full use of the transient advantage that they have gained (Mathews, 2006). This is the opportunistic phase, where the firm will seize all opportunities to expand overseas. They are not concerned to establish solid international
structures, but rather quickly develop flexible and “lattice-like” structures spanning diverse countries and markets.

However, as highlighted by Mathews (2006), such rapid internationalisation comes with higher risks and uncertainties than the normal incremental approach, since the company might not have all the market intelligence and information before it makes its moves. Hence, it is not unexpected that some of these ventures will fail, or at least, are not achieving the level of returns expected for the resources invested (under the framework proposed by Mathews (2006), the firm should insure itself against such failures by adopting lower commitment collaborative entry modes). Therefore, at some point, the firm will have to take stock of its overseas ventures and rationalize them. This is especially so when there are events that affect market sentiments, such as the financial crisis in the late 1990s. This is the de-internationalisation phase.

After the firm completes its rationalization, it would have learnt a lot from the earlier round of opportunistic expansion. It should now be clearer on its strengths and weaknesses vis-à-vis the various markets, and can formulate a more focused overseas expansion strategy, possibly riding on the a few key strategic footholds it has already developed. This is the maturisation phase. As can be seen from the Parkway and HMI cases, both emerged from the de-internationalisation phase more focused, and with a stronger platform to pursue further internationalisation.

The above shows that the four phases of internationalisation process observed in Laanti et al (2009) ties in well with the LLL framework proposed by Mathews (2006) for the internationalisation of emerging/second wave MNEs. Similar to the findings in Laanti et al (2009), some unique patterns of internationalisation were recognised in each of the phases of the internationalisation process which the case firms went through, though as can be expected, they may not be the same as the patterns exhibited by the telecoms MNEs. For example, in the opportunistic phase, the role of psychic distance was relatively smaller, while other factors, especially market potential of the host market, play a bigger role in influencing the market selection. However, psychic distance becomes more important as a factor in the later phases. The firms also adopted more collaborative and lower commitment modes during the opportunistic phase, while the bulk of their internationalisation activities were via higher commitment modes in the maturisation phase.
This finding highlighted the importance for the manager to recognize the phase that the firm is in and take the necessary measures to capitalize on the opportunities while avoiding the pitfalls. It also points to the need for managers of second wave MNEs to relook at their strategies as the firms enter different phases of their internationalisation process.

Notwithstanding the above, it should be emphasised that not all healthcare firms from Singapore will exhibit the phases of internationalisation process discussed, as they are linked to firms that internationalise in line with the LLL framework of Mathews (2006). It can therefore be expected, for example, that a firm that adopts a conservative or incremental approach towards internationalisation may never need to enter the de-internationalisation phase. However, this may also mean that they may not have exploited all the potential opportunities which could have been tapped for growth.

8.5 IMPACT OF REGIONAL INTEGRATION

One key objective of this research is to look at the impact which regional integration has on the internationalisation of healthcare firms from Singapore. As highlighted in the introduction, this is an important issue for healthcare firms from Singapore, as well as internationalising healthcare firms from other countries in the region, as regional integration will affect the way they operate within the region.

Some aspects of the firms’ response to regional integration were covered earlier in proposition 9 in Chapter 7. However, as ASEAN is in the process of moving towards regional integration, the observed behaviours probably did not reflect the potential full impact of regional integration on firm internationalisation yet. Therefore, to provide a better appreciation of the impact of regional integration on the internationalisation of healthcare firms from Singapore, a model needs to be developed on how the firms will behave in terms of their international operations when the region is more closely integrated. This will then provide a framework for considering the internationalisation behaviour of firms as the region integrates further.

The model will be developed taking into account the various existing internationalisation theories relating to the impact of regional integration, the context of
the regional healthcare industry, as well as the insights gained through this study regarding the internationalisation of healthcare firms.

8.5.1 Regional Integration and Expectations of Stakeholders

Before moving on to discuss the model, it is useful to first recap what changes can be expected as ASEAN integrates, and consider what the different stakeholder groups would like to see in the area of private healthcare (public healthcare is excluded here as that is largely the domain of the government).

As highlighted in Chapter 1, the ASEAN region is moving towards the ASEAN Economic Community by 2015. This will lead to changes in the operating environment for businesses, including healthcare. Some of the key changes that will happen include:

a) Liberalisation of investment control for ASEAN firms within the region. For healthcare, the ownership cap by foreign firms from within ASEAN has already been raised to 70% since 2010;
b) Liberalisation of movement by professionals; this is already covered in the Roadmap for Integration of Healthcare Sector in ASEAN, though some country-specific restrictions still remain. Some of these restrictions may be relaxed to facilitate greater cross-border movement of healthcare professionals as the region integrates;
c) Harmonization of business rules and regulations, which should lower the cost of coordinating activities across border;
d) Even freer movements across borders.

8.5.1.1 Expectations of Stakeholders

Given these and other changes arising from regional integration, the people will certainly like to have more choices, with respect to private healthcare services in the region. For those from developing countries in the region, they will desire choices of healthcare services at different price/quality combination to suit their needs and profile, with choices of decent quality facilities within their country or overseas. For people living in the more developed countries within the region, they will hope to have lower
cost alternatives, especially for those without insurance cover or those going for elective procedures.

The service providers will want to expand their appeal to cover as wide a population as possible, not just the rich travelling for premium healthcare but also more affordable offerings for the Middle Income or the more price-conscious groups. They will also hope to widen their geographic coverage as much as possible, to expand their potential customer base. This is especially important for Singapore-based healthcare groups, given their limited domestic population base. With a larger network, they will also seek to derive cost savings through economies of scale in purchasing and optimized usage of resources within the group, while hoping that the transaction cost for cross-border operations be reduced over time.

The government will hope that the private healthcare providers provide as many alternatives for their population as possible. This will relieve some pressure from the public healthcare system, especially for the groups that can afford private healthcare. They will also hope to gain economically through consumption of healthcare services by foreign patients, or for the less developed countries, by reducing the amount of leakage through their citizens travelling overseas for healthcare.

8.5.2 The Proposed Model

As discussed in Chapter 7, it was observed that healthcare firms are moving towards a “Global factory” model, albeit with some adjustments to take into account the service context. The concept of “Global factory” is therefore used as the basis in proposing a possible “ideal” model of a multinational healthcare service firm in an economically integrated region, which the healthcare firms can be expected to move towards.

Applying the key elements of a “Global factory”, the author proposes a parallel in the service industry of a “regional service network”. The term “regional” is used instead of “global” as the immediate application of the model will be in the regional context, where economic integration is more likely achievable than an integration at the global level. This is even more so for service firms, as Rugman and Verbeke (2008) have pointed out. The proposed model will be developed with the healthcare firms from
Singapore as the basis, and will take into consideration the interests of the different stakeholders.

8.5.2.1 “Fine-slicing” the Value Chain

First, the model will require some way of “fine-slicing” (or disaggregating) the value chain. As explained in Chapter 4, the offshoring process for services has to be treated differently from that for manufacturing, at least in the context of healthcare. While there are parts of the hospital service process that can be offshored and will continue to be offshored where it makes commercial sense (such as radiology services), their impact on the delivery of service is negligible. Therefore, the “fine-slicing” of production activities, which is a key feature of the “Global factory”, needs to be done differently for services.

Based on the strategies observed of the case firms, it appears that the firms offshore some of the “care” traditionally delivered at its hub hospitals to some of the spoke-hospitals, to capitalize on the factor advantages of the location. For example, when Parkway acquires a hospital in Malaysia, a patient staying near the hospital who used to travel to Parkway hospital in Singapore now has the option of using the cheaper service at this hospital, while still getting the quality assurance provided by the Parkway brand. This can be seen as “offshoring” the care from the hub to the new location. The care can now be delivered at a lower cost, and the patient benefits from the lower charges. A patient from Indonesia who used to fly to Singapore for treatment now also has the option of getting his or her treatment at this Malaysian hospital, or in Singapore. Again, if this patient chooses the new location, the care is “offshored”. While Parkway’s hospitals in Singapore may lose some of their existing patients to this new hospital, the firm as a whole gains from adding the population base at this new location, as well as the non-Parkway foreign patients who will now use Parkway’s services because of the more affordable pricing at this new location. The hospitals in Singapore may eventually gain, as patients with more complex illnesses will still have to be referred to them, and the enlarged pool of patients increased the potential pool of patients who needed to be referred to their Singapore hospitals.

To best match the competitive advantages of the location to the services to be delivered there, the disaggregation of value chain within the regional service network is likely to
be done based on the levels of care available. The care delivered at a hospital can
generally be classified into three levels, namely, secondary, tertiary and quaternary\textsuperscript{137}. Such an approach to disaggregate the value chain is already being done by Parkway to some extent, for example, it concentrates its capabilities for quaternary care in its Singapore hospitals.

8.5.2.2 The Regional Service Network

Under the proposed model, the “regional service network” will comprise of three parts – a regional hub with quaternary capabilities, sub-regional hubs with tertiary capabilities and local spoke-hospitals with secondary capabilities.

The regional hub will have the capabilities to treat all levels of illnesses, including highly sub-specialised cases. It is likely to have specialty centres with some tie-ups with research institutions, and is able to offer the latest treatment modalities available. The term “hub” does not necessarily mean a single institution but can comprise of a few institutions within a country covering the entire range of care. It will serve the local population as well as medical travellers referred to it.

The sub-regional hubs will have capabilities up to tertiary level, and are located at lower cost locations. They will target both locals and medical travellers, and may have their own networks of sub-regional spokes feeding them, as well as tap on the group’s larger network of spokes. They also serve as spokes for the regional hub, by referring patients who require higher standard of care or require more complex treatments that are not available at the centre.

The spoke-hospitals will comprise of local hospitals with largely secondary capabilities focused on serving the local population and will refer patients to the hub or the sub-regional hubs for more complex cases.

There will likely be other spokes in the forms of clinics/medical centres/representative offices, which already existed today, but will not be included in this discussion, as they do not form part of the direct hospital care value chain.

\textsuperscript{137} Quaternary care is considered an extension of “tertiary care” and includes advanced levels of medicine that are highly specialised, not widely used (for example, experimental medicine) and very costly. Quaternary care is typically provided by tertiary care centres (Green and Bowie, 2010: p12).
The combination of the hub/sub-regional hubs/spoke-hospitals offers a range of choices for the patients, who can make their selection depending on the level of care they need and their preferences according to their own price/quality trade-offs. For the firm, it is able to leverage on the comparative advantages of the different locations to increase the range of choices for the patients and attract a wider patient-customer base.

In addition, the presence of the sub-regional hubs and spoke-hospitals closer to the target markets allows the group to better adapt their products, services and marketing campaigns to the needs, preferences and cultures of the local population. It also allows the patients to receive the higher quality “branded” care closer to home, which can represent a significant cost savings in some cases, as certain Asian culture sees the entire family following the sick to the treatment destination for the entire duration of treatment.

8.5.2.3 Ownership

In terms of the relationship between the group and the spoke-hospital, the group could either own it through a joint venture or manage it via a management contract, both of which enable the group to have control over the operation. Joint Venture is preferred to ensure longer term continuity of the relationship, though contract management can be adopted to enable more accelerated internationalisation, especially if the partner has the same long term outlook as the group. There is also the possibility for the group to acquire an existing chain to provide the sub-regional/spoke network for a particular sub-region, similar to Parkway’s acquisition of Pantai in 2005.

8.5.3 Evolution towards the “Regional Service Network”

The main concept behind the above model is offshoring. While the Singapore-based hospitals currently attract patients to their home base to undergo treatment, from secondary to quaternary level care, the model argues for some of the “care” to be offshored. The firm will then have its secondary and tertiary level care also available at other locations, at a different price and service level, and with relevant local adaptations. The patients thus have more options when they need care at the secondary or tertiary level.
The proposed “regional service network” for healthcare takes into account the opportunities that can be capitalized on in an economically integrated region, as well as the nature of healthcare as a service trade. It is a win-win model for all the stakeholders – patients get their choices, providers get their growth, and governments are happy that the country gains revenue by serving foreign patients (via the sub-regional hub) or by retaining some of the patients who would otherwise have travelled for healthcare (when spoke-hospitals are set up within the country). Given that the pie for healthcare is growing, with population growth, aging population, and rise of health issues linked to growing affluence, the gain by one country needs not be the loss for another. For the system as a whole, it is most efficient to tap on the comparative advantages of the different countries to get the most optimal outcome, which in this case, is better health for the population in the region. The big question is how to do this in the most sustainable way (for example, with minimal travel, at reasonable cost, and so forth) and also best serve the needs of the people (for example, providing choices, localization, and so forth). With healthcare MNEs internationalising in the region towards the model proposed, it has the best hope of achieving both.

As discussed in chapter 7, Parkway already owns such a network to some extent. For example, its network of hospitals in Malaysia includes two tertiary hospitals which have been known for attracting a good number of medical travellers, mainly the more price-conscious Indonesians. However, Parkway’s network has yet to reach the pervasiveness and potential of a fully implemented regional service network. Such hub-and-spoke service network is common within large developed countries like the USA, and is being developed in developing countries such as Thailand and Malaysia by the leading healthcare groups there. With regional integration, it provides the setting for such networks to be extended throughout the region, hence allowing the healthcare MNEs to cover an even greater pool of patient-customers, as well as providing more opportunities to capitalize on the factor advantages of the different countries, more than can be achieved for networks within the same country.

One constraint in moving towards such a network is the availability of professional staff with the necessary level of proficiency to provide the level of care expected of the firm. It will be disastrous for the group to open a hospital in a location where the standard of care cannot meet the group’s own expectation, as any incident arising from that facility
will affect the image and branding of the entire group. In a way, Malaysian hospitals are now ready to form part of such a “regional service network” because they have improved over the years to the extent that their quality of care is close to the level in Singapore, at least for the majority of cases. There are certain complex procedures or treatments where the medical teams in Singapore still have an advantage over the Malaysian hospital, though the gap is expected to close over time.

Over time, as equipment becomes more powerful and medical standards become higher even in the less developed countries, more countries will be ready for the establishment of hospitals as part of the regional service network. Besides, the return of doctors from these developing countries who had studied and worked in the developed countries would also add to the skills and expertise within the healthcare systems in those countries. This was the case of India, which was able to develop its private healthcare sector over the past 10 years due to the return of many Indian doctors who had previously worked in the USA.

While these countries who freshly cross the “threshold” of care quality are not expected to immediately deliver the same premium quality of care delivered at the hub hospitals, the much lower prices would nevertheless make them attractive for patients looking for healthcare services that are higher quality than what were previously available locally and yet significantly cheaper than the cost of travelling to another country for the care, especially for the more routine treatments with low risk of complications. The branding of the group would also have provided some assurance to the standard of care.

8.5.4  Further Impact of Regional Integration

The viability of developing a fully trans-regional service network is subject to many factors, such as the extent of economic integration achieved, the speed with which the healthcare standards in the developing countries in the region catch up, and so forth. Hence, it may be some time before such developments take place at full swing.

Nevertheless, healthcare development in the region can be expected to move towards that gradually, especially with the full implementation of the ASEAN Economic Community. Therefore, we can expect the leading healthcare MNEs to move towards setting up their own respective regional service networks. While some firms may view
setting up of medical facilities overseas or helping overseas facilities improve as a 
potential cannibalization of their business interests back home, the important 
consideration is that if they do not do so, other firms will. When that happens, the more 
difficult medical cases will be referred to hospitals in these competitors. In the longer 
run, those firms which do not build up their networks of healthcare facilities overseas 
will be starved of referrals.

It can therefore be postulated that with regional integration, all the leading operators in 
the various “medical hubs” within the region will compete to set up their respective 
regional service networks, so as to safeguard their channels of foreign patients. This 
means that internationalisation by healthcare MNEs in the region will increase and there 
will be further consolidation within the regional healthcare market. Healthcare MNEs 
from small countries like Singapore are likely to compete particularly strongly, as they 
are under even greater pressure to secure the foreign markets given the constraint of 
their small domestic population.

8.5.5 Applicability of the Proposed Model to Other Contexts

The proposed “regional service network” model was developed and discussed above 
using with Singapore healthcare firms and the ASEAN region as the context. As 
discussed in Chapter 7, healthcare MNEs from Singapore tend to be more externally-
oriented and will actively seek overseas expansion opportunities given the limitation of 
the domestic market. Therefore, although the model may be considered for firms from 
other countries in the ASEAN region, those firms may have a different propensity 
towards internationalisation, given their different home country circumstances.

Further, the generic nature of the “regional service network” model means that it may 
be considered for application to other services with similar characteristics as healthcare. 
It can certainly be considered for application to healthcare firms from other SMOPECs 
in regions undergoing similar integration process as ASEAN.

8.6 CHAPTER CONCLUSION

This Chapter had sought to discuss the results from the cross-case analysis in relation to 
four issues that have emerged from this research.
The first section proposed a characterization of how a private healthcare firm from Singapore internationalises, in terms of its overall strategy, market selection, entry mode and timing of entry. While there is scope to apply the characterization to other context such as other service firms from Singapore or healthcare firms from other SMOPECs, caution needs to be exercised when applying the characterization, as there may be circumstances that cause the internationalisation of certain firms to deviate from the “typical” behaviours expected of them, such as the attitude of the controlling shareholder towards internationalisation as highlighted in Chapter 7.

The second section proposed a conceptual model on the internationalisation of healthcare firms. The model was developed by identifying factors which were found to have influenced the internationalisation of healthcare firms from Singapore, based on the findings from the case studies and the cross-case analysis, and then updating the conceptual framework proposed in Chapter 4. Compared to prevailing models on internationalisation of service firms, the new model includes additional factors which have been found to have influence on the internationalisation behaviours of healthcare firms. The model should be useful for researchers for future research on internationalisation of service firms, especially healthcare firms, and as a reference for practitioners.

The third section noted that healthcare MNEs which have embarked on internationalisation for some time go through 4 phases of the internationalisation process, namely, learning, opportunistic, de-internationalisation and maturisation, rather than an incremental straight-line progression. Further evaluation showed that the 4 phases were well-aligned with the LLL framework proposed by Mathews (2006) for emerging/second wave MNEs. The finding highlighted the importance for the manager to recognize the phase that the firm is in and take the necessary measures to capitalize on the opportunities while avoiding the pitfalls. The establishment of the theoretical basis for the observed phases of internationalisation process also highlighted that not all healthcare firms venturing overseas from Singapore will exhibit the phases of internationalisation process discussed, as they were linked to firms internationalising in line with the LLL framework, rather than healthcare firms from SMOPECs per se.
The fourth section sought to derive further insights on the impact of regional integration on internationalisation of healthcare firms from Singapore by proposing a possible “ideal” model for a multinational healthcare service firm in an economically integrated region. Adapting from the concept of “Global factory”, it was proposed that firms will move towards a “regional service network” comprising of a regional hub, sub-regional hubs and local spoke-hospitals. The implication of such a trend is that internationalisation by healthcare MNEs in the region will increase and there will be further consolidation within the regional healthcare market, as the region integrates further. Healthcare MNEs from small countries like Singapore will compete particularly strongly, as they are under even greater pressure to secure the foreign markets given the constraint of their small domestic population.

The findings arising from the discussion of the four issues offer new perspectives to the study of internationalisation of service firms. There is scope for these new perspectives to be further tested in other similar situations, such as on healthcare firms from other SMOPECs, or be applied more generally to other service firms with similar characteristics as healthcare.

The next and final chapter summarizes the study and points out the contributions which the research had made to practitioners and to knowledge on internationalisation of firms. It also discusses the implications of the thesis for managers, business owners, investors and the policy makers, as well as addresses the limitations of the study and suggests directions for future research.
CHAPTER 9 – CONCLUSION

9.1 INTRODUCTION

The objective of this final chapter is to summarise the main findings of the thesis. The chapter will also draw conclusions from the findings, and show how the thesis has contributed to the body of knowledge concerning international business. The implications of the findings to managers involved in internationalisation of healthcare firms, business owners and investors, and policymakers are also presented. Finally, limitations encountered during the study are highlighted and suggestions for future research are made.

9.2 SUMMARY OF MAIN FINDINGS

The origin of this thesis was to look at the phenomenon of established hospital groups expanding beyond their home country by setting up operations in less developed countries, and patients travelling outside their country for healthcare services. These are areas which are seeing exciting developments due to globalisation, but have been under-researched over the years. The research studied the phenomenon by looking at the internationalisation of four private healthcare firms from Singapore using a multiple-case study approach.

Leveraging on the author’s in-depth primary knowledge of the industry and the case firms, and extensive analysis of data on the four firms, detailed analyses of the four cases were presented in Chapter 6. Results of the cross-case analysis were presented in Chapter 7, along with examination of nine propositions relating to various behaviours expected of the firms based on extant theories.

9.2.1 Findings Relating to Existing Literature

The analysis has yielded findings which enhanced the understanding of the internationalisation of healthcare firms. The analysis of the four case firms showed that the internationalisation strategies adopted by healthcare firms from Singapore, in relation to market selection, entry modes and timing of entry were well-explained by the
latest theories on internationalisation of firms, some of which the older theories might not have been able to explain.

For example, the Uppsala 2009 Model (Johanson and Valhne, 2009) helped to explain certain market selections which deviated from the incremental market entry model proposed by Johanson and Valhne (1977, 1990), such as TMC’s entry into Vietnam and Parkway’s JV in Brunei and management contract in the UAE. The extensive use of collaborative market entry modes and the unusually fast rate of internationalisation by Singapore healthcare firms were rationalised by the internationalisation behaviour of emerging/second wave MNEs as articulated by Mathews (2002, 2006). In addition, existing theories on internationalisation of firms from SMOPECs (For example, Hirsch, 2006; Benito et al, 2002) explained the outward orientation of the firms and the significant role played by the government in supporting their internationalisation. On the other hand, Rugman and Verbeke (2008)’s argument that service firms have regional focus was useful in explaining the failure of Parkway’s failed entry into the UK healthcare market. Nevertheless, it was also observed that the behavioural model advocated by Johanson and Valhne (1977; 1990) still have significant application, at least for healthcare firms, as the case firms generally still sought to enter their neighbouring markets when they first started their internationalisation.

One deviation from the theory involved a case firm which did not appear to be as aggressive in venturing overseas as would be expected of a firm from Singapore. This led to the identification of ownership of the firm as a key factor which may influence how the firms choose to internationalise, notwithstanding the environmental factors that compel it to do so. In particular, it was noted that as family-owned firms may follow the preferences of the owner rather than the most profit-maximising approach, they may not internationalise as actively as can be expected.

The study also identified that the way healthcare services are developing in the ASEAN region – the emergence of regional transnational demand for healthcare, and the availability of locations within the region with different factor advantages which a healthcare MNE can tap on – made “Global factory” (Buckley and Ghauri, 2004) a relevant model for studying healthcare MNEs in the region. However, significant adaptations need to be made to fit the model to healthcare services, given that the “Global Factory” model was developed largely based on the manufacturing sector rather
than the services sector. Analysis showed that to varying degrees, each of the hospital operators is adopting a hub-and-spoke strategy, leveraging on its network of clinics/medical centres/hospitals/representative offices to bring in patients from overseas. However, at this moment, only one firm had been actively setting up spoke-hospitals overseas which leverages on the relative strengths of the different locations within the region, though others are starting to move in that direction.

Specifically on the internationalisation of healthcare MNEs, the study showed that healthcare services in Singapore is undergoing commodification like that observed in Malaysia (Chee, 2007) and US (Stoeckle, 2000), with the increasing use of and emphasis on ‘marketing’ as an important activity by which to procure patients-customers; the increasing emphasis on quality, and in order to achieve it, the use of benchmarking and standardization in accordance with internationally recognised markers; and the creation of customers and consumers. In terms of internationalisation, this has made healthcare services increasingly “exportable” in the sense that they can be “sold” overseas away from the point of “production”, via representative offices. This is demonstrated in the extensive use of representative offices as a mode of market entry by the healthcare firms from Singapore. This is an interesting insight as much of the literature on entry modes for service firms have considered soft service, which healthcare still is, to require non-export modes such as sole ownership, joint venture, franchising, or management contracts for foreign market entry. Another deviation from literature was the case firms’ stated preference to make market entry using management contract instead of joint venture. This can be attributed to their strategic need to internationalise quickly and the high cost of building new healthcare facilities, which resulted in their preference for lower commitment/lower risk entry mode, notwithstanding the threat of their FSAs being copied by the partner firm. In any case, the firms will usually negotiate for an option to acquire stakes in the venture to be embedded in the contract, which will give them the option to turn it into a joint venture later.

9.2.2 New Perspectives Derived from the Study

The results from cross-case analysis were discussed in Chapter 8 in relation to four issues that emerged from this research, namely, the internationalisation strategy of a private healthcare firm from Singapore, factors that influence the internationalisation of
healthcare firms, the phases of internationalisation process, and the impact of regional integration. The aim was to derive new perspectives which will be useful both for the academic community as well as the practitioners.

Briefly, using the findings from the study, it was possible to characterise an internationalising healthcare firm from Singapore as follow: In terms of overall internationalisation strategy, it is expected to adopt a hub-and-spoke strategy to bring patients to its hub hospitals. It is able to leverage on the support provided by the government for its overseas ventures and usually seeks a suitable international accreditation to help attract foreign patients. In terms of market selection, the firm will still generally start with neighbouring countries where ‘psychic’ distance is short, but that does not preclude it from internationalising to more distant markets at an early stage should there be an appropriate network or link which it can tap into. Its focus will be regional, rather than global. In terms of entry modes, the firm will use collaborative entry modes for market entry, to link up with sources of resources which it can access. It has a preference to use management contracts with embedded option for the market entry, and will use representative offices for entering markets which are attractive but is not yet suitable for use of high commitment modes of entry. In terms of timing of entry, the firm will internationalise rapidly. And as the region integrates further, the firm emphasises even more on regional strategy, steps up its overseas expansion, looks for mergers and acquisitions opportunities and works towards deploying location strategy which exploits even more on differentiated manpower resources in locations within the region.

Based on the findings from the case studies and the cross-case analysis, factors that were found to have influenced the internationalisation behaviours of the case firms were identified, and the conceptual framework proposed in Chapter 4 was updated to develop a conceptual model on the internationalisation of healthcare firms. The proposed conceptual model therefore provides an overview of the factors which may influence the internationalisation behaviours of healthcare firms. The new model offers a useful framework for future research on internationalisation of service firms, especially healthcare firms. It also highlighted additional factors which may influence the internationalisation behaviours of service firms, compared to prevailing models on internationalisation of service firms.
On the internationalisation process, it was observed that the internationalisation processes of healthcare MNEs from Singapore have not been linear; for the two firms which have embarked on internationalisation for some time, they were observed to have gone through four phases of internationalisation process, namely, learning, opportunistic, de-internationalisation and maturisation. These phases were first observed by Laanti et al. (2009) in their study of internationalisation of telecommunication firms from SMOPECs. Further analysis via this research showed that the four phases tied in well with the LLL framework proposed by Mathews (2006) for emerging/second wave MNEs.

Some common patterns in the internationalisation of firms in each of the phases were identified. For example, during the learning phase, the firms find ways to learn about internationalisation, including by serving foreign patients in their existing hospitals and acquiring hospitals with experience in internationalisation. In the opportunistic phase, the firms began to actively expand their operations overseas, including countries from where the patients they had been serving come from, as well as more culturally and physically distant markets with great potential. During the de-internationalisation phase, operations that were not viable were closed down, and the firms’ internationalisation strategies became more focussed. Finally in the maturisation phase, the firms started to grow their businesses again, focussing on the neighbouring markets and the region. They also became more focused in their internationalisation strategies. From the perspective of market selection, psychic distance appears to play a smaller role in the opportunistic phase, with other factors such as market potential having a bigger influence; psychic distance becomes more important in the later phases. There are also differences in the main entry modes deployed for the different phases, with greater use of collaborative and lower commitment modes during the opportunistic phase, and higher commitment modes in the maturisation phase.

On regional integration, a possible “ideal” model for a multinational healthcare service firm in an economically integrated region was proposed, to enable further examination of its impact. Adapting from the concept of “Global factory” proposed by Buckley and Ghauri (2004), the proposed “regional service network” comprises of a regional hub, sub-regional hubs and local spoke-hospitals. Unlike for manufacturing, it was proposed that disaggregation of a service can be done by elements of the value chain rather than by production activities. The implication is that as the region integrates further and as
each firm evolves towards such a network, internationalisation by healthcare MNEs in the region will increase and there will be further consolidation within the regional healthcare market. Healthcare MNEs from small countries like Singapore will compete particularly strongly, as they are under even greater pressure to secure the foreign markets given the constraint of their small domestic population.

### 9.3 CONTRIBUTIONS AND IMPLICATIONS

#### 9.3.1 For Theory

This study contributes to the research on the internationalisation of service MNEs, MNEs from small economies, emerging/second wave MNEs and healthcare MNEs by providing data on the internationalisation of healthcare MNEs from Singapore, by developing a conceptual model to analyse the internationalisation strategies, and identifying factors influencing these strategies. The study not only covers the overall internationalisation strategy of the firms but also the three dimensions that make up the internationalisation process – entry modes (how), choice of markets (where) and timing of entry (when). The study also studied how regional integration has influenced the internationalisation strategies.

As highlighted in the summary in the previous section, the empirical data demonstrated that the internationalisation strategies of the case firms, in relation to their market selection, entry modes and timing of entry, were generally well-explained by the latest theories on internationalisation of firms. These show the robustness of some of these recent theories and their applicability to healthcare firms and possibly to service firms in general. The study also highlighted some deviations to the theories, which were analysed and addressed.

This research project aimed to extend traditional theories by providing more understanding of the internationalisation of service MNEs from Singapore. It focused on healthcare companies, thus the findings are limited to this particular type of companies. However, it is argued that the results could also be applicable at some level to other service firms with similar service characteristics facing similar challenges. Results can also be applied to MNEs from other small countries, which are still at an early phase in their internationalisation development.
This research project also aimed to extend theories on service MNEs by providing more understanding of the internationalisation of healthcare MNEs, a particular service sub-sector which has historically been under-researched. This paper provided further evidence on the increasing commodification of healthcare services, as the extensive use of representative offices for market entry showed that healthcare services are now marketed and sold overseas almost like service commodities, though consumption still has to take place at the home base. More importantly from the internationalisation perspective, healthcare firms now have low risk low cost ways of entering market to better understand it before making higher commitment entry. The observation of a preference by healthcare MNEs to use management contracts instead of joint ventures in relation to collaborative modes of entry was another key contribution.

The characterization of an internationalising healthcare firm from Singapore discussed in Chapter 8 and summarized in the previous section offers a model which can be tested or applied in other relevant contexts. These include internationalisation of other service firms from Singapore, healthcare firms from other SMOPECs, other service firms from other SMOPECs, or even healthcare firms in general.

The study also proposed a conceptual model on the internationalisation of healthcare firms. The proposed model makes a useful contribution to extant literature in terms of highlighting additional factors which should be considered when studying the internationalisation of service firms, including some which are needed to explain the internationalisation behaviours of healthcare MNEs. The proposed conceptual model also offered a useful framework for researchers to conduct further research on internationalisation of healthcare firms. It should also be a useful framework which can be adapted by researchers for research on internationalisation of other services.

The study offered a new perspective in the study of internationalisation of firms by examining the phases of internationalisation process of the firms and linking the observed behaviour to the LLL framework proposed by Mathews (2006) for emerging/second wave MNEs. By identifying the phases of internationalisation process which emerging/second wave MNEs go through, it provides a new perspective for the analysis of firm internationalisation.
Lastly, this research project had sought to improve the understanding of how regional integration influences the internationalisation strategy of these healthcare firms. The study showed that healthcare firms from Singapore exhibited the behaviours as expected from extant literature – increasing emphasis on regional strategy, active seeking of opportunities for mergers and acquisitions, and deploying location strategy which tap even more on differentiated manpower resources in locations within the region. The study further extends existing theories by adapting the concept of “Global factory” to propose a possible “ideal” model of a multinational service firm in an economically integrated region. The paper also proposes a new way to disaggregate a service, and develop the “regional service network” as the services industry equivalent of the “Global factory”. The application of this model on the healthcare firms from Singapore has yielded further insights on the impact of regional integration on healthcare MNEs.

Notwithstanding that the “regional service network” model discussed was developed to study the impact of regional integration on internationalisation of healthcare MNEs, it is an interesting model that can be considered for application to other services with similar characteristics as healthcare. This offers an idea for possible future research on internationalisation of service firms. The model can certainly be considered for application to healthcare firms from other SMOPECs in regions undergoing similar integration process as ASEAN.

9.3.2 For Managers

Beyond the contributions to theory, this study aims to make key contributions to managerial practice for the healthcare service sector.

In general, the research has provided a better understanding of the internationalisation strategies and choices adopted by healthcare firms from Singapore. The conceptual model developed in section 8.3 provides a useful framework to analyse these issues and the dynamics between the different sub-strategies and the different groups of factors. The detailed discussion on the various aspects of internationalisation, including market selection, entry modes and timing of entry, as well as the characterization articulated in section 8.2 will also be useful reference for managers. For managers of healthcare firms which are already venturing overseas, it offers a point of reference to review their current efforts. For managers of firms planning to venture overseas, the findings offer
them a useful basis to decide how they wish to go about it. The ultimate challenge faced by managers will be to identify the optimal mix of internationalisation strategies to achieve their objectives for venturing overseas, bearing in mind the various changes that are happening in the industry, such as globalisation, regional integration and commodification of healthcare services.

More specifically, the conceptual model proposed in section 8.3 contributes to managerial practice by identifying the various factors which may influence the internationalisation choices to be made by healthcare firms. This is the first time that such a model has been specifically developed for healthcare firms, so hopefully it will create a breakthrough in terms of the understanding on the internationalisation behaviours of these firms.

With the conceptual model developed, a further contribution which the thesis aims to make is to have an in depth discussion on the managerial implications of the findings, and through that, help managers of healthcare firms to understand not just how they can pursue internationalisation but more importantly, how to do it effectively.

To recap, the conceptual model involved five groups of factors that may influence the internationalisation choices made by healthcare firms. The implications of each group of factors will be discussed in turn, followed by the implications of changes that regional integration may bring and of other findings arising from the study. The applicability of these managerial implications in other contexts will also be discussed.

9.3.2.1 Leveraging on Home Country Advantages

On the home country factors, it was proposed that market size, government support, intensity of domestic competition, status of economic development and region the country is in have influences on the internationalisation choices to be made by the healthcare firms. Of these, four of the factors are beyond a firm’s control, namely, market size, intensity of domestic competition, status of economic development and region the country is in; government support is the only one where the firm can potentially try to influence.
As discussed at section 8.3, where the country size is small or the domestic competition is intense, or both (such as in the case of Singapore), there will be pressure for the healthcare firm to pursue growth overseas, partly to seek additional demand for its service and partly to create greater economies of scale for its business. The question is – how do they internationalise, especially if they are small and lacked resources? For small countries, researches have shown that the government usually recognises the limitations faced by their firms and offer support in various forms. Managers of healthcare firms from small countries should always try to leverage on the government’s facilitation for their firms’ internationalisation, as the government has more weight in helping to open doors (for example, organising trade shows overseas or helping to match-make collaboration partners). The government can also publicise the quality of healthcare services in the country, thereby providing a “reputation” which all the home firms can leverage on. Firms can also look at using collaborative modes of entry to reduce the cost and risk of the market entry, while enabling it to enter the market quickly, if there are partners they can link up with.

Where the domestic competition is intense, firms usually have the advantage of having strong systems and processes in place, relative to healthcare firms in other countries where there are less competition. This is because the intense competition forces the firms to constantly upgrade and improve to keep up with one another in terms of quality and standards. This makes the firms attractive to overseas partners, which is a strength the managers can leverage on when pursuing internationalisation.

While it was mentioned above that firms should always try to leverage on government’s support for their internationalisation, managers should realise that government officials are not practitioners and hence, they will not know what support is most needed by the industry unless the industry communicates its needs. Therefore, it is important for the private healthcare firms to have regular communication with the government on the types of support they need, including for internationalisation. This is especially important for private healthcare operators from small countries, where such support will be even more critical for them. The industry should give feedback on the countries to target and the types of facilitations most needed by them from the government. Smaller operators may sometimes have to request for separate communication with the government, as the larger firms may have better access to the government, and the types of support the large and small firms need may be different. Other than specific support
for market entries, the private healthcare firms could also lobby the government to help in overcoming certain entry barriers in specific markets (which may have to be taken up at the government-to-government level), as well as to push for further progression in regional integration, if that is desired. The industry can also give their support to government’s efforts to strengthen the healthcare industry, such as enhancing the training and education of healthcare professionals, or development of the pharmaceutical and biomedical industries, all of which are part of the healthcare ecosystem.

In terms of status of economic development, for firms from emerging or Newly Industrialised Economies, managers should leverage on the strength of their firms as second wave MNEs for their internationalisation. One reason why second wave MNEs like Acer (for computers) and Samsung (for mobile phones and other electronic equipment) have been successful in their internationalisation in the face of competition from larger and more established firms from the developed countries was a combination of their lower cost structure with manpower and technology of equal competence as the developed countries. The same situation is applicable to healthcare, where Asian providers, for example, in Singapore, Thailand and Malaysia, have been able to provide healthcare services of equivalent quality to that in the developed countries at significantly lower cost. This was one of the driving forces behind the growth of medical tourism, which attracted patients from developed countries like the US and Japan to travel to ASEAN countries for healthcare. Increasingly, healthcare firms from Singapore are also sought-after as collaboration partners for setting up new hospital, for example, the management contract secured by Parkway in the UAE, where in the past, the Middle Eastern countries usually look to top hospitals in the developed countries for such projects. However, as discussed in the literature on second wave MNEs, managers have to be mindful that the advantages their firms enjoy are transient, so they should internationalise their firms quickly while the window of opportunity is still open. For example, as hospitals in Malaysia and Thailand gain greater experience in internationalisation, they may become more attractive collaboration partners than the Singapore operators by virtue of their lower costs.

On the region the country is in, managers have to bear in mind that their firm’s firm-specific advantages tend to be region-bound, hence it would be advisable to keep their focus on internationalising within the region. While they may come across opportunities
outside the region which appear attractive, they may want to start with some low commitment mode such as representative offices to understand the market first before considering any major investments. The managers will do well remembering the difficulties Parkway faced in their short entry into UK.

9.3.2.2 Mitigating Host Country Factors

On the host country factors, the conceptual model suggested that market potential, country risk, rules and regulations, psychic distance, availability of necessary resources, normative forces and cognitive forces should be considered in making internationalisation choices.

All of these factors are beyond the firms’ control, at least for the short-term; hence, they may impose certain constraints on the firm’s internationalisation choices. However, for rules and regulations and availability of necessary resources, these are factors that can potentially be addressed in the longer run. In particular, rules and regulations can potentially be changed over time, for example, through dialogue with the government (especially where a win-win arrangement can be worked out), working with the relevant interest groups (for example, the hospital association in the host country), or seeking help from the home government to raise the matter with the host government. In terms of resources, the managers can work on raising the competency of the staff in the host country, if there is an existing competency gap. They can, for example, set up a training institute to train or retrain their staff there, similar to what the Singapore government did when they invested in the Suzhou Industrial Park in China in the 1990s, where they set up a training institute to train workers for the park using Singaporean trainers and curriculum. The firm can also arrange for the host country staff to be sent to their home base for short attachments or postings.

For factors like country risks, rules and regulations, psychic distance, normative forces and cognitive forces, these are sometimes too complicated for the managers to address on their own, certainly not within a short time. However, there are various options that are available to the managers, for example:
a. Enter the market using collaborative mode with a local partner; however, the firm will have to first find a reliable and committed partner. This will be discussed in greater details under the firm-specific resources later;

b. “Acquire” market experience by hiring a senior executive with experience operating in the target country (possibly a local of the target country) to lead its entry into the market. The sharing by Dr Jonathan Seah, former Parkway CEO for China, on how he tapped on his Business School alumni network to assemble a small team of employees to kick start Parkway’s exploration process in China in 2004 (section 6.2.2.6) was insightful on how normative forces can be overcome through use of local staff who are familiar with the forces at work in the country;

c. “Acquire” a local entity to quickly gain a base from which the firm can grow, though this is a potentially high risk strategy, given the commitment needed. As former Parkway CEO for China, Dr Jonathan Seah, shared, this was the reason for Parkway’s purchase of the World Link Group in Shanghai, China in 2007, ie, “to give us a base of people that we can use to help us grow very quickly.” (section 6.2.2.6)

d. Learn more about the market through a low commitment mode such as a representative office; this offers the opportunity to learn about and explore opportunities within the market, while learning more about the needs and idiosyncrasies of patients from the country by serving them in the home hospital. Much patience will be needed in the initial phase of the entry, though things will become easier as the firm gains experience on servicing the market.

As highlighted in the conceptual model, the manager can possibly address the cognitive forces by following the entry mode used by other successful market entries, especially by firms from the same home country, as this may be an easy way for the entity to gain “legitimacy” quickly.
9.3.2.3 Leveraging and Strengthening Firm-Specific Resources

On the firm-specific resources, factors highlighted in the conceptual model were firm size, network, international business experience, specialised assets, reputation and quality assurance. Other than firm size, which is a given, there are ways the managers can leverage or strengthen the other factors.

The firm’s network has significant influence on the internationalisation choices of the firm, and the importance of linkages and leverage is one important finding that arose from this study. Therefore, an important implication for managers will be how they can go about establishing the necessary networks. There are many ways to do it, and it will not be possible for a comprehensive discussion on this subject in this thesis, but broadly, the following are some strategies they can adopt:

a. Attending industry seminars and networking events, and possibly give talks or be panellists at such events. This is one of the ways to get to meet other people within the industry and to raise the profile of the firm;

b. Leverage on facilitation by the home government, for example, participating in trade mission or trade shows organised by government agencies as part of their efforts to promote the healthcare industry;

c. Building networks from scratch in the host country, for example, by setting up a representative office there to explore opportunities and develop relationships;

d. “Acquiring” key executives with relevant networks.

One important point that managers have to bear in mind is that besides trying to establish networks, for the network to bear fruits in terms of market entry collaboration, the firm itself must have some strategic assets of interest to the other party. This is where the other factors, namely, specialised assets, reputation and quality assurance come in.

Specialised assets can include specialised clinical teams, innovative information technology systems, industry-leading business processes, and so forth. These are built
up over time by the firm, and may be difficult to be achieved within a short time. Given the benefits that such assets can bring in terms of facilitating formation of networks, managers should consciously seek to develop them, and if the firm already have such assets, to find ways to sustain them. Managers should also bear in mind that it will be easier for them to develop specialised assets if they focus on certain niche areas rather than target too many areas at the same time. TMC is a good example of a healthcare firm which developed a strong niche in Obstetrics and Gynaecology.

Similar to specialised assets above, reputation is built up over time, and it is also easier for the manager to focus on one or a few niche area(s) which it can develop a reputation for, if resources are limited. Once a reputation is established, managers should be mindful of the importance to carefully manage the brand and continuously strengthen it.

Unlike the specialised assets and reputation, quality assurance, such as an accreditation by the JCI, can be acquired fairly quickly, say, within two years, provided the firm has all along maintained a relatively good standard of clinical systems and processes. While a JCI accreditation would not have the same level of attractiveness as specialised assets or a strong reputation, it is a useful endorsement which helps to convey a certain level of standard and quality assurance to potential partners and patients who may not be familiar with the hospital. Hence, this is something the managers can leverage on for a start as they work on developing other strategic assets.

On international business experience, this is an asset that will accumulate in the firm as it internationalises. To gain international business experience, the firm must start internationalising. This may sound obvious, but it is an important point to remember for the managers, as there are firms where the management was fearful of internationalising because it did not have existing experience, and the firm ended up missing out on opportunities. The managers can start accumulating international experience by starting with small steps, such as participating in overseas trade shows facilitated by the home government, followed by entering a market with lower psychic distance from the home country via a representative office. As experience accumulates, and the management and the organisation get more comfortable with internationalisation, higher commitment modes and more distant markets can be considered. However, if the firm wishes to cut short the learning curve, international business experience can be “acquired” by hiring a
senior executive with extensive international experience to lead the effort, or by acquiring a local (home) firm with such experience.

9.3.2.4 Understanding the Nature of Product

On nature of the product, the factors highlighted by the conceptual model were inseparability, extent of commodification, and capital intensity.

Inseparability of healthcare services is a given, so until the day when healthcare services become separable, healthcare service cannot be exported like goods or hard services. Fortunately, as highlighted in the study, commodification of services have made it possible for even soft services like healthcare to enter markets with low cost low risk modes like representative offices, which allow the firms to attract patients to use their services at the home base, while learning more about the market and exploring networks which it can later leverage on.

In attempting to use representative offices for attracting foreign patients, it is important for managers to consider how they can package their firm’s services so that it is easier for the representative office to “sell” them. With the increasing commodification of healthcare services, it is not uncommon to see hospitals selling packages for their services ranging from simple colonoscopy procedure to complex procedures like open-heart surgery and neurosurgery. If the firm does not have packages which can be easily compared with the other hospitals’, it may be more difficult for the foreign patient to “buy” the firm’s “product”, unless the firm has other strategic assets which differentiate itself, such as a renowned specialist in a particular field or a strong reputation for a particular specialty.

The high capital intensity of the hospital business is also a given, which managers of firms with resource constraints will have to consider entering the foreign market with lower commitment modes like representative office, medical centres or management contract.
9.3.2.5 Strategic Considerations

On strategic considerations, the conceptual model highlighted motives for expansion, business strategy, degree of control and owner’s preferences as factors for consideration in making internationalisation choices. These are usually strategic decisions taken at the Board or owner’s level, hence generally beyond the control of the managers. However, given that they have significant influence on the internationalisation choices of the firm, it is important for the managers to get clarity from the decision body of the firm on these issues, and to ensure that the managers are then given full backing to execute those strategies. Otherwise, a lot of efforts may be wasted if the managers spent time sourcing for opportunities, only to be rejected by a conservative decision body when the time comes for the investment decision to be made.

Specifically on the issue of control, the conceptual model has highlighted that control can be achieved without equity stake through management contract. It is therefore important for the managers to ensure that the management contract is negotiated properly. For the relationship to be a long-term one, the arrangement should be a win-win one. For example, the partner in the host country may be interested in financial returns, so the contract should provide for them to be able to get a good return if the venture does well. As for the firm making the market entry, they may desire full control to refer more complex cases back to their home base, a decent management fee, and possibly an option to purchase a certain equity stake at par value, which will align their interests with the host partner in terms of ensuring long term growth of the venture.

9.3.2.6 Leveraging on Regional Integration

The impact of regional integration on internationalisation of healthcare firms from Singapore was discussed extensively in the thesis, including being included in the conceptual model as a factor that affects the “host country factors” and “strategic considerations”. Given that the ASEAN region will become more integrated as 2015 approaches (the deadline for formation of the AEC), this is a factor that managers of healthcare firms will have to watch closely. In particular, as the region integrates further, managers should more actively look for opportunities to internationalise to capitalise on the lowering of barriers for cross-border investments and operations. Where resources permit, they should also guide the firm to develop a regional service
network as discussed in section 8.5, by developing sub-regional hubs and local spoke-hospitals overseas to secure the referral channels for their hub while expanding their coverage in the region.

9.3.2.7 Phases of Internationalisation Process

A new perspective which emerged from this study is the phases of internationalisation process. Given that there are different strategies and internationalisation choices to be adopted by the firm for different phases, it is important for managers to recognize the phase that the firm is in and take the necessary measures to capitalize on the opportunities while avoiding the pitfalls. It also points to the need for managers of emerging/second wave MNEs to relook at their strategies as their firms enter different phases of their internationalisation process, rather than automatically “follow-the-herd” in the industry, for example, because of financial market pressures.

9.3.2.8 Applicability of the Managerial Implications in other Contexts

It can be argued that there is significant scope for the findings in this paper to be applied to other services, hence, the implications may go beyond managers of healthcare firms but other service firms as well. As many of the findings in this study draw from the characteristics of the case firms as second wave MNEs, some of the findings should be relevant for managers of emerging/second wave MNEs from other countries as well. As regional integration levels the playing field for all firms within the region, the findings should be of interest to managers in other countries within the region so that they can strategise accordingly to position themselves for the opportunities and threats arising from regional integration. This last point can also be applied to firms in other regions which are undergoing similar economic integration process as ASEAN.

9.3.3 For Business Owners and Investors

For hospital business owners and investors who are looking at expanding their business or entering the healthcare industry respectively, the findings from this research will be useful for them to evaluate the internationalisation strategy adopted by their firms or the target firms, as well as assess the opportunities that are open to the firm. The phases of internationalisation process discussed in this thesis also offered another perspective
which they should consider in evaluating the firm, as this will have implications for the choices the firm will have to take with respect to internationalisation in the short to medium term, which in turn have implications for the investment needed in the firm.

With an understanding of the internationalisation strategy of the firm and phase of international process the firm is in, an investor will be better able to make a considered decision whether to invest in or buy the firm. An investor will have to consider whether the profile of the target firm is aligned with his investment objectives, for example, is he targeting growth or a steady flow of income? An investor will also have to decide whether he or she has the resources to back the firm to embark on the optimum strategy it should be taking at that particular point and moving forward.

9.3.4 For Policymakers

For policymakers, the main implication arising from this research is to understand the different groups of factors influencing the internationalisation strategies of firms, and to understand better the potential industry specific differences in how companies internationalise. For example, service firms are often very different from manufacturing firms with regards to their optimal internationalisation patterns.

Further, for policymakers, both at the national and regional level, it is important to acknowledge the important roles of government and political strategies in the process of internationalisation of firms, so that they can take the necessary measures to develop the industries in line with their policy objectives. This is especially so for firms from SMOPECs, which government tends to play an even greater role in supporting firms’ internationalisation. Therefore, the findings from this study bear significant implications for policymakers.

The policymakers will have to decide if healthcare services will be one of the key sources of growth for the nation. If so, they will have to find ways to facilitate the growth of the sector and the firms, including their internationalisation. In Singapore, the government has decided that internationalisation of the healthcare firms is important, not just as a source of foreign exchange but more importantly, as a way to create economies of scale to sustain the more specialized medical services which Singapore has developed over the years. Nevertheless, as the region integrates, and as discussed in
the impacts of regional integration, the government will have to consider should it continue to focus on supporting the firms in terms of attracting foreign patients to Singapore, or to be more proactive in supporting the firms in expanding their hub and spoke network overseas so as to secure the channels of foreign patients. The government also has a key role in making resources available for their home-grown firms to grow, such as land for facility expansion and high quality healthcare manpower to staff the services.

The new perspective on phases of internationalisation process will have implication to the policymakers, as they need to recognise that the assistance and facilitation needed by firms may vary at the different phases. For example, in the learning phase, the focus should be on getting access to learning opportunities for the firms, so government agencies can play the role of linking up with opportunities overseas, as well as offering more support in branding the local healthcare services overseas and in attracting foreign patients (for learning through inward internationalisation). In the opportunistic phase, the focus will be to support the firms in growing their facilities at the hub, both in terms of capacity and capabilities, as well as in expanding their network overseas. Government can even look at co-investing in some of these projects via government-linked firms, given that the healthcare firms may lack resources to internationalise as quickly as they should to capitalise on their transient advantages. The challenge, therefore, is for policymakers to find the appropriate policies to help the firms in the different phases of their internationalisation process.

As discussed in the thesis, regional integration has significant impact on the internationalisation of firms, and this is an area which the government has a significant influence over. Recognising the benefits of regional integration for a small country like Singapore, the Singapore Government has been active in pushing greater liberalisation of service trade in the region, including healthcare. While this is certainly beneficial for Singapore and Singapore firms, it is also in the interest of other countries as regional integration will enable the optimum utilization of resources among all the countries within the region. As argued in the thesis, if the development of the regional service network by the healthcare firms is facilitated across the region, it should lead to better healthcare services for the region as a whole. The developing country can worry less about losing patients to the hub countries, while the hubs will gain in the longer run by focusing on higher value-added complex procedures which it has the competitive
advantage. Each government will have to decide what are the best policies they should adopt, bearing in mind their own country’s respective strengths and weaknesses, or CSAs, using Rugman’s terminology. The policymakers at the ASEAN level can consider the findings from this study and evaluate their policy options to develop the sector in the most advantageous way, for the region as a whole.

While the context of the study is healthcare, many of the findings can be suitably applied to other services as well, hence their usefulness to policymakers may be extended to internationalisation of firms from other service sectors. They should also be useful sources of reference for policymakers of other SMOPECs as well as from other countries in the region.

9.4 LIMITATIONS

There are a few limitations in this research. Firstly, the changes and development of environmental, market and other conditions in ASEAN are continuing, and the regional integration that was discussed in the paper is progressing as the paper is written. This study has attempted to be as updated as possible, with most of the information cutting off in year 2010, but some of the findings will still get outdated over time. In taking reference from the findings in this research, care needs to be taken in accounting for the prevailing situation at that time.

Secondly, as explained in the research design, this research uses a case study methodology. A total of four firms are selected for the study, and these represented all the hospital groups in Singapore which fit the profile for this research. As an exploratory study, the research had provided useful insights into the issues that are being investigated, but given the methodology, it will not be possible to generalise the findings in the conventional sense, say, as theories for application to the services industry in general.

Thirdly, due to special circumstances of the author highlighted in section 5.4.5, this study relied on published information and materials for analysis. While the thesis has produced some useful findings and original contributions to knowledge through the use of an extensive range of data and through leveraging on the author’s strong industry background for analysis, there are some limitations.
One limitation is the potential difficulty in explaining all the observed internationalisation behaviours completely, due to unavailability of certain information. This is especially so where “bad news” are concerned, such as failed market entries, as the companies have a tendency to announce only good news or being vague on the reasons for failures. Nevertheless, as can be seen from the case studies, such instances are minimal, with most of the observations adequately explained, through a combination of both primary and secondary data. In any case, it is unclear if the company would have shared the “real” reasons for “bad news” in details with outsiders, given the sensitivity of such disclosures, especially where it might affect the market’s confidence on the company and in turn, its share price.

Another limitation of using published data is that the data may be outdated and hence, may not reflect the latest situation. There is also a possibility that the data available may be general and vague and may not be helpful in explaining certain observed behaviours. Fortunately, this research was largely unaffected by these limitations as the case firms are all publicly listed firms in Singapore with relatively high public profiles, hence, most information are up-to-date and large amount of information is available to people who are familiar with the industry and know where to find the information.

Fourth, it must be recognized that the findings emerging out of the qualitative analysis are not free from the researcher’s own interpretations when collecting data, and when attempting to summarize, analyze and reconstruct the data. This is a limitation implicit in all qualitative analysis. It must be recognized that qualitative analysis is, at least in part, the result of the researcher’s reflection and sense-making. To minimize bias and enhance reliability of the analysis, as expressed in the methodology chapter, the process of qualitative data analysis was carefully conducted. Emerging categories were repeatedly cross-checked with the data, and alternative explanations were built which were in turn critically evaluated.

Fifth, while the findings discussed provided useful insights on the internationalising behaviour of healthcare firms, caution should be exercised in applying the findings to similar firms in other countries and regions, given the differences in terms of culture, practices, stage of economic development and other aspects.
It also needs to be noted as well that this study did not include the analysis of financial performance in its framework. Some observations were made about the level of success of different international ventures of the case firms, but these were mostly based on statements by the companies and their key executives, or reports by the media and financial analysts. This is because the objective of this study was to illustrate the patterns of different internationalisation strategies and the factors influencing these strategies. While it will be useful to study the financial performance of the various internationalisation ventures for identifying optimal strategies in the long-run, this was not pursued in this study, partly due to the scope of the study and partly due to the expected difficulties in getting detailed financial performance information on the individual ventures from the case firms. This can possibly be studied further in future researches.

### 9.5 Future Research Directions

Several additional avenues of future research are opened up by this research.

Firstly, future research studies may use a similar framework to investigate the internationalisation behaviour of other service sectors from Singapore, beyond healthcare. This will provide a chance to gain a more in-depth understanding of the similarities and differences in internationalisation strategies for the different types of services, tied to the service characteristics and the extent to which the service has evolved over time, like the way healthcare has become more commodified.

Secondly, the framework can be used to study the internationalisation strategies of healthcare firms from other countries in the region. This will allow testing of the various findings and propositions relating to the internationalisation in a region undergoing economic integration, as well as contrast the strategies adopted by firms from larger countries versus those from a SMOPEC.

Thirdly, a future research study may also extend this study to healthcare or other service firms from other SMOPECs in other regions which are undergoing increasing integration, to further test the findings arising from this study.
It is evident that globalisation of the healthcare industry is still ongoing. Interesting questions remain with regard to healthcare firms’ internationalisation in the future – what will be the most effective strategies and business models to adopt for such firms in their internationalisation, and more specifically, for firms within a region undergoing rapid integration like ASEAN? A model had been proposed in this paper on how the internationalisation for healthcare firms, and more generally, service firms, may pan out within ASEAN moving forward. This is an area that merits more research, and the proposed “regional service network” model can be subject to further study, both for healthcare and other relevant service industries. Over time, it will also be interesting to investigate how the situation changes when the industry matures further and the healthcare development gaps among the regional countries become closer than at present. For example, will the expected further consolidation among the regional healthcare firms take place? And what new strategies will firms from a SMOPEC like Singapore adopt to stay competitive in the new landscape? These are all potential areas for future research.

As mentioned in the previous section, future research can also consider a performance factor in the analysis of the internationalisation of a firm, if the challenges in terms of data availability can be overcome. Such a research will be very relevant from a strategic point of view; that is, what will be the most feasible alternative internationalisation strategies with regards to financial performance for a healthcare MNE from a certain country, or more generally, a healthcare MNE.
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